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THE JOURNEY OF INFERTILITY

An exploration of how women in Nairobi, Kenya experience infertility in relation to gender and how they navigate within different 'fields of infertility'

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Abstract

According to the World Health Organization[1], more than 180 million couples in developing countries suffer from primary or secondary infertility. Existing literature on gender and infertility mainly focusses on the 'suffering' of women. However, to date, there is hardly any literature available on infertility in Kenya. This research aims to address the experiences of infertile women in Nairobi, Kenya. Guided by a thematic content analysis of thirty in-depth interviews, two focus group discussions and several ethnographic observations this thesis explores how women experience infertility in relation to gender and how they act upon this. By analyzing both infertile women's experiences and practices, I argue that gender norms in relation to infertility in the Kenyan society are moving. Moreover, I argue that women in this study navigate - act, adopt and move - in reaction to the structures of the 'field of infertility'.

Keywords

women; infertility; Kenya; gender; experience; practice; gender as lived social relation; social navigation

[1] National, Regional, and Global Trends in Infertility Prevalence Since 1990: A Systematic Analysis of 277 Health Surveys - collaboration with WHO in 2004.

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1. Introduction

This research is part of a broader comparative study that is carried out in Ghana and Kenya, entitled "Involuntary Childlessness, 'Low Cost' IVF and Fertility Associations in Ghana and Kenya: Enhancing Knowledge and Awareness" and has a quantitative and a qualitative part. The project is funded by Share-Net International and is conducted in collaboration with the Master Medical Anthropology (MAS) and the Educational Master (EM) at the University of Amsterdam. The overall goal of this research is to increase knowledge and awareness about infertility and childlessness among stakeholders and to generate insights into the impact of two currently undertaken activities - the introduction of more affordable In-Vitro Fertilization (IVF) and patient organizations - to address infertility in Ghana and Kenya[2]. Infertility is a highly prevalent reproductive health condition in the global South, which often has a devastating impact on the people concerned. Yet, thus far it has hardly received attention from policy makers, Non-Governmental Organizations (NGOs) or donors. Insights gained from the proposed project are expected to improve infertility interventions in Ghana, Kenya and other countries in the global South[3] .

This study aims to address infertility in Kenya. The Footsteps to Fertility Centre (FFC) in Nairobi is a fertility clinic that collaborated with this research project, and it has been the main research site of this study. Together with Luca Koppen (student MAS) and Anna Jansen (student EM) I have spent 10 weeks in Kenya, Nairobi, to investigate experiences with infertility. For this project Anna was responsible for the quantitative data, and Luca and I were responsible for the ethnographic part. My research is concerned with the experiences of infertile women in Nairobi. In this thesis I explore how experiences of infertility are influenced by gender, and how women act upon this. On the one hand I will look at the views and experiences of infertile women, and on the other hand I will analyze their practices.

This thesis is divided into seven chapters. After this introduction, I will elaborate on the context in which this research has taken place. In the third chapter I will discuss relevant anthropological theory regarding gender, social experience and practice, to understand women's experience with infertility. In order to analyze how gender influences the

[2] Due to circumstances the introduction of more affordable IVF by The Waling Egg (tWE) in Kenya is postponed. The focus of this study has therefore shifted to experiences of infertile women in Kenya.
[3] Retrieved from research proposal ''Involuntary Childlessness, 'Low-Cost' IVF and Fertility Associations in Ghana and Kenya: Enhancing Knowledge and Awareness''.

experiences of infertile women I will explain the concept of ‘gender as a lived social relation’ (McNay 2004). This concept approaches gender as a fluid relation rather than a fixed, context-free, determined structure. In addition, I will elaborate on the concept of ‘social navigation’ (Vigh 2006), which is a tool for anthropological analysis of practice. Social navigation looks at ‘how people act in difficult or uncertain circumstances and to how they disentangle themselves from confining structures, plot their escape and move towards better positions’ (ibid.: 419). To situate the experiences and practices of infertile women in Nairobi, I explore theories around the categories of ‘woman’ and ‘African men’ and relate this to the Kenyan context. Combining these theories is useful as it allows an approach to the experiences and practices related to infertility without portraying the women in this study as sufferers. Moreover, these theories illustrate how social and cultural structures are changing and context specific.

In the fourth chapter I will elaborate on the methods that have been used in this study. Chapter five and six are empirical chapters in which I show and argue that the experiences and practices of infertile women in Nairobi are in constant movement and that these experiences, in turn, are situated in moving structures. Chapter five looks into how women’s experience with infertility is related to gender and vice versa. Chapter six explores the daily practices of the women situated in the different ‘fields’ related to infertilely. To conclude, in chapter seven I will summarize the major findings of this study. In this concluding chapter I relate my findings with wider debates around the experiences of women with infertility and I will provide my indication of broader implications to this debate.

2. Infertility and ARTs (Assisted Reproductive Techniques)

This chapter will provide an overview and background of infertility, ARTs and the context in which the research is done. First, the concept and the meaning of infertility will be explored. Further, the experience of infertility will be related to gender roles, as this is the main focus of the study. Subsequently, the globalization of ARTs will be analyzed. Lastly, I will review the literature on infertility in the Kenyan context.

2.1 Infertility

Worldwide more than 15% of all reproductive-aged couples are affected by infertility.[4] According to the World Health Organization, more than 180 million couples in developing countries suffer from primary or secondary infertility[5]. Within the biomedical context the term 'infertility' is used to describe the inability to conceive after 12 months of regular unprotected intercourse (Greil et al. 2011: 736). This is also called 'primary infertility'. 'Secondary infertility' refers to couples who have been able to become pregnant (but did not necessarily experience giving birth) at least once, and experience infertility after their pregnancy (Larsen 2005: 857). In over 85% of women experiencing infertility in Sub-Saharan Africa, infertility is caused by infections, compared to 33% worldwide. Similarly, male infertility in Sub-Saharan Africa is mostly caused by infections (Ombelet 2011: 258).

Facing fertility issues and being childless has implications for the well-being of women and men around the world. Looking at the social and cultural consequences of being childless in poor-resource areas, Van Balen en Bos (2009) found that 'the frequently mentioned serious consequences of being childless are in the realm of community effects, in-law effects and effects on marriage' (ibid.: 116). Generally speaking, experiences related to infertility are shaped by several factors, such as kinship systems, family and conjugal ties, moral and legal rules, and religious customs in both the Western and non-Western world (van Balen & Gerrits 2001: 216). This idea is supported by Greil *et al.*, who argue that experiences of infertile couples are shaped by sociocultural influences such as gender ideology, access to care, family structure, ethnic identity, and social class (2011:742). Put differently, how somebody experiences infertility depends on various social and cultural factors. The authors therefore state that infertility is best understood as a 'socially constructed process whereby

[4] Website: http://www.who.int/bulletin/volumes/88/12/10-011210/en/
[5] National, Regional, and Global Trends in Infertility Prevalence Since 1990: A Systematic Analysis of 277 Health Surveys - collaboration with WHO in 2004.

individuals come to regard their inability to have children as a problem, to define the nature of that problem, and to construct an appropriate course of action' (ibid.: 737). This means that based upon various social and cultural factors, for example, couples can experience infertility without having tried to conceive for less than 12 months. At the same time, couples that are classified as infertile within the biomedical discourse might not identify as infertile due to a lacking desire for children.

2.2 Infertility and Gender

In the 1970's feminist and social scientists came up with an explanatory model which conceptualized two categories: sex and gender. In this model, sex is seen as the essential underlay of the body and gender is the social overlay of the body. With other words, gender is the culturally and socially constructed difference between men and women (Fausto-Sterling 2003: 123-124). Looking at infertility and gender, literature shows that, generally speaking, women experience more distress due to infertility than men, and being childless has greater impact on life in the non-Western world than in the Western world (Inhorn & Patrizio 2015: 412). Inhorn and Patrizio state that in non-Western parts of the world women are mostly held responsible when a couple faces infertility (ibid.: 411).

The differences between 'the two worlds' is mainly due to sociocultural context, including gender (ideology). In non-Western worlds women's roles are in general more closely related to having children (Greil *et al.* 2009: 148-149). This might explain why women are the ones who are held responsible when a couple faces infertility and, why women are often more active in fertility seeking (Gerrits and Shaw 2010). However, as De Kok (2009) argues, attributing experiences with infertility to cultural norms such as gender is problematic. According to De Kok this approach has several limits such as methodological issues and theoretical – and moral problems (ibid.: 189-199). De Kok suggests 'an alternative approach to ''culture'' and ''norms'', which examines how they are (re)produced and used within specific contexts, and which effects these uses have, rather than treating them as context-free determinants of behavior' (ibid.: 199) in relation to infertility.

Generally speaking, looking at gender and infertility, several studies highlight the suffering of women. For example, a research in South-Africa has shown that many infertile women experience negative social consequences including marital instability, stigmatization, and abuse (Dyer *et al.* 2002: 1663). Another research in Zimbabwe shows that women are

mistakenly blamed for male infertility. Most of Zimbabwean population is poor and can't afford going to the hospital. Because infertile men go to traditional healers, men rarely get help from health professionals and they therefore put the blame on their wives. However, even though women are blamed for (male) infertility, Zimbabwean infertile men live with low self-esteem and depression (Folkvord *et al.* 2005: 242). As the previous studies highlight, blaming women for infertility is not always related to the biomedical notion of infertility. Without being medically classified as infertile, women around the world are mistakenly blamed for infertility and therefore seem to suffer the most.

Looking at studies that focus on couples in the African context, various studies demonstrate the differences between men and women in relation to infertility. In the case of couple infertility in South-Africa researchers found that men experience levels of psychological distress, but do not suffer from psychopathology (Dyer *et al.* 2009: 2821). This quantitative study highlights that women experience greater distress due to infertility than men in the case of couple infertility, and that they bear the greatest burden of infertility (ibid.: 2824). Furthermore, a study to couple infertility in Mali shows that men are reluctant to biomedical infertility care. According to Hörbst this reluctance has to do with the fact that men have to reckon the possibility of being diagnosed with male factor infertility when seeking biomedical help. In addition, men refuse biomedical diagnosis since different social solutions, like extramarital sex or the marriage of a second wife, become more difficult (Hörbst 2010: 26).

While the above findings are not necessarily directly applicable to the Kenyan context, they do give insight in the complex relation between gender and infertility in the African context. Moreover, the previous examples show that. in relation to gender and infertility, the focus of most studies is on the suffering of women and/or the differences between men and women. However, as Gerrits (2012) suggests: 'Ways should be found to address the vulnerable position of infertile women at the conjugal, familial and community level. As discussed in the Expert Meeting[6], the 'coming out' of successful childless women (and men) in the mass media could be one means to achieve this' (ibid.: 6). In line with Gerrits' recommendation and taking into consideration that there is hardly any recent

[6] 'The expert Meeting, which was held in Genk, Belgium, in November 2012, was organized by the social science study Group of the ESHRE special Task Force on 'Developing countries and infertility', in cooperation with the Walking egg Foundation, the World health Organization and the Amsterdam institute of social science research (AISSR) of the University of Amsterdam' (Gerrits 2012: 2).

literature available related to gender and infertility in Kenya, in thesis I will elaborate on the existing insights and relate them to the Kenyan context.

2.3 Globalization of ARTs

Since 1978 In Vitro Fertilization (IVF), 'a technique whereby sperm and eggs are retrieved from the human body, allowed to fertilize in a petri dish, and then transferred back to the uterus as fertilized embryos', is practiced in the developed world (Inhorn & Birenbaum-Carmeli 2008:178). Over the past decade there has been an increase in the number of IVF clinics world-wide (Inhorn & Patrizio 2015: 415). Despite the fact that the majority of couples dealing with infertility are residents of developing countries, infertility medical services, such IVF and other ARTs, are of poor quality or very costly in developing countries (Ombelet *et al*. 2008: 605). This finding is confirmed by Gerrits and Shaw (2010) who looked into how ARTs are offered, used and experienced. Based upon the reviewed studies the authors '(…) emphasize the need to improve the quality of (low tech) infertility care in the public health sector by means of standardized guidelines, training of health staff and improved counseling' (ibid: 1). In addition, and as described before, infertility in developing countries is mostly caused by infections and this condition is best treated by ARTs (Ombelet *et al*. 2008: 606). The reasoning behind the neglect of infertility as a reproductive concern is represented the two frequently heard key arguments in the debate about globalization of ARTs in developing countries, namely that 'in countries where overpopulation poses a demographic problem, infertility management should not be supported by the government' and 'it is hard to justify expenses for fertility treatment in settings with few resources and more important challenges to deal with' (Ombelet 2011: 258-259). The globalization of ARTs is a recent development, in particular to resource poor countries.

The globalization of ARTs influences the impact and experience of infertility in various ways. Some studies have shown that the availability of ARTs can have negative consequences. Since ARTs are generally speaking more applied to women's bodies, this can facilitate the view that women are held responsible for reproductive problems. Subsequently, ARTs might serve to reinforce cultural 'motherhood mandates' for women. At the same time, women's heightened embodiment of ARTs also leads to men being treated as the second sex in the field of ARTs (Inhorn & Birenbaum-Carmeli 2008: 180). In addition, the consequences of traveling ARTs have changed over time. In the beginning of 2000 a study to

male infertility in Egypt showed that the availability of ARTs doesn't necessarily take away the mistaken blame on women. This study showed that fertile women risked being divorced by infertile men (Inhorn 2003: 245). Inhorn argued that the risk of women being divorced was related to introduction of intracytoplasmic sperm injection (ICSI), the 'newest' reproductive technologies in the early 1990s. When ICSI was introduced 'unfortunately, many of the wives of these Egyptian men, who have ''stood by'' their infertile husbands for years, even decades in some cases, have grown too old to produce viable ova for the ICSI procedure' (ibid.: 1846).

