

Cultural Misconceptions And Emotional Burden Of Infertility In South East Nigeria

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Citation

O Umeora, G Igberase, S Okogbenin, I Obu. *Cultural Misconceptions And Emotional Burden Of Infertility In South East Nigeria*. The Internet Journal of Gynecology and Obstetrics. 2008 Volume 10 Number 2.

Abstract

Background:

Infertility is prevalent in Southeast Nigeria and may impart negatively on the emotional and social wellbeing of affected couples.

Aims & Objectives

To assess the prevalence, pattern, misconception and sources of infertility crisis among the Igbo population of Southeast Nigeria.

Materials and Methods

In depth interviews with women attending infertility, over a six month period (July to December 2006).

Results:

Twenty four women were interviewed, 66.7% had secondary infertility. Women were held responsible for infertility and bore the burden of seeking treatment. They suffered intimate partner abuse, psychological and emotional trauma from their families, as well as isolation and stigmatization from the society

Conclusion.

Medical education on the physiology of infertility may play a role in the integration of men in treatment seeking process in infertility. Doctors should manage the emotional and psychological aspects of infertility.

INTRODUCTION

Infertility is a global problem particularly in the developing countries. It is estimated that one in three couples is affected in countries within central Africa according to a report ¹.

Infertility is common in gynecological clinic consultations in Nigeria. The African society places passionate premium on procreation in any family setting. The woman's place in marriage remains precarious till confirmed through child bearing. In the society, a woman has to prove her womanhood through motherhood. The man also has to confirm his manhood in same fashion. Children are held as sources of pride, strength and economic fortune for the family, a man's wealth and strength being equated to his progeny. Infertility therefore entails a loss of something even though previously inexistent is thought to be tangible and therefore impacts negatively on a couple's mental and social

wellbeing ².

Infertility constitutes a crisis in the affected African family. The attendant emotional, psychological, cultural and social burdens drain the couple of self belief and esteem. The unsolicited and often inpatient societal demands and expectations place on such couples unimaginable pressure and tension. They may become isolated and neglected consequent upon the attendant social stigmatization ³.

Illiteracy is rife in most communities in Southeast Nigeria. Medical knowledge is abysmal. Diseases and disease processes are interpreted variously to suit the different fora and situations. Many notions exist as to the etiopathogenesis of infertility. Taken generally, the female is held responsible for virtually all cases of infertility. The men folk are held as above board. Consequent upon this, the woman is humiliated

isolated, derided, abused and rebuffed. Undergoing such life crisis has been the stories of most infertile women in Africa. They go to varying lengths visiting orthodox medical practitioners, herbalists, traditionalists and spiritualists in search of needed reprieve and solution. Such women have consulted our clinics and this study sought to assess the sources, pattern and extent of such emotional crisis among this subset of the population in South East Nigeria.

MATERIALS AND METHODS

This was a qualitative survey involving women who attended the infertility clinic of the Ebonyi State University Teaching Hospital, Abakaliki over a six-month period (July to December 2006). Ethical clearance was sought and obtained from the hospital's Ethics and Research committee. Infertility consultations are held weekly (Mondays) by the infertility and endocrinology unit of the Obstetrics and Gynecological department of the hospital. By random selection the 2nd and 3rd Mondays of each month was selected for the study. New patients referred for infertility consultations were numbered on each day. The Principal investigator handed over cards in sealed opaque envelopes to the clinic nursing staff for distribution to the patients before consultation. Only two of such cards were marked 'YES' and this implied recruitment for the survey. All the patients were seen and managed according to the normal clinic procedures. Identified patients (with YES) were further educated on the survey and their consent sought before eventual recruitment for an in-depth interview.

The interviews were undertaken personally by the first and last authors. Questions ranged from the biodata of the patients to cover aspects of emotional, social and psychological burdens to the patients. The interviews were recorded on a Tape recorder and later transcribed for analysis.

RESULTS

The randomly selected twenty-four women with infertility consented to and were the subjects of this study. They were interviewed separately in the clinic. Each session lasted between 35 minutes and 72 minutes with a mean of 49.5 minutes. Almost all the women had an initial uncertainty and were apparently withdrawn at the beginning of the sessions. They however became more confident and were happy to relate their experiences as the interview progressed in a more relaxed atmosphere. Invariably they showed satisfaction and gratitude at the end of the interview.

