University of Zurich[UZH]

Department of Social Anthropology and Cultural Studies

12 Working Paper №

ZANTHRO

Zurich Anthropology Working Papers

Not (yet) a mother – Dealing with involuntary childlessness in Kenya

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ZANTHRO - Zurich Anthropology Working Papers

Published by
ISEK – Ethnologie
Andreasstrasse 15
CH 8050 Zurich

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ISSN: 2571-6190

Not Yet a Mother – Dealing with Involuntary Childlessness in Kenya

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"Thank you for giving us a child" or "*Ni mtoto yetu, Mungu akubariki*" (Swahili: "It is our child, God bless you") are expressions I heard many times when I lived with my Swiss-Kenyan daughter in Kenya in 2009. My interest in infertility arose when I experienced the value of having children and how becoming and being a mother significantly changed my role as a woman in Kenya. How would it be to live involuntarily without a child in Kenya, I wondered.

This working paper draws on the life story of Syokau,[1] a woman struggling with infertility. I first met her in her small second-hand clothes shop in a poor, crowded Nairobian suburb. Her shop, a simple stall made of iron and plastic sheets, was located next to the local fruit and vegetable market that my daughter and I often visited. After a round through the market, my daughter and I liked to stop at Syokau's place for a chat. My daughter often played with colorful bottle tops or the many items she found in Syokau's shop, while Syokau and I would sit on plastic chairs or bulky garbage bags filled with clothes, talking and relaxing amid the bustle of the surroundings.

Over the last twelve years, Syokau has shared the story of her involuntary childlessness with me, which forms the basis of this article. It illustrates, as idiosyncratic as it is, the experiences of women battling infertility in Kenya, and it informs my critical assessment of women in this liminal state of not yet being a mother.[2] Syokau's story exemplifies the struggles of a woman for whom motherhood is culturally mandatory but who has no access to assisted reproductive technologies (ART[3]) because of financial constraints. Following varying stages of hope and hopelessness, attempts, resignation, and imaginary futures[4] entailed by the desperate struggle of trying to have a child shows the agony of infertility for women like Syokau in Kenya.

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[1] All names in this working paper are pseudonyms. This working paper has been written with Syokau's consent, and we agreed together on the use of her pseudonym. Syokau encouraged me to write this article because she would like the problem of infertility affecting Kenyan women to be seen and understood. This article has been written collaboratively: Syokau was involved in all stages of writing process of this article, she read various versions of this article, and we discussed it several times.

[2] This expression has been inspired by Artur Greil's seminal work on infertility with the title *Not Yet Pregnant: Infertile Couples in Contemporary America* (1991).

[3] I use ART as an umbrella term for biomedical technologies that help involuntarily childless women to achieve pregnancy either with their own biological eggs and/or their partners' sperm or with the help of an egg and/or sperm donor. ARTs are particularly important because they create 'visibility' of motherhood through pregnancy (see also Bharadwaj 2016, 43). Thus, I do not refer to other methods like surrogacy which do not lead to pregnancy in the woman herself. In Kenya, ARTs are often used interchangeably with IVF (in vitro fertilization). IVF is particularly used to treat women with blocked fallopian tubes, which is the most common cause of infertility in women in Kenya (KTN Kenya 2014).

[4] The concept "imaginary futures" has been inspired by Sarah Franklin (2005). The realm of imaginary futures consists of converging global and local influences generating positive possibilities as well as

Inspired by Syokau's story and my own changed status as a mother in Kenya, I conducted research for a bachelor thesis from December 2013 to February 2014 in Nairobi. In addition to Syokau, I conducted semi-structured interviews with another childless woman, Brenda, who had founded a self-help group for women afflicted with involuntary childlessness in Kenya, and about a dozen more women and men directly affected by – or indirectly confronted with – involuntary childlessness. Other interlocutors included a male midwife who had experienced the difficulties of infertility in his work environment and a lawyer who researched the legal vacuum of ARTs in Kenya. Additionally, I carried out participant observation in a Tunza clinic[5] offering primary maternal and child healthcare to vulnerable and underserved populations. The Tunza clinic where I conducted my research was situated in Syokau's suburb and was run by Mercy, a nurse. It was visited mainly by women at the lowest income levels. Besides interviews and participant observation, I analyzed how the issue of infertility in Kenya was represented in the media, i.e. in talk shows, other discussion formats, and documentaries broadcasted by Kenyan television stations; in local newspaper articles in English and Swahili; and in posts on social media platforms. Although this paper is mainly based on ethnographic research conducted in 2013 and 2014, it is important to point out that several longer stays before and after, as well as ongoing conversations over the phone and on social media, allowed me to gain an in-depth understanding of the problem of involuntary childlessness in Kenya. This long-term engagement with people affected by infertility in Kenya has also allowed me to critically assess how perceptions of involuntary childlessness have changed over time, both at an individual and at a broader societal level.

To contextualize the shifts within a more diachronic perspective, I first outline the politics of infertility in Kenya since colonial times. By giving an overview of these politics, I show that they still strongly correlate with the availability of infertility services. To account for the social stratification of accessibility and affordability, I apply the lens of "stratified reproduction" (Colen 1995) and "liminality" (Turner 1967 and 1977a; Douglas 1966). By subsequently providing the reader with an ethnographic description of Syokau's different life stages of trying to have a child, I aim to show the struggles most married, financially disadvantaged Kenyan women go through when they cannot conceive naturally.

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negative consequences, especially when possibilities are unreachable for the economically disadvantaged (see also Ginsburg and Rapp 1995, 12, on their concept of the politics of hope).

[5] Tunza clinics were established in 2008 by the Population Service Kenya (PS Kenya), a Kenyan social marketing and franchising firm that partners with national and county governments. Tunza clinics are run privately by medical practitioners in a "social franchising model" with donor-funded programs for providing health practitioners and contraceptives (https://www.pskenya.org/tunza/). The services are subsidized, so poor women have access to family planning methods like intrauterine devices (IUDs) at low or no cost, though they had to pay for other services out of pocket. Currently, health practitioners running Tunza clinics face major economic and structural challenges due to Kenya's transition towards universal health coverage. Not all Tunza network members are yet accredited by the National Health Insurance Fund (NHIF) that has started providing free healthcare services (https://www.pskenya.org/tunza/accelerating-universal-health-coverage/). As I will outline further, the NHIF does not cover infertility treatment for the general public but only partially for civil servants (Njenga 2019; NHIF Civil Servants Handbook). Nevertheless, those Tunza clinics not yet accredited have lost patients who are NHIF members. These patients try to get free healthcare at NHIF-accredited clinics, which has entailed economic challenges for the non-acredited clinics, thus compromising treatment options.

Situating infertility and involuntary childlessness in Kenya

In 2007, The Kenyan Ministry of Health stated in the "National Reproductive Health Policy":

> Infertility is an important public health concern in Kenya. However, the problem has been inadequately addressed at both policy and service levels, mainly due to its ranking against other perceived pressing priorities of maternal and child health care. Prevalence of infertility in Kenya remains inadequately determined, but depending on the definition applied it may range from as low as 2 per cent to over 20 per cent (Ministry of Health 2007a, 21).

That infertility is a major problem was recently also emphasized at a Congress of the Kenya Obstetrical and Gynecological Association. Kenyan gynecologists found, based on a recent study by the Kenyatta Hospital,[6] that about nine million Kenyans[7] have infertility-related issues and that three-quarters of gynecological consultations are due to infertility (Chepkoech 2019). The World Health Organization (WHO) has confirmed this high incidence of infertility.[8] However, although numbers and research show that Africa is the continent most afflicted by infertility, the problem has still not gotten much attention in the Global Health Agenda (Inhorn 2015, 108; Gerrits et al. 2018; Inhorn and van Balen 2002; Nachtigall 2006; Okonofua et al. 1997; Pilcher 2006). Rates of infertility in sub-Saharan Africa have long been underestimated or downplayed in global health statistics for a variety of reasons. First, numbers of infertility, despite high, are mostly underestimated due to the severe stigmatization of infertility in these countries, leading to a bias in data (e.g. Daar and Merali 2002, 16). Second, statistics of infertility fluctuate because the definition of infertility is vague and ambiguous (Sandelowski and de Lacey 2002, 35). Infertility cannot always be easily detected and diagnosed by a simple test like for HIV or malaria. Thus, the infertility status of women shifts significantly during reproductive age. Third and most importantly for the lack of recognition of infertility in the Global Health Agenda, overpopulation in sub-Saharan Africa is more of a focus, and the speed of population growth is often represented as the major problem in the Western public opinion.[9] However, the paradox of "barrenness amid plenty" – that high fertility rates coexist with high infertility rates – means that both require attention (Inhorn 2015, 109).