More recently, Inhorn and Patrizio (2015) have argued that (better) access to ART might positively change gender relations in the non-Western world:

> 'Overall, access to ART appears to be changing gender relations in several positive ways through: (i) increased knowledge of both male and female infertility among the general population; (ii) normalization of both male and female infertility problems as medical conditions that can be overcome; (iii) decreased stigma, blame and social suffering for both men and women; (iv) increased marital commitment as husbands and wives seek ART services together and (v) increased male adoption of ART, especially for male infertility problems' (ibid.: 8-9).

Thus, while earlier studies have argued that the availability of ARTs in the non-Western world reinforces traditional reproductive ideas, the globalization and availability of ARTs may also come with positive consequences too.

2.4 Infertility and ARTs in Kenya

Overall, there is little known about infertility in Kenya. In 2007 the Ministry of Health Division of Reproductive Health published a review called 'Magnitude of Infertility in Kenya – Desk Review August 2007'. The Division of Reproductive Health received financial support from the United Nations Population Fund (UNFPA) for making this report. The report is based upon a survey in sampled districts and a review of existing studies on the

magnitude of infertility and common causes. According to this desk review, the primary infertility rate is around 2 percent and 10 to 30 percent of all reproductive-aged couples in Kenya are effected by secondary infertility (Ministry of Health Kenya 2007: 22-23). Looking at infertility and gender in Kenya this review points out that 'a woman's social status, direction in life, economic achievement, well-being and the very meaning marital life hinges around her ability to beget and rear children. The ability to beget children is therefore seen as a true mark of womanhood and as the pride of a man. A childless marital union is plagued by tensions resulting from numerous problems; social stigma, economics exploitations, and psychological pressure from the husband's relatives' (ibid.: 41). So, while women in Kenya generally suffer the most from infertility, men may also suffer from their infertility. The report makes the following recommendations:

> '(i) the Ministry of Health needs to take the leading role in addressing management, policy and research issues; (ii) an expansion of the research base to obtain data and evidence on various aspects of infertility; (iii) efforts should be made to standardize infertility management; (iv) STI/HIV & AIDS prevention and education strategies to include infertility as a key component; (v) urgent need for ART services in some selected private and public health facilities' (ibid.: 44).

Whilst these recommendations were made in 2007, Ndwega (2014) argues that infertility remains an entirely neglected reproductive concern in Kenya.

A relatively old article about infertility, written in 1993 (Leke *et al*.: 76), states that infertility in Kenya is mainly caused by STDs. The authors also mention poor access to reproductive healthcare and marked inequalities in care between rural and urban areas. Looking at gender in relation to infertility in Kenya, Leke *et al.* (ibid.: 76-77) mention that women experience a great pressure to have children which stems from economic and social security they provide. Nonetheless, a more recent article reports complementary findings. Nowadays public fertility care is still poor, simply because it is not a priority in the country. In 2014, there were less than ten well-trained IVF specialists in Kenya, all of which were working in private clinics. Moreover, Ndegwa (2014) describes that women in Kenya are still largely defined through motherhood (ibid.: 21).

Furthermore, in his dissertation, 'The Experiences of Infertility among Married Kenyan Women' Patrick Mugi Kamau (2011) refers to literature that is not available, but this literature revealed that previous studies and reports on infertility in Kenya focus on the (1)

traditional understanding of infertility and all its social consequences (Kanyoro & Onyango, 1984), (2) causes of infertility (Wamue & Getui, 1996), (3) consequences of infertility (Mburugu & Onyango, 1984), and (4) society's negative attitude towards infertility (Bara, 1961). However, there are hardly any studies that focus on the experience with infertility or ARTs. In particular, there are no recent studies that focus on the relation between gender and infertility in Kenya. Therefore there is a need for research to infertility in Kenya, and experiences with infertility that focus on gender in particular, to address and increase knowledge and awareness about infertility among stakeholders. This study will therefore focus on the experiences and practices of infertile women in Nairobi, Kenya by using a gender lens.

2.4 Relevance and research aims

As argued before, the experience of infertility is socially constructed and related to different factors such as religion, kinship, and access to care. As the reviewed literature has shown, gender seems to be an important factor in the experiences with infertility. In addition, available research on gender and infertility is mainly focused on the suffering of women or on the differences between men and women in relation to infertility (care). Moreover, as previously showed, anthropological research to infertility and gender in Kenya is scarce and limited. My aim is to gain insight into the experiences of infertile women in Nairobi, Kenya through a gender lens. I aim to do so without only focusing on the suffering of women or on the differences between men and women in relation to infertility. To do so, I will to analyze their daily practices and 'navigation' in relation to 'the field of infertility'. The term 'navigation' which comes from 'social navigation' which is used for an anthropological analysis of practice. This term refers 'how people act in difficult or uncertain circumstances and to how they disentangle themselves from confining structures, plot their escape and move towards better positions'(ibid.: 419). When referring to the 'fields of infertility', I refer to social fields as presented by Pierre Bourdieu (1984) as I will further elaborate on in the following chapter. In this thesis I intend to gain insight into the experiences of women in Kenya with infertility by addressing the following research question:

How do women in Nairobi, Kenya navigate within different 'fields of infertility'?

3. Theoretical Framework

In order to understand how Kenyan women's experiences with infertility are related to gender norms and how women navigate in the 'field of infertility', this chapter discusses relevant anthropological theory regarding gender, social experience and practice. First of all, the concept of 'gender as a lived social relation' will be discussed (McNay 2004). McNay explains that approaching gender as a lived social relation is the opposite of approaching gender as determined by structures. Further, to understand the daily practices and different experiences of women with the 'field of infertility', I discuss the concept of 'social navigation' (Vigh 2006). Concluding, to contextualize the field of gender in which the experiences of Kenyan women that face fertility issues are situated in, I will briefly discuss gender and the concept of 'woman' in the African setting. I will use Oyewumi's (2002) conceptualization of gender which informs renewing gender norms in the African context. Since the women's experiences in this study are also related to men, and in particular, how they talk about them, I will shortly elaborate on the concept of 'African men' (Spronk 2014). This concept reveals the complex relation between structures and gender identity within the Kenyan context.

3.1 'Gender as lived social reality' versus 'social navigation'

McNay and Vigh on agency

Lois McNays's (2004) idea of 'gender as a lived social relation' is contrary to the idea of gender as a 'structural location'. Gender in the latter sense is considered as a position within structures. Even though materialist feminists and cultural feminists differ in their conceptualization of gender, both approaches explain gender in this latter way. Material feminists argue that gender is a structural location within or intersecting with capitalist class relations, and cultural feminists believe that gender is a location within symbolic or discursive structures (ibid.: 175). According to McNay however, both material and cultural analysis fail to recognize that the forces of gender structures are not revealed when gender is approached as a fixed position within structures. According to McNay, gender structures only reveal themselves in the lived reality of social relations. It is therefore important to look at gender in relation to how people negotiate their lives, with other words *agency*. Only by looking at agency, the determining forces of economic and cultural relations can be made visible (ibid.: 175). McNay argues that, when looking at agency in this sense, it becomes

inevitable to look at experience. In McNay's view there are several problems with how 'experience' is approached by feminist thinkers. The problem starts with the belief that the analysis of experience is central to an understanding of agency. However, McNay argues that: 'an idea of experience is essential to an account of agency, but that it must be understood in relational terms rather than in an ontological sense as the absolute grounds of social being and genuine knowledge' (ibid.: 175). With other words, experience in this sense should be understood as related to agency, rather than to the nature of being. The concept of gender as a lived social relation approaches agency within structures as a way for individuals to make sense of their lives rather than a free choice.

In his explanation of 'social navigation' Henrik Vigh (2006) also looks at agency in relation to structures. He uses the concept of social navigation for an anthropological analysis of practice. As described before, social navigation refers to 'how people act in difficult or uncertain circumstances and to how they disentangle themselves from confining structures, plot their escape and move towards better positions'(ibid.: 419). In order to define social navigation as an analytical tool, Vigh moves the concept of 'navigation' from the *map* to the *environment*. He uses this analogy to illustrate the misunderstood manner in which the concept is most often used (ibid.: 419-420). Vigh argues that 'despite the fact that social environments are always moving and changing, the stability of socio-political formation in the context of social navigation is often taken for granted and conceptualized through an imagery of hardened and solidified surfaces and structures' (ibid.: 423). Social environments are in motion all the time, according to Vigh. People are constantly coping with these motions and act, adjust and attune to it (ibid.: 420). This approach gives the concept of social navigation a 'third dimension' when analyzing practice because it approaches movement within movement.

Looking at social settings, anthropologists tend to look at how they change over time *or* to look at how agents move within the settings. However, recognizing the third dimension of navigation allows anthropologist to see the interactivity between the two. Acknowledging practice as movement within movement, Vigh argues, enables anthropologists to focus on the intersection between structure, agency and change. This approach allows to look at how practice moves structures. The analytic tools of both authors focus on how individuals make sense of their lives and agency. McNay does so by looking at experience, and Vigh by looking at practice. In their concepts both approach agency not as a true essence of being, but rather as relational. By analyzing individuals' agency in either their daily experiences or

practices, both authors reveal the social structures that these experiences/practices are situated in. In the next section I will show how both authors similarly state that social structures should be approached as moving and relational by using Bourdieu's theory.

The influence of Bourdieu

In order to understand how structures such as gender norms have changed over time, McNay argues that agency around the notion of experience has to be rethought. She does this by reviewing Pierre Bourdieu's game analogy. Bourdieu discussed social life as a game:

> Bourdieu suggested that, just as in football, the social field consisted of positions occupied by agents (people or institutions) and what happens on/in the field is consequently bounded. There are thus limits to what can be done within a particular field, and what can be done is shaped by the structures of the field and by the position an individual has in the field' (Grenfell 2014: 67).

Habitus is the physical embodiment of cultural capital[7] of an individual and determines the field positioning and movement within the field (Bourdieu 1984: 127). Habitus is created by an interplay between social structures, including the family, and individual will or choice (ibid.: 170). McNay critiques Bourdieu's game analogy for the stabile and determinist structures of the field. Subsequently, McNay comments on the fact that 'whereas habitus may adopt to the objective demands of the field, there is no sense of countervailing alteration of the field by habitus' (2004: 180). In other words, while Bourdieu states that the field influences habitus, habitus doesn't influence the field. McNay wants to take Bourdieu's theory a step further, and also looks at the interactivity between the field and habitus, and the possibility of a changing field.

In line with McNay, Vigh critiques on Bourdieu's work to elaborate on the concept of social navigation. Like McNay, Vigh explores the possibilities of a changing field, which he calls social environments. To explain the importance of acknowledging the motion of social

[7] Bourdieu also developed other forms of capital, but since they are not relevant to this thesis, the other forms of capital are not discussed.

environments, in line with McNay, Vigh compares the concept of social navigation with Bourdieu's analogy of games. Vigh states that 'in Bourdieu's game analogy people may move in the field and therefore move in relation to each other and the field, but they don't have to worry about the movement of the field itself' (ibid.: 427). So like McNay, in developing his own concept he stresses the importance of a moving 'field'.

Besides critiquing on Bourdieu's work, McNay is also influenced by his work. McNay is inspired by the idea of 'actors that are able to occupy positions within social fields that are determined both by the distribution of resources within a given field and also by the structural relations between that field and others' (2004: 184). According to McNay, this approach allows interaction between experience and structures. Using Bourdieu's spatial metaphor to look at experience allows McNay to think of experiences as situated by and within social structures rather than being determined by invisible forces. Applying this to the concept of gender as lived social relation means that the position of actors in the field of gender is both related to one's personal experience *and* the structures of the field, with other words, the gender norms. By using the concept of gender as lived relation McNay shows that analyzing one's agency when looking at experience, helps in understanding the gender norms that one's experience is situated in. Moreover, she approach highlights the possibility of experience shaping gender structures.

Similar to McNay, Vigh states that individual's position in the field is relational and context specific. In other words: '[…] We all navigate, but the necessity of having to move in relation to the movement of social forces depends on the speed and volatility of change as well as the level of exposure or shelter that our given social positions and 'capital' grants us [cf. Evans and Furlong, 1997, Virilio, 2001]' (2006: 430). Social navigation is related to one's personal position in relation to change rather than just societal characteristics. On a personal level people might experience stability in some areas of their lives and change and uncertainty in others. Like McNay, Vigh shows that the position of actors in the field is both related to one's personal experience and the structures of the field.

Despite these similarities, there are also differences in McNay's and Vigh's theory. McNay looks at experience and gender, and Vigh looks at practice and change. Both of the authors insights are useful in analyzing Kenyan women's experience with infertility and how these experiences are related to gender norms and change. In this thesis, by analyzing women's experience with infertility, I will argue that these different experiences are related to

gender as a lived social relation. In addition I will use these insights to, by looking at practice and the social navigation, show that social structures in the 'field of infertility' are moving.

3.2 Gender and 'Woman' in the African Context

The theoretical concept of gender is based upon Eurocentric foundations developed by Euro/American feminist thinkers according to Oyeronke Oyewumi (2002). In an essay on conceptualizing gender, Oyewumi argues that this Eurocentric conceptualization and knowledge comes from the modern era. According to Oyewumi this era is marked by 'the expansion of Europe and the establishment of Euro/American cultural hegemony throughout the world' (ibid.: 1). Similar, gender research mostly comes from European and American studies. This has resulted into gender being an explanatory model in which the patriarchal nuclear family system is the basis. In addition, she argues that the concept of the patriarchal nuclear family is the grounding for Western gender theory. She describes the patriarchal nuclear family as following:

> 'The nuclear family is gendered family par excellence. As a single-family household, it is centered on a subordinated wife, a patriarchal husband, and children. The structure of the family conceived as having a conjugal unit at the center lends itself to the promotion of gender as a natural and inevitable category because within this family there are no crosscutting categories devoid of it. In a gendered, male-headed two-parent household, the male head is conceived as the breadwinner and the female is associated with home and nurture' (ibid.: 2).

