Talking about infertility in Malawi

A starting point for developing interventions in order to alleviate the problem of infertility

Report by
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Foreword

The aim of this report is to raise awareness about, and increase insight into, the problem of infertility. In developing countries such as Malawi, infertility is a serious personal and public health issue, which is intertwined with other public health problems such as HIV/AIDs.

For too long, the traditional prioritisation of peri-natal services and birth control in African reproductive health (RH) programs has led to a neglect of the needs of people suffering from infertility.[16, 3] There is a need for programs and services based on people's own views, which enable them to attain their own reproductive health goals, which go beyond family planning.
This report forms a starting point for development of such services and programs. It is based on the first in-depth qualitative study of infertility in Malawi.

The research findings (section 3) are presented in 4 parts.

- Parts 1 to 3 are particularly relevant for those involved in (design of) health promotion.
- Part 3 will also be of special interest to health practitioners: it provides insights into people's intense health seeking behaviour.
- Part 4 pertains to indigenous and biomedical practitioners' views and practices, making it of interest to them and to those involved in their training and management.

The appendix contains methodological details, including interview extracts referred to in section 3.

A draft of this report was discussed with organisations involved in design and delivery of reproductive health (SRH) services in Malawi. Specifically, the following stakeholders were consulted: the Reproductive Health Unit (RHU) and Health Education Unit (HEU) of the Ministry of Health, NGOs (Banja La Mtsogolo (BLM), Story Workshop, Salvation Army, Interact Worldwide), medical institutions (Mulanje Mission Hospital, Queen Elizabeth Hospital) and training institutes (College of Medicine, Kamuzu College of Nursing). Stakeholders' valuable advice regarding interventions has been incorporated in section 5.

It is hoped that the findings and ideas presented in this report will be taken up and translated into practice. Note that although they pertain specifically to Malawi, some of them may be transferable to other developing countries, especially those in sub-Saharan Africa.

I would like to express my sincere gratitude to the Malawians who participated in the study, the consulted stakeholders, the University of Edinburgh Knowledge Transfer Office, Prof. Patricia Jeffery and Dr. Julia Hussein, who all contributed to this report. The project was made possible by an ESRC/MRC postdoctoral fellowship (PTA-037-27-0145).

Dr. Bregje de Kok
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Executive Summary

'Everyone has stories, but some stories actively devalue people and other stories are not recognized as valuable at all. Some stories empower people and other stories disempower people' [1]

Infertility is a significant public health problem in African countries like Malawi. There are strong expectations that married people ought to bear children, and those who do not are often excluded, (verbally) abused and blamed for their infertility.[2,3,4] Tackling infertility is essential, if the holistic reproductive health concept adopted by the Malawian government: 'a state of complete physical, mental and social well-being' is to be met.[5]

This study examined how people in Malawi with a fertility problem, their relatives and practitioners talk about infertility, its consequences and solutions. In particular, it looked at effects of their descriptions and explanations, such as justifying actions or attributing blame. Four ways of talking about and understanding infertility may have problematic consequences, thus contributing to the problem of infertility:

- People portray polygamy and extramarital affairs as culturally required, reasonable and inevitable responses to infertility. This minimizes people's responsibility for these practices, which may have problematic (health) implications.
- People avoid blaming others when describing relationship troubles. This may limit their potential to stand up for themselves.
- When explaining their (in)action, people take into account that they *ought* to seek help. However, seeking help intensively may have financial and physical consequences, and places considerable demands on Malawi's health system.
- Some practitioners emphasize their ability to cure infertility, and some attribute problems to patients. This may give clients false hopes, and obscures health services as a potential source *and* solution for problems.

Call for action

The government, NGOs, medical institutes, traditional and religious leaders should develop cost-effective ***social*** *interventions,* ***aimed*** at:

- Raising awareness about:
  - the problem of infertility and related problematic practices (e.g. having unsafe sex to solve a fertility problem).
  - unhelpful ways of describing and understanding childbearing, infertility, its consequences and solutions, which contribute to the problem.
- Discouraging unhelpful practices and ways of talking, whilst facilitating more empowering alternatives (e.g. 'marriage is not about children', rather than 'when married you have to have children').

How:

- For instance, through initiating critical discussions (in communities, churches, media) of exemplary 'unhelpful' and empowering stories of childbearing, infertility, its consequences and solutions.

1. Why should infertility be tackled?

- **Secondary infertility (i.e. infertility after the birth of a child) rates are considerable:** an estimated 17% of Malawian couples between 20 and 44 years old suffer from it [6]. An additional 15.8% are estimated to have had infertile periods (failing to conceive for 5 to 7 years) at some point in their life [7].
- Infertility has many **serious psychological and especially social consequences**, such as social exclusion, (verbal) abuse and marriage breakdown.[3,4, 8,9]
- **Infertility is intertwined with other major public health problems**, in particular sexually transmitted infections (STIs), including HIV/AIDS. STIs are amongst the main causes of infertility in Africa[6], and infertility contributes to their spread: it often leads to increased number of sexual partners.[8,10,11]
- People with fertility problems tend to consult large numbers of practitioners.[3,12] Hence, infertility cases form a large percent age of gynaecological consultations in African countries; sometimes as much as 33%.[14] Since Malawi's health care system is said to suffer from 'an acute human resources crisis',[15] **infertility clients take up precious resources which could be used for more soluble problems.**

