Gender Differences in Experiences with and Adjustments to Infertility: The Case of Infertility Patients at Family Guidance Association of Ethiopia

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Abstract

While the experiences of infertile women to infertility have been well studied in African countries, the gendered differences in experiences with infertility and how men and women respond to infertility in societies with strong social expectations of becoming a parent is understudied. This article discusses how women's and men's experiences with infertility is molded by the prevailing structure of gendered behaviours, roles and expectations and how they process, make sense of, and negotiate their identities in relation to 'failing' upon a highly expected dimension of life, namely parenthood. To address this dearth, phenomenological research design and a combination of methods, such as in-depth interviews, key informant interviews, review of secondary literature, and case histories, were used. The study was conducted at Family Guidance Association of Ethiopia model clinic in Addis Ababa. The study reveals that infertility challenges self-perceived gender identity of women and men. However, at the social level, women's gender identity is more strongly challenged than men's. Further, there are tremendous and gendered variations in the types of stigma and psychological distresses experienced and coping mechanisms adopted. In general, women carry the greatest burden of infertility within the existing gender structure, and social sufferings resulting from infertility have not produced new alternatives to masculine and feminine identities.

Keywords: Infertility, gender, social suffering, copping strategy

1. Introduction

Infertility is defined as ''the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or therapeutic donor insemination'' (American Society of Reproductive Medicine 2013: 63). Infertility is further classified as primary infertility and secondary infertility. Primary infertility refers to the inability of couples to conceive a first child while secondary infertility refers to the inability to

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conceive after a first child (WHO 1987). More than 70 million couples suffer from infertility around the globe (Boivin *et al.* 2007). Prevalence rates of infertility vary considerably from country to country due to environmental, cultural and socioeconomic factors. In the worst affected areas, over 25% of couples may be unable to have children (Ombelet *et al*. 2008). Women and men have equal probability of being infertile and each is responsible for 20–30% of infertility and the rest is attributable to a combination of both male and female factors and unexplained reasons (American Society of Reproductive Medicine 2013).

Infertility is a social construct, and the experience of those affected by infertility is shaped by political, social, cultural and economic contexts. Social construction of gender and the gender role expectations of women and men and the greater value ascribed to children are central in shaping the experiences of infertile women and men in Africa (Kimani and Oleja 2001). Cultural meaning of full adult womanhood and manhood is defined by marriage and children in many African countries. Men's social identity is that of becoming head and protector of their families while women's identity is mainly derived from wifehood and motherhood. Masculine identity is associated with power and status while feminine roles are associated with solidarity and closeness.

Reproduction is regarded as the most important function of families in Africa, and marriage without children is regarded as incomplete and insecure. Children are a means of acquiring social status, wealth, and prestige in many African communities, and they are vital to continue the family name and lineage, inherit family land and wealth, and create a sense of continuity and purpose in life (Dyer 2007). Because of the high values ascribed to children, voluntary childlessness remains an unacceptable condition within marriage in Africa (Inhorn and Van Balen 2002). On the contrary, in European countries that have negative population growth, voluntary childlessness is becoming a trend and child bearing is considered as a choice. Nevertheless, for those who remain childless due to involuntary infertility, infertility remains to be an issue (Bentley and Mascie-Taylor 2000).

Much of the literature on infertility in Africa has ignored the gendered aspects of infertility and focuses more on experiences of infertile women. This serves to reproduce the idea that infertility is a woman responsibility (Lloyd 1996:16). The available literature on the experiences of infertile women shows that being childless has more negative social, cultural, and emotional consequences for women than, perhaps, any other non-life-threatening conditions (Kimani and Oleja 2001). Women are blamed for infertility by their society and carry the burden of infertility. Infertile women are often stigmatized, ostracized, feared and pitted, and subjected to domestic violence, shame, and public humiliation (Gerrits 1997; Kimani and Oleja 2001). In addition, infertile women experience psychological pain in form of surprise, denial, isolation, anger, guilt grief, stress and depression (Whiteford and Gonzalez 1995). A few of the research done in Africa, that addressed the gender differences in experience with infertility, reported that infertile women had more negative experiences with infertility than men had, and infertility compromised the gender identity, self-esteem, and psychological health of women more than of men (Fatoye *et al.* 2008; Inhorn 2003; Mabasa 2002).

The available literature on infertility in Ethiopia is scant when compared to research done in Africa. Most of the studies on infertility in Ethiopia are quantitative in nature and focus on the prevalence of infertility across different provinces (Mamo and Morgan 1986), perceived causes and experiences of infertility (Deribe *et al.* 2007) and socio-demographic characteristics of infertile women who failed to complete fertility treatment (Tadesse 2000). Qualitative studies that address women's experiences of infertility in the Ethiopian context focused on the main causes of infertility (Mekdes 2008) and the implication of socio-cultural perceptions of infertility on the lives of childless women (Fikir 2011). To date, no study has been conducted on the gender differences in the experiences with and adjustments to infertility in Ethiopia. This study aims to fill this gap in the literature.

2. The Social Suffering Approach

The concept of social suffering is used, in the present study, as a point of departure to understand the gendered experiences with and adjustments to infertility and to explore whether individual sufferer's experience shapes gender norms and vice versa.