Oyewumi describes how in European and American experiences gender is used to account women's subordination and oppression. In this gender model the concepts of 'women' and 'subordination' are used as universal. In contrary, Oyewumi states that gender is a social construct and that there are other forms of oppression and equality in different societies, so therefore woman and subordination in this sense can't be approached as universal concepts (ibid.: 1-2). Looking at gender in the African context, Oyewumi shows that gender 'transcends the narrow confines of the nuclear family' (ibid.: 2). Therefore, she argues that the problem with the conceptualization of gender in the Euro/American way is not that it starts with the nuclear family, but that it doesn't allow feminist thinkers to analyze gender beyond the structures of the nuclear family.

She explains this by using the category of 'mother' within the patriarchal nuclear family. The concept of mother within the white feminist thought is not possible to use as a category, unless mother is defined as wife of the patriarch. Oyewumi argues that there is no possibility of thinking about the mother as independent of her sexual ties to a father. However, Oyewumi states that based upon an African perspective mothers cannot be 'single' (ibid.: 3).

Oyewumi argues that the category mother within African societies is not defined by the sexual ties towards a patriarch. In contrary to Western societies, African motherhood is defined in relation to descendant. Further, Oyewumi states that within white feminist literature womanhood is incorporated with wifehood: 'Because woman is a synonym for wife, procreation and lactation in the gender literature (traditional and feminist) are usually presented as part of the sexual division of labor. Marital coupling is thus constituted as the base of societal division of labor' (ibid.:3). To illustrate the need of a different conceptualization of gender within the African context, Oyewumi gives several examples about the category of woman within the African society. These examples show that within the African society there are several and different understandings and realities of a 'woman' which are not related to the patriarchal nuclear family or wifehood. By doing so, Oyewumi highlights that the category 'woman' within African contexts challenges universalists thought of feminist gender discourses that are based up on the patriarchal nuclear family (ibid.: 4). As Oyewumi shows, gender norms and the category of woman is fluid. She concludes with stating that: 'Analysis and interpretations of Africa must start with Africa. Meanings and interpretation should derive from social organization and social relations paying close attention to specific cultural and local contexts' (ibid.:4). In accordance with Oyewumi, in this thesis I will argue that the category of 'woman' and 'womanhood' are indeed not first defined as the wife of the patriarch. In addition, I will use these insights to show how new notions of being a woman develop in the context of gender and infertility.

3.3 'African Men'

The term 'African men' is used as a natural category and justifies behavior by men that is considered to be morally or socially inappropriate, as illustrated by Rachel Spronk (2014) According to Spronk the term 'African men' is not only a term used by women and men in her research, it is a term which is also used in the field of global health. Spronk argues that

both in the academic context and in (post)colonial times, constructions of Africans as distinct people have contributed to use of 'African men'. She highlights that research on sexuality in Africa is closely related to HIV/AIDS and that this type of research is policy driven and therefore uses *a priori* categories. Moreover, Spronk emphasizes that in reports explaining sexual behavior of men in relation to HIV/AIDS for example, economic status is ignored and results are generated to Kenyan men in general. Spronk shows that, since research on sexuality in Africa is mostly focused on problems, it is related to multiple-partnered sex, infections and unwanted pregnancies. In sum, according to Spronk knowledge gained through research on sexuality is prejudiced and far from complete (ibid.: 506-507). Moreover, Spronk illustrates that during the colonial period the British used 'tradition' as a category to distinguish Africans and non-Africans. After the colonial period, Kenyan political leaders accepted and adopted these categories in order to fight to notion of inferiority. By doing so, they, according to Spronk (ibid.: 508) reproduced the assumptions about Africans as one race. This has resulted in the portraying of, specifically male, gender norms without keeping account of changes over time.

Speaking with the men themselves, however, Spronk found that gender norms in Kenya are changing and conflicting. The dominant notions of masculinity in Kenya are related to the patriarchal ideology (ibid.: 51). Nonetheless, masculinity is caught up in cultural contradictions. More specifically, being a man in Kenya is exercised through various ways but at the same time contested via paradoxical practices. The idea of 'African men' is for example used to justify (modern) polygamy. However, at the same time a man is supposed to sexually control himself and behave. On the one hand, men in her study identify themselves with the category of 'African men'. On the other hand, men portray themselves as different from the 'African men' (ibid.: 513-514). Spronk thus concludes that 'masculinity is caught up in the cultural contradictions of sex: gender is not a stable category, it is always in the making' (ibid.: 514). She argues that the use of the term 'African men' should therefore be seen as a performative act that is meaningful to the men themselves, but that both enables and limits them (ibid.: 514). When Spronk uses the concept 'performative act' in relation to the use of 'African men' she refers to a 'gender as performative quality that is both constructed and meaningful' (ibid.: 504). Thus, the use of 'African men' in this sense becomes an act that constructs male identity. In other words, approaching the use of 'African men' as a performative act helps in understanding gender as fluid and changeable. At the same, Spronk shows that men themselves are taking part in the construction and meaning

making of gender. Similar to McNay, she approaches gender as a social lived relation. By looking at the experiences of the men themselves, Spronk is able to reveal the social structures in which these experiences are situated. Further, she gives a deeper understanding of how men relate to these structures and vice versa. Experiences related to social structures such as gender norms can change between societies and on personal level. In my research both men and women often made use of the term 'African men'. Therefore, in this thesis I will use the concept of 'African men' to highlight the fluid aspect of gender norms. Approaching the concept of 'African men' as a performative act helps in marking this aspect.

3.4 Conclusion

In this theoretical framework I have showed and argued that approaching gender as lived social relation is a suitable theory to get a better understanding of how gender structures influence social experience and vice versa. In McNay's (2004) view agency in relation to experience should be analyzed in order to reveal invisible gender structures. So, by looking at how women experience infertility in relation to gender norms in this thesis, I will reveal the gender structures in the 'field of infertility'. Moreover, Vigh's (2006) concept of 'social navigation' shows how people navigate within social fields, or with other words, within the moving structures of social environments. Moving structures influence people's practices, and these practices, in turn, influence movement. However, the daily lives of people are not only related to changing structures. Their own position in relation to these structures influences the way people react, move and adopt to these structures. This explains why people move and act differently and therefore helps in understanding different experiences. So, on the one hand I will be looking at experiences, and on the other hand I will analyze practices, in order to reveal the changing structures in the 'fields of infertility'. To situate the 'field of infertility' in relation to gender in the Kenyan context I will use the conceptualization of gender and the category of 'woman' as presented by Oyewumi (2002). In addition, to understand how women talk and relate to men I will use the concept of 'African men' (Spronk). Approaching this term as a performative act is theoretically meaningful since it explains how gender norms are constantly changing and fluid in Kenyan society

3.5 Research questions

As described in chapter two, the research question that I am to answer in this thesis is:

How do women in Nairobi, Kenya navigate within different 'fields of infertility'?

Informed by the discussed theory, the related sub-questions that guide this thesis are as following:

1. How is gender experienced in relation to infertility and vice versa?
2. How do Kenyan woman relate to the concept of 'woman' in the context of infertility?
3. What do Kenyan women say about 'African men' in the context of fertility problems?
4. How can similarities and differences between women and what women say about men be understood in the context of current day Kenyan social-cultural context and expectations of male and female gender roles in particular?
5. What are the practices of infertile Kenyan women looking at different 'fields related to infertility'?

4. Methodology

In this section I will elaborate on the methods utilized in order to answer the research question. First of all, I will elaborate on the ethnographic study and stetting. Following, I will elaborate on the methods that have been used in order to answer the research question and how the data is this study is analyzed. Thereafter I will reflect on the limitations and my positionality during this research and finally, I will conclude with ethical considerations.

4.1 Ethnographic Study & Setting

For this ethnographic study fieldwork was done in Nairobi, Kenya. The main research site has been the Footsteps to Fertility Centre (FFC) which is a gynecological private clinic. Since the FFC is a gynecological clinic, the clinic also deals with other topic than infertility. The clinic has recently opened and during this research the clinic was still 'starting up'. This means that the clinic was not open every day, and on an average day the clinic was visited by four patients. In addition, it regularly happened that 'other people' like workers, painters or sales men working in medicine would visit the clinic. Together with my research colleagues Luca Koppen and Anna Jansen, I have spent ten weeks in Nairobi. As described before, Anna and Luca are research colleagues part of the Share-Net-project that conducted research at the same research site during the same period. Anna focused on the quantitative part of this project by using qualitative surveys, while Luca and I conducted qualitative research by using various ethnographic research methods which I will elaborate on later in this chapter. The criteria for the research participants in this study was 'anybody that is trying or tried to conceive and faces or faced fertility problems'. For this research age, socio-economic background, cause of fertility problems and years of trying to conceive did not matter. In addition, I have spoken to women with primary and secondary infertility. The social background of the patients varied. However, since most of the patients were recruited through private clinics in Nairobi, most of the participants had a middle to high socio-economic background and were living in and around Nairobi.

As described in the introduction, the FFC is part of the Share-Net collaboration and access to the clinic was therefore already been arranged before arrival. For this research the gynecologist, Doctor Ndegwa, and the receptionist, Jacinta, of this clinic have served as 'gatekeepers' and they recruited most of the participants for this research. Recruitment of participants was done by sending an email to all attending fertility patients of the clinic. In

this email the research was explained and patients were asked if they were interested in participating. The receptionist and the gynecologist have also approached patients individually by asking for their participation, and if patients agreed, their phone number was shared with me. Altogether, the search for participants resulted in seventeen interviews. Eleven of these participants were women facing fertility problems, and two interviews have been done with couples facing fertility problems. Moreover, to include other perspectives within this research and get a broader insight in the experience of infertility, I have interviewed four pastors and two gynecologists. For this thesis I will also use Luca's interviews, Luca's qualitative research focusses on policy and care but she also includes women facing fertility problems in her study. We have worked together in searching for participants but Luca interviewed different participants. Therefore we have decided to share interviews in order to have more data. Luca has interviewed nine women, one man. In total, twenty women, three couples and one men, two gynecologists and four pastors participated in this research. A few of the interviews were done together with Luca (see annex).

4.2 Data collection

Observations

In order to find an answer to the research question various qualitative research methods have been used, namely: informal conversation and in-depth interviews, ethnographic observation and focus group discussions. The first research method that I have used is 'ethnographic observation' of a social setting. This method describes the collection of information through all the senses – sight, hearing, touch, smell and taste – to 'take in stimuli from all sources of the cultural environment in which they are studying' (Whitehead 2005: 11). The whole body becomes a data-collecting instrument to gather stimuli that 'might have meaning for the members of the community, or that provides insight regarding their life ways' (ibid.: 11). During this research I have mainly collected data through seeing and hearing. Observations have taken place in waiting room of the FFC and during two focus group discussions. In addition, I have done observations during a support group organized by an NGO called 'Fertility Kenya' and during several church visits. The different observations are captured by detailed field notes.

Interviews

During the entire research period I have had many informal conversations with different participants such as taxi drivers, pastors, security guards, research assistants, university teachers and Jacinta, the receptionist at the clinic. An informal interview or conversation is quite similar to a casual conversation. The goal of this technique is for the researcher to 'participate in naturally unfolding events, and to observe them as carefully and as objectively as possible' (DeWalt & DeWalt 2011: 137). This method allows for insights into the point of view of the informants, because they will bring up the issues that are most relevant to them or want to share. After approximately two weeks, I have started to use in-depth interviews, with a duration between one and two hours. All the interviews were recorded with a tape recorder. Participants were free to choose the place for the interview. Interviews have taken place either at participants homes, the clinic or a café. Interviews always started with asking about personal history which was followed by specific questions in relation to experience with infertility. I wrote a topic-list before the interviews (see annex), however, during the interview I did not make much use of list which allowed me to respond as naturally as possible. Women were usually alone, however in two cases their children were around. In-depth interviewing has been my main method to gain information, because it allowed the interviewees to tell their (reproductive life) story and their experiences with infertility problems. Moreover, I have also done three couple interviews or so called 'joint-interviews' with husband and wife together.

The snowballing technique has been used to find more participants. Different social networks and communities have helped in helping the sample group grow. First or all, visiting a gynecologist, Doctor Wanyowike, in a private clinic 'next door' to the FFC resulted in a list with phone numbers of fertility patients that were possible participants and an interview with himself. Secondly, organizing two focus group discussions and my presence at a support group from an NGO called 'Fertility Kenya' also helped with finding participants. Third, a visit to two different churches resulted in two spontaneous interviews with a church member and a female pastor with fertility issues. In addition, I have asked all my research participants if they knew anybody else that would possibly be interested in participating and I recruited one more participant through this technique. Several church visits resulted in four interviews with different pastors.

Focus group discussions

The last research method I have used, are so-called ‘focus group discussions’ (FGD). For this methodology a small group of participants comes together to discuss a certain issue. The main characteristic of a FGD is ‘the interaction between the moderator and the group, as well as the interaction between group members’ (Wong 2008: 256). Wong states that: ‘FGD is an excellent method for collecting qualitative data where participants are able to build upon one another’s comments, stimulate thinking and discussion, thus generate ideas and breadth of discussion. It can produce high quality data because the focus group moderator can respond to questions, probe for clarification and solicit more detailed responses’ (ibid.: 259-260).

Two FGD’s have been organized at the FFC. The group members were recruited trough the clinic. Patients were invited by email and WhatsApp which were send by Jacinta. During the first focus group, all the group members were attending patients of the FFC. During the second focus group, some members from Endometriosis Kenya, an NGO that focusses on endometriosis, attended. Doctor Ndegwa gave a speech on their member day, and announced the FGD on the end of her speech. On the first FGD 6 women attended and 13 women were present during the second FGD. During the second FGD different women attended than during the first FGD. Both FGDs lasted around two hours. In order to moderate the FGDs a topic list was made beforehand. The first FGD was moderated by Anna and Luca and the second FGD was moderated by me. With consent of all the attending women, both times detailed notes were taken of what has been said.