Although traditionally neglected, infertility was put on the international agenda in 1994, at the United Nations' International Conference on Population and Development. Its *Program of Action* acknowledges that infertility affects reproductive health, and calls for comprehensive reproductive health services, which incorporate infertility treatment and prevention.[16]

Indeed, several recent health policies in Malawi demand that infertility is tackled:

- The RH strategy (2006-2010) adopted a comprehensive reproductive health concept: *Complete mental and social as well as physical well-being*[5]. Infertility affects all three dimensions.
- The RH strategy aims to increase 'equity and access to services.'[5] (p.13). Services which focus only on those who can bear children, and neglect those who do not, are inequitous.
- The RH Policy (2002) acknowledges the seriousness of infertility and the growing demand and need for infertility services.[17]
- The HIV/AIDS policy (2003) requires tackling practices such as consensual adultery for infertile couples.

This study, the first in-depth qualitative study of infertility in Malawi, forms an important basis for developing RH programs and services which are:

- Based on the understandings, concerns and rights of individuals
- Culturally sensitive, i.e. acknowledging local meanings of (not) bearing children and related behaviours.16

It should be taken into account that there are barriers to the development of such interventions, related to the context of Malawi (e.g. poverty, lack of human resources, number of other pressing health problems to be tackled). They are addressed in section 5.

2. The study

Interviews were conducted with:

- Men (8) and women (12) with a fertility problem (suffering from both primary and secondary infertility)
- Significant others (friends, relatives) of people with a fertility problem (7);
- Indigenous healers (8)
- Malawian (28) and expatriate biomedical practitioners (4).

Discourse analysis was used to analyse the interviews. It is a method of analysis which:

- Examines culturally shared ways of talking, explaining and understanding
- Provides a fine-grained analysis of the patterns in *what* people say as well in *how* they say it (e.g. particular kinds of words, phrases or examples used).
- Considers language as a tool to get things done: people's descriptions have certain effects and are used to perform certain actions (e.g. blaming, justifying).

The focus on language as tool 'to get things done', however, does *not* imply that people use their descriptions manipulatively, in order to 'play tricks' or deceive people (see Appendix I. for methodological details).

Analysis was led by the following **research questions:**

1. How do people describe and explain infertility, its meanings, consequences and solutions?
2. What sorts of interpersonal actions and effects do these descriptions and explanations perform?
3. What are the wider (positive and empowering or negative and disempowering) consequences of people's descriptions and explanations?

3. Key findings

3.1 Minimizing choice and responsibility for polygamy and extramarital affairs.

Strong cultural expectations that one ought to bear children make not being able to bear (sufficient numbers of) children particularly troublesome[8]. This study examined when and how people refer to such cultural expectations and the need to bear children. They do this especially when explaining polygamy and extramarital affairs as responses to fertility problems (see e.g. extracts 1:58-59; 2:556-563). This has several consequences:

- It provides a rationale for these practices, making them understandable and reasonable, practical solutions to the problem.
- It normalises them: they are portrayed as shared by at least some members of the cultural tradition, and therefore as (relatively) widespread, recurrent, and routine (within the particular cultural group).
- It minimizes individual choice and responsibility for extramarital affairs or polygamy. They become practices which any member of the culture would do[19] and 'culture', rather than individuals, becomes responsible (see e.g. extract 3: 'it's the culture, there's nothing wrong with that' (139)). People's responsibility is minimized as well by portraying polygamy as 'automatically' happening ('you automatically become a polygamist', 1:70-72), or having affairs as imperative ('a man *must* go to another woman' (2: 555))

Some respondents did reject polygamy or affairs on the basis of religion or health risks (see Appendix III).

Conclusion & Practical implications

Responses to infertility such as polygamy or extramarital affairs may lead to personal hardship (especially for women who are being 'replaced') and have health consequences (unprotected sex with additional partners puts people at risk of STDs and HIV/AIDS). Their portrayal as reasonable, normal practices for which 'culture' rather than individuals are responsible, facilitates engaging in them. Therefore, interventions are proposed which address these ways of talking, and have the following aims:

- People depict *not* having affairs or a polygamous marriage as the reasonable, normal course of action.
- People acknowledge their ability to make their own decisions.

This can be achieved through initiating critical discussions, about:

- The reasonableness, 'normality' and inevitability of affairs, polygamy and divorce as response to infertility (capitalizing on health- or religious arguments already used)
- The idea that 'culture' makes people automatically do certain things.

3.2. Avoiding blaming others for relationship troubles

Although the literature reports that infertility commonly affects people's spousal, family and community relationships[2, 7,] many people in the study here reported depict their relationships as good. At times, people do address relationship change or troubles, such as a husband having extramarital affairs, being told by parents-in-law to leave, or feeling shy in the company of friends. Three features of these descriptions stand out:

- They are remarkably neutral: explicit negative judgements of the situation and other people are lacking.
- Some women minimise the seriousness of their husbands' extramarital affairs (e.g. by indicating that they were based on instrumental reasons (i.e. wanting to have a baby) rather than more personal motivations such as love for someone else. (NB. No men reported a spouse's affair)
- Some portray others as not to blame for relationship problems, by:
  - o Explicitly denying that others are the cause of troubles, attributing them instead to oneself or the person with a fertility problem (e.g. 'but they don't laugh at me, but ah myself, I feel' (1:196); 'It's not that those people will be avoiding you, but it's you who would be (.) avoiding them' (2:683-684)).
  - o Attributing troubles to features of the 'infertile' person ('he has nothing to talk about' (2:674); not having much in common, 2:686)). The implication: troubles do not arise from others' problematic behaviour.