Social suffering is not only about physical pain, but it involves social, embodied and psychological experiences. Social suffering refers to "what political, economic, and institutional power does to people and, reciprocally, how these forms of power themselves influence response to social problems" (Kleinman *et al.* 1997). A social suffering approach emphasizes that individual experiences of suffering cannot be analysed in separation from the collective, economic, political and social structures. This understanding is useful to illustrate the link between individual experiences and gendered norms and expectations. One way social suffering is manifested, in context of infertility, is through stigma. Stigma is, thus, defined as "an attribute that is deeply discrediting" (Goffman 1963: 3) that makes a person culturally unacceptable in their local context. Stigma is further classified as enacted stigma, which refers to "intentional discriminatory attitudes and behaviours of 'normal' people towards the 'stigmatized', and felt stigma, that refers to "the shame felt by the stigmatized because of their internalization of the stigma or because of their deviation to live up to the accepted standards of the society" (Scambler, 1984: 215).

Suffering is also understood as a struggle to create positive meaning and purpose in life (Adahl 2007) by drawing on a number of resources, including reasons, explanation and medicine (Whyte 1997). Suffering can also be dealt with using emotion-focused, problem-focused, and meaning-based approaches (Schmidt *et al.* 2005). These understandings are useful to highlight how women and men negotiate their identities and everyday sufferings arising from infertility.

3. Methods

The study was conducted at a model clinic of Family Guidance Association of Ethiopia (FGAE) in Addis Ababa, which is located behind Tikur Anbessa High School. Family Guidance Association of Ethiopia is an indigenous, non-profit, volunteer-based association and was established in 1966. The clinic provides comprehensive reproductive and sexual services, such as pre-cancer examinations and treatments, family planning, safe abortion care, diagnosis and treatment for sexually transmitted diseases and infertility. Infertility diagnostic treatment services, provided by the clinic, include urinalysis, stool exam, pregnancy test, bacteriology, blood group and other related tests. The clinic refers patients to other fertility clinics for semen analysis and other tests. The clinic does not provide advanced medical treatment, such as *in Vitro* Fertilization (IVF) and intracytoplasmic sperm injection (ICSI).

In order to explore the experiences of individual infertile women and men, phenomenological research design is employed. The study looks at the phenomenon of infertility from individual point of view of infertile women and men, including their perceptions, feelings and responses/reaction to infertility as they experience it. Further, opinions of communities, relatives or in-laws of the affected individuals are explored from the perspectives of individual infertile women and men.

A combination of methods, such as in-depth interviews, key informant interviews, review of secondary literature, and case histories, were used to understand the meaning research participants place on infertility. In-depth interviews were conducted with 15 women and 11 men to build a sufficient dataset to look for emerging themes. In order to validate the findings and exemplify unique stories, four case histories were constructed. Further, key informant interviews with four (two men and two women) medical staff of the clinic were conducted to gather general information about the association/the model clinic and to explore the situations of infertile women and men. Focus group discussion was not used due to the very sensitive nature of the topic.

Purposive and snowball sampling techniques were used to select research participants. Research participants were selected purposively based on their

infertility status (the study included only those with primary infertility), their sex, and marital status (the study included only those who are married). Though age was not set as a clear-cut criterion, attempt was made to include younger and older women and men in the study to take into account their diverse experiences and perspectives. Participants who were available during the data collection period and gave their consent to be interviewed were included in the study. Purposive sampling technique was also used to select key informant participants based on the length of year they served at the clinic and the service they provide to infertile women and men or their level of interaction with them. Further, snowball sampling technique was used to access infertile men as it was not easy to find men at the clinic when compared with women and a few of those found at the clinic were not willing to be interviewed. Therefore, in addition to men who were interviewed at the clinic, more men were accessed through infertile men and women who were found at the clinic. The data was collected in Amharic and interviews, which were audio-recorded from the interviewees, were transcribed in English. A primary cycle of coding was conducted by assigning words and brief phrases to the concepts described in the transcripts and then they were analysed thematically.

Infertile women and men said that they came to know about the clinic through their friends, families, community members and the media. All of the research participants had primary infertility, were married and most of them were followers of orthodox religion. Women informants were between the ages of 30 and 45 whereas men informants were between the ages of 35 and 55. All of them had educational level ranging from high school to bachelor degree.

4. Results

4.1. Gender differences in experiences with infertility

4.1.1. Crisis in gender identity

Infertility affects the self-perceived gender identity of both infertile women and men. However, the gender identity of infertile women is severely affected than that of men at social level due to patriarchal construction of

infertility as "women only problem", husbands' shifting of the blame on to their wives and wives taking in the blame.

In Ethiopia, women are closely associated with their body and are defined by their reproductive capacity (pregnancy, birthing and breastfeeding) while men are expected to exhibit high degrees of virility and sexuality. In line with these gender norms, infertile women and men perceive their gender identities on the basis of their reproductive bodily functions and socially constructed notions of gender roles. Accordingly, men who were found to have infertility problem used expressions, such as "unproductiveness" to denote their bodily/sperm dysfunction and "failure" to express their struggle with becoming a father and husband. On the other hand, infertile women use expressions such as "incompleteness" to signify their sense of dysfunction with their bodies and expressions such as "guilt", "unfulfilled" and "worthless" to signify their struggle with becoming a mother and a woman. This perception is commonly shared by women whether or not they are the infertile partner as they attribute the problem to themselves.