4.3 Data analysis

For analyzing the data I have used the data analysis program called ‘ATLAS.ti’. First, I collected the transcripts of interviews, notes of observations and the notes of FGDs in one document. Following, I started with coding the interviews, subsequently I coded the FGD’s and I finished with coding my observations. Beforehand I made a coding scheme with codes related to specific themes such as gender in medical care, womanhood, and blaming women. The coding list also entailed a short description of the meaning of each code. During the process of analyzing new themes would emerge, so I kept updating the coding list. So, codes were developed from the empirical data. While going through the data, I had a printed version of the coding list in front of me in order increase the consistency and validity of the analysis. This type of qualitative analysis is also called ‘thematic content analysis’. This

approach is useful to present the key elements of respondent's account or to identify typical responses (Green & Thorogood 2014: 198). To minimalize reliability I looked at a frequency of key times such as gendered experiences with infertility, general experience with infertility, 'African men' and financial issues. Moreover I compared data between and within stories and to to maximize validity I analyzed deviant cases (ibid.: 219).

4.4 Positionality and limits

This research is mostly based upon how participants express their experiences with infertility and therefore I agree with Valentine (1999): 'Researchers need to reflect on how different interview constellations contribute to the production of particular relationships and the telling of particular stories' (ibid.: 73). My positionality influenced how the participants located themselves towards me but it also plays an important role since it influences how I interpreted the participants' stories. Being a researcher related to a medical clinic has led to some confusion. At the beginning of the study I have introduced myself as medical anthropologist, however, I noticed that the word 'medical' generated even more confusion. I quickly decided to not use the word 'medical' anymore and emphasized the fact that I am not medically trained. However, some participants would still approach me as a medical student by asking specific medical questions related to infertility. Moreover, my own position as a feminist and a researcher have influenced the interpretation of participants' stories by the research questions that I asked, the theories that I chose to use and the examples that I decided to show.

In addition to my positionality, being a young white women without children might could have led to the women identifying me as an outsider and influence their expression of feelings and thoughts. The same applies to the few men that I spoke with during the couple interviews; they might not have always answered honestly because of for example feelings of shame. However, my experience in the field didn't give me this impression. Several times participants would thank me after an interview and highlight the fact that they experienced the interview as a relieving moment, since 'they were able to share their feelings'. Some participants also highlighted that they valued the fact that they could talk with a stranger (me) because it made it easier to share their stories. In addition, I have received text messages from participants in which a similar message was shared. After organizing the FGDs Doctor Ndegwa received several emails from participants that expressed their gratefulness.

In regard of research limits, couple interviews come with some specific restrictions (Gerrits & Hardon). Couples might restrain each other from expressing themselves, interviewees might actually be reluctant to openly share their ideas when interviewed together with their partner and couples might deliberately attempt to generate a unified image of reality (ibid.: 6). Moreover, the use of this technique has showed to have both advantages and limits in regard of male involvement. While 'men are found to be more inclined towards personal disclosure in joint interviews compared to lone interviews', Gerrits and Hardon also refer to researchers that weren't able to involve men by using this interview technique. Similar, in this study I intended to speak with (more) men after interviewing their wife's, but most male partners refused to participate in both joint interviews and individual interviews.

Moreover, this research has some practical limits such as the sample (size) and a relatively short research time of ten weeks. Another limit of this research occurred while doing participant observation. As described earlier, the doctor of the FFC also focuses on other topics related to gynecology like pregnancy. So when doing participant observation in the waiting room, it wasn't clear which patient had fertility problems and which patient came to see the doctor for other reasons. In addition, the clinic was just starting up and therefore it regularly happened that 'other people' like workers, painters or sales men working in medicine would visit the clinic. As described before, the participants that we spoke to were mainly women with middle to high socio-economic backgrounds. This has implications for the sample. More specifically regarding the sample size, as mentioned above, I was not able to recruit any male participants that wanted to talk to me individually. Lastly, the three men that I spoke to during the couple interviews were men that did not face fertility problems themselves. Since this research is concerned with gender relations and infertility, it is therefore very important to be aware of the fact that this study is entirely based upon women's experiences and what women say about men. So besides the fact that this research is a story about stories, it is also a story based upon one side of the stories. In order to have a complete understanding of gender relations men need to be included in follow-up research.

4.5 Ethical considerations

Before leaving to the research site I received ethical clearance from the Amsterdam Institute for Social Science Research (AISSR) and a research permit for doing research in Kenya. In addition, this research is approved by The National Commission for Science, Technology and

Innovation (NACOSTI) which is the advisory institution of the Government of Kenya on matters of national science, technology, innovation and research. As described earlier, at the beginning of this research, to recruit participants, an email has been send to all the patients of the Footsteps to Fertility Centre. In this email possible participants were informed about the aim and procedure of the study. In line with the Ethics Code of the American Psychological Association (APA), I emphasized in this letter: (a) that participation is voluntary and whether someone decides to participate or not does not have any consequences for their relationship with the Footsteps to Fertility Centre or other infertility treatment, (b) the confidentiality of information obtained from the participants, (c) that participants may skip any question that raises discomfort, or discontinue the interview at any time, and (d) if a participant objects to any question, she or he is given an opportunity to inform the investigators of this objection. The participants that I recruited in other ways were orally informed about these ethical principles at the beginning of each interview. The study is 'partly anonymous': contextual information such as work place or village names are withhold and pseudonyms have replaced participants real names. However, I do mention the reals names of Fertility Kenya, the FFC, both the gynecologist and the receptions working in the clinic and the gynecologist 'next door' to the FCC, but I do this with their consent. For participants that could possibly feel any discomfort after an interview I had the contact information of a counsellor available and I was aware of the fact that talking about sensitive topics can create discomfort. However, there was no need to share this contact with any of my participants. Regularly participants would express how the interview itself served as a form of 'counselling'. According to several participants, sharing their problems with me helped them in emotionally coping with it.

During some interviews women got emotional talking about their experiences. Being aware of the sensitivity of the topic was helpful in these situations. When these emotional moments occurred I expressed empathy by holding a hand, touching a knee or offering a tissue. Moreover, I reminded the participant of the possibility of stopping the interview. However, in all cases the women continued talking and no interview had to be to be stopped. In addition, during couple interviews I was aware of some ethical issues that may occur when interviewing couples together. As mentioned before, like Gerrits and Hardon (2016) describe: 'partners for various reasons might restrain each other from expressing themselves', 'interviewees might actually be reluctant to openly share their ideas when interviewed together with their partner'. According Morris (2001: 6) interviewers should be aware of 'the

potential of stirring up antagonisms and conflicts of interests' during couple interviews. In two cases I was aware of information about one of the couples that was not mentioned during the interview. In both cases I did not ask any questions regarding that topic. In addition, I have not asked in-depth questions about previous relationships or marriages in presence of partners.

5. The gendered experiences of infertility

To understand women's gendered experiences with infertility, this chapter looks into the relation between how women experience infertility in relation to gender norms. In this chapter, I argue that existing gender norms, while highly influential regarding the experience of infertility, are changing, flexible and in constant making. First, I illustrate the different meanings and experiences of womanhood in relation to infertility to argue that gender is a 'social lived relation' (McNay 2004) rather than a position determined by invisible structures. Further by describing the women's agency in relation to their experience with societal pressure, I argue that the gendered experiences of women with infertility are related to both the gender structures of the field and their own position in the field. Moreover, I will use Oyewumi (2002) conceptualization of gender in the African context to highlight the renewing gender norms in the stories of the women in this study. To conclude, I will look at how women in this study make use of the concept of 'African men' (Spronk 2012) to argue that this term is a performative act which marks the fluid aspect of gender norms. In addition, I share the stories from the few men that participated in this study to confirm and argue from a different perspective that gender norms are changing and in constant making.

5.1 Experience of womanhood

When women in this study talked about how their issues with fertility influenced their feeling of being a woman, in most cases two extreme answers were given. They either said that infertility doesn't influence their feeling of being a woman at all, or they expressed that infertility does make them feel less of a women. Generally speaking, women with better socio-economic background due to a university college degree and/or a good job expressed that their infertility status did not influence the feeling of being a women. However, some of them reported different answers. The stories of these women show that gender identity is not just based upon their socio-economic status. Their stories highlight that the position of these women in the field of gender is both related to one's personal experience *and* the structures of the field, with other words, the gender norms. Building on the insights of these stories, I argue that the way infertility is experienced is affected by gender norms which are relational instead of 'an end in itself' (McNay 2004: 188). On the one hand, gender related to the patriarchal nuclear family like conceptualized by Western gender theory (Oyewumi 2002) applies to their stories. On the other hand, gender is experienced in different and renewed

ways which shows that gender is a lived social reality (McNay 2014) instead of a structural location. To illustrate this I will share two stories about two women called Anne and Esther.

Anne is 40 years old and is a pilot by profession. She was born and raised in Kenya but did her study to become a pilot in Florida, the United Sates. Anne has a boyfriend named Mark with whom she has been together for nine years. They met each other while working, now he works as an engineer. They want to get married, however he first needs to '*arrange some things in court*' because of his ex-wife. Her husband has three children with his ex-wife. Anne and her partner have been trying to get pregnant for about two years. As Mark already has children, Anne thinks that he experiences their issue with conceiving as different. In September 2015 Anne visited a gynecologist and found out that one of her tubes are blocked. Despite her blocked tube Anne got pregnant in a natural way last December but the fetus stopped growing after six weeks. She lost her pregnancy and started with fertility treatment at the FFC. When I asked her about the meaning of being a woman she described that for her to be fulfilled as a woman, she needs to be a partner and a mother:

> ***Anne:*** *Uh, I think uh I think a woman is a man's partner, I've never wanted to stay at home [not working] but I also believe that if I'm in a…you know for me Anne to be fulfilled uh I am happy in the relationship that I am, I am financially independent, that I do not need Mark. I have made more money than him, so I'm not with him because of money. I mean I can take care of myself, so I believe in a partnership. I also believe that, I really want to be a mother- it's very important to be a mother and the way I'm in the office is not the way that I am at home. So I cook, I clean, I enjoy it I like it when Mark does it, uh he grew up abroad [without maids] and they [Mark and his brothers] were all boys, so he's like really helpful when I'm really lazy but I believe that the home is mine and I just have to have children.*

The above story shows that Anne relates herself and the notion of womanhood to the patriarchal nuclear family like conceptualized by Western gender theory, like illustrated by Oyewumi (2002) . Like described earlier, within this theory, a woman is a man's partner and, subsequently, having children is part of being a woman. During our conversation Anne

described that for '*African women it is not 'normal'* to not have children. When I asked her opinion about the fact that African women are 'supposed' to have children, she answered by identifying herself with this notion: *'[..]I am supposed to have children. I have never not wanted to be a mother'*. Moreover, she referred to a situation in which a client called her a 'working career women' when he asked whether she had children or not. This bothered her she explained, because she '*doesn't want to be seen as a career women'* and she is trying to get pregnant. In this sense, the term career women represented something opposed to something that she wants to be. Thus Anne's notion of womanhood correspondents to the notion of womanhood related to the patriarchal nuclear family as suggest by Western feminist thinking (Oyewumi 2002).

This is in contrast with another woman I met at the Footsteps to Fertility Centre, Esther. Esther is 33 years old and she is busy finishing her psychology master. Her husband Gabriel works as an engineer. They met each other nine years ago in campus and they have been together ever since. Three years ago they got married. Since their wedding night they have been trying to conceive. When three months after their wedding night *'nothing happened'* Esther decided to go and see a gynecologist. The gynecologist found out that she has blocked tubes and advised her to try IVF. In September 2015 Esther did an IVF at a private fertility clinic in Nairobi, which was not successful. She '*wanted to find out what happened'* and went to look for a second opinion, and that is when she was diagnosed with endometriosis. Esther will probably do another IVF this year. During my conversation with Esther she explains clearly that having fertility issues never made her feel less of a woman. In addition, her husband once told her that *'whether you have kids or not it does not make you less of a woman, you'll still be my wife'*. She refers to this conversation as helpful. She calls herself and her husband both 'open-minded' to the option of not having kids. When I asked her about her personal opinion about being a woman she explained that it is not related to having children:

> ***Esther:*** *Euhm, for me being a woman is not about having kids, it's not about having kids, it's about, euhm, it's about, euhm, being able to, be like me, be courageous, be in a position to help others. (...) So I think, euhm, having the ability to stand with people, encourage them in the difficult moments and the happy moments, I feel that is my purpose in life, being there for people, yeah.*

Esther's personal opinion about what being a woman is clearly doesn't relate to the idea of African women as expressed by Anne. Moreover, she and her husband have their own ideas as a couple about what having a family means:

> ***Esther:*** *(…) As much as you would like to have kids of your own, but there is something else you can do cause having kids is about carrying on the family name, you as a woman taking care of your family and all that. But family it's not necessarily, it does not necessarily have to involve kids, like, euhm, when, when my husband says my family and it's the two of us, I normally laugh, I tell him, but he says yeah that's my family. So I've come to accept we are a family even if we are two, that is our family yeah.*

As opposed to Anne, Esther thus relates her gender identity as a woman to other aspects than having children, such as helping other people. In addition, their opinions about what a family or home means differs in terms of having children. So, the influence of infertility on their gender identity is related to their own opinion about what being a woman means, but also to their ideas about the family/home. Moreover, Esther's story also shows that having a supportive husband influences the way in which her fertility issues affected her feeling of a woman. Her position in the 'field of gender' influences how she experiences the gender norms. While these women share the same socio-economic background, their gender norms are different and 'under change'. This seems to affect the experience of their gender identity and, in turn, their experience of infertility is therefore different. This not only highlights that gender norms within the 'field of gender' in relation to infertility are changeable but also that gender (identity) is relational since it is based upon several and different social structures and circumstances. How these women experience their gender identity is partly related to their infertility and how women experience their infertility is partly related to the experience of their gender identity. Build upon these examples and several other examples in my fieldwork, following McNay (2004), I argue that gender is a lived social reality and that gender is experienced different. In turn, infertility is experienced different in relation to gender. By looking at agency the gender norms that these experiences are situated in can be further

analyzed. In the next paragraph I will therefore look at the relation between structure, agency and experience in relation to gendered societal pressure due to infertility.

