

**THE EXPERIENCES OF INFERTILE AFRICAN WOMEN
IN DURBAN**

BY

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DECLARATION

THIS STUDY IS THE ORIGINAL WORK OF THE AUTHOR, UNLESS SPECIFICALLY INDICATED TO THE CONTRARY IN THE TEXT. IT IS BEING SUBMITTED FOR THE DEGREE OF MASTER OF CURATIONIS (FAMILY-CENTRED MATERNAL AND CHILD HEALTH NURSING), AT THE UNIVERSITY OF NATAL, DURBAN. IT HAS NOT BEEN SUBMITTED BEFORE FOR ANY DEGREE OR EXAMINATION IN ANY OTHER UNIVERSITY.



NELISIWE DORCAS NDABA

DECEMBER 1994

DEDICATION

I dedicate this thesis to my late mother, *THOKO LILLY NDABA (u ma Ndlovu, uka Makhanya)*, for your love and care since conception until now. Though gone, your loving memories live on and your love for education remains my source of encouragement through thick and thin. I thank you, my dear mother, for everything.

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ABSTRACT

The experiences of African women with primary infertility were explored. These women were from Durban and surrounding rural areas, in KwaZulu / Natal. The aims of the study were to describe their perception of infertility using King's (1981) Interacting Systems Model and to describe the actions they undertook in response to their problem of primary infertility.

A purposive sample of the first ten consenting women with primary infertility, five from the academic hospital and five from a private gynaecological practice were selected on the day when they attended either health centre. Case studies were conducted using in-depth interviews.

Women's personal, interpersonal and social systems were adversely affected by their problem of being unable to conceive. For example in the taped discussions, all ten participants had a low self-image in regard to their personal system which was reflected in all but four, when measured with Rosenberg's Self-Esteem Scale (Rosenberg, 1979). All women were found to be at various stages in the grief process, only one having attained acceptance (Kubler-Ross, 1969).

Eight women were married and the remaining two were single. Four of the married participants had experienced problems with "in-laws", which has led to poor interpersonal relationships, unlike the other four married participants.

Despite not being major decision-makers in the household, all the participants were allowed to make their own decisions about whom they saw in regard to infertility. All

the women concerned made use of formal medical facilities but four participants made use of traditional and/or faith healers as well.

Some of the problems identified were the lack of emotional support from nursing personnel as well as their own lack of understanding of causes, investigations and treatment of female infertility.

Recommendations regarding effective nursing care of women with infertility and the possible formation of support groups, were made. As all the participants were literate, informative pamphlets could be developed. Areas of further research were identified.

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CHAPTER ONE

INTRODUCTION

1.1. BACKGROUND TO THE STUDY:

The first setting for this study is an academic hospital which is a referral hospital for the greater Durban area, KwaZulu Natal. This hospital is the biggest in Natal with 1983 beds. The total number of deliveries in the year 1993 was 11 680 and the total number of gynaecological outpatients with acute and other problems was 31 533. This gynaecological clinic attends to patients with problems such as pelvic inflammatory disease, ectopic pregnancy and per vaginal bleeding including abortions. The patients with chronic diseases including infertility, fibroids, carcinoma of the reproductive organs are referred to a special gynaecological clinic situated in the ante-natal clinic. In 1993, 523 women attended the clinic with infertility problems.

The second setting is the obstetrician and gynaecologist's practice in the city of Durban. This is situated centrally and is very popular among African women with gynaecological and obstetrical problems.

The researcher's interest in the subject of infertility in women has been aroused by the observation that infertile women's emotional needs often go unmet. The researcher observed this while she was working in the obstetric and gynaecological clinic in one of the hospital's in Natal.

The researcher was motivated by a desire to be able to give support to infertile women. The researcher chose women as the focus of this study because they are the people who present themselves to the clinic with the problem of infertility, and men seldom accompany them.

1.2. DEFINITION OF INFERTILITY:

The World Health Organisation defines primary infertility as "a woman who has never conceived despite cohabitation and exposure to pregnancy for a period of two years or more" and secondary infertility as "a woman who has previously conceived but is subsequently unable to conceive despite cohabitation and exposure to pregnancy for a period of two years or more." (W.H.O., 1975, p.20).

Jensen & Bobak (1987,p.14) define infertility as "the inability to conceive after at least one year of exposure to pregnancy when no contraceptive measures were used."

In discussion with the hospital gynaecologist working in the gynaecology unit of an academic hospital, it was identified that their definition of primary infertility is similar to that of the World Health Organisation's. The only difference is the period of exposure to pregnancy. In the academic hospital they start investigating when the women has been exposed to pregnancy for a period of eighteen months or more, not waiting until the full two years (Monokoane, 1994). The marital status and age factors were not taken into consideration, as long as the woman presents herself to the clinic with the

problem of infertility. The woman is investigated whenever she wants to exclude herself as being responsible for the infertility. However, World Health Organisation indicates that age should be considered, since the proportion of couples who are naturally infertile increases with age, particularly rapidly after 35 years, and also occurs in the first two to four years after puberty (W.H.O., 1975).

Thus, in this study, women at extremes of age in their reproductive years, will not be taken into consideration. This includes the adolescent near puberty whose fertility is not well developed and also the middle and older adolescent as they are often at school until about nineteen years of age and in the researcher's view, may be unlikely to have a year or more of regular sexual relations. It also includes older women, because of the decline in fertility as age increases beyond thirty-five years. The researcher will thus focus on women between the ages of twenty to thirty five years, despite the reproductive age span being between fifteen to forty-nine years (Wallace & Giri, 1990).

OPERATIONAL DEFINITION

For the purpose of this study, a woman with primary infertility is a woman who has never conceived despite exposure to pregnancy for a period of eighteen months or more, without use of contraceptives and who is attending the gynaecological clinic either in the hospital or in the consultant's practice because of infertility. This definition is in line with the understanding of infertility in the hospital under study as well as in the consultant's practice.

1.3. **PROBLEM STATEMENT:**

Infertility is an important gynaecological problem in the developing world as indicated by Williams, Baumslag and Jelliffe (1985), who report that not only is fertility highly prized in the developing world but infertility is a common occurrence in about 40% of women. Winnikoff in Wallace & Giri (1991, p.181) also found the infertility rate in the sub-Saharan Africa as being as high as 50% as compared to 11% in the developed world.

This general fertility rate in the U.K. has been defined by Hibbard (1988, p.11) as "the number of live births / 1000 women aged 15-44". The world-wide extent of infertility has never been systematically described and therefore the prevalence of infertility is very difficult to obtain. This is due to lack of uniformity in diagnosing, investigating and treating each partner in regard to infertile couples. This makes the comparing of data very problematic (Cates, Farley and Rowe, 1985). The problem of infertility has emotional and social sequelae (Belsey, 1976). Another problem is that health professionals often lack insight into infertile women's emotional needs, (Sherrod, 1988). Furthermore, according to Davis (1987), the psychological effects of infertility are often not taken into account by health professionals. There is however, considerable research on the psychological effects of infertility that has been undertaken in the developed world, particularly in the United States.

However, research that has been carried out in South Africa has mainly addressed the causes, the effects of infertility and its treatment. It is thus basically medically orientated. No research has been identified that was undertaken by nurses with regard to infertility in South Africa.

In order to determine the feasibility of the present study, the preliminary analysis of records in a academic hospital was conducted in May 1994. In the gynaecological clinic dealing with infertility, carcinoma of the cervix, fibroids and other chronic problems, the total number of patients who attended the clinic in 1993 was found to be 523, and 32% of these women had infertility problems, which indicated its importance.

1.4. THE PURPOSE OF THE STUDY:

The main aim of the study is to examine infertility through women's perceptions and to explore their experiences, responses and actions following the diagnosis of infertility.

1.5. RESEARCH OBJECTIVES:

1.5.1. To describe the perceptions of infertility on African women with regard to their personal, interpersonal and social systems.

1.5.2. To describe their actions in response to infertility.

1.6. THEORETICAL FRAMEWORK:

The most appropriate conceptual framework for focusing on infertility is King's dynamic interacting system. This is because infertile women are affected in their personal, interpersonal and social systems.

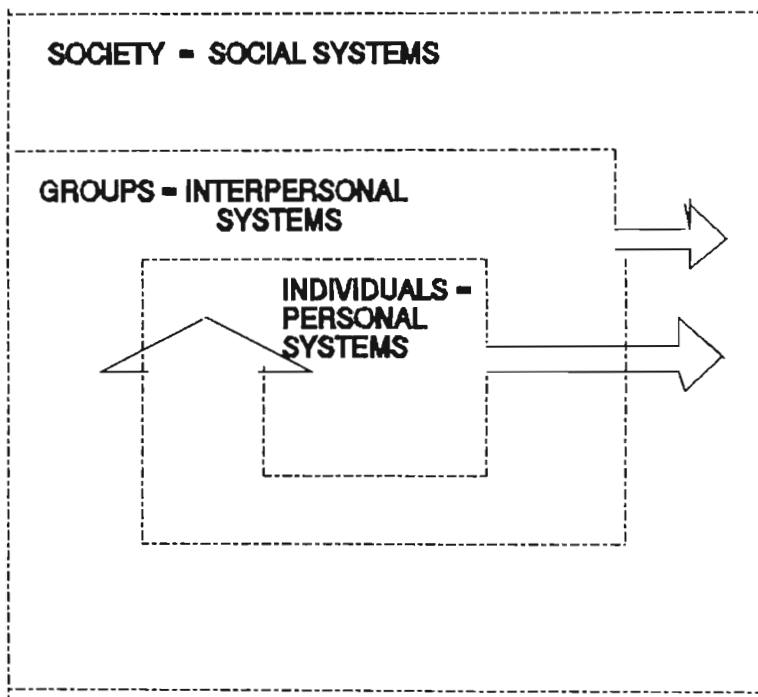


Figure 1 : King's Dynamic Interacting System (King, 1981).

A theory for nursing systems, concepts and process.

1.6.1. PERSONAL SYSTEM

Individuals are personal systems characterised by a perceptive ability, thinking ability, goal setting and decision-making ability. These abilities enable human beings to react to their experiences as total beings. The concepts of self, body image, growth and development are within the personal system. Each individual thus perceives infertility in a unique way (King, 1981).

1.6.2. INTERPERSONAL SYSTEMS

The personal system reactions to infertility can influence the infertile individuals relationships with others. Within the interpersonal system King (1981, p.59) included the concepts of interaction, communication and transaction. Infertility has negative effects on marital relationships. Communication problems may exist between couples with an infertility problem and partners have reported experiencing difficulty in sharing feelings with each other (Davis, 1987). Infertile individuals may experience conflict at the interpersonal level because of inability to acquire the role of the parent.

1.6.3. SOCIAL SYSTEM

King's discussion of the concept of social system is directly related to the nurse's functioning in a large organisation. The concepts used in social systems are power, authority, decision-making and status, and all three concepts apply to infertile individuals. The infertile individual often feels powerless to control events, and effect change since her life seems to be guided by the menstrual cycle. Social activities and work schedules are arranged to accommodate the plans for conception if at all possible (Davis, 1987).

These feelings of powerlessness may be associated with the realisation that infertility cannot be consciously controlled by the individual and with need for individuals to submit themselves for diagnostic tests, prescribed treatments and often rigid routines accompanying the medical regime for infertility.

Infertile individuals may sense a loss of status among family and friends who have children (Davis, 1987). According to King (1981, p.129) status is defined as "the prestige attached to a role" and for the individual who is infertile, the prestige as well as the privileges, duties and obligations attached to parenthood are unobtainable (Davis, 1987).

Authority is defined as "the power to make decisions regarding one's own actions and the actions of others" (King, 1981, p.124). For the infertile individual, authority figures such as parents who want to become grandparents, may exert

considerable influence that may be either negative or positive. The physician treating the infertile couple may become an authority figure.

Finally, infertile women may lack a sense of how to go about or organise making decisions about her future. The more the individual is unable to achieve her goal of motherhood, the more likely she will desire her goal, which produces a circular interaction that keeps reoccurring until she resolves her feelings (Davis, 1987).

1.7. CONCLUSION:

The literature in relation to infertility is reviewed in the following chapter. Where applicable, literature on infertility is related to King's Model which has been presented in this chapter.

CHAPTER TWO - LITERATURE REVIEW

INTRODUCTION

In this chapter literature related to infertility will be presented under the following headings: prevalence; causes in females and in males; investigative procedures, current status of treatment and the effects in relation to personal interpersonal as well as social systems according to King's Interacting Systems.

2.1. THE PREVALENCE OF INFERTILITY:

According to Gray (1990, p.155) "the prevalence of primary infertility in Africa as a whole is around 10% compared to 3% to 6% in other developing countries."

The World Health Organisation report that between 60% and 84% of couples in the developed world needing infertility investigations, have primary infertility. However, this is not the case in Africa where a primary infertility rate of 48% has been reported (W.H.O., 1975 in Gray 1990, p.156). In a study that was sponsored by the World Health Organisation, with the aim of collaborating and ensuring a standard approach in the evaluation of infertile couples, Cates, Farley and Rowe (1985) found that the pattern of infertility in African centres was different from those in the developed countries, as well as other developing countries. The African couples were found to have more secondary infertility from sexually transmitted diseases. Winnikoff in Wallace and Giri (1990, p. 181) found the infertility rates to be as high as 50% in the Sub-Saharan Africa as compared to 11% in the developed world.

The fact that the world-wide extent of infertility has never been described systematically, poses a problem in trying to find the prevalence of infertility in South Africa. This is because various centres use a variety of methods in the investigation, diagnosis and treatments of infertile couples (Cates, Farley and Rowe, 1985).

2.2. THE CAUSES OF INFERTILITY IN WOMEN:

Kruger in Odendaal, Schaetzing and Kruger (1993, p. 131) supported by other authors such as Gray (1990) and Jensen and Bobak (1987), identified the following causes of infertility in women:

2.2.1. CONGENITAL OR DEVELOPMENTAL FACTORS

Infertility could result from congenital or developmental factor, for example, abnormal external genitalia, where the women will present with an enlarged clitoris or fused labia leading to difficulty in penetration during intercourse. Another problem could be genetresia where there is an absence of vagina or shallow vagina, resulting in problems with intercourse. Infertility could also result from tubal defects as well as abnormalities of the ovaries. Therefore, it is clear that infertility can occur from any malformation or absence of reproductive tract structures.

2.2.2. OVULATION DISTURBANCE

Disturbance in ovulation could result from a dysfunction of the organs responsible for the production of the hormones necessary for ovulation, which may be either in the hypothalamus or in the ovaries. Hypothalamic tumours as well as ovarian cysts and tumours, can disturb the normal function of releasing hormones. The women will present with an anovulatory cycle. Diseases, for example, diabetes mellitus, Cushing's syndrome, Addisons disease, hyper and hypothyroidism are cited as having an association with anovulation. The use of oral contraceptives, especially those with a high oestrogen component, are also associated with anovulation.

Wheeler and Polan (1985) suggest that severe disturbances in nutrition, for example, anorexia nervosa leading to excessive weight loss, is associated with ovulatory dysfunction. Obesity is also associated with anovulation, due to increased levels of oestrogen in the blood stream. Besley (1976) cited the direct relationship between infertility and nutritional deficiencies due to hormonal changes.

Certain lifestyles, for example, people who are involved in strenuous exercise, often present with ovulatory disturbances. There is no clear association found between cigarette smoking, coffee drinking and ovulation dysfunction. However, Laurent,

Thompson, Addy and Moore (1992), cited that cigarette smoking increases the risk of primary infertility.

2.2.3. TUBAL PROBLEMS

The problems with the uterine tubes could be blockages or altered functioning. These may cause primary or secondary infertility. The blockage can occur as a result of scar tissue formation from pelvic inflammatory disease and this could lead to primary or secondary infertility. Blockage could also occur following pelvic surgery (Jensen and Bobak, 1987).

Gray (1990, p.155) indicated that gonorrhoea and chlamydia are the most common sexually transmitted diseases leading to pelvic inflammatory disease and subsequently to tubal damage. Infection-related causes of infertility were reported to be more common in Africa, a developing country, than in the developed countries (WHO., 1987, p.968). Besley (1976) also found tubal occlusion to be the most common cause of infertility in South Africa. Studies done in Kenya, Ghana, Sub-Saharan Africa and Gabon demonstrated that tubal occlusion is the most common cause of infertility in Southern Africa (Besley, 1976). Larsen (1978) reported that induced abortion may lead to damage to the fallopian tubes which could lead to secondary infertility.

2.2.4. UTERINE PROBLEMS

A malformed uterus could result in infertility, as well as an endometrium that is not adequately prepared for fertilised ovum which may occur due to the malfunctioning of the hypothalamus pituitary gonadal axis.

Endometrial infection has been mentioned as a cause of infertility (Jensen and Bobak, 1987). Endometriosis is also cited as a possible cause of infertility (Russel and Ziegler, 1993).

2.2.5. VAGINAL-CERVICAL PROBLEMS

The states that alter the vaginal pH, for example douches, infections, as well as the use of antibiotics, could give rise to a change in vaginal environment that is unfavourable to spermatozoa. Diabetes Mellitus, poor hygiene and emotional stress are the other factors which could change the pH of the vagina, thus resulting in infertility problems. The woman could also develop antibodies against a specific male's spermatozoa (Jensen and Bobak, 1987).

2.2.6. SOCIO-CULTURAL FACTORS

Socio-cultural practices in the community have been identified

as possible causes of infertility. These factors include migration of men which could affect the duration of cohabitation and thereby reducing the period of exposure to coitus. Both marital instability and polygamy may also have a direct effect on the frequency of intercourse, thus reducing the chance of pregnancy (W.H.O, 1975).

Houghton and Houghton (1987), state that the tendency of delaying having children by certain couples has led to an increase in the rate of infertility. This is true because infertility tends to decrease with increasing age. According to Jensen and Bobak (1987), some religions have certain prescriptions about sexual intercourse. It is, for example, a taboo for the Orthodox Jewish couple to engage in sexual relations during menstruation and for seven days thereafter, this is because of the dangers of "pollution". Fertility problems could thus arise when a woman is having a short cycle.

Other social factors which were identified by Ebomoyi and Adetoro (1990), are extremes of age in the reproductive years, women's level of education and religious affiliation. As has been mentioned previously, fertility decreases with increasing age and it is not well established within the first two to three years after puberty. Education as a social factor was found to have an influence on the use of health services by the infertile women. The women with either primary or post-primary school certificates were found to be using health services more than

those who were illiterate. Religious affiliation was also found to have a significant influence on how women deal with their infertility problems. It was discovered that certain Christians worshipped to enhance their fertility function and others used certain healing techniques to deal with their fertility problems. The unbelievers were found to suffer more reproductive problems than these Christians.

2.3. THE CAUSES OF INFERTILITY IN MEN:

According to Kruger, in Odendaal, Schaetzing and Kruger (1993, p.131), the causes of male infertility are pre-testicular, post-testicular, genito-urinary and immunological causes.

2.3.1. PRE-TESTICULAR OR PRE-GERMINAL CAUSES

This could be due to central gonadotrophic releasing hormones which may be due to tumours, infection and cerebral trauma. The pituitary gland may also have a deficiency in secreting follicle stimulating and luteinizing hormones which could be due to tumours, infection and trauma. Diseases, for example hypothyroidism and diabetes mellitus, can lead to central gonadotrophin deficiency thus resulting in infertility (Kruger, et al, 1993).

2.3.2. TESTICULAR CAUSES

The testicular causes of infertility could be due to chromosomal abnormalities resulting from idiopathic maturation arrest, radiation chemotherapy, mumps and trauma and these could lead to the problem of infertility.

2.3.3. POST-TESTICULAR CAUSES

The post-testicular causes could be from the congenital ductal obstruction of the vas deferens or blockage of the epididymis. The other cause of infertility can be impaired motility of the spermatozoa due to enzyme deficiency.

2.3.4. GENITO-URINARY TRACT CAUSES

Benson (1980) included epispadias and hypospadias as congenital causes of male infertility as the altered position of the external urethral orifice interferes with the spermatozoa having access to the cervical os. The penis and urethra may have other congenital malformations that may lead to interference with erection during intercourse and thus result in infertility. Urethral stricture from infections such as gonorrhoea, could also be a problem by interfering with the

passage of spermatozoa. Temporary infertility could result from infections of the prostate gland and the seminal vesicles.

2.3.5. IMMUNOLOGICAL AND SPERMATOZOAL CAUSES

Immunological factors causing infertility may be abnormalities in spermatogenesis such as oligospermia and aspermia. Male infertility can result from spermatozoal abnormalities for example, in volume, pH, viscosity, motility, numbers and morphology. A spermatozoa with any of the above-mentioned abnormalities can lead to infertility in men.

2.4. THE INVESTIGATIVE PROCEDURES OF INFERTILITY IN WOMEN AND THE CURRENT STATUS OF TREATMENT:

According to Wheeler and Polan, in de Cherney, Polan, Lee and Boyers (1988), the infertile couple should be investigated as a unit initially and then separately. A detailed history should be obtained from the women paying attention to the medical, surgical, gynaecological, contraceptive and socio-demographic histories. The women's general health including the nutritional status as well as the psychological well-being should be observed and problems identified. The occupational history is of importance since exposure to certain chemicals in the work place can cause infertility. The physician should do a thorough physical examination paying special attention to the reproductive system.

Observation of ovulation can be done by teaching the women how to check and chart her body temperature on a daily basis (see Figure 2). This procedure will help in the identification of ovulation problems. The checking of the ovulatory cycle will include the following: the regularity of the cycle depending on the individual's variation which is from 26 to 32 days, mid-cycle pain and appropriate mid-cycle mucus secretion. The cervical mucus should be examined by a doctor or nurse specialist for the amount, macroscopic appearance and ferning.

Anovulation problems will be diagnosed by abnormal menstruation for example, amenorrhoea and oligomenorrhoea, and where a woman presents with cycles that are longer than 35 days.

The laboratory investigations that are done are: checking of progesterone level on day 21, and it should be more than 30nmol/l in an ovulating woman, E2 (oestradiol) on day 12 to 14, the normal being 700 to 1200pmol/l, endometrial biopsy can be done on day 24 to 26 whereby the secretory pattern is checked on histology and luteinizing and follicle stimulating hormones that are more than 30IU will be indicative of ovarian insufficiency.

Post coital test (PCT) is an investigation undertaken to evaluate the production of cervical mucous and to assess its interaction with sperms. It is done in the pre-ovulatory phase, two days prior to ovulation, when the level of oestradiol is at its maximum and there is plenty of mucous. The couple should be given information on the preparation for the test such as abstinence from intercourse two to three days before the test and that the test is performed two to twelve

hours post intercourse. It is important that the couple should be given up to twelve hours before the test to alleviate pressure.

Evaluation of the pelvis and the fallopian tubes can be done using an ultrasound scan. The physician can also do a hysteroscopy or a hysterosalpingogram (HSG) to check for tubal patency. A laparoscopy can also be done in combination with hysterosalpingogram, the timing of which is crucial and the times are indicated in Figure 2, hysteroscopy with chromopertubation may also be undertaken. These procedures should be done on day 6 to 10 when the menses have stopped because there is minimal endometrial lining and there is no possibility of the woman being pregnant. The presence of any infection in the reproductive tract should be excluded to prevent introduction of infection into the fallopian tubes.

Wessels, (1994, p. 264-269) gives the following current status of infertility treatment; induction of ovulation, artificial insemination, regulation and restoration of cervical mucus quality, immunosuppressive therapy treatment of endometriosis, microsurgical repair of the fallopian tubes, gamete intrafallopian transfer, embryo intrafallopian transfer and micromanipulative techniques in an attempt to achieve fertilisation. The type of treatment depends on the specific cause of infertility.