Conclusion and practical implications

Complaining about, and blaming others for relationship troubles are sensitive activities[20]: they expose people to complaints and blame themselves, for instance for being disloyal regarding spouse, relatives or neighbours. Playing down problems and not complaining about or blaming others may be ways to avoid such problems.

Descriptions provided by people in this study differ from those in the literature, which overall portray infertile people as victims of (blameworthy) extramarital affairs, social exclusion and stigmatisation. When attempting to address infertility related relationship troubles, one must work with people's own understandings of these troubles. This is not to dismiss the hardship which infertility can cause. Indeed, playing down the seriousness of affairs, not complaining about, or blaming others for relationship troubles, may aggravate the quandary for people with fertility problems: it makes standing up for oneself more difficult.

Thus, interventions could be developed, which have as their aim that:

- People treat relationship troubles, resulting somehow from fertility problems, as inappropriate.
- People accept responsibility for making those who are infertile feel good when being amongst others

This could be achieved through:

- Promoting discussion about whether strained relationships and extramarital affairs are acceptable and fair consequences of fertility problems.
- Discussing stories of relationship troubles, and reflecting on who (spouse, relatives, community member) could be seen as co-responsible for the relationship strains, *and* for solving them

3.3. 'I really tried hard': Expectations that one ought to take action

Examination of how people talk about (in)action in response to fertility problems showed that they take into account expectations that they ought to take action, and to provide detailed explanations of failure to do so.

When explaining inaction, respondents portray themselves as committed and avoid being seen as not motivated to do something about their fertility problem. They do this by:

- Depicting themselves as having put effort into seeking solutions, for instance by referring to their attempts ('I really tried hard' (2: 197) and (repeatedly) to previous actions (e.g. consulting various hospitals), whilst depicting them as enduring and intense.
- Referring to their intention to take action in the future ('but we wanted to go to the private hospital', 2: 1145 -1147, 1167-1168, 'we decided to go to the private hospital' (2: 162))
- Attributing inaction to *external* factors, such as lack of money (2: 1166-1167) or other people such as a husband (extract 1) or doctor (extract 2: 'the doctor sent me away' (1157-1158)). Consequently, respondents prevent attribution of their inaction to (internal) lack of motivation.

Note however that some people already explain their inaction in terms of deliberate decisions (e.g. a respondent decided not to try to conceive again, since she had had a life-threatening ectopic pregnancy).

Conclusion & practical implications

These findings resonate with the frequently reported endless search for a cure; like the descriptions discussed, people's quests for a cure can be seen as 'displays' of motivation. People's treatment of inaction as an undesirable breach of expectations that they ought to take action seems unhelpful. It appears to facilitate intense health-seeking behaviour, which may give rise to financial troubles and even additional health problems when medical interventions lead to secondary infections,[4, 11] whilst the chance to find a cure is very limited. Therefore, it could be beneficial to design interventions, which the following aims:

- Ceasing action (early on) is treated as acceptable and reasonable.

This can be achieved through:

- Discussion of examples of people with a fertility problem (role models) who frame inaction as deliberately chosen (e.g. based on health risks).
- Health practitioners (in hospitals, health surveillance assistants (HSAs), indigenous healers) discouraging intense health seeking behaviour.

3.4 Practitioners portraying themselves as successful and competent

When describing their successes and failures in helping infertility patients, several practitioners portray themselves as successful and competent (see extracts 1 and 2). Indigenous healers portray their success as more widespread than biomedical practitioners, which is understandable: healers' income is dependent on their ability to attract patients.

When acknowledging problems in helping infertility patients, some practitioners use descriptions which make them not responsible for them. They achieve this effect by:

- Describing problems over which, according to common sense, practitioners can exert limited influence (e.g. patients mixing medication at home, not being able to accept a diagnosis).
- Depicting patients' problematic actions as recurrent and predictable ('usually' (....) 'they *will* try the herbs', 3: 426-429).

The implication: the behaviour is due to some inherent disposition[23].

- Portraying medical care as problem free (e.g. 'they will get the medicine okay from the hospital', 3: 428).
- Attributing communication problems and misunderstandings to patients' limited knowledge or intelligence (e.g. 'if they are intelligent probably they understand very well, if they are not, maybe not at all'), or the interpreter used (I'm not hundred percent sure if [the interpreter] tells what I'm telling the woman').

Conclusion & practical implications

Portraying oneself as successful and minimizing responsibility for problems is understandable; it enables practitioners to portray themselves as competent experts, a project more often found to inform (descriptions of) medical practice.[4, 21,22] However, these ways of describing successes and failures can be problematic too:

- Claims of widespread success may give patients false hopes, pushing them to continue taking action.
- Attributions of problems to patient characteristics make patients unjustifiably responsible, whilst obstructing reflection on how care provided may contribute to and prevent (communication/other) problems.
- Implications for audits of care: in medical records, practitioners may give those versions of events which do not damage their perceived competence and identity as competent experts.

Hence, interventions could be developed aimed at awareness raising,

- amongst potential clients: practitioners may portray themselves as overly successful.
- amongst practitioners: their explanations and descriptions of problems may make patients too responsible.

