ORIGINAL RESEARCH ARTICLE

Psychological, sociocultural, and coping experiences of women with infertility using traditional healthcare services in Harare urban, Zimbabwe: A qualitative study

DOI: 10.29063/ajrh2024/v28i6.3

Thokozile Mashaah[1], Exnevia Gomo[2], Julita C. Maradzika[1,3], Mugove Gerald Madziyire[4] and James January[1,5]*

Department of Global Public Health and Family Medicine, Faculty of Medicine and Health Sciences, University of Zimbabwe[1] ; Department of Laboratory Diagnostic and Investigative Sciences, Faculty of Medicine and Health Sciences, University of Zimbabwe[2]; Department of Health Sciences, Africa University[3]; Department of Child, Adolescent and Women's Health, Faculty of Medicine and Health Sciences, University of Zimbabwe[4]; Department of Psychiatry and Mental Health, Kamuzu University of Health Sciences, Malawi[5]

***For Correspondence:** Email: *thokozilemashaah@gmail.com*; Phone: +263773839697

Abstract

This study focused on the psychological, social, and cultural dimensions of infertility among women with infertility in Harare Urban who have utilised traditional healthcare systems to address their infertility problem. It also emphasises their coping strategies for dealing with the challenges encountered along the infertile journey. This was a qualitative study using a phenomenological approach, focusing on the experiences of five women. Data from the interviews was analysed using a simplified version of Hycner's (1985) five-step explication process. The study produced three main themes: psychological experiences, socio-cultural experiences, and coping experiences, along with seven sub-themes. The results showed that women experienced intense distress, sorrow, and self-blame because of their inability to have children, further compounded by the stigma they faced from their families and communities. Women with infertility are subjected to derogatory labels, social contempt, ridicule, and being undervalued, which leads them to develop coping strategies to endure the adverse encounters. These coping mechanisms can have either positive or negative effects on their overall welfare. The exploration of psychological, socio-cultural factors, and coping mechanisms of women with infertility problems' presents a chance to co-create interventions that empower them. *(Afr J Reprod Health 2024; 28 [6]: 25-38).*

Keywords: Female infertility, traditional healthcare services, women

Résumé

Cette étude s'est concentrée sur les dimensions psychologiques, sociales et culturelles de l'infertilité chez les femmes infertiles de Harare Urban qui ont utilisé les systèmes de santé traditionnels pour résoudre leur problème d'infertilité. Il met également l'accent sur leurs stratégies d'adaptation pour faire face aux défis rencontrés tout au long du parcours stérile. Il s'agissait d'une étude qualitative utilisant une approche phénoménologique, axée sur les expériences de cinq femmes. Les données des entretiens ont été analysées à l'aide d'une version simplifiée du processus d'explication en cinq étapes de Hycner (1985). L'étude a produit trois thèmes principaux : les expériences psychologiques, les expériences socioculturelles et les expériences d'adaptation, ainsi que sept sous-thèmes. Les résultats ont montré que les femmes éprouvaient une détresse, un chagrin et une culpabilité intenses en raison de leur incapacité à avoir des enfants, encore aggravés par la stigmatisation à laquelle elles étaient confrontées de la part de leur famille et de leur communauté. Les femmes infertiles sont soumises à des étiquettes désobligeantes, au mépris social, au ridicule et à la sous-évaluation, ce qui les amène à développer des stratégies d'adaptation pour supporter les rencontres défavorables. Ces mécanismes d'adaptation peuvent avoir des effets positifs ou négatifs sur leur bien-être global. L'exploration des facteurs psychologiques, socioculturels et des mécanismes d'adaptation des femmes souffrant de problèmes d'infertilité présente une opportunité de co-créer des interventions qui les autonomisent. *(Afr J Reprod Health 2024; 28 [6]: 25-38).*

Mots-clés: Infertilité féminine, services de santé traditionnels, femmes

Introduction

The World Health Organisation defines infertility as "a disease of the male or female reproductive system defined by the failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse"[1]. Infertility is often not just a medical condition but it can be a solitary ordeal that can have significant psychological, social, and cultural consequences for women[2,3].

Furthermore, the cultural attitudes and societal expectations related to fertility can worsen the difficulties experienced by women with infertility. In the African context, failure to procreate is usually a tragedy for women as they are blamed for failure to conceive[4,5]. This is further intensified by the fact that children, particularly biological offspring, are much esteemed. The children are valued for their potential impact on future generations within families and communities, as well as in providing economic stability[6–8].

Studies have shown that women with infertility suffer from physical[9–11] psychological, emotional, social humiliation, stigma and divorce within their communities[12–15]. 65.5 % infertile women reported verbal violence and 69% experienced physical abuse in a study in Egypt[16]. In Nigeria reported domestic violence prevalence among infertile women ranged from 32.3% to 54.2%[17,18]. In societies where adoption is not commonly accepted[19,20], women face the burden of ensuring their ability to conceive. This may lead engagement in several sexual relationships as a means of demonstrating fertility[21]. Thus increasing the risk of acquiring sexually transmitted infections (STIs)[21], which can further exacerbate infertility A study in Zimbabwe reported that 20% of the women with infertility had tubal blockage which is caused by infections[22].

There is limited research on the psychosocial and cultural experiences of women with infertility living in Zimbabwe who have sought traditional healthcare systems. Previous research has primarily concentrated on male counterparts[23,24]. Moyo[23] who focused on 'Indigenous knowledge systems and attitudes towards male infertility' in rural Zimbabwe reported that male infertility was associated with feelings of inadequacy, disappointment, suffering, exclusion from society, social disgrace, instability in marriage, discomfort, and even suicide. Thus, our study addresses the lack of information regarding the psychological, sociocultural, and coping experiences of women with infertility in the local context.

