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Battling with Failed Procreativity: Involuntarily Childless Patients' Experiences in Bulawayo Public Hospitals, Zimbabwe

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ABSTRACT

Involuntarily childless women seeking medical attention in Bulawayo's public hospitals sometimes experience loss reminders that lead to a depleted sense of worth and feelings of social rejection. The purpose of this study was to understand their psychological, sociocultural and spiritual experiences so as to develop an evidence-based wholistic approach of addressing their needs. Ten married childless women were interviewed using semi-structured in-depth interviews. The researcher adopted a qualitative paradigm. He utilized Giorgi's phenomenological approach in analysing the data. Women in this study experienced many negative emotions that made them feel worthless. They could not fit in the company of those that had children. They also felt cursed by God or bewitched by their enemies. The study concluded that carefulness in treating involuntarily childless patients was essential. This included the selection of words when addressing them. A special ward for them was necessary in order to prevent the resurfacing of loss reminders. Adequate counselling before they left the hospital was viewed as imperative. Education and awareness were seen as invaluable in lowering the stigma attached to this challenge. The provision of chaplaincy services was comprehended as indispensable if these women were to receive wholistic patient care.

1. INTRODUCTION

There are several clinics and hospitals that offer gynaecological services in the city of Bulawayo. Among these, Lady Rodwell Maternity Hospital (LRMH) and Mpilo Central Hospitals (MCH) are the major public hospitals. Women with minor and major gynaecological morbidities are referred to them. Involuntarily childless women also visit them during pregnancy losses, for removal of myometrial masses, myomectomy and even hysterectomy in worst case scenarios. The obstetrics and gynaecology sections of each hospital are serviced by several doctors, nurses and nurse aides. Each gynaecologist comes with his/her patients to access services that he/she cannot provide in his/her private practice. When patients who do not have personal doctors visit the hospitals, they are assigned to any of these women specialist doctors. Alongside these clinicians, hospitals receive spiritual caregiving services from volunteers and clergymen who offer Sunday morning prayers.

The hospitals under the study are in Zimbabwe's second largest city. The cultural setting is predominantly Ndebele. Among these people there is an expectation that married couples should have children. Consequently, involuntarily childless patients may face a number of sad experiences when accessing medical care related to their unproductiveness. The private mourning experienced by these care seekers renders the spiritual care offered by the volunteers who are not trained to meet spiritual needs irrelevant. These people who visit the hospitals only preach, sing and pray. They do not have the ability to walk with patients who may be grieving the loss of their reproductivity.

2. LITERATURE REVIEW

This section is devoted to literature that deals with infertility. The search for meaning when one is suffering childlessness, the condition of childlessness as an ambiguous loss and a socio-cultural construct are looked into. A brief discussion of spiritual care provision forms the last segment of this subsection.

2.1 Search for Meaning in Experiencing Childlessness

In any crisis, care-seekers evaluate their belief system. Doehring (2015) opined that they act upon life-limiting imbedded theologies and may attempt to make them life-giving. A huge loss leads them to ruminate over their plight

(Rice, 2014, p. 21). Their convictions and perceptions about life are thus shattered and they are left incapacitated (Wright, 2011, p. 204). In the case of childlessness, Mosalanejad and Koolee (2013, p. 225) suggested that a sense of meaninglessness is created, leaving the sufferers more susceptible to an assortment of ailments.

There is a series of feelings that the involuntarily childless women go through. They are hopeful after a menstrual period; pessimism sets in before the next one and when they have it, they become hopeless. Optimism ensues again as they look forward to the next month. Such women's emotional discomfort includes culpability, self-incrimination, coveting expectant mothers, incredulity and being distraught (Atang, 2016, p.11, 13). One study also showed that their failure to carry the pregnancy to term is more distressful than those who eventually had children. Those who experienced a miscarriage while having children had lower levels of distress than those who did not (Kersting & Wagner, 2012, p. 189). Another research revealed that the levels of psychological distress that are experienced by involuntarily childless women were like those of "patients with grave medical conditions such as cancer, heart disease and hypertension" (Domar et al., (1993) in Pedro, 2015, p. 50). Consequently, they are faced with an intermittent challenge of dealing with their harrowing experiences and they search for the meaning of life.

2.2 Childlessness as an Ambiguous Loss

An ambiguous loss is one in which there is inconclusiveness (Boss & Yeats, 2014, p. 63). Involuntary childlessness involves grieving a loss in which the care seeker may not find resolution. Both infertility and unchosen childlessness are seen as ambiguous losses (Burns, 2013, p. 9; Gilligan, 2017, p. 231). In this situation, the infertile woman experiences the loss of a child who is very much alive in her mind but is non-existent (Burns, 2013, p. 9). Grieving becomes secretive and disenfranchised because of the contrariness of the desire to have children and their physical unavailability. Mourning is usually associated with grief, which is not temporal, as it may last till the end of life if not properly dealt with or cared for.

Psychological distress in childless women heightens because the society does not create an environment where they can mourn for their loss (Lang, et. al., 2011, p. 183). Burns pointed out that the grieving individual mourns the forfeiture of the past and the time ahead in the prospective baby (Burns, 2013, p. 9). Furthermore, Kersting and Wagner (2012, p. 188) saw the absence of rituals that facilitate mourning and the unrecognition of the loss in pregnancy termination as exacerbating the pain among women. For some, the loss is chronic, making it accumulative. Speaking about recurrent losses, Clinton and Trent (2009, p. 175) added that losses that were not grieved for have a way of resurfacing when there is another loss. Care seekers must be assisted to mourn their losses as this may help them in the future when they encounter other losses.

2.3 Socio-cultural View of Childlessness

The western and the African worldviews are different on issues of childlessness. Greil, McQuillan and Slauson-Blevins compare advanced industrial communities, where voluntary childlessness is acceptable with other societies where having a child is key to womanhood. They explain that in industrialised societies, "many women experience infertility as a 'secret stigma' [while] in other cultures . . . infertility may be impossible to hide" (2011, p. 741). Dimka and Dein also highlighted that in Sub-Saharan Africa, the involuntarily childless are considered to be "social deviants" (2013, p. 103). Although the causes of childlessness are scientific, the African worldview presents socially defined grounds for the condition. A case in point is a study conducted in South Africa where some women reported that their childlessness was a result of being bewitched or a punishment from angry spirits (Dyer, et. al., 2002, 1659).