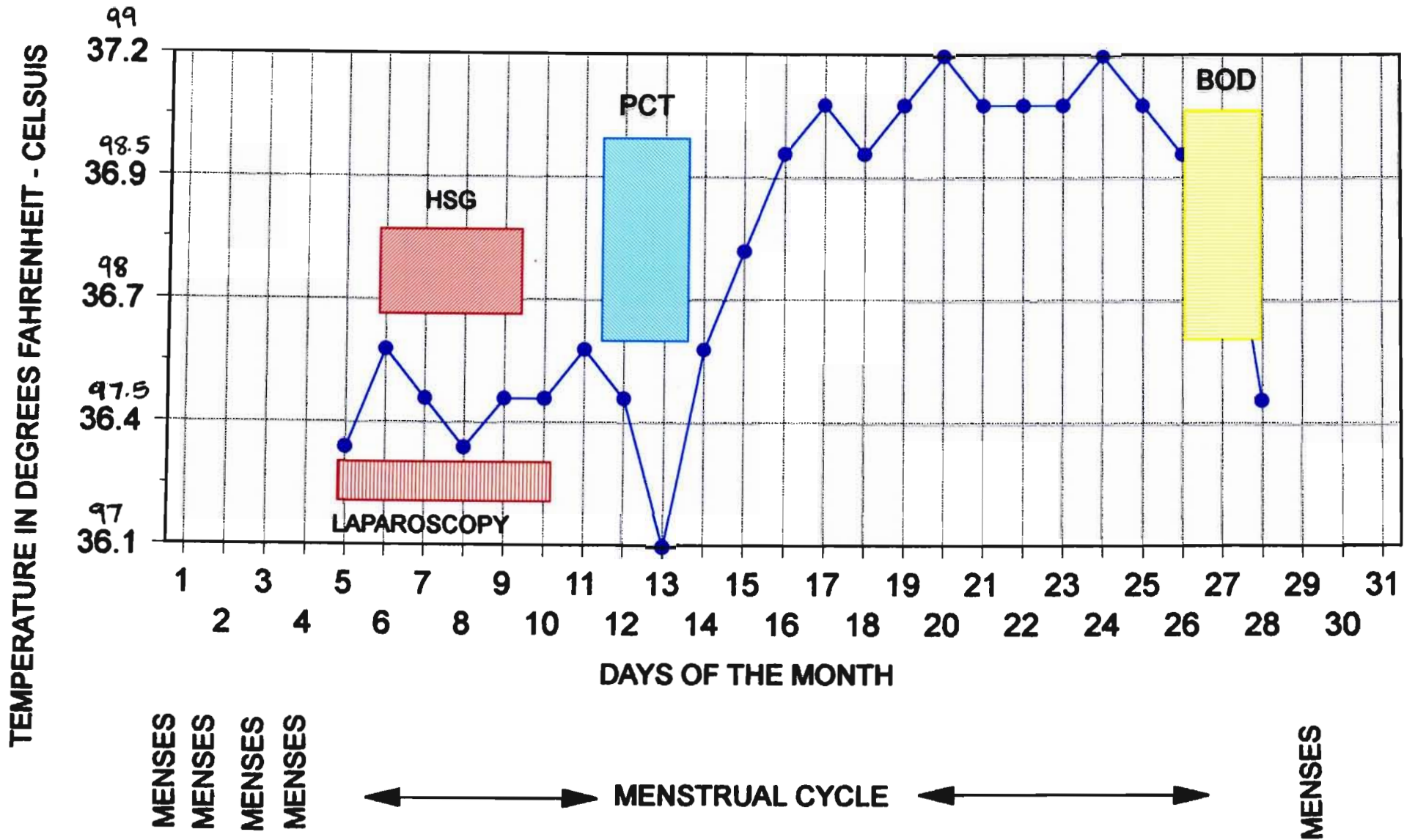


FIGURE 2 :BASAL BODY TEMPERATURE CHART SOURCE : (RUSSEL & ZIEGLER, 1993)
 THERAPY THIS CYCLE LENGTH OF CYCLE

Key

HSG	=	Hysterosalpingogram
PCT	=	Post Coital Test
BOD	=	Endometrial Biopsy

2.4.1. THE INVESTIGATIVE PROCEDURES THAT ARE AVAILABLE IN THE ACADEMIC HOSPITAL

The physician starts by obtaining a detailed history from the women. A thorough general physical and gynaecological examination is then performed. The period of exposure to pregnancy is assessed, then the investigation process should be initiated. Bloods are taken for hormonal analysis. The day 21 progesterone level in blood is estimated. The follicle stimulating hormone, luteinizing hormone and prolactin levels are also estimated. A laparoscopic dye test and dilatation and curettage is performed under general anaesthesia with an aim of viewing the tubes. Hysterosalpingography may be done to inspect the uterus and the tubes for abnormalities and blockage. In the event of the tubes being blocked, tuboplasty is undertaken to unblock the tubes. If the woman is having an ovulatory problem it is corrected by prescribing clomiphene citrate 50mg daily for five days until successful or for five days per cycle for a period of three months. All infertile patients are screened for sexually transmitted diseases and treated before commencing infertility treatment.

The physician gives the woman psychological counselling and advises her to encourage her partner to come for investigation. If all the above investigations fail, the woman is then referred to the specialist dealing with infertility in one of the neighbourhood hospitals for further treatment. Depending on her economic status, if she can afford the cost, the treatment may be continued in a private hospital (Monokoane, personal communication, May 10, 1994). In the private practice the same investigative procedures are performed that have already been described.

2.5. INVESTIGATIVE PROCEDURES AND TREATMENT OF INFERTILITY IN MEN:

A careful history is taken and a thorough general examination is performed. Special investigation for male infertility include the following special investigations: basic semen analysis, mixed agglutination reaction test, immunobead test sperm penetration assay, hemizona assay and hypo-osmotic swelling test. In basic semen analysis the following criteria are used for evaluation of the spermatozoa: number of spermatozoa per millilitre, it is normal if there are above 20 million; sub-fertile if the number ranges from 5 to 20 million and there is possible infertility when the count is less than 5 million. The normal volume is 2,5 to 3,5ml. There should be more than 30% of motile sperms within half an hour of collection. More than 20% of spermatozoa should have normal morphology. The forward progression should be > 2 on a scale of 0 - 4.

Where the problem of azoospermia (absence of spermatozoa) can be treated then medical or surgical treatment may be required as in retrograde ejaculation. Asthenozoospermia (poor movement of spermatozoa) can be confirmed by three semen samples and treated by intra-uterine insemination, gamete intrafallopian transfer or in-vitro fertilisation.

In teratozoospermia (low sperm morphology) the couple may be offered an in-vitro fertilisation (IVF) or gamete intrafallopian transfer (GIFT). Patients with antisperm antibodies are offered artificial insemination or gamete intrafallopian transfer. Then micromanipulator is another procedure that can be performed, whereby the spermatozoa are injected directly to the oocyte, when the patient's partner has a very low sperm count (Kruger, 1993 and Bornmann, 1994).

2.6. THE EFFECTS OF INFERTILITY ON WOMEN'S PERSONAL SYSTEM:

2.6.1. SELF AND SELF-ESTEEM

Self is defined as "the individual as known to the individual." It is that to which we refer when we say "I" (Jersild, 1952, p.9-10 in King, 1981). King (1981, p.26) further defines self as "the way the individual defines herself to herself and to others. It is all that an individual is capable of being and doing." Self is said to have a set of beliefs and values and is dynamic, therefore it strives to maintain a state of equilibrium at all times. Individuals with problems of infertility were unable to

fulfil the desired state of pregnancy, an important part of most peoples value systems. Their social interactions were also negatively affected by this problem they were facing. Davis (1987) found that infertility can affect an individual's perceptions of herself to herself and to others.

Beck, Rawlins and Williams (1988, p.170) define self-esteem as "a judgement or evaluation of one's ideal self and to the performance of others." It was reported that women with infertility were found to have low self-esteem (Hirsch & Hirsch, 1988, Dearman, 1991, Draye in Woods, Olshansky & Draye, 1991 and Nachtigall, Becker & Wozny, 1992).

2.6.2. BODY IMAGE

King (1981, p.33) defines body image as "a person's perceptions of his own body, others reactions to his appearance, and is a result of other's reactions to self." It was found that women with infertility experience disturbances in their body images due to the emotional trauma of being infertile (Davis, 1987).

Hirsch and Hirsch (1988) found that women with infertility perceived themselves as being more masculine than their female counterparts who are fertile.

2.6.3. **GROWTH DEVELOPMENT AND GOAL ORIENTATION**

Growth and development are defined as "processes that take place in people's lives that help them move from potential capacity for achievement to self-actualization" (King, 1981, p.31). Davis (1987) reported that the problem of infertility had a negative effect on the individual's growth and development. To produce children is part of the process of growth and development, which is unobtainable in individuals with infertility. Therefore this problem will hinder them from progressing to the highest level of self-actualization. Havinghurst in King (1981) suggested that in adulthood the developmental task can be achieved because of the individuals personal goals, values and societal expectations. Woods et al (1991) contends that child bearing is a social expectation in every women.

Individuals are said to be goal-orientated meaning that they direct all their activities towards fulfilment of self (King, 1981). The problem of infertility may interfere with the individual's goal-orientated activities. The individual may lose sight of her personal goals whilst working on the infertility problem. Clapp (1985) found that individuals with infertility may postpone their career development because they expect pregnancy to occur in the near future.

2.6.4. THE PSYCHOLOGICAL EFFECTS OF INFERTILITY

Clapp (1985), Sherrod (1988), Woods et al (1991) and Jensen and Bobak (1987), describe the grief response or the emotional stages experienced by the individuals who are infertile. These are based on original work undertaken by authors such as Kubler-Ross (1969) and Menning (1977). These stages are experienced at different rates and there is no sequential form as the individual undergoes each stage. Not all authors, such as Unruh and McGrath (1985) in Woods et al (1991), agree with the stages of grief but focus on the concept of chronic sorrow. However, the researcher has found more support in the literature for the grief response and will briefly describe the various stages.

Surprise Stage:

Infertility is an unexpected, unanticipated stressful event. Women with infertility become surprised when they first learn that they are unable to bear children. This is because it is assumed that pregnancy is an "optional event." It is only when the individual faces reality with this problem that she realises the emotional trauma involved, then she will be surprised that it is occurring to herself.

Denial Stage:

Individuals functioning at this stage are unable to face the reality of the problem of infertility. They will seek various medical and traditional opinions with the hope of finding "magical" help to solve their problem. They just cannot believe that they are unable to bear children. Denial can be identified when the patient uses the words as "not me", "it cannot happen to me."

Anger:

Individuals with infertility can be angry with themselves, with others, at home, at work and at the institution where they are being treated. Anger and frustration could also result when treatment seems to be unsuccessful

Bargaining:

Individuals with infertility when functioning at this stage, often make promises to God about the things that they will do for God if only they can fall pregnant.

Depression:

This is often accompanied by isolation. Infertile individuals may lose their friends who are engaged in social activities with their children. They may feel profoundly depressed and experience feelings of being worthless and think about death. They remain

depressed because the problem of infertility has no clear cut end point. Severe depression can lead to physical illness, for example, lethargy resulting in slowing down of the body processes, including speech, thought and motor functioning.

However, there is no mention in the literature of depression which is severe enough to require professional treatment.

Guilt Feelings of Unworthiness:

Individuals with infertility often experience guilt feelings from the things done in the past, for example, use of contraceptives, sexual enjoyment, past abortion and extra-marital relationship. They may feel that they are being punished for their wrongs.

Acceptance

This is the final stage of the emotional response to the problem of infertility. It is also known as the resolution stage. The individual with infertility, at this stage, starts to reorganise herself and learns to live with her problem. This stage can be recognised by a change in behaviour, improved self-esteem and reinvolvement in normal social activities.

2.7. THE EFFECTS OF INFERTILITY ON THE WOMEN'S INTERPERSONAL SYSTEM:

2.7.1. MARITAL RELATIONSHIP

Davis (1987) reported that couples who are infertile experience communication problems, which occur as a result of difficulty in sharing feelings. The problem in communication can result in marital discord when the couple is not sharing the same feelings. A closer bond is maintained in couples who share the same feelings with each other. Salzer (1991) found that infertile couples often accuse each other of guilt and this leads to marital disharmony, such as putting the marriage at risk and resulting in marital collapse. Infertility has a direct negative influence on sexual relationships, whereby the goal of intercourse becomes conception rather than enjoyment. Prescribed forms of intercourse during infertility investigations or treatment can lead to frustration and worsen the marital relationship (Hirsch and Hirsch, 1988).

Woods et al (1991) suggested that for some couples the quality of their marriage depends on the presence of a child, and then their marriage is said to be complete. Therefore if they cannot have a child their marriage will not be fulfilled. Infertility can result in separation and divorce (Barnmann, 1990). Ogbu (1977) and Pearsall (1947) reported that infertility lead to repaying of bridewealth and therefore the marriage is dissolved. Gumede (1978) asserted that the marriage of couples experiencing the problem of sterility or impotence, was regarded as an unhappy marriage.

2.7.2. RELATIONSHIPS WITH FAMILY AND FRIENDS

Family relationships can be affected by infertility either negatively or positively. Elderly family members can exert pressure on the couple to have children, because they want to be grandparents (Davis, 1987). A good family relationship will be enhanced by supportive family members. Woods et al (1991), reported that individuals with infertility tend to avoid friends with children and also people who ill-treat children.

2.7.3. ROLE FAILURE

King (1981, p.93) defined role as "the behaviour that is expected of one who occupies a given position in the family or in the organisation." Woods et al (1991), suggest that women have been socialized to value their childbearing role. Various authors discuss the aspect of role failure in an individual who is infertile. Davis (1987), Woods et al (1991) and Nachtingall et al (1992), all suggest that a woman who is infertile may experience role failure since she cannot fulfil her anticipated motherhood role. Role failure can happen both at individual and interpersonal levels. It is the social expectation that a woman should bear children. If she cannot she will perceive herself as a failure and society will see her as not matching up to societal expectations.

2.8. THE EFFECTS OF INFERTILITY ON THE WOMEN'S SOCIAL SYSTEM:

2.8.1. GENERAL OVERVIEW

The concepts involved in the social system are power, authority, decision-making and status. King (1981, p.126) defines power as "the process whereby one or more persons influence other persons in a situations. It defines a situation in a way that people will accept what is being done while they may not agree with it." Power in the traditional Zulu family is exercised by the elders in the family over their children. Traditionally women in their reproductive years have no power to control events in their lives, men and to a lesser extent post menopausal women are in control (Dube, 1994). Brindley (1985) found that old women in the Zulu culture have considerable power and influence on matters pertaining to childbirth.

Authority is defined by King (1981, p.122) as "the power to make decisions that guide actions of self and others." In the Zulu family the authority figures are the elders in the family who make decisions of what should be done and how it should be done. They also provide the means to take action. These elders may be both men and women, particularly as more families are currently being headed by women (Dube, 1994).

King (1981, p.131) defines decision-making as "a process of choosing one alternative from many based on facts and values, implementation of the decision and evaluation of achievement of goals." Davis (1987), noted that the decision-making ability for the individuals who are infertile may be influenced by the health professionals who often make decisions for individuals on infertility treatment. Also, as mentioned previously, the elders in the household may decide on when the woman who is infertile goes for treatment, who treats her - a traditional healer, faith healer or/and western doctor. The elders may also decide on the extent of the investigation and of the treatment which she undergoes (Dube, 1994). However, Gumede (1978) cited that nowadays, women and even young girls of 26 years decide themselves to consult medicine men or doctors for treatment of infertility.

Status is defined as "the position of an individual in a group in relation to other groups in an organisation. It is that which is attached to role or position and has privileges, duties and obligations" (King, 1981, p.129-130). Davis (1987), reported that women who are infertile often experience loss of status because they cannot attain the role, obligations and privileges that are attached to their status of wife. Thus infertility precludes them from the expected role of childbearer and childrearer, thus not attaining their role of motherhood.

**2.8.2. BELIEFS, ATTITUDES, VALUES AND CUSTOMS
LEARNED BY INDIVIDUALS WITHIN THE SOCIAL
SYSTEM WITH REGARDS TO INFERTILITY**

Beliefs regarding the causes of infertility vary according to one's cultural or sub-cultural group. Western belief is usually based on physical causes. However, traditional belief focuses more on spiritual causes such as those prevalent in traditional Zulu culture which will be discussed later.

The attitudes towards women who are infertile vary in different societies. In western culture there may be pity for women who are infertile, whereas in Zulu society she may be blamed for being unable to procreate (Gumede, 1978 and Chalmers, 1988). Fertility, childbearing and childrearing are highly prized in all societies, but even more greatly valued in the developing world as children are providers in old age and they are seen as the means for continuation of the lineage (Dube, 1994). Gumede (1978), explained that in Zulu society, a large family with many children was regarded as an insurance meaning that the children will provide for food and shelter to their frail and old parents, in their old age.

Individuals' reactions to infertility will be greatly influenced by the beliefs, attitudes, values and customs which a women has with the problem learned in her society. Davis (1987), suggested that individuals who get to know about the problem

of infertility in their childhood will be able to face the problem of infertility should it arise in the reproductive years, better than those who come to know about it in their adulthood.

The researcher has been unable to access much literature on beliefs, attitudes, values and customs with regards to infertility. Bornmann (1990), presented a paper entitled "The whims of African infertility" where she indicated that infertility is usually regarded as the woman's fault and thus she is blamed for the situation. The person who is often consulted is the traditional healer "isangoma", as the cause may be seen as spiritual rather than physical. In traditional Zulu culture the problem of infertility may be associated with ancestors who are said to be angry with the couple if certain rituals were not performed such as slaughtering of the goat to introduce the bride, "umakoti", to the groom's family ancestors, "umkhwenyana", on the wedding day (Dube, 1994).

2.8.3. THE IMPORTANCE OF CHILDBEARING IN THE ZULU CULTURE

According to Gumede (1985), childbearing and child care in the Zulu society were regarded as sacred duties for any woman in the society. He also cited that a woman with the problem of infertility was known to be unhappy and was given a labelling name "inyumba" meaning that she is sterile. This is in

agreement with Chalmers (1988), who noted that a childless woman is often frowned upon and also blamed for being infertile.

The importance of childbearing in Zulu cultures is also evident by the fact the infertility could lead to separation, paying back of bridewealth to the man's family and ultimately, to divorce (Barnmann, 1990; Ogbu, 1977 and Pearsall, 1947). In traditional Zulu culture, once it is discovered that the woman cannot bear children for her husband, the husband may decide to marry his wife's sister so that she can bear children for him. By doing so the brideswealth is not returned (Dube, 1994).

Preston-Whyte (1989) found that childbearing is valued in Zulu cultures. It is seen as an important status that a woman can achieve. Women with children are seen as more valuable than those without children.

2.8.4. THE TRADITIONAL PRACTITIONER'S ROLE IN INFERTILITY IN WOMEN

Bryant (1970, p.63) described the treatment that was used by people in the olden days to treat barrenness. He also suggested that they did not know the physiology of procreation as well as the pathological cause of barrenness. The herbalist, the inyanga used a mixture of *Gloriosa Virescence* (ihlamvu), whereby the

roots of this plant were mixed with food and taken by the couple that was infertile. According to his informants, the use of this mixture usually resulted in pregnancy.

According to Gumede (1978), the cause of sterility and impotence in the Zulu society was thought to be due to witchcraft and therefore it was the duty of an izangoma (traditional healer) to find the spell and remove it. The inyanga used to crush herbs of a green wood plant known as Orchidacea habanera species "inhlamvu" and mix them for the infertile couple to drink. Another form of mixture was made from eriosema salignum "Ubangalala" which was also taken by the childless couples to boost their sexual appetite. Eriosema cordata "Umhlabankunzi" was used by men and thought to be a powerful aphrodisiac.

2.8.5. THE NURSES ROLE IN CARING FOR WOMEN WITH INFERTILITY PROBLEMS

Nurses working in hospitals and in private practitioner's rooms where infertility care is provided, are often the first health professionals who come into contact with women who have problems of infertility (Sherrod, 1988; Ollivier, Lessar & Bell, 1984). Nurses are therefore faced with the challenge of recognising and responding to the women's emotional needs. Nurses are in the best position of assessing the stage(s) of grief

which a woman is experiencing and to offer appropriate help or care.

Christianson (1985) also noted that nurses are the first to have contact with the client and are also with clients most of the time whilst they are awaiting consultation with the doctor(s). Nurses thus have a vital role to play in infertility care.

2.8.5.1. The Expansion of the Nurses Role in Infertility Care

Ollivier et al (1984) gave some contributing factors which have led to the expansion of the nurses role which incorporate provision of infertility care. The nature of the problem of infertility requires intervention by the nurse because reproduction and sexuality matters have emotional as well as physical involvement. Nurse practitioners, particularly those with psychiatric nursing, have an ability to help with emotional crises which may arise in these clients. The other factor that has influenced nurse practitioners' involvement in the funding of family planning services in which nurses were the primary care givers and therefore they have had to learn the initial investigative procedures of an infertility work-up. The involvement of nurses in infertility care was found to be less expensive in dealing

with problems of infertility than those of doctors (Ollivier et al, 1994). Other aspects of the nurses expanded role will be dealt with in the following sections of this chapter.

2.8.5.2. Establishment of a Therapeutic Environment

The nurse working in an infertility clinic can best perform her role by first establishing a close therapeutic and safe environment so the patient is enabled to express her feelings (Gaze, 1990 and Bor & Watts, 1993). The nurse should ensure privacy and confidentiality when discussing sexual issues and should therefore learn specific counselling skills in dealing with sexual matters. Communication skills for dealing with sexuality should be part of the nurses education prior to her working in infertility clinics and this will enhance the client's confidence in nurses (Bor & Watts, 1993 and Christianson, 1985).

2.8.5.3. Nurse's Role in Infertility Counselling

Christianson (1985), Sherrod (1988), Swaffield (1988), Kuczynski (1989), Millard, (1991) and Jennings (1992)

all suggest and further expand on the nurses counselling role in infertility.

According to Jennings (1992) nurses are expected to deal with all the difficult situations and often have to perform their role of counselling without adequate education and supervision. She further recommended the nurses should be trained in counselling skills which are client centred and non-directive and which will allow the nurses to be able to help clients make their decisions to help them find solutions to their problems.

Davis (1991) and Jennings (1992) recommended that informal as well as formal counselling sessions could be offered to patients by giving information with regards to available investigative procedure and various methods of treatment. Hirsch and Hirsch (1984) and Davis (1991) contend that nurses should encourage clients to express their feelings and concerns with regards to the problem of infertility. Jennings (1992) gives the qualities and skills of the counsellor that should be developed by nurses in infertility care. The nurse should also act as a patient advocate in infertility cases (Swaffield, 1988).

2.8.5.4. Nurses Role in Patient Education in Infertility

Bell (1984), Sherrod (1988), Swaffield (1988), Kuczynski (1990) and Millard (1991) give the nurses role in patient education in infertility care. The nurse should educate the client about causes, investigative procedures and treatment in infertility. She should further assist the client in choosing the procedures that are suitable for her. Walker (1983) envisaged the nurses role as educating patients about the prevention of sexually transmitted diseases since they may lead to the problem of infertility. The nurse should be able to empower women by educating them about how to take and record their temperature in the evaluation of ovulation as means of diagnosing as well as timing of sexual activity.

Throughout the infertility work-up, nurses educate patients appropriately with the aim of minimising the stress, anxiety and frustrations that are experienced by women with infertility (Bell, 1984). Nurses are also involved in formulation of individualised care plans which help to decrease stress. These care plans are included by Sherrod (1988) where she gave an example of using the nursing care process in dealing with infertility.