This was a follow-up to our study on traditional management of female infertility, which centred on the experiences of traditional health practitioners (THPs)[25]. The present study thus focused on the experiences of women in an urban setting who have sought management of infertility within traditional healthcare systems within a heterogeneous environment with different backgrounds. This article explores the psychological, social, and cultural aspects of female infertility. It emphasises on the emotional consequences, societal expectations, and cultural standards that influence women's encounters with infertility. The study also delves into the coping mechanisms employed by women with infertility. The goal is to enhance understanding and promoting empathy towards women experiencing infertility. Ultimately, providing a platform for interventions that address these societal pressures.

Methods

Study design

The article follows the guidelines set by the Consolidated Criteria for Reporting Qualitative Research (COREQ) to report the design, analysis and findings of the study[26]. This was a qualitative study using the phenomenological hermeneutic approach to explore the psychological, social, and cultural aspects of infertility based on experiences of women who have been treated at traditional healthcare systems. Study participants were clients of Traditional Health Practitioners (THPs) who specialise in infertility and registered with Zimbabwe Traditional Medical Practitioners' Council (TMPC). These THPs had participated in the phase one of the study[25]. Contact information of the women was provided by the THPs. The researchers contacted a total of nine women to take part in the study. This was in line with the recommended sample size for phenomenological studies which is 3-25 individuals[28]. Recommendations sample sizes for doctoral level studies range between 4-10 participants for phenomenological studies[27]. In this study, saturation was achieved with the five women with sufficient information generated to enable to understand the phenomena[29]. Women who gave their consent to participate were recruited. All of the five women had sought treatment from the THPs with four of them been successful and 1 unsuccessful. Detailed information of the women is presented in Table 1. The recruitment process and

Table 1: Participants profiles

Woman	W1	W2	W3	W4	W5
Current Age (years)	56	27	35	44	35
Level of Education	Secondary	Tertiary	Secondary	Tertiary	Tertiary
Occupation	Farmer	Bank Teller	Hairdresser	Corporate Sales Representative	Lawyer
Number of biological Children	0 (3 adopted)	1	1	2	1
Medical diagnosis	N/A	PCOS	Tubal obstruction	N/A	Endometriosis and fibroids
Current marital status	Single (divorced)	Married	Single (divorced)	Single (divorced)	Single (divorced)
Duration of Marriage (years)	10	5	7	7	3
Duration of seeking treatment (years)	9	3	6	4	2

interviews took place between September 2023 and February 2024.

Research team and reflexivity

All interviews were performed by the primary author and a research assistant, both of whom are female PhD candidates at the University of Zimbabwe and have previous experience in qualitative research. The primary author also holds a position as a research administrator, while the research assistant is employed as a research nurse within the same institution. Prior to the study's commencement, the researchers did not establish a relationship with the participants. Initially, participants were recruited to participate in the study by telephone calls. During these calls, they were provided with information about the study, allowing them to make an informed decision about whether to participate. Additionally, appointments for interviews were scheduled, including the specific date and venue. The interviews were conducted at a location of the participants' choice, usually their residence or workplace. At the outset of the interviews, the researchers, who identified themselves as PhD students, provided a concise explanation of the study's objectives to the participants. The participants then underwent the written consent procedure, and efforts were made to create rapport to ensure their comfort. Two interviews were conducted with each woman, primarily in Shona, which is the participants' and researchers' native language. The interviews followed a semi-structured format with prompts and had been pre-tested beforehand. The initial interview, conducted in person, documented the first-hand accounts of the women's experiences. The duration of the interviews ranged from 40 to 90 minutes. Following the initial interviews, the audio recordings were transcribed verbatim. Visual observations and reflections were documented through the use of field notes. An independent translator subsequently translated the Shona transcripts into English. The second interviews were conducted over the phone to verify the data trustworthiness and obtain additional clarity. Every woman concurred that the obtained material accurately mirrored their authentic lived encounters.

Data analysis

The researchers analysed the data using a simplified version of a five-step process proposed by Hycner and Groenewald[30,31]. The first step of '*bracketing and phenomenological reduction'* involved listening to the audio recording multiple times to become familiar with the information and identify any potential biases which were then set aside during the interview and data analysis. The second step (*Delineating units of meaning)* involved extracting and isolating important meanings from the data and removing any redundant units. Therefore, the material was evaluated based on the frequency of its mention. The third process of '*clustering of units of meaning'* involved clustering units of meaning to create themes by grouping them together. The fourth step of '*summarising each interview'* involved validating and modifying where

necessary. Validating was done through returning the summaries to the participants to ensure credibility and gather additional information. Finally, the fifth step involved '*extracting general and unique themes*' and making a composite summary. This article thus presents the themes that have emerged from the study.

Trustworthiness

The researchers used the Lincoln and Guba model to assess the reliability of the study[32–34]. We achieved this through four strategies: credibility, dependability, confirmability, and transferability. Credibility was upheld by using two autonomous individuals (the researcher and assistant) to verify and scrutinise the data, in addition to utilising audio recorders. Furthermore, the participants were actively involved in confirming the precision of the material produced during the interviews. We ensured dependability by maintaining an audit trail for potential peer review. We verified confirmability by involving an impartial translator and conducting separate analyses to reach a consensus on the final themes derived from the study. We ensured transferability by providing a thorough description of the employed research methodology. Participants provided written consent to participate in the study and for the future publication of the study findings. The study received ethical approval from the Joint Research and Ethics Committee of the University of Zimbabwe Faculty of Medicine and Health Sciences and Parirenyatwa Group of Hospitals (JREC/200/2020), as well as the Medical Research Council of Zimbabwe (MRCZ/A/2689). The researchers were vigilant to any indications of distress among the participants and ensured that distressed participants had the right to either continue or end the interview. The research team provided the participants with their contact information, allowing them to reach out to any team member for additional discussions if needed.

Results

The findings of the study are based on the experiences of five women who have utilised services from traditional healthcare systems. Their profiles are presented in Table 1.