The current emphasis on overpopulation obscures the fact that concerns about high infertility rates dominated discourses on reproduction in colonial times, and reproduction politics turned into a site of intense political struggle (Thomas 2003, 4). In the 1920s, colonial administrators tried to ban "tribal customs and practices," namely excision and abortion, because they would eventually lead to infertility and compromise the number of births. Against the backdrop of pronatalist campaigns, colonial administrators introduced a rationalized health service delivery apparatus focusing on maternal and child health to ensure that enough children were born to expand the availability of cheap labour (Thomas 2003, 13; see also Lock and Nguyen 2010, 157–58 and Maternowska 2006, 41). Female reproduction and childbirth became increasingly biomedicalized, and concerns about improv-

[6] Kenyatta Hospital is the largest public hospital in Nairobi.

[7] According to the most recent census, Kenya's population is 47.5 million (Kenya National Bureau of Statistics 2019 and 2020).

[8] https://www.who.int/reproductivehealth/topics/infertility/burden/en/, accessed on 05.07.2021

ing women's status an instrument of population control were subtly interwoven into the fabric of society (Thomas 2003, 12–13; see also Boddy 2007, 310; Feldman-Savelsberg 2002, 218–19). Adhering to newly introduced (biomedical) technologies became a status symbol of the emerging elite (Thomas 2003, 51 and 174; see also Browner and Sargent 2011, 21 and Spronk 2009, 501). By the 1950s, giving birth in a hospital signalled belonging to the enlightened and school-educated classes. Hence, through maternity wards, colonial reformers' visions of "uplifting" African women and thereby creating a "black pool of labour" by the reduction of pre- and post-natal complications became entangled with the local process of class formation (Thomas 2003, 77). These shifts of healthcare delivery have had an impact on the healthcare system and the perception of legitimate treatments to this day.

This close entanglement of reproduction with politics and power structures again became clear after Kenya's independence in 1963. The previous pro-natalism became gradually replaced with a concern to limit births, and "modern" nuclear families with fewer children were encouraged (Lock and Nguyen 2010, 160). "Overpopulation" and "hyperfertility" were constructed as obstacles to economic development (Thomas 2003, 179). To slow down population growth, family planning programs were introduced in the mid-1960s in Kenya and were promoted as a way to lift people out of poverty (Connelly 2008, 8). However, family planning programs had little to do with "planning a family" in an all-encompassing manner but were mainly designed to prevent pregnancies or to "space" births of children by making contraceptives widely available (Thomas 2003, 179). The biased and one-sided emphasis on the control of female fertility is still deeply ingrained in the conceptual framework of global health programs, but it is slowly changing, also due to the emphasis on the problem of infertility by Kenyan doctors, as I will describe below.

In 1994, the Programme of Action agreed upon at the International Conference on Population and Development (ICPD) in Cairo made first steps towards the recognition of the problem of infertility. The conference, under the auspices of the United Nations and with many non-governmental organizations and Third World feminist groups present, crucially shifted the focus from a macro concern with rapid population growth and a focus on "fertile" women towards individual rights, including those of "nonfertile" women (DeJong 2000). This recognition of infertility as an important global concern within the then-coined concept of "reproductive health" was significant, particularly for infertile women in sub-Saharan Africa whose suffering had been completely overshadowed by the focus on population growth.

In the Programme of Action developed in the ICPD, participating stakeholders and states, including Kenya, agreed that there is a need for comprehensive reproductive healthcare (Sundby 2002, 248), which should include accessible treatment at the local level (Hörbst 2012, 165). The need for comprehensive infertility treatment in "developing countries" was also emphasized in a meeting entitled "Medical, Ethical and Social Aspects of Assisted Reproduction," organized by the WHO in 2001 (Ombelet and Onofre 2019, 66; Griffin et al. 2001). However, the treatment available in Kenya has never been comprehensive, and it emphasizes prevention as more cost-effective (Inhorn and van Balen 2002; Birenbaum-Carmeli and Inhorn 2009). Obviously, prevention programs do not help women who already struggle to have a child.

Prevention programs have also entailed the perception that a woman has been careless and has compromised her fertile status in her past, and these deficiencies must be corrected – something that has been criticized by scholars (Rabinow 2005, 187). While it is

not to deny that many life-threatening diseases weigh heavily on the already overburdened and underfinanced healthcare system in Kenya, Thomas has argued that solely stressing prevention corroborates the "deep-rooted Western stereotypes of Africa as a place of disease and promiscuity," triggering the spread of sexually transmitted diseases (STDs) and unwanted pregnancies (Thomas 2003, 10–11 and 181; see also Livingston 2012, 31). Prevention also contains a retrospective moralizing of past behavior. As I will outline below, women I talked to in my research have been continuously confronted with moralizing "you should not have"-discourses. They would have been "given" a baby, or God would have "rewarded" them, if they had not failed to preserve their "fertile status," be it through "unfaithful" sexual intercourse, weak faith in God, or not "listening to God's timing" and waiting till they are too old to have a baby. Financially disadvantaged women are disproportionally affected by the lingering moralizing power of these discourses, since they have no access to infertility treatment which could rebut the blame put on them by showing a "swelling belly."[10] As a result of their experiences of being blamed for their childless status, many women emphasized in conversations that they had never done anything that could have compromised their fertility.

In recent years, subtle shifts give hope that infertility might become a "high priority topic" in Kenya and sub-Saharan Africa at large. In 2019, the International Conference on Population and Development held the ICPD+25 summit, a continuation of the conference held 25 years before in Cairo. There, the realization and implementation of the promises made in Cairo were discussed (Butler et al. 2019). The global debate on the topic of reproduction at large has changed in the wake of the global moves towards Universal Health Coverage as part of the United Nations' Sustainable Development Goals (SDGs), in which human sexual and reproductive rights play a crucial role (UNFPA 2019). Unlike the Millenium Development Goals, the SDGs explicitly recognize sexual and reproductive health as essential to health, development, and women's empowerment (UNFPA 2019, 7). But like other human rights, they often remain "paper promises" since the financial resources to implement them which are often not allocated (Bharadwaj and Inhorn 2007, 78; Inhorn 2003, 1838; Feldman-Savelsberg 2002, 221; Parker 2012, 207 and 216–18; Richey 2003, 276; Ahoya 2018b).

In Kenya, the Assisted Reproductive Technology Bill came into force in 2016 and legally regulated the use of ARTs, which had long been practiced in a legal vacuum (see Thiankolu 2007). Currently, the Kenyan senate is debating a reproductive healthcare bill (Art. 9) that includes a right to assisted reproduction, among other contents like abortion services and sexuality education for adolescents (Idowu Ajayi and Mwoka 2020). Art. 9(1) of the draft of the bill reads: "Every person has a right to assisted reproduction." Millie Odhiambo, a Member of Parliament who has openly spoken about her struggles to have a baby (as I outline further below) has been at the forefront of visibilizing the problem of

[10] In my conversations, a visible pregnancy was often mentioned as important to break the stigma and to "become a complete woman" even if the woman miscarries or loses the child after birth. Adoption and fosterage were often mentioned as acceptable but "last resort" after the lack of a visible pregnancy. However, the legal adoption process is not an option for people with scarce economic resources. Syokau explained in the same sentence the high costs, of both ARTs and adoption: "One needs to have cash [to afford ARTs]. Even to adopt a child, one needs to go through a legal procedure, which is very expensive" (see also KTN Kenya 2013). As much as these new laws and related processes have helped to protect children, they have also reinscribed inequalities and have continued stratified reproduction, which is strongly intertwined with other social institutions.

infertility, creating change through legislation and make infertility treatment available in Kenya (CitizenTV 2019). In sum, all of these public initiatives seem promising, as infertility is becoming a publicly discussed topic and is becoming acknowledged as a severe health issue. However, Ombelet and Onofre argue that despite the awareness of infertility as a severe concern in sub-Saharan Africa, the worldwide attention and policy concerning infertility in Africa has not changed (2019, 66). It is also unclear whether the increased publicity of reproductive technologies in sub-Saharan Africa is not merely adding to the agony of those women who do not have access to them, since accessibility, affordability and availability has not improved as fast the awareness of infertility treatment or as quickly as alternative ways of dealing with involuntary childlessness are being discredited, as I outline below.