5.2 Experience with societal pressure

In each and every interview the notion that infertility is a ‘women’s problem’ came up. All study participants reported that in Kenya women are being held responsible for fertility problems. In addition, almost all of the women reported to experience some sort of negative impact and pressure from society. This varies from being isolated from the community to family members asking questions about ‘getting’ children. Again, generally speaking women with lower socio-economic backgrounds seemed to experience more societal pressure than women with better socio-economic backgrounds. One of the women, living in small village, that participated in the first focus group discussion expressed that the community members didn’t let her around other children. In the village where she lives it is common for women to send other people’s children out for groceries. But when she asked a child of someone else to do something like that for her, people responded by saying that she should first get her own children before she can ask other people’s children to do things for her. This, for her, is very painful. Daisy, a 34-year-old single women working as a hairdresser, experienced something similar:

> ***Daisy:*** *(…) If another mother has, gets a baby, other women will be able to go there and hold that baby, but if I have no baby I am not allowed to go there and hold it [the baby].*

One could argue that these kinds of examples show that ‘traditional’ gender norms are still ‘the same’. It may seem that women that don’t identify with gender as related to the patriarchal nuclear family receive pressure from society. However, looking more closely at to what extent this happens and how this differs among women gives an interesting insight in how gender norms are shifting. Analyzing the agency in women’s experience with societal pressure helps in highlighting the flexible gender norms in the Kenyan context. Moreover, it is again too simplistic to argue that the degree of societal pressure women experience is only related to socio-economic background. The

following examples from different women but both with lower backgrounds illustrate this. For example, Eunice is 41 and was divorced by her husband because of her fertility issues. Currently she is saving money for an IVF. She is unemployed but has '*little jobs*' that are related to buying and selling clothes and jewelry. Eunice expressed that she didn't experience any pressure from her community, which is apparently due to her young appearance and her role in the church:

> ***Eunice:*** *They [the community] usually say I am not old. Then, ehm.. The second thing, I am a committed Christian [active church member, but not a nun], so they [the community] think that I am 'in the church' [as a nun]. So, you know when you are in the church, you can even stay, even 50 years without getting married or having a kid. Because you are, you are in the Church, you are a committed to the Church. So no one can ask you, they don't ask me anything.*

Eunice's story illustrates two things. First, the acceptance of childless women is related to gender norms. In this case it seems that she is begin accepted because of her 'young' appearance, and this illustrates that young childless women in Kenya are nowadays more accepted. Second, she is being accepted as childless women due to the position as 'nun' in the 'field of gender'. Another example comes from Suzy. Suzy is Suzy is a 46-year-old woman that used to work as a teacher, but is currently supervising a construction site at the church. Her husband divorced her because she couldn't conceive and currently she is single. Similar to Eunice, Suzy explained that she doesn't experience any pressure from society because of her (financial) status within the community:

> ***Suzy:*** *Mmmh, you know, there is something else in the society that they will take you to be a bother when you are not financially able, but when you are financially able they look at you with a different eye. So, so far I do not have any problem with the community, though I rarely intermingle so much with them because there is this fear that the married women have that you might steal their husbands (laughs). So, to a point, such kind of a confrontation I keep and maintain my distance, yes I keep my borders, yes.*

These stories highlight that having different positions a Kenyan woman, such as a church member or being financially independent, influence how gender norms are experienced in relation to infertility. Moreover, both of these women highlight how gender norms about childless women are flexible and fluid. Looking at the different experiences of Daisy, Eunice and Suzy show that the gender norms are different in the same (Kenyan) context and that these norms help in being accepted as childless woman. Following their stories I argue that the way women experience infertility is related to *both* their position in the 'field of gender' *and* the fluid gender norms within this field. Further, these examples show that the category of 'woman' as in Western feminist thinking is not universally applicable (Oyewumi 2002).

Another example is the story of Magy. Magy is a 47-year-old single businesswoman. She explained that she did experience pressure from her aunties asking when she will have a child. However, when I asked Magy about how the community reacts to her status as an 'older' childless women she also directly referred to 'changing norms':

> ***Magy:*** *Well, now in Kenya there are a lot more single women than you would imagine. There are so many! We keep saying, maybe it is the ratio of the men to the women, I don't know. But there are a lot more single women..*
>
> ***Aida:*** *Yeah?*
>
> ***Magy:*** *There are a lot more single women! And, and, and, older women.. I have friends, I, I know people who are my age, who don't have children. Some maybe are single mother, or others who maybe never have been married or even had children. So, it really is, it, it, it is more common, than not, actually.*

None of these stories are used to argue that women facing fertility problems don't experience any societal pressure. The fact that every participant mentioned that women are being blamed for fertility problems has to be taken seriously. Nonetheless, the above stories reveal how gender norms within the 'field of gender' in relation to infertility are changing. Moreover, these stories show how gender norms are relational and in constant making. If and how you

experience societal pressure does not simply depend on the solid structures of dominant gender discourses. Similar to the gender norms, the experiences of infertility in relation to gender are in constant movement. To understand the experiences of women, the experiences have to be situated in these changing gender norms in the Kenyan context. How they experience these norms is not only related to the changing norms, but also to their position in the 'field of gender'. These examples show that the gender norms within the 'field of gender' in relation to infertility are flexible and the experience of societal pressure therefore varies. Therefore it is simplistic to argue that societal pressure only depend on socio-economic background. These findings are contrary to the common focus of women as sufferers in studies about gender and infertility as reviewed in chapter two. However, as showed by Gerrits (2012), these 'success stories' are highly valuable since they are way to 'address the vulnerable position of infertile women at the conjugal, familial and community level' (ibid.:6).

5.3 Experience with 'African men'

Gendered expressions about 'African men'

The term 'African Men' was used in almost every interview. Generally speaking, participants used this term to make four negative statements about men related to fertility problems. All of these statements apply to fertility problems in general. So, it doesn't matter whether it is the man, or the woman facing fertility problems within the marriage. First of all, 'African men don't talk about fertility problems'. Second, 'African men can't have fertility problems'. Third, 'African men blame their wives' for fertility problems. Fourth, when fertility problems come into the marriage, 'African men will cheat and divorce their wives'. Some women indeed reported similar experiences. However, most of the women that participated in this research were still together with their husband and referred to their husbands as supportive. This also includes women with middle and lower socio-economic backgrounds. When most of the women in this study referred to 'African men', they were referring to other men than their husbands. So, when looking at the experiences of women with infertility in this study, the four negative general statements about 'African men' are partly applicable. In addition, when women talked about their own husbands they would refer to them as '*not the typical African men*' or '*different*'. Furthermore, three women that participated in this research are married to men from different countries in Africa. All women reported to have supportive

husbands, but all of them also highlighted that it would be different when they would be married to Kenyan men. For example, Abby's husband is from Tanzania and supports any kind of ARTs:

> ***Abby:*** *(…) In fact he had said even if, if they say 'you cannot carry', we can even go for surrogate mother, he was just open to all, all options, which really encouraged me to be honest, I wasn't expecting that from him, maybe because it's not really Kenyan men, maybe if he was a Kenyan men he would have already stepped off, married someone else, but he was very, very open to everything, yeah. Everything, including adoption.*

The above example, and other similar examples in this study show how the term of 'African men' is used as a performative act with a paradoxical aspect like explained by Spronk (2014). On the one hand the term represents a fixed stereotypical idea about how 'African men' behave in relation to fertility problems. On the other hand women use the concept to describe how different and changing their 'own' 'African men' are. Thus, the use of 'African men' in this sense becomes an act that constructs male identity. In addition, women exchanged the term 'African men' by the term 'Kenyan men' while it seems to contain the same static and stereotypical meaning. So, in this chapter I argue that the concept of 'African men' both represents and highlights how gender norms within the Kenyan context are fluid and changing. To show and analyze this further I will discuss the four general statements about 'African men' one by one.

'African men don't talk about fertility problems'

As described before, in this study it was hard to find male participants to talk about issues around fertility. Based upon these experiences one could argue that the first statement – 'African men don't talk about fertility problems' – is therefore applicable to this study. However, the fact that it was hard, but not impossible, to find men that were willing to participate also highlights the stereotypical aspect in the use of 'African men'. The men that participated in this study were all very open in sharing their experiences. In fact, some men were more 'talkative' than their wives during couple interviews. In addition, Lynne expressed

that in contrary to herself her husband Peter was very open to talk about their fertility problems with other people:

> ***Lynne****: I think men are usually, they have a lot of ego. They don't want seem like they failed. And they don't like to share their personal issues, specially African men. I would say my husband is different. When I was trying this process I was telling him, don't even tell, because I am quite reserved, And he went! And he told (laughs)! Telling his brother, his sister, his mother.. So I was like, I told him not to tell, but he doesn't know how to keep something inside. I am sure even if he was here [at home], he could have contributed to the research. He doesn't like to keep things to himself.*

At same time, during his study I came across one man, Alan, who faced fertility problems himself. Even though his wife Rose participated in this study, he didn't want to participate himself. Alan' example seems to illustrate that for 'African men' that face fertility problems themselves it is harder to talk about it than for 'African men' with a partner that faces problems. However, such statements can't be made based upon one example. So, I argue that the first statement – 'African men don't talk about fertility problems' – is *partly* applicable to this study. It is exactly the word 'partly' that makes the difference here, and that highlights the fact that neither the African men nor (male) gender norms should be approached as static. In contrary, this again confirms the fluid aspect of gender. Like the category of 'women' as conceptualized in Western feminist thinking, the term 'African men' is not universally applicable. Not approaching the use of the term 'African men' as performative concept fails in recognizing the fluid and renewable aspects of gender.

'African men can't have fertility problems'

While doing participant observation in the Footsteps to Fertility Centre the second statement – 'African men can't have fertility problems' – seemed to be widely applicable. During one of the many days that I spend in the waiting room I wrote down the following field notes in my journal:

When I walk into the room I see Jacinta sitting behind the desk. She looks at me, smiling, but with her mouth closed. I walk behind the desk, and greet her. It is quiet in the waiting room, upon entering I only hear the sound of the television in the background. Despite the fact that the sun is not shining today, it's hot . I have not seen the workers over the last three weeks but I can still smell the smell of paint very lightly. After I greet Jacinta we whisper about how she is doing and what we I have been doing these days. There are two women in the waiting room. The two women are sitting on the large four seater. Both of them are sitting on the ends of the sofa with their bags beside them which makes it not possible for another person to come and sit between them. Both women are swayed back and look straight at the white floor. While I am sitting next to Jacinta and helping her with making a table on the computer, I hear voices in the hallway. The voices come from a young couple that said goodbye to doctor Ndwega. The couple enter the waiting room and walk up towards Jacinta's desk. The man is holding a paper and asks Jacinta what to fill in. She answers him and then she tells him how much a consultancy costs. He pays with cash money, the couple and Jacinta greet each other and they walk away. I immediately ask Jacinta whether this couples are patients that came to see doctor Ndegwa for fertility issues. She replies that she doesn't think so and explains that the couple came here for the first time, and that she saw that the drug that doctor Ndwega recommended drug them has nothing to do with infertility (Observations waiting room Footsteps to Fertility Centre 23 March 2016 15:55) .

This observation is a representation of a regular day in the waiting room of the FFC. My reaction towards seeing a man in the clinic explains the daily reality of the waiting room. There were hardly any men, or couples, that visited the clinic. During an interview with the Doctor Wanyoike, a gynecologist by profession that works at a clinic next to the FFC, he confirmed to experience this in his own clinic. When he was asked about whether more men or women visit his clinic he answered:

Doctor Wanyoike*: Women, women, men even if they have a problem they would not come and it's very difficult to investigate men in this country because of, the belief that if they are able to perform sexually, then they are not infertile, they don't seem to understand that actually that you are sexually able does not mean that the sperms are normal. So there is a disconnection on that issue, so they refuse to come for checking, yeah. So you find that almost, it is very rare that you find the couple coming, the man and the wife, no, it's the woman who will come, then men, fifty percent may not come at all.*

Based upon Doctor Wanyoike's experiences in his clinic he argues that '*African men think that they can't be infertile'* and therefore 'African men' don't come for check-ups to his clinic. In addition, Jerimiah, the husband of Helen, told that he struggled with the fertility test that he had to do when they visited a gynecologist for their fertility problems. He explained that initially he didn't want his sperm to get tested, but after talking with Helen he had agreed. This seems to shows that the possibility of being tested as infertile was something Jeremiah didn't accept. Based upon my observations, these stories and other similar stories, looking at the second statement – 'African men can't have fertility problems' – this statement seems to be true. Without having talked with infertile men themselves, this insight shows something about the complexity of (male) gender norms in relation to infertility. Moreover, without the intention to talk on behalf of all Kenyan men, my observations and Doctor Wanyoike's insight tell something about the field of gender that women's experiences are situated in. However, this doesn't mean that this statement reflects a fixed gender norm that determines how women experience fertility issues. As showed before, the way in which women experience their fertility issues in relation to gender norms is related to their own position in the field. In addition, none of this is to argue that 'Kenyan men can't admit to have fertility problems'. However, analyzing this stereotype shows that the concept of 'Kenyan/African men' and statements like these should be approached as a performative speech act since that enables to get insight in the experiences of Kenyan women that face fertility issues.

'African men blame their wives for fertility problems'

Looking at the third statement – 'African men blame their wives for fertility problems' – this statement seems to be partly applicable in this study. During this study I came across two women, Daisy and Mercy, who explicitly described that their ex-husbands blamed them for infertility. In both cases their ex-husbands accused them of being a witch. All the women that were still married to their husbands reported different experiences. In contrary to being blamed, several women expressed that their relationship got better due to their fertility problems and that they feel supported. In addition, the few men that participated in this study, seem to contradict this statement. David's wife Sophia has blocked fallopian tubes. They have been trying to conceive for about one year. His wife is from eastern-Europe and David has lived in America for sixteen years. David describes that he is totally fine with the idea of not having children. David is not blaming Sophia for not having children, but leaves the decision totally up to her. Another example comes from Jeremiah. Jerimiah is married to Helen, who has endometriosis, fibroids, cyst and damaged fallopian tubes. Jerimiah and Helen have been trying to conceive for about 2 years. In November 2015 they have done an IVF but it failed. Helen told me before the interview that her husband is more pro-active in looking for (medical) information than her. When I asked Jerimiah about this he acknowledged this. So, instead of blaming Helen, Jeremiah actively looks for information about endometriosis and infertility on the Internet. What these stories, again, confirm is that when analyzing the contradictory use of the concept of 'African men' it becomes clear that this is a term that reflects the fluid aspect of gender norms and it therefore confirms the idea of gender as a social lived relation.