> I really felt very bad when I visited women who had given birth. I felt guilty as if something was missing from my life and as if I was incomplete. I felt "unfulfilled" and "worthless" as a woman. The doctor told me that I had ovulatory dysfunction. I asked myself whether I was a woman or not, whether something was incomplete in my body or not. I did not feel attractive and lost interest in sex. (36-year-old infertile woman; interview date 07/07/2015).

> It was very hard for me to accept that I was infertile as I never assumed that the infertility was with me. I had severe sperm count and motility problems and sexual dysfunction. I felt like a "failure" because I did not have the capacity to have my own children and was not able to impregnate my wife. I struggled with a question as to why my sperm was unproductive. I was also hurting my wife by not giving her children. (44-year-old infertile man; interview date 11/07/2015).

Infertility strongly challenges the gender identity of women than men at social level. This is because of patriarchal construction of infertility as "women only problem", women's internalization of this construction and men's shifting of the blame onto their wives through silence. Infertile women feel responsible for the couple's infertility even when the problem lay with their husbands and take the blame by keeping their husbands' infertility secret through silence. It is only when the pressure from their

husbands' family is stronger that they will be forced to disclose their husband's infertility. Infertile men, on the other hand, do not share their fertility problem with their families, which inevitably shifts the blame on to their wives.

> In our society, infertility is perceived as if it was only women's problem. But we know from our experience that it is also men's problem. However, when it happens, it is women who are labelled as infertile. (medical staff; interview date 08/07/2015).

> I told my natal families that the problem laid with me though the doctors informed us that the problem was with my husband's sperm. I did not want him to feel bad about himself. (39-year-old infertile woman; interview date 07/07/2015).

> My wife thought the problem was with her even though I told her that the problem laid with me as the medical result proved it. Whenever I told her that I was the reason why we did not have children, she thought that I was just trying to comfort her. My family also blamed her for our infertility as they did not know the problem was with me. I told my family not to interfere in our marriage, but did not tell them about my infertility problem. (43–year-old infertile man; interview date 09/07/2015).

4.1.2. Experiences of "Enacted" stigma

The deviation from gendered norms, not only causes crises in gender identities, but also produces social stigma and social pressure on women and men affected with infertility. Both women and men are subjected to social stigma in community, family and friendship contexts. However, there is remarkable gendered variation in experiences with "felt" stigma; infertile women are more prone to internalizing the stigma directed at them than men are. That difference is due to societal stronger negative reactions towards infertile women and women's frequent social encounter with communities/neighbours.

4.1.2.1. Community level

In community settings, women experience greater verbal and non-verbal stigma than men do due to their deviation from norms of womanhood and societal construction of them as the "other". The stigma is frequently experienced by women due to their living arrangement pattern and frequent social encounters with communities. As a result, infertile women experience verbal stigma that signifies their "otherness", "deviant" and "outcast"

positions in society. For example, they are insulted as "mule", "barren" and "cursed" when conflicts and disagreements occur between them and their neighbours. They are subjected to intrusive comments and questions; they are discouraged to work hard (due to questions like 'whom do you toil for?') and are instead urged to comment about raising children in their everyday social encounters. Further, they are considered to have an "evil eye" that causes sickness on children and, thus, children are kept out of their sight. Their "deviant" position in society is further reaffirmed through non-verbal stigma, such as unusual stares and expressions of pity. On the contrary, infertile men are rarely subjected to verbal stigma from their neighbours and communities due to their infrequent contact with them as their activities and social lives are located outside of the house. They are not also strongly identified by their infertility status in society unlike that of women. In rare social occasions, they are accused of "eating alone" and "lacking strength", insulted as "barren" and are not encouraged to acquire resources such as land by their neighbours.

> I and my husband tried to have a child for four years, but with no result. I spent most of my time at home, as I had no job. We lived in the same compound together with a few of our neighbours. The stigma from my neighbours and pain resulting from it was much stronger than the pain resulting from not being able to have had a child. I was given names and insulted as "mule". Our neighbours perceived that I had an "evil eye" and hid their children from me and blamed me for their sickness. They asked me, constantly, why I have not had children. When I told them the truth or shared my worries and concerns with them, they made my infertility a topic of discussion during coffee ceremonies and other social events. They also talked about other infertile women in my presence and labelled them as "barren". This made me feel that they were talking about me. (33-year- old infertile woman; interview date 8/10/2018).

> I was a teacher in an elementary school. I and my wife had been trying for a child for ten years, but with no result. I had sperm motility problem and my wife also had other medical problems. Female members of our community did not show hostility against me. But I had problem with male neighbours on issues related to land. When there was disagreement between me and my neighbour on land issues, they said I did not have to bother about having or maintaining my land since I did not have a child. When the conflict escalated, they even insulted me saying "barren" and accused me of "eating alone" and of lacking "strength". (43-year -old infertile man; interview date 08/10/2018).

4.1.2.2. Family level

Women further carry greater burden of stigma in family setting, as they are assumed to be the source of infertility and, thus, are blamed for it. Stronger stigma is directed at women mainly from their husbands' families, whose dissatisfaction with their son's childlessness and their inability to continue their family line/name is projected onto wives in forms of stigma, ranging from intrusive comments/questions to rejection. Wives who live in proximity to their husbands' families and who have frequent contacts with them are exposed to more stigma than those whose husband's families live in rural or far places. Relatives of the wife perpetuate stigma with their intrusive comments and questions and may further extend the stigma to the women's mothers by labelling them as "cursed". Men are confronted with strong pressure from their natal families to explain the infertility and/or to seek divorce or other alternatives to get a child. Infertile men experience pressure from their wives' families indirectly through their wives.