(Bio)Medicalization of infertility, stratified reproduction and liminal status of involuntarily childless women

The medicalization of female reproduction during colonial times and the medicalization of infertility in general as a condition that requires medical solutions is closely entangled with the advent of assisted reproductive technologies in the late 1970s (Greil and McQuillan 2010, 137). Sandelowski and de Lacey write:

> Infertility was "invented" with the in vitro conception and birth in 1978 of Baby Louise. (…) Whereas barrenness used to connote a divine curse of biblical proportions and sterility an absolute irreversible physical condition, infertility connotes a medically and socially liminal state in which affected persons hover between reproductive incapacity and capacity (2002, 34–35).

In the late 1970s, the WHO defined infertility as "a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse" (Zegers-Hochschild et al. 2009, 1522).[11] Since then, this biomedical definition of infertility, which differs from demographic and epidemiological definitions, has been used globally and has also been cited extensively in Kenyan clinics, medical guidelines, and local television shows (see e.g. KTN Kenya 2020).

The medicalization of infertility, "especially through the development of reproductive technologies, has (…) redefined and further entrenched the ideology of motherhood within society," as Bell aptly pointed out (2019, 482). Against the backdrop of the promises of new medical technologies, infertile women have increasingly been encouraged to see themselves as not *yet* being mothers. Women have been encouraged to hope and to seek medical intervention to overcome this liminal state. Thus, on the one hand, the availability of ARTs can ease burden of childlessness for women who living in societies where marriage and children are seen as necessary elements for an individual's place in society and where an identity as a mother plays a large role (Riley 2018, 126). However, on the other

[11] In 1991, the WHO revised its initial definition of infertility into "primary" and "secondary" infertility, which emphasized the woman's disrupted reproductive condition. Primary infertility means that a woman fails to get pregnant without having a prior history of pregancy. Secondary infertility is considered as following a prior pregnancy but not necessarily a live birth. This revision has further entrenched the medicalization of infertility (see e.g. Martin 1987; Rapp 2001; Rothman Katz 1986; Sandelowski and de Lacey 2002) and has emphasized women's reproductive status even more. Male infertility, meanwhile, has become more and more absent in statistics and societal perception (Lock and Nguyen 2010, 254).

hand, infertility and its management highlight perhaps more than any other topic “a great divide between those who live in perpetual poverty and have little or no access to health care and those who are better off,” as Lock and Nguyen have pointed out (2010, 254; see also Ombelet 2015, 106; Connelly 2008, 382). Those who can afford ARTs are likely to overcome this liminal phase, while those with constrained financial means remain in the stage of not yet being mothers.

ARTs may assist global elites in reproducing socially esteemed children, but these prohibitively expensive reproductive technologies are rarely subsidized for those who need them most, namely poor women who are at the greatest risk of infertility. However, due to the persistent belief that women of low socioeconomic status have too many children, their needs for fertility treatment and maternal care have been silenced and instead the focus lies on their presumed “hyperfertility” and the reduction of births through Western-sponsored regimes of population control (Inhorn and Fakih 2006). In sub-Saharan Africa, infertility is often even seen as a “blessing in disguise” (Kielmann 1998, 128)[12] and thus, the fertility of poor women in particular is still constructed as a social problem, while their infertility is not (Wilson 2014, 32; Ombelet and Onofre 2019, 71; Bell 2014). Consequently, these women often struggle to get access to preventive gynecological and maternity treatments leading to higher rates of infertility due to advanced stages of infections caused by STS or unsafe and botched abortions. Additionally, as outlined in this paper, women of low socioeconomic status often resort to unsafe ways of conception like unprotected intercourse with multiple men in their desperate quest for a baby which can again cause infertility. Inhorn emphasized that categorizing infertility in Africa and other parts of the Global South as a low-priority issue or invoking it as a “solution to overpopulation” perpetuates a eugenic view that infertile people in “developing countries” are unworthy of treatment; thus, it a continuation of population control on other terms (Inhorn 2015, 109–10; see also Hörbst and Wolf 2014, 190 and Connelly 2008, 370ff.). Therefore, ARTs often perpetuate existing social inequalities because who has access underscores how reproduction – from conception to birth to raising children (Riley 2018, 117) – is embedded in the social, economic, and political fabric of a society, its interwoven inequalities, and whose procreative choices are impaired and constrained.

ARTs, the accompanying medicalization of infertility, and associated legitimate forms of motherhood are important elements of stratified reproduction (ibid.) – a concept developed by Colen (1995) that helps to frame the structural inequalities emanating from the politics of reproduction, mirrored in Syokau’s idiosyncratic experiences described below. Ginsburg and Rapp employed the concept to “describe the power relations by which some categories of people are empowered to nurture and reproduce, while others are disempowered” or, in other words, to look at “arrangements by which some reproductive futures are valued while others are despised” (Ginsburg and Rapp 1995, 3). In general, the concept helps to understand inequalities in reproduction, and feminist medical anthropologists have applied the concept to delineate how social stratification is shaped and maintained by reproduction (Smith 2019, 4; Inhorn 2020, 49-50).

Women who are not valued as childbearing women usually remain in a state of “not yet being mothers,” which I frame with the concept of liminality. The concept of liminality has been very productive and used in multifaceted ways in anthropology (see for example

[12] Critical race studies scholars are addresssing “reproductive racism,” see e.g. Bridges 2011.

Jackson 2005; Jaye and Fitzgerald 2012; Malkki 1995; Squier 2004; Persson 2011; Taylor-Alexander et al. 2016; Wilson 2002). It can be traced to two distinct but related approaches by Victor Turner and Mary Douglas, who both drew on van Gennep's idea of liminality as a crucial phase in rites of passage (Jackson 2005, 333). While van Gennep stressed the transitional aspect of the liminal period and the reproduction of societal strutures, Turner emphasized that the concept of liminality also helps to describe marginal, not necessarily transitional phenomena in non-ritual contexts. Turner elaborated that the concept of liminality can frame "inter-structural situations," or, in other words, the "betwixt and between the normal" understood as the attributes, circumstances, or roles that are socially and culturally established (Turner 1977b, 33). According to Turner, the liminal zone does not necessarily reproduce former structures (Turner 1977b, 37, and Turner 1977a, 95 and 109). In a similar way, Douglas analyzed what happens when the categorical order of a society is challenged or subverted. People who fall in between categories become a "matter out of place" and different forms of pollution are attached "to beings and objects that fail to fit into the classificatory categories society constructs" (Jackson 2005, 333). People in liminal positions become structurally, not physically, invisibile (Turner 1977b, 37). Turner observed that the "structural" invisiblity of liminal personae has a twofold character. They are at once *no longer* classified and *not yet* classified (Turner 1967, 95–96). According to Turrner, the ambiguity of "liminal personae" or "threshold people" renders them dangerous, deviant, or polluting, but the liminal zone is also a space of "potency and potentiality" (1977b, 34). Anthropologists have used this concept to frame the experiences and stigma of HIV-negative people who are in a relationship with HIV-positive people. The former become invisible due to transgressing classificatory boundaries, and their challenges remain unrecognized since they are not yet classified (Persson 2011). Malkki, to mention another example, described how politically marginalized and displaced people in refugee camps fall in between categories of the national system and thus become structurally invisible during their liminal period of displacement (Malkki 1995).