In an African setting, motherhood defines womanhood. Consequently, Van der Spuy (2009, p. 8) pointed out that voluntary childlessness is not common. Although a few families are now embracing it, its rareness communicates the importance attached to child bearing. One study intimated that in Rwanda, once a couple gets married, harassment and pressure from the husband's extended family members ensues if a child is not born. It is expected that the wife must have children (Dhont, et. al., 2011, p. 626). While Tabong and Adongo (2013, p. 5) noted that among the elite Ghanaian families the pressure imposed on involuntarily childless women is minimised, they also underscored that women viewed this condition as failure. In the light of the Ghana Demographic Health Survey reports which recounted that voluntary childlessness is uncommon, it is likely that the involuntarily childless women undergo stressful moments. In concurrence, Alhassan, Ziblim and Mutaka (2014, p. 1) concluded that such ladies face social rejection that leads them to cognitive maladies. Furthermore, Hansen indicated that eighty to hundred percent of the women derive happiness in bearing children as compared to five percent of the same in rich Organization for Economic Cooperation and Development countries like the Netherlands (Hansen 2012). Precursors

of involuntary childlessness like pregnancy loss distress women. As Shreffler, Greil, McQuillan (2011) have noted "that women experience a variety of psychological distress outcomes following miscarriage, including grief, anxiety, depression, and guilt" (p. 342).

3.4. Spiritual Care Intervention

A judiciously studied spiritual care plan is necessary in addressing the needs of the care seekers. Speaking of the bearing of being unintentional in caregiving, [the Author, 2018, p. 24] pointed out that it leads to regret. He further argued that unintended harm may be caused by the thought patterns influenced by the minister's unhealed wounds. Helman (2007, p. 186) also added that the therapist's thoughts and beliefs may have an impact on the depth of anguish.

Addressing the search for meaning calls for the understanding of the care seeker's spiritual purview. [the Author, 2019, p. 55] explained that sometimes the care receiver may be angry at God. To support his suggestion, he cited Clinebell (2011, p. 206) who opined that in such a situation it will be unwise to make the mistake of attempting to answer their theodicy questions. Instead he proposed that care seekers should be allowed to be open in venting out their anger. The pastoral caregiver will be able to do this only as s/he uses receptive power. Doehring (2015, 57, 65) explained that this style allows the client to take the lead in storying his/her challenge. The caregiver does not use directing power but listens as the story unfolds. It prevents the caregiver from falling into the expert trap that is motivated by empathetic distress. It also helps him/her to co-create meaning with the care seeker. Meaning making will be a collaborative process rather than impositions by the caregiver.

3. METHODOLOGY

The investigator adopted a qualitative paradigm that was ethnographical and phenomenological. Giorgi's approach of phenomenology was followed in analysing the data—which "aims to uncover the meaning of a phenomenon as experienced by a human through the identification of essential themes" (Koivisto, Janhonen & Vaisanen, 2002, p. 258). The rationale for using this method was twofold: First, the shame associated with childlessness and the secretive nature of the phenomenon reduced the size of the sample. Thus, a quantitative study would not have achieved an adequate statistical power due to the low sample size. Second, to get an in-depth understanding of the gravity of experiences that the unwillingly childless patients go through and their socio-cultural setting, a search for empirical predictability was considered as unsuitable in yielding the desired results. Streubert and Carpenter (1999, p. 55) pointed out that a qualitative study is an effective way of understanding the life of humanity. It helps to reveal the meanings that people attach to certain phenomena.

Qualitative methodologies are for description and not prediction. This study was a close look at the phenomenon for this particular population and context. An ethnographic study of the patients involved an understanding of the cultural background that either inhibits or promotes coping with distress. A phenomenological approach revealed the lived experience of involuntary childless women visiting LRMH and MCH. The comprehension of the socio-cultural context within which the childlessness phenomenon exhibits itself amongst the Bulawayo population was necessary to understand the meaning and rich descriptions of this experience for the participants.

3.1 Population and Sampling Procedures

The study population was recruited from involuntarily childless in-patients and those that have passed through either MCH or LRMH. The transitory nature of the care seekers made it difficult to determine the size of the population under study. Snowball sampling was used to recruit childless patients. Besides the childless women who referred the researcher to other women like them, doctors and senior matrons in the two hospitals also aided the researcher by referring consenting individuals to the investigator. Thus, ten patients were interviewed.

Although the investigator utilised snowball sampling for recruiting the participants, he was deliberate in varying their number of years in marriage. The basis for this was to understand if the number of years as a married childless woman impacted the way individuals responded to the pain that comes with being unable to have a child. Consequently, unmarried women were excluded from the study. Whites and biracial childless individuals were not part of this study. The basis for this exclusion was to focus only on the African worldview of the phenomenon in a marriage context.

In the recruitment of the participants, the self of the investigator was mentioned. The researcher has a personal experience of childlessness. Having lived in this condition for ten years, he could easily relate with the responses

that the interviewees gave. Interviewees who heard that he was childless felt comfortable to share their lived experiences. Table One (appendix B) shows the demographics of the recruited participants.

3.2 Data Collection

This research used semi-structured in-depth interviews with the sampled population. The investigator developed the schedule of interview questions. It was sent to the medical doctors serving at LRMH and MCP who made some important observations to enhance trustworthiness and to receive feedback related to ethical issues of the study. The instrument was then approved by the Adventist University of Africa Theological Seminary Proposal Committee which acts as the ethics committee.

Coupled with the interview schedules, the researcher utilised observation forms to record non-verbal elements and field notes. The interviews were an appropriate data collection instrument for the sample population and setting. They made it possible to go in-depth because of their allowance for probing in cases where more clarity was needed. Furthermore, the chosen mode enabled the participants to freely express themselves in the language they understood best. This enhanced a clearer articulation of feelings and lived experiences related to the phenomenon of childlessness.

Since childlessness is a sensitive socio-cultural issue, unintended harm to the patients was possible. The researcher was prepared to minimise this risk as much as possible. First, he facilitated the provision of referral in interviewees who demonstrated that need. Considering the pronatalist research context, some patients had issues that needed professional counselling. The researcher encouraged those who demonstrated that need to do so. Second, at the inception of the interview, the researcher told the participant to feel free to withdraw from the interview if she felt uncomfortable or was not prepared to reveal some information in her private life. This prevented any sense of coercion for the participants, who were treated with dignity.