These interventions can take the following form:

- Health messages, delivered by health professionals
- Discussions with practitioners of problems in health care (e.g. through case studies), exploring ways of explaining them in terms of design or delivery of services, whilst avoiding viewing patients as responsible culprits.

4. Additional advice regarding how to tackle infertility

Discussions with stakeholders in Malawi led to additional recommendations. In general, it transpired that:

- Communities, or 'societies' need to be tackled, rather than individuals, since not bearing children is problematic due to pressures from others and social meanings of childbearing and infertility.
- (Additional) examples of unhelpful ideas and social meanings which could be targeted:
  - o 'Once married one has to have children', and the idea that marriage is inadequate if there are no, or not enough, children. *Ideally, communities (including, but not restricted to, those with a fertility problem) acknowledge that one can lead a happy and fulfilled life even without children.*
  - o The idea that adopting orphans is not a proper solution: one has to have one's own child. *Adoption would benefit the many Malawian orphans and may alleviate individuals' (infertility related) economic and other problems.*
  - o The idea that infertility is a woman's issue. Many participants in the study acknowledged that men can be infertile too, yet women tend to be blamed for it, and take the task upon themselves to solve the problem. *It is therefore important that in any intervention, men are targeted and included as well.*
- Infertility clients are vulnerable as they are often desperate to have a child, and are under pressure to seek help intensively. Certain malpractices were noted, which abuse this vulnerability:
  - o Some traditional healers offer sex as treatment to infertile women, although this practice may be rare.
  - o Some biomedical practitioners appear to offer treatment without proper diagnosis; (e.g. a patient was given several treatment courses for STIs, whereas upon examination by a second practitioner it transpired that she did not have a uterus).
  - o Some churches offer to pray for someone fertility's problem, *but only in exchange for payment.*
- HSAs feel that they do not have sufficient knowledge of the biomedical facts of infertility to advice people. *Although their main focus should be on social support/interventions, some additional training or leaflets containing biomedical information could be beneficial.*
- Preventing infertility, through prevention of STIs, unsafe abortions and deliveries, remains an important task, and has therefore been a major focus of the Ministry of Health and its Reproductive Health Unit.

Stakeholders identified several **potential interventions** [potential agents within square brackets]:

Changing social meanings and related unhelpful practices:

- Utilise the media to change social meanings, in particular, dramatisation on radio and plays performed in rural communities. [Health Education Unit, NGOs e.g. Story Workshop]
- Initiate public discussion about infertility, rather than keeping it a secretive issue. This strategy has been beneficial in reducing the stigma of HIV/AIDS. [e.g. HSAs, who have strong community links and monthly community meetings, and NGOs can initiate discussion (e.g. following dramatisation in village plays or radio soap operas, which can also raise awareness of mal practices such as healers offering sex)]
- Use role models, i.e. successful people 'coming out' as being infertile: this can reduce stigma [HE unit, Story Workshop].
- Involve traditional or community leaders: this is important in order to change notions of culture and cultural meanings [Government and NGOs, e.g. Salvation Army has links in specific areas].
- Involve the youth: achieving change may be easier with younger people. This is also the ideal target group for prevention. If there are established youth groups, they should be made use of. [Primary Health Care Departments (some already run youth groups); Story Workshop].
- Flyers and posters (to be spread e.g. in health and community centres), spelling out advantages and disadvantages of certain practices such as having affairs in order to solve a fertility problem [HE unit].
- Involve religious institutions [churches, mosques, Malawi Interfaith Organization]: discussions can be initiated and ideas can be challenged through sermons and discussion groups. Important because some use biblical arguments to declare that bearing children is essential, or that those who do not bear children are cursed. Yet, some churches already spread helpful messages such as 'marriage is not just about children' and infertility is no valid reason for divorce or extramarital affairs.
- Liaise with the Traditional Healers Association to discuss certain problematic practices and solutions [HE, Story Workshop; HSAs].

Health education:

- There appears to be a need for (basic) health education, which improves communities' knowledge about:

o The fertility cycle (i.e. when is sexual intercourse likely to result in pregnancy) and amount of time it normally takes to get pregnant: this can prevent unnecessary feelings of inadequacy and help seeking.

o Causes of infertility, in particular STIs: this will aid prevention.

Social support/advocacy:

- Media can be employed for advocacy and awareness raising [HEU, Female Lawyers Associates].
- Marriage councillors could be employed to offer (regular, enduring) counselling; service exists in some (urban) areas at the moment but could be expanded. [RHU, Women Affairs Department, Salvation Army]

Potential barriers to change and successful interventions were identified as well. However, it may be possible to remove them:

- There are issues with involving Muslim communities and leaders as they favour polygamy. *However, they do not promote polygamy as response to fertility problems, and involving them is desirable* [Malawi Interfaith Association, Health Education Unit].
- The ability to develop interventions requires funding and prioritisation of infertility issues by the Reproductive Health Unit and SWAP secretariat, and inclusion of infertility in District Implementation Plans.
- Changing meanings of childbearing, and making not having children more acceptable, is difficult because the need and desire for children is deeply rooted in local cultures. *However, it is now widely acknowledged that 'cultures' are dynamic rather than static. Change will be slow but is possible if initiatives are taken.*
- Children offer economic security, which makes increasing a couple's acceptance of their infertility difficult. *Perhaps relatives or neighbours can be stimulated to provide practical (as well as social) support (somehow facilitated by the government/NGOs), especially when infertile people grow old*
- Some feel that infertility is not a serious issue since people get too many children in Malawi, which decreases clinicians' motivation to pay much attention to infertility clients. *Such feelings make it all the more important to set up social interven tions which change the importance of childbearing in Malawi and increase communities' acceptance of childlessness. This should decrease people's intense health seeking behaviour, resulting in infertility clients taking up less of clinicians' time.*
- Lack of financial and human resources to carry out interventions. HSAs have large workloads and are often seen as too young to give advice regarding childbearing, volunteers often loose motivation. *Integration with existing programs and services will contribute to keeping the costs down*[12] *and social interventions, using volunteers, require limited financial and human resources. Volunteers' motivational problems may be prevented by paying small amounts of money and/or using volunteers with a direct interest in interventions, i.e. those who experience(d) fertility problems themselves. This has the additional bene fits of empowering people with a fertility problem and addressing their financial problems.*
- Getting healers to be realistic about their ability to cure infertility (or churches not to offer healing prayers in exchange for money) is difficult: their income is dependent on these activities. *Could healers (and traditional birth attendants) be given other (paid?) roles in supporting people with fertility problems?*
- Some representatives of organisations (e.g. BLM) feel that dealing with infertility would contradict their messages about family planning. *However, according to the widely advocated holistic approach to reproductive health attention ought to be paid to infertility as well as family planning. Social interventions, which e.g. stimulate communities to help those with few or no children and increase communities' acceptance of childlessness, do not contradict family planning initiatives.*

Integration with policies and services is encouraged by Malawi's national RH programme. It is particularly feasible to extend policy commitments concerning STDs, including HIV/AIDS in order to incorporate infertility, such as the commitment to promote and encourage monogamous marriages and fidelity 'within any type of marriage' (National HIV/AIDS Policy[18], p.24). *Childless marriages could be specifically targeted.* In addition, the policy proposes to address *widow/widower* inheritance to reduce risk of HIV transmission by empowering people to make independent decisions regarding this practice, and ensuring support for those who are victimized because of rejecting widow/widower inheritance (National HIV/AIDS Policy, p.24). *The same strategies can be employed to address extramarital affairs and polygamy in response to infertility.*

5. Summary and Conclusion

In this report, a study has been presented which examined shared ways of talking about and understanding infertility in Malawi, and the effects of people's descriptions. People describe infertility, its consequences and solutions, in such a way that:

- Polygamy and affairs are made reasonable and normal, individuals' responsibility for them is minimized.
- People avoid complaining about, and blaming others for, relationship troubles
- People take into account expectations that they ought to do something about a fertility problem.
- Successes in treating infertility are highlighted, whereas problems in care are attributed to patients.

Because these descriptions have problematic effects, social (rather than medical) interventions are proposed, with an **overall aim** of:

- Changing the social meanings of childbearing, infertility, its consequences and solutions by getting people to describe and frame these matters in more helpful, empowering ways.

How:

- Initiate discussion about, and thereby raise awareness of, unhelpful ways of talking about childbearing, infertility, its consequences and solutions.
- Provide examples of, and thereby facilitate, alternative, more helpful and enabling ways of framing these issues. (see e.g. examples in appendix III).

Through:

- Messages in media (radio, newspapers), health institutions, churches
- Discussion groups (in communities, hospitals/ health centres)
- Plays in communities, soap operas on radio.

Who (Key-players):

- Government
- NGOs
- Health practitioners (especially community health practitioners, HSAs and indigenous healers)
- Traditional and religious leaders, including those giving instructions in marriage rites
- Community groups, whether existing or **to be established**
- Volunteers (including those with no or few children themselves).

Furthermore, the discussions with stakeholders highlighted the need for **inexpensive**, social interventions, which, in addition to changing social meanings:

- Increase social support for those with fertility problems.
- Target *and* involve communities.
- Take up few human resources, and require limited involvement from clinicians working in hospitals/clinics.

Conclusion

- Although limitations in human and financial resources have to be acknowledged, a variety of interventions have been proposed to address the problem of infertility, and a number of potential agents which can initiate development of such interventions in Malawi have been identified.
- These interventions are in line with principles of community development and empowerment, methods of health promotion advocated by the World Health Organization[26], amongst other organisations. Facilitating new ways of talking is one way to empower people: 'Everyone has stories, but some stories actively devalue people and other stories are not recognized as valuable at all. Some stories empower people and other stories disempower people'[1].

Appendix I. Methodological details.

Recruitment

Participants were purposively recruited in all three regions (North, Central, and South) of Malawi, in rural and urban areas. Both Muslims and Christians were interviewed, and people who speak English and those who do not, in which case an interpreter was used.

Recruitment of people with a fertility problem was based on a social rather than medical or demographic definition of infertility, to which people's own perspective is central: 'infertile people' are those who see themselves, or are seen by others, as having a fertility problem, regardless of number of children, duration of their fertility problem and marital status. Thus, participants include those suffering from primary as well as secondary infertility.

The majority of respondents were recruited in communities, mostly through HSAs, with the exception of biomedical practitioners who were mainly recruited in hospitals and clinics.

Ethics

Ethical approval was obtained from Malawi's Ministry of Health, as well as from the University of Edinburgh. Oral consent to conduct and record the interviews was obtained after it was explained to respondents, amongst other issues, that the interviewer could not solve people's fertility problems, and that their anonymity was guaranteed. Since infertility is a sensitive topic, the 'relatives' interviewed were not related to the respondents with a fertility problem, and interviewing both the man and woman of 'infertile' couples was avoided.