In this paper, the concept of liminality is particularly helpful when looking at the threshold phase – characterized by uncertainty, possibility, marginality, and transformation – of women who are of childbearing age but not (yet) mothers and their paradoxical role of visibility and invisibility within the Kenyan society (Taylor-Alexander et al. 2016, 150). Furthermore, as Syokau's story shows, this liminal phase also has the potential to eventually change the childless women's self-perception and hence social perceptions of involuntarily childless women in Kenya because more childless women share their experiences in public and become visible in a powerful way. Squier, the author of *Liminal Lives* (2004), also observed this dichotomy of powerlessness and power. In his current ethnography, which engages the concept of liminality in the context of embryo adoptions, stem cells, and intra- and inter-species transplantations, Squier writes:

> Although the liminal zone can provide us with a source of creative play, possibility, and human agency, it can also generate personal, cultural, and institutional tension. As assisted reproduction, genomics, biotechnology, and other biomedical interventions become increasingly common (at least in the industrialized world), liminal lives have become symbolically privileged and troublingly unstable, even dangerous (Squier 2004, 5).

In contrast to Squier, who looks at how life created through biomedicine is liminal, I am interested in how life *not* created keeps involuntarily childless women in a liminal and thus marginal state. However, as recent research drawing on the concept of liminality

shows, liminality can also account for cultural and social shifts in dealing with yet structurally invisible phenomena. In this working paper, it is helpful to understand the concept in relation to the reproduction of and the transition of social structures. By not making ARTs available to economically disadvantaged women, for example, social structures are reproduced in that certain women are valued and empowered to reproduce. However, it can also show how these disenfranchised and involuntarily childless women use the power gained through their liminal status to seek new lives and fulfillment as child*free* rather than child*less* women, emphasizing the freedom gained rather than deficiency.

In conclusion, drawing on the concept of liminality allows to understand how infertile women hover not only between hope and despair of "not yet being mothers" at an individual level but also within structural boundaries of healthcare's stratified reproduction system. Syokau's experiences demonstrate not only how she became gradually marginalized and structurally invisible in society due to her involuntary childlessness but also how the transitional, processual, and experimental power within the liminal state helped her to regain strength and fight – even if in very limited, yet burgeoning ways – against prescribed gender roles.

"I was waiting to have a baby": On the social and cultural timing to become a mother

"We were just automatically ready for a child," Syokau replied when I asked her when she and her husband started talking about having a child. "Normally," she said, "there is no sitting down," pointing at the collectively shared cultural assumption that children follow shortly after tying the knot and that most couples would usually not "sit down" to discuss the "right" moment for starting a family (see also KTN Kenya 2014a). Syokau suggested the term "marriage chronicles" in one of our conversations to account for this collectively shared assumption. When getting married, one would "enter the club," Syokau said, and the rest would follow. The social "expectation number one" was also described in an article in *Business Today:* "As is the norm, a couple is expected to have a child within the first year of marriage, and for those who miss this target, pain and anguish become part of their married life" (Njenga 2019). Tellingly, the biomedical definition of infertility, in which the emphasis lies on the miracle period of one year, has also been embraced in cultural perceptions of the "normal" and culturally tolerated timeframe of starting a family.

Syokau and her husband were longtime friends before they got married. They decided to marry after both had finished school. When I met Syokau for the first time in 2009, she was 27 years old, and she had recently been abandoned by her husband, who had slowly disappeared from her life. "Without a trace," she said. He stopped talking to her or replying to messages and eventually stopped sending her money for her upkeep – something that he had continued to do despite a total breakdown of communication. She was forced to make a living on her own but was also still supporting other family members in the rural area.

Syokau told me that the absence of a visible pregnancy in the first year after the wedding would often trigger multiple responses by family members and the couple's wider social networks. This is something that was echoed by other women I talked to, but also by the many testimonies of women that I listened to on local talk shows (see e.g. CitizenTV 2016b; KTN Kenya 2014a; K24 TV 2014). After a year, rumors about the couple not

having a child would start spreading. Harsh words would usually come from the "in-laws" – encompassing the wider family from the husband's side – while the woman's "own" family was mostly supportive. In this sense, families were both sites of nurture but also of repression and rejection. Sometimes, women also mentioned that their in-laws felt that their payment of the *mahari* (Swahili for "bridewealth") did not "pay off," and that, therefore, the feelings towards them turned into open hatred, often even involving physical violence. In an article in the Daily Nation, Osur told the story of a woman who experienced humiliation and mockery by in-laws for not conceiving. They would tell her: "It's a waste of family resources feeding you each day," or "You have nothing to show for it. It's like throwing food to the dogs – in fact the dogs are even better, they get puppies." The mother-in-law would also pressure her son, asking him, "if a cow is not calving, why should you keep it? Isn't it better to sell it to the butcher and buy a better one?" (Osur 2014).

Syokau did not experience open hatred from her parents in law – maybe because she and her husband had not settled in his parents' compound but had rented their own flat. However, her former husband would usually go to visit his relatives and come back very anxious, she remembered. He never shared with Syokau what they told him about her, but the pressure was mounting month after month, period after period – the period a visible sign of "failure" and "disappointment." "Red," Syokau recalled without mentioning the word periods, "I didn't want to see this colour. I hated this color." Pressure to conceive started dominating her whole life. "24/7, I used to cry day in, day out," she said. "I was waiting for a baby, now I want a baby," she told me. In Syokau's case, her husband was supportive and tried to ease the pressure by trying to convince her to "stop pressuring" herself. Syokau started reaching out for help and approached her mother and sisters, who had all had no problem conceiving. "Can you explain to me how it feels to be a mom?" she would ask them again and again. "How can you give my mom nine kids, and I don't get even one?" She approached God and "was on her knees." Due to the high social pressure and emotional suffering, women mostly rely on a mix of strategies – from consulting doctors in the biomedical field to local healers – to overcome their childlessness (Hörbst 2012; Inhorn and van Balen 2002, 10), as Syokau also did.

"May God give you this child you're praying for": On the struggles of becoming a mother

Syokau went through a wide variety of biomedical and herbal treatments, desperately trying to get pregnant. She took *Clomid* (an ovulatory stimulating drug) over a long period and had been to hospitals several times. "I have been to [operating] theatre twice." She told me about the horrible pain she endured going through these surgeries without anaesthetics to unblock her fallopian tubes. During the operation, she conversed with God that she "will endure the pain as long as I will have the baby." She recalled how she told the doctors: "Do what you want to do, even if you have to remove a breast so that I have a child." After the operation, during which she had "not moved an inch," the medical personnel told her, reacting to her bravery: "May God give you this child you're praying for."

Later on, she had another surgery under anaesthetics. When she came out of the operating theatre, she was left with a visible reminder, "a scar down there like a CS (cesarean section)." "This is like a CS," she repeated several times, seemingly vividly remembering the times when it all happened. After the surgical intervention, she had to spend about one week in hospital, which shows that the intervention was (and often still is) a highly

invasive intervention and was far from the “scarfree” and “carefree” interventions that private healthcare centers advertise for highly priced laparoscopic surgeries often used to repair blocked fallopian tubes.[13] “After the operation,” she finished her long narration of this painful process, sighing, “you’re given a sheet of paper with the days you’re supposed to try.”

Fortunately, the costs of Syokau’s operations were met by the National Health Insurance Fund (NHIF), since her husband’s NHIF membership also covered Syokau as his spouse.[14] As a side effect of abandonment or divorce due to childlessness, many women like Syokau lose insurance coverage because they are pushed into the informal economy, where it was impossible to get NHIF coverage until recently. Only very recently, and in the context of universal health coverage as part of the Sustainable Development Goals, more Kenyans have access to the NHIF and no longer have to pay fully “out of pocket.” Although NHIF membership is now also possible for people working in the informal economy, it must be actively acquired and does not include the same services as for employees in the formal economy or civil servants. Furthermore, financially better off Kenyans also often purchase additional private insurance, which covers further healthcare services not (fully) covered by NHIF (Njenga 2019).