The interviewees' responses were captured in a sound recording device and stored in a password locked computer. The transcribed interviews were kept in an encrypted file to enhance confidentiality. These files were deleted after the whole research process was completed. After the transcription process was finished, the researcher used Giorgi's four-phased approach in analysing the data.

3.3 Data Analysis

The data analysis addressed the overarching research questions below:

1. What are the socio-cultural lived experiences of the involuntarily childless patients?
2. What psychological and emotional challenges did the participants go through because of being childless?
3. To what extent does the challenge of being childless impact the patient's sense of worth?
4. What was the connection between spiritual issues and being childless?

In an attempt to get the "sense of the whole," the researcher employed phenomenological reduction or a bracketing approach. This entails putting aside personal beliefs, purviews, and affective projections in order to be able to consider a wide variety of meanings attached to the phenomenon from the perspective of the participants (Streubert & Carpenter, 1999). While coming to the research without any preconceived ideas is not possible, being conscious of the need for not projecting personal viewpoints on the findings was critical to understanding what participants mean by their choice of words and stories. Whiting's discussion of Giorgi's methodology in analysing data was utilised as a template throughout the data analysis process (Whiting, n.d.). Figure One (see Appendix A) is a summative view of the sequence followed by the investigator.

Step One. After all the interviews were written out, the researcher read through all of them to get the bigger picture. On the first reading of the transcripts, the researcher felt the emotional burden that these women are experiencing. The magnitude of emotional impact by most of the women experiencing infertility and childlessness was intense. While there were variations in individual stories, the overall impression was that these women experienced abuse in a pronatalist community and felt worthless because of failed procreativity. In his study of the transcripts, he considered Aanstoos proposal on phenomenological reduction—which meant that as the researcher familiarised himself with the content of the responses, he did not ignore already existing information. However, he acclimatised himself with the phrases in the transcripts in order to analyse the lived experiences of interviewees in an unbiased way (ibid).

Step Two. Establishing the "meaning units" was the second step. Themes emerging from the natural units were identified. Whiting pointed out that a natural unit is the participant's response cited verbatim and a central theme is the matter in question in the natural unit. Meaning units thus become a product of reading and re-reading the scripts then highlighting the experiences of the participants (ibid).

Step Three. This stage involves establishing what the natural units and central themes reveal in relation to the intent of the research. The investigator adopted the term emerging themes to describe the issues from the study. After recording all the emerging themes from each participant, the researcher identified those that recurred in most responses. Table Two (see Appendix B) is a summative presentation of the identified emerging themes.

Step Four. This last stage is a synthesis of the themes and assigning descriptive sentences to them. The researcher exemplified the reality of these descriptions by citing the responses of the participants. In the discussion section, some of them were compared with similar studies.

3.4 Trustworthiness of the Analysis

Qualitative studies are not predictive or generalisable, but they are exploratory in nature. Therefore, trustworthiness in qualitative research concerns providing clear rich descriptions rather than projecting generalisations about a population or issue. The researcher utilised direct quotes in some instances to support the descriptive statements emanating from interrelated themes.

To improve the validity and trustworthiness of the findings, the researcher used member checking. While he failed to get in touch with two of the ten participants, the rest responded and gave their viewpoint on the research findings. This was possible because the investigator had requested consenting participants to share their mobile phone numbers. This was meant to keep them informed of the reporting on the findings of the study and the program development.

To further enhance the trustworthiness of the research the investigator also used "peer scrutiny of the research project" (Shenton, 2004, p. 67) which in this instance, consisted of two other researchers who were naïve to the setting. These scholars reviewed transcripts and themes and provided feedback. In the discussion section, triangulation of other extant sources was used. This further improved the trustworthiness of the study.

4. RESULTS

There were socio-cultural, psychological and spiritual issues that were revealed by the study. Below is an analysis of the issues that came from the emerging themes.

4.1 Socio-cultural Concerns

There are several socio-cultural concerns that were raised by the patients. These include social rejection, coping with insensitive comments, blame by self and others, spousal and familial support and coping with suggestions.

Social rejection. Participants revealed that life without a child in a pronatalist society makes them feel like outcasts. They saw themselves as not being able to fit in the company of those who had children. Speaking about social rejection P9 protested, "The situation of not having a child is like being a leper in the Bible times. When those who have children relate with you, you see yourself as an outcast that is supposed to shout, 'unclean, unclean!!'" In concurrence P10 said:

> Putdowns from those who are supposed to be giving hope, make me realise that I am not socially accepted. Even when I do something great, they always tell me that there is one more thing left. Being childless in my African society makes me hide in my cocoon and fear to receive insensitive comments from people that are blessed with children.

Childless women indicated that social rejection was also evident in some family meetings, social gatherings and in situations where people were introducing themselves in terms of the children they have. For example, P4 reported,

> In one married couples' outing, people decided to introduce themselves in terms of the children they had. Instead of saying "I am so and so's wife, or so and so's husband" they pompously said, "I am so and so's

> mother. I am a proud mother of so many children." I wept because while they knew that we did not have children, they decided to use that as the tagline for introductions.

Patients did not only experience social rejection from families and the communities they came from but also from certain healthcare personnel. Some patients reported that in some instances, nurses used hurtful language. P1 reported that during her loss of a second child, while she was separated from other women who had given birth to live babies, the midwives sarcastically named the ward she was in *'Chandagona hapana'* – literally meaning: what I have achieved is nothing. She felt it was insensitive. Another interviewee protested that, "In some cases, nurses use unkind words. Statements like 'You should be a strong woman with a competent cervix' are uncalled for." She felt that this was demeaning and labelling her as a failing wife. The same sentiments came from P5 who said, "When a nurse told me that I should be strong like other women, I was pained by those words. She said that I should behave normally like other mothers and not have needless demands."

Coping with insensitive comments. In this study, most patients described involuntary childlessness as a complicated phenomenon. They pointed out many hurdles that came with being without children. The moment of waiting for a child to come was traumatising to them. Most of them reported the embarrassment of not being able to procreate. They cited people's comments as aggravating their painful experiences. On that point, P3 said:

> Being childless is a big challenge. People with children sometimes pass insensitive comments. Others think that we are not praying enough to be blessed as they are. They sometimes ask questions that raise painful emotions. The proposals that they make are sometimes are not called for. They seem to have solutions for every challenge.