> When I and my husband went to visit his mother and sisters, they paid no attention to me and ignored me as if I was not there. This made me feel like a stranger, less important and unwanted and I decided to never go to their house. (40-year-old infertile woman; interview date 09/07/2015).

> Whenever disagreement arose between my mother and her relatives, they insulted her saying that she had received her punishment through her daughter and labelled her as "cursed". It hurt my mother a lot. They also frequently asked me why I still did not have children though many years had passed without me having children. (42-year-old infertile woman; interview date 11/07/2015).

> My family frequently asked me to explain why my wife did not get pregnant and wondered why I kept quiet and did not take action. For them children were more important than marriage and, thus, put pressure on me to try another marriage. I also felt the pressure coming from my wives' family as my wife continuously talked about how her mother was deeply saddened by our childlessness. (42-year-old infertile man: interview date 06/07/2015).

> The main reason patients come to the clinic is to avoid the social impact of infertility as it is the most challenging aspect of living with infertility. Husband in-laws push their sons to divorce and try another marriage, or mistreat their wives so that they may seek for divorce. (medical staff; interview date 08/07/2015).

4.1.2.3. Friends

Both infertile women and men are stigmatized by their friends, though there are differences in the types of stigma they experience. Both women and men experience stigma in forms of intrusive questions and comments from their friends. Infertile men commonly experience minor mocking/taunting from their friends. Whereas women are stereotyped as "less mature and experienced" by their fertile friends, which imply power relationship between fertile and infertile women.

> When I encountered my old friends accidentally, they told me about their children, and asked why I had not had children and what went wrong. My close friends mocked me saying I was getting older without having children. I tried to change the topic to divert their attention from my infertility. (44-year old infertile man; interview date 19/05//2017).

> My friends questioned me why I had not had children and tried to tell me that they were older and mature than me, although they were younger than me, because they had children. That hurt me a lot. (35-year -old infertile woman; interview date 07/07/2015).

4.1.3. Experiences of "felt" stigma

Women do not only experience greater enacted stigma, but that they are also more predisposed to internalizing the stigma than are men, which results in feelings of shame and loss of self-esteem and feelings of "otherness"/invisibility. Infertile women's sense of self is dependent on others, which make them vulnerable to internalizing the stigma directed at them and, thus, resulting in emotional distress. Infertile men, on the other hand, are confident and protect their sense of self by refraining from internalizing the stigma directed at them. Similarly, older women who lived with infertility for many years are confident and ignore the stigma directed at them and associate with those who understand and share their experiences.

> I had confidence in myself even though people talked about me. I did not dwell on the stigma directed at me, as I knew that it could make me weak and vulnerable and affect my work performance. (48-year-old infertile man; interview date 07/07/2015)

> I thought a lot about what people said about me and lost my sleep as a result of it. I took the stigma directed at me to my heart and it made me question myself and awakened my deep pain of infertility and gave me headaches and made me fearful. I saw myself inferior to my juniors who had children and felt

> ashamed to be with them. (35-year-old infertile woman; interview date 8/10/2018)

4.1.4. Psychological suffering

Infertility does not only cause social suffering, as explained above, but also psychological suffering. Both women and men struggle with psychological distresses, which are expressed in terms of losses at not having children, loneliness, lack of meaning, regrets and moral dilemmas linked with the "why me" question.

Both infertile women and men feel losses for not having children, which is specifically expressed as not being able to replace themselves and continue family line and heritage; not being able to be a mother and father and perform gender roles; not being able to pass their properties to children and secure old age. These losses are constantly felt in mundane social encounters and conversations such as when their friends' talk about their children or when they pass by children's stores or when they attend events that celebrate motherhood and children. In addition, both women and men struggle with feelings of loneliness that come as a result of not being able to share the joy and love of raising children; this is particularly felt by women whose activities are confined to the house. The above losses are translated into loss of meaning or emptiness in their lives. While men express their struggle with meaning in terms of lack of motivation for life, women express it by ranking the value of children above everything else in life be it property, education or work. This perception negatively affects self-esteem of women and creates feelings of shame.

> The state of not having children hurt a lot. I was not able to replace myself. I also struggled with feelings of loneliness. If we had our own children, they could have made noises and took our time, thoughts and energy. People felt alive when they saw their children. Having children was more important to me than property, education or work. I felt that my life was meaningless. (35-year-old infertile woman; interview date 8/10/2018).

> I felt the loss of not having children when my friends talked about and played with their children. I also felt lonely in the evening at home, especially when my wife was not in the house. I and my wife had not much to do in the evening, except eating our dinner, listening to radio and sleeping. My wife felt lonelier than me since she spent most of her time at home alone. I lost the

> motivation to work and educate myself further and to build a house. (43-year-old infertile man; interview date 08/10/2018).

Both infertile women and men struggle with "why me" questions, which cause them to question their past "moral" and "immoral" life in relation to their infertility. Furthermore, fairness of God or life, in general, is questioned, in relation to the basis on which many get children easily while a few others struggle. This unanswered question causes stress, anxiety and deep regrets in women and men and makes them doubt themselves.