Syokau, like the majority of Kenyans, has no access to ARTs due to the prohibitive costs which are, for almost all Kenyans, not covered (or only partially covered) by health insurance (see also Bell 2009; Mkanyika 2017). The lack of specialized Kenyan doctors, the reliance on foreign doctors, and the high taxes of imported pharmaceuticals and laboratory equipment render ARTs very expensive (see Ombelet 2013 and 2014 on approaches towards universal affordable infertility treatment). The example of IVF, mostly used in the case of blocked fallopian tubes, a common cause for infertility, demonstrates that this technology is out of reach for most couples in Kenya. One cycle of IVF in a Kenyan clinic costs about 450,000 KES (4,500 CHF) but can go up to 1,000,000 KES (10,000 CHF), depending on the complexity of the treatment and if travel and accommodation expenses are also considered in the budget.[15] An IVF treatment often requires several cycles until it results in pregnancy, since IVF has a high failure rate. Syokau earns only 17,000 KES in an extraordinarily good month, an average wage earned in the informal economy in urban areas. According to the 2014 statistics by the Kenyan National Bureau of Statistics, the informal sector represents 82.7 percent of employment in Kenya (World Bank Group 2016, ii).[16] It is evident that most Kenyans cannot afford IVF, as Syokau’s income exemplifies.

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[13] Laparoscopy is a minimally invasive surgery commonly used in high-resource settings since the 1980s. Laparoscopic surgeries help diagnose causes of female infertility like ovarian cysts, uterine fibroids, or blocked fallopian tubes. Doctors can treat these causes by inserting a thin fiber optic telescope through a tiny incision. In low- and middle-resource countries like Kenya, however, laparoscopic surgery is not yet routinely offered due to the high capital investment and the required specialized training for doctors (Mugo 2019). Thus, surgeries that leave almost no physical scars in advanced healthcare settings can be highly invasive in low-resource healthcare settings (see e.g. Makin et al. 2017; Alfa-Wali and Osaghae 2017).

14 NHIF covers the spouse as well as the children, expanding the focus to the family unit rather than the individual. If a woman is excluded from this, she also loses access to these services. However, as mentioned above, NHIF has been restructured recently and she can now pay for NHIF membership individually.

[15] See e.g. CitizenTV 2016b; various websites of clinics, e.g. https://kenyaivf.com/ivf-cost-kenya/, accessed on 05.07.21

[16] To get an idea of average wages in Nairobi, see e.g. Economic Survey 2019 (Kenya National Bureau for Statistics 2019, 50). According to the Kenya Labor Law, the minimum wage is 13,572 KES per month. However, many people working in the informal economy earn less than the legal minimum wage.

When I conducted my first research in 2013, there were four known private, for-profit clinics in Kenya offering a vast array of ART procedures. In the meantime, online research has revealed that there are approximately 10 private centers offering ARTs in Nairobi alone – but not a single public clinic.[17] Kenyan doctors have criticized the fact that no public hospitals offer infertility treatment that is affordable to the wider public (Chege 2017). Kenyan gynecologists urgently recommended the inclusion of infertility treatment *for all* in "essential health packages," for which costs are met by the NHIF. NHIF has started to cover infertility services for civil servants[18] but has, due to financial constraints, not included infertility treatment in the essential package for others (Muchangi 2017).

All financially available biomedical interventions remained unsuccessful in Syokau's case. Interestingly, when Syokau told me about her struggles of becoming a mother, she only told me about the biomedical interventions. That she had simultaneously sought treatment from specialized doctors in herbal medicine only was mentioned when I asked her about it. In her search for herbal specialists, she drew a clear line between "real doctors" and the *waganga* (Swahili for "witchdoctors") who "are liars" as she said, laughing out loud with her typical humor. I remembered the hundreds of *waganga* advertisements I had seen pinned to trees, poles, and walls throughout Nairobi, often with promises to cure *utasa* (Swahili for "infertility"). Syokau got to know about the herbal specialists she consulted through friends or family in her region of origin, where many of her family members still live. She was told that the herbs would help to "heal the womb" and help her "eggs to warm up." She forced herself to take the extremely bitter herbs, which are usually taken with water or *uji* (Swahili for "porridge")[19] – the latter often used to prevent women from vomiting due to the herbs' extreme bitterness. She told me how she followed this routine over several weeks, taking herbs once to three times per day. She could hardly swallow it, but "I did all to get a kid [...]. I was so possessed with having a kid. Yes, the best term is possession."

The treatment of infertility is often very difficult for women with little economic resources, as also Mercy, the medical practitioner, told me. Women who struggle to conceive often come to her clinic and seek help, but she has very few options to help these women. She takes the medical history and tries "to find out what is the cause [of the woman's infertility]. We also find out whether she had a baby, if it is primary or secondary infertili-

17 Bearing in mind that most Kenyans cannot afford the costly ARTs, the prevalence of these ART-clinics in Nairobi is surprising at first. However, these clinics are also engaged in global reproductive tourism. Patients from Africa, Europe, or the United States seek treatment in Kenya (Okwemba 2012). Meanwhile, Kenyans would often travel abroad, particularly to India, to get access to more affordable assisted reproductive treatment (Ahoya 2018a; see also Gerrits 2018; Hörbst and Gerrits 2016 on reproduction travel in Ghana and Uganda). In India, ART procedures are less expensive than in Kenya and much cheaper than in the Global North (see e.g. Deomampo 2013). Indian hospital chains have also started offering services in Kenya, e.g. WINGS IVF, mostly in collaboration with Kenyan doctors. To get an overview of clinics offering ARTs in sub-Saharan Africa at large, see e.g. Oketch 2018; Inhorn and Patrizio 2015; or Ombelet and Onofre 2019.

18 NHIF coverage has significantly increased in Kenya in the last years. Although NHIF is now open for all Kenyans, civil servants and formal sector workers enjoy benefit packages that are superior and more comprehensive to sponsored programs for other members. According to an Assessment of the Kenya Health Financing Assessment, there were 241,316 civil servants who had 346,843 secondary beneficiaries, mostly spouses and children of civil servants, in Kenya in 2016. Yet, not all of them had access to infertility treatment (Dutta et al. 2018, 67).

19 *Uji* is also strongly associated with motherhood as well as fertility and is taken by women after giving birth. *Uji* is generally associated with giving strength, healing capabilities, boosting milk production, and providing important nutrients for breastfeeding.

ty." She continued that she "would only, maybe, treat STDs (...) and refer her for a scan. They usually come back very disappointed. They go from one hospital to the other. Some get help, but others don't." The lack of access to treatment was even more painful because women were mostly aware of the inequality behind opportunities. Syokau once said, laughing bitterly: "They are highlighting certain sicknesses on TV that are affecting the poor, only to find that they cannot afford treatment. I find it cannot be treated in Kenya. So many people cannot afford it." In Mercy's clinic, as in many similar clinics, the one-sided focus on reducing the numbers of children also became visible when I looked at the piles of glossy brochures and flyers covering Mercy's simple wooden desk. The brochures and flyers contained numerous pictures of various forms of contraceptives like IUDs, female and male sterilization, and various injections and patches, free for women because they are funded by international healthcare organizations.[20] However, subsidies for biomedical treatment for women suffering from infertility was inexistent. Local healthcare providers' ability to help women treat their reproductive tract infections or, even worse, to offer treatment to those whose reproductive tract infections have caused irreparable infertility, is extremely limited (see e.g. Kielmann 1998, 133; KTN 2014b).

The women who came to Mercy's clinic could not afford costly assisted reproductive technologies, they could also not afford further diagnostic consultations to find the exact cause of their inability to conceive. Therefore, Mercy was regularly confronted with childless couples resorting to the woman "going out," as she called it. This term was used to describe the strategy used by financially disadvantaged couples trying to get pregnant: engaging in extramarital sex. She explained that these women did not have access to other forms of infertility treatment. "They go outside for various reasons. Not so much for sexual satisfaction, but they go out there to get a child or try to get a child."

Women also decide to "go out" because male infertility is often the cause of marital childlessness, but it is highly stigmatized and often goes undiagnosed (Inhorn 2009a). Brenda, one of my interlocutors, explained that "when a couple cannot get a child, immediately it is the woman. Nobody ever thinks the problem could be the man. (...) The men are not free to go to the hospital. They might not even want to go through with the whole treatment, what happened with my husband." Men who have difficulties with fertility are often ridiculed as being impotent and do not get treated, although they are the cause for a woman's struggle to conceive[21] (see for example Cui 2010; Daar and Merali 2002; Hörbst 2012; Kielmann 1998; Opara 2006). Stephen, the midwife, added that there is a lack of adequate treatment options and facilities for men:

> "If it is a man, a man would go out to try with another lady. If the other lady conceives, then he will be able to say, yeah, that is the wife who was not fertile. Instead of this man going to the health care provider to find out, he goes secretly to find another woman to try conceiving with the other woman [...]. And as he goes round trying with the other partners, he is doing unprotected sex. And in so doing he or she might get infected without knowing."