Blame by self and others. Most participants reported that they were blamed by others for failed procreativity. The patients interviewed had pathological challenges that led to their failure to have children. Most of their husbands did not go for fertility tests because the perceived source of childlessness was their wives' ill health. A case in point, P8 pointed out that, "My situation is obvious because I had several surgeries related to this issue. While my husband did not go for fertility tests, no one blames him for not having a child." P6 added "I am the one who has a problem because I found my husband having kids. There was no need for him to go for fertility tests." On the contrary, while P2 was considered as the source of the challenge like other participants, her husband conceded to have the fertility test.

On the other hand, there was self-blame in some cases. While the participants were cognisant of other issues that could have caused childlessness, they blamed themselves for certain decisions they took. P1 reported, "I feel guilty because I couldn't protect my baby. My own body failed my child. I feel like I should have done something differently." Some added a spiritual dimension to the blame. While P2 said, "I presume that God doesn't acknowledge my marriage because of my wrong choice," P3 said, "I just thought we were not committed to God in the way that He expected. Maybe He wanted to use us in His ministry, that is what I thought."

Spousal and familial support. In some cases, having no children resulted in receiving little or no care from the husband's families. However, some got support from their husbands and few stated that their spouses cared less. Those who did not get the support from their partners experienced more emotional pain when they tried to come to terms with their situation. A case in point is P5's experience. She pointed out that she was frustrated about her husband who seemed not to care about her plight. Her situation was worsened by the indifference that she got from her in-laws. Speaking of the situation she said:

> When I lost my baby, the father of the child did not talk about the loss. He did not even ask me what transpired, and how I was feeling. We continued as if everything was normal. I did not even speak to the in-laws about it. At some point this makes me angry, and I and my husband end up not understanding each other. I find it hard to appreciate whatever he is doing. I see myself going back to that time when I lost my baby.

In agreement with this participant, P4 said, "Many families in our culture do not support childless women. They look down upon them. Some husbands divorce such women. This is even when no tests have been carried out to prove who the virility of the husband." P1 hinted that divorce and marital infidelity are likely to happen when a woman does not produce children. In her situation she noticed that patience wears out and love for the wife dies

down as the pressure to procreate mounts. She reported that her husband had two other children outside of the wedlock. This was his attempt to perpetuate the name of his clan.

> My husband changed his behaviour after my fifth baby died. At first, he was a bit sympathetic and then he got impatient. I have noticed that this happens a lot. A man cannot stand being in a childless marriage. He would rather have someone else who can give him kids. In my case when we got to the fourth baby loss, I found out that he had a baby with someone else.

On the contrary, some stated that they did not have problems with their husband's families. They were supportive. P8 pointed out that while her husband did not go for fertility tests, her in laws never treated her with scorn as she has heard from others who share her experience.

Coping with trivialising suggestions. Childless women viewed the suggestions from people with children as sometimes irrelevant and trivialising their pain. They felt that the society did not understand what they are going through. In some cases, they considered those propositions as motivated by either mockery or misunderstanding of the discomfort that comes with being childless. P9 reported that a friend recommended that she and her husband should try different procreation techniques. Quoting her words, she said: "My friend was so daring to tell me that I am wasting my husband. He openly said I should try different styles in bed or else give him to her. I was so hurt that I lost appetite that day. I felt this was insensitive, sarcastic and uncalled for." This participant's concern was not that the advice came from someone with a child but that she was unkind in her speech. She saw the woman as someone on a mission to harass her. As someone who was friends with her, she did not understand why she spoke in that way. P6 added:

> There is one friend who had invited me to visit a modern-day prophet, but I refused. After some time, she was pregnant, and gave birth. She said I must have gone to the prophet but because of my being stubborn, I would die childless. She was bragging that she will soon have her second child. My belief in waiting upon God could not allow me to do so. I was pained by her response to my childlessness.

4.2 Psychological and Emotional Issues

Varied psychological and emotional concerns emerged from the study. These include the childless women's responses to loss reminders, their anger against self, God and others, the feelings of guilt and sadness, a depleted sense of worth.

Response to loss reminders. Patients experienced negative emotions when they encountered loss reminders. These included pregnant women, messages from the social media announcing the birth of babies belonging to friends and/or relatives, and birthdays of children born when the woman lost a pregnancy. While all women had to deal with these loss reminders, those who had suffered miscarriages or stillbirth experienced more painful emotions and even symptoms of trauma. A case in point is a participant that had lost five babies through miscarriage and stillbirth. In her response she said, "I can't stand the sight of pregnant people. I cannot look at babies. In cases where I meet an infant or see an expecting mother, I fail to sleep. I actually sleep for three hours a night. Mostly emotions during the night will be just hard. I will be replaying events of my fifth pregnancy loss."

The other loss reminder was admitting bereaved mothers with those that had successfully delivered. Such patients felt that it was insensitive on the part of the nurses to be put in the same ward with celebrating mothers. P9 who had miscarried six times stated that when the midwives did so, they reminded her of her incompetence. As she narrated this, tears rolled down her cheeks. She was in deep pain. Thinking about that event became another loss reminder. P5 that had lost her baby shared the pain that she had when she was in the hospital. In the explanation of her situation she said:

> One challenging thing is that when I lost my baby, I was put in the same ward with those who had successfully delivered. This reminded me that I was not woman enough. When I saw these women breastfeeding, I covered myself with blankets and wept ceaselessly. I could hear the ululations from those who had visited mothers that had living babies.

The loss reminder that the above patient experienced led her to feel empty. She recounted that she battled with lost motherhood. As someone who was recently married, she was driven into desperation.

Anger against self, God and others. Patients were either having anger against themselves, healthcare givers, or family members. Some of them had moments when they were angry with God. They felt that He was sometimes very silent. Another participant reported that she was bothered by the thought of being childless. Every time this thought came, she became infuriated.

Sometimes this feeling of anger emanated from loss reminders. P7 code-named them as "emptiness reminders." She stated that they caused her to be angry. Having kept herself as a virgin, she felt that God was unfair to her. Speaking about this she said, "I have been a virgin all my life until I got married. Why does He [God] reward me in this way? Sometimes I am driven into despair and wet my pillow with tears. I become angry at God and feel separated from Him."

Some patients were also angry at those who either caused them to be in pain or those who spoke ill of their plight. P5 admitted that she was not happy with her husband. Although she had a stillbirth, she projected this predicament to him. This was probably because he did not comfort her during the loss.

