"I Dreamt I was Holding a Baby Boy": Infertility in Northern Malawi

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Extended Abstract

BACKGROUND: Infertility can have profound and damaging effects on women's lives, especially in societies where women's status is largely constructed through childbearing. However, little attention has been paid by reproductive health policy to the problem of infertility in the developing world.

METHODS: In-depth life history interviews with forty three fertile and infertile women were carried out to explore how infertility affected women's lives, and in particular, their health and marital status, in rural northern Malawi. Other qualitative methods such as key informant and group interviews supplemented these data.

RESULTS: A minority of women with fertility problems reported 'risky' sexual behaviour associated with their infertility. Infertile women had often left marriages in preference to living with lowered status, and pressure to remarry was subsequently high. However, many infertile women had supportive and stable marriages, particularly with polygamous men whose desire for children was met by other wives. Even for these women, their desire for children and quest for fertility treatment persisted for many years.

CONCLUSIONS: These results confirm findings from elsewhere and add weight to the argument that infertility should be considered a public health problem. However, existing literature does not fully capture the wide range of outcomes for infertile women in this rural sub-Saharan African setting. The demand for infertile women as wives and long duration of some childless marriages challenges the notion that in such societies, without the production of children, marriages inevitably falter.

Introduction

Young women in sub-Saharan Africa are exposed to numerous threats to their reproductive health and future fertility, and have limited resources available to understand or manage them. Few medical services exist to manage infertility, beyond basic STD treatment. Yet fertility is a key component of reproductive health, and experience of infertility has complex interactions with health and social factors across often lengthy periods in women's lives. While the developed world advances expensive, high tech reproductive technologies, infertility in sub-Saharan Africa fails to be recognised as a public health problem in national and international health policy and implementation, perhaps because of numerous other public health problems, high fertility rates at the population level, and concerns about over-population.

Infertility affects eight to ten million women in sub-Saharan Africa (Ties Boerma and Mgalla 2001). The small anthropological and demographic literature on infertility in sub-Saharan Africa focuses on its disruptive and distressing effects, especially on women's lives (Inhorn 1996; Okonofua 1999). Several studies have linked women's experience of infertility to marital instability and/or having extra-marital partners in an attempt to get pregnant (both of which may be associated with increased risk of STDs including HIV) (Boerma and Urassa 2001; Ikechebelu, Ikegwuonu et al. 2002), mistreatment or violence in the home, psychological distress, social stigmatisation, and impoverishment in old age (Feldman-Savelsberg 1999; Leonard 2002).

This paper examines qualitative data from northern Malawi to see how infertility affects women's lives, especially in relation to their health and marriages. In particular, it assesses whether there is any evidence for the sort of 'risky' sexual behaviour associated with infertility described above; namely, those behaviours linked to marital instability and having extra-marital partners. The literature on social aspects of infertility in this region merits updating and expanding: recent socioeconomic changes across sub-Saharan Africa mean that infertility has potentially new meanings, interpretations, and consequences. These include the development of the AIDS epidemic, changing costs and benefits of children, and increasing poverty and economic insecurity. No work on infertility has been carried out in this particular region, which is socially and culturally very different from West and North Africa, where similar detailed research has taken place.

Methods

This study was carried out under the auspices of the Karonga Prevention Study (KPS)[1], as part of the main author's PhD research. This paper presents results from the qualitative component of the study, although the ultimate aim of the PhD is to synthesise detailed qualitative case studies with quantitative analyses of demographic survey data recently collected by the KPS. These data include a census of 30,000 people, and a survey of women who had not attended an antenatal clinic in the past four years (the antenatal non-attenders study, or ANA study), nested within the census. 'Infertility' was defined in a broad, colloquial sense: the inability to bear a live child when desired. Although this paper talks about 'infertile woman', this only refers to self-perceived infertility, and does not imply that such women will never bear a child, or that the underlying cause of infertility might not lie with her husband.

Life history interviews were carried out with 43 women aged 20 to 30 years. The ANA study acted as the sampling frame to select infertile women for in-depth interview, as it asked women whether they were currently using any methods to help them get pregnant (these were almost exclusively 'traditional' methods). Other infertile women were referred for interview by KPS nurses when they came across women complaining of infertility in the course of carrying out the ANA study (as infertile women would not necessarily be using traditional medicine all of the time). The census provided a sampling frame to select 'fertile' women (with an average/high parity for age) who acted as a comparison group. Purposive sampling from within the sampling frames of the ANA study and census ensured a range of women were interviewed: fertile and infertile, in polygamous and monogamous marriages, in first or higher order marriages, and living in remote areas or close to trading centres. Two-thirds of infertile women were followed up with a repeated interview to probe on more specific questions. Local women trained in open-ended interviewing skills carried out interviews at women's homes following a booking visit, explanation of the study, and gaining informed consent. Interviews were carried out in Chitumbuka (the local language) and were recorded digitally. The main author was present at most interviews. Interviews were transcribed and translated into English alongside the original Chitumbuka text. In-depth interviews were also carried out with older women, husbands of infertile women, traditional healers and other service providers; and group interviews were carried out with adolescent girls and women in their twenties and thirties, to investigate attitudes in the wider community.