> I cannot understand why God denied me something I wanted more than anything in life. I have led a life according to His will, for instance, I did not engage in sexual activity before marriage, while my friends got pregnant when they were teenagers. I wondered if I should have done the same. My encounter with beggars with children surrounding the church made me question why I could not have children while those who could not care for their children seemed to have it easy. These caused distress and made me to be anxious. (40-year-old infertile woman; interview date 09/07/2015).

> I blamed myself for aborting my unborn child when I was very young. Then, I spent my young age supporting my family without securing marriage. By the time I wanted to have children, it was too late. I deeply regret the choices I made. (44-year-old infertile woman; interview date 09/07/2015).

> I thought that there was something missing in me in the eyes of God and that was the reason God did not give me a child. I needed to fulfil what He required to get a child (49-year- old infertile man; interview date 20/05//2017).

4.1.5. Strain on couples' relationship

Infertility causes tensions on couples' relationship due to fear, insecurities and negative emotions that arise from lack of bonding factor (children) in marriage. However, the tensions are expressed differently by wives and husbands. Wives suffer from insecurities in their relationships/bonds as they fear that husbands' may abandon them for another woman or that they may try to have a child in secret. This fear of divorce is rooted in the prevailing patriarchal structure that, implicitly, privileges men in childlessness marriage to use divorce as a vehicle to end childless marriage and remarry. Women are expected to be tolerant to childless marriage because their option for remarriage is limited due to stigma surrounding childless women and also because older women are less desired for marriage. In contrast, husbands are not that concerned that their wives would leave them even when the problem lies with them. Rather, they suffer from their wives'

emotional reaction to the infertility. Husbands emphasize that their wives' continuous need to share their worries and concerns exacerbate the existing stress and pain resulting from the infertility itself. In general, the above tensions and general dissatisfaction, arising from absence of children in marriage, affect the tolerance and trust level of the relationship.

> When I knew that the problem was with me, I wondered if my husband would leave me. I heard that many marriages failed because of infertility. I told to myself that I did not have to worry about all these things which were beyond my control. (30-year- old infertile woman; interview date 14/07/2015).
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> The infertility problem lied with me. My wife had accepted that we could live without children. I had less worry that she would leave me because she was a decent one. It was love and the fear of God that sustained our marriage. (40-year-old infertile man; interview date 13/07/2015).
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> My wife constantly nagged me asking why she did not get pregnant, which I found to be very offensive. Whenever I allowed her to talk, she said that she wanted to die. I was not sure if I could handle it anymore, and this affected me more than the infertility. (41-year-old infertile man; interview date 19/05/2017).

4.2. Coping strategy

4.2.1. Coping with social stigma

Gender difference is not only observed in experience with infertility, but also in adjustment to infertility. Women and men cope with social stigma differently in accordance with socially constructed gendered behaviours. Infertile women cope with stigma through avoiding social occasions and encounters that remind them of their infertility; hiding information about their infertility and pretending that they have no problem. These strategies are used to avoid negative feelings that come as a result of the encounters or questions. On the other hand, infertile men cope through ignoring people's comments and reasoning against societal discrimination against infertile people. Both women and men give false information to pass as "normal" when they are questioned about their infertility by those who do not have close relationship with them. However, the strategies that women and men use are subject to change depending upon the number of years they have lived with infertility. For instance, older women who have lived with infertility for many years cope with stigma by defining their lives in their own terms and increasing their confidence.

> I just gave my neighbours false information since I had no other best reason to satisfy their questions. Sometimes, I said I was using contraceptives and, other times, I said that I wanted to spend time with my husband before having children or we did not have the economic capability to raise children. (34-year-old infertile woman; interview date 14/07/2015).
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> My neighbour said that they felt sorry for me. I smiled and went home. I tried to pretend as if I had no problem because I understood that stress might cause further problems (30-year-old infertile woman; interview date 10/07/2015).
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> If I saw someone who always asked me why I didn't have children, I changed my direction to avoid seeing that person and not to face the same question. I also tried to avoid pregnant women. (36-year-old infertile woman; interview date10/07/2015).
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> I ignored people's comments because I did not want to carry the burden with me, and I needed to free my mind. I used to internalize people's comments and questions as to why this and that person said that, which made me lose my sleep and get depressed and became dysfunctional in my marriage and work. Thus, I decided to ignore people's comments. Infertility was given to me. It was my matter, not a societal matter. I did not accept the low status and values ascribed to infertile people. I considered such kind of discrimination against infertile people as evil, and I tried to be myself and live my life. (42-year-old infertile man; interview date 21/05//2017).
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> It was my community who told me that life was meaningless without children, not me. I lived in my own world and did not compare my life with others. The fact that I was educated gave me confidence, and I had decided that I cannot live with misery for the rest of my life. (45-year-old infertile woman; 8/11/2018).