Guilt feelings. Among these patients, strong feelings of guilt were observed. Speaking about this emotion, P1 said that she always looked for someone or something to blame. She felt guilty because she could not protect her baby. She concluded that her body failed her child and believed that had she done differently; she could have saved her babies. Some feelings of self-reproach came from what the patients did in the past. P2 reported that she felt guilty because of the decision she had made when choosing a life partner. According to her, marrying someone who was not of her faith may have displeased God and she was being punished for her sin.

Feeling of despair. Women with fewer years in marriage exhibited a feeling of despair. Speaking about her desperation a woman that had lost five pregnancies said, "As an African woman I needed to strengthen my marriage by giving my partner a child. When I failed to do so. I was driven to desperation." P6 that was married for four years was also in despair because she had kept herself as a virgin till marriage. However, she consoled herself that her situation was a temptation from the devil.

Worthlessness. Women felt that having no child is a challenge. It caused them to have a low sense of worth. P6 wondered if she will ever hold a baby in her hands. Consequently, like other interviewees in this study she felt worthless. Most patients indicated that their loss reminders brought about the feelings of being depersonalised. As stated earlier on, posts on social media and being in a ward with mothers that had delivered live babies brought pain. Speaking about this, P9 said, "When I saw myself in the midst of mothers with babies, I was reminded that I am an incapable woman. It made me feel less of a human being and worthless." She was so emotional about this that she could not hold her tears. Thinking about the number of years in her marriage she added, "The feeling of worthlessness is the strongest in my twentieth year of marriage. I do not feel like a woman of worth. I see myself as secluded . . . I can't fit into the community of those blessed with children." When she said this, she was filled with sadness and tears continued to fall.

4.3 Spiritual Concerns

Being mostly Christian, patients raised some spiritual concerns. These included trying to find meaning in loss, reconciling spiritual beliefs about God, estrangement from God, the impact of witchcraft, and the desired spiritual care.

Trying to find meaning in loss. Some of the patients considered childlessness as a divine retribution. Such participants saw a curse resting upon the whole family. This was more evident in those whose family members suffered from the same challenge. As they tried to find meaning in this plight, they concluded that the mistakes of older generations are having an impact on them. Speaking about this, P9 said, "I feel that we were cursed because most of my family members are struggling to have children. This must be a generational problem that has been passed on to us by those who committed sins before we were born."

On the other hand, other patients saw it as the decision of God to be silent on the matter. P8 considered the cause of her condition as best known by God. She stated that God has a reason why He allowed them to be childless. While

she had a hysterectomy before having a baby, she opined that maybe the children that she could have had were going to be a "thorn in the flesh."

Reconciling spiritual beliefs about God. Coming to terms with childlessness and the silence of God in this matter worried some participants. They were troubled why God allows bad things to happen to them. P8 indicated that she was still struggling with many theodicy questions. P2 added that she tried to reconcile why God allowed women who in their teen years aborted several times to have children, while others who were well behaved are struggling. This made it hard for her to reconcile her spiritual belief in God.

Patients reported that, at some point in their lives, they would have feelings of anger against God. P4 that was married for 21 years explained that she felt that God was unfair to her. In her anger, P1 pointed out that, "When it comes to God, I feel that He doesn't like me that much. When it is about Him, I am totally dead. I do not really believe in Him anymore. That's the bottom line." She expressed her anger and disappointment at His silence.

On the other hand, other participants accepted that God allows certain things to happen for a reason. They did not blame Him for being silent because they did not know what is hidden. They saw in their challenge, an opportunity to worship God. Speaking about this, P3 said:

> In times of hardship and . . . sorrow, God is still God . . . Although He has not given me a child, He is blessing others and we should celebrate with them. Even though in my view, ten years is a long time, but He remains God. I can also say that it makes us cling to the Lord . . . Having challenges in life makes us go back to Calvary.

Estrangement from God. Among some participants, there was a feeling of being disconnected from God. While others still believed in Him, when they tried to reconcile their childlessness with the omnipotence of God, they felt estranged from Him. P9 spoke in her tears when she explained how she experienced this separation from God. She was overwhelmed with a feeling of sorrow as she described her ordeal. In her response she said' "I feel the pain of a rejected and dumped child. I am worried about why He is silent when I ask Him to give me a baby. Because no response is coming from Him, I feel that He has separated Himself from me. Sometimes it makes me very angry and sad. Why should God turn His back against me?"

On the other hand, some participants fought against this feeling of being separated from God. They saw it as a suggestion from the devil. They maintained their faith in God. A case in point is P10 who had lost her first baby. She still had trust in God. She refused to call herself barren but had trust in divine providences. However, periodically she had moments when she questioned why God is silent.

> While I feel far from God, I have refused to believe the devil's suggestion that God has forsaken me. I have also stopped calling myself barren. I know that my God will come through one day. He may be silent for now, but I still have hope. I still fast and pray for a miracle child. If He finally says "No," I will accept what He said. For now, I will continue with my prayers.

The impact of witchcraft. Some patients saw witchcraft as the cause of their plight. They pointed to certain events in their lives that are suggestive of this. Although they did not deny the pathological explanations given by their doctors, they insisted that their childlessness was spiritually caused. P8 associated her unfortunate hysterectomy with the mysterious disappearance and reappearance of her skirt. She said that after wearing it, she immediately began experiencing unbearable excruciating pain. P6 pointed to her childhood where one woman bewitched her to be in perennial menses. P9 connected her six miscarriages to seeing an old woman touching her private parts each night before her loss. In another interview, P7 said:

> My childhood days were littered with witchcraft. There strange things that were happening to me. Every morning when I woke up, my underclothing would be having blood. What made me wonder is that at that time, I would not be having any menstrual periods. This is only the work of witchcraft. While the doctor told me that I have salpingitis, I feel this is beyond the premise of medical issues.

Some of the childless women stated that their family members called for meetings where they could appease the angry spirits. P5 pointed out that while her mother was a Christian, she took her to a folk healer who was meant to help her deal with the challenge of childlessness through a ritual which is called *ukumiswa*.

The desired spiritual care. The patients desired the ministry of presence from the spiritual caregivers. They intimated that when too much words are said to them, the likelihood of wounding them was high. They also pointed out that when they are in the hospital, especially when they have lost their children, someone who will provide care without talking too much is more preferred to someone who will begin to preach to them. P1 described one spiritual caregiver who was a pastor as a bother to her. In her response she pointed out that the cleric was using too much of scripture to suppress her pain. She concluded that she did not benefit from the care given. On the other hand, P7 reported that she benefited from the care she got from her pastor. Speaking about it, she said, "When I left the hospital, I met my pastor. He and his wife said, 'We do not understand the pain you are having; we can't share the experience of your plight. We are here to tell you that we care.' That meant a lot than what other people were preaching to me."