[1] A London School of Hygiene and Tropical Medicine epidemiological, demographic and immunological research site currently funded by the Wellcome Trust and LEPRA.

Interviews are analysed with the recognition that the interviewer and interviewee create the interview together, and that a recounted life history does not equate with the actual events of a woman's life. Rather, a life history interview creates an interpreted version of a life, and reflects how people make sense of their situation, moulded by complex conscious and subconscious motivations. Narrative case analysis was used to address both pre-existing and emerging hypotheses concerning the effects of infertility on women's lives. This involved writing a detailed case-study for each woman, to which field notes were added. Each case was re-read, and key themes identified. All qualitative data were coded and organised by analytical themes using Microsoft Word. Quotations are inserted in the text below to illustrate certain points, or demonstrate the manner in which people typically expressed themselves.

Results

An overview of key contextual factors in women's life courses is presented, followed by a brief description of the way that infertility is conceived of in the study area, including aetiologies of infertility, and typical treatment seeking patterns. The evidence for infertility being linked to adverse health and social outcomes, and in particular, 'risky' sexual behaviour, is presented. This is followed by a description of selected cases that do not fit the hypothesised models of risky sexual behaviour, which demonstrate the wide range of outcomes reported by infertile women, and challenge many of the images of infertile women in both academic literature and popular discourse. Findings are then placed in a broader context in which the problems associated with infertility are contrasted with the risks that fertile women experience during pregnancy and childbirth.

WOMEN'S LIFE COURSES IN NORTHERN MALAWI

The study was based in southern Karonga district, a rural area bordering Lake Malawi, with several small trading centres, and numerous dispersed villages. The majority of people rely on subsistence agriculture and fishing, and most are Christian, from a mixture of African, Catholic and Protestant churches. Primary education is free though resources are scarce, and few pupils continue to finish secondary school. Commercial and domestic activities start at a young age, and children (especially girls) are frequently transferred to live with other relatives for several months or years at a time. Although children frequently reside away from their biological parents, there is no permanent transference of custody rights and residence is usually temporary; we found no evidence of adoption. Children have a high value in terms of their present and potential economic worth, and in strengthening kin ties, partly through child migration to live with other relatives.

Sexual activity before marriage is common: 62% of all under 20 year old never married women interviewed for the ANA study were not virgins. Should pregnancy occur, cash compensation is demanded from the man involved by the woman's family if he fails to marry her. Other events leading to marriage are varied: some are a romantic match, some marry to escape problems at home (usually poverty related), and others describe coercion into marriage by their husband. Marriage is almost universal[2] and only 1.5% of women live alone. Marriage is usually defined by co-habitation; most couples do not have a church or traditional ceremony. Getting married is often a process, rather than a discrete event, including a system of payments from the husband to his wife's relatives (chuma, or bride-price), which may be made over the course of many years of marriage. Marriage and having children are frequently synonymous (both concepts are referred to as 'banja', or family). Polygamy is fairly common: the census showed that a quarter of married women have co-wives.

Marital disruption is also common: the census found 13% of all women over 20 to be currently divorced or separated. Marital disruption is the appropriate term in this context to describe separation and divorce, as partnership formation and dissolution are often not formalised: partners may separate for months or years and eventually reunite, especially if they have children together. Separation may be initiated by the husband or wife. If (sufficient) chuma has been paid, a woman leaving her husband may lose custody and contact with her children as children then 'belong' to the father's family. Women usually return to their parental or fraternal home after divorce or aim to set up their own household by running small businesses or with help from boyfriends. Re-marriage following separation is the norm and usually occurs swiftly in women under a certain age: of women aged 15-29 who were divorced at the time of the census, 36% were re-married when interviewed for the ANA study (which was on average slightly over a year later). Seven per cent of women in the area had not had a live birth by age 44, in spite of near universal marriage and little use of modern contraception by married nulliparous women.

[2] Only 2% of women aged over 20 in the census area have never married.