Participant's profiles

The participants' ages ranged between 27 and 56 years at the time of the interviews. Two of them had reached the secondary education level, while three had achieved the tertiary education level. All of them were gainfully employed. Three of them reported having undergone medical diagnoses, specifically: polycystic ovary syndrome (PCOS); tubal obstruction; and endometriosis and fibroids. Four of the women were now divorced at the time of recruitment.

Main Themes and sub themes

The study yielded three main themes and seven sub themes. The primary themes encompass psychological experiences, socio-cultural experiences, and coping experiences. Table 2 outlines a summary of the coding tree and Table 3 provides an overview of the themes, which will be further elaborated on.

Main theme 1: Psychological experiences

The participants experienced psychological anguish because of the infertility struggle. They elucidated the profound anguish, grief, and self-reproach resulting from the inability to conceive children, to the point where some likened infertility to a type of impairment. Consider the remarks by W1 below:

"The inability to have children should also be viewed as a disability because people with infertility suffer a lot mentally and, in the communities, they live in, it's a disability that is hidden."

Sub-theme 1: Pain and sorrow

Participants contemplated the anguish and grief they experienced because of the significance they attributed to children. The presence of children was crucial for aiding in old age, and the prospect of becoming old without offspring was extremely distressing to them. In addition, they conveyed that there are certain health conditions they considered preferable to infertility, given the suffering they encountered as women struggling with infertility.

Table 2: Summarised coding tree

Main Theme	Sub theme	Category	Codes
Psychological experiences	Pain and sorrow	Feeling emotional	I was in a depressive state
			I was hurt I cried the whole night thinking that I was now a laughing stock
			I would lock myself inside the house and cry
		Hopelessness	Sometimes I even wish that it was better if I was born blind than not to have a child
		Marital instability	My marriage is failing, my business was failing as well
	Self-blame	Acceptance of fate	I had accepted my fate
			So I opted to leave the marriage since I was the one who had an infertile problem
		Self-diagnosis	The guy who left me went ahead and had kids
			He impregnated a girl so everyone had the belief that I was the one with fertility issues
Socio-cultural experiences	Family experiences	Experience with in-laws (emotional abuse)	His mother she would talk a lot up until the time he left
			She said so what's the point of you staying together if you don't have children
			I had problems with my in-laws my husband's mother and father to the extent that they had arranged for me to sleep with my brother in-law
			It reached a point were even my father in law would pass on indecent comments to me and that made me very uncomfortable in that home
		Experience with husband (blame)	He mentioned it once that I should go and seek help and stop doing nothing about our childlessness.
			He said I was to look for help anywhere even prophets of the apostolic churches
		Experience with husband – Matrimonial support	My husband though did not give me any problems, if I say he did I would be lying, he would also sympathize with me
		Experience with relatives (physical and verbal abuse; lack of respect)	Things never got better it got worse to the extent that I got poisoned
			Even if you contribute something meaningful, they don't take you seriously
			Sometimes they accuse me of witchcraft, they say I sacrificed my womb to have money
			Even our own families also look down on us because we don't have children
		Experience with biological family	Even my own mother don't fully understand my predicament
			My family is talking too much so it was quite a traumatic time for me
	Community experiences	Emotional and verbal abuse	I was deeply hurt and I went back home crying because it felt like the world was mocking me
			They call me a witch just because you don't have a child, they call you a witch
			Sometimes they say you sacrificed your womb for rituals to get rich
			I ignored him then another man said "..leave her alone don't you know that she is barren.."
			People know my history, they tell each other
		Lack of respect (social stigma)	Women with infertility are looked down upon in the community

			The community look down upon us because we don't have children, failure to have children is not easy I had challenges here in the community
		Perceived social expectations (assets and adoption)	I have a plot that I acquired long ago people used to laugh at me saying how can a barren woman have a farm Even though I have adopted and foster some children still the society sees me as barren
		Church - unvalued	Even at church you are usually quiet you don't contribute much because people don't value you
		Work experience (stigma)	At work you hear people talking about their children every day and you are there and have nothing to say it's not easy.
Coping experiences	Personal strategies	Unhealthy strategy (self-isolation)	I would say I'm fine I'm in counselling you know meanwhile I was lying to them I couldn't even sleep I spend about 8 months without even communicating with my family I would lock myself inside the house and cry avoiding people so that they don't call me *ngomwa*/barren Sometimes I dread even going outside of my house
		Unhealthy strategy (multiple sexual partners)	Obviously I dated other people and I was trying and trying In the process of sleeping with different men I will also contract HIV because I will never use protection or a condom because I am looking for a child.
		Unhealthy strategy (change in behaviour)	Since he left me I became a different person I was rebellious to my family
		Unhealthy strategy (alcohol abuse)	I started drinking cause I'm left alone
		Healthy strategy (spiritual)	At church I didn't have any problems…you know those churches are big so no one would actually know you
		Healthy strategy (self-protection)	I just gave an excuse to the family that I was still studying so I didn't experience any challenges with the family
	Family support	Biological mother support	Mama came and prayed and a lot of people came My mum realized that I think I need to be there, so she took time off work and stayed with me for 3 months So when I did open up to her and tell her that I have endometriosis, I have a fibroid she also went on a mission out of her way to find a solution
		Relatives support	I never had any problems with relatives they never showed it to my face unless they chose not to show me.
		Immediate family support	I did engage my family and they were willing they said whatever its fine just go
	Child fostering and adoption	Community perceptions of adoption and fostering	Even though I have adopted and foster some children still the society sees me as barren
		Church stigma	Even at church they just see me with a 7-month-old baby from nowhere obviously even when I don't say anything, they just know that these children are adopted.
		Family perceptions of adoption	They say how can I take strangers and make them part of the family you will create problems for us in the future if anything happens to them
		Lack of family support	My own siblings don't even understand my situation, they actually don't support my decision to adopt and foster children
		Lack of family support	When my first child (adopted) passed away they did not even attend the funeral I buried my child with church members and

	Verbal abuse by foster children	people from the department of social welfare no relative of mine attended because they said the child is not mine They now they call me a witch, because I was strict when raising them

Table 3: Main themes and sub themes

Main Theme	Sub theme
Psychological experiences	Pain and sorrow Self-blame
Socio-cultural experiences	Family experiences Community experiences
Coping experiences	Personal strategies Family support Child fostering and adoption

W 1 stressed that *"...so this issue of not having your own children is not easy ...Sometimes I even wish that it was better if I was born blind than not to have a child, you see this infertility problem gets worse as you grow older, let's say I am blind today I not saying being blind is good it's God's will but if I am blind and have a child then my child will take care of me in old age my child will look after me, you understand...*" (Participant cries)

The participants experienced pain and grief because of the stigma they faced from the community. Using derogatory name calling diminished their humanity and eroded their confidence inside society.