2.8.5.5. Nurses Role as a Support Person in Infertility

Sherrod (1988), Hirsch & Hirsch (1989), Kuczynski (1990) and Davis (1991) noted that nurses have a supportive role to play in infertility care. Clapp (1985), Woods, Olshansky & Draye (1991) recommend that nurses can help women to cope with their infertility problems by providing emotional support as well as by understanding the stages of grief and offering support according to the women's needs. Nurses can arrange for the information of a support group by linking women with infertility problems. They can also arrange forums for sharing of feelings where women can offer support to each other. Continued contact can be maintained telephonically, where nurses organise a service where women can phone in and ask for help (Sherrod, 1988).

2.8.5.6. Nurses Expanded Role in Infertility Work-Up

Nurses obtain complete histories pertaining to the client's infertility problem. They undertake physical examinations, general and gynaecological, and assist the physicians in diagnosing whether the infertility is primary or secondary. Trevelyan (1990) suggested that specialist nurses can give injections to stimulate ovulation, take bloods for estimation of hormonal levels

and perform artificial insemination and refer to the doctor where there is any change in treatment.

2.8.6. THE ROLE OF VOLUNTARY SUPPORT GROUPS

Sherrod (1988), Hirsch & Hirsch (1989), Davis (1991), Kuczynski (1990) and Lentner and Glazer (1991) all agreed that a voluntary support group can be of help to the women experiencing infertility problems. Lentner and Glazer (1991) found that infertile couples who participated in a support group found it very beneficial. The support groups role in infertility is to provide a sense of belonging, information and education, as well as strength to go on with life. The perceived benefits by the couples, for example, decreasing isolation, provision of a forum for expression of emotions as well as offering of practical information was found to be met by the supportive group. The support group can also help by providing information on adoption, pursuing treatment or the choice of a childfree living and counsel women to accept the problem if it could not be solved. The nurses' role in the support group can be that of a facilitator. Lentner and Glazer (1991) also suggested that nurses need to embark on studies on the use of the support groups for individuals with infertility problems.

According to Hallot (1994), the functions of a support group are to provide information to infertile couples through a library

system by inviting guest speakers to come and talk to couples about infertility related subjects, so that couples can make informed choices. Monthly meetings are held one evening every month in a member's home, for a friendly and warm environment. The group also hold open meetings every two months where even non-members are invited. The researcher had an opportunity of attending one such meeting in May 1994 which was held at Westville Library. The main aim of a support group is to provide support throughout and involves couples rather than women only.

Christianson (1986) cited the need of a support group where a nurse can act as an advisor or group leader according to client needs. She can act as a liaison person making referrals to other community resources, for example, to the social worker, marriage counsellor and psychologists. She may encourage group development and should be independent from hospitals or clinics. She ensures continuous contact with group members and helps them towards achievement of their goals.

The literature relating to infertility has been analyzed in relation to Kings Interacting System's Model. It has focused mainly on women as they are the centre of the study. The literature relating to the research methodology will be discussed in the following chapter.

CHAPTER THREE - RESEARCH METHODOLOGY

INTRODUCTION

In this chapter the methodology used in this study will be presented under the following headings: research design; ethical considerations; case selection; pilot study; research tool; reliability; validity and limitations of the study.

3.1. RESEARCH DESIGN:

This is an exploratory qualitative study which focuses on infertility as experienced by African women in KwaZulu / Natal. It is explorative because it intends to explore the phenomena without any manipulation and control of human behaviour. The researcher aims to obtain a deeper understanding of how women perceive and respond to the problem of being infertile. The researcher identified the case study method as being appropriate in gaining indepth knowledge regarding the problem of infertility as seen by women who experience it.

As discussed by Wilson (1989), Yin (1989) and Basson & Uys (1988) case studies are useful to obtain extensive current information on previously unstudied or understudied subjects. It has also been reported that health professionals lack insight into the emotional needs of women who are infertile (Sherrod, 1988). The experiences of African women with the problem of infertility appear not to have been studied in South Africa. This was evidenced by the fact that the researcher was unable to access literature on this aspect. Therefore the use of a case study method will be of value in order to gain

indepth and unrestricted information on African women's experiences of infertility.

In order to gain maximum information on the subject, unstructured interviews will be conducted in order to gain qualitative data. King's (1981) interacting systems model will be used as a guide to explore how African women experience infertility. This model was discussed in Chapter 2. The concepts of the model which will be used are the personal, interpersonal and social systems.

The interviews will be conducted in the vernacular to facilitate indepth communication. The participants will be interviewed individually, because the problem of infertility has two emotive aspects. The results of the interview will be presented in Chapter 4 and will be analyzed in Chapter 5. The socio-demographic data, because of its nature, will be gathered through an interview schedule (see Annexure A). This will be the part of the study that will gather quantitative data including aspects such as age, level of education, household monthly income and the Body Mass Index (Ellis 1994, p.584). The only other part of the study focusing on quantitative data will be Rosenberg's Self-Esteem Scale (Rosenberg, 1979).

In view of the above discussion, the methodology can be described as a multi-method approach using a qualitative case study design, a semi-structured interview where required and a rating scale to measure self-esteem as well as body mass index to indicate nutritional status.

3.2. ETHICAL CONSIDERATIONS:

The researcher obtained approval from the Ethics Committee of the Faculty of Social Science of the University of Natal, Durban. Permission to undertake the study was given by the Natal Provincial Administration, the Medical Superintendent and Chief Matron of the academic hospital as well as by the specialist gynaecologist and obstetrician in private practice. The research was discussed with the Head of the Department of Obstetrics and Gynaecology at the University of Natal, Durban and he approved this study.

Consent will be obtained from the participants (Annexure E). It will be clearly explained to those who cannot read. The consent will also be confirmed verbally just before an interview. The purpose of the study will be explained to the participants. Participants will be free not to participate or withdraw if they so wish. Partners of participants will not be involved since the study is specifically on women's experiences. Respondents will be reassured about confidentiality. Privacy will be ensured by interviewing participants alone in a separate room which will prevent others from over hearing the discussion.

3.3. CASE SELECTION:

Purposive sampling will be used to select the participants. According to Wilson (1989, p.261) purposive sampling is the process whereby the researcher "uses her judgement to select a particular group based on certain criteria". The first ten consenting participants with primary infertility fitting the criteria of the operational definition given in Chapter 1, will be selected.

Five from the hospital gynaecological outpatients and five from the gynaecological rooms. The researcher found this method of sampling suitable for this study because of the qualitative nature of the study.

3.3.1. CRITERIA FOR SELECTION OF CASES

3.3.1.1. Criteria

The researcher will use the criteria of primary infertility as was previously presented in Chapter 1. These criteria were:

- * Women who have never conceived despite exposure to pregnancy for a period of eighteen months or more.
- * Without the use of contraceptives.
- * Who are attending the gynaecological clinic either in the hospital or at the gynaecologists practice because of infertility.

3.3.1.2. Age Group

Women between the ages of 20 to 35 years will be chosen as participants in this study.

3.3.1.3. Language Group

Women who are either Zulu-speaking or Xhosa-speaking will be included in the study.

3.3.1.4. Consent

The researcher will interview the first five consenting women in the academic hospital as well as the first five consenting women in the private practice.

3.3.1.5. Number of Cases

The researcher will choose ten respondents so as to be able to understand the experiences of African women who are infertile. Burns & Groove (1993) contend that if the researcher is interested in examining the situation in depth, a small sample size will be most relevant.

3.4. PILOT STUDY:

According to Basson & Uys (1985, p.95), a pilot study "is a sample scale study using a small sample of the population, but not the ones who will eventually be part of the sample group." It is a trial run of the major study, used to assess the feasibility of the major study (Polit & Hungler, 1993).

For this study a pilot study was conducted on two African women with the problem of primary infertility, one from the academic hospital and the other from the gynaecologist's practice. The results of the pilot study will not form part of the results of the main study.

The pilot study helped in trying out the interview since the researcher obtained experience in facilitating the discussion by encouraging the women to talk about their experiences. Probing questions were designed as a guide during an interview (see Annexure C). Some additional information was obtained from the participants in the pilot study hence it was included in the interview schedule. The researcher noted that the writing of notes during an interview was time-consuming and distracting, and it was therefore abandoned during the main study where a tape recorder was used with the clients permission.

3.5. PROCEDURE FOR COLLECTING DATA

Data collection was carried out from October to November 1994. The researcher used the tape recorder to capture the discussion with the permission of each informant. The initial contact with participants lasted from 10 to 30 minutes, where the researcher established rapport and made appointments for interviews. The interviews lasted from 45 minutes to one hour. Some participants had second interviews which took place in a private area in the hospital ward during hospitalisation or at home and/or through telephonic follow-up at home.

To identify the participants, the researcher requested doctors who were attending to the clients in the gynaecological clinic at the academic hospitals' consulting rooms, to refer those clients with primary infertility to the researcher in a secluded room. However, this proved to be unsuccessful, because clients had to undergo various procedures before being diagnosed as infertile. The researcher had hoped to attain her sample from the appointment lists in the gynaecological clinic in both settings. Unfortunately, the appointment lists in both settings did not indicate the patient's problem. The researcher then decided to also look for those clients who had already been diagnosed and had come for a hysterosalpingogram in the X-ray Department.

In the private practice, the hysterosalpingograms were carried out on Saturdays in one of the private hospitals, therefore clients were obtained on that day, before the procedure.

The participants gave consent before the interview commenced, which was also confirmed verbally just before the interview (see Annexure E). All interviews were preceded by a warming up introduction. The interviews were tape recorded as has been mentioned earlier. An interview guide was used to ensure that the discussion has covered all the aspects that the researcher was interested in. The interviews were translated into English when they were transcribed.

For those participants who became emotional, the interview was stopped, the participant comforted, and the interviewer went on once the participants were calm. The researcher felt that this was a valuable and important aspect which revealed these women's emotional needs.

3.6. RESEARCH TOOL:

A number of research tools were used. These included access of Socio-demographic information, health history and a section for recording body mass and height from which the Body Mass Index and nutritional status could be worked out (see Annexure A). This information was mainly in the form of closed-ended questions except for the health history which incorporated a general health history and more specifically, a gynaecological history. This tool was drawn up with particular reference to what could impinge on infertility and on future education of these women, these aspects were also based on the literature survey undertaken in Chapter 2.

The second instrument was a case study protocol based on King's Interacting Systems Model (see Annexure B). In case clients did not discuss areas freely or omitted to cover some areas, open-ended probing questions were drawn up in relation to the model and based on the literature survey (see Annexure C).

The interview schedule (Annexure C) was only used in areas where there had been little or no information. Women were also free to present their experiences outside these questions. Important concepts and the probing questions were translated by a language expert into vernacular to ensure congruency of meaning between interviewer and informant.

Lastly, the fourth tool was Rosenberg's Self-Esteem Tool which focuses on women's self-esteem which for the purpose of this study was equated to self-image as both these measures are of self-worth. This tool is a ten item

Guttman Scale to which the subject responds on a 4 point scale from strongly agree to strongly disagree. Lewis in Frank-Stromberg (1988, p.102) reported that the reliability co-efficient varied from 0,85 to 0,92 and validity correlation from 0,56 to 0,83, for the purpose of this study and as discussed by Lewis and with the University's Statistician this Self-Esteem was scored as a Likert Scale. The items were translated into vernacular for clarity of meaning by a language expert. The objective of using this instrument was to test the reliability and validity of the qualitative data obtained in regard to the self-image aspect of the personal interacting system.

3.7. RELIABILITY:

Polit & Hungler (1983, p.621) define reliability as "the degree of consistency or dependability with which an instrument measures the attribute it is designed to measure." Measures to reduce bias were sought. Interviews were conducted by the same researcher, using the same format and the environmental influences were reasonably similar for each group of participants.

The instrument for measuring the self-image according to Rosenberg's Self-Esteem Scale (Annexure D), was translated into Zulu by a language expert from the Department of Zulu at the University of Natal and then discussed with two nurse experts in the field of sexuality. Key concepts which were part of the case study protocol were also translated and tried out to ensure congruency of meaning between researcher and informant.

Finally, all the annexures were scrutinized by the Head of Department of

Obstetrics and Gynaecology at the University of Natal, and agreed that the relevant information should be obtained.

3.8. VALIDITY:

Validity refers to "the degree to which an instrument measures what it is intended to measure." (Polit & Hungler 1983, p. 624). To ensure validity the researcher prepared the interview protocol schedule with open-ended probing questions using information obtained from the literature reviewed. Basson & Uys (1985, p.78) wrote:

"Content validity is a valuable assessment approach for validity, especially for investigators who are designing questionnaires and interview schedules because of its focus on balance and presentation of items related to the study."

The researcher also showed all the tools to be used to two nurse experts on sexuality, one of whom was well-versed in the vernacular. These experts agreed that there was 'face validity' with regard to these instruments.

3.9. LIMITATIONS OF THE STUDY:

The fact that the researcher could not find the client's problem from the appointment list made the sample attainment a difficult procedure. This problem also led to difficulties in obtaining the annual statistics of infertile

women from the academic hospital, as well as at the gynaecologist's practice. The researcher could not make follow-ups to some participants at home because they came from areas some distance from Durban.

The sample was small and not randomly selected and thus results could not be generalised to the total population. Results are only tentative and may give some trends although they depict some understanding of women's experience of infertility. A theoretical sample was not obtainable because of the time limitation of this study, and thus continuing to interview women until no new information could be obtained, was not possible.

The decision not to include women under the age of 19 years and over the age of 35 years could have been detrimental to the study as some women over 35 were identified and could have perhaps broadened the study.

It was also decided to exclude infertile women who had no further hope of fertility because of hysterectomy. This was not part of the operational definition but a decision was taken in this regard after a discussion with the supervisor. This may also have limited the study as women's experiences prior to inevitable infertility following hysterectomy were not identified.

Although a decision was made to include half the respondents from a private practice, it was unfortunate that these participants had little experience of nurses and thus could not easily identify the nurses role.

Although the researcher was able to tentatively establish the credibility , transferability and dependability of the personal systems through triangulation

with Rosenberg's Self-Esteem Scale, it was not possible to do this with the interpersonal and social systems as these could not be observed in the home and community situations and further interviews were not possible because of time constraints.

The study was not longitudinal which could have enriched the data obtained over the whole process from the diagnosis of infertility until the final outcomes, positive or negative. As this could only have been done over a number of years this was impossible within the time constraints of a course work masters.

As the sample was small and randomised, the researcher could not establish the relationships between infertility and the socio-demographic variables, although this has been done in other research studies.

In the next chapter the study of each case is discussed in detail.

CHAPTER FOUR - CASE STUDIES

INTRODUCTION:

In this chapter, data obtained from each of the ten participants is presented in a case study format. Apart from the socio-demographic data, health history and nutritional status, data is analyzed according to King's (1981) model of interacting systems as discussed in Chapter 2.

The information provides an indepth understanding of women's experiences with regard to the problem of infertility. This approach is justified by Burns and Grove (1993, p.28) who wrote,

"Qualitative approach assumes that subjectivity is essential for the understanding of human experiences."

The emotional, social and cultural effects of infertility as experienced by women have been explored.

As the researcher could not access much literature related to the experiences of women with infertility, she therefore felt that this field of study has been under-researched. The information will thus be presented in detail.

In order to ensure that the data obtained in regard to self-image, Rosenberg's 10 point Guttman Scale was used to measure self-esteem (Annexure D). This allowed for triangulation in this area and the findings of this instrument will be incorporated in each of the cases.

The ten cases will now be presented, five hospital cases and five private cases in which the socio-demographic data is presented in tabular form, unlike the rest of the information.

The remaining data was analyzed mainly according to King's (1981) Interacting Social Systems. The Personal System also incorporated scores from Rosenberg's (1979) Self-Esteem Scale and their stages of the grieving process according to Kubler-Ross (1969). Cultural aspects were incorporated under the social system.

Analysis of the material in the form of cross-case analysis follows in Chapter 5.

4.1. CASE NUMBER 1 : (ACADEMIC HOSPITAL)

SOCIO-DEMOGRAPHIC INFORMATION

AGE.	34 YEARS.
MARITAL STATUS.	MARRIED LEGALLY FOR 5 YEARS.
RELIGION.	PRESBYTERIAN.
ETHNIC GROUP.	ZULU.
OCCUPATION.	EMPLOYED.
TYPE OF WORK.	HOUSEHOLD WORK AND PHYSICAL TRAINING.
LITERACY.	READS AND WRITES ZULU AND ENGLISH.
EDUCATIONAL LEVEL.	TERTIARY EDUCATION.
PLACE OF RESIDENCE.	UMLAZI - URBAN AND FORMAL.
NUMBER OF HOUSEHOLD MEMBERS.	THREE.
IDENTITY OF HOUSEHOLD MEMBERS.	HERSELF, HER HUSBAND AND THEIR HELPER.
NUMBER OF ROOMS IN THE HOUSE.	FOUR.
HOUSEHOLD MONTHLY INCOME.	R3 400.

MEDICAL AID.	HUSBAND'S.
LENGTH OF TIME OF PRESENT RELATIONSHIP.	FIVE YEARS.
LENGTH OF TIME OF TRYING TO CONCEIVE.	FIVE YEARS.

4.1.1. HEALTH HISTORY AND NUTRITIONAL STATUS

The participant presented with no history of significant medical illness and has had no surgery. Her height was 1,55m, her weight was 59kg and her Body Mass Index was 19, which is within the normal limit (Ellis 1994, p.581). She has never made use of any dependency producing substances.

4.1.2. GYNAECOLOGICAL HISTORY

Menarche commenced at 15 years. She has had menstrual periods with a normal flow for 3 to 4 days without pain. She had one previous partner with whom she had a sexual relationship. The respondent at that time was on "NurIsterate" for a period of two years from 1983 to 1985. In the present relationship she has never used any form of contraceptives. She has been trying to conceive since 1989.

4.1.3. PERSONAL SYSTEM

The participant was found to have a disrupted image of herself when she said: "I think my image has changed since I am no longer interested in making myself to look beautiful." Her self-esteem appeared low as she scored 16 points which indicate low self-esteem according to Rosenberg's Self-Esteem Scales. She also felt that she is not the same as other women who have children. She thought that the significant people in her life think of her as a "failure".

The problem of infertility has affected the participant's thought processes. She has occupied herself with studies but stated that "I am struggled to study well since I am always thinking about this problem." Her future plans have been affected since she had planned that she would have completed her family at the age of 34. Her inability to conceive has affected her financially since she has attended two gynaecologists for investigations and treatment, which will be discussed under the section on social system.

She was found to be experiencing denial when she said to herself "This is not happening to me." She has not believed the rest results as justified by her moving from one doctor to another with the hope of confirming the findings.

She has felt isolated from her partner because she thought he

was not concerned. The fact that she has kept her attempts of pregnancy to herself has further isolated her from her companions, because she has not disclosed her problem to them. She has felt like avoiding her friends who have children. She has wished to hold children of people who are unknown to her as they do not know her problem.

The participant was experiencing anger when she asked herself "Why me?", because she was not aware of anything wrong that she had done that could have resulted in infertility. Regarding people who ill treat their children, she felt "like taking them to court for punishment." She also felt that people with many children are "crazy" because it is costly to raise one child. She wished to have only one child.

She appeared to have a strong belief in God when she said "I think that my christianity is being tested like Job, who God took away all his kids." She further said "I will endure" and believed that God will eventually answer her prayers. She has bargained with God but has not yet disclosed the promises she made should she have a baby. She does not believe in the ancestors.

The participant has experienced feelings of worthlessness but not to the extent of thinking about death. She stated that she will continue to live without children and even if her husband leaves her because "There is nothing I can do." She did not

blame herself for this problem because she has not done anything wrong to deserve it, as has been mentioned earlier. However, she blamed her husband for excessive alcohol drinking since she knew from Biology that this can interfere with spermatogenesis. She has had investigations and treatments but not on a continuous basis. She stated that she wants to restart afresh.

She has not reached the stage of acceptance since she wants to start the process of investigation and treatment again with regards to her problem of being unable to conceive. As has been mentioned, she will continue with treatment up to the age of 36 because of her fear of the risks that are associated with old age in childbirth which according to her is 36. She reaffirmed that she will continue with life even without children.

4.1.4. INTERPERSONAL SYSTEM

Though she has communicated about this problem to her husband, it has resulted in them quarrelling over it. The husband has blamed her for the problem since he has a child from a previous relationship, and she has blamed him for drinking alcohol excessively. Since 1991, which was two years after their marriage, she felt anxious about getting pregnant to an extent that she no longer enjoyed sexual intercourse, therefore her reactions to having sex has been negatively

affected. She was sure about her partners feeling in relation to their sexual relationship. She felt he was not concerned since he did not want to go to the clinic. They have not experienced the threats of separation and divorce since they are still living together.

She stated that her relationship with her mother-in-law was "poor" because the mother-in-law liked the other girl who has had a child with her son and the child was staying with the husband's mother. The respondents relationships with her companions at work has changed since she suspected that they may gossip about her problem. She has isolated herself from them because they "always talk about their children during tea breaks." However, her own family appeared to be supportive. Her mother and sister had reassured her and advised her to "relax and not to think about it." The relationships between her own family and her husband's family have been affected when the two mothers confronted each other, each blaming the one who was not her child.

4.1.5. SOCIAL SYSTEM

The participant's husband was the head of the family who had power and authority and influences the decisions made in their family. However, the decision of going to her own mother for help in her inability to conceive, was made by her. She went to

her mother for some guidance of where to go for help. She then went to her aunt who took her to a faith healer, well known in the Nquthu area, who prayed and gave her some holy water. The reason for having been to a faith healer was to identify the person who caused the problem, which was found to be incongruent because the faith healer does not identify the person causing the problem; this is normally done by the traditional healer - the "inyanga". She thought her aunt had called an "inyanga" as a faith healer "Umthadazi", because the aunt knew that "I would not go to an inyanga.". She then went to her Priest in the Presbyterian Church and has asked for prayers which she received.

Though she understood the traditional Zulu beliefs and actions with regard to infertility, she has not been affected by the Zulu culture - she has been influenced by Western practices, though she did not understand the Western causes of infertility in women. This was evidenced by the fact that she did not know what has caused her infertility. However, she understood the cause of male infertility due to the problems related to spermatogenesis.

She knew about the effects on the women's status in the community when she has children that of being referred to as mother of so and so meaning "maka bani bani", as apposed to being referred by your name or "sisi" - sister, if you are childless. However, she further said "The value of women with

children in Zulu society was of great concern in the olden days, presently most women are valued for their education and knowledge as well as their helping role in the community."

The fact that the participant was influenced by Western medicine was evidenced by her own decision to go to the doctor for her problem. She has had the following investigations and treatments with the doctor in the clinic: physical examination, blood tests, laparoscopy in 1991, hysterosalpingogram and "Clomid" for three months in 1993. She stated that one nursing sister at the clinic has reassured her which gave her some hope that pregnancy would occur after treatment. She was, however, disappointed when nothing happened and has never seen that nurse again. She suggested that nurses could help clients by explaining in simple terms what the doctor has identified as the cause of infertility, since doctors have used "big terminology" which clients do not understand. She felt that nurses should be there for clients and not be changed from one clinic to another. Lastly, she said that nurses can assist clients by answering their questions "honestly and earnestly".

When discussing the possibility of a women's support group, she thought it would be helpful to those who have decided to give up on treatment and investigations. Health professionals are needed to support those who are still having hope by giving them information.