UNDERSTANDING INFERTILITY

> *Some people said, 'those who are holding you are from where you are married'; some said, 'it's your grandmother', so that was what was happening. And then other people said, 'you are fertile'. I found that when I was sleeping, I found that I was holding a baby boy in my dreams, then I realised that, ah! It was just a dream. (31 year old woman, married twice, no children)*

This quotation illustrates some of the important beliefs about infertility in the study area. When this woman talks about 'those who are holding her', she is referring to the belief that fertility can be blocked by other people engaged in witchcraft or thinking negative thoughts, which close the womb and prevent conception. These malevolent forces are frequently thought to originate in the extended family that has been married into (co-wives or sisters in law, for example), or from relatives at the natal home who may have been slighted in some way: frequently due to inadequate marriage payments or an unpopular choice of marital partner. This woman's confusion over what might be causing her infertility, and whether she is infertile at all, is typical of how women responded when asked to explain what they thought was causing their infertility. The specialised realm of knowledge relating to infertility was not easily accessible to young women: they typically sought, or were offered advice from older relatives or traditional healers (zing'anga).

Other perceived causes of infertility included congenital abnormalities of the womb that 'blocked the path' (known as jalawe, nguli, and kawinkha). Traditional medicine was thought to be needed to open the path again. 'God' was often cited as the ultimate source of women's fertility problems, whereas 'diseases' (usually syphilis) were only linked to difficulties in conceiving on a few occasions. Thus although there was some awareness that sexually transmitted diseases could affect fertility, supernatural causes held a far greater importance in aetiologies of infertility, as explained to us by both infertile women and other interviewees. Following the dominance of beliefs in 'traditional' causes of infertility, and perhaps because hospitals and clinics were not believed to offer much help in these matters, most women sought treatment with a succession of traditional healers. Women's infertility problems were often compounded by other reproductive health problems such as known or suspected infection with an STD (several women had been treated for syphilis or another unknown infection by KPS nurses or at clinics). Additionally, several women with secondary infertility had already had one or more children who had died in infancy, so were effectively childless.

INFERTILITY, MARRIAGE AND RISKY SEXUAL BEHAVIOUR

The literature on fertility and marriage in sub-Saharan Africa stresses the fundamental importance of childbearing to the marital relationship, and marriages are frequently assumed not to endure prolonged infertility. Recently the public health implications of this have been discussed, with infertile women increasingly identified as a potential 'risk group' for HIV infection. The proposed mechanisms for this are that firstly, infertile women may have more sexual partners than fertile women due to marital disruption as they repeatedly marry and divorce, or divorce and subsequently have multiple sexual partners (Boerma and Urassa 2001). Secondly, infertile women are hypothesised to be more likely to have extra-marital relationships in an attempt to get pregnant (sometimes with the tacit support of their husband or extended family) (Gerrits 1995). These hypotheses found some support in the course of this research. However, detailed descriptions of marital breakdown and comparisons between fertile and infertile women showed that numerous other factors precipitated divorce and the degree of 'risky' behaviour that women were exposed to, and infertility could be considered a principle or even contributory factor in only a few cases.

Of 33 women who reported past or current infertility, 12 had ever been divorced. Of these, only three cited infertility as the main cause of divorce: one woman reported that her husband did not want her due to her infertility, and two women decided to leave for themselves due to their husband's 'bad behaviour' (beatings and abuse linked to their infertility). Additionally, three infertile women's divorces could plausibly be linked indirectly to infertility. In one case, a woman temporarily left her husband because she was angered that he had never paid chuma (bride-price) to her father, whereas he had just paid chuma for his junior co-wife who had just had a child. Two woman reported being bewitched by their co-wives (who had children) and returned home to escape the situation. The fact that the 'innocent' party, the infertile women, rather than the fertile women, had to leave in these situations suggests that the women with children were more firmly established in the marital household. Mary's story[3] (below) demonstrates events by which infertility might increase the chance of infertile women being exposed to further health risks due to having more sexual partners than if they had remained married:

Mary was married at 16 and had two children. Her marriage ended when her second child was still a baby after her husband insulted her father. Soon after this her second child died. Her first child remained with his father (according to customary child custody arrangements). In 2001

[3] Not her real name

she re-married, to a man with two wives with several children each. She failed to get pregnant. After a year and a half, the marriage ended after she suspected her co-wives of witchcraft: she found some of her underwear to be torn, and she suspected that the water in her cooking pot had been poisoned. When she confronted her husband,

> "He was also chasing me away [from the marriage], when I asked about my underwear, then he started saying, 'you should just go, if you don't want to live here, you can go, do you have a child here?' So that's why I came back."

She returned to her father's house, and has had a several boyfriends since her divorce. She wanted to get pregnant with one serious boyfriend and marry him, but her boyfriend's parents refused to let him marry her because they suspected she was infertile (having heard about her previous marriage). She went to a private hospital, where they x-rayed her and told her to return with her husband in a few months. Because she was not married, she did not go back. She broke up with that boyfriend recently and still lives with her father. She still occasionally visits her first child, for instance, if he is sick. Her first husband continually proposes that they should re-marry, but her father refuses due to the insults of the past. She fears that it would bring bad luck if she disobeyed her father, though she would love to go back because of her child.