W 3 shared her experience as follows: *"I had challenges here in the community, I remember one day I was walking past some shops on my way to work. There were some men sitting on the roadside one of them called out to me and I ignored him then the other man said "...leave her alone don't you know that she is barren..." I was deeply hurt, and I went back home crying because it felt like the world was mocking me."*

Sub-theme 2: Self-blame

Participants expressed a sense of self-blame, attributing their failure to have children in the marriage to themselves. They, even without a medical diagnosis, assumed that because their partners or previous relationships had already conceived children, they themselves were the ones experiencing infertility. Consequently, some individuals choose to terminate their marriage. Below are excerpts from the women.

"My husband had already had a child, he had a child whilst he was still in high school, he impregnated a girl, so everyone had the belief that I was the one with infertility issues." (W 2)

"The guys who left me went ahead and had kids…so it started playing in my mind and (during) *that time I wouldn't lie people would even suggest for me to go and see apostolic prophets."* (W 4)

"*…I opted to leave the marriage since I was the one who had an infertile problem.*" (W 1)

Main theme 2: Socio-cultural experiences

The socio-cultural experiences of infertility are intricate and closely connected to societal standards and cultural beliefs. The participants recounted the challenges they encountered within both their immediate family and the broader community.

Sub-theme 1: Family experiences

The participants had varying responses regarding their experiences inside the family unit. Several participants described their interactions with their spouses, siblings, parents, and in-laws as unfavourable, lacking respect, and judgmental. They were despised and subjected to mistreatment to the point where it was proposed that their marriages be terminated. Some were expected to have a sexual relationship with a relative chosen by the family members.

W1 stated this with regards to her relationship with her in laws "*... I had problems with my in-laws my husband's mother and father to the extent that they had arranged for me to sleep with my brother in-law so that I could have children for my husband. It reached a point were even my father-in-law would pass on indecent comments to me and that made me very uncomfortable in that home and when I showed them that I didn't like it they hated me, and things were never okay in my marriage."*

She also had this to say about her experiences with her own family *"Even in families you are not given enough respect if you don't have a child even if you*

contribute something meaningful, they don't take you seriously. Sometimes they accuse me of witchcraft, they say I sacrificed my womb to have money." (W 1)

W 4 echoed that *"...his mother she would talk a lot up until the time he left. She said so what's the point of you staying together if you don't have children. you know those type of things.*"

Participants who were secretive of their infertility challenges to their in-laws did not experience any problems with the in-laws.

W 2 stated that *"I just gave an excuse to the family* (in laws) *that I was still studying so I didn't experience any challenges with the family."*

Participants also reported a good relationship initially with their spouses although the spouses would also emphasize the need for the woman to seek treatment.
W 3 mentioned that *"...he* (husband) *was not giving me problems at first, but he mentioned it once that I should go and seek help and stop doing nothing about our childlessness. He said I was to look for help anywhere even prophets of the apostolic churches."*

Sub-theme 2: Community experiences

Experiences of social exclusion and marginalisation were reported with labelling or name calling very common amongst the women. Some of the women thought that the community did not appreciate their contributions and held a negative opinion of them due to their childlessness. Consequently, they experienced a sense of inadequacy, diminished self-worth, and self-isolation. Consider the remarks below by W 1:

"*Women with infertility are looked down upon in the community, you see I am old but sometimes I dread even going outside of my house. Even though I have adopted and fostered some children still the society sees me as barren..."* (W 1)

Participants experienced emotional and verbal abuse emanating from the interactions within their community.

W3 recalled this experience *"I had challenges here in the community.....I was deeply hurt and I went back home crying because it felt like the world was mocking me"*

"People know my history, they tell each other" (W 4)

The community did not consider it vital for a woman with infertility to possess material riches. Thus, the woman was mocked for acquiring assets with children who would inherit them.

"*I have a plot that I acquired long ago people used to laugh at me saying how can a barren woman have a farm, they would mock me to the extent that I would lock myself inside the house and cry avoiding people so that they don't call me ngomwa* (barren)*... "* (W 1)

The act of adopting or fostering did not offer any relief for those experiencing infertility, since societal attitudes persisted in stigmatising women who had adopted or fostered children.
"Even though I have adopted and foster some children still the society sees me as barren" (W 1)

Women who experience infertility are often marginalised and their perspectives are rarely taken into account within the community. The participants had a restrained demeanour in church due to the lack of appreciation for their contributions.

W 1 stated *"Even at church you are usually quiet you don't contribute much because people don't value you"*

Adverse encounters also occurred in work environments. Conversations about children in the workplace served as reminders and catalysts for women's emotional distress and anguish.

"At work you hear people talking about their children every day and you are there and have nothing to say it's not easy" (W4)

Main theme 3: Coping experiences

Participants shared their coping experiences, which included personal strategies, family support, as well as fostering and adoption. These strategies were critical for them to ensure the continuation of their lives while dealing with infertility.

Sub-theme 1: Personal strategies

Participants employed both healthy and unhealthy strategies to manage their infertility issues. Healthy personal methods encompassed the utilisation of faith-based tactics and employing ways of safeguarding their emotions. Attending church served as both a means of seeking a resolution to their problem and a sanctuary where the participant could blend in with a large crowd and remain unidentified.