4.2. CASE NUMBER 2 : (ACADEMIC HOSPITAL)

SOCIO-DEMOGRAPHIC INFORMATION

AGE.	26 YEARS.
MARITAL STATUS.	MARRIED LEGALLY FOR FIVE YEARS.
RELIGION.	ZIONIST.
ETHNIC GROUP.	ZULU.
OCCUPATION.	UNEMPLOYED.
TYPE OF WORK.	HOUSEHOLD WORK.
LITERACY.	READS AND WRITES ZULU AND ENGLISH.
EDUCATIONAL LEVEL.	STANDARD NINE.
PLACE OF RESIDENCE.	MOBENI - FORMAL - URBAN.
NUMBER OF HOUSEHOLD MEMBERS.	TWO.
IDENTIFY OF HOUSEHOLD MEMBERS.	HERSELF AND HER HUSBAND.
NUMBER OF ROOMS IN THE HOUSE.	THREE.

HOUSEHOLD MONTHLY INCOME.	R1 200 (HUSBAND'S INCOME).
MEDICAL AID.	NONE.
LENGTH OF TIME OF PRESENT RELATIONSHIP.	FIVE YEARS.
LENGTH OF TIME OF TRYING TO CONCEIVE.	FIVE YEARS.

4.2.1. HEALTH HISTORY AND NUTRITIONAL STATUS

The participant presented with no history of significant medical illness and has had no surgery. Her body mass was 67,5kg and her height was 1,63m. Her Body Mass Index was 20.7 which was within the normal limit (Ellis 1994, p.581). She has never made use of any dependency producing substances.

4.2.2. GYNAECOLOGICAL HISTORY

Menarche commenced at 13 years. She has had a regular cycle and her period lasted for four days with a moderate flow and she has used about three pads a day. She experienced no pain during menstruation. She has missed her periods in some months last year and thought she was pregnant, but she was

not. She has never conceived in her lifetime. She presented with no gynaecological problems. She has had one injection as a contraceptive measure while she was still at school in 1986, when they were sent to family planning by their teacher. Otherwise, she has never used any form of contraception since that time. She has been trying to conceive for a period of five years.

4.2.3. PERSONAL SYSTEM

This was evidenced by the score of 27/40 she obtained from the Rosenberg Self-Esteem Scale which indicated that she had an above moderate self-esteem. She appeared a pleasant person who was happily married. The present problem of not being able to conceive up until now appeared not to have affected her self-image. She was not depressed at the moment because she still hoped that the problem would be identified since she was undergoing tests. The problem has not yet interfered with her goal-setting ability and her future plans. She felt that she has not matured sufficiently since she has had no child of her own. She is beginning to feel pain when she is asked by others about her children. The problem has had no financial implications at the moment, she has only payed R12 for two visits at the hospital. At that moment she was not experiencing any grief in relation to her difficulty in conceiving.

4.2.4. INTERPERSONAL SYSTEM

She has communicated the problem to her husband who seemed to be sharing the similar feelings with her. He expressed concern and that "we will have to accept if it is Gods will that we will have no children in future." She states that her husband was very loving and supportive. Their relationship was still healthy and their sexual relationship has not changed. She only experienced the problem of loss of libido which her husband understands and has thus not caused her any trouble. She stated that the relationship with her family was not good because her mother married another man and neglected her after the marriage to that man. She has never reported to her mother that she was experiencing difficulty in trying to conceive. She thought that it was probable that her mother-in-law was worried about this problem but has never said so. The relationships with her friends were still healthy. She still visited her friends and they also visited her even those with children. Her friends kept on telling her "to relax" so that she will conceive. She was free and communicated well with them.

4.2.5. SOCIAL SYSTEM

She did not believe in the Zulu perspective of blaming women for infertility. She thinks that it could also be a problem from the male partner. She has suspected that the problem could be

in her partner's family since her husband's eldest brother has no children. She thought that the Western beliefs regarding the causes of infertility were true, unlike the traditional beliefs. However, her husband's family believe in the ancestors because they perform certain rituals. Her husband had not suggested anything in the line of ancestors as possibly being the cause of their problem. She described the fact that woman with children are valued and were offered a high status in the family as well as in the community. Her husband is a powerful figure in the household. She is free to make decisions in relation to this present problem in regard to where to go for help. Her husband did not mind her going to the herbalist with her cousin and also to her coming to the hospital. He has also gone for semen analysis.

She felt that other women will be as shy as she was when talking to male doctors about infertility problems. She thought that nurses should play an important role of explaining the investigative procedures to clients, simply because it is easier to speak to another female about infertility problems than to a male. When asked about a support group, she stated that she has never heard of any but she thought that maybe it will be of help to those who are desperate and whose marriages are being threatened. She felt that maybe this support group can help those couples with adoption if it is the only solution to their problem. She strongly emphasized the point of psychological preparation of the client before a procedure so that the client knows what

to expect. She felt happy that the researcher had explained the hysterosalpingogram to her. She admitted that she was a bit uneasy before the procedure. She even remarked that "if all nurses were like you sister, things would be much better for us."

4.3. CASE NUMBER 3 : (ACADEMIC HOSPITAL)

SOCIO-DEMOGRAPHIC INFORMATION

AGE.	33 YEARS.
MARITAL STATUS.	MARRIED CUSTOMARILY.
RELIGION.	METHODIST.
ETHNIC GROUP.	XHOSA.
OCCUPATION.	UNEMPLOYED.
TYPE OF WORK.	HOUSEHOLD WORK.
LITERACY.	READS AND WRITES ZULU.
EDUCATIONAL LEVEL.	STANDARD FIVE.
PLACE OF RESIDENCE.	KOKSTAD - RURAL.
NUMBER OF HOUSEHOLD MEMBERS.	THREE.
IDENTITY OF HOUSEHOLD MEMBERS.	HERSELF, HER SISTERS TWO SCHOOL-GOING CHILDREN.
NUMBER OF ROOMS IN THE HOUSE.	SIX.
HOUSEHOLD MONTHLY INCOME.	± R350.

MEDICAL AID.	NONE
LENGTH OF TIME OF PRESENT RELATIONSHIP.	15 YEARS.
LENGTH OF TIME OF TRYING TO CONCEIVE.	15 YEARS.

4.3.1. HEALTH HISTORY AND NUTRITIONAL STATUS

The participant presented with no significant history of previous medical illness and no history of surgery. Her weight was 89kg, her height was 1,60m and her Body Mass Index was 28, which indicated that she was overweight (Ellis 1994, p.581). She has never used any dependency producing substances.

4.3.2. GYNAECOLOGICAL HISTORY

Menarche commenced at 16 years which indicated a normal to late onset. She has had irregular cycles whereby she missed her periods in some months. During her menstruation period she had experienced severe pains (dysmenorrhoea). She has never been pregnant. Her hospital notes revealed that she was treated for pelvic inflammatory disease by a private doctor in Kokstad in 1993. She has never used any form of contraceptives in her life. She has been trying to conceive for fifteen years.

4.3.3. PERSONAL SYSTEM

Her self-image has been negatively affected by this problem of inability to conceive. She felt masculine rather than feminine. She felt that others have perceived her as a failure in life. They have looked down upon her and called her by names, for example, "inyumba" - a sterile woman. She was frustrated by the fact that she will not inherit anything from her husband when he dies because she has no child. Presently her main goal was to conceive and she cannot think of anything else. She expressed that she feels that she has not grown to the fullest capacity because she cannot produce a child. Her feelings of worthlessness were evidenced by the findings from Rosenberg's Self-Esteem Scale where she obtained 14/40 indicating low self-esteem.

She was worried about the future and was concerned about who will look after her in her old age. Her husband was still supporting her but her mother-in-law was not happy about this because the client stayed with her sister's two school-going children. The mother-in-law said that they were wasting her son's money. The husband was supportive and had given her money to go to the hospital which was a long way from her home.

It was obvious that she was the one with the problem because her husband had six children with the second wife. She stated

that "I will go anywhere, to any doctor, who can help me." She was not bothered about the distance she travelled from home to King Edward because she hoped that the problem will be identified and treated. So far the blood results showed no abnormality and she was eager to know about the H.S.G. results on the next visit which was the 31st October. She felt isolated from women of her age in the neighbourhood. She kept on praying and had promised God that should he give a child she will do the best to raise her child according to God's word. She strongly believed that God will one day hear her prayers. She even asked the researcher to pray for her. She felt angry about the fact that her husband's second wife has six children. She stated that she only needs one, but initially she wanted two, but now she prayed just for one. She felt depressed about this problem. She has not yet accepted it. She felt motivated enough to go on with investigations and probably treatment.

4.3.4. INTERPERSONAL SYSTEM

Her relationship with her husband was no longer the same as it was before he married for the second time. They have not communicated about the problem. It was because of this problem that the husband was told by the elders in his family to get married to the wife who will bear children for him. Before he got married a goat was slaughtered asking the ancestors to give her a child, but it was in vain because nothing

happened after that. After a period of six years of marriage the husband got married for the second time. Their sexual relationship has changed since they are no longer staying together, therefore they only have sexual intercourse twice a month unlike when they were staying together when it was more often. However, she was sure that her husband loved her because he continued to support her financially. He also agreed to a semen analysis which detected no abnormalities. He also agreed that she go for investigations.

Her relationship with her neighbours who were her friends, has changed dramatically. She isolated herself from social gatherings which she no longer attended. She still went to church where she felt at ease to talk about her problem.

4.3.5. SOCIAL SYSTEM

Though they were not staying with her in-laws after marriage, the in-laws, the elders in the family - both males and females, influenced decision-making and they possess power in the making of decisions. Fortunately for the respondent, her decisions with regard to this problem of infertility are not influenced by anyone since she was not staying with the elders, but in her own house which her husband built for her. She said it was a big house and her neighbours keep on saying "why such a big house because you have no children to stay in it."

This made her feel sad. She said this with tears in her eyes. She feels she is not valued in the community and that she is not recognised. She actually said "if you do not have a child you are nothing."

She understood the cultural beliefs and practices that are related to infertility. She did not believe in the ancestors, but her husband and his family do. She felt bitter and sad because in her case it was obvious that she was the one who had the problem and that is why she was being blamed.

She suggested that if nursing sisters can understand the pain of being childless, they will be able to help the infertile individuals by explanation of procedures and orientation to the hospital environment. The sisters should be the ones who talk to patients as they are also women. She said sisters should make themselves available to offer help because we see them ever busy, and we are therefore shy to disturb them and ask about our problems."

When discussing support groups she said she thought that it will be helpful to urban woman only, because infertility problems are treated in the city where there are big hospitals, unlike the rural areas. She said if the researcher could come to Kokstad maybe it will work but that women from the rural areas are "under" their husbands, "so husbands should also be involved if you want to be successful." She also suggested that the

researcher should speak to "inkosi", the Chief, and to "izinduna", the elders because they were authority figures and thus powerful.

4.4. CASE NUMBER 4 : (ACADEMIC HOSPITAL)

SOCIO-DEMOGRAPHIC INFORMATION

AGE.	35 YEARS.
MARITAL STATUS.	MARRIED LEGALLY.
RELIGION.	METHODIST.
ETHNIC GROUP.	ZULU.
OCCUPATION.	UNEMPLOYED.
TYPE OF WORK.	HOUSEHOLD WORK.
LITERACY.	READS AND WRITES ZULU AND ENGLISH.
EDUCATIONAL LEVEL.	STANDARD SEVEN.
PLACE OF RESIDENCE.	NTUZUMA - URBAN.
NUMBER OF HOUSEHOLD MEMBERS.	SIX.
IDENTITY OF HOUSEHOLD MEMBERS.	HERSELF, HER HUSBAND AND HER HUSBAND'S FOUR SCHOOL-GOING CHILDREN.
NUMBER OF ROOMS IN THE HOUSE.	FOUR.

HOUSEHOLD MONTHLY INCOME.	R900 (HUSBAND)
MEDICAL AID.	NONE
LENGTH OF TIME OF PRESENT RELATIONSHIP.	FIVE YEARS.
LENGTH OF TIME TRYING TO CONCEIVE.	NINETEEN YEARS.

4.4.1. HEALTH HISTORY AND NUTRITIONAL STATUS

The participant has had asthma since she was a child. She was using a bronchodilator spray. Her last attack was in January 1994. She had no history of any surgery. Her nutritional status appeared satisfactory. Her weight was 64kg, her height 1,59m and her Body Mass Index was 20, which was within the normal limit (Ellis 1994, p.581). She has never made use of any dependency producing substances.

4.4.2. GYNAECOLOGICAL HISTORY

Menarche commenced at the age of 13 years. She had experienced no problems with her menstruation until May 1994 when she presented with severe lower abdominal pain and had

experienced uterine fullness. She thought she was pregnant but on ultrasound a uterine fibroid was discovered. She has been trying to conceive for 19 years. She never used any contraceptives with both the previous and present relationships. She had previous history of vaginal discharge which suggested infection of the genital tract and it was treated effectively in 1989 with antibiotics.

4.4.3. PERSONAL SYSTEM

She was found to be a very friendly person who was willing to talk about her problem. She was an approachable person. On the first encounter with the researcher she expressed that her struggle of trying to conceive had come to an end because she had realised that it was impossible for her to have a baby. The fact that her uterus was probably going to be removed had helped her to accept the situation as "God's Will." However, she stated that she hoped that the doctor would only remove the fibroid and leave the uterus because she know of people who had fibroids and their uteri were not removed. She ultimately agreed stating that the doctor knows what was best for her as an individual and her problem was not the same as the others whom she knew.

When questioning her about her self-image during the period when she was trying to conceive, it was found that she had a

low self-image. She stated that "right through the period when I was trying to conceive I had no peace of mind. There was no happiness in the world and I have hoped for happiness in heaven." She had a poor image of herself and was no longer grooming up herself as she used to before. Her first husband kept on blaming her and beating her which resulted in divorce. He referred to her as "inyumba" - sterile woman and swore at her. Her poor self-image was also evidenced by the low score of 18/40 she obtained on the Rosenberg Self-Esteem Scale. She stated that her mind was preoccupied and she could not think of anything else nor plan for the future because she hoped that she would conceive soon. The problem has drained her financial resources because she had to steal from the grocery money to pay for the doctors she attended. She stated that she has used a great deal of money because she had been to several doctors.

She was found to have reached the final stage of the grief process, that of acceptance. She stated that her faith has actually helped her to accept the situation. She knows of parents who are beaten by their children and thanked God that she will not experience that pain. She believed that it was God's will that she will have no child and she was not angry with God because there were also childless women that she read of in the Bible. As it was probable that she would have a "total abdominal hysterectomy", she has come to accept the situation of infertility as this means that she will have no more hope.

She expressed that she has had feelings of depression when she was still trying to conceive. One day her mother scolded her for beating her sister's child and stated that she should bear her own child that she can beat. She said "on that day I wanted to kill myself and I felt so worthless." She related this incident with tears in her eyes.

4.4.4. INTERPERSONAL SYSTEM

With her first husband, this problem of being unable to conceive resulted in problems and ultimately in divorce. With her second husband it has been different. He has been supportive and understands her problem. She thought this may be because he has his own children from his previous marriage. She had no problem with her parents-in-law from her previous marriage as they loved her so much. She stated that she has had some problems with sexual relationships with all her partners. She said that during sexual intercourse she has never reached an orgasm. The other problem with her present partner is that he sleeps a great deal and does not know about pre-sexual foreplay.

The relationships with her friends has not changed. They still visit her at her home but she has not been in the habit of visiting them. She said "I just keep quiet when they talk about children because it makes me feel bad."

4.4.5. SOCIAL SYSTEM

Her husband is the decision-maker in the family regarding family matters. She has been able to make decisions with regards to this problem of infertility without her husband raising any objections. Her mother was the first person to discuss this problem with her because she was concerned about her not being able to conceive and she kept on asking her whether she had conceived or not. The next person she went to was a doctor at Merebank who was well known for treating infertility problems. This doctor was recommended by her friends, those with whom she was sharing her problem.

She acknowledges that in Zulu culture it was the woman who was blamed for infertility and that people go to traditional healers for help. However, these beliefs and actions of Zulu's have not influenced her, since she has never been to traditional healers. She is a christian. She thinks that her problem has been caused by dysmenorrhoea, a severe current discharge and the presence of a fibroid, the latter being the reason given by the doctors. She stated that women should not be solely blamed for infertility, men should also be investigated.

She has been to several doctors in private practice and has also attended the hospital. She indicated that she has been treated for the vaginal discharge with Flagyl and Potassium Citrate, the latter in the researcher's opinion, for a urinary tract infection.

She felt that the nursing staff were always 'scolding' clients in hospital and suggested that they should exercise some patience and reassure the client. She pointed out that some of the doctors abuse clients when they do per vaginal examinations. She also felt that doctors are so full of knowledge that they do not want to listen to each client's individual problems.

When discussing a support group she suggested that patients with the problem of infertility should get together so that they can influence nurses and doctors to try to understand the experiences they are undergoing and plead with them to treat them more sympathetically. The support group can also help by providing a platform whereby women with infertility can share their sexual problems. She suggested that women should start and males should be involved at a later stage as well as health professional who can give guidance. She stated that there were some women whom she had reassured and supported through the word of God. She concluded by saying "those who do not have children should not feel bad about it because those who have children are cursing them because children are so troublesome nowadays, to an extent of even beating their parents." This participant said she would be a member of a support group as she felt she could offer help and reassurance to other women with infertility problems.

4.5. CASE NUMBER 5 : (ACADEMIC HOSPITAL)

SOCIO-DEMOGRAPHIC INFORMATION

AGE.	30 YEARS.
MARITAL STATUS.	MARRIED - CUSTOMARILY.
RELIGION.	UNITED CONGREGATIONAL CHURCH.
ETHNIC GROUP.	ZULU.
OCCUPATION.	UNEMPLOYED.
TYPE OF WORK.	HOUSEHOLD WORK.
LITERACY.	READS AND WRITES ZULU.
EDUCATIONAL LEVEL.	STANDARD FOUR.
PLACE OF RESIDENCE.	MAPHUMULO (NORTHERN NATAL) - RURAL.
NUMBER OF HOUSEHOLD MEMBERS.	ONE.
NUMBER OF ROOMS IN THE HOUSE.	THREE.
HOUSEHOLD MONTHLY INCOME.	HUSBANDS - UNKNOWN.
MEDICAL AID.	NONE.

LENGTH OF TIME OF PRESENT RELATIONSHIP.	TEN YEARS.
LENGTH OF TIME OF TRYING TO CONCEIVE.	TEN YEARS.

4.5.1. HEALTH HISTORY AND NUTRITIONAL STATUS

The respondent had no history of significant medical problems and no surgery. Her height was 1,46m, her weight was 57kg and her Body Mass Index was 19,5 which was within the normal limits (Ellis 1994, p.581). She has never made use of any dependency producing substances.

4.5.2. GYNAECOLOGICAL HISTORY

She presented with no significant gynaecological history of diseases and no history of sexually-transmitted diseases. The respondent had one previous partner with whom she had no sexual relationship. She has had this present relationship with her husband for ten years. She has been trying to conceive for the period of ten years. She has never used any form of contraceptives. The consultations and treatment related to her infertility will be discussed later under the section on social system.

4.5.3. PERSONAL SYSTEM

The respondent was found to have a poor self-image due to the fact that she was unable to conceive. She thought she was a "bad" person because of being unable to bear children for her husband which is important in Zulu culture. She said "I have been trying to conceive for a long time and I suspect that my husband may stop loving me." She felt that her image was affected negatively as she said "I no longer look pretty like before I realized about this problem." Although the score she obtained on the Rosenberg Self-Esteem Scale was 21/40, indicating borderline moderate self-esteem, the qualitative material indicated a poor self-image.

Her husband was concerned about this problem. Her father-in-law and the whole extended family were also worried. She kept on thinking about this problem and had prayed and said "Lord why can't you hear my prayers?" She had no plans for the future except to have a baby. She has attended the clinic in the academic hospital three times and had to pay bus fare which is R25 from Maphumulo, which was costly for her since she was not working. Her husband has supported her financially.

In assessing the grief process, she was found to be experiencing denial when she said, "No, this is not happening to me." She has not heard the test result yet but she hoped that she will get help from the doctors in the hospital. She does not feel isolated

because she has discussed the problem with her husband. She discussed her attempts at pregnancy with her friends but not with her neighbours. She has visited her friends at their homes and they also visit her at home.

She has experienced anger and had asked God why this was happening to her as she has not done anything wrong and because all the "makotis", brides, in her family have children "Why me?." She felt pity for those people who ill-treat their children. This situation has increased her resentment. She has congratulated people with many children as well as those who have recently had babies.

The respondent had experienced the bargaining stage and said "I will call the christians to come and rejoice with me when I have a baby." She has also made promises to her ancestors that she will slaughter an animal and arrange a large feast should she give birth to a live infant. As has been mentioned before, she did not feel that she is not good because she had done nothing wrong. She also did not feel that her ancestors were angry with her because she said "All our wedding rituals that were supposed to be done were performed accordingly."

She used to be very depressed initially but now she has put her trust in God and has hoped that God will hear her prayer. She stated that no one is to be blamed because they both do not have children from previous relationships. She had no doubts

about continuing with treatment since she said "I will continue until I finish the course and I think God brought me to this clinic so that I will get help." Therefore she has not reached the stage of acceptance. She said "I have hope and I don't think about not having a baby in my life." She was in tears at this point of the interview.

4.5.4. INTERPERSONAL SYSTEM

As mentioned earlier, her husband was worried too and they do communicate about this problem. Their marital relations were still healthy as there were no threats of separation or divorce. They have been living in separate residences for ten years. Their sexual relationships have not been affected by this problem of infertility, they still have sexual intercourse although limited, over month ends when he visits her at home. The husband was supportive and he had consoled her that it was God's will and God's plan that they do not have children. He has had girlfriends in Durban but did not want to marry any of them. Her in-laws are worried about this. One brother-in-law had at once stage suggested that she should go to Shembe's Church - an African Church which deals with customs such as holy water, healing as well as prayers. Her relatives and friends sympathise with her and the relationships have been healthy since she visits them at their homes. Her own family members

which are her sisters and her brother-in-laws are also concerned and supportive.

4.5.5. SOCIAL SYSTEM

The father-in-law was the head of the family and he had power and authority to make decisions pertaining to family matters. However, the decisions pertaining to this problem of infertility has been made by herself in consultation with her husband. The whole issue started after a period of four years of marriage when the elders in the family went to a traditional healer for some family problems. This spiritual leader worshipped at Shembe's Church and used holy water, prayers and reading of scriptures from the bible for healing. This faith healer was recommended to her by her husband's aunt. She went to Shembe first for help where she was given holy water, after he had prayed for her. She has been to Shembe's Church for the third time and nothing has happened since. She then went to the clinic at the academic hospital. On the day of the interview she had come for blood test results.

She was found to have been affected by Zulu traditional beliefs and actions with regard to infertility. She was found to be influenced by traditional beliefs, African church practice and western medicine since her actions have related to all three views. She thought that her relatives sympathise with her

whereas she thought that her neighbours might look down upon her. She said the community should not look down upon infertile women as they are called "inyumba" - infertile women, but they should sympathise with them because it is such a "painful experience." She recognises that children are valued in Zulu society because the family name will be carried on when parents die, therefore childless women are less valued than those with children because of her failure to attain the motherhood status. This is more prominent in the rural areas where most women are not working and their main job is procreation.

The investigations that she had are urine testing, physical examination, blood testing, ultrasound and hysterosalpingogram. Before coming to the hospital, she has used holy water. She has not had any form of treatment yet.

She found the nurses to be helpful and suggested that they would be more helpful if they have patience when dealing with women who have problems of infertility. She commented that doctors are trying to help her but they have not told her what is wrong with her.

When discussing the formation of a support group she said she thought that it will be of help because women will come up with suggestions of how they have tackled this problem.

Women who have had this problem may help by giving advice as to where to go for treatment.