SOCIO BIOLOGICAL VARIABLES

The subjects' ages ranged from 22 years to 40 years. The mean was 30.6 ± 5.4 years and the duration of infertility was from 1 year to 11 years. The mean duration was 3.2 years. Eighteen respondents (75%) had secondary infertility. The mean and modal parities were 1 and 0 respectively. Two of the respondents were grandmultiparas. Between the respondents were a total of 16 early pregnancy losses via induced (66.7%) or spontaneous (33.3%) miscarriages. Four (16.7%) were in a polygamous family setting while one of the women just re married. Using the Olusanya et al₄ (1985) formula for socio economic stratification, one and three respondents belonged to the first and second classes respectively, while the rest were mainly in the lower echelons (Classes 4 and 5).

MISCONCEPTIONS AND BURDEN OF INFERTILITY IN NIGERIA

Figure 1

Table 1: Socio biological Variables of the 24 respondents.

Parameters	Number	Percentage(%)
Age (years)		
20 – 24	4	16.7
25-29	7	29.2
30-34	10	41.7
35-39	2	8.3
≥40	1	4.2
Parity		
0	12	50.0
1-4	10	41.7
≥5	2	8.3
Family Setting		
Polygamous	5	20.8
Monogamous	19	79.2
Social Class		
I	1	4.2
II	3	12.5
III	2	8.3
IV	7	29.2
V	11	45.8
Duration of Infertility (years)		
<2	7	29.2
2-5	14	58.3
6-10	3	12.5

PREVIOUS MANAGEMENT FOR INFERTILITY

AND MALE INVOLVEMENT

Nineteen of the subjects had earlier sought treatment from different facilities before referral to the Teaching hospital, ten of these were referred from peripheral clinics and Health centers within the State. Two came from a traditionalist in a nearby village acclaimed to be able to remove uterine fibroids without surgery, while the remaining seven came in from spiritual and herbal homes respectively. In all the cases above, desire to seek management emanated from the women and only in two of the cases from the peripheral clinics were the husbands involved having undergone seminal fluid analysis. In all the cases (24), the present desire to pursue further management in the Teaching Hospital was female-driven and only in the seven cases were the husbands present during this initial visit. In four of the cases referred from the peripheral health facilities, the husbands had out rightly rejected prescribed investigations for the fact that they were 'normal and had no problems'. The ones from the traditionalist did not have support of their spouses either. Majority of the women (5 out of 7) who presented from the spiritualists and herbalists however had their full husbands' co operation.

ETIOLOGY OF INFERTILITY

The spiritualists, herbalists and traditionalists who attended to the women believed that the women were responsible for the infertility. The diagnoses from the orthodox centers were also female-centered. In 17 of the total 24 (70.8%), the husbands also held the women responsible for the infertility. As Mrs. EJ – a 31 year old petty trader from Afikpo (a semi urban setting) and referred from a peripheral facility put it:

‘ My husband told the doctor that I was responsible for this problem, that he is very normal, after all, he already had a son from his former (girl)friend 10 years ago. He said I must have destroyed my womb (uterus). He even refused to do the test the doctor asked him to do”

The traditionalist had her own etiopathogenic explanation. She related to Mrs. NN – a 34 year old primary school teacher that

“The fibroid you have is as a result of old and dirty blood you got when you were meeting various men in the past. This has now blocked your Fallopian tube and you cannot get pregnant unless I remove it”

More interesting was the etiology offered by the spiritualist to Mrs. MJ – a 29 year old farmer from Ndubia (a rural settlement). He said

“This your problem is not your fault, but your mother annoyed some people before she delivered you and those people are now attacking you through witchcraft to make your mother unhappy. They have blocked your womb and kidneys.....”

THE EMOTIONAL CRISIS

“If they left me alone, I will not have any problem. They have convinced my husband who had been by my side to join them and now I do not know where he belongs to again, he now gets irritated quite easily. God, I cannot just bear this again. Please doctor help me” Mrs. CA – a 25 year old primary infertility patient and a Law undergraduate cried as she narrated her experiences.

Other women related their unpleasant experiences likewise. Mrs. IG was a 30 year old staff of the State tertiary institution.

“Doctor, it has been quite terrible, quite terrible. I wished I was not married rather than go through all this. I can hardly concentrate on my duties these days, my appetite is poor. The pressure is just too much; I just hope this will be over one day. You cannot believe some uneducated women, illiterates at best could stand up to me during a meeting, abused and derided me just because of my childlessness. Doctor, do your best, I know God almighty will answer me”

Most of the respondents admitted going through emotional and psychological crisis with a feeling of worthlessness especially in company of their peers. They feel lonely in the midst of friends and relatives. The despondency in their tones could easily be deciphered. This was a 39 year old multipara with a 7 year history of secondary infertility.