W 3 explained that *"At church I didn't have any problems besides I wasn't even that serious about church back then I would go to* (name of church) *church looking for solutions so you know those churches are big so no one would actually know you."*

Safeguarding one's emotional space was used as a strategy to mitigate any negative effects from the family. Consider the remarks by woman 2
"I just gave an excuse to the family that I was still studying so I didn't experience any challenges with the family"

Unhealthy personal methods included involvement in multiple sexual partnerships, the misuse of alcohol, crying and self-isolation. The participants entered other sexual relationships after their initial marriages were terminated. The rationale behind their decision was two-pronged: firstly, they wished to avoid the difficulties they had previously encountered in their marriages, where they were unfairly held responsible for their inability to have children; secondly, they were actively attempting to conceive with other partners.

W 3 stated that *"I was no longer interested in serious relationship. I only wanted to have fun. I didn't want the stress of getting married again and go through the mockery of being called barren again. I had accepted my fate."*

W 4 echoed that *"So thereafter being single and alone obviously I dated other people, and I was trying and trying."*

Personality change was described by some of the participants which led to their engagement in alcohol abuse and rebellious behaviour.

W 4 mentioned that "*I think from there onwards till now I became a different person. I started drinking …. and I was rebellious to my family…my family was talking too much so it was quite a traumatic time for me then."*

Crying and self-isolation were some of the personal coping mechanisms the participants reported.
W 1 stated that *"Even at community boreholes I don't go there to fetch water I send my helper because people talk about me."*

Sub-theme 2: Family support

The family served as a supportive platform throughout the participants experience with infertility. The family offered comfort and identified alternative options for pursuing infertility treatments. Curiously, the participants disclosed their willingness to discuss their problem and seek treatment alternatives with their mothers, while keeping it a secret from their fathers that they had sought traditional healthcare systems.
W 3 remarked that *"I did not tell my father because he doesn't believe in traditional healers, but I told my mother she knows that I got this child through traditional means. My father would encourage me to wait on God's time… he thought it was God's timing."*

W 5 mentioned that *"…her eldest daughter in her mid-30s … no grand babies she was very desperate to find out the problem you know, so when I did open up to her and tell her that I have endometriosis, I have a fibroid she also went on a mission out of her way to find a solution for her daughter"*. She added that *"...mama was like have you gone now* (to see THP) *to such a point whereby my first meeting with* (THP) *I went with my mum."*

Sub-theme 3: Child fostering and adoption

Exploring alternative paths to parenthood provided new avenues for fulfilment and joy. One of the participants utilised fostering and adoption as strategies.

W 1 stated that *"I have never had children in my life, these kids I live with I have adopted them."*

The participant experienced a negative attitude within the family unit due to myths and misconceptions surrounding the practice of fostering and adoption. These children were labelled as 'strangers' and perceived as potential sources of future difficulties for the family.

She further added that "*My own siblings don't even understand my situation, they don't support my decision to adopt and foster children, they say how can I take strangers and make them part of the family you will create problems for us in the future if anything happens to them. They fail to understand my need to also have children of my own…*" (W 1)

The participant encountered a lack of familial support over their choice to foster and adopt children. The family's actions caused them to feel stigmatised and ostracised.

"…*when my first child passed away, they did not even attend the funeral. I buried my child with church members and people from the department of social welfare no relative of mine attended because they said the child is not mine… he was my child and I loved him they actually laughed, and no one came to the funeral.*" (W 1).

Discussion

This study explored the psychological, social, and cultural aspects of female infertility. The findings indicate that infertility has profound psychosocial and cultural implications for women. The study revealed that women experiencing infertility experience psychological and socio-cultural encounters within their family units and broader community as agonising, emotionally difficult, disheartening, and degrading. The participating women described three specific ways they used to manage their infertility problems: personal coping mechanisms, support from their families, and the option of fostering or adopting a child. Our study revealed that the women perceived their infertile status as a disability due to the mental suffering they experienced. This aligns with the assertion made by Khetarpal et al. (2012) to classify infertility as a disability[35]. In their 2015 study titled "Perceptions of Women with Infertility on Stigma and Disability" conducted in the USA, Sternke *et al*. found that most participants responded favourably to the categorization of infertility as a disability. They believed that this classification would result in an increased availability of resources for women struggling with infertility[36]. Consistent with previous research conducted in Ghana, China, India, Gambia, Kenya and Uganda, our study found that women with infertility issues encountered diverse psychological impacts that significantly influenced their everyday lives[8,15,37–42]. Distress, self-reproach, grief, pain, and sorrow arising from the social disapproval are linked to the condition. This is a result of the derogatory labelling, social disapproval, and blame they encounter from their relatives and society. Contrary to other studies[10,16,41,43,44], physical pain or violence was not reported in our study. Our study, like previous research among Ugandans, showed that women often blamed themselves for their inability to conceive within a marriage[38], even without a medical diagnosis. The women engaged in self-diagnosis and ascribed their inability to have children in their marriage to themselves, because their spouses had previously had children or had gone on to have children with other partners. Some women chose to end their marriage because of this self-imposed social disapproval.

Our study also shows that there is a lot of stigma within the family and community surrounding female infertility. Some women in our study were labelled as "*ngomwa*", which is the local term used for barrenness. They were looked down upon, undervalued and mocked similar to other studies in Ghana and Uganda[7,38,40,45,46]. Some being called 'witches' who had sold their wombs for rituals to get money. This cultural association of female with infertility and witchcraft was also reported in studies in Ghana and Gambia[4,39]. Another key study is the community's opinions towards women with infertility and their ownership of assets. The community derided women who had assets but lacked children to inherit them. Our study revealed that there were tensions within families, particularly involving the in-laws. Some individuals advised the couples to pursue divorce, arguing that there was no need to remain in a marriage without children which was similar to studies in Africa[2,37,40,47] Our study also found that, in some cases from a cultural perspective, the family addresses infertility by discreetly arranging for the woman to engage in a sexual relationship with a carefully selected family member. A study on male infertility in Zimbabwe also cited this intervention method when infertility is attributed to the male factor[24]. This absolves the woman of blame and protects her from wanting to conceive outside of the home. Although the church was a place of solace and possible solution for some, it

also triggered pain and sorrow as the women felt unheard and unappreciated. Our research found that conversations about children in social settings, such as workplaces and community spaces, elicited distressing emotions because they facilitated the continuation of social stigma. Therefore, women have a tendency to socially withdraw from such environments. Uganda and Ghana yielded comparable results[37,38]. These socio-cultural experiences would thus lead women to isolate themselves from regular social activities.