4.6. CASE NUMBER 1 : (PRIVATE PRACTICE)

SOCIO-DEMOGRAPHIC DATA

AGE.	30 YEARS.
MARITAL STATUS.	SINGLE - LOBOLO PARTIALLY PAID.
RELIGION.	METHODIST.
ETHNIC GROUP.	ZULU.
OCCUPATION.	POLICE OFFICER.
TYPE OF WORK.	WAS INVOLVED IN STRENUOUS EXERCISE IN POLICE TRAINING.
LITERACY.	READS AND WRITES ZULU AND ENGLISH.
EDUCATIONAL LEVEL.	STANDARD TEN.
PLACE OF RESIDENCE.	ULUNDI (URBAN).
NUMBER OF HOUSEHOLD MEMBERS.	ONE.
IDENTITY OF HOUSEHOLD MEMBERS.	SELF.
NUMBER OF ROOMS IN THE HOUSE.	ONE.

HOUSEHOLD MONTHLY INCOME.	R1 700.
MEDICAL AID.	OWN.
LENGTH OF TIME OF PRESENT RELATIONSHIP.	FOUR YEARS.
LENGTH OF TIME OF TRYING TO CONCEIVE.	TWO YEARS.

4.6.1. HEALTH HISTORY AND NUTRITIONAL STATUS

The participant has had no significant previous history of medical illness and has undergone one surgical procedure. She appeared tired and stated that she has lost weight whilst on training. However, her weight was 59kg, her height 1,62m and her Body Mass Index was 18.2 which was within the normal limit (Ellis 1994, p. 581). She had a history of having used dependency producing substances. She stated that she had smoked one cigarette a day as a young girl at school and has wine occasionally. She was involved in strenuous exercise whilst on training in Hammanskraal.

4.6.2. GYNAECOLOGICAL HISTORY

Menarche commenced at 13 years. She has had regular cycles, receiving her period every month with moderate pain during the first day of her period and a moderate flow for three days. She had severe abdominal pain in 1993 and was diagnosed as having pelvic inflammatory disease which was treated by the doctor who performed a dilatation and curettage in theatre in 1993. She reported that she has been experiencing lower abdominal pain since that procedure was done. She stated that her uterus "feels as if it goes into spasms at times." This private doctor has told her that her uterine tubes were blocked. The researcher met her on the day when she came for a hysterosalpingogram. She has been trying to conceive for two years. She was on Nurlsterate injections for ten years during which she has had three sexual partners, and has stopped using contraceptives for the last two years. She has been on the injection for two months when she first related to her present partner at the beginning of 1992. She delayed having a baby purposely because she wanted to qualify first. She has also used oral contraception (Diane 35) for three months in 1992 which she took for treatment of acne not knowing that it was also a contraceptive. She has been trying to fall pregnant for the period of two years.

4.6.3. PERSONAL SYSTEM

She stated that her perception of herself and body image has changed from what it was previously. She thinks of herself as a failure. This was evidenced by her low self-esteem score of 15/40 as measured using the Rosenberg Self-Esteem Scale. She feels that those who are significant in her life sympathise with her. Her family members, especially her elder sister, seem to share the same feelings with her as well as her boyfriend. This problem of being unable to conceive up to now has affected her future plans, because she wishes to study for a degree in police science through UNISA, but now she is also hoping to conceive soon.

She was a member of a medical aid scheme which has helped her with payments for investigations and treatment of her problem of lower abdominal pain. The fact that she has to go to Durban for investigations has affected her because she has to pay taxi fare of about R40 for a return fare to Ulundi. Normally she goes home once a month.

When assessing the grief process, she was in the stage of denial because she sometimes said to herself this cannot happen to her. She has faith in the doctor's findings and that is why she comes for treatment and further investigations. She stated that she was hoping that she will someday fall pregnant because she trusted that the gynaecologist would help her. She said that her

boyfriend also wanted a baby, so she does not hide her feelings from him. She has sometimes had feelings of anger towards God and to a lesser extent, towards the ancestors. According to her she sometimes speaks to her ancestors (her parents) and asks them "why are you not looking after me properly."

She felt strongly that the Child Protection Unit should punish people who are ill-treating children. She suggested that the Government should restrict the number of children each couple should have to about two to three. She believed that children are a gift from God and she bargained with God at times. Though a christian, she thought that the ancestors have a role to play in childbearing. She said she does not understand why her ancestors are not giving her a child because according to her knowledge, all the cultural rituals that were supposed to be celebrated were performed accordingly, for example, on her twenty-first birthday "umemulo" and the unveiling of her parents tombstones. She mentioned that it sometimes came to her mind the notion that she was being punished by God because she has had several sexual partners.

She stated that when she heard about her inability to conceive due to blocked tubes, she felt worthless, but since she is attending this gynaecologist, she has hope. She wants to continue with investigations and treatments. She said she was prepared even to adopt if she finds that she will never be able to conceive, because she feels that life is boring without a

child. She said "after all, the children are the same depending on how you raise them up."

4.6.4. INTERPERSONAL SYSTEM

She communicated the problem to her boyfriend who seemed to be sharing the similar feelings with her. The boyfriend said that he will also go to the doctor for investigations because he has no other children. She said their sexual relationship was the same as it was before this present problem of being unable to conceive. Her relationships with her family members was still healthy and she thinks that her elder sister was sympathetic . The relationship with her boyfriend's family is still the same because they do not know that she is trying to conceive. Her relationship with her friends at work has not changed. They still have tea together. She visits her friends who have children because she loves children. Her friends also visit in her cottage.

4.6.5. SOCIAL SYSTEM

Her oldest sister is the powerful figure in her home, because her parents have died. Her oldest sister is the head of the family who makes decisions about family matters. The decisions that affect her with regard to her infertility problem have been made by herself. Her sister offered assistance to take

her to a well known doctor but she told her that she is attending the other doctor who is also "famous." She believes that a woman without a child has a low status in Zulu culture and that she is less valued because of this. She strongly disagreed with the cultural beliefs that women should be blamed for infertility. She said that men too can contribute to the problem. She mentioned the problem of low sperm count due to excessive drinking of alcohol. She also does not believe in Zulu practices of going to an "inyanga" or faith healer. However, she believes that the ancestors have a role in childbearing although she has not performed any rituals for that.

With regards to care-givers, she suggested that if they could have more patience when talking to clients, that would make a big difference in the care rendered. She said that nurses are over-busy and they seem to be short-tempered and appear to have no time for each client.

She praised doctors in the private sector as they offer explanations which make things easier for the clients. She said that this private doctor has given her hope when he assured her that he will do his best to help her.

When talking about a possible support group, she suggested that it will be useful to women who have had all the tests and investigations but still cannot conceive. For those who are still trying, the group can offer information about investigative

procedures. To those who do not know where to go to for help, the group members can educate the community about centres where help is available. She felt that most people do not know that something can be done, because it is not easy to discuss this problem.

4.7. CASE NUMBER 2 : (PRIVATE PRACTICE

SOCIO-DEMOGRAPHIC INFORMATION

AGE.	25 YEARS.
MARITAL STATUS.	MARRIED LEGALLY FOR FOUR YEARS.
RELIGION.	ZION.
ETHNIC GROUP.	ZULU.
OCCUPATION.	UNEMPLOYED.
TYPE OF WORK.	HOUSEHOLD WORK AND GARDENING.
LITERACY.	READS AND WRITES ZULU AND ENGLISH.
EDUCATIONAL LEVEL.	STANDARD TEN.
PLACE OF RESIDENCE.	NTUZUMA - URBAN.
NUMBER OF HOUSEHOLD MEMBERS.	TWO.
IDENTITY OF HOUSEHOLD MEMBERS.	HERSELF AND HER HUSBAND.
NUMBER OF ROOMS IN THE HOUSE.	THREE.

HOUSEHOLD MONTHLY INCOME.	± R3000.
MEDICAL AID.	HUSBAND'S.
LENGTH OF TIME OF PRESENT RELATIONSHIP.	FOUR YEARS.
LENGTH OF TIME OF TRYING TO CONCEIVE.	FOUR YEARS.

4.7.1. HEALTH HISTORY AND NUTRITIONAL STATUS

The participant presented with no history of significant medical illness and no history of previous surgery. Her weight was 56kg, her height was 1,62m and her Body Mass Index was 17.2 which was within the normal limit (Ellis 1994, p.581). She has never used any form of dependency producing substances. She was never involved in any form of strenuous exercise.

4.7.2. GYNAECOLOGICAL HISTORY

Menarche commenced at 14 years and her menstrual periods have been normal since then. Though she experienced dysmenorrhoea, her flow had been normal and lasted three to four days without clots. She presented with a history of vaginal

discharge which has been intermittently presenting over the past two years. She has been consulting the gynaecologist for this problem and has been treated with antibiotics, for example, Flagyl. She was on 'Triphasil' with her only previous partner. However, she has taken no contraceptives throughout the present relationship. She has been trying to conceive for a period of four years. She has never conceived before.

4.7.3. PERSONAL SYSTEM

Her self-image appeared not to have been severely affected as evidenced by a score of 29/40 which indicates moderate to high self-esteem according to Rosenberg's Self-Esteem Scale. However, the findings from her qualitative information revealed that her self-image was affected by the problem of infertility.

She expressed that she sees herself as having become short-tempered and she has looked down on herself. She thought that she does not have a feminine image because of her infertility problem. She was also frustrated by the fact that she felt useless since she does not contribute anything to the household finances as she was not working. She stated that her mother was supportive to her and to her husband who blamed her for not being able to conceive. The husband said that "since he is a male he does not have a fertility problem." This problem of being unable to conceive has, up to now, affected her future

plans because she had planned to go to the College of Education and study teaching but her husband said she should have a baby before commencing her studies. She sees this problem as a hinderance to her progress in life and thus her growth and development process is retarded. She does not feel self-fulfilled because she feels useless and dependent. She cannot focus on her future plans at present because this problem is delaying her career plans.

She stated that this problem has not had any bad financial implications because she used her husband's medical aid for payment of doctors.

According to the grief stage assessment, she was experiencing some denial and anger. This was evidenced by her feelings that "this four year period was as if it has been for seven years now." She does experience anger towards God and kept on asking him "what has she done to deserve this kind of problem?" She wished that people with many children could give some to her as well as those who ill-treat children. She sometimes bargained with God asking him "why this problem was not being solved?" She said God answers our prayers when we ask for one thing at a time and that was what she was doing presently, asking for a baby. She keeps on wondering why her prayers are not being answered. She and her husband do not believe in the ancestors.

She was depressed and felt worthless and useless in the house. She keeps on blaming herself for being responsible for the problem. At the same time she wants to continue with treatment. She has not reached the stage of acceptance since she was still looking forward to becoming pregnant. However, she expressed that this is her last try. She said that she will be able to continue with life even if she does not conceive. It was for this reason that she wants to study and be independent so that if her husband decides to leave her she will have something to do in life.

4.7.4. INTERPERSONAL SYSTEM

She has communicated the problem to her husband but they ended up quarrelling over it. This problem of not being able to conceive has brought about some misunderstanding between them because they quarrel each time they talk about it. The husband said "it was her problem because he is a male so he cannot have problems with fertility." This has resulted in her being short-tempered and suspicious that whenever he is not in the house she thought he has a girlfriend that he was visiting. The problem has also affected their sexual relationship and has resulted in her having loss of libido. They have sexual intercourse only once or twice a week which was no longer as frequent as it was before when they were just married. She suspected that this problem may eventually lead to separation

if her attempts of falling pregnant continue to be unsuccessful. Her relationship with her parents-in-law remained unchanged as they have never talked about the problem of infertility. Her relationship with her friends are still healthy as she visited them in their homes and they also visited her in her home.

4.7.5. SOCIAL SYSTEM

Her husband was the decision-maker in the family. He was very authoritative and does not want her to look for a part-time job, he wants her to stay indoors. He bought a video-machine with the aim of keeping her in the house. She, nevertheless, has taken decisions with regards to the problem of infertility. She goes to any doctor that she wishes to attend.

She first reported this problem to her mother because she was the only person she feels free to talk to. She then went to a private doctor who was recommended by one of her best friends with whom she had discussed the problem. She has also been to a faith healer to whom she was referred to by her mother's friend. The faith healer gave her holy water to drink and to use as an enema "to cleanse the womb". She was attending the private gynaecologist at the time of the interview. She thought that her status in her husband's family had been affected because they expected her to fall pregnant immediately after marriage which has not occurred up to now. She thought

that her problem of infertility was due to "the infection of the womb" since she had a vaginal discharge, which has been intermittent for a period of two years. She also suggested that the problem could arise from her husband's side since two of his brothers do not have children. The Zulu cultural beliefs and actions with regards to infertility have not affected her, since she did not believe that she was bewitched and therefore she has never attended a traditional healer. She said women should not be blamed for this problem because it may also occur if the male partner is physically weak.

She said she did not really know what nurses can do to help people with infertility because she has never been exposed to nurses since she has only attended private doctors. She thought that doctors can help with the treatment of infertility. When we were discussing a support group she suggested that the individual who had infertility problems felt "neglected by husband and family members so they needed love like a sick person." A caring attitude could perhaps be supplied by others in the support group.

4.8. CASE NUMBER 3 : (PRIVATE PRACTICE)

SOCIO-DEMOGRAPHIC INFORMATION

AGE.	32 YEARS.
MARITAL STATUS.	MARRIED FOR SEVEN YEARS.
RELIGION.	JEHOVAH'S WITNESS.
ETHNIC GROUP.	ZULU.
OCCUPATION.	UNEMPLOYED.
TYPE OF WORK.	HOUSEWORK AND GARDENING.
LITERACY.	READS AND WRITES ENGLISH AND ZULU.
EDUCATIONAL LEVEL.	STANDARD TEN.
PLACE OF RESIDENCE.	MANDENI - RURAL.
NUMBER OF HOUSEHOLD MEMBERS.	FOUR.
IDENTITY OF HOUSEHOLD MEMBERS.	RESPONDENT , HER HUSBAND, HER HUSBAND'S SCHOOL- GOING SISTER AND HER HUSBAND'S SCHOOL-GOING NEPHEW.
NUMBER OF ROOMS IN THE HOUSE.	SEVEN.

HOUSEHOLD MONTHLY INCOME.	R1 560 (HUSBAND'S).
MEDICAL AID.	HUSBAND'S.
LENGTH OF TIME OF PRESENT RELATIONSHIP.	TEN YEARS.
LENGTH OF TIME TRYING TO CONCEIVE.	SEVEN YEARS.

4.8.1. HEALTH HISTORY AND NUTRITIONAL STATUS

She had no history of significance medical problems and no surgery. Her height was 1,53m, her body mass was 91kg and her Body Mass Index was 29,7 which is the upper limit of normal indicating that she is overweight, but not clinically obese (Ellis 1994, p.581). She has never made use of any dependent substances.

4.8.2. GYNAECOLOGICAL HISTORY

The participant only had one sexual partner prior to her present partner. She never made use of contraceptives except for therapeutic purposes when she had Depo Provera prescribed over one year in 1989 as she had irregular menses. She had a

relationship with her husband for three years prior to their marriage and for seven years up to the time of the interview, and she has tried to conceive for this period of time. She has had a history of sexually transmitted diseases which she said was treated with "Betadine douches." The consultations and treatment related to her infertility will be discussed under the section on social systems.

4.8.3. PERSONAL SYSTEM

The participant's self-image has been affected by not being able to conceive. She thinks of herself as being unlike other women of her age. She said "it is a very painful experience being unable to fall pregnant, especially when I see young unmarried girls having children." She perceived herself as a failure. This has also affected her image because she is no longer interested in using make-up and grooming herself. This was evidenced by her low self-esteem score of 16/40 as measured using the Rosenberg's Self-Esteem Scale. Although her husband and mother are supportive, the respondent thinks that these significant people in her life perceive her as a failure, because they have expected her to fall pregnant although they have not indicated this to her verbally. This perception has further influenced her negative self-image. She stated that the problem of infertility has been painful because it has hindered her personal growth and development as reflected in the following:

"You are unable to reach a certain stage in your life which is important as a woman." She said that she was continually thinking about having a baby to the extent that her mind has also been occupied by dreams of being pregnant. She has therefore been unable to plan for her future. She indicated that she has no motivation or energy to study further as she is hoping to fall pregnant soon which will then interfere with her school programme. She also felt strongly that there was no need for her to strive for achievement because she has no child to work for and to support.

The problem has affected her financially, because when she attended a clinic in a hospital in Durban, the bus fare to and from the hospital was expensive. At that time her husband did not have a car, but has recently obtained one and drives her to the private doctor. She is presently using her husband's medical aid to pay for the medical care she has received from the private doctor.

In assessing the grief process, she denied the problem of infertility because she kept on asking herself whether it was really happening to her. Although she denied this, she accepted the result of the tests that were performed by the doctor. She believed the test results because all the doctors gave her the same reason for the problem.

She did not feel isolated, because she has been able to discuss this problem with her husband. However, she has not talked to her neighbours about it, because they do not have good relationships. She does not avoid her friends who have children because they still visit her with their children. She loves children. She has decided to keep quiet when they speak about children because she has nothing to say about childrearing and thus withdraws from this aspect of the conversation.

She experienced anger as she continuously asks herself "Why me?" Her anger has been increased when unmarried women have unplanned children outside the accepted norms of marriage. Her perception was that they did not feel the need to have children which made her even more resentful. She viewed child abusers negatively and as irresponsible parents. She felt that they should give these children either to childless couples or take them to a home. She felt pity for those who have many children because these parents were mostly poor, thus could not meet their children's basic needs such as food, clothing and shelter. She felt angry about this situation as "children should be the parent's responsibility because they have not asked to be in this world."

The participant was also in the bargaining stage. She has made promises to God that if she falls pregnant she will teach her child about "the wonders of God and will tell her child about the stories from the Bible and interpret it to him or her

according to Jehovah's Witness beliefs." She kept on praying and hoping that God will finally hear her prayers. She did not believe that the problem occurred because she has not been good enough, but she has prayed and asked for forgiveness in case she has done something wrong that she has not been aware of.

She is depressed because she feels that her problem has lasted for a long time but she has never thought about death because her husband is supportive. She recognises that the infertility problem has been due to her tubes being blocked but she does not blame herself for it because she said, "I have not asked for it." She wants to continue with treatment, in fact she said "I am very eager to continue with treatment up until the age of 35 years, then I will accept that it is God's will if I do not have a baby at that age."

4.8.4. INTERPERSONAL SYSTEM

She has communicated with her husband about this problem. Her husband was supportive and he regards this problem as theirs and not as hers alone. So far the problem has not affected their marital relationship since there are no threats of separation or divorce. She and her husband have enjoyed sexual intercourse as much as they did before discovering that infertility was a problem.

Her overt relationship with her in-laws has not changed. However, she was not quite sure what they discuss about her behind her back, since her mother-in-law is a "talkative person." Her relationship with her own family is good. Her mother has been supportive to her emotionally and has given her financial help as she gave her money to enable her to see the doctor. She was still maintaining good relationships with her friends who still visit her at home and give her reassurance. Most of her friends are also members of the Jehovah's Witness church. They have supported her with their prayers.

4.8.5. SOCIAL SYSTEM

Her husband was the head of the family and has made the decisions about family matters. He was authoritative and possesses power in the family. However, discussions pertaining to the problem of being unable to conceive have been initiated at the respondent's request. The results of decision-making resulted in the following consultations: Eshowe Hospital was the first place she went to for the problem of infertility, two years after her marriage. The doctor at Eshowe hospital referred her to a private doctor who was dealing with infertility treatment in Eshowe. She has also attended the Gynaecological clinic at the academic hospital in Durban. The last consultation was with the specialist in Durban. He had been recommended by her husband's friend as his wife was also having some

infertility problems which were resolved through treatment from this particular doctor.

She thought that her status in the family has been affected since she was not referred to as "mother of so and so", but only by her name by members of their extended family. She said having a child and being referred to as "maka bani bani" (mother of "so and so") gives you a certain status in the family and even in the community. She understood that children in the Zulu culture are highly valued because they support their parents when they are old and unable to work.

She believed that her problem was a medical problem and occurred because of the disturbances with her menstruation and because of her tubes being blocked due to infection. This was the information given to her by the doctors. She has had blood taken and has had a hysterosalpingogram. Her husband has had semen analysis. The treatment that she has received in the past was Depo Provera to regulate her menses and a treatment for vaginal discharge as previously discussed. She has had a tuboplasty which was undertaken by her present specialist about three years ago.

As she has had little contact with nurses, she did not comment on whether nurses helped or made things difficult for her. However, she suggested that nurses can help because of their knowledge. This can be through discussing with women's

groups the causes of infertility and how infertility can be prevented. She said "We want to know about how to take treatment properly." She stated that infertility treatment is complex as it includes many medications to be taken at prescribed times, even the time to have intercourse is prescribed. Nurses are thus the ideal people to teach women about this.

She stated that nurses and other health professionals, for example, social workers, should be involved in women's support groups to offer professional guidance and advice. In these groups women with infertility problems who have achieved pregnancy should support women who are still trying to conceive by telling them where and how they obtained help.

4.9. CASE NUMBER 4 : (PRIVATE PRACTICE)

SOCIO-DEMOGRAPHIC INFORMATION

AGE.	33 YEARS.
MARITAL STATUS.	MARRIED LEGALLY FOR 13 YEARS.
RELIGION.	ROMAN CATHOLIC
ETHNIC GROUP.	ZULU.
OCCUPATION.	UNEMPLOYED.
TYPE OF WORK.	HOUSEWORK AND FARMING.
LITERACY.	READS AND WRITES ZULU.
EDUCATIONAL LEVEL.	STANDARD SIX.
PLACE OF RESIDENCE.	MTHWALUME (RURAL).
NUMBER OF HOUSEHOLD MEMBERS.	FOUR.
IDENTITY OF HOUSEHOLD MEMBERS.	HERSELF, HER HUSBAND AND TWO SCHOOL-GOING CHILDREN WHO ARE RELATED TO HER HUSBAND.
NUMBER OF ROOMS IN THE HOUSE.	SEVEN.

HOUSEHOLD MONTHLY INCOME.	± R2 500.
MEDICAL AID.	HUSBAND'S.
LENGTH OF TIME OF PRESENT RELATIONSHIP.	THIRTEEN YEARS.
LENGTH OF TIME OF TRYING TO CONCEIVE.	THIRTEEN YEARS.

4.9.1. HEALTH HISTORY AND NUTRITIONAL STATUS

The participant had no significant history of previous medical illness and has undergone no surgery. She appeared obese with a weight of 108kg and height of 1,72m. Her Body Mass Index was 31,3 which evidenced the fact that she was obese (Ellis 1994, p.581). She was involved in subsistence farming since 1981. She has never used any form of dependency producing substances.

4.9.2. GYNAECOLOGICAL HISTORY

She had her menarche at 15 years. She has had regular cycles every month with no problems. She stated that the problem of dysmenorrhoea started after she got married in 1981. She has

also had a dark brownish discharge on two occasions towards the end of her menstrual period during last year, for which she was treated with antibiotics. She has never made use of contraceptives previously, either with a previous partner or with her husband. She has been trying to conceive for thirteen years. She has never been pregnant.

4.9.3. PERSONAL SYSTEM

She obtained the score of 27/40 from the Rosenberg's Self-Esteem Scale which indicated that she had an above moderate self-esteem. However, she reported that this problem of being unable to conceive up to now has been a very painful experience. She said the pain was unbearable when she first recognised that she had this problem. She stated that "if you do not have a baby you feel as if you have not grown to be a woman." She, however, stated that the pain was now better because of the two children whom she had "adopted" had received the same love that she would have given her own. She thinks she was being seen as a failure, especially by her mother-in-law. She was happy because her husband is supportive and recognises this problem as theirs, not as hers alone. This problem has interfered with goal setting because it has disturbed her plans of further her studies in a college of education. She had thought that she was pregnant at one stage and had cancelled all her arrangements to go to college, only to

find out mid year that she was not pregnant and by that time the colleges allowed no new intakes. She repeated that this problem has been a painful one because "it is always on one's mind and it is not an easy subject to anyone." She stated that a great deal of money has been involved.