'African men cheat and divorce their (infertile) wives'

Similar to the third statement, the fourth statement – 'African men cheat and divorce their (infertile) wives' – seems to be partly true in this study. The few women that experienced divorce experienced this in a negative way. In all these cases the men wanted to divorce. Eunice, Suzy, Daisy and Mercy were left and divorced by their husbands because of infertility. Nadia has experiences with the stereotypical cheating 'African man'. She is married for 16 years to her husband and describes him as a good man who understands her. Nonetheless, she also expressed that she knows that her husband is cheating on her. However, the women that are still married to their husbands reported something contrary to these experiences. Besides the fact that most of the married women experienced support from their

husbands, most women also reported that the relationship was influenced positively because of the fertility problems.

> ***Sabrina:*** *Mmm, I think it has become more closer, the, the time we are supposed to do the [pregnancy] test he is always on my toes: are you okay, do you need something, he wants to take me out, he just want to keep me happy that moment, he will be extra, extra keen that I, so even to do the results, he will make sure he is always there, he's the one to pick the results so that is also something that surprised the doctor (…).*

The only married women that expressed a negative influence on the relationship because of fertility problems was Rose, a women with a husband that has low sperm count:

> ***Luca****: And did your relationship change because of the fertility problems?*
>
> ***Rose:*** *Yeah, sometimes I feel there is a gap.*
>
> ***Luca****: Yeah? Between the two of you?*
>
> ***Rose****: Yeah, between the two of us. Euhm, I think for him, he is very low. And when he is low, the relationship becomes, yeah there is a gap in between the relationship. There is some gap, always. I do what is necessary, he does what is necessary, but I still feel there is a very big gap in between the relationship, between us, it is different than before. Yeah.*
>
> ***Luca****: So how is that for you?*
>
> ***Rose:*** *It's a problem for me. It affects me because, euhm, when you are not receiving that kind of love from you partner, you find yourself, you find yourself on a down point. Yeah. Because, at this moment (…) I don't feel close, close together, because I feel so tired, there is a problem that is supposed to be tackled, that is supposed to be managed. But we are finding ourselves in a*

different direction, yeah, in a different direction that is seemingly, yeah, he his on his own side, I am on my own side, euhm, we no longer go for out, we no longer go for coffee, we lead a normal life, yeah, work, home, work, home, work, home. So there is a function [a social activity] maybe once in a long time, but I find it different from that particular time. Yeah.

Luca: *And has the experience of fertility problems played and role in this and if so, how?*

Rose: *Yeah, I'll tell you. Yeah, yeah. It is so different. Even the, euhm, even the sex life, even the sex life is totally different. It is not like the way it just to happen so often during that time. This time around it happens once in a while, yeah. So, it's totally different. And I decided it has really affected, yeah, it has really affected the mind, in a way the body.*

The fact that the only women who expressed to experience problems in her relationship is married to a men who has fertility problems himself, seems to show the complex relation with men and infertility. Nonetheless, again, such statements can't be made based upon one example. However, the different experiences of women show that the fourth statement – 'African men cheat and divorce their (infertile) wives' – in reality differs and are changing. Even though all participants used these statements to say something about African men in general, most of their 'own' African men are different. When analyzing what the few men that participated in this study say about this statement, this finding is confirmed. For example, Nate and his wife Wendy have a son and a daughter, and they are facing secondary infertility problems. They have been trying to conceive for five years but they don't know what the problem is. Nate and Wendy have never heard of IVF but want to go and see a doctor if they don't conceive this year. I spoke to them together and during this conversation Nate expressed that even though he experiences pressure from his family, '*the issue of infertility*' brought him and his wife Wendy closer. Something similar was expressed by Morgan. Morgan and his wife Tanisha have been trying to conceive for two years. They recently started to visit the clinic and his wife is diagnosed with hormonal imbalance. During a couple interview Morgan expressed that he and his wife are still '*great friends*'. However, this could also be related to 'selection-bias'. Like Gerrits and Hardon put it: 'The intention to study couples rather than individuals can lead to selection bias, because couples who agree to

participate in such studies might have more harmonious relationships and/or fewer disagreements about the study topic (unpublished paper : 10). Thus, to further analyze this statement, and the three other statements, individual male stories from male that face infertility themselves or have an infertile partner, should be included.

5.4 Conclusion

In this chapter I have showed that gender is a social lived reality (McNay 2004) by looking at the experiences of women with fertility problems. How women experience their gender in relation to fertility problems is relational and therefore different. Their experiences are situated and shaped by different social factors rather than determined by invisible dominant gender norms in the Kenyan society. The interactivity between gender, experience and infertility is represented in these stories. How women experience their gender identity is partly related to their infertility and how women experience their infertility is partly related to their gender identity. None of this is to argue that there doesn't exist such a thing as gender norms related to patriarchal nuclear family (Oyewumi 2002) in the Kenyan context and that these norms still highly affect women's experiences with infertility. However, the stories also have shown that these dominant gender norms are changing and fluid, and how women experience and react to these gender norms therefore differs. In addition, the varieties of ways in which society reacts to women with fertility issues and vice versa, show that gender norms are flexible and changing over time. Moreover, I have showed that the flexible and paradoxical use of the concept of 'African men' highlights the fluid aspect of gender norms. Approaching the concept of 'African men' (Spronk 2014) as a performative act helps in marking this aspect. Again, the concept of African men shows that gender norms are not determined by the invisible determined gender structures. Looking at what men say themselves confirms that (male) gender norms are in constant movement.

6. Navigating in the field

The previous chapter examined how gender norms are moving structures in relation to the experience of infertility and vice versa. Regardless of socio-economic background, the women in this study are constantly coping with issues around infertility and act, adjust and attune to it. When women in this study talked about their experience with infertility, they often referred to this as the '*journey of infertility'*. Approaching the experience with infertility as a journey highlight the different navigations of infertile women in Kenya. Similar to a journey, the journey of infertility contains different practices, experiences and paths. Nonetheless this term doesn't highlight what Vigh (2006) calls 'movement in a moving environment' when analyzing practice (ibid.: 421). So besides looking at how women that have fertility problems navigate, in line with Vigh, this chapter also explores the moving structures in the 'fields of infertility'. As in the previous chapter explored I the 'field of gender' in relation to infertility, in this chapter I will take look at four other fields in relation to infertility: 'the field of finances', 'the field of family', 'the field of sharing' and the 'the field of religion'. First, I will show how women move in relation to their daily lives and in relation to prospective positions regarding fertility problems. In regard of the speed and acceleration of change, I will argue that women's 'position within social environments influences the way they navigate and their ability to control its flow and movements' (ibid.:430). Finally, I will show that not only the women, but also other 'actors' also navigate within the moving field of infertility. I will show and argue that these navigations influence the way in which women experience their fertility problems and this, in turn, contributes to moving structures within the different 'fields of infertility'.

6.1 The 'field of finances'

A major structural barrier for women in this study was finance. Almost all women in this study that had used, or wanted to use ARTs reported to experience '*financial issues'*. Since the use of ARTs in Kenya is not covered by medical insurance, payment for treatment was an often-heard struggle in their stories. Most of the women in this study were not able to finance these medical costs by themselves. Looking at how women financially navigate, most of the women in this study coped with financial issues by asking for financial support from family members or in-laws. Lynne's husband for example, asked his family members for support when they wanted to do an IVF. In the case of Lynne and her husband, the immediate family

members were aware of the fact that the couple was facing fertility problems. However, there were also stories in which couples were experiencing financial issues but the family members were not at all aware of the fact that they were dealing with fertility problems or seeking for medical solutions. In these cases women coped with this by telling a different story. For example, Alexandra, is a married 35 year-old women and comes from a poor background. Alexandra told her family members and her husband that she needs money for a medical procedure, but they didn't exactly know what it was for. After sharing this with her family, her family organized '*something like a function, like a tea, a get together'*. So without exactly knowing what for, the family of Alexandra collected money for a '*medical procedure'*. Alexandra's husband Joe knows that she has difficulties getting pregnant, but he also doesn't know that she needs money for an IVF. By telling him that she has '*difficulties with getting pregnant'* but not explaining what these difficulties contain , she manages to get his support.

Moreover, an often-heard issue is that people with from lower socio-economic backgrounds can't afford ARTs such as IVF. As one of the gynecologists, Doctor Wanyoike that works at a private clinic and participated in study puts it: *'[…] IVF is costing about 400000 (Kenyan shillings) in the private sector, that is about 4000 dollars, just a lot of money for an average Kenya. They don't even earn that in a whole year, some people here live in about one or two dollars in a day, so it's a lot of money*'. Nonetheless, Alexandra's example shows that women coming from lower socio-economic backgrounds that face fertility problems do navigate themselves through these financial structures by, for example, asking family members for help or hiding the reason for treatment. The women in this study thus adjust and attune to the financial issues which occur while facing fertility problems. Highlighting Alexandra's agency in relation to her practice in the financial field reveals the financial structures her practices are situated in. The financial structures influence her practices, and vice versa. On the one hand, Alexandra organizes '*something like a get togethe*r' because of financial barriers. On the other hand, by organizing this she changes these financial barriers on a personal level. This shows that the structures in the financial field are not solid, but again they are flexible and how women navigate through these structures therefore differs.

Another example of how women from low socio-economic backgrounds financially navigate is the principle of 'merry-go-round'[8]. Even though the merry-go-round didn't gave her enough money for in IVF, Nadia participated in a merry-go-round which enabled her to see a doctor. Nadia is 42 years old and sells dresses on '*the street'*. In this study Nadia was the only one that had participated in a merry-go-round. However, during my presence at a support group organized by the NGO Fertility Kenya, the only NGO in Kenya that deals focusses on infertility, this concept was openly several times mentioned when women shared their experiences with infertility. Again, this shows that the structures of the financial field are flexible. Moreover, illustrating Nadia's agency in her practice of participating in a merry-go-round shows how she navigates herself through these structures. Again, the concept of social navigation highlights how practices influence the structures of the field and vice versa. In this case, the financial structures influence that Nadia participated in a merry-go-round, and by participating in a merry-go-round women can influence the availability of medical treatment on personal level. I therefore argue that in these stories there seems to be an interaction between structure, agency and change.

A few women that were planning on doing an IVF did not receive financial support from their husbands. Luckily, these women were in a position in which they were able to cover the medical costs by themselves. While one may consider that a lack of financial support puts the women in a disadvantaged position, some of the women in this study said to experience this as an advantage. For example, Cecile is 38-year-old woman who teaches French at a private school in Nairobi, said that her relationship didn't change in a negative way because she used her own money to finance the IVF:

> ***Cecile:*** *I used my own money. Yeah. That, that was the good thing, because if I was asking for his own money, that's when now he'll be feeling the pinch. You know, I felt the blow, when, the baby, they told me it didn't work. So, you can imagine, if I was using his money, it would have been worse. But, yeah, euhm, but, but, okay, I have been forced to lie to him at the second time, so there are all*

[8] This concept is used to refer to: 'self-help groups formed by individuals to pull their resources together for the purpose of uplifting their standards of life. These self-help groups acquired the name merry-go-round because they pull their resources for a member at a time until all members are served then start again from the first member to receive the pooled resources. So they keep on rotating like a merry-go-round' (Makhanu 2006 : 6)

these games you have to play, because if he gets to know that I am really ''coughing all that cash'', it is not going to be good. You get it? Yeah.

In addition, the way in which women with good socio-economic positions are able to financially navigate themselves, make them also look for other creative ways to get their husband's corporation for an IVF. Like Cecile expressed in the above story expressed: '*there are all these games you have to play'*. Another example comes from Brenda. She is 33 years old and works as for an '*American non-profit with a mission to train and empower women and kids to find decent jobs'*. Brenda and her husband Mark are trying to conceive for about one year. While her husband wanted to wait before seeking medical assistance, Brenda went to see a gynecologist by herself. Because of her relatively good financial position, she was able to do so. Brenda looked for information about infertility issues on the Internet but couldn't find answers to her questions since she feels that her menstrual cycle is perfect. Without telling him, Brenda went to visit a gynecologist. As she expressed herself, she decided to '*blindside*' him, because she went to the gynecologist without telling him. Later on she shared the information that she got from the gynecologist with her husband and she feels that '*he became more open to come and see the her [the gynecologist]'*. So, she concludes that '*the next appointment, I will try to bring him along*'. This example shows that the 'field of finances' is closely related to the 'field of gender' in relation to infertility.

However, when couples decide visit the FCC together, the women are being checked first. During an interview with Doctor Ndegwa she confirmed that she firsts *'checks'* women, and explained how she navigates with financial structures when a couple comes to see her:

Doctor Ndegwa: *I do because at the beginning I was like no, no, no we have to test everybody and then women would come and we have tested them and when they are the ones with the problem, the man doesn't come anymore, because he knows okay I'm okay. So I start with the woman, because I have seen very cocky men, I'm sorry, I have seen men and it is true, unfortunately most of the time it is the man paying for the consultation heh, so if you first do him and he is okay, he will not come back.*

In her work, the financial structures (and gender norms) influence the way in which doctor Ndegwa navigates herself towards her patients. Subsequently, this influences her patients' experiences with infertility. By looking at Doctor Ndegwa's practice it becomes clear how structure, agency, and practice are all interrelated with each other. Experience in this sense is thus not only related to women that face fertility issues, but to all the other actors in the field of infertility. The above example shows how other actors, such as gynecologists, also navigate themselves through the field of finances in relation to infertility. The above examples also clearly confirm what Vigh (2006) and McNay (2014) both argue, fields do not stand by themselves. Fields are also related to other fields. Like the above examples shows, the field of 'finance and infertility' is closely related to the 'field of gender and infertility'. In her work, Doctor Ndegwa acts and reacts in relation to the 'field of finances and gender' in relation to infertility. By doing so, her agency influences the structures of these fields but these structures also influence her practice. Thus, there is not only an interaction between structure, agency and change within fields, but also between fields.