4.2.2. Dealing with stressful emotions

The way women and men deal with the stress of infertility differs and is largely shaped by constructed gendered behaviours that construct women as emotional and men as rational. Accordingly, infertile women deal with stressful emotions arising from infertility through sharing their experience with people whom they trust, including their husbands, infertile friends and family members. Further, the clinic has provided them with opportunity for bonding with infertile women with similar experiences. On the contrary, infertile men prefer to keep silent about the problem since they do not believe that the problem could be solved through recurrent talk about the problem. These differences create tensions in marriages as men consider their wives' need for sharing the problem with them, as an emotional burden; and when their wives share the couple's infertility with others, as a

violation of their marriages' privacy. Further, while women rely on task oriented and self-stabilization strategies to distract themselves from stress of infertility, men focus on relaxing strategies including use of alcohol. However, both infertile women and men emphasize the importance of spousal support in terms of love and respect to cope with the stress of infertility.

> I communicated with God about my problem. I compressed my feelings inside as much as I can. But sharing my pain with my friends, who struggled with infertility, helped me to feel good about myself (36-year-old infertile woman; interview date 09/07//2015).
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> I did not raise the issue as a problem most of the time unless it was necessary. However, my wife wanted to talk about her worries related to her menstrual cycle and our failed medical treatments to get relief from her worries and anxieties. But I preferred to keep silent because talking about the problem could make things worse. (40-year-old infertile man; interview date 26/08//2015)
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> I read spiritual book that helped me to lead my life properly. I also got busy with my work and household activities to avoid thinking about my infertility. (36-year-old infertile woman; interview date 09/07//2015).
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> I watched football games, did gardening and drank alcohol to relax myself. My wife, on the other hand, cooked food that involved a long process and slept too much. I also visited my relatives who lived in rural area. (49-year-old infertile man; interview date 15/08//2015).

4.2.3. Infertility treatment

Women are mainly responsible for seeking care for infertility when compared with men. This difference is in accordance with constructed gender roles in which health seeking is assigned to women while men are expected to be passive actors in health seeking processes.

Infertile women are quicker to pursue medical, spiritual and traditional treatments as the blame for infertility rests on them and as they also consider it their duty to seek health care. Family and community members and neighbours play role in sharing information about available health care treatments and are also involved in health seeking decision making. Accordingly, women seek different types of treatments such as Holy Water (*tsebel*) at known churches and monasteries and traditional and medical treatments. In rare occasions, they cross their religious boundaries to seek

healings outside of their religion. The available treatments are sought simultaneously or sequentially, depending upon the outcomes of the treatment, the length of scheduling of appointment and the cost and the perceived healing power of the treatments. This pursuit of multiple treatments enables women not only to seek healing, but also to have a sense of control over their situation.

On the contrary, infertile men's participation in seeking care for infertility is minimal as they consider it to be women's duty. However, the participation of men in biomedical treatment is increasing as medical doctors require both married partners to undergo infertility examinations. However, some men refuse to attend biomedical care not to be blamed for the infertility and thus protect their masculine identity.

> I planned to visit Aba-kiros church after we finish our medical follow-up at the infertility clinic. Everybody talked about the healing power of the holy water at the church and my mother and sisters strongly encouraged me to go there. I heard that many people received what they prayed for after they had visited the church. At least, it could help me tell myself that I had tried everything within my power. (30-year-old infertile woman; interview date 14/07//2015).

> I was initially reluctant to pursue medical treatment as I never assumed that I was infertile and I did not want to put myself in a situation where I would be told that I was infertile. But I accepted my infertility problem gradually after my encounters with medical doctors. However, it was my wife and her family who pursued care for our infertility as women are the ones who often seek health care. (51-year-old infertile man; interview date 17/08//2015).

4.2.4. Divorce and separation

The majority of the research participants did not experience divorce or separation since they were in process of trying for a child. However, medical staff of the clinic explained that couples might give-up and get divorced when the medical treatment took long and that divorce was a common experience among those with primary infertility. The continuity of marriage, relative to infertility, depends on strength of married partners' relationship, which involves avoiding blaming one another for infertility and keeping meddling of families' at bay. In addition, it is influenced by couples' openness for discussion and other future alternatives including adoption or fosterage and individual decision to continue or discontinue the

marriage. In rare cases, when divorce becomes imminent, women may allow their husband to have a child outside of their marriage in secret. Those women may do so to avoid moving back to their natal families, to protect themselves from shame and disappointment that comes if their husbands do it without the knowledge of the wife. Other reasons, those infertile women may allow their husband to have a child secretely out of wedlock, may include those wives' desire to maintain their status of being married and the benefits associated with it, such as economic and social security, protection and companionship. However, this strategy was common in earlier times and is rarely practiced nowadays.

> I lost a child while giving birth ten year ago due to negligence of health care providers, and it was not also easy for the baby to come out of my womb. I got pregnant again from my pervious partner, but miscarried it accidently when I fell down. My present husband had been supportive and we had mutual understanding, but I did not conceive from him for six years, due to complications that occurred in my fallopian tube and my age. My husband had three children from pervious relationships, but did not have close contact with them. He repeatedly expressed his strong desire to have a child. I told him to go elsewhere and have a child, but the result may not be good. I allowed him to have a child outside of marriage because I did not want him to do it without my consent and, consequently, did not want to return back to my natal family and lose his companionship. But our sexual life had been disrupted since he had the new baby from another woman. (45-year-old infertile woman; interview date 8/11/2018).

> As to my observation, many patients got divorced due to infertility. I had encountered many clients with broken heart who were even unable to express themselves and who just could not stop weeping. Even if they accepted the problem, the pressure from society could be very challenging and could lead to divorce. (medical staff; interview date 08/07/2015).