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[20] This system has been discontinued due to the efforts by the Kenyan government to offer universal health coverage.

[21] As Stephen's comment makes clear, male and female infertility are closely entangled. Many studies have stressed the importance of research on the male perspective on infertility (see e.g. Barnes 2014; Inhorn and Patrizio 2015; Inhorn 2020, 49).

These practices often entail women becoming infected with STDs. Untreated or inadequately treated STDs can result in reproductive tract infections by damaging a woman's fallopian tubes, rendering her infertile (Inhorn 2003, 1837; Inhorn 2015, 108). The reason for a woman's inability to conceive naturally may thus shift over time. Often, women undergo risky forms of unnecessary treatment such as hormonal stimulation, surgeries, or taking locally used herbal remedies to overcome the alleged infertility. These treatments are often dangerous to the women's reproductive health and can cause irreparable damage. Thus, there are complex interrelations between inadequate diagnoses, a shortage of specialized physicians and economic resources, and gender-biased treatment regimes. Furthermore, as studies have shown, involuntarily childless women are also at significantly increased risk of becoming infected with HIV mainly as a result of extramarital attempts to conceive (Boerma and Mgalla 2001, 20; Dyer 2008, 73; KTN Kenya 2013). Inhorn also states that infertile women who are abandoned by their husbands may be forced to turn to prostitution as a form of economic survival (2009b, 173). Inhorn's research was confirmed in my interview with Brenda, who started prostituting herself to survive financially after losing support from her family and church. Frequently changing affairs with different mostly married men were also mentioned as an opportunity to get "kitu kidogo" (Swahili for "something small" or a "small amount of money") in conversations with other women. Ombelet and Onofre stressed that is "is striking that budgets for HIV research are huge and the information on HIV is easily available while the contrary is true for infertility" (2019, 71; see also Richey 2011 on integrating HIV/AIDS in reproductive health agendas). Tellingly, several research participants stressed that, thanks to subsidized antiretroviral treatment made available by Global Health Organizations, they did not perceive HIV as a "death sentence" anymore. Rather, they often described infertility as a "death sentence." This designation is widespread in Kenya (see e.g. Njenga 2019; KTN Kenya 2013), and reflects the strong stigma that infertile women have to bear and the "social death" they often face when unable to bear children.

An extreme case that exemplifies the potentially drastic consequences of infertility in Kenya is that of Jackline Mwende. At the beginning of August 2016, the 27-year old's husband attacked her with a machete. He chopped off her hands and severely injured her head. The case dominated the headlines of national and international newspapers. One article reported that "she was brutally attacked by her husband who blamed her for not being able to conceive any children during their seven-year marriage" (Muktar 2016). Other articles stated that Jackline's husband attacked her because she had cheated on him. These two lines of argument are closely interrelated, as explained above. In a newspaper statement, Mwende expressed that reproductive issues forced her to "go out of marriage" to try to conceive. "I wanted a child," she stated; "I was desperate and I was yearning… and probably the devil too… that made me stray out of my marriage. But I did it to save my marriage" (Star Reporter 2017). In Kenya, this gruesome incident provoked a vivid public discussion about the stigma of infertility and the roles of men and women, but many newspapers reported that not Mwende had fertility problems.

Beyond such extreme examples, the description of infertility as a "death sentence" for women must foremost be understood socially. Involuntarily childless women can die a "social death" when they are ostracized, abandoned, avoided, or not seen as full members of society (Bochow 2012; Dhont et al. 2012). Certainly, infertility can also unsettle women's sense of womanhood and feminity in resource-rich and privileged settings but, due to the consequences described above, infertility particularly compromises living conditions of

women in resource-poor settings who strongly depend on social networks to make a living (Manderson and Smith-Mooris 2010, 96). Involuntarily childless women often lose the support of their husbands, friends, and sometimes even of their family members. Mercy, the owner of the Tunza clinic, strongly emphasized: "The worst nightmare is if a woman cannot have a baby. Yeah. I'm sure it's not even in Kenya only. I think it's the whole world. But in Kenya, it's worse." Having a baby in Kenya might be "worse" due to direct physical violence against the involuntarily childless woman, as described above, or indirectly through abandonment and ostracism.

Thus, it is essential to understand why women resort to risky forms of "treatment". Many recent ethnographic accounts have addressed the rapid transfer of assisted conception technologies to the Global South and have explored how biomedical responses to infertility are socially and culturally perceived, conceived, and applied in different contexts. Comparatively, little research has been done on women in the Global South who are now surrounded by discourses on ARTs but do not have access to advanced biomedical technologies due to financial constraints (Bennett and de Kok 2018, 92; Gerrits and van Balen 2001, 217).

When women like Syokau fail to conceive within a "normal" period of time, which is not only defined culturally but also strongly influenced by global definitions of infertility such as that of the WHO, they "slip through the network of classifications that normally locate states and positions in cultural space" (Turner 1977a, 95). Having a child would have assigned value to the woman and been interpreted as that God means well for the couple's future. Being a married woman without a child, Syokau gradually lost her societal position and become "a matter out of place" (Douglas 1966), as shown below.

"How many kids do you have?" On a childless married woman's process of concealing

One day Syokau and I talked on the phone, as we often did when she was in the shop. We were continuously interrupted by customers buying items or depositing and withdrawing money at her small M-Pesa agency[22] within her shop.[23] Syokau often cracked jokes with her customers and shared stories. She then usually laughingly commented that I would hear a lot of *udaku* (Swahili for "gossip") today. One time, while I was on the phone with Syokau, a friend I had never met passed by. Syokau introduced her to me as Virginia, then added, "or you can also call her Mama Grace or Mama Brendon."[24] In the background, I heard her friend saying that she prefers being called Mama Grace. "I'm proud of being called Mama Grace," she said in Swahili. Syokau laughed it off. "The pleasure of being a Mom," she commented. But this incident exemplifies how the role of being a mother is interwoven in societal structures in Kenya. Often, I did not know women's birth names but solely their names in relation to their children. Syokau told me that people she recently

[22] M-Pesa is a mobile phone-based money transfer system in Kenya. Customers can withdraw and deposit cash in M-Pesa agencies scattered all over the country.

[23] By this time, Syokau was forced to give up selling second-hand clothes due to the high taxes that have crippled Kenya's second-hand clothes market. Being at the end of the chain of intermediaries, Syokau could not make a living anymore from selling second-hand clothes. This forced her to venture into new markets and to combine her new small shop with an M-Pesa agency. Syokau had continuously struggled to make a living ever since I got to know her.

[24] A woman is often called Mama followed by the name of her child. If the woman has more than one child, the name of the child that follows depends on the context.

met would often ask, “By the way, what should I call you?” as a way of finding out whether and how many children she has. Some would ask more openly, “how many kids do you have?” “That’s when it’s touchy,” Syokau mentioned and got very sad, remaining silent for an unusually long time. She developed many strategies to “brush that question off,” she explained to me: either by giving the name of one of her sister’s children (“Call me Mama Vincent”) or simply lying that the kids “are in the house and why should they come to my workplace” when people did not stop nagging her about where her children are.