Transcription

The recordings were transcribed literally and in detail. Since interpreters do not passively convey messages but contribute actively to the production of meanings, translations of the exchanges between interpreters and respondents were obtained in order to make them available for analysis (displayed in the extracts in italics). Translators were linguistic students at the University of Malawi, and professional translators at Lowani, African Language Institute in Leiden, Holland.

Analysis

A form of discourse analysis (DA)[27, 28] was used which has been fruitfully applied before to health issues[25]. It is based on a constructionist29 perspective, treating descriptions as creating realities [27, 28,] rather than neutral, passive pathways to pre-existing realities 'out there' (e.g. concerning actions which people take) or in people's minds (e.g. regarding people's beliefs, cognitions, emotions).

Generalizability

The statistical generalizability of findings in small-scale qualitative studies is limited. Nevertheless, DA considers ways of talking and understanding to be culturally shared, and as such the findings may be generalizable to people living in the same cultural context. In addition, there is scope for analytical or theoretical generalizability of the insights into ways of talking and their interpersonal effects to similar social situations and contexts. Potential users of this research are encouraged to make their own judgements about the similarity of the context they are interested in and the transferability of the findings.[28]

Suggestions for further reading regarding method of analysis:

Berger, P.L., & Luckmann, T. (1966). *The social construction of reality*. Harmondsworth: Penguin

Burr, V. (2003). Social constructionism. London: Routledge

Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour.* London: Sage

Willig, C. (2001). *Introducing qualitative research in psychology, chapter 6*. Maidenhead: Open University Press

Appendix II. Examples of identified ways of talking

Transcription notation

(word)	Words in brackets indicates that speech is unclear
( )	Inaudible speech
!	Exclamation marks indicate an animated or emphatic tone
under	Underlining indicates emphasis
((brother))	Additional commentary is put in double brackets.
[his]	When context suggests that the 'wrong' gender is used, correct gender is put in square brackets.

Text in *italics* is a translation.

'R' stands for respondent, 'I' for interviewer, 'T' for interpreter/translator

I. Playing down responsibility for polygamy and extramarital affairs.

Extract 1.1 Interview 48, relative

54. R And if African doctors fail then it is up to the man, if he feels it is not his fault –
55. I Uhu
56. R then you look for an alternative.
57. I Like, what kind of alternative might he look for?
58. R You need children. In our context, in our eh cultural beliefs, if you marry have no
59. children then you are unfortunate, very unfortunate.

((respondent mentions several problems of not having children))

67. R So, if I've a alternative, what alternative can you have, if you love your wife you cannot
68. divorce,
69. I Uhu
70. R automatically you will marry another wife.
71. I Uhu
72. R So you automatically become a polygamist.

Extract 1.2 Interview 10, biomedic. ((respondent has mentioned just before that 'before a year' a man has already gone somewhere to test his fertility, and stated that 'people prefer a man in the family (if) fertility can be proved.))

541. R Normally in a tradition, they give you maybe up to eh three months.
542. I Hmhm
543. R Suppose eh people
544. I Three months!
545. R People are married today
546. I Hmhm haha
547. R They expect by three months ((smiley voice)) the woman hehehe he [she]
548. has to be impregnated.
549. I Yah, yah
550. R Yeah.
551. I Hmhm
552. R Well, this couple stays for three months, nothing happens.
553. I Hmhm
554. R Then it goes maybe to what age, nothing happens. Now. When
555. it comes to three years. This time, a man must go to another woman.
556. I Hmhm

((some lines omitted in which the respondent explains that when a man has a child with another woman 'the family becomes shaken')

572. R Yeah. So (in)fertility in Malawi, the common cause of marriage
573. break ah- breakdown and divorces.

Extract 1:3 Interview 35, relative

120. I I see. And you say eh previous- previously it used to be common that then the brother
121. would for example sleep with the wife.
122. R Yes, it's the culture.
123. I Uhu
124. R In some places, I understand, they might still be doing it.
125. I Uhu
126. R Let's say a husband is out for the country for a period so they are afraid that the wife
127. may misbehave.
128. I Uhu
129. R So they ask the young brother.

((some lines omitted))

139. R So it's the culture, there's nothing wrong with that.
140. I Yah.

II. Not blaming others for relationship troubles

Extract 2:1 Interview 28, woman

173. I Okay, I see. Yeah. And if you ehm walk around here in the
174. neighbourhood in ((name town)). Ehm how how do you feel do you
175. think about , does this issue bother you that you don't have children if you deal
176. with others here, in the community.
177. R Yes some- sometimes I get it (bored) and I feel shy.
178. I Hmhm
179. R To be among, among women those who have children.
180. I Okay
181. R Yes,
182. I Yah.
183. R eh but they don't laugh at me. But ah myself, I feel.
184. I Yah
185. R ah
186. I Okay
187. R Yes.