Important to keep in mind when discussing financial navigation is that the women participating in this study were mostly recruited trough the FFC. This means that these are mostly stories from women that used, use intent to use ARTs. The stories of women that can't afford using ARTs are less represented. Nonetheless, the few stories of the women that can't afford ARTs show that they too navigate themselves in the moving fields of gender and infertility. Like described before, Vigh argues that, on a personal level, if and how people navigate themselves is related to one's personal position in relation to change rather than just societal characteristics such as socio-economic background. People all navigate in their own way and might experience stability in some areas of their lives and change and uncertainty in others. (ibid.: 430). So women with the same, low socio-economic, backgrounds might have the ability to organize a merry-go-round or ask family members for financial support, while others don't. However, it doesn't mean that the women that are not able to financially navigate themselves, are not able to navigate themselves at all in the moving 'fields infertility'. In the next section I will show how these women also move and navigate in their moving environments and how this relates to their experience with infertility.

6.2 The 'field of family'

Another field that women navigate in, is the 'field of family'. Looking at the practice of women in this study reveals the changing family structures their experiences are situated in. In this study, an often-heard alternative for ARTs is adoption. As described in the previous chapter, Eunice is 41, single and saving for an IVF. She is unemployed but has '*little jobs*' that are related to buying and selling clothes and jewelry. Whenever she doesn't manage to safe the money by the age of 45, she says, will adopt. She expressed that she '*found*' a friend that is willing to donate his seeds. Eunice lives in a small community and to avoid receiving pressure from outside, she will move to another place when she decides to adopt. Even though Eunice might not have the financial means or a supportive husband, this example clearly shows how she navigates herself through the 'field of family' in relation to infertility. By looking for a friend that is willing to donate sperms, or by moving to another place when she adopt, she actively navigates herself. Looking at her agency in these practices reveal that the structures that her experiences are situated in, are different from the patriarchal nuclear family. Another example of how a single woman without husband or financial means navigates herself comes from Suzy. As described in the previous chapter, Suzy is a 46-year-old woman that used to work as a teacher, but is currently supervising a construction site at the church. Her husband divorced her because she couldn't conceive and now she decided that she will either live alone, or marry a man that already has children:

> ***Suzy:*** *I'm not married [now] but I got married at an age of 24 and after we discovered that I could not…maybe I don't know how to put this. After 6 years of trying to get a child the man became impatient and left and I was so hurt and I felt that such kind of a thing should never happen to me again and I decided that if I if I have to get married again I will have to get married to a man who has children.*

Important in the above example is to emphasize that based upon her experiences, she *decided* only to marry again with a man who has children. Her practice reveals how her agency is situated. By acting and reacting to this, she is able to navigate herself through the 'field of the patriarchal nuclear family' in relation to infertility. A similar example comes from Daisy. As mentioned before, she is a single woman that is 34 years old and works as a hairdresser in

a hair salon. Daisy decided to have 'fun' and by interacting with men in 'town', away from her own community, she accomplishes this:

> ***Daisy:*** *I don't want people to see me, but I realize life is out there, without friends, without husband, without kids, life is good and it is sweet. Okay, around here they know me, outside there (in town) they don't know me, so I go out there. I don't have much fun around here, I have fun out there, in here I come to sleep, when I'm sleeping nobody will talk bad about me, but out there, I have fun, there is the life.*

The examples of Eunice, Suzy and Daisy clearly show how these women 'disentangle themselves from confining structures, plot their escape and move towards better positions' (Vigh 2006 : 419) Analyzing the above practices also show that regardless of socio-economic background, these women all find their own way in how they navigate themselves. Again, the different ways in which these women navigate and their ability to control the issues they face because of infertility, depend on their own position within their social environments. None of this is to argue that these women didn't experience any negative consequences during their 'journey' of infertility. It is precisely how they move in response to, and within, these negative consequences that shape their journey. These stories highlight the interactivity between structure, agency and experience. The structures in the 'field of family' influence, to a certain extent, the way in which these women navigate themselves. Based upon their own position in relation to these structures, their agency makes them to navigate and experience different practices. Subsequently, their experiences shape different realities which in their turn contribute to the structures in the moving field of infertility.

6.3 The 'field of sharing'

The structures in the 'field of sharing' in relation to infertility leads women to be cautious about sharing their problems with fertility. Most of the women that participated in this research expressed that they do not share their fertility problem with anybody. During the first FGD this was one of the first topics that came to light as described in the following field notes:

Peninah says that not a lot of people want to talk about it [fertility problems]: 'we tend to keep it for ourselves'. Anna [my research colleague] responds by saying that she has heard other people say that too, and that in the Netherlands it is the same, she uses the word taboo. Then Anna asks Eunice how she feels about this, and if she shared her experiences with friends. She answers that she is not sharing it with a lot of friends. She had one friend she talked to about it, who also had some experiences with IVF. But in general she keeps it to herself and maybe shares it with people that are very close to her. Luca asks the group 'why do you think that it is?'. Abby responds that it is considered a private matter in Kenya and that it is seen as something that is between you and your husband. If you would tell other people they might laugh at you. As the effect of this, you want to keep it to yourself and hope that a miracle or something will happen. She then adds that she trust a stranger more to tell about her infertility but not her mother in law.

However, when going in further detail and asking about which people are aware of their fertility problems, I learned that in most cases the women did tell their problems to their closest family members or friends. So, even though all the participants all had at least one family member or friend that were aware of their problems, at the same time they expressed that they couldn't *share* their problems with anybody. Tara for example, expressed that she doesn't talk about her problems with anybody. However, when my research colleague Luca, asked Tara about whether her mother and sister know about her fertility problems she answered that they know about the fact that she is facing fertility problems, but that she didn't 'opened up' to them. Nonetheless, later in the interview she referred to some of her colleagues that she opened up to:

Tara: *I just opened up to one lady who was in the office, she [a colleague] told me, remember that woman from the office, you know right, now she is getting her twins. So, I was like oh I'm happy for her, I do. So, I talked to her she [pregnant collegue] told me it was with IVF. Even right now in Mogadishu [at work] we*

have a lady who unfortunately way back in 2009, 2010, her one tube was removed, right in Mogadishu in 2012 another tube was removed, so she is just without any tubes, but as we are talking she has a baby boy.

Tara's story illustrates what all women in this study expressed to experience. On the one hand, they expressed that they don't share their stories with anybody. On the other hand, when asking in further detail, all the women shared their stories with at least one person that experienced something similar. Based upon the above examples and other examples from this study, it seems that navigating through the 'field of infertility' is experienced as a *'lonely journey'*. While the women in this study all have some immediate family members or friends that *know*, there are hardly any people around to *share* their problem with. In their stories, the discrepancy between knowing and sharing becomes important.

Looking closer at how women navigate themselves in order to share their stories, it seems that women find their ways to other women that share the same experience. Whether another women shares the same experience or not, seems to be a key condition for the women to share their stories. For example, during the FGD one of the participating women said: *'going through IVF you find friends'*. Finding women to share their personal experiences through IVF was a common topic in the stories of women in this study that used IVF. They, for example, met other women, which were doing an IVF at the same time, in the waiting room of the clinic. In addition, some women in this study were members of Fertility Kenya. Fertility Kenya is the only NGO in Kenya that organizes support groups for people facing fertility problems. Most of the participants in this study were not aware of the fact that this NGO existed. However, the few active members expressed the benefits of sharing their experiences with other women through Fertility Kenya:

***Nadia**: Eh, Fertility Kenya is good, I go, when I meet, I feel, in fact I feel very good. Okay, I feel very comfortable, because we are sharing the problems, we share. You see, you are not the only one, there are other persons, you know. Even when you see that someone is pregnant, you see that there is hope. Even though she may have not gone through the IVF, but you see there is hope. There is*

support, they can't abuse you, no, because you have met each other through this [Fertility Kenya], you talk, you share, I think that is good.

This story is similar to the feedback that was received after organizing the support groups. During the interview with doctor Ndegwa, she referred to emails that were sent after organizing the second support group:

Doctor Ndegwa*: Like those women [the women that attended the second FGD], they were like 'I am not the only one' and they were so happy, I think we got some emails heh, Jacinta showed you some emails of women who were extremely happy that they actually came and yeah.*

Interpreting how all the women in this study at least found one person that they could share their stories with, and experienced this as something positive, through the lens of social navigation, highlights that the structures in the 'field of sharing' in relation to infertility are not as solid as they seem. Again it shows that the 'field of sharing' is related to the 'field of infertility' and vice versa. Their practices and how they navigate themselves in this field highlight the interaction between structure, agency and change. Even though the structures in the 'fields of infertility and sharing' make infertility a 'secret' topic to talk about openly, women's agency within these structures make them to navigate themselves and talk about their fertility problems with other women. Subsequently, these practices contribute to the movement of structures within the 'field of sharing'.

6.4 The 'field of religion'

Besides sharing their stories with women with similar experiences, the women in this study also expressed to share their stories with God. In Kenya there are hardly any support groups, NGO's or other institutions that deal with the issue of infertility. When the women in this study were asked about where they receive emotional support from, religion seemed to be the most important source. When talking about religion in this sense, they all referred to Christianity. As Clara puts it:

__Clara:__ Well the thing with religion in Kenya is that it's the only support structure, if I can put it that way, because the state is so deficient that, you know, whether it is with other illnesses, or fertility, or even just basic uh feeding the family, how should I say, you know, the state is non-existent. So the next step you'd think would be family but everybody's struggling so much so we just try to make the ends meet. So family cannot step in, yeah, because they have their own daily struggles, that kind of don't leave room, even for emotional support. So the church then becomes the only support system, so whatever topic you pick, Kenya's church will feature very strongly in it because you know that's the only institution that will catch you when you fall regardless of what problem you were dealing with.

Infertility might not be a topic that is openly discussed in the church. However, based upon observations in the church and interviews with several pastors, it seems that infertility is a topic that, again, is being discussed 'secretly'. This shows that the 'field of religion' is related to the 'field of sharing' in relation to infertility. The topic of infertility however comes across different chapters in the Bible, and it may occur that during a mass or a private counseling session these chapters are discussed:

__Aida:__ And are these stories [infertility stories in biblical chapters] shared in church or, I don't know?

__Pastor Munyoki__: We share the stories mostly in counselling situations but of course when you are preaching from it [the Bible] and you get to that chapter so you tell the story, but if somebody comes to you for counselling then you can directly go to that story and bring out some lessons for them.

Attending several Sunday Masses, this is also something that I have observed. Religion can be seen as a vehicle which helps women navigate themselves through the 'field of infertility'. The women themselves can navigate by approaching a pastor for counseling. Helen, for example, approached her pastor before she did her first IVF. She expressed that she '*wanted to know what the church thought about this issue, and luckily she got his blessing*'. In

addition, not only the women themselves but churches also navigate themselves in the field of infertility. Since infertility is not a topic that is discussed openly, the church looks for other ways in which they can support woman. Besides sharing biblical stories related to fertility problems, women that have experienced fertility problems and conceived hold testimonies in church. Pastor Jessica for example, a female pastor that also experienced fertility issues herself said '*I usually share it with women as a testimony'*. However, she started sharing her story as a testimony after she was 'successful'. She also said that she has never witnessed a testimony from a women that wasn't 'successful'. According to pastor Jessica, only women that conceive hold testimonies. When I asked her why that is, she explained that *'people don't want to be seen as weak'*. In our conversation she later referred to a women that came to talk to her after she heard Pastor Jessica's testimony:

> ***Pastor Jessica****: She [a woman facing fertility problems] is in the leadership and we pray together, and when I was sharing the testimonies after I had the baby, she heard. So I think when we share, and I also shared among the young ladies who have not yet gotten married, I shared how I prayed, how I waited. So then when this lady had her wedding and a baby was not forthcoming she came to talk to me. I am having this challenge, we need to pray together. So I think, if people are open about their experiences, then eh other people would not be so afraid to approach them to seek for help, yeah. I think openness also in the church.*

Even though the stories of 'unsuccessful' conceiving are not shared, the example of pastor Jessica shows that the testimonies of 'successful' women can serve as a form of support. So, without actively and publicly organizing support groups for women facing fertility problems, churches navigate themselves in various ways in order to offer support. Another example comes from CITAM (Christ Is The Answer Ministry) church. CITAM is one of the biggest churches in Nairobi, and have an average of fifteen thousand members. During an interview with two pastors about how the church addresses fertility issues, pastor Erik described that in their church the pastors *'quietly'* link women that face fertility problems with each other:

> ***Pastor Erik****: Yes, we can't say there is a group I can show you tomorrow and tell you this is a group of women who have no children we don't have such but we*

link people quietly and privately because one of our job is an issue of confidentiality so you don't just go there and tell people other people's stories. So even the one we connect we ask them for their consent "can I talk to somebody else over the same issue and I connect you?" if they say yes we will do if they say no we respect them.

In addition, this church has another way of discussing fertility issues, namely via a radio station. The radio station is called Hope FM, and gives women the opportunity to anonymously ask questions: '*There is a gynecologist that every other Thursday talks about gynecological issues from 10:00 until 12:00'*. The pastors explained that women could ask questions about any gynecological issues related to the reproductive system and infertility is an often-discussed topic. Even though this is just one example of one church, the practices of CITAM show how other actors, besides the women facing fertility issues, navigate themselves through the 'field of infertility'.