5. DISCUSSION

Three issues are discussed in this section. These include the impact of spirituality, psychological and emotional, and sociological issues in care provision.

5.1 The Impact of Spiritual Issues and Wholistic Patient Care

The study revealed that spiritual issues are important in providing whole patient care. Narrations by the childless women showed how they have an impact in addressing their needs. The research further exposed how such issues affected the care seekers' health seeking behaviours. Spirituality and entrenched cultural beliefs were so inseparable that even participants from mainline Christian denominations attributed their failed procreativity to them. Thus, spiritual caregiving is a ministry that calls for understanding the care seeker's spiritual needs. A case in point is what was observed in a study of mental health patients from non-western settings. It was noted that such care seekers "do not abandon their own perceptions, culture, or belief systems regarding diseases or medicine" even when referred to Western psychiatry for treatment (Al-Krenawi & Graham, 1997, p. 211).

While patients considered childlessness as resulting from a pathological challenge, malevolent spirits were mentioned as the perceived cause for involuntary childlessness. Even those who were Christian, it seemed hard for them to rule out the work of spirits. This revealed the African philosophy on suffering. Every problem has a spiritual cause that needs to be solved by spiritual means. In a different study, Rey (2013, p. 68) wrote about the impact of the spirit world on marriages. Speaking about them she mentions spirit spouses. In her description she explains that these are believed to be responsible for the problem of childlessness.

Another spiritual component that emerged from the patients' responses was that God was behind their childlessness. While others saw the will of God others viewed it as His unfairness. An analysis of the responses revealed that while suffering may sometimes cause one to lose confidence in God, it may increase dependence upon Him. Consequently, spiritual caregivers must be careful in the way that they present God to those in pain. They need to walk with them through their challenges.

In the study, one patient lost her hope and belief in God because she did not get an answer to her prayer for a child. She did not even appreciate the services provided by the pastor in one of the hospitals she attended. On the contrary, other patients understood that the pain they were going through was a test of faith. While they had some anger against God, they still depended on Him. Thus, spiritual care given to such patients must take into cognisance their anger against God whom they perceive as the One who has "closed their wombs."

Another issue was the belief in generational curses resting on the entire family. Patients interpreted the childlessness that was in their families as being caused by such curses. While such care seekers may benefit from biomedical practice, their thoughts may hamper their wholistic healing. When they think about their plight, they will be emotionally down and spiritually disconnected. In the light of this, spiritual caregiving must take this aspect into cognisance. Helman (2007, p. 85, 87) illustrates how folk healers manage to do this. He opined that they know the art of taking care of the whole person. They do not only focus on the pathology, but they involve the whole family that is affected in coming up with the solution. From this approach, not only the worry about generational curses will be addressed, but spiritual caregivers may learn how to address spiritual problems with a wholistic focus.

5.2 Psychological/Emotional Issues and Wholistic Patient Care

Feelings of guilt, anger, worthlessness, despair and sadness were observed among the patients. While they experienced these negative feelings differently, an analysis of the patients' responses revealed a retrogressive pattern as the years progressed. Figure Two (appendix A) is the investigator's illustration of the trajectory of the emotions in view of the number of years as a childless woman.

To address the emotional needs, a social support system would work better. Establishing an online community were the needs of such patients will be met may help them to share their burdens. Whole patient care would be incomplete without addressing the emotional needs of these patients. In the hospital, counselling services must be provided to help them talk about their problems.

5.3 Sociological Issues and Wholistic Patient Care

The way people view childless women makes them feel social outcasts. Consequently, they lose their sense of worth. From the responses of the patients it is evident that they have felt it difficult to fit in the community of those with children. Sometimes people may be saying some things out of ignorance. Therefore, a program that would create awareness among the members of the public may help in lowering the incidence of social rejection.

The society blames women for failed procreativity. In this study, some husbands of the participants did not go for fertility tests. While all women had pathological challenges that resulted in childlessness, the reticence of men to be tested for virility, was culturally motivated. This hesitancy indicated either ignorance or disregarding the male factor infertility. Njovana and Watts (1996, p. 50) reported that traditionally, no men is considered sterile. The cultural belief that men cannot be infertile is disputed by some studies carried out in Zimbabwe. One research revealed that of the 2003 cases of infertility treated in twelve months in one healthcare facility, 26.5% were men (Mbizvo, Chimbira and Mkwananzi, 1984). It is highly probable that the figures of infertile men in the area served by the centre was higher because men generally shun being tested. Furthermore, some African studies have revealed that 50% of the infertile Zimbabweans studied suffered from male factor infertility (Moyo and Muhwa, 2013).

6. LIMITATIONS

The research had three limitations. First, it is likely that the self of the investigator impacted the data analysis procedure. While his childlessness was advantageous to the participants, his intrinsic biases may have affected the process. Second, participants were free to have their responses to be recorded. However, one of them declined. In that case, the researcher took extensive notes during the interview. This could have interrupted the flow of thought as the interviewee had to pause to wait for the researcher to write down the discussed matters. Third, some interviewees used their own mother language to express the deep feelings of their painful narratives. While this provided a richer description of their lived experiences, translation into English may have watered down the strength of their thoughts.

7. CONCLUSION

The involuntarily childless patients not only encountered physical complications but also emotional, spiritual, psychological and socio-cultural torment in their attempts to correct their failed procreativity. Their experience led them to a search for meaning, where they struggled to deal with suffering and had theodicy questions. Their desire for the longed-for-child who was a mental object but not physically present made them experience ambiguous loss and suffer social inadaptability. Their challenge transcended the pathological confines and called for caring for the whole person. Thus, great caution was seen as important in caregiving because whatever the healthcare team members did, it was either cathartic or harmful. An intervention focused on medical intervention only does contribute to the curing of the patient. However, it falls short of the healing virtues that are derived from caring for the whole person.

The existence of loss reminders among the involuntarily childless patients calls for the health carers to be more careful in how they treat them. One such thing raised by patients is being admitted in a ward with nursing mothers. This could be avoided. Taking into cognisance the increasing volume of healthcare seekers in need of maternal services in public healthcare institutions, the management should consider the construction of separate wards were such women are admitted for care.