Women in this study used both healthy and unhealthy methods as personal coping strategies. Similar to studies in Zambia, China and Turkey, healthy coping strategies included seeking comfort in their religious beliefs by attending church, hoping to find a solution to their situation[9,15,48]. Additionally, the large congregation at the church provided them with anonymity, ensuring that their condition would remain unknown to others. Another unique finding which was reported as an effective method for emotional self-protection mechanism, was the woman's pursuit of education and her clear communication with the family about her decision not to have a child within the study period. Although this was deceiving to the family, it provided an emotional buffer to the woman with infertility. Findings from this study revealed unhealthy coping mechanisms such as having multiple sexual partnerships, the misuse of alcohol, crying, change of behaviour (rebellious) and self-isolation. Similar to other studies in Iran, Mali, Uganda, South Africa, Nigeria and Ghana, our study showed that crying and social self-isolation is common among women facing infertility challenges[3,8,38,49–51].Our study confirmed other studies that have reported that women get involved in several sexual relationships as a coping strategy[21,52]. The women's sense of helplessness led them to seek out other partners to try to conceive. This has a profound impact on the sexual and reproductive health of women, as it increases their likelihood of acquiring STIs, which in turn exacerbates their infertility. Therefore, sexual and reproductive health interventions must successfully incorporate infertility into their programming. Congruent to this study finding, results from Ghana and Romania showed misuse of alcohol as a coping mechanism[52,53].This coping strategy may not only lead women to engage in several sexual relationships[54] but also increase the likelihood of infertility, as observed in the United States and Sweden[55].

Family support played a crucial role in helping women deal with infertility. Assistance was mostly offered by their parents. These results are comparable to those observed in Uganda and Turkey[38,48]. While some women originally received support from their spouses, some later experienced their partners expressing frustrations. One of the women in our study made the decision to engage in fostering and adoption as a strategy. However, her immediate family and the community did not support this decision, despite the lady feeling fulfilled by caring for these children. Prevalent myths and misconceptions influenced the prevailing societal perspective on fostering and adoption. Research has indicated that opinions might differ based on cultural, religious, and socio-economic aspects. Women with infertility in Ghana, India and Iran did not view adoption as a viable alternative[37,42,56]. Conversely, a study conducted in Nigeria found that half of the participants expressed a willingness to consider adoption if their infertility issue became "intractable"[57]. Our study examined the psychological, socio-cultural, and coping experiences that women in Harare have encountered. We firmly believe that the presented information will provide crucial insights for the development and implementation of interventions specifically targeting women with infertility in Zimbabwe.

Limitations

We narrowed the scope of our research to women in the urban area of Harare who specifically sought traditional methods to manage their infertility condition. In addition we restricted our participants to the ones that were recommended by their THPs who had participated in the first phase of the study. Further research can be explored in other settings to add to the body of knowledge. We would have loved to incorporate the viewpoints of the partners, however four of the women were divorced at the time of recruitment. It would be beneficial to conduct a study that involves multiple community stakeholders in order to gain a more comprehensive understanding of their views on female infertility. Nevertheless, this paper magnified the perspectives of a diverse group of women who experienced

difficulties with infertility in an urban environment.

Conclusion

The study findings revealed that women experiencing infertility who seek traditional healthcare system in Harare urban have gone through numerous psychological and socio-cultural challenges. These issues stem from the cultural norms and expectations that determine the significance of fertility in the country. Consequently, women engage in positive and negative coping mechanisms. It is thus crucial for policy makers to co-create interventions that empower affected women with effective healthy coping skills without negatively affecting their reproductive health.

Ethical approval and consent to participate

The study was ethically approved by the Joint Research and Ethics Committee of the University of Zimbabwe Faculty of Medicine and Health Sciences and Parirenyatwa Group of Hospitals (JREC/200/2020) and Medical Research Council of Zimbabwe (MRCZ/A/2689. Written consent for interviewing, audio recording and publishing was obtained from all participants.

Availability of data and materials

All the data, transcripts and supporting documents used for this current study are available from the corresponding author upon reasonable request.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

The author contributions are as follows: Conceptualisation TM, JJ and EG; Writing of the original draft TM; Writing – reviewing and editing EG, JM, MGM, JJ. All the authors proofread the manuscript and approved the final version.

Acknowledgements

The authors are grateful to the research assistant, independent translator, independent analysis, and women who participated in the study.