According to the grief stage assessment, she is not experiencing denial but has some anger as demonstrated by the fact that she keeps on wondering "why the Lord is not giving her a child because he has helped her throughout her other problems." She was found to be in a depressive stage. She sometimes thinks that this problem has occurred because of her wrong doings in the past. She related a story that when she was a young girl she missed her period and then her friends advised her to take supertabs "to clean her womb." She became sick and she passed a large clot of blood. She then suspected that she had aborted, but it was not her aim to abort. She related this story with tears in her eyes. It was only now that she thought that she was being punished for that. She kept on blaming herself for the problem of infertility because her husband had a child with another girl before they got married. She has not yet reached the stage of acceptance. She said she will continue trying to fall pregnant until she reaches menopause.

4.9.4. INTERPERSONAL SYSTEM

As already mentioned, she communicated well with her husband about this problem. Her husband was supportive and understood all the pain she was going through. Their marital relationship has not been affected by this problem. They still enjoyed sexual intercourse in the same way as in the past. The relationship with the family at large appeared to be the same, but her only problem was her mother-in-law, whom she strongly felt has bewitched her. She related three stories which confirmed to her that her mother-in-law bewitched her long ago. She stated that her mother-in-law did not like her from the beginning because she was staying with the girl who had a baby after having a relationship with her husband. One day she overheard her mother-in-law swearing "that she will never carry a baby." This was also evidenced by an "inyanga" who told her "that her mother-in-law was casting a spell on her to have severe dysmenorrhoea due to the snake that was buried with two mielie grains near the path to their house under her mother-in-law's instruction." The other incidence that confirmed her mother-in-law's malevolence was when a person's head was found in the neighbourhood and her mother-in-law remarked that it would have been best if it was found by herself.

Lastly, her mother-in-law instructed her to give her her menses whenever she felt that it was a miscarriage. She said she never had one and so did not give her this, which would have been used to harm her. She felt that her mother-in-law was happy that her problem had not been relieved. She stated that she does

not have friends in Mthwalume because her friends are in Eshowe, where she originally came from. She felt that her neighbours are sympathetic towards her because they often offer advice that she should seek help from various people, both traditional and western. The relationship with her own family members is healthy and they sympathise with her.

4.9.5. SOCIAL SYSTEM

Though her husband was the head of the family, anyone with a suggestion can make a decision after a family discussion in which they come to an agreement.

The whole issue started when the mother-in-law questioned her about conception only two months after they got married. She then took her to a faith healer who suspected that she was pregnant and gave her some holy water. That was not true because she had her periods after that. She had dysmenorrhoea thereafter and she was taken to a traditional healer by her husband. The mother-in-law did not know about that and "she scolded them for going to a person she did not know and not taking her along with them." From then onwards they have been to various doctors and various traditional healers and at present they use both traditional and western medicine.

They have been greatly influenced by Zulu beliefs and actions

with regards to infertility. Though she comes from a pentecostal background and has become catholic, she has learned much about life and other religions such as traditional aspects, since she got married.

She feels that her status has changed in the community as well as in the family at large, though people will not directly inform her, she also felt that she has not come to maturity as she does not have a child. When people talk about babies she has nothing to say and feels threatened by the fact that she cannot look after a baby when an emergency occurs. She suggested that women should not be blamed because they do not warrant this problem, people should sympathise with them instead.

The investigations and treatments that this couple have undergone are tuboplasty and semen analysis, both in 1993. Her husband has had treatment for weak sperm. She has also been treated with antibiotics, for example, Cerophine.

She said nursing care depends on different personnel rendering the care, which was different in hospitals and private rooms. She believed that she was a person of "bad luck" and that she was thus not treated as others in similar situations. She did not have any suggestions about how nurses can help individuals with infertility. When discussing a support group she said people have different problems and her problem is unique as her infertility has different causes than the common ones which

she knows about from other women with the problem of infertility.

4.10. CASE NUMBER 5 : (PRIVATE PRACTICE)

SOCIO-DEMOGRAPHIC INFORMATION

AGE.	29 YEARS.
MARITAL STATUS.	SINGLE - LOBOLO NOT PAID.
RELIGION.	ANGLICAN.
ETHNIC GROUP.	ZULU.
OCCUPATION.	EMPLOYED.
TYPE OF WORK.	HOUSEWORK AND STRENUOUS ACTIVITY - AEROBICS.
LITERACY.	READS AND WRITES ENGLISH AND ZULU.
EDUCATIONAL LEVEL.	STANDARD TEN WITH TERTIARY EDUCATION.
PLACE OF RESIDENCE.	DURBAN - CITY - URBAN.
NUMBER OF HOUSEHOLD MEMBERS.	ONE.
NUMBER OF ROOMS IN THE HOUSE.	ONE.
HOUSEHOLD MONTHLY INCOME.	± R3000.

MEDICAL AID.	OWN.
LENGTH OF TIME OF PRESENT RELATIONSHIP.	FOUR YEARS.
LENGTH OF TIME OF TRYING TO CONCEIVE.	FOUR YEARS.

4.10.1. HEALTH HISTORY AND NUTRITIONAL STATUS

The participant had no history of significant medical problems. She had an operation which was done for a suspected ovarian cyst in 1988. Unfortunately, the cyst was not found so the operation ended by being a laparotomy only. Her height was 1,54m and her body mass was 59kg which is within the normal limit, as the Body Mass Index was 19,1 indicating that she is not overweight or undernourished (Ellis 1994, p.581). Her lifestyle includes the use of dependent substances, for example, smoking and drinking alcohol. She smokes about six cigarettes a day and drinks about three to four bottles of beer over weekends. She was found to be involved in strenuous exercise in the form of aerobics every weekday afternoon.

4.10.2. GYNAECOLOGICAL HISTORY

The participant had menarche at thirteen years. She has had

normal menstrual periods from menarche until 1988 when she started experiencing lower abdominal pain. Whilst she was undergoing investigations for the pain it was discovered on X-ray that she had a loop in her uterus which was removed vaginally. She stated that the loop was inserted in 1983 when she was doing standard ten without her knowledge, when her mother, a nursing sister took her to the doctor. She said her mother told her that the doctor would only examine her. She remembers that the procedure was very painful but she did not question this.

She has had five previous partners and she has had sexual relationships with three of them, including her present partner. She was on NurIsterate for a period of approximately eight years. She has also had a Depo Provera injection once and has also used Dianne 35 for a period of six months for treatment of acne when she was much younger.

She was suspected of having an ovarian cyst in 1988. An operations was performed but the cyst was not found as was mentioned previously. She also had endometriosis diagnosed in July 1993. The treatment of which will be discussed in detail under the section of social system.

She has had no history of sexually transmitted diseases. She has had relationships with the present partner for four years. She has been trying to conceive for the past two years. The

consultations and treatment related to her infertility will be discussed under the section on social systems.

4.10.3 PERSONAL SYSTEM

The participant's self-image was found to be affected by not being able to conceive. This was evident when she said "I think I am nothing, just an incomplete woman." Regarding her image of herself she said "I have a very bad image of myself to an extent that I put on bigger clothes and pretend to be pregnant at times." This image of herself is different from how she used to think of herself before she had this problem. The respondent used to be a "carefree" person and she used to say "I do not want to have a baby." She was also found to have a low self-esteem which was indicated by a low score of 16 according to Rosenberg's Self-Esteem Scale. She thought that her family members and her boyfriend were also concerned. Their concerns will be discussed further under the section on her interpersonal system.

Though the participant thought about progress in her work, the problem of being unable to conceive has interfered with her thoughts. In her future plans she imagines herself having a baby. She said "If I can't conceive my whole life will be disturbed." She has a medical aid which has helped her to pay the two gynaecologists she has attended.

In assessing the grief process, she was found to be experiencing denial when she said "God will not do this to me, I will have a baby." She has mixed feelings about this problem because at times she has thought that she has conceived, she then felt happy, prayed and thanked the Lord, the next moment she had her period and once again became disappointed. She believed the test results that identified she had endometriosis.

Though she did not hide her feelings from her partner, she felt isolated because she cannot talk about this problem to her friends. She stated that the researcher was the only friend she had discussed this problem with, otherwise she has kept all her attempts at pregnancy to herself. She did not avoid her friends who have children but she has envied them.

She was found to be experiencing anger, especially after false hopes of pregnancy, and she asked herself "Why me?" Her displeasure was increased when she saw people who ill treat their children and she has often scolded them for that. Her resentment was evidenced by her following statement "I always ask the Lord why has he given poor people a lot of children whom they cannot afford to look after well." This situation made her feel furious since she thought she can afford to give her child the "best."

The participant was also in the bargaining stages as evidenced by her following statement, "I will protect my baby and give

her or him the best of my love. I will praise the Lord till I die." She sometimes "calls" her late father and asks him "Why is he quiet about this?" She felt that she was being punished for her previous statements when she said "I do not want to have a child nor do I want to get married", which she said many times whilst she was studying at the university. She did not think that her father (her ancestor) was angry with her, instead she thought that "he is so quiet that I scold him whenever I speak to him when I visit his tombstone."

4.10.4. INTERPERSONAL SYSTEM

She has communicated with her partner about this problem of infertility. This problem does not seem to have directly affected their sexual relationship but their relationship has been directly affected, since they do not cohabit although he visits her regularly, at times her menstruation affected their sexual relationship. The participant thought that her partner felt very bad about her inability to conceive. Although her relationships with her friends, apart from her inability to share her problem, have not been beneficial as she has been unable to visit them recently because of her busy schedule at work. She indicated that she would love to visit them, especially those with children, because she loves children. Her relationship with her workmates have not changed since they still have tea together, but she has decided to remain quiet when they talk about their

children because "I envy them." Her relationship with her family members has been affected since they are also concerned and worried. She said "My sister is prepared to be the surrogate mother of my baby." This has demonstrated her sister's concern for her and also her support.

4.10.5. SOCIAL SYSTEMS

The respondent's mother was the head of the family, who had power and authority and has influenced the decisions made in her family. However, decisions pertaining to the problem of being unable to conceive have been initiated by the respondent. The results of her decision-making has resulted in the following consultations: She has been to one gynaecologist because she wanted to conceive and also had abdominal pain. That private doctor referred her to the present gynaecologist as the first doctor was ill and was thus unable to continue with his work.

She thought her infertility was caused by endometriosis which she believed was successfully cauterised and further said "Now I do not know the cause, really." She felt that women should not be the ones who are regarded as being at fault but with her case she said "It is me who is at fault." She understood that males too can experience the problem of infertility when they have problems with spermatozoa either in formation or its movement.

She has not been affected by traditional Zulu beliefs and actions with regards to infertility. She believed in Western causes of infertility. She said the woman's status in the family, as well as in the community, will depend if she has a child and how she will treat her child. "If she ill treats her child, her status will be negatively affected, whereas if she treats her child well, her status will be positively affected." She did not think that women should be blamed for childlessness. She understood the value of children in Zulu society when she said "Children are wonderful creatures, everybody loves children. Parents do sometimes spoil their children out of love."

She has had the following investigations - a physical examination and a hysterosalpingogram at the beginning of 1993. She underwent surgery for cauterisation of endometriosis in July 1994, after which she had 'Clomid' for three months. At the time of the interview she was on no contraceptives.

The care givers that she has been in contact with are the two gynaecologists that she attended. Both of them made things easier for her by explaining all the procedures for investigations as well as treatment. This was evidenced by her statement when she said "I was well prepared and informed about what was happening."

She suggested that nurses can help the childless women by supporting them throughout when they undergo their

investigations and treatment. Nurses can also help by telling women about the available services that offer treatment for infertility, because "most women do not know about these services." She thought the support group of women will be able to help women to discuss their shared feelings with other women who have similar problems and who speak the same language. By sharing their experiences, their frustrations will be lessened. She ended by saying "You feel free when discussing your problem with a person with whom you are sharing the same problem."

CHAPTER FIVE

CROSS CASE ANALYSIS AND DISCUSSION

5.1. INTRODUCTION:

In this chapter the socio-demographic information of the ten case studies will be analyzed initially. A summary of all these findings will be presented in Table 1. The participants were asked about the place of employment of their husband or partner to ascertain whether they were staying together or separately. This was then presented in the table under the heading Living with Consort / Husband.

The aspect on the head of the household will not be discussed under the socio-demographic data but will be incorporated under the section on social system because of its relevance to power, authority and decision-making. The health history will also be incorporated in Table 1.

The findings from the ten case studies will be analyzed and related to relevant literature reviewed in chapter 2. Other than the socio-demographic and health history data, the analysis will be presented according to King's (1981) interacting systems model.

5.2. SOCIO-DEMOGRAPHIC INFORMATION:

The socio-demographic information although not directly linked to experiences could influence them, an example being educational status and access to health service. Some aspects could also improve on the aetiology of infertility such as abnormal medical and gynaecological history and under-nutrition as measured by the Quetalet Body Mass Index (Ellis, 1994).

5.2.1. AGE

The age range was between 25 and 35 years. The mean age was 30.7 years. Seven of the participants were between 30 to 35 years of age which could indicate that they were 'desperate' to conceive. They appeared to be aware that it was hazardous to fall pregnant for the first time after the age of 35 years as indicated in hospital case (H.C.) number 1 and private case (P.C.) number 3, who said that they would accept the problem of infertility at 36 years as being inevitable. They may have also realised that fertility decreases with age as was indicated by WHO, (1975) who pointed out that infertility increases with age and particularly rapidly after 35 years. This would be the case with those who had spent many years trying to conceive such as H.C.'s numbers 3, 4 and 5 who had spent 15, 19 and 10 years respectively, and P.C. number 4 who had spent 13 years trying to conceive.

5.2.2. MARITAL STATUS

Six participants were legally married and their marriages were registered. Two participants were customarily married and therefore their marriages were not registered. The effect of infertility on the marital relationship will be discussed under the interpersonal system. The researcher noted that both the women who were married customarily were, as could be expected, from rural areas. Two participants were single, one had "Lobola" (bride wealth) partially paid and the other had no "Lobola" paid. Of those who were married legally, one participant - H.C. number 4 was married for the second time as a result of the problem of infertility which had led to divorce from her first husband.

5.2.3. RELIGION

All participants belonged to a religious group. Seven were members of the formal Christian churches, two belonged to African Zionist church and one was a Jehovah's Witness. They all had hopes that God would answer their prayers and give them children. Religious beliefs have affected the behaviour of all participants and these behaviours will be further discussed under the social system. No informant was a member of a church that has some prescriptions for sexual intercourse as was cited by Jensen and Bobak (1987) who indicated that some

religious prescriptions can result in the problem of infertility if a woman has a short cycle.

5.2.4. ETHNIC GROUP

Nine participants were Zulus and only one was Xhosa. Although the remaining participant was a Xhosa, she was affected in much the same way as the others because she was married to a Zulu. The implications of infertility in Zulu society will be discussed under the social system.

5.2.5. EMPLOYMENT STATUS

Six of the participants were unemployed, three were employed and one was self-employed. The significance of the employment status will be incorporated under the personal system in relation to the financial implications of infertility.

5.2.6. EDUCATIONAL LEVEL AND LITERACY

Three participants had post matriculation qualifications, these were hospital case number 1 and private cases numbers 1 and 5. Three had standard ten, these being private cases 2, 3 and 4. The remaining four hospital cases, numbers 2, 3, 4 and 5 had

standards 9; 5; 7 and 4 respectively. Houghton and Houghton (1987) contend that the tendency of delaying having children by certain couples has led to increasing fertility problems because of the decline in fertility with increasing age. This was possibly reflected in private cases numbers 1 and 5 and hospital case number 1 who stated that they had delayed having a child purposely because they wanted to finish their studies first.

According to Operation Upgrade (1994) a person is considered literate if she has achieved a standard four level of education. All the participants were literate as their educational levels ranged from standards four to ten and three had post matriculation qualifications. This was consistent with what was reported by Ebomoyi and Adotoro (1990) that literate women used health facilities more than illiterate women.

5.2.7. PLACE OF RESIDENCE AND PHYSICAL ACTIVITY

Five participants were residing in urban formal areas whereas five were from rural areas. All those who were from the rural area were at one stage, or were still involved in subsistence farming which in this study was regarded as strenuous activity. Three of those from the urban areas were involved in physical exercise which was also graded as strenuous exercise, unlike the remaining two who had no excessive activity. Kruger in Odendaal, Schaetzining and Kruger (1993) cited that strenuous

exercise often results in ovulatory disturbances and thus contributes to infertility.

5.2.8. LIVING WITH HUSBAND OR CONSORT

Six of the participants lived together with their husbands which enabled them to have regular sexual relationships. The remaining four participants did not stay permanently with their partners. Two of these were married women whose husbands were migrant labourers, an important contributing factor in fertility (WHO, 1975). These two participants indicated that their husbands cohabitated with other women in the city. This could contribute to the increased likelihood of sexually transmitted diseases. The problem was compounded for one of these women as her husband had married a second wife because of her inability to conceive. He only cohabitated with her at the end of every month, but continued to support her. This factor of polygamy has also been identified as contributing to infertility (WHO, 1975). The last two participants were single, but as they lived near their partners, living separately did not appear to affect their relationships. However, one private case, number 5, had menstrual problems which limited her sexual activities.

5.2.9. NUMBER OF HOUSEHOLD MEMBERS IN RELATION TO NUMBER OF ROOMS IN THE HOUSEHOLD

Both these factors were included in order to ascertain the availability of privacy within the household. Three participants were residing alone and one informant looked after her sisters children in the home. Six participants stayed with their partners and three of these also had their relatives children staying with them. All participants had privacy since their houses had more than one bedroom.

5.2.10. PERSONAL MONTHLY INCOME, HOUSEHOLD MONTHLY INCOME AND MEDICAL AID

The three participants who were employed had adequate personal monthly incomes ranging between R1600 to R3000. These incomes were well above the 1992 household subsistence level (HSL) in Durban of R787,86 per month (Potgieter in Ardington, 1994 p.48). Only one informant, hospital case number 3 had an income below the HSL, indicating poverty. One informant was unable to give the household monthly income and she appeared to be poor. The remaining four participants had household monthly incomes between R1200 and R3000. All the private participants had an income of R1700 per month or more and all of the hospital participants had lower incomes except for case number 1 who had a monthly

household income of R3400, R1600 of which was her personal income. All the private participants had medical aid support which gave them the financial support needed to consult the private gynaecologist. Four of the five hospital participants lacked this resource, only one having a medical aid yet choosing hospital treatment.

5.2.11. LENGTH OF TIME OF PRESENT RELATIONSHIP

All participants were found to have a period of more than two years in their present relationships which indicated stability in their relationship.

5.2.12. LENGTH OF TIME OF TRYING TO CONCEIVE

The range of the period of trying to conceive was from 2 to 19 years. The mean period was 8.2 years. This period could influence the women's perceptions of self and her reactions to infertility.

5.2.13. MEDICAL HISTORY

Four of the participants have had surgery. Case number 5 from the private cases had a laparotomy which was not related to

fertility problems. Private cases numbers 1 and 3 had dilatation and curettage and tuboplasty respectively. Hospital case number 1 had had a laparoscopy and hysterosalpingogram. The remaining six participants have never had surgery.

5.2.14. NUTRITIONAL STATUS

Nine participants had a normal nutritional status according to the Quetalet Body Mass Index (Ellis, 1994). Only one informant, hospital case number 3, was found to be overweight but not clinically obese. Besley (1976), cited that there is a direct relationship between infertility and nutritional disturbance due to hormonal changes.

5.2.15 DEPENDENCY-PRODUCING SUBSTANCES

Eight participants had never used any form of dependency-producing substances. Two participants were drinking alcohol and smoking cigarettes socially. These were private cases numbers 1 and 5. Laurent, Thompson, Addy and Moore (1992) asserted that cigarette smoking increases the risk of primary infertility.

5.2.16. GYNAECOLOGICAL HISTORY

Four participants have previously had vaginitis which presented with a discharge for which they have been treated with antibiotics and one with "Betadine douche". Two have had pelvic inflammatory disease, an important cause of infertility. One informant had a problem of irregular menses and another endometriosis, the latter being implicated in infertility. Two participants had no known gynaecological problems. One of the participants, hospital case number 3, who had vaginitis also had a late onset of menarche which was at sixteen years.

Wesley (1976) reported that tubal occlusion was the most common cause of infertility in South Africa. Tubal occlusion could be due to recurrent pelvic inflammatory disease. Two participants whose partners were involved in migrant labour presented with pelvic inflammatory disease which could have resulted from sexually transmitted diseases which could be due to their partners having additional sexual partners since they were not residing together. Two participants who were both younger and single, had a history of more than two previous sexual partners and one of them had vaginitis. One informant had endometriosis which could have caused her infertility problem (Russel and Ziegler, 1993). One informant related a story which suggested that she had procured an abortion when she was younger. Larsen (1978) reported that induced abortion

can lead to damage of the fallopian tubes which could lead to infertility later in life.

5.2.17. USE OF CONTRACEPTIVES

Five participants had used contraceptives in their previous relationships before trying to conceive. Hospital case number 1 and private case number 3 were given Depo Provera as treatment for irregular menses. Private case number 1 has used "Diane 35" as treatment for acne but she was not aware that it was also a contraceptive measure. The remaining four participants have never used any form of contraceptives. It was noted that the majority of women who never used contraceptives were from the rural areas, that was three women out of four participants, which could indicate non-availability or inaccessibility of services in the rural areas.