> It has been ten years since we married, but with no child. I and my wife discussed openly about our problems, including whether we will commit to our marriage in face of childlessness. We made sure that we were not influenced by our family and took care of each other's needs and did not share our private matters with others. We lived as if we had children because we accepted it and this gave us freedom to live on equal bases with those who had children. (49-year-old infertile man; interview date 17/08//2015).

4.2.5. Alternative futures

The majority of interviewed informants were in the process of seeking care and it was not clearly determined whether they would become a biological

parent or not. Thus, alternative futures such as adoption and fosterage were mainly considered by older women who had had infertility problems for many years. These women consider building a family by raising their relatives' children or adopting children, either with their husbands or without them, in case of divorce. Many of the interviewed women preferred to raise their relative's children than adoption as they feared that adopted children were "unknown" biologically and real sense of motherhood could not be achieved. However, they considered adoption than living alone in order to avoid loneliness and social risks that came as a result of living alone and to play the role of motherhood. Infertile men, on the other hand, considered adopting and raising a child together with their wives or considered remarriage or cohabiting with another woman in case of divorce. However, deciding to adopt was complex as it is influenced by married partners, families and community's attitude towards adoption.

> We were unable to have our own biological children. I wanted us to adopt a child because sharing my life with children was important to me. But my wife's parents opposed the idea because they feared that she would be stigmatized. The surrounding people's negative attitude towards adoption was a constraining factor for us not to adopt. (42-year-old infertile man; interview date 14/08//2015).

> I had seen infertile couples' get divorced only because they were infertile. If, in case, my husband wants to leave me so that he may try another marriage to get children, I want to separate peacefully and raise my sister's children. I took care of my sisters' children when she was very busy, and I accompanied them when they went to attend church services. I did not consider adoption as adopted children are "unknown" and cannot be my own son or daughter. (35-year-old infertile woman; interview date 07/07//2015)

4.2.6. Faith in God

Though faith is a source of struggle as explained in the previous section, it is also a significant resource to give meaning to infertility and to accept it as "God given or will". The majority of the research participants were followers of orthodox religion, and drew upon stories from the bible to make sense of their suffering. For the research participants, faith meant not only believing in God for miracles, but putting their trust in Him through their struggles and accepting His will in their lives even though it might not be in accordance with their dream of having children. This understanding

helped both infertile women and men to accept their infertility and to put the impetus outside of their control or identities.

> I believed children were gift from God. It is only God who can create humans. This is God's work; it is Him who gives or denies children. Although we may try thousands of treatments, it is only God who can give a baby. I believed in this idea. Otherwise, the medical treatment was just to try. (39-year-old infertile man; interview date 13/08//2015).

> I did not want to consider each and every problem. What I told to myself was that God had a reason to do everything. So, I had to be ready to accept what God does. (37-year-old infertile woman; interview date 14/07//2015).

> Science has been changing, and God has always been in process. There were even those who gave birth to children after trying for many years. Sara gave birth in her old age. I expect God's miracle, and will accept His Will in my life. (42-year old infertile man; interview date 14/08//2015).

5. Discussion

5.1. Gendered suffering

This study explored women's and men's experience with and adjustment to infertility from gender perspective. The results shed light on distinct gender differences in experiences with and responses to infertility.

Construction of masculinity is reflective of patriarchy in Ethiopia. Masculinity traits are closely tied to virility and fertility while femininity is constructed around behaviours and characteristics associated with closeness and motherhood. Men and women are socialized to embody these socially constructed gender identities. Deviations from these gender norms threaten self-imagined gender identities. Deep sense of perceived gender role failure is felt by women, whether or not they are the infertile partner, and by men, who are found to have fertility problem. While women perceive themselves as "incomplete" "unfulfilled" and "worthless", infertile men perceive themselves as "failure". Furthermore, at social level, infertility more severely challenges the gender identity of infertile women than of men. That is due to patriarchal construction of infertility as women's problem, husbands' shifting of the blame onto wives through silence and wives' taking on the blame. Similarly, studies in Africa indicate that men's infertility remains hidden in many societies as it is one of the most stigmatizing conditions of all men's health problems, and patriarchy operates to keep men's infertility secret (Inhorn 2004). Infertile women are

considered as "worthless" and may not even be considered as mature/adult women as being pregnant or motherhood is considered as a rite of passage to enter into the stage of mature or adult women (Inhorn 1996; Hollos *et al.* 2009).

Studies on infertility in Africa indicate that infertile women severely suffer from stigma as infertility is perceived as women's problem (Inhorn 1996; Kimani and Olenja 2001; Ombelet *et al.* 2008) and the burden of stigma fall on them whether or not they are the infertile partner (Sciarra 1994; Ying *et al.* 2015). The findings of the present study indicate that stigma, due to infertility, is felt by both infertile men and women. Yet, there is huge and gendered variation in the degree and type of stigma experienced. Both enacted and felt stigma are more common among women than men whether or not women are the infertile partner. Infertile men and women are considered as deviants because of their deviations from gendered norms of masculinity and femininity, respectively, and women are held responsible for acquisition of the stigmatizing condition. While women face stigmatization in forms of blame, devaluation, stereotyping, labelling, exclusion, and rejection, infertile men experience minor mocking and intrusive comments and questions. Infertile women are mainly subjected to stigma from those called "the wise" (close family members whom they are supposed to empathize) including their relatives, mother-in-laws and female members of their husbands' family (Goffman 1963:41). The stigma is not only confined to individual infertile women, but also spread to their natal families, mainly mothers. In terms of labelling, while men are accused of "eating alone" (without sharing food with children) and "lacking strength"; women are insulted as "mule" that symbolizes them with a sterile animal and put their identity as human in question. Further, "felt stigma" (internalization of stigma) is a common experience among infertile women than men as infertile women perceive and define themselves in relation to others.