References

1. World Health Organization. Infertility prevalence estimates, 1990–2021 [Internet]. Geneva: World Health Organization; 2023. Available from: https://www.who.int/publications/i/item/978920068315
2. Elwell K. The social and cultural consequences of infertility in rural and peri- urban Malawi. African Journal of Reproductive Health. 2022 Jul;26(7):112–26.
3. Hasanpoor-Azghdy SB. The emotional-psychological consequences of infertility among infertile women seeking treatment: Results of a qualitative study. Iran J Reprod Med. 2014;12(2).
4. Ofosu-Budu D and Hänninen V. Herbalists' explanations of infertility: The case of Northern and Southern Ghana. African Journal of Reproductive Health. 2022;26(5):96.
5. Tabong PTN and Adongo PB. Infertility and childlessness: a qualitative study of the experiences of infertile couples in Northern Ghana. BMC Pregnancy Childbirth [Internet]. 2013;13. Available from: http://dx.doi.org/10.1186/1471-2393-13-72
6. Iwelumor OS, Jamaludin SSS, George TO, Babatunde SK and Olonade OY. "A Child is as important as Life": Reflections on the Value of Children from Infertile Couples. Open Access Maced J Med Sci. 2020 Apr 20;8(E):302–7.
7. Kuug AK, James S and Sihaam JB. Exploring the cultural perspectives and implications of infertility among couples in the Talensi and Nabdam Districts of the upper east region of Ghana. Contracept Reprod Med. 2023 Apr 19;8(1):28.
8. Tabong PTN and Adongo PB. Understanding the Social Meaning of Infertility and Childbearing: A Qualitative Study of the Perception of Childbearing and Childlessness in Northern Ghana. Wainberg M, editor. PLoS ONE. 2013 Jan 16;8(1):e54429.
9. Howe S, Zulu JM, Boivin J and Gerrits T. The social and cultural meanings of infertility for men and women in Zambia: legacy, family and divine intervention. 2020;12(3):185–93.
10. Omidi K, Pakseresht S, Niknami M, Kazem Nezhad Leilie E and Salimi Kivi M. Violence and Its Related Factors in Infertile Women Attending Infertility Centers: A Cross-Sectional Study. JMRH [Internet]. 2021 Oct [accessed 2024 Apr 8];9(4). Available from: https://doi.org/10.22038/jmrh.2021.58462.1708
11. Sharifi F, Jamali J, Larki M and Roudsari RL. Domestic Violence against Infertile Women: A Systematic Review and Meta-Analysis. Sultan Qaboos Univ Med J. 2022 Feb 28;22(1):14–27.

12. Bista B. Lived Experience of Infertility Among Community Dwelling Infertile Women. Journal of Nobel Medical College. 2015;Vol. 4, No.1(Issue 7):46–56.
13. Chimbatata NBW and Malimba C. Infertility in Sub-Saharan Africa: A Woman's Issue for How Long? A Qualitative Review of Literature. Open Journal of Social Sciences. 2016;04(08):96–102.
14. Chingombe A. Perception and Management of Human Fertility: A Shona Landscape. International Journal of Management and Sustainability. 2012;1(1):1–12.
15. Tiu MM, Hong JY, Cheng VS, Kam CY and Ng BT. Lived experience of infertility among Hong Kong Chinese women. International Journal of Qualitative Studies on Health and Well-being. 2018 Jan 1;13(1):1554023.
16. Nasr Abdelhalim EH, Ibrahim AM, Hassan HE, Wahba NM and Moawd SAA. Silent struggles: Unveiling the unspoken epidemic of domestic violence against infertile women in Egypt. International Journal of Africa Nursing Sciences. 2024;20:100663.
17. Fiebai PO and Omoruyi SA. Domestic Violence amongst Infertile Women Attending Gynaecological Clinic at the University of Port Harcourt Teaching Hospital. International Journal of Research and Reports in Gynaecology. 2022;5(3):16–22.
18. Po E, Tz S, Sk HH, Ao O, Bt U, Onyemocho A, and Eu, U. Domestic Violence among Infertile Women in Makurdi, North- Central Nigeria. Gynecol Reprod Health [Internet]. 2019 Oct [accessed 2024 Apr 8];3(5). Available from: http://scivisionpub.com/pdfs/domestic-violence-among-infertile-women-in-makurdi-north-central-nigeria-870.pdf
19. Nachinab GT enkawol, Donkor ES and Naab F. Perceived Barriers of Child Adoption: A Qualitative Study among Women with Infertility in Northern Ghana. BioMed Research International. 2019 Jun 9;2019:1–9.
20. Oladokun A, Arulogun O, Oladokun R, Morhason IO, Bamgboye EA, Adewole IF and Ojengbede, O. A.. Acceptability of Child Adoption as Management Option for Infertility in Nigeria: Evidence from Focus Group Discussions. African Journal of Reproductive Health. 2009;13(1).
21. Bayu D, Egata G, Kefale B and Jemere T. Determinants of Infertility among Married Women Attending Dessie Referral Hospital and Dr. Misganaw Gynecology and Obstetrics Clinic, Dessie, Ethiopia. International Journal of Reproductive Medicine. 2020 Mar 27;2020:1–6.
22. Madziyire MG, Magwali TL, Chikwasha V and Mhlanga T. The causes of infertility in women presenting to gynaecology clinics in Harare, Zimbabwe; a cross sectional study. Fertil Res and Pract. 2021 Dec;7(1):1.
23. Moyo S. Indigenous knowledge systems and attitudes towards male infertility in Mhondoro-Ngezi, Zimbabwe. Culture, Health & Sexuality. 2013 Jun;15(6):667–79.
24. Moyo S and Muhwati I. Socio-Cultural Perspectives on Causes and Intervention Strategies of Male Infertility: A Case Study of Mhondoro-Ngezi, Zimbabwe. African Journal of Reproductive Health / La Revue Africaine de la Santé Reproductive. 2013;17(2):89–101.
25. Mashaah T, Gomo E, Maradzika JC, Madziyire MG and January J. Experiences of traditional health practitioners in the management of female infertility in Harare urban areas: A qualitative study. African Journal of Reproductive Health. 2024 Jan 25;28(1):110–22.
26. Tong A, Sainsbury P and Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. International Journal for Quality in Health Care. 2007 Sep 16;19(6):349–57.
27. Clarke V. Review of the book "Interpretative Phenomenological Analysis: Theory, Method and Research". Psychology Learning & Teaching [Internet]. 2010 Oct [assessed 2024 Jun 6];9(1). Available from: http://www.psychology.heacademy.ac.uk/s.php?p=55
28. Creswell JW. Qualitative inquiry and research design: choosing among five approaches. third edition. Los Angeles, Calif. London New Dehli Singapore Washington DC: SAGE; 2013. 448 p.
29. Malterud K, Siersma VD and Guassora AD. Sample Size in Qualitative Interview Studies: Guided by Information Power. Qual Health Res. 2016 Nov;26(13):1753–60.
30. Groenewald T. A Phenomenological Research Design Illustrated. International Journal of Qualitative Methods. 2004 Mar;3(1):42–55.
31. Hycner RH. Human Studies. In: Some guidelines for the phenomenological analysis of interview data. Martinus Nijihof; 1985. p. 279–303.
32. Ahmed SK. The pillars of trustworthiness in qualitative research. Journal of Medicine, Surgery, and Public Health. 2024 Apr;2:100051.
33. Lincoln YS and Guba EG. Naturalistic inquiry. SAGE Publications; 1985.
34. Nowell LS, Norris JM, White DE and Moules NJ. Thematic Analysis. International Journal of Qualitative Methods. 2017;16:1–13.
35. Khetarpal A. Infertility: Why can't we classify this inability as disability? AMJ. 2012 Jul 1;5(6):334–9.
36. Sternke EA and Abrahamson K. Perceptions of Women with Infertility on Stigma and Disability. Sex Disabil. 2015 Mar;33(1):3–17.
37. Annan-Frey L, Boateng EA, Lomotey A, Lartey C and Dzomeku V. Lived experiences and coping strategies of persons seeking infertility treatment in the Kumasi metropolis: a descriptive phenomenological study. BMC Women's Health. 2023 Feb 20;23(1):74.
38. Asiimwe S, Osingada CP, Mbalinda SN, Muyingo M, Ayebare E, Namutebi M and Muwanguzi, PA. Women's experiences of living with involuntary childlessness in Uganda: a qualitative phenomenological study. BMC Women's Health. 2022 Dec 19;22(1):532.
39. Dierickx S, Balen J, Longman C, Rahbari L, Clarke E, Jarju B and Coene, G. 'We are always desperate and will try anything to conceive': The convoluted and