6.5 Conclusion

In this chapter I have showed how approaching the experience of infertility through the lens of social navigation (Vigh 2006) helps in disclosing the interactivity between structure, agency and change. By analyzing their practices, I show how the women in this study move in relation to different fields related to infertility, such as the 'financial field', the 'field of family', 'the field of sharing' and the 'religious field'. I have showed that all of these fields are interrelated and that there is a constant interaction between the structures of these different fields. Moreover, I argue that, based upon their own position in this field, the women act and react towards different positions which subsequently leads to a changing environment. This explains why and how all the women experience infertility in different ways, and with a different 'speed'. How, if and when women need to react, and their capability to react to the field of infertility is different. Like within a journey, the journey of infertility has different paths, and different people, such as doctors and pastors, that the women meet along their journey. The way in which these people act and react to both the structures of gender and infertility, as well as the experiences of women, all contribute to movements in the 'field of infertility'. Looking at the practices of women, pastors, and gynecologists shows movement in the moving 'fields of infertility'.

7. Conclusion

The aim of this research has been to gain a better understanding of how experiences of infertility are influenced by gender and how women act upon this. On the one hand I have illustrated the gendered experiences of infertile women in Kenya as a social lived relation (McNay 2014), and on the other hand I have analyzed their practices through the lens of social navigation (Vigh 2006). By focusing on agency in either their experiences or practices, I have situated their stories and revealed the different and moving structures in the field of infertility.

An analysis of the personal experiences with womanhood and societal pressure showed that gender is a lived reality (McNay). Moreover, I have argued that gender norms in relation to infertility in the Kenyan society are moving. Rather than being determined by invisible gender structures, gender identity is a lived social relation and situated in a field of moving structures. The dominant category of 'woman' within Western feminist thinking is not completely applicable to the experiences with womanhood in relation to infertility of women in this study. In addition, the changing gender norms make it possible for women to experience new female gender identities that are not based upon the patriarchal nuclear family. This challenges the universalist beliefs of gender discourses based upon the patriarchal nuclear family (Oyewumi 2002). I argue that the way women experience infertility is related to both their position in the 'field of gender ' and the fluid gender norms within this field. By looking at what women say about 'African men' in the context of infertility I have emphasized the changing gender norms in Kenya. This is confirmed by the experiences and stories of various – albeit few - Kenyan men whom I spoke with. In addition, I argue that the concept of 'African men' (Spronk 2014) should be approached as a performative act. Only by this approach the moving structures in which the concept of 'African men' is constructed, are revealed.

By discussing the social navigation (Vigh 2006) of women in different fields related to infertility I have showed how there is an interaction between structure, agency and change. The women in this study all differently navigated themselves in relation to changing structures towards different positions. I argue that the experiences of infertility are situated within the structures of different 'fields related to infertility'. The fields of gender, infertility, finances, sharing, family, and religion are constantly related to each other. If and how women navigate in these fields is related to more than their position in these fields. Social navigation

is related to the moving structures of the field and other fields. I have showed that all the women act, adopt and move in reaction to the structures of different fields. I do not argue that the women in this study didn't experience any negative consequences during their 'journey' of infertility. It is precisely how they move in response to, and within, these negative consequences that shape their journey. In addition, precisely these movements subsequently move the structures in the fields. Moreover, I have showed that other actors in the field, such as gynecologists and pastors, also navigate in order to move and adjust themselves to the moving fields. The navigations influence the way in which women experience their fertility problems and this, in turn, contributes to moving structures in the different fields of infertility.

As described in chapter two, research to infertility in Kenya is scarce. In addition, fertility care is poor and there is hardly any attention paid by the Kenyan government to address issues around infertility. This study addresses different structures that the experiences of women are situated in. As this study has showed, one of the main issues of women facing infertility is related to the 'field of gender' and it is therefore important to include men in studies to experiences with infertility in Kenya. Moreover, this thesis has highlighted the different side of experiences in relation to gender compared to existing literature. Without neglecting the impact that infertility can have on women, I have showed that the women in this study are more than just 'sufferers'. I believe this approach can be valuable in how infertility is addressed as it gives a more complete insight in the *different* experiences women that have. In line with Gerrits (2012), I therefore argue that it is not only interesting but also needed to further inquire the different experiences of women with infertility.

Literature

Bourdieu, P.

1984 *Distinction: A Social Critique Of The Judgement Of Taste*. Cambridge: Harvard University Press.

De Kok, B.C.

2009 'Automatically you become a polygamist': 'culture' and 'norms' as resources for normalization and managing accountability in talk about responses to infertility. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine,* 13(2): 197:217.

DeWalt, K. M., DeWalt, B. R.

2011 *Participant observation: A guide for fieldworkers.* Rowman Altamira.

Dyer, S. J., Abrahams, N., Hoffman, M., van der Spuy, Z. M.

2002 Men leave me as I cannot have children': women's experiences with involuntary childlessness. *Human Reproduction*, 17(6), 1663-1668.

Dyer, S. J., Lombard, C.,Van der Spuy, Z.

2009 Psychological distress among men suffering from couple infertility in Sout Africa: a quantitative assessment. *Human Reproduction* 24(11), 2821-2826.

Fausto-Sterling, A,

2003 The problem with sex/gender and nature/culture. In: Williams, Birke and Bendelow (eds), *Debating Biology. Sociological reflections on health, medicine and society.* London, New York: Routledge, 123-133.

Folkvord, S., Odegaard, O., Sundby, J.

2005 Male infertility in Zimbabwe. *Patient Education and Counselling*, 59: 239-243.

Gerrits, T.

2012 Biomedical infertility care in low resource countries: Barriers and Access. *Facts, Views & Vision in ObGyn,* 1-6.

Gerrits, T., Shaw, M.

2010 Biomedical infertility care in sub-Saharan Africa: a social science review of current practices, experiences and viewpoints. *Facts, Views & Vision in ObGyn*, 2(3): 194-207.

Gerrits, T., Hardon, A.

Studying Couples (unpublished paper).

Green, J. and Thorogood, N.

2014 *Qualitative Methods for Health Research.* Los Angeles, London, New Delhi, Singapore, Washington DC: SAGE Publications.

Greil, A. L., McQuillan, J., Slauson-Blevins, K.

2011 The social construction of infertility. *Sociology Compass*, 5(8), 736-746.

Greil, A., Slauson-Blevins K., McQuillan, J.

2009 The experience of infertility: a review of recent literature. *Sociology of Health & Illness*, 32: 140–62.

Grenfell, M.

2014 *Pierre Bourdieu: Key Concepts*. New York: Routledge.

Hörbst, V

2010 Male perspectives on infertility and assisted reproductive technologies (ART) in sub-Saharan contexts. *Facts, Views & Vision in ObGyn, 22-27.*

Inhorn, M.C.

2003 Global infertility and the globalization of new reproductive technologies: illustrations from Egypt. *Social Science & Medicine,* 56(9): 1837-1851.

Inhorn, M.C.

2003 The worms are weak: Male infertility and patriarchal paradoxes in Egypt. *Men and masculinities*, 5(3): 236-256.

Inhorn, M.C., Birenbaum-Carmeli, D.

2008 Assisted Reproductive Technologies and Culture Change. *Annual Review Of Anthropology*, 37: 177-196.

Inhorn, M.C., Patrizio, P.

2015 Infertility around the globe: new thinking on gender, reproductive technologies and global movements in the 21st century. *Human Reproduction Update*, 21(4): 411-426.

Larsen, U.

2005 Research on infertility: which definition should we use? *Fertility and Sterility,* 83 (4): 846–852

Leke, R. J., Oduma, J. A., Bassol-Mayagoitia, S., Bacha, A. M., & Grigor, K. M.

1993 Regional and geographical variations in infertility: effects of environmental, cultural, and socioeconomic factors. *Environmental health perspectives*, 101(2), 73-80.

Kamau, P.M.

2011 *The Experiences of Infertility among Married Kenyan Women.* Western Michigan University (Unpublished PhD dissertation).

Kimani, V., Olenja, J.

2001 Infertility: Cultural Dimensions and Impact on Women in Selected Communities in Kenya. *Journal of The Pan African Anthropological Association*, 2(8): 200:216.

McNay, L.

2004 Agency and experience: gender as a lived relation. *The Sociological Review,* 52:173-190.

Morris, S.

200 Joint and individual interviewing in the context of cancer. *Qualitative Health Research,* 11(4): 553-567.

Ndegwa, S.W.

2014 Affordable ART in Kenya: The only hope for involuntary childlessness. *Facts, Views & Vision in ObGyn*, 21-22.

Ombelet, W. & Cooke, I. & Dyer, S. & Serour, G. & Devroey, P.

2008 Infertility and the provision of infertility medical services in developing countries. *Human Reproductive Update*, 14:605–21.

Ombelet, W.

2011 Global access to infertility care in developing countries: a case of human rights, equity and social justice. *Facts, Views & Vision in ObGyn*, 3(4) : 257-66.

Oyewumi, O.

2002 Conceptualizing Gender: the Eurocentric foundations of feminist concepts and the challenge of African epistemologies. *Journal of Culture and African women studies,* 2(1): 1-5.

Spronk, R.

2014 The idea of African men: dealing with the cultural contradictions of sex in academia and in Kenya. *Culture, Health & Sexuality: An International Journal for Research, Intervention and Care,* 16(5): 504-517.

Valentine, G.

1999 Doing household research: interviewing couples together and apart. *Area* 31(1), 67-74.

Van Balen, F., Bos, M.W.

2009 The social and cultural consequences of being childless in poor- resource areas. *Facts, Views & Vision in ObGyn*,1 (2): 106-121.

Van Balen, F., Gerrits, T.

2001 Quality of infertility care in poor-resource areas and the introduction of new reproductive technologies. *Human Reproduction*, 16(2): 215-219.

Vigh, H.

2006 Motion squared: A second look at the concept of social navigation. *Anthropological Theory*, 9(4): 419-438.

Whitehead, T. L.

2005 Basic classical ethnographic research methods. Ethnographically Informed community and cultural assessment research systems. *Working Paper Series*.

Online Available at: http://www.cusag.umd.edu/documents/WorkingPapers/ClassicalEthnoMethods.pdf

Wong, L. P.

2008 Focus group discussion: a tool for health and medical research. *Singapore Med J*, 49(3), 256-60.

Annex: Research participants

Pseudonym participant	Married, divorced, in a relationship or single	Age	Primary or secondary infertility	Cause of fertility problems	Years of trying to conceive (with or without fertility care)	Interviewed by
Anne	In a relationship	40	Secondary	Blocked fallopian tube	One to two years	Aida
Ashley	Married	37	Secondary	Hormonal imbalances	2 years, succeeded	Aida
Brenda	Married	33	Primary	Unknown	One year	Aida
Cheryl	Married	44	Primary	Septum in uterus	4 years	Aida
Clara	Divorced and single	35	Primary	Husband has low sperm count + could not hold pregnancy	Succeeded	Aida
Esther	Married	33	Primary	Endometriosis + blocked fallopian tubes	3 years	Aida
Eunice	Divorced and single	41	Primary	Blocked fallopian tubes	16 years	Aida
Helen and Jerimiah	Married	26 & 33	Primary	Endometriosis + fibroids + cyst + damaged fallopian tubes	2 years	Aida
Lynne	Married	37	Primary	Blocked fallopian tubes	6 years	Aida
Magy	Single	47	Primary	Endometriosis + unknown	A few months	Aida
Mary	Married	41	Primary	PCOS + removed fallopian tubes	Unknown	Aida
Morgan and Tanisha	Married	28 & 25	Primary	Hormonal imbalances	2 years	Aida
Suzy	Single	46	Primary	Unknown	6 years, but stopped with trying	Aida
Abby	Married	33	Primary	Blocked fallopian tubes and fibroids	5 years, now succeeded	Luca
Alexandra	Married	35	Primary	Has no fallopian tubes	10 years	Luca

Cecile	Married	38	Primary	Problems with fallopian tubes	3 years	Luca
Daisy	Divorced and single	34	Primary	Damaged fallopian tubes	Around 10-13 years	Luca
David	Married	48	Primary	Partner has blocked fallopian tubes	1 year	Luca
Nadia	Married	42	Primary	Blocked fallopian tubes/ no hair in tubes	15 years	Luca
Rose	Married	35	Primary	Partner has low sperm count	3 years	Luca
Sabrina	Married	35	Primary	Endometriosis and fibroids	2 years	Luca
Sophia	Married	38	Primary	Blocked fallopian tubes	1 year	Luca
Tara	Married	46	Primary	Unknown	10 years	Luca
Nate & Wendy	Married	42 & 38	Primary	Unknown	5 years	Luca and Aida

Table 1. Characteristics of women and men that participated in this study.

Pseudonym participant	Profession	Interviewed by
Ashley	Pastor	Aida
Erik	Pastor	Aida
Munyoki	Pastor	Aida
Ndegwa	Gynecologist	Luca and Aida
Tom	Pastor	Aida
Wanyoike	Gynecologist	Luca and Aida

Table 2. Characteristics of pastors and gynecologists that participated in this study.

Annex: Interview topic list

1) **Introduction of the research**
   Aim of the research
   Confidentiality
   Explanation and signing informed consent letter
   Right to not answer questions or stop the interview

2) **Personal data and history**
   Date of birth/age
   Profession
   Education
   Region of origin/ethnic group
   Growing up
   Family background
   Current living situation
   Economic status
   Partner/marriage

3) **Personal history with involuntary childlessness**
   Encounter fertility problems
   Children/foster children
   Personal reaction to fertility problems
   Partner's reaction
   Family/friends' reaction
   Reaction from community
   In-laws
   Influence on personal daily life
   Influence on relationship with partner
   General experience of infertility
   Partner's experience
   Feeling of being a woman/man
   Differences and similarities with partner

4) **ARTs**
   Experience with medical treatment
   Partner's experience
   Differences and similarities with partner
   Family/friends' opinion about treatment
   Financial issues
   General view on ARTs
   Family/friends' view on ARTs

5) **Influence of treatment on personal life**
   Influence treatment
   Impact of treatment
   Support during treatment
   Sharing during treatment
   Feeling of being a woman/man

6) Religion
Support from religion
Visiting church
Praying
Counseling
Sharing with pastor

7) Receiving support
Emotional support
Financial support
Support from partner
Support from friends/family
Sharing with friends/family
Other women/men that experience the same

8) Future expectations
Of life
Of treatment
Hopes, dreams, fears, goals