Women carry the major burden of psychological distress in forms of personal anxiety, frustration, grief, marital duress, divorce and abandonment (Van Balen and Inhorn 2001; Ying *et al.* 2015). The findings of the present study indicate that psychological suffering of infertile women and men is

embedded in the strong value attached to becoming a parent. However, women suffer more psychological distress than men. Both childless women and men struggle with loss of meaning in their lives and live with feelings of loss at not having children and "why me" questions. Women mainly suffer from low-self-esteem, shame and feelings of "otherness"/invisibility. Further, infertile women suffer from uncertainties and insecurities in their marital bonds while infertile men, with either male or female factor infertility, suffer from the way their wives' respond to infertility emotionally. This goes in line with literature that underscore that men suffer more indirectly from infertility through their wives while women suffer more directly from infertility (Greil 1997)

5.2. Gender differences in adjustments to infertility

Although men and women experience suffering within gendered expectations and norms, their coping mechanisms are, however, different. Coping strategies, infertile men and women adopt, can be grouped under emotion-focused, problem-focused, and meaning-based strategies of coping (Schmidt et al. 2005). Literature indicates that infertile women employ escapism strategy on both psychological and psychic levels, social avoidance (Pedro 2015) and self-control (Fiker 2011) to cope with stigmatization depending on social support and positive reappraisals (Abbey 2000). The findings of the present study showed that infertile women coped with social stigma through hiding information and their feelings, avoiding social occasions and encounters while infertile men ignored people's comments and relied on reasoning to reject societal discrimination against infertile individuals.

When confronted with issues of stress, women share their feelings with their partner or others as a means of coping (Keystone and Kaffko 1992) while male partners tend not to talk about infertility with anyone. Men instead use avoidance, minimization, and denial strategies (Tabong and Adongo 2013). However, a study conducted in Northern Ghana revealed that infertile women depended on internal coping strategies (Tabong and Adongo, 2013). The present study revealed that men coped with their internal feelings through silence while women found comfort through sharing their

experience with trusted friends and family members. Further, women used task-oriented approach and self-stabilization strategies while men used relaxation strategies and drinking to avoid stress. The approaches adopted by women and men to manage their stress reflect wider construction of femininity and masculinity.

Literature indicates that women are more involved in the process of trying to get a child than men (Vizheh *et al.* 2015), and men do not show willingness to pursue medical treatment to escape the blame for infertility (Inhorn 2002). Another reason why couples seek remedies individually is to avoid blaming one another for their infertility (Tabong and Adongo, 2013). The findings of the present study revealed that infertile women were more actively engaged in problem solving approach in trying to seek treatment when compared with men. Men were reluctant to pursue medical treatment as they did not consider it their duty and as it also threatened their masculine identities.

Having faith in God and hoping for a miracle to occur is found to be an important coping mechanism (Tabong and Adongo 2013). In Botswana, the negotiation of reproductive status among infertile women is mediated in culturally appropriate frameworks and narratives of witchcraft and western contraception, which enable infertile women to put the infertility condition outside of their own personal behavior and social identity (Upton 2001). The findings of the present study revealed that both men and women drew upon their faith to interpret and accept their conditions and relinquished their control to God. Faith also helped both infertile men and women to be hopeful and have positive attitude despite their infertility. By recasting their infertility in culturally appropriate understandings of children as "gifts from God", they were able to locate their infertility outside of their identities.

6. Conclusion

The social suffering experiences of infertile women and men is influenced by the prevailing socially constructed gender identities, perceived gender roles and patriarchal constructions of infertility. Gender plays a key role in distribution of social suffering relative to infertility. Infertility challenges self-perceived gender identity of infertile women and men. However,

women's gender identity is strongly challenged than that of men at social level due to patriarchal construction of infertility as women only problem, husband's shifting of the blame on their wives, and wives taking on the blame. Women carry the lion-share of stigma, blame and psychological distresses as they are held responsible for acquisition of the stigmatizing condition and as patriarchy implicitly privilege men in childlessness marriage.

Both infertile women and men are not passive, but actively engage to create positive meaning and continuity in their lives through negotiation of their identities within the existing gendered expectations and norms of femininity and masculinity. Men engage in emotionally detached strategies and reasoning that go in accordance with masculine attributes of being strong and rational, while women mainly adopt emotion-focused coping, social support and problem-solving strategies that reflect the dominant feminine behaviours. Both infertile women and men draw upon their faith to make sense of their sufferings, which helps them to put the impetus outside of their identity. In general, experiences and responses to suffering relative to infertility are negotiated within the existing gender norms and expectations. Women bear the greatest burden of infertility within this gender structure, and social sufferings, resulting from infertility, have not produced new alternatives to masculine and feminine identities.

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