“My husband has just gone to marry another young woman. I have two children for him but he still wants a male. He has totally neglected me and makes me feel like a rag in his house. I am alone in this world but I pray that one day I will win again and I will stop crying at nights”

For Mrs. ER, her future remains uncertain without a child for her husband – a thought that erodes her self confidence and makes her withdrawn.

“My cries have not solved my problem. The worst is that I do not know of my place in this family. It scares me and makes me keep to myself. In fact it affects me in everything I do”.

For the grandmultipara:

“Well I do not really have any problems with any body. My husband only wants more children, if God answers us, we will be happy”.

For over a half of the respondents however, it is all a feeling of abandonment, frustration and depression. Mrs. EC again puts it succinctly:

“Doctor, it has not been easy for me. My mother in law has been a pain on my neck and does not allow me any peace. She blames everything on me, even when her son refuses to be tested. God knows I have not done anything in the past to deserve this. It is really frustrating for me. But for you listening to me and my fellowship (Christian community) members, I would have been depressed”.

More humiliating for her was once her mother-in-law came back from a child's naming ceremony to rain insults on her in the presence of her visitor.

“Come o! this girl, I am just coming back from my friend's house where we enjoyed ourselves for the naming ceremony of her granddaughter (emphasis). Come and see us and everybody dancing and making merry, you should have been there to see for yourself, to see what you have been denying me and this family all these years; I ask you again, when are my going to invite my friends for child's dedication service, for a child's naming ceremony and all that. Do I need only to be invited all the time and all over the place? Can't I invite others to my house? When am I going to hear a baby cry in this house? ANSWER ME YOU WITCH (Emphasis), you worthless man in a female's body.....”

Her response was cries, sobs and cries and tearful supplication to God, but she felt thoroughly humiliated and obviously abused.

Varied were the sources of this pressure for the various women. Implicated most often were the Mothers-in-law (75%), Husbands (58.3%), Friends (41.7%), Other relatives (58.3%), Patients own mothers (50.0%) Sisters/brothers-in-law (45.8%) and the Fathers-in-law (20.8%).

Figure 2

Table 2: Sources of Pressure for the infertile women.

Sources	Number	Percentage (%)
Mothers	12	50
Mothers-in-law	18	75
Sisters/brothers-in-law	11	45.8
Fathers-in-law	5	20.8
Husbands	14	58.3
Friends	10	41.7
Other relatives	14	58.3

The attendant intimate partner violence was captured in the words of Mrs. NK

‘Doctor, I have really suffered. You can't believe my husband as educated as he is beats me because of this (infertility), yes, he beats me..... I really regret the day this man came to our house to seek my hand in marriage. It must have been a cursed day, because this man is a devil, a devil in human's skin. He has turned me into a punching bag. I don't think he would have one this if I had a son or even a daughter because they will stand up to him no matter how small they are' .

Some women however may be luckier in terms of spousal support and compassion. However, this still affects the woman who feels worthless in herself and unworthy for her husband and may become depressed with some fatalistic desires. Mrs AK, a 29 year old nursing staff with secondary infertility of 5 years was a typical example:

Doctor, I am tired and I mean it I am very tired of the whole thing. I feel my body is not mine again. Why is my case so complicated, I now have chest pain, waist pain and all sorts of problems. The worst is that any time I consult with the Physicians' they believe it is 'Hysteria' because of my condition. In fact, if death will come now, that will be okay. I only feel for my husband, only if he were okay himself (said to be oligospermic), we would have married another girl for him and let me die off....’

Interviewer: Why do you feel this way, is anybody worrying you or putting you under pressure?

Mrs. AK: ‘ No, nobody worries me but I need to worry myself, yes I need to. Why am I like this, in fact death should come'.

DISCUSSION

Gender inequity permeates the African society and pervades all aspects of her cultural, socio economic and health systems. In many of these settings, the domineering male sets the agenda and takes the decisions on all issues affecting the family generally including the reproductive health of the woman. Most reproductive health programs especially targeting maternal health and mortality have realized this negative trend and concerted efforts made to address them. Access to quality maternal health programs aimed at reducing maternal mortality and serious morbidities are now seen in the light of reproductive health rights and constitute a major target in the millennium development goals. Unfortunately, this focus has not been beamed on issues of infertility³ which lie in the heart of the African women, debasing them, humiliating them and eroding their basic human dignity and rights. This study has revealed the unenviable status of the African woman in an infertile family setting.