TABLE 5.1

CROSS CASE ANALYSIS

CASE NUMBER	HOSPITAL					PRIVATE				
	1.	2.	3.	4.	5.	1.	2.	3.	4.	5.
1. SOCIO-DEMOGRAPHIC INFORMATION										
AGE IN YEARS	34	26	33	35	30	30	25	32	33	29
MARITAL STATUS	M(L)	M(L)	M(C)	M(L)	M(C)	(L.P.P.) SINGLE	M(L)	M(L)	M(L)	(L.N.P.) SINGLE
RELIGION	PRESBYTERIAN	ZIONIST	METHODIST	CATHOLIC	UNITED CONGREGATION	METHODIST	ZIONIST	JEHOVAH'S WITNESS	METHODIST	ANGLICAN
ETHNIC GROUP	ZULU	ZULU	XHOSA	ZULU	ZULU	ZULU	ZULU	ZULU	ZULU	ZULU
EMPLOYMENT STATUS	EMPLOYED	UNEMPLOYED	UNEMPLOYED	SELF EMPLOYED	UNEMPLOYED	EMPLOYED	UNEMPLOYED	UNEMPLOYED	UNEMPLOYED	EMPLOYED
EDUCATIONAL LEVEL	DIPLOMA IN TEACHING	STD 9	STD 5	STD 7	STD 4	DIPLOMA IN POLICING	STD 10	STD 10	STD 10	DEGREE IN NURSING
PLACE OF RESIDENCE	URBAN (F)	URBAN (F)	RURAL	URBAN (F)	RURAL	URBAN (F)	URBAN (F)	RURAL	RURAL	URBAN (F)
LIVING WITH CONSORT / HUSBAND	YES	YES	NO	YES	NO	NO	NO	YES	YES	NO
NUMBER OF HOUSEHOLD MEMBERS	3	2	3	6	1	1	2	4	4	1
NUMBER OF ROOMS IN THE HOUSE	5	3	6	4	3	1	3	7	7	1
PERSONAL MONTHLY INCOME	R1600	-	-	R350	-	R1700	-	-	-	R3000
HOUSEHOLD MONTHLY INCOME	R3400	R1200	R350	R1250	NOT KNOWN	R1700	R3000	R1560	R2500	R3000
MEDICAL AID	PARTNERS	NONE	NONE	NONE	OWN	OWN	PARTNERS	PARTNERS	PARTNERS	OWN
LITERACY	LITERATE (E & Z)	LITERATE (E & Z)	LITERATE (Z)	LITERATE (E & Z)	LITERATE (Z)	LITERATE (E & Z)	LITERATE (E & Z)	LITERATE (E & Z)	LITERATE (E & Z)	LITERATE (E & Z)
TYPE OF WORK	STRENUOUS EXERCISE	HOUSEHOLD	HOUSEHOLD	HOUSEHOLD	SUBSISTENCE FARMING	STRENUOUS EXERCISE	HOUSEHOLD & GARDENING	HOUSEHOLD & GARDENING	SUBSISTENC E FARMING	HOUSEHOLD
LENGTH OF TIME OF PRESENT RELATIONSHIP	5 YEARS	5 YEARS	15 YEARS	5 YEARS	10 YEARS	4 YEARS	4 YEARS	10 YEARS	13 YEARS	4 YEARS
LENGTH OF TIME OF TRYING TO CONCEIVE	5 YEARS	5 YEARS	15 YEARS	19 YEARS	10 YEARS	2 YEARS	4 YEARS	7 YEARS	13 YEARS	2 YEARS
2. HEALTH HISTORY										
MEDICAL HISTORY	NONE	NONE	NONE	NONE	NONE	NONE	NONE	NONE	NONE	NONE
SURGICAL HISTORY	LAPAROSCOPY H.S.G	NONE	NONE	NONE	NONE	D & C	NONE	TUBOPLASTY	NONE	LAPAROSCOPY
QUETELET BODY MASS INDEX	NORMAL	NORMAL	OVERWEIGHT	NORMAL	NORMAL	NORMAL	NORMAL	NORMAL	NORMAL	NORMAL
DEPENDENCY PRODUCING SUBSTANCES	NONE	NONE	NONE	NONE	NONE	SMOKING & ALCOHOL	NONE	NONE	NONE	SMOKING & ALCOHOL
GYNAECOLOGICAL HISTORY	IRREGULAR MENSES "CLOMID"	NIL	P.I.D	VAGINITIS DYSEMENORRHO EA	NIL	P.I.D BLOCKED TUBES	VAGINITIS	VAGINITIS	VAGINITIS	ENDOMETRIOSIS "CLOMID"
USE OF CONTRACEPTIVES FOOTNOTE	YES	YES	NO	NO	NO	YES	YES	YES	NO	YES

CONTRACEPTIVES USED PRIOR TO TRYING TO CONCEIVE EXCEPT FOR CASE 1 (HOSPITAL) & CASE 3 (PRIVATE) (REFER TO TEXT)

KEY:

M (L)	=	MARRIED LEGALLY
M (C)	=	MARRIED CUSTOMARILY
5 (L.P.P.)	=	SINGLE LOBOLO PARTIALLY PAID
5 (L.N.F.)	=	SINGLE LOBOLO NOT PAID
URBAN (F)	=	URBAN FORMAL
URBAN (I)	=	URBAN INFORMAL
LITERATE (E)	=	LITERATE ENGLISH
LITERATE (Z)	=	LITERATE ZULU
D & C	=	DILATATION AND CURRETAGE
P.I.D.	=	PELVIC INFLAMMATORY DISEASE

5.3. PERSONAL SYSTEM:

Women's experiences will be dealt with under the sub-sections related to personal system as was presented in the case study protocol.

5.3.1. SELF-IMAGE

Rosenberg's Self-Esteem Scale, translated into the vernacular was used on all ten participants. The scale was scored as a Likert Scale and the mean was 19,9, the median being 17, and the mode being 16. Any score below 20 demonstrated a negative self-image which was found in three of the five hospital cases and three of the five private cases. Because of the small size of the sample and the fact that this was not a quantitative study the standard deviation was not measured.

The qualitative data reflected the quantitative data except for four participants, hospital cases numbers 2 and 5, and private cases numbers 2 and 4, who obtained the following scores: 27; 21; 29; and 27 from Rosenberg's Self-Esteem Scale. These scores were moderately positive because they were more than 20 but less than 30. There was some ambivalence with these scores because all four participants expressed that their self-image was affected by this problem of being unable to conceive. Although some of these examples could have been included under interpersonal systems, the researcher believed

that they more specifically reflected poor self-image. Private case number 2 said "If you do not have a child you look down upon yourself, you do not feel like a female." Private case number 4 said "It is a very painful experience being unable to conceive."

For the remaining six participants, this qualitative information was congruent with the scores obtained from Rosenberg's Self-Esteem Scale. They all had scores below 20 which illustrated negative self-esteem. This was in agreement with the reports of various authors that women with infertility problems have low self-esteem. Hospital case number 1 and private case number 3 felt that if you do not have a child "you are not like other women of your age who have children." Hospital case number 3 and private case number 5 said "you are nothing without a child and you feel like an incomplete woman." Hospital case number 4 and private case number 5 expressed that they have a "poor self-image" due to the problems of infertility. Hospital case number 4 further said, "I have no peace of mind, I look down upon myself and I am hoping for happiness in Heaven." Private case number 1 felt that she was a 'failure in life', because of her inability to conceive. Private case number 3 expressed that it was a "very painful experience" to be unable to bear children.

5.3.2. PERCEPTION OF SELF AS PERCEIVED BY SIGNIFICANT OTHERS

Davis (1987) reported that infertility can affect an individual's perception of herself to herself and to others. This fact was found to be true for three participants who thought that the people who are significant to them namely, their husbands, thought of them as "failures". However, seven participants expressed that the significant people in their life, being their partners and their own family members were concerned and very supportive. All eight married participants reported that they were perceived negatively by their in-laws. This aspect will be discussed under the relationship with in-laws which falls under the interpersonal system.

5.3.3. GOAL-SETTING

All the participants had experienced problems with regard to setting of their goals. Their inability to conceive had focused their activities towards self-fulfilment through childbearing. Four participants expressed that the problem of infertility has interfered with their personal goals of wanting to further their studies because of hopes of achieving pregnancy soon. Clapp (1985), asserted that an infertile individual may lose sight of her personal goals whilst working on infertility problem as reflected in the above findings.

5.3.4. GROWTH AND DEVELOPMENT

Nine participants stated that they had not achieved their highest level of growth and development because the problem of infertility has hindered their personal growth. Bearing of children is regarded as the process of growth and development of an individual. Davis (1987) cited that the problem of infertility had a negative effect on the individual's growth and development as demonstrated by the participants' responses. Havinghurst in King (1981), asserted that in adulthood the developmental task can be achieved because of individual's personal goals, values and societal expectations. Woods et al (1991), contend that childbearing is a societal expectation and private case number 2 expressed that childbearing is an expectation and especially for a 'newly wed' couple.

All participants expressed that this problem of being unable to conceive has interfered with their future plans. One participant said "you always think about having a child and cannot think about anything else." One informant was frustrated by the fact that she will not be able to inherit anything material from her husband if she cannot bear a child for him. One participant said "It is so painful to be unable to reach your dreams."

5.3.5. FINANCIAL IMPLICATIONS

Six participants with medical aides or who were using their partners, have not experienced major financial implications except for hospital case number 1, who had payed R2000 to the gynaecologist for investigations and treatment. All five participants from the private practice had a medical aid which was paying for their investigations and treatment. For hospital clients, though the hospital fee was graded according to income, R13 being the basic fee, the fact that they travel from their different areas using public transport had some financial implications. Four hospital clients were not employed, one being self-employed, had minimal financial resources. Three private cases, numbers 2; 3 and 4 were also unemployed. Hospital cases numbers 3 and 5 and private cases numbers 1; 3 and 4, all came from areas that are far from Durban and had to pay for public transport. Private case number 3 had used her husbands transport.

5.3.6. GRIEF PROCESS

The stages of the grief process were analyzed according to Kubler-Ross (1969) foundational work. The stages being denial, isolation, anger, bargaining, depression and acceptance. All participants were found to have experienced the grief process which was characterised by these different stages occurring at different times. Only one participant, hospital case number 4, experienced the acceptance stage, all others were eager to

continue with investigations and probable treatment. Most participants denied the problem in the following words "This is not happening to me." Although they believed the test results that indicated that they had this problem, they were unable to accept this. Two participants had hope and said that "God will answer my prayers."

All the three participants who were employed felt isolated from their workmates. They all decided to remain quiet when workmates talked about their children at tea breaks. Even those participants who were unemployed felt isolated from their friends and neighbours.

All the participants bargained with God and/or Ancestors, making promises of what they would do should they have babies. Two participants felt that they were being punished for what they had done or said in the past. Private case number 5 recalled what she used to say prior to trying to conceive: "I don't want to have a child." Private case number 4 recalled an event where she procured an abortion accidentally by taking some "super tabs" given to her by a school mate.

5.4. INTERPERSONAL SYSTEM:

5.4.1. RELATIONSHIP WITH PARTNER

Hospital case number 4, despite a good relationship with her present husband, had experienced very poor relationships with her previous husband. She was married for the second time. She divorced the previous husband because he had beaten her and he also referred to her as "inyumba", a derogatory Zulu term for infertile woman. This has led to separation. Salzer (1991), reported that infertile couples often accused each other and this could lead to marital disharmony and result in separation or divorce. Hospital case number 1 had experienced poor relationships with her husband who blamed her for the problem of being unable to conceive. This has led the husband to alcohol abuse. Eight participants expressed that they had communicated with their partners about the problem of infertility. However, one informant stated, "we always end up by quarrelling each time we discuss about it." This has affected their sexual relationship since she has experienced loss of libido, which has worsened by the problem. Couples who are undergoing infertility treatment have to have sexual intercourse at prescribed times, this factor may affect the sexual relationship negatively and also when the goal of intercourse which is normally enjoyment, has been changed to conception (Hirsch and Hirsch, 1988). Eight participants expressed that they had communicated to their partners who seemed to be sharing their feelings since there were no threats of divorce or separation. Salzer (1991), indicated that a closer bond is maintained in couples who share the same feelings. Although hospital case number 3 was not divorced, her husband has

remarried as directed by the elders in the family. They were married customarily so he was able to marry a second wife. This was consistent with some of the literature findings where Barnmann (1990), Ogbu (1977) and Pearsall (1947), reported that infertility may lead to marriages being dissolved. Eight participants expressed that their marriages were unhappy, which was congruent with Gumede's (1978) report that marriage of couples experiencing sterility, was traditionally regarded as an unhappy marriage. Hospital case number 5 reflected poor self-image by saying "I think I am a bad person" and " I think that my husband may stop loving me if I cannot bear children for him because it is vital in the Zulu culture."

5.4.2. RELATIONSHIP WITH OWN FAMILY

Nine participants stated that their family members were concerned and supportive. Private case number 5 said "my sister is prepared to be a surrogate mother of my child." However, hospital case number 2 reported that her family members were not supportive because they did not even have good relationships before she got married.

5.4.3. RELATIONSHIP WITH IN-LAWS

All married participants stated that they had poor relationships

with their "in-laws" especially their mother-in-laws. Hospital case number 1 and private case number 4 said their mother-in-laws favoured other girls who had children with the participants' husbands. Private case number 4 knew that her mother-in-law had bewitched her so that she would never conceive because the mother-in-law "loved the other girl who had conceived her husband's child" and his mother stayed with this woman who had proved her fertility. The unmarried participants, private cases numbers 1 and 5 had no problem with their consort's parents because they were not aware of their fertility problems.

5.5. SOCIAL SYSTEM:

5.5.1. POWER, AUTHORITY AND DECISION-MAKING

Seven of the married participants indicated that their husbands were the head of the household. Their husbands had power and authority in family matters. One married woman, hospital case number 5, said her father-in-law was the head of the household and he had the power and authority regarding family matters, but had not made decisions with regard to her inability to conceive. Although the husbands of married participants were the heads of the households, decisions pertaining to the problem of infertility, for example, where to go for help, were made by the participants themselves in consultation with their husbands.

Of the unmarried participants, private cases numbers 1 and 5, one had her eldest sister and the other her mother, respectively as heads of the families. Decisions pertaining to the problem of being unable to conceive were made by these participants. This was consistent with Gumede (1978) who noted that nowadays women and even young girls decide themselves to consult either traditional healers or doctors for investigation and treatment of being unable to conceive.

5.5.2. STATUS

Davis (1987) noted that infertile individuals may sense loss of status among family, friends and the community at large. This was found to be true for all participants though they gave varied responses which all indicated loss of status among their families and friends who have children. Three participants indicated that "if you have no child, you are not respected since you cannot be referred to as 'mama kabani bani', (meaning mother of so and so), but you are just referred to by your name." Being referred to as 'mother of so and so' gives the woman a certain status in the community. Two participants stated that "if you are childless, you are looked down upon by family members as well as by your community members." One informant said "a woman with a child is more respected and valued than the childless woman." This was similar to Preston-Whyte's (1985) findings who reported that childbearing was

valued in Zulu cultures and was seen as an important status for women. Also King (1981), reflected that there are obligations and privileges that are attached to the status of motherhood. Because infertile individual's cannot attain these obligations and privileges, they may often experience loss of status.

5.5.3. CULTURAL BELIEFS AND ACTIONS OF WOMEN IN RESPONSE TO THEIR INFERTILITY PROBLEMS

Two hospital cases, numbers 2 and 5, had been to traditional healers "izinyanga", who gave them traditional medicine for "cleansing the womb." Both these two participants did not report about the findings of the izinyanga regarding being bewitched. Private case number 4 had been to an "inyanga", traditional healer, who told her that her mother-in-law had bewitched her. For all the three aforementioned participants, traditional cultural beliefs and practices have influenced them. This was consistent with Gumede (1978) who reported that in Zulu traditional society sterility was thought to be due to witchcraft and Zulu people used to go to an inyanga so that he could identify the harmful spell and give the couple medicine to help them overcome the spell and achieve pregnancy. None of these three participants knew the name of the medicine that they had used. Hospital case number 2 said she had received "imbiza yokugeqa isibeletho" meaning traditional medicine to

'clean the uterus'.

Hospital case number 1 and private case number 4 have been to faith healers who gave them holy water for cleansing the uterus, which for both clients had not yielded any positive results. Private case number 3, being a member of the Jehovah's Witness church, was prohibited by her religious beliefs from attending traditional healers.

The remaining six participants knew about the cultural beliefs and practices of traditional Zulus with regards to infertility, but were not influenced by them. They were influenced by western beliefs and practices hence they attended doctors either in the hospital or in private practice. These participants thought that the causes of their problems were physical. This was true even for those three participants who were initially influenced by Zulu cultural beliefs because they also attended Western medical practitioners as the researcher included them in her sample, two from the academic hospital, and one from private practice. Thus traditional and western medicine was being used in tandem as were 'christian beliefs' and Western medicine.

Six participants, five Zulus and one Xhosa, were not influenced by traditional cultural beliefs and practices, since they did not seek help from traditional healers but from formal health facilities. Of the remaining four participants, three were influenced by Zulu traditional beliefs and practices and those

participants attended traditional healers, the remaining informant was influenced by African church practices being blessed with holy water. Although these women were influenced by traditional beliefs, they used the formal health facilities in

tandem. Those who attended traditional healers have had unnamed medicine for 'cleansing the womb.'

Although women made their own decisions as to where to go for help, directions and guidance were given by relatives and friends who had heard about these healers, who were noted for their success with infertile women.

The decision in regard to attending the private practitioner or the academic hospital was based in all but one instance on the availability of medical aid. Hospital case number 1 had a medical aid and a good income but chose to be a hospital patient. The remaining four hospital cases would have preferred going to the private practitioner, because of his success in dealing with infertility if financial circumstances had permitted them. The private practitioner, a specialist gynaecologist although not an infertility expert, had built up a reputation in the community as being successful in this field and was thus the first choice of the five participants attending his practice.

5.5.4. CARE-GIVERS

Participants were asked about how the nursing staff helped them or made things difficult for them. Their varied responses will be analyzed as well as their suggestions. Though they were asked about nursing staff, they also commented about medical care and have put forward some suggestions to improve both medical and nursing care with regard to infertility.

Hospital cases numbers 2 and 3 reported that nurses have never talked to them about their problem of being unable to conceive. Hospital case number 2 felt shy about discussing her infertility problem with a male doctor and suggested that female health professionals should talk to clients about fertility matters, with regard to procedures to be performed and the results or findings from those procedures. Hospital case number 3 said that the researcher was the first nurse to talk to her about her problem of being unable to fall pregnant. She suggested that nurses should understand the agony of being childless and be available to clients to offer help, because clients see nurses as "busy at all times and clients are shy to disturb busy nurses."

Hospital case number 1 stated that she had only one contact with the nurse who reassured her, she then hoped that pregnancy would occur but she became upset again when nothing happened after treatment. She pointed out that nurses can help by explaining to clients in simpler terms because the doctors use "big words" which the clients do not understand. She suggested that nurses could help by answering clients'

questions earnestly and honestly.

Hospital case number 4 complained that nurses "scold" clients when they relate to them. She then put forward the idea that nurses should have patience and reassure clients. In contrast to that, hospital case number 5 viewed the nurses as very helpful people though she did not explain how they helped her. She further stated that doctors are also helpful. She was frustrated because the doctor had not told her what was wrong from her blood results.

None of the private cases have had contact with the nurses since they were attending private doctor(s) where there were no nursing personnel. Private case number 1 praised the gynaecologist for the explanation and reassurance she received from the doctor. She suggested that "busy" nurses in hospitals should have patience when dealing with women who have infertility problems. Private case number 2 asserted that doctors should help clients who have infertility problems with treatment. Private case number 3 put forward the view that nurses can assist clients by explaining the causes and prevention of infertility because of their knowledge of gynaecology. Private case number 4 put forward the notion that the care given by nurses depended on the nurses personal attitude towards the client. She stated that for her things had not been easy and she regarded herself as being "unfortunate in life."

She had no suggestions as to what nurses could do to help the clients. Private case number 5 said that the gynaecologist made things easier for her when he explained to her the procedures undertaken, and that had allayed her anxiety and lessened her fear of the unknown. She alleged that nurses should support childless women throughout the period of investigation and treatment.

Nine participants recognised that nurses have a role to play in infertility work-up, except for one informant, private case number 4, who gave no such suggestions. It was noted in the literature findings that care-givers often become authoritative to infertile individuals and prescribe for them what to do and what not to do. Participants have highlighted that they need care-givers who will show that they care and who will be able to act as their advocates and be there all the time. The participants suggestions were in agreement with the expected nurses role in infertility work-up, that of being an advocate, educator, counsellor and a supportive person (Davis (1991); Jennings (1992); Sherrod (1988); Clapp (1985); Olshansky and Draye (1991).

5.5.5. SUPPORT GROUPS

Regarding the idea of a support group, all participants with their multiple and varied responses were in favour of the

formation of a support group. Hospital case number 1 and private case number 1 felt that the support group would help those women who have finally accepted their problem and have given up trying to conceive. The support group will help them to accept the situation of childlessness as being inevitable.

Hospital case number 2 and private case number 1 came up with the idea that the support group should consist of professional health workers who would be helpful by giving the infertile women information regarding investigations and procedures undertaken in infertility work-ups. Private case number 5 suggested that women who have achieved pregnancy can help those who are still trying by directing them as to where to go for help.

However, hospital case number 3 felt that these support groups would help women in the urban areas where infertility is being treated and put forward the notion that support groups should also be established in rural areas. Private case number 2 reported that women with infertility often feel neglected and so she suggested that nurses should show them love and should support them throughout infertility work-up.

CASE NUMBER	HOSPITAL CASES					PRIVATE CASES				
	1.	2.	3.	4.	5.	1.	2.	3.	4.	5.
PERSONAL SYSTEM	"I am not like other women who have children."	"I get worried when other people ask me about a baby."	"I am nothing." not a complete woman.	"I look down upon myself, I have no peace of mind. Poor image. Hope for rest in Heaven.	"I am a bad person and I think my husband will stop loving me if I don't bear children for him - Bearing on Zulus.	"I feel I am a failure in life and I'm not like other girls of my age."	"I look down upon myself, I feel not feminine and short tempered."	"I'm not like other women of my age. It's such a painful experience."	"It's a very painful experience."	"I'm nothing. an incomplete woman."
SELF IMAGE	Low self esteem. 16	Moderate self esteem. 27	Low self esteem. 14	Low self esteem. 18	Moderate self esteem. 21	Low self esteem. 15	Moderate self esteem. 29	Low self esteem. 16	Moderate self esteem. 27	Poor image. 16
PERCEPTION BY SIGNIFICANT OTHERS	Failure	Husband supportive	Husband own ma supportive	Beating referred as "Inyumba" previously divorce. P.Husband support	Husband, father in law, family all concerned.	Boyfriend concerned.	I think I'm useless. No contribution. Not working, not studying dependant on my husband.	Husband & mother supportive.	Mother in law is happy. Own family members & husband's family are sympathetic.	Boyfriend & family concerned.
GROWTH & DEVELOPMENT & FUTURE PLANS	Not achieved. Interfered.	Not achieved. Include children in plans.	Not achieved. No heritage from husband.	Not achieved. Unable.	Not achieved. Having a child.	Not achieved. Interfered.	Not achieved. delayed.	Unable to plan.	Not achieved. Unable to reach her dreams.	Not achieved. Interfered thoughts & plans.
FINANCIAL IMPLICATIONS	Affected. R2000	Not affected. R24	Cost of bus fare R55 & hospital care x2 R12	Had been to several doctors.	Bus fare R30 Hospital fare All x 3	Has medical aid. Taxi fare R35	Not affected. Used partners med aid	Used partners med. aid. Bus fare to KE R15 x 2	A lot of money since 81 presently use partner's med aid.	Has medical aid to 2 gynaecologists.
GRIEF PROCESS	Experienced. All except acceptance.	Experienced all except isolation depression acceptance.	Emotional, too isolated experienced all stages except acceptance.	Has progressed through all stages.	Not isolated not accepted experiencing others.	Isolation, has not accepted.	Not isolated not accepted.	Experiencing all stages except acceptance.	Experiencing all except acceptance.	Experiencing all stages except acceptance.
GOD ANSWERING PRAYERS	Experienced. All except acceptance.	Experienced all except isolation depression acceptance.	Emotional, too isolated experienced all stages except acceptance.	Has progressed through all stages.	Not isolated not accepted experiencing others.	Isolation, has not accepted.	Not isolated not accepted.	Experiencing all stages except acceptance.	Experiencing all except acceptance.	Experiencing all stages except acceptance.
INTERPERSONAL SYSTEM RELATIONSHIP OF PARTNER	Affected Partner blames her. Partner drinks excessively.	Communicated. Husband supportive.	Communicated. No longer live together. Husband remarried.	Present husband communicated sexual problems. Divorced first husband.	Communicated. He is supportive. Relationship good.	Communicated sympathy.	Communicated Quarrelled loss of libido blamed.	Communicated. Healthy relationship. regard problems "theirs"	Communicated. Healthy relationship.	Communicated. Supportive. Sexual relationship affected.
RELATIONSHIP OF FAMILY(OWN)	Supportive	Poor relationship	Her mother supportive.	Her mother supportive.	Sympathetic.	Sympathetic.	Mother supportive offered help.	Mother supportive. Financial assistance.	Supportive.	Supportive, concerned.
RELATIONSHIP OF IN LAWS	Poor.	Suspected to be poor.	Poor.	Previous in laws loved her. Present unknown.	Worried & concerned	Problem not known to in laws.	Never heard their comments.	Ma in law talkative might be complaining.	Believed that mother in law has bewitched her.	N/A not worried.
RELATIONSHIP OF FRIENDS	Isolated.	Good.	Isolated.	Good. Keeps quiet in discussions about children.	Good. Also supportive.	Talk to close friends only.	Not affected.	Not affected.	Friend far neighbours sympathetic.	Friends good workmates affected.