dynamic process of health seeking among women with infertility in the West Coast Region of The Gambia. Fledderjohann J, editor. PLoS ONE. 2019 Jan 31;14(1):e0211634.
40. Fledderjohann JJ. "Zero is not good for me": implications of infertility in Ghana. Human Reproduction. 2012 May 1;27(5):1383–90.
41. Njogu A, Njogu J, Mutisya A and Luo Y. Experiences of infertile women pursuing treatment in Kenya: a qualitative study. BMC Women's Health. 2022 Sep 2;22(1):364.
42. Sambasivam I and Jennifer Hg. Understanding the experiences of helplessness, fatigue and coping strategies among women seeking treatment for infertility – A qualitative study. J Edu Health Promot. 2023;12(1):309.
43. Kordi M, Ghasemi Gujani M, Andaroon N and Shakeri MT. Relationship Between Perceived Violence and Post-traumatic Stress Disorder in Infertile Women: A Case-Control Study. Health Scope [Internet]. 2023 May 4 [accessed 2024 Apr 10];12(2). Available from: https://brieflands.com/articles/healthscope-134367.html
44. Silwal A and Thapa B. Prevalence of Domestic Violence among Infertile Women attending Subfertility Clinic of a Tertiary Hospital. JNMA J Nepal Med Assoc. 2020;58(226):372–6.
45. Cui W. Mother of nothing: the agony of infertility. Bull World Health Org. 2010 Dec 1;88(12):881–2.
46. Inhorn MC and Patrizio P. Infertility around the globe: new thinking on gender, reproductive technologies and global movements in the 21st century. Human Reproduction Update. 2015 Jul 1;21(4):411–26.
47. Temitope L. A qualitative synthesis of the impact of infertility on the mental health of African women. African Journal of Reproductive Health. 2022 Dec;26(12).
48. Karaca A and Unsal G. Psychosocial Problems and Coping Strategies among Turkish Women with Infertility. Asian Nursing Research. 2015 Sep;9(3):243–50.
49. Hess RF, Ross R and GilillandJr JL. Infertility, Psychological Distress, and Coping Strategies among Women in Mali, West Africa: A Mixed-Methods Study. African Journal of Reproductive Health. 2018;22(1):60–72.
50. Maduakolam I, Umeh U, Ndubuisi I and Onyekachi-Chigbu A. Coping strategies of infertility clients attending gynecological clinic in South-eastern Nigeria. Niger J Med. 2021;30(1):40.
51. Pedro A. Coping with Infertility: An Explorative Study of South African Women's Experiences. Open Journal of Obstetrics and Gynecology. 2014 Dec 25;5(1):49–59.
52. Tabong PTN and Adongo PB. Infertility and childlessness: a qualitative study of the experiences of infertile couples in Northern Ghana. BMC pregnancy and childbirth. 2013;13(1):72.
53. Iordăchescu DA, Paica CI, Boca AE, Gică C, Panaitescu AM, Peltecu G Veduță, A and Gică, N.. Anxiety, Difficulties, and Coping of Infertile Women. Healthcare. 2021 Apr 15;9(4):466.
54. Bazargan-Hejazi S, Gaines T, Bazargan M, Seddighzadeh B and Ahmadi A. Alcohol Misuse and Multiple Sexual Partners. WestJEM. 2012 May 1;13(2):151–9.
55. Eggert J, Theobald H and Engfeldt P. Effects of alcohol consumption on female fertility during an 18-year period. Fertility and Sterility. 2004 Feb;81(2):379–83.
56. Bokaie M, Farajkhoda T, Enjezab B and Zarchi MK. Barriers of child adoption in infertile couples: Iranian's views. Iran J Reprod Med V. 2012;10(5).
W7. Adewunmi AA, Etti EA, Tayo AO, Rabiu KA, Akindele RA, Ottun TA and Akinlusi, F. M.. Factors associated with acceptability of child adoption as a management option for infertility among women in a developing country. IJWH. 2012 Jul;365.