Due to the unavoidable insistence on married couples to have children, giving education and public awareness on the subject is important. The existence of infertility and the ignorance of the societies may be causing the mental health burden to be increased. The administration needs to partner with the churches, social services, and non-governmental organisations in teaching communities about the effects of abusive language and the pressure to have children exerted on the involuntarily childless women. This may not only lower the incidence of stress but also improve their sense of worth.

The existence of psychological challenges that were heightened by the pressure from the society to have children, meant that such a situation will continue as long as there is no intervention. The provision of psychological services by mental healthcare professionals to patients needing such is highly recommended. While these experts may not exterminate all the mental illnesses, they may help to meet the psychological needs of the patients.

Spirituality played a major part in the healing of the patients. Consequently, spiritual care was seen as an important component in the healthcare provision. However, both MCH and LRMH did not have these services. In this light, the use of chaplaincy services is highly recommended. The hospitals need to engage clerics with an understanding of the provision of spiritual care in a healthcare setting.

This study was focusing on married childless women. More research needs to be done to those who had been divorced because of their childlessness. Further inquiry into this area will create an understanding of the contribution of pronatalist socio-cultural context towards the instability of marriages. Furthermore, a comparative qualitative study of Africans and biracial or white childless people in the same territory may amplify the impact of the African ethos on childless marriages. Another study can compare the lived experiences of men without children with women suffering the same challenge.

REFERENCES

[1] Alhassan, A, A. R. Ziblim, & S. Muntaka. (2014). A Survey on depression among infertile women in Ghana. *BMC Women's Health, 14*(42), 1–6. Retrieved from http://www.biomedcentral.com/1472-6874/14/42

[2] Al-Krenawi, A., & J. R. Graham. (1997). Spirit possession and exorcism in the treatment of a Bedouin psychiatric patient. *Clinical Social Work Journal, 25*(2), 211–222.

[3] Atang, N. C. (2016). Involuntary childlessness: An interpretative phenomenological analysis of black women's experiences in Luton. (MPhil thesis). University of Bedfordshire, Luton, England.

[4] Boss, P., & J. R. Yeats. (2014). Ambiguous loss: A complicated type of grief when loved ones disappear. *Bereavement Care, 33*(2), 63–69. Retrieved from, https://doi.org/10.1080/02682621.2014.933573

[5] Burns, L. H. (2013). Psychological changes in infertility patients. In A. Rosen & J. Rosen (Eds.), *Frozen dreams: psychodynamic dimensions of infertility and assisted reproduction* (pp. 3–32). New York, NY: Routledge,

[6] Clinebell, Howard. (2011). *Basic Types Pastoral Care and Counseling: Resources for the ministry of healing and growth,* third edition. Nashville, TN: Abingdon Press.

[7] Clinton, T., & J. Trent. (2009). *Marriage and family counseling*. Grand Rapids, MI: Baker Books.

[8] Dimka, R. A., & S. L. Dein. (2013). The work of a woman is to give birth to children: Cultural Constructions of infertility in Nigeria. *African Journal of Reproductive Health/La Revue Africaine de la Santé Reproductive, 17*(2), 102–117.

[9] Doehring, C. (2015). *The practice of pastoral care: A postmodern approach*. Louisville, KY: Westminster John Knox Press.

[10] Dhont, N., J. van de Wijgert, G. Coene, A. Gasarabwe, & M. Temmerman. (2011). "Mama and Papa Nothing": Living with infertility among an urban population in Kigali, Rwanda. *Human Reproduction, 26,* 623 – 629. DOI: 10.1093/humrep/deq373

[11] Dyer, S. J., N. Abrahams, M. Hoffman, & Z. M. van der Spuy. (2002). Infertility in South Africa: Women's reproductive health knowledge and treatment-seeking behaviour for involuntary childlessness. *Human Reproduction, 17,* 1657–1662.

[12] Gilligan, P. (2017). Responding to child abuse in religious contexts. In B. R. Crisp (Ed.), *The Routledge handbook of religion, spirituality and social work* (pp. 210–219). New York, NY: Routledge.

[13] Greil, A. J. M., & K. Slauson-Blevins. (2011). The social construction of infertility. *Sociology Compass, 5*(8), 736-746.

[14] Hansen, Thomas. (2012). Parenthood and happiness: A review of folk theories versus empirical evidence. *Social Indicators Research, 1,* 29–64.

[15] Helman, C. G. (2007). *Culture, health and illness,* 5th Edition. Boca Raton, FL: Francis and Taylor.

[16] Kersting, A., & B. Wagner. (2012). Complicated grief after perinatal loss. *Dialogues in Clinical Neuroscience, 14*(2), 187–194. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3384447/
[17] Koivisto, K., S. Janhonen, & L. Vaisanen. (2002). Applying a phenomenological method of analysis derived from Giorgi to a psychiatric nursing study. *Journal of Advanced Nursing, 39*(3), 258–265.
[18] Lang, A., Fleiszer, A. R., Duhamel, F., Sword, W., Gilbert, K. R., & Corsini-Munt, S. (2011). Perinatal loss and parental grief: The challenge of ambiguity and disenfranchised grief. OMEGA—Journal of Death and Dying, 63(2), 183–196.
[19] Mbizvo, M. T., T. H. K. Chimbira, & J. B. Mkwananzi. (1984). Aetiological factors of male infertility in Zimbabwe. *The Central African Journal of Medicine, 30*(12), 233–238.
[20] Mosalanejad, L. & A. K. Koolee. (2013). Looking at infertility treatment through the lens of the meaning of life: The effect of group logotherapy on psychological distress in infertile women. *International Journal of Fertility and Sterility, 6*(4), 224-231.
[21] Moyo, S. & I. Muhwa. (2013). Socio-cultural perspectives on causes and intervention strategies of male infertility: A case study of Mhondoro-Ngezi, Zimbabwe. *African Journal of Reproductive Health, 17*(2), 89–101.
[22] Njovana, E., & C. Watts. (1996). Gender violence in Zimbabwe: A need for collaborative action. *Reproductive Health Matters, 4*(7), 46–55.
[23] Pedro, A. (2015). Coping with infertility: An explorative study of South African women's experiences." *Open Journal of Obstetrics and Gynecology, 5*, 49–59.
[24] Rice, R. (2014). *Suffering and the search for meaning: Contemporary responses to the problem of pain*. Downers Grove, IL: InterVarsity Press.
[25] Rey, J. (2013). Mermaids and Spirit Spouses: Rituals as technologies of gender in transnational Pentecostal spaces." *Religion and Gender, 3*(1), 60–75.
[26] Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information, 22*, 63–75.
[27] Shreffler, K M., A. L. Greil, & J. McQuillan. (2011). Pregnancy loss and distress among U.S. women. *Family Relations, 3,* 342–355.
[28] Streubert, H. G., & D. R. Carpenter. (1999). *Qualitative research in nursing.* Philadelphia, PA: Lippincott.
[29] Tabong, P. T., & P. B. Adongo. (2013). Infertility and childlessness: A qualitative study of the experiences of infertile couples in Northern Ghana." *BMC Pregnancy and Childbirth* 13: 1 – 10.
[30] Whiting, L. (n.d.) Analysis of phenomenological data: Personal reflections on Giorgi's method. *Nurse Researcher, 9*(2), 60 – 74. Retrieved from https://pdfs.semanticscholar.org/d8b0/b68d5a4dd7f4703006b47522d23fd5af75f.pdf.
[31] Wright, H. N. (2011). *The complete guide to crisis and trauma counselling*. Grand Rapids, MI: Bethany House Publishers.