In this survey, infertility cut across all age groups, social classes and parities. Women of high parities were caught in the web in their quest for a male offspring an important ingredient in the patrilineal proclivity and family perpetration desire in the traditional African society. The preponderance of the cases among the lower socio economic strata confirms earlier such observances wherein high prevalence of poorly treated pelvic inflammatory disease among such groups was deemed responsible². Tubal factors remain the commonest etiological issue in infertility in sub Saharan Africa^{2,5}.

Traditional norms in Nigeria and Africa generally accord a domineering place to the men folk. They determine the cultural and traditional ethos which often is skewed in their favour. They reserve the family's economic and decision-making power. They make medical assumptions and diagnosis without any clinical or diagnostic aids. As a result women are held responsible for all cases of infertility⁶ even though male factors are known to be contributory in about 59% of all cases in Nigeria⁵. Infertile women are believed by the men to have lived unhealthy past with repeated cases of abortions and sexually transmitted diseases precipitating their current condition. No thought is spared for the men and their ability to have also been afflicted with sexually transmitted infections which may also make them responsible for the present childlessness. They remain deluded about their satisfactory reproductive health status and would not be drawn to any orthodox medical

evaluations. The women are thus driven to seek solutions for 'their' problems. This is in contrast to a South African study in which the men aware of male contribution to infertility were involved in the health-seeking process⁶.

The ignorance and deceit perpetrated by some traditional healers and spiritualists were evident in their summation of the causations of infertility and their claims to provide unorthodox remedy. Supernatural and mythical dimensions also color the etiology of infertility in Africa. Unfortunately, the frustrations inherent in the situation and primarily borne by the women make them easy preys for such charlatans. They spend their time, money and occasionally pay with their lives. The author has in his clinical practice managed cases referred from such charlatans often with pelvic and intraperitoneal abscesses and overwhelming sepsis. Two of such women have been lost. It also appeared that even the orthodox medical practitioners fall into the conspiracy of feminizing infertility as regards its etiology. The two referrals from the peripheral clinics implicated "Female factors" even when no medical history, physical examination nor investigations were carried out on the men. No mention was made of male factor in the referral notes as a possible contributor to the infertility state.

The life crisis implicit in infertility was shown in this study. Most of the women have their stories to tell, some sad, some emotional, some frustrating, some abusive, some annoying but all humiliating and dehumanizing. Men in such family set up are also derided by their peers. They in turn take it out on their spouses, constantly reminding them of their childless status and bringing shame and ignominy to the family. Such constant domestic violence in terms of verbal abuse, insults and occasionally, physical harm serve as permanent psychological impediments to these women to pass through the stages of crisis to attain the final resolution stage. For them 'waiting for the fruits of the womb' as is put in local parlance becomes a nightmare with which they cannot cope. Living within the immediate family becomes a torture as the mothers-in-law in most cases lead other family members in verbal and psychological oppression of the woman. The husband is spared and when he teams up with the family, the hopeless and tortuous cycle is complete for his spouse. Intimate partner abuse, separation, abandonment or divorce may follow^{2,7,8}. The 'loss' of children who never existed and who could have 'protected' her from the various assaults deepens the emotions and crisis. Unfortunately, this pressure is neither eased by their mothers nor friends. The mothers do not want to be 'disgraced' by an infertile

daughter. Even those that are spared from this family or intimate partner abuse become eroded of all self esteem and dignity, life becomes worthless, meaningless and an inescapable torture where only death becomes the only desire.

CONCLUSION

Infertility as regards its etiology and management is being feminized in South East Nigeria. The women bear the brunt of infertility and are stigmatized even when the males adamantly refuse medical evaluation. They undergo a lot of mental, emotional, psychological and physical pressure and often times falling prey to Charlatans in their arduous quest for fertility. Doctors and Gynecologists working in this area should never lose sight of the emotional and psychological aspects of infertility and its management and should utilize the opportunity of such clinic consultations to evaluate the psychological impact of the pathology on the couple and offer appropriate counseling.

There is need for community education on the physiology of involuntary childlessness and appropriate counseling of men in order to integrate them into infertility treatments. Meanwhile, governments in the developing countries, donor agencies and international organization should realize that infertility management may be more important to the African woman than issues of their physical health irrespective of whether such illnesses could precipitate further morbidities or even death. In this way then may the targets of the millennium development goals as regards women's wellbeing be realized.

ACKNOWLEDGMENT

The authors are grateful to all the women who participated in this study as well as the nursing staff in the gynaecological clinic of the Ebonyi State University Teaching Hospital, Abakaliki for their co operation.

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