Extract 2:2 Interview 35, relative

668. I Okay. And ehm, any other relationships which were also affected do you think by this
669. fact that he couldn't produce children?
670. R Eh, yah even friends,
671. I uhu
672. R yes, even friends. Because I said we are three, (we are two) my my my child is now in
673. standard one or my child now is ten years old, we started discussing. Ah but, (he) is
674. very clever, he has nothing to talk about. So( ) whenever I'm in companies of
675. those boys or those men they always talk about their children,
676. I Uhu
677. R so I'm no longer going to, be in their company. You see.
678. I O:kay
679. R Definitely, it means that relation has been affected.
680. I Okay, so people e- like your [relative] might cut themselves off a bit from their friends
681. R Yes
682. I because they don't really, can't talk about the same issues.
683. R It's not that those people will be avoiding you, but it's you who would be (.) avoiding
684. them
685. I Okay I see.
686. R because you don't have much in? Common.
687. I Yah, okay.
688. R Yes

III. 'I really tried hard': Normative demands to take action

Extract 3.1 Interview 53, woman

192. R		*May be this is a chance that you have*	Mwina uwuwu ndi mwayi mwabwera-
193.		*come, because of what happened the*	mu, chifukwa zimene zidachitika ulendo
194.		*other time I went again to the hospital.*	wina ndidadzapitanso kuchipatala
195.			
196.R		*I went to the hospital there, they told me*	Nditapita ku chipatala kuja adandiwuza
197.		*to bring (.) I really tried hard, so that*	kuti mukabwere.(.) ine ndidayesetsa
198.		*there is even a book there at the hospi-*	ndithu, moti buku liliko kuchipatalako.
199.		*tal. After giving [it] to me, they told me*	Adandipatsa ndithu kuti mukabwere ndi
200.		*to bring my husband, I told my husband,*	banja lanu, kuwawuza banja lathuli
201.		*he refused. I told him, he refused! Ah (.)*	kukana. Kuwawuza kukana! Ah. (.) ah (.)
202.		*ah (.)me, to the hospital, I went.*	ine ku chipatala, ndinapitaa.
203.		*Oho*	Oho
204.			
205. T			
206. T	so he [she] went to		
207.	the hospital to explain		
208. I	H:mhm		
209. T	And they asked her		
210.	to br- to take- to go		
211.	with the husband.		
212. I	Yah.		
213. T	So when she came		
214.	back she told the		
215.	husband, the		
216.	husband didn't take		
217.	it seriously.		
218. I	Hmhm.		
219. T	She told she never		
220.	went back to the		
221.	hospital.		
222. I	Okay		
224. R		*Upon telling him, he has refused to go.*	Kuwawuza kuti tipite kukana. Nthawi ija
225.		*That time there was Mr.Banda , he*	kunali a Banda kuti tipite ku chipatala,
226.		*refused to go to the hospital, this hus-*	ai ndithu abambowa kumakana kuti
227.		*band refusing to go for a test for them to*	akatiyese akawone chikuchitika ndi
228.		*see what is happening in our bodies.*	chiyani m'nthupimu. Mwina pena pake
229.		*Sometimes, I have sharp pains in my*	ine m'mimbamu mmandipota, kupota,
230.		*stomach, sharp pain, the strength of*	mphamvu yofuna kutani? Kubereka.
231.		*wanting what? To give birth. So I do not*	Ndiye sindidziwa kuti chimatika
232.		*know what is happening.*	ndichiyani.
233.			
234.			
235.			
236. T	So until now, he has		
237.	not accepted to go to		
238.	the hospital to see the		
239.I	hmhm		
240.T	doctor, so it happens		
241.	that sometimes she has		
242.	abdominal pain		
243.	intensively,		
244. I	Hmhm		
245.T	Eh but eh it continues		

[3] Pseudonym

Extract 3.2 Interview 12, woman

1136.	I	Okay, yah, so what did you	
1137.		do to solve your problem?	
1138.	T		*And what did you do to solve the*
1139.			*problem? I looked for some medicine and*
1140.	R		*while taking the medicine, I got money*
1141.			*to take us to the hospital. We wanted to*
1142.			*go to the private hospital because I have*
1143.			*been to the government hospital but*
1144.			*they were just doing other things and*
1145.			*ignoring me. The first time, we visited the*
1146.			*hospital, they only*
1147.			*examined my husband's sperms.*
1148.			*Now, they told me that 'you too are*
1149.			*required to go (so that) they are going to*
1150.			*test you so that we may see that your*
1151.			*problem which makes you fail to give*
1152.			*birth is what'. And after going there the*
1153.			*doctor sent me away, saying 'No, go*
1154.			*back, you are old, don't come again, go.*
1155.			*So we just returned home. When we*
1156.			*came back we said no it is better we get*
1157.			*money for us to go to a private hospital.*
1158.			*When we got the money another*
1159.			*problem came in and we spent it on that.*
1160.			*But we wanted to go to the private*
1161.			*hospital within the next month.*
1162.			
1164.			
1165.			
1166.			
1167.			
1168.			
1169.			
1170.			
1171.			
1172.			
1173.			
1174.			
1175.	T	Hmhm she's saying that	
1176.		they went to the traditional	
1177.		healers and they gave some	
1178.		medicine, and when they	
1179.		nothing happened. And they	

Ndiye munapanga chiani mutafuna kuti vutolo lithe?
Ineyo tinakafuna mankhwala, tiri pakati pakudya mankhwala ajandimmene ndinapeza ndalama kuti tipite kuchipatalako. Timafuna
chipatala cholipira chifukwa chikakhala chipatala chakuboma ndinazapita koma akungondizengereza.
Titapita ulendo oyamba anangotenga mphamvu ya bamboyo ndikuyeza
Tsopano anandiuza kuti inunso ndiofunika mupite akakuyeze- ni kuti tione kuti vuto lanu likulepheretsa kubereka ndi chiani. Ndiye kupita kuja adokotala ati 'iyayi tiyeni pitani mwakalamba musabwerere pitani'. Basi tinangobwerako, kubwera kuno tiri iayi kuli bwino tipeze ndalama tipite chipatala cholipira ndi mmene ndalama tinazipeza kugwanso vuto lina ndalama zija tinaononga koma tinafuna kuti tipite mwenzi
wa mawa.