Anaitwa tasa[25] is the most common way in Swahili to express women without children. A woman can be labeled *tasa* (“barren”) publicly and then perceived as infertile, regardless of her actual medical status and the man’s medical condition. *Tasa* stresses the woman’s socially and culturally understood “deficiency” and degrades her to her (non-)reproductive status. Thus, women are assigned a sort of nonidentity: it is not the life created but the life *not* created by these women that renders them dangerous, polluted, or ostracized. The difficulty in remaining (in)voluntarily childless is demonstrated by accounts of publicly known women who are childless. For example, the story of the Member of Parliament (MP) Millie Odhiambo shows that involuntary childlessness can be highly disabling even with a social standing. Odhiambo has often been publicly insulted for being a childless MP who would – due to her childlessness – lack the moral authority to lead Kenyans (see e.g. Osen 2019). She has often defended herself publicly, arguing that “God intended me in Parliament without a child. So that I can be a voice of the childless women because I have seen what women go through” (Radio Jambo Kenya 2018). Odhiambo, like other publicly known women, for example the former High Court Judge Roselyn Nambuye, faces public rejection and ridicule for not bearing children (Wakhisi and Barsulai 2014). Although these socially and financially well-situated women have treatment options at home or abroad to overcome their infertile status, the treatment is not always successful, as in Odhiambo’s case.

Recently, women who are voluntarily childless have been voicing their choices publicly. For example, Tarurî Gatere explained in an article in the Kenyan newspaper *Daily Nation* that “although not having kids is a private decision, I have chosen to speak of my decision on several public platforms to prove that we do not have to stick to the paths that society expects us to follow” (Jones 2020). This public “outing” drew many of comments: although some applauded her for changing perspectives by speaking about her voluntary childlessness publicly, many commentators remarked that her decision was “un-African” or “against the African tradition,” or they interpreted it as a false pretense to cover up an allegedly promiscuous life followed by abortions during her teenage years that caused infertility (Facebook; see also comments on CitizenTV 2018).[26] Although, her background allows her to live financially indepent, it is nevertheless a new and promising development that women speak publicly about alternatives to becoming a mother or being in the limbo of not *yet* being a mother.

[25] Swahili for “she is called barren” or “her name is barren”. There are several derogatory terms in local languages meaning barren or infertile and are solely used for women. Examples are: *thaata* (Kikuyu), *lur* (Dholuo), *ngungu* (Kikamba) or *mkumba* (Luhya) (see e.g. Ministry of Health 2007b, 42; CitizenTV 2019).

[26] Side-effects of contraceptives and multiple abortions were mentioned as risk factors potentially leading to infertility (Kaler 2009; Nguyen 2005, 137; Okonofua et al. 1997, 207). Thus, most women I talked to face-to-face and on social media emphasized not having taken any contraceptives nor having aborted (see also CitizenTV 2019).

Social mechanisms like levirate unions, sororate unions, polygyny, or woman-to-woman marriages[27] have long protected women from public mockery by enabling a woman to have a role as a mother even if she is not personally able to conceive – either due to her or her husband's medical status or because her husband died before they had children together (see Wasunna 1999, 13–21; Bukusi et al. 2015, 5; see also Obi and Omulo 2019). These social mechanisms aimed *inter alia* at avoiding the exclusion of women from social networks[28] (see e.g. Wasunna 1999). To what extent these strategies are still practiced is not fully clear, but they have lost legitimacy with the advance of ARTs. In the Kenyan newspaper *Daily Nation,* Obi and Omulo stated:

> "Due to advancements in science, many traditional practices, such as begetting children out of wedlock, have been fast replaced with very advanced technologies, such as assisted reproductive techniques (ART). These include in vitro fertilization (IVF) or surrogacy to help couples have their own children. Couples who cannot bear children, therefore, have some of these options at their disposal, even though they tend to be quite costly for the average Kenyan" (2019).

Traditional practices thus increasingly lose acceptance, particularly in urban areas. This is not only because they are seen as outdated but also because they are inconsistent with the predominant discourses of HIV and STDs prevention campaigns that preach sexual abstinence, stable nuclear families, and the use of condoms (Wasunna 1999, 13–23; Parker 2012). Extramarital sex, often the only way to become pregnant, is increasingly represented as sinful. In Kenya, more and more emphasis is being placed on biological parenthood of children conceived within marriage, also mirrored in the important sign of the "swelling belly" (see also Hiadzi 2014 for parallels with Ghana). The medicalization of infertility and the induction of ARTs have caused a replacement of traditional (and increasingly illegitimate) practices, and religious leaders are encouraging new "modern" biomedical technol-

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[27] A levirate union would be arranged if it is determined that the husband is infertile. The husband's brother or a close male relative would try to get the wife pregnant, and the child resulting from this union between the wife and relative would be deemed the husband's own (Wasunna 1999, 17). A sororate union is similar to the levirate union as a third party is engaged, this time on behalf of the infertile wife. The third party can be the sister to the wife or a female cousin. The child born from this union would be considered the wife's own child and would prevent her from being chased away or that the bridal price must be returned because there are no children born out of union (ibid, 18-19). A woman-to-woman marriages means that two women get customarily married to each other. In one of our conversations, Syokau mentioned this arrangement called *iwieto* in Kikamba, the language spoken by Syokau's ethnic group. Syokau told me it is a still relatively common practice among members of her ethnic group in rural areas (see also CitizenTV 2016a for the same practice by another ethnic group). Women who do not have children and are not married or divorced can practice *iwieto* "to get a name" by having a child in their name. These women "get married" to a fertile woman, commonly one who has "proven" to be fertile by already having given birth to a child. This "female wife" gives birth to a child who becomes socially the child of the infertile woman, thus improving her social status. Polygyny is another arrangement that is sometimes used when the first wife is infertile. The second wife's children would also be brought up by the first wife and refer to her as mother. Against all the criticism of polygyny as discriminatory against women, Wasunna observed that this arrangement can also serve as a security valve for childless women who now easily fitted into activities such as collective labor and childcare (Wasunna 1999, 14-16). For a detailed explanation of these practices, see Wasunna 1999, 13–21.

[28] Women never mentioned these concepts uncritically, however. All told me in some way that a woman would never be happy to become a second wife or to become the first wife when the husband decides to get married to another woman. This often happens without the first wife's knowledge. "We all want to be number one," Syokau said. However, this pain was mostly weighed against the other burden of a childless life.

ogies. In a television show, a woman reverend argued that "if the science can help you and if it is not interfering with God [...], you are not doing it in sin. What is sin, is going to sleep around" (KTN 2013; Ministry of Health 2007a, 40; see also Beckmann et al. 2014, 3). This kind of religious legitimation of ARTs makes it even more difficult for financially disadvantaged infertile women who have no access to ARTs.

"Having a name" – getting a name through a child – is also often crucial for women to find a new partner after being divorced or abandoned. A woman's childlessness is often publicly discussed – even if behind her back or in hushed tones. Thus, a potential new partner would often hear about it. Several women told me that it could be important to first "get a name" – thus, have a child – in order to find a partner. Therefore, to become a mother, "to get a name," and to become destigmatized before remarrying is often seen as the only way to find a new partner. Elite women or those who have access to money, e.g. from relatives living abroad, might consider IVF with a sperm donor. Most women with limited economic resources have few options, however. If they engage in extramarital sex, church and society at large will accuse them of sinning against God – as was illustrated in the case of Jackline Mwende.

"God has a reason": On juggling hope, guilt, and blame of not giving birth to a child

Whenever I talked to childless women in Kenya, all of them used sentences starting with "I've never ..." in reaction to the public blaming of childless women for being solely responsible for their infertility – be it because of abortions or other "mischievous behavior" in their teenage years, or because of their lack of faith in God. Syokau stressed in one of our very first conversations:

> "I've never had an abortion, I've never taken – even I don't know the names of those things – the injections, the what... I've never tried any since my teenage years. You know when you are a teenager you might fear getting pregnant and you just jump in one of those things, you might do them early in advance. I didn't do any of those. [...] I've never done it, my dear. I've never been treated for any STDs.".

People would often comment, for example, that infertile women would "cry out loud" now, but that in fact their infertility is a punishment by God for earlier "unfaithful behavior." Syokau recalled that she wrote letters to God over a long period, "requesting him to give me a baby." "I humbled him for forgiveness in case I have done something wrong," she recalled. For most people in Kenya, God is perceived as the giver of children, and the ability to conceive becomes a vital sign to reassure one's faith. Women who fail to bear a child are often seen as inauspicious in religiously based moral systems (Bharadwaj and Inhorn 2007, 84; see also Ahlberg 1991, 59). Most people would "try to isolate and get away from" a relationship with such a woman, said Stephen the midwife, one of my interviewees in 2013.