CASE NUMBER	HOSPITAL CASES					PRIVATE CASES				
	1.	2.	3.	4.	5.	1.	2.	3.	4.	5.
SOCIAL SYSTEM	Husband	Husband	Husband	Husband	Father in Law	Eldest Sister	Husband	Husband	Husband	Mother
POWER	Husband	Husband	Husband	Husband	Father in Law	Eldest sister	Husband	Husband	Husband	Mother
DECISION MAKING	Husband	Husband & herself	Husband	Herself	Husband & herself	Herself	Husband & herself	Husband & herself	Husband & herself	Herself
STATUS	Not referred as "Mother of so and so"	Not respected in the family and the community	Not respected as "Mother of so and so"	Not respected in the community. Unsure about status in the family.	Looked down upon.	No respect in the family and in the community.	You are not recognised as a mother.	Being called mother of so and so. Status family/community.	Depending individual "you have no say"	Depends on how you rear your child - negative - positive
CULTURAL BELIEFS	Not influenced.	Had been to a herbalist.	Not influenced.	Not influenced.	Influenced by African Church Beliefs and cultural beliefs and practices.	Not influenced.	Has been to a traditional healer.	Not influenced.	Been to various traditional healers & doctors.	Not affected. Western beliefs.
CARE GIVERS	Explanation - causes & previous teaching. Answering questions.	Explanation - procedures & results. Explanations.	Nurses do not talk to patients - ever busy. Understanding of pain & agony of childlessness. Patients shy to talk to male doctors about fertility issues.	Nurses scold clients. Doctors abuse clients when performing per vaginal examinations. Too knowledgeable and does not listen to patient.	Nurses are helpful.	No contact. Nurses should be patient.	No contact with nurses. Doctors can help.	No comment about nurses. - no contact - knowledge in gynae help causes & previous.	Personal and institutional attitudes differ. No comment on how nurses can help.	No contact with nurses. Doctors help - well prepared - give explanations - nurses should support
SUPPORT GROUPS	Helpful. Need for professional support to give info.	Never heard - help couples about to separate or divorce - adoption	Will help women in the urban areas. Sisters should go to the rural areas.	Sharing of feelings Sexual - to plead nurses and doctors to help them. Males to join professional guidance.	Will be helpful. Nurses to have patience. Women who have been through the problem of infertility can give advice on where to go for help.	Helpful to those who have accepted. Still trying need information re investigation and procedures.	We feel neglected. We need love like sick a person.	Prescribed times of treatment and of intercourse. Women with similar problems. Where help was obtained. Health profession social workers & nurses.	People have different problems. Hers is unique to others. Know other women. Not in favour of a support group.	Give info re available services. In favour of a support group. Showing of feeling. Free communication.

CHAPTER SIX - CONCLUSIONS AND RECOMMENDATIONS

6.1. INTRODUCTION:

In this chapter conclusions and recommendations in relation to the study will be presented. Identified problems in regard to the socio-demographic data will be initially presented. The case study protocol which was formulated using elements of King's Interacting Systems Model will be used as a guide for the remaining discussion. Generalizations could not be made because of the small size and non-randomized nature sample, but some common threads were identified and are presented in this chapter.

6.2. CONCLUSIONS AND RECOMMENDATIONS:

6.2.1. SOCIO-DEMOGRAPHIC DATA

The socio-demographic aspect was structured to attain information which could affect the informant's personal, inter-personal and social systems, such as marital status, religion and ethnic groups which could have a bearing on the informant's behaviour within these systems. The socio-demographic data could also assist in identifying possible contributing factors to infertility such as activity level, age, privacy in the home and migrant labour status of their partners. In addition, weight for height status, as well as the informant's past medical, surgical

and gynaecological histories were obtained, those also helping to identify aspects related to infertility.

The seven participants over the age of 30 years were more anxious than the younger participants, who had also spent less time trying to conceive. The significance of these relationships could not be tested. Two of these women indicated that they would give up trying to conceive when they reached 36 years, as child-bearing was too dangerous after that. Three of the participants with tertiary education had delayed trying to conceive until they had completed their education. Advancing age is a factor known to be related to lower fertility. A recommendation is that women should be educated about the fact that fertility decreases with increasing age, so that they will be empowered to seek help before it is too late.

Of the eight participants who were married, two participants had marital changes because of being unable to bear children. One of these had divorced and the other informant's partner had customarily married a second wife. The recommendation is that there should be a family therapist available for consultation in the proposed support groups in order to prevent marital problems or to facilitate conflict resolution.

All the participants were literate in Zulu and of these, eight were also literate in English. Literate people seek help more readily than the illiterates (Ebomoyi and Adetoro, 1990), but

this finding does not mean that infertility is not present in illiterate women. The recommendation to these high levels of literacy is that appropriate literature could be developed in Zulu and in English in regard to infertility in both the hospital and private practice.

All participants had privacy in their households, which indicated that they should have experienced no problems with privacy in relation to sexual intercourse.

Eight of the participants were well above the household subsistence level unlike two of the hospital participants, one lived below the household subsistence level and the remaining one, whose income was unknown, appeared to be poor.

All participants from rural areas were unemployed and were still or had been involved in the strenuous activity of subsistence farming which could interfere with ovulation. No participant was found to have weight problems as was indicated by their Body Mass Index which for all were within the normal limits. The other factors which could interfere with ovulation are cigarette smoking and alcohol consumption. Two participants smoked and drank, one of these had ovulation problems which were treated with "Clomid." The recommendation related to ovulatory problems is that nurses should be educated to take a thorough history which will help to identify the relative contributing factors which could lead to

infertility. It is also the nurses task to educate women about these contributing factors. The nurse is thus able to help clients to understand the effect of these factors with regard to infertility and its prevention.

Two participants whose partners were involved in migrant labour, presented with infection which could have resulted from sexually transmitted disease, since the participants indicated that their partners had other sexual partners near their workplace. Woman should be educated about signs and symptoms of infection and where to go for help and prevention of complications. However, the nurse may be faced with professional dilemmas such as telling the client about the use of condoms to prevent infection when the client is desperate to conceive.

6.2.2. PERSONAL SYSTEM

All participants had a poor self image of themselves as was evidenced by their qualitative data and all, except four participants, had low self-esteem scoring below 20 on the Rosenberg's Self-Esteem Scale (see Annexure D). One of the remaining four scored 21 indicating a borderline moderate self-esteem. Of the other three, two scored 27 and one 29 indicating in these instances that the self-esteem score did not reflect the qualitative data obtained unlike the majority of participants. All

ot these three participants thought that they were perceived as failures by their significant others, these being their husbands. All participants experienced problems with their goal-setting abilities. They felt that their process of growth and development was interfered with since they could not reach the stage of self-fulfilment. They were found to be unable to plan for their future since they were pre-occupied with the thought of conceiving in the near future. They were all grieving, experiencing different stages of different times and only one participant had reached the stage of acceptance. None were in the stage of surprise because they knew about their problem and had been attending to the health centre for some time.

It is recommended that there should be a specific infertility clinic so that there can be continuity of medical and nursing care. The same medical and nursing staff should be allocated in the clinic to ensure congruency of advice. A therapeutic environment should be created, where it would be easier for the client to express her feelings. Women should be educated about infertility and its effects on the personal system. Individuals who are already diagnosed as having infertility problems should be reassured and supported as they go through the various stages of the grief process, and they should be helped to understand that it is normal to go through the grief process. However, when women are severely depressed, they should be referred for assessment and professional help by clinical nurse experts in the field of psychiatric nursing, nurses with

psychiatric as well as gynaecological expertise in nursing could fulfil this role in the clinic.

6.2.3. INTERPERSONAL

The interpersonal relationships of individuals who are having a problem of infertility are adversely affected, at home, within the immediate and extended family, in the neighbourhood and at work. Communication with the partner could be affected and this could lead to problems with sexual intercourse which can result in separation or divorce. Two participants had experienced marital disharmony as one was divorced and the other's partner had a second wife. The remaining eight participants experienced no marital discord. It is recommended that marriage guidance counsellors and sex therapists should be available for consultation. The latter is recommended as two participants expressed that they had experienced problems in sexual intercourse including loss of libido and inability to reach orgasm.

The participants were blamed by their partners for being responsible for the infertility problem. The remaining eight did not mention that they were blamed by their partners, but the fact that the participants were the ones coming to the clinic without the partner, probably meant that they have identified

themselves as having the problem. Males should be educated that they can also contribute to the problem of infertility.

All participants except one, had good family relationships with their present partners. The remaining participant had a poor relationship with her own mother prior to this problem. The other participants' families formed good family support which should be strengthened by educating family members about the importance of the support role they can play in infertility care.

The relationship with in-laws was reported to be poor by all the married participants because of infertility problems. Health education should be directed to elders in the family and family members about the needs of infertile women and how to help them cope with the situation and not to call them by derogatory names. There should be inclusion of trans-cultural nursing in the nursing curriculum to enable nurses to understand different cultures, and respect their clients' culture so that clients realise that nurses understand them. Nurses need to be empowered to gain entrance into communities as it is only then that they are accepted, trusted and listened to within the community.

6.2.4. SOCIAL SYSTEM

All participants had their husbands, mothers or older sisters as head of the household. These household heads made decisions

pertaining to family matters. However, decisions regarding the problem of infertility were made by the participants themselves. One informant had her father-in-law as an authoritative member of the family, but he had not influenced her decision as to where she should go for help. Therefore elders in the family were not found to be the decision-makers regarding infertile women as was indicated in the literature review. This may have been due to the fact that all participants were not staying in the same household as their elders. Women should be given information about where to go for help, and care-givers should not make decisions for women, but should give information and help them to make informed decisions. The elders who exert pressure on the childless women should be educated with an aim of changing their attitudes to be able to support the women.

All participants indicated that a childless women has a low status in the family and in the community, so that she is not respected and not valued since she is unable to bear children.

It is recommended that communities should be educated about changing their attitudes towards childless women and that they need support and love, not disrespect. Community members should not refer to childless women using derogatory words such as "inyumba" a derogatory Zulu word for infertile women.

Zulu cultural beliefs and practices have influenced three of the participants' actions and responses to being unable to conceive.

They were found to have used both traditional and Western medicine in tandem. The remaining seven were influenced by Western beliefs. It is therefore recommended that traditional healers should be included in the health care system.

The participants knew about traditional Zulu cultural beliefs that women are blamed for infertility. The fact that it is taboo amongst Zulus to speak about sexuality poses a problem for health care workers. The fact that it is a societal expectation amongst the Zulus that a woman is only complete when she has a child is problematic. These beliefs must be addressed by teaching children at an early age that it may happen that one does not have a child and what could cause this, as well as where to go to for help. Infertility education should be gradually built into sexuality education in the schools.

6.2.5. NURSES ROLE

All, but one of the hospital participants, who have had contact with nurses indicated that nurses have not helped them, often 'scolded' them and that they have not felt supported by nurses. The private participants have not had any contact with nurses but gave suggestions as to how nurses should be more empathetic, have good communication skills and understanding of infertility and its effects on the individual, on the relationship with other people, as well as the relationship with

care-givers. Nurses should be well prepared for their extended role in care of clients with infertility. This could be done through in-service education, lectures given by experts in infertility, skills workshops, symposia and relevant literature. Nurses should be encouraged to be involved in formal and informal education regarding prevention of infertility and aspects such as the infertility workup.

Fertility and its problems as a component in gynaecological nursing should be emphasized to undergraduate students with the aim of developing interest in this field of study. The nurse should be able to perform all her roles in infertility such as counselling, educating and supporting. She should be a client's advocate. The nurse should also be able to educate the client about the physical aspects involved in infertility such as investigation and treatment and participate therein.

6.2.6. SUPPORT GROUPS

Although a support group exists for middle class white couples, it is not really appropriate for most African women. The idea of a support group for African women was favoured and accepted by all but one of the participants who indicated that her problem was unique "and not like other people's problems." The recommendation in relation to this is the formation of acceptable and appropriate support groups. The

role of such a support group would be the provision of information on treatment, and if unsuccessful, adoption or the choice of a child-free life as well as counselling women to accept the problem. The idea of adoption is not favoured by Zulus, but for childless couples, where all treatment has failed, it could be a solution. In the support group the nurse can function as an advisor, a group leader, or as a liaison person with other members of the health team. There should be involvement of both males and females in these support groups.

6.3. FUTURE RESEARCH

Future research could investigate the effectiveness of a support group. If an information pamphlet is produced its effectiveness could be assessed. Research on experiences of men with infertility would be of value and could help to change attitudes, especially those of men who believe infertility is a women's problem. More extensive research using random sampling and with a more structured questionnaire could be conducted to yield more information on the subject of infertility. Community-based research, particularly in rural areas could be undertaken to identify childless couples who had not sought medical help for their problems. This research could also help identify the prevalence of primary and also secondary infertility in the province as well as throughout South Africa.

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ANNEXURE A

INTERVIEW SCHEDULE FOR THE STUDY OF EXPERIENCES OF WOMEN WITH THE PROBLEM OF INFERTILITY IN THE ACADEMIC HOSPITAL AND IN PRIVATE PRACTICE

CASE NUMBER: _____

DATE OF INTERVIEW(S): (1) _____ (2) _____

PLACE OF INTERVIEW(S): (1) _____ (2) _____

LENGTH OF INTERVIEW(S): (1) _____ (2) _____

SOCIO-DEMOGRAPHIC DATA:

1. AGE IN YEARS

20 - 24

25 - 29

30 - 35

2. MARITAL STATUS

Single - Lobolo not paid

Single - Lobolo partially paid

Married - Customarily

Married - Legally

Living with consort

3. Length of time of relationship with present partner.

4. Length of time trying to conceive.

5. **GYNÆCOLOGICAL HISTORY**

5.1. Any contraceptives used with previous partner?

--

5.2. Any contraceptive used with present partnet?

--

5.3. Any history of sexually transmitted diseases?

--

5.4. Any history of diseases of the reproductive system?

--

6. **MEDICAL HISTORY**

7. **SURGICAL HISTORY**

8. **EMPLOYMENT STATUS**

Employed

Unemployed

Self-employed

9. PLACE OF EMPLOYMENT:

10. TYPE OF WORK INCLUDING WORK AT HOME:

11. CONSORT / HUSBAND'S PLACE OF EMPLOYMENT:

12. PERSONAL MONTHLY INCOME:

13. HOUSEHOLD MONTHLY INCOME:

14. MEDICAL AID:

Own

Partners

15. NUMBER OF HOUSEHOLD MEMBERS AND IDENTITY THEREOF:

16. NUMBER OF ROOMS IN THE HOUSE:

17. HEAD OF THE HOUSEHOLD:

18. EDUCATIONAL LEVEL:

No Schooling

Junior Primary (Sub A - 2)

Senior Primary (3-5)

High School (6-10)

Other _____

19. RELIGION:

Christian

Zionist

Apostolic

Traditional

Other (Specify) _____

20. ETHNIC GROUP:

Zulu

Xhosa

Other (Specify) _____

21. PLACE OF RESIDENCE:

Rural

Urban

If urban, is it:-

Formal
Informal
Street

22. LIFESTYLES:

(A) DEPENDENT SUBSTANCES:

Smoking
Drinking Alcohol

Other (specify) _____

(B) STRENUOUS EXERCISE:

Sport
Walk
Subsistence Farming

Other (specify) _____

23. NUTRITIONAL STATUS:

Obese
Normal
Undernourished

Specific (comments) _____

ANNEXURE B

CASE STUDY PROTOCOL

CASE NO: _____

Procedure and rules to be followed during data collection using the elements of King's Interacting Systems Model as a framework. The following areas of infertility will be explored. The interviewer may start with less sensitive parts of this protocol according to each individual respondent's emotive state.

PERSONAL SYSTEM:

- * Self-image.
- * Perception of self as perceived by significant others.
- * Goal-setting.
- * Growth and development.
Self-fulfilment
Future plans.
- * Financial implications.
- * The grief process - denial, isolation, anger, bargaining, depression and acceptance.

INTERPERSONAL SYSTEM:

- * Partner communication.

- * Relationships with partner, family (own / in-law), close friends and work-mates.

SOCIAL SYSTEM: (Family, Groups, Care-Givers and Social)

- * Power
 - Authority
 - Decision-making
 - Status
 - Cultural beliefs and practices
 - Care-givers
 - Support groups.

ANNEXURE C**QUESTIONS TO GUIDE INTERVIEW**

These questions will only be used if the person does not include aspects in discussion.

PERSONAL SYSTEM:

How has this problem of not being able to fall pregnant up to now affected how you think about yourself?

What is your image of yourself at present?

Is this different from how you felt before?

How do you think people who are important to you think about you at present?

Have you been able to think about any other things you want to achieve since you have had the problem of not being able to have children at present?

Has the problem of not up to now being able to conceive interfered with your plans for the future?

Has this problem affected you financially?

GRIEF STATE ASSESSMENT: (Sharrod 1988, p.194)

DENIAL STAGE

Have you said to yourself "This is not happening to me?"

Do you believe that the test results indicate that you have a problem of infertility are false?

ISOLATION STAGE

Do you feel the need to hide your feelings from your partner?

Do you feel the need to keep your attempts at pregnancy to yourself?

Do you feel like avoiding your friends who have children?

ANGER STAGE

Do you ask yourself "Why me?"

How do you feel about people who ill treat their children?

How do you feel about people who have a lot of children?

Do you feel angry about this situation?

BARGAINING STAGE

Do you make promises to "GOD" about the things that you will do for him if you become pregnant?

Do you make promises to your Ancestors about what you will do for them if you become pregnant?

Do you feel that the problem of infertility occurred because you are not good before GOD?

Do you feel that it occurred because your Ancestors are angry with you for any reason?

DEPRESSION STAGE:

Do you experience feelings of worthlessness to an extent that you even think about death?

Do you feel that this problem occurred because of your wrong doings in the past?

Do you blame yourself or your partner as being responsible for the problem?

Do you have feelings of doubt whether to continue with the treatment or to abandon it?

ACCEPTANCE STAGE:

Did you recently feel a new sense of energy?

Do you feel that the struggle is over in your attempts of trying to conceive?

Do you think that you will be able to carry on with life even if you do not fall pregnant?

INTERPERSONAL SYSTEM:

Have you communicated with your partner about this problem of being unable to conceive up until now?

How has this problem of not being able to conceive affected your marital relationship?

Have your reactions to having sex with your partner been affected by your problem?

Does your partner have similar feelings to you?

Has this problem resulted in problems such as threatened separation or divorce?

What are the relationships with your in-laws like?

Has this problem affected your relationships with your friends?

Do you visit your friends at their homes?

Has this problem affected your relationships at work?

Do you have tea together with your workmates?

How do you feel about the relationships in your own family since this problem has arisen?

SOCIAL SYSTEM:

Who influences the decisions made in your family?

Have you been able to influence the decisions made in regard to your not being able to fall pregnant?

Who makes the decisions affecting you within the family?

Who did you first go to for help in regard to not being able to fall pregnant?

Why?

Have you been to anyone else?

Why?

Who are the other people you have gone to?

Why?

Has the fact that you have not fallen pregnant up to now influenced your status in the family?

What do you think has caused your infertility?

Do you think that infertility is the woman's fault?

What do Zulu people usually believe and do if people are infertile?

Do these beliefs and actions influence you?

How do Zulu's and others respond to you not having children?

Does having children change your status in the community?

Should women be the ones blamed for childlessness?

Are women with children more valued than those without children in the Zulu society?

What investigations have you had?

1) Before you came to the clinic / before you saw the doctor?

2) In the clinic / with the doctor?

If you have been treated - what treatment have you had?

1) Before you came to the clinic / before you saw the doctor?

2) In the clinic / with the doctor?

Describe how the nursing staff have helped you and / or made things difficult for you?

How can the nurses help you more?

What do you think about a group of women with problems of childlessness coming together to help each other?

COMMENTS (GENERAL):

ANNEXURE D - ENGLISH

CASE NUMBER: _____

NEW YORK STATE SELF-ESTEEM SCALE

(ROSENBERG SELF-ESTEEM)

SOURCE : ROSENBERG, 1979, P. 291-292

The RSE is a 10-item Guttman Scale with a co-efficient of re-productibility of 92 percent and a co-efficient of scalability of 72 percent. Respondents are asked to strongly agree, agree, disagree, or strongly disagree with the following items (asterisks represent low self-esteem responses):

ON THE WHOLE, I AM SATISFIED WITH MYSELF.	SA	A	D*	SD*
AT TIMES I THINK I AM NO GOOD AT ALL.	SA*	A*	D	SD
I FEEL THAT I HAVE A NUMBER OF GOOD QUALITIES.	SA	A	D*	SD*
I AM ABLE TO DO THINGS AS WELL AS MOST OTHER PEOPLE.	SA	A	D*	SD*
I FEEL I DO NOT HAVE MUCH TO BE PROUD OF.	SA*	A*	D	SD

I CERTAINLY FEEL USELESS AT TIMES.	SA*	A*	D	SD
I FEEL THAT I'M A PERSON OF WORTH, AT LEAST ON AN EQUAL PLANE WITH OTHERS.	SA	A	D*	SD*
I WISH I COULD HAVE MORE RESPECT FOR MYSELF.	SA*	A*	D	SD
ALL IN ALL, I AM INCLINED TO FEEL THAT I AM A FAILURE.	SA*	A*	D	SD
I TAKE A POSITIVE ATTITUDE TOWARDS MYSELF.	SA	A	D*	SD*

ANNEXURE D - ZULU

CASE NUMBER: _____

I-RSE IYISILINGANISO SEZITATIMENDE EZIYISHUMI ESAZIWA
 NGOKUTHI YI GUTTMAN. NICELWA UKABA NIPHENDULE LEMIBUZO

ELANDELAYO KANJE: SA = NGIYAVUMA NGIYAGOMELA

A = NGIYAVUMA

D = ANGIVUMI

SD = ANGIVUMI NEZE NEZE

EQINISWENI, NGANELISEKILE NGOBUMINA.	SA	A	D	SD
NGISINYE ISIKHATHI NGIYAZENYEZA.	SA	A	D	SD
NGICABANGA UKUTHI NGIQOTHO NGINEZIMPAWU EZINHLE.	SA	A	D	SD
NGIYAKWAZI UKWENZA KONKE NJENGABO BONKE ABANTU.	SA	A	D	SD
NGIZIZWA NGINGENAKHO ENGINGAZI QHENYA NGAKHO.	SA	A	D	SD
NGESINYE ISIKHATHI NGIZIZWA NGINGENASIZO.	SA	A	D	SD

NGIZIWA NGINGUMUNTU OBALULEKILE, CISHE NGOKULINGANAYO NABANYE ABANTU.	SA	A	D	SD
NGIFISA UKUTHI NGINGAZIHLONIPHA.	SA	A	D	SD
EQINISWENI, NGIZIZWA UKUTHI NGIYISEHLULEKI.	SA	A	D	SD
NGIZIBUKA NGINGCONO.	SA	A	D	SD

ANNEXURE E

STATEMENT OF CONSENT

Sr Ndaba is studying the African women's experiences with regards to infertility. The purpose of this study is to examine infertility through women's perceptions and to explore their experiences, response and actions following the diagnosis of infertility. In view of the sensitivity of the subject, your name will not be required and all information given will be handled as confidential.

You are hereby kindly requested to participate in an interview based on the topic. This will take place in the Gynaecology Clinic where you attend either in the hospital or private practice. The results of this study will be made available to you on your request.

The participation in this study is voluntary. It is your right to withdraw at any time even during the interview if you feel emotionally upset. However, you are reassured that there is no physical harm or danger that you will be exposed to by participating. If you do not wish to participate, feel free to inform the researcher.

Your co-operation will be highly appreciated.

SIGNATURE OF RESEARCHER

SIGNATURE OF RESPONDENT