Appendix A

Figure 1. Steps Taken in Data Analysis Using Giorgi's Methodology

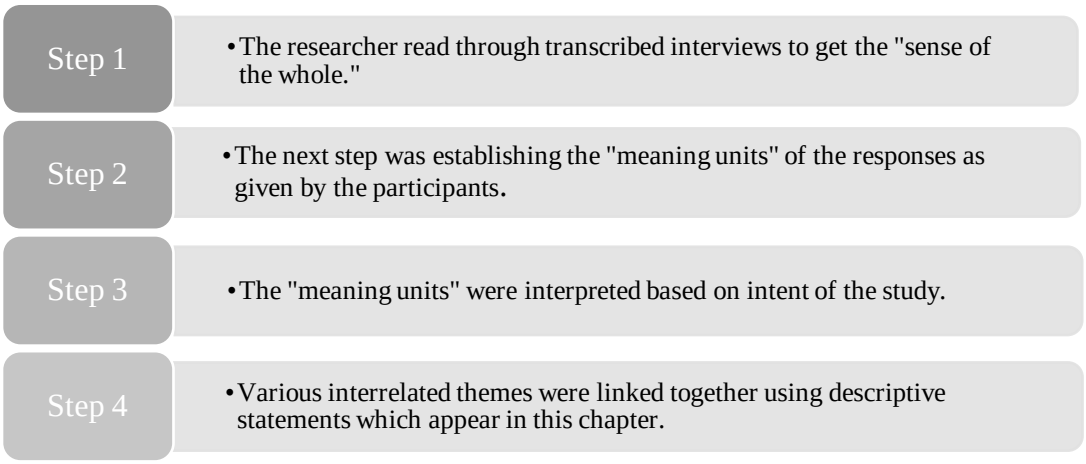
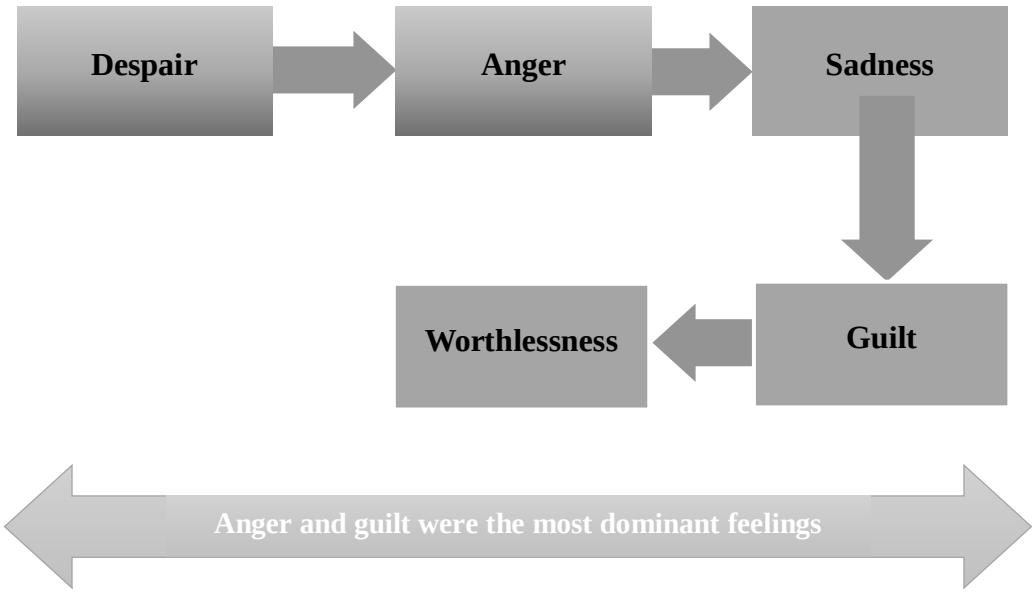


Figure 2. Trajectory of Feelings in Lieu of Number of Years in Childlessness



Appendix B

Table 1. Demographics of the Patients

Number of Years in Marriage	Level of Education	Pathological Challenge	Participant Number
2	O' Level	Stillbirth	P5
3	Diploma	Miscarriages and Stillbirth	P1
4	Master's degree	Salpingitis	P7

5	Diploma	Ovarian Cysts	P10
5	Bachelor's degree	Blocked fallopian tubes	P2
6	O' Level	Hormonal imbalance	P6
8	Bachelor's Degree	Hysterectomy	P8
10	Diploma	Fibroids	P3
20	O' Level	Miscarriage	P9
21	O' Level	Miscarriage	P4

Table 2. Emerging Themes

Component	#	Emerging Theme
Socio-cultural	1	Women found childlessness as a difficult thing.
	2	Childless women considered as outcasts and treated with suspicion
	3	Blame by self and others.
	4	Did not want suggestions from people who have children on how to handle their situation.
Psychological	5	Psychological distress, puerperal psychosis, postpartum depression and anxiety
	6	Feelings of guilt, anger, worthlessness and sadness.
	7	Childlessness increased the feeling of worthlessness
Spiritual	8	A punishment from God – a generational curse to the family or the silence of God on the matter.
	9	Feeling of alienation from God prevailed.
	10	God's purpose was seen as the cause for childlessness. In other cases, it was seen as caused by witchcraft.
	11	Reconciling childlessness and maintaining a relationship with God was hard for the participants.
	12	Desired the spiritual caregivers to be present and not to say much.