Relying on God seems paradoxical at first sight: God is mentioned as punishing and comforting regarding infertility. The failure to overcome the status of childlessness is explained with God's will. "God has other plans for me," was often given as an explanation, or that the devil is interfering with "God's will." Syokau told me about a cycle of herbal medicines she took with a friend who also struggled to conceive. They would call, support,

and encourage each other not to give up over the phone. "If we both don't succeed, God has a reason. That's how we consoled each other," Syokau narrated.

Syokau did not experience ostracism in church, but she realized that people "talked behind my back." However, childless women can be excluded from church, as another woman explained to me in October 2014:

> "Me not giving a child could mean that maybe they [the church members] are not serious [they do not pray enough for her] [...]. When you don't have children, people tend to feel you are not very strong in your faith, or maybe you are not very strong in your walk with God. Some people don't want to be associated with that."

Therefore, she was ostracized in church and was encouraged not to come to the weekly services or church gatherings any longer. The religious and moral element of infertility adds another severe challenge to involuntarily childless women's suffering, since when they lose the church, they lose a crucial area of social support (see also Wanyama 2014). It explains further why these women persist in their search for treatment and therapy at all costs as they intensify their prayers.

"It's now my time to sleep": On trying to overcome social expectations and individual pain

"When I was up, that thing was haunting me day in, day out," Syokau recalled the many years she tried to conceive. Over the years, she talked a lot to me about her former husband, who never gave her the chance to get formally divorced or an explanation for his disappearance. Syokau had long agonized over questions about how she could be "thrown away" by the man she had loved and admired for so many years because "she could not bear children". When I met her in 2009, she always explained to me that her husband must have been bewitched while working in Tanzania, "where witchcraft is very common." More than a decade later, she could eventually talk about her pain of being abandoned for being infertile. "Is it a second wife he wanted? Was it the pressure by the family?" Syokau revealed questions that have caused her so much distress over so many years. "I cried so much," she said. "Maybe that is why my tears are always dry now."

Once in a while, she gets to see some of his family members because they live near her. In 2019, she told me about an incident when a nephew of her former husband passed by and said that her former husband would like to see her. Syokau said with a bitter voice that he was mocking her, and she added harshly: "They [her former husband's family] think I'm going to die of depression" hinting at the collective cultural assumption that there is no happiness or fulfilment in a woman's life if she does not have children. Living nearby, Syokau's sister, who had always backed her up and defended her against mockery with sarcasm and dark humor, told Syokau that she should send the nephew a message reading: "*Waambie, tuko* (Swahili for "Tell them, we are around"), we're not going to die anytime soon, love you." We both laughed out loud about this reaction to mockery that would have been unthinkable when I first met Syokau twelve years ago. The way Syokau's sister used "we," referring to herself and Syokau, also shows the strong bond between them and her undying support for Syokau. This incident also exemplifies Syokau's transitional process and way of dealing with her status as a childless woman. I also remember well when she decided to pack all of her husband's clothes and other items he had left

behind in their then shared flat. She had never gottenn rid of them although they filled almost her entire wardrobe. She packed the clothes in boxes, first storing them on her wardrobe, and eventually took the bale to his family. After she had returned the clothes, she called me with regained self-confidence resonating in her voice. It seemed to me as if this step had made visible and tangible a process of transition: a process of letting go but also of reintegration. She also told me that she recently got rid of all the x-ray pictures and documents issued by hospitals during her experience of trying to get pregnant.

By around 2018, it seemed that Syokau was tired of continuously cultivating hope for her husband to come back or to get a child from another man, which also involved recurring despair when discovering month after month that she was "not yet pregnant" (Greil 1991). She had been in the state of being "betwixt and between" (Turner 1977a, 95) for years. She accepted "to stay this way," thus as a woman without a child, communicating with God, as she told me. What struck me was that whenever I tried to talk to Syokau about ARTs – the "technology of hope" as Franklin (1997) coined it in the 1990s – she seemed reluctant to talk about it. Rather than hopeful, these technologies seemed to uncover the painful realization that one is disconnected from potential futures, as Ferguson showed (1999; see also Bell 2009). Trying to get access to ARTs would mean being dependent on unpredictable subsidies, changing laws, new donation campaigns, and not least on the highly uncertain outcomes of ARTs – and would therefore draw her back into another liminal state. Syokau told me that her mother would usually tell her that "it is not yet over" when they talked about Syokau's intermittent acceptance of remaining childless. Syokau told me that she always responded with "keep on talking." Syokau then added determinedly: "I told God that I will not complain anymore." She continued: "I'm now too old for having babies. I'm completely healed [from suffering from her childlessness]." "I'm so free," she said decisively, as if she wanted to convince herself. As usual, Syokau cracked a joke: "It's now my time to sleep," she said, bursting out with laughter, which was somewhere between the tears of pain of still not having a baby and confidence and joy of letting go all the anguish of her silent struggle in the past up to this day. Ever since, our frequent phone conversations have oscillated between Syokau telling me about her freedom of having a life without a child and desperation of not having a child. Surrounded by increasing alternative narratives on being childless, Syokau must pick from these narratives about motherhood and nonmotherhood to make sense of her own life as an involuntarily childless woman (Wilson 2014, 38).

Conclusion

In Kenya, childlessness can jeopardize a woman's reputation, marriage, livelihood, long-term security, and physical health. Thus, having a child in Kenya, where motherhood is culturally and socially mandatory, is not a matter of choice (Bharadwaj and Inhorn 2007, 101; Lock and Nguyen 2010, 254–56; Feldman-Savelsberg 1994). However, the experiences of financially disadvantaged, involuntarily childless women like Syokau have not been given much attention, and the focus on the fertility of poor women in Kenya as in the Global South at large continues to be constructed as a problem contributing to overpopulation (Wilson 2014, 32). Involuntarily childless women become disenfranchised of their reproductive rights in a system in which biomedically assisted reproductive technologies have become the epitome of procreative freedoms and opportunities. If fertility of economically marginalized women in Kenya is dealt with at all, pregnancy prevention is

constructed as the most promising and cost-effective way to deal with it. However, the emphasis on prevention has contributed to the image that there is “immaculate” fertility at the beginning of a woman’s life, and that this fertility must have been compromised by unsafe and/or immoral behavior that led to involuntary childlessness.

Access to ARTs is unequal and mirrors a deeply ingrained and stratified idea of reproduction: some women are valued by reproducing, while others are not. Thus, reproduction does not just “naturally” occur at an individual level; who should or should not reproduce is shaped by complex social, political, and moral discourses (Sobonya and Sargent 2018; Thomas 2003). Although financially disadvantaged women do not have access to ARTs, they are not oblivious to the discourses about the promises of reproductive technologies and their effects on society. Longstanding social practices to overcome childlessness are becoming gradually devalued, ridiculed or villified. Thus, new technologies are not liberating for these women but rather emphasize the stratification that manifests in society and is deeply ingrained in the healthcare system. Women who have access to these technologies and who conceive and carry a baby to term attain societal personhood. By going through the transitional period of pregnancy, marked by a “swelling belly,” they can reproduce culturally and socially accepted gender roles. Economically disadvantaged women, however, cannot bypass infertility, and they often get caught in a liminal state of “not yet being a mother” when lacking the “visuality” of motherhood (Bharadwaj 2016, 43). Aware of the unattainability of ARTs, women like Syokau try to access whatever biomedical technologies are available (like invasive surgeries for unblocking fallopian tubes) as they oscillate between hope and despair and between acceptance and vague, intangible imaginary futures of “yet becoming a mother.”

While the liminal state mostly weakens these women, it also bears the potential for change at an individual and societal level. Women in the liminal state within imaginary yet unattainable futures reflect on “objects, persons, relationships, and features of their environment they have hitherto taken for granted” (Turner 1987, 14). Syokau’s story shows that she has started questioning the culturally and socially constructed and entrenched gender roles. Her liminal role of not yet being a mother has become a space of potency and potentiality, not only one of structural invisibility. Syokau has expressed a personal shift towards self-determination and redefinition of her role as an involuntarily childless woman in urban Kenya trying to resist, redefine, deconstruct and simultaneously accept discourses on childless women in Kenya, though her hope seems fragile, always capable of turning again into despair over being childless.

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