1180. went to the hospital and the
1181. doctor told them that to, he
1182. she told
((end of tape, part missing))
1181. I And they should collect
1182. sperm
1183. T Yah, yah, so when they went
1184. to the hospital they they they
1185. checked the sperm at
1186. government hospital.
1187. I Hmhm
1188. T So, they chased him [her]
1189. away, saying that ah you're
1190. old, you can't even manage
1191. to have a kid.
1192. I The husband, or; they
1193. they they chased the
1194. husband away?
1195. T Yeah, both of them, so
1196. they wanted to go to a
1197. private hospital, so that
1198. they can help them.
1199. I Oho, oh.

IV. Practitioners portraying themselves as successful and competent.

Extract 4: 1 Interview 38, indigenous healer

108. I	Cause do you also		
109.	have medicines to help		
110.	the man if he has a		
111.	problem?		
112.T		*She is saying do you have medicine if a*	Wakuti kasi muli nayoso mankhwala ya
113.		*man is, has this problem?*	mwanalume kuti usange wawe
114.		*Hmm*	wanaproblem iyo Hmm
115.R			
116. T	Yes, she has the such		
117.	(medicines).		
118. R		*I use pounded herbs, they are usually 3,*	Nkhuyesa wakupula makuni ya-kuwapo
119.		*after pounding this tree, then I sieve very*	yalinga yatatu sopara napula makuni
120.		*well and tell him to put in tea, to put in*	yala mbwenu nkhusefa makola nkhuti
121.		*tea, as he goes to sleep he is supposed to*	waka- thire mu tea para wakuthira mu
122.		*eat a little roasted maize. One week,*	tea para wagonenge wakwenera kurya
123.		*that's it, he will be on the road. Yes!*	tuvingoma twakukazinga tuchoko. One
124.			week basi walipa- msewu. Eeh!
125.			
126.			
127. T	Okay. She says,		
128.	she takes two or three		
129.	herbs the she pounds		
130.	those into flower like		
131.	then she advises that		
132.	man to take a little		
133.	flower and put it into		
134.	tea so that whenever		
135.	she tastes that tea it		
136.	goes straight and		
137.	possibly within a		
138.	week or two then he's		
139.	assisted.		
140. I	Okay. Oh, that's quite		
141.	quickly. Yah.		
142. T	Hhuhu		
143. I	Okay.		
((respondent gets up and walks to a pile of dried roots in the room))			
146.	R	*Here are the herbs*	Munkhwala wake ndi uwu.

Extract 4: 3 Interview 62 biomedic.

417. I I was wondering what, infertility is that from your perspective very difficult to treat or
418. good to treat?
419. R It's easy.
420. I It's easy.
421. R It's easy.
422. I To treat.
423. R Because you depend on first of all examining the woman or the client,
424. whoever it is, examine urine, stool, blood for VDRL, and then you can
425. decide from there. But if at all he really obeys the rules of medicine, there
426. will be no problem. No problem. Because they usually, they get
427. infected. After the infection you want to clear the infection away, but they will mix.
428. You see that's where we get the problem. They will get the medicine okay from the
429. hospital but when they go home they will try the herbalist. So they cannot go well if
430. they mix this and that.

Appendix III. Examples of alternative ways of talking

I. Minimizing choice and responsibility for polygamy and extramarital affairs.

Extract 1.4 Interview 12, woman

63.	I	Ehm:, can you		
64.		explain to me why		
65.		you would like to		
66.		have children?		
67.	T		*How can you explain to her if it so*	Mungawalongosolere bwanji kuti
68.			*happened that you have children?*	zitachitika zoti mukhale ndi ana.
69.	R		*I will be very happy*	Ndizakala osangalala kwambiri
70.	T		*Okay*	Okay
71.	R		*Because my marriage nearly broke*	Chifukwa banja langa limafuna
72.			*because of not having a child. But*	kutha chifukwa chopanda mwana.
73.			*because I am a strong Christian and also*	Koma chifukwa cha kupemphera
74.			*the church has been talking to us*	kwambiri ndikulimbikitsidwa
75.			*encouraging us then the husband was*	kutcharichi, ndiye anakhala ngati
76.			*talked to and encouraged, saying that*	amuna aja anawalimbitsa kuti, iyayi,
77.			*marriage is not about children, no, be*	banja simwana iyayi piriranibe ee
78.			*strong, yes, maybe with God's grace you*	mwina mwachisomo chamulungu
79.			*may get a child later on.*	mudzakhonza kupeza mphatsomwina
80.				kumbuyo kwake mwina
				mutakalamba eetu.

Extract 1.5 Interview 28, woman

174. I For you that would not be an option to also (.) try to look for other men
175. maybe.
176. R No, I've never tried because I'm af- I don't feel free hhu
177. I hmhm
178. R because I'm afraid
179. I okay
180. R eeh I'm afraid, not afraid of him but eh (.) maybe if I try to look for other
181. men I will get s- incurable diseases, so it's not good.

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