Having had two unsuccessful marriages, Mary was not keen to marry again unless she got pregnant, even if her boyfriend's parents had given the marriage her blessing. Thus Mary's infertility both prompted her divorce and discouraged her from marrying again, leaving her in a potentially vulnerable position as a single women. Single women are likely to have one or more boyfriends: such women told us that they needed boyfriends to survive economically as they brought them cash and other goods, and alluded to the fact that they still enjoyed sexual relationships (that they were still young, their 'blood was still running', and they wanted to make their bodies happy).

We found little evidence, perhaps unsurprisingly given the intensely secretive nature of the problem, of the other proposed mechanism for the possible link between infertility and risky sexual behaviour: women having extra-marital affairs in an attempt to get pregnant. Only one woman told us that she had tried to get pregnant with a boyfriend while she was married (and this was with a previous husband). After six or seven years of being married without getting pregnant, she wanted to try with another man in case her blood differed from her husband's (another perceived cause of

infertility). When her husband went out drinking beer she would meet another man 'in the bush'. This man had been proposing to her for a long time and she eventually agreed: he persuaded her by saying that he might be able to help her with her problem of infertility. He told her that any baby she might have had would have been a gift. She was not happy with what she had done, bemoaning that even though she had gone to many traditional doctors, she still 'ended up [sleeping around] with men', and without a child:

> *"…You who can tell those people [who read your research] that this is what my problem is like….For a person to stay at their marriage, they need children…you can go through many marriages, but what is needed is a child. Even if you go to many traditional doctors you will just end up with men, and they will call you prostitute. I have already decided that if this marriage ends, I will just live at home [with my parents]" (30 year old woman, no children, in second marriage)*

Two women reported that neighbours or friends had advised them to try to get pregnant by sleeping with another man, but they refused, saying they were scared of 'diseases of nowadays' (a euphemism for AIDS). However, a number of women reported that their husbands were 'going out of the house' (having extra-marital affairs) to try to have a child with another woman. This could expose their wives to risks from a larger sexual network, and could also weaken the marital relationship making divorce more likely. Although it might seem unfair to rely on women's testimonies of their husband's behaviour, that these affairs took place was often undeniable, in the form of the presence of children from these liaisons, or additional wives who had started off as girlfriends to men who were already married.

INFERTILITY AND STABLE 'LOVE' MARRIAGES

Although we found cases in which infertility contributed to marital instability and subsequent risks to health via risky sexual behaviour, we found a similar number of seemingly stable 'love marriages' where infertile women were accepted into the household, and sometimes treated to even greater resources and attention from their husbands than other wives who had children. In these cases, women married into polygamous households as the second or third wife, where the man already had children. Some were divorced women who were 'established' as being infertile due to long previous marriages without children. They were nevertheless very much in demand as wives: they reported being proposed to by many men, both for marriage and more casual relationships. In their subsequent marriage their husband was aware of their 'infertile' status but married

nevertheless for love. This was the case for one woman who had been married for ten years with no children in a marriage where she was abused for her infertility. However, she is now married to a man who has two other wives and eight children:

> *"Yes, he definitely knew [that I was infertile].. I told him that 'you are proposing me, you have seen that ever since you started proposing me I have been refusing because I am barren, I know what men are like, if I fail to give birth I shall be in problems" (29 year old woman, two marriages, no children)*

Despite her initial reservations, they had been married for three years and she says that he still supports her. In other cases, women entering their first marriage subsequently had difficulty in conceiving, but did not report problems in their marriage as their husband already had children with his other wives (who they often had fallen out with), and had married 'for love'. Women in this situation might appear to have stable marriages and thus avoid some of the problems related with infertility as their husband supports them and already had children, but the social status of such women is somewhat compromised. Having sex without producing children was spoken of derogatorily in several interviews: a verb in Chitumbuka describing this state (kukhuluzganenge waka thena) is used as an insult. It implies that the couple have married for sex and enjoyment, without any of the corresponding duties of raising children. Additionally, all women in this position still wanted to get pregnant and were concerned about the stability of their marriages. If love and affection breaks down in a marriage, a husband may stop sleeping in his wife's house, and may spend his time with a co-wife. However, lack of love will not necessarily lead to divorce if a couple have children together, even if they do not have an 'active' marriage. For childless women, there is little to keep them in a marriage if love fades. One woman worried that her husband would grow tired of being faithful after five years of marriage if she did not have a child:

> *What will happen is that, he will just say, 'my friend, may you pack and go, we have to share our properties out, do have anything here?'. Which means he has first started to see someone outside [have an affair]. I have to give birth, [if I don't, he will say] 'my friend you go, you have built the house for nothing'. Then I will just pack my things to go back home.*

One interpretation for the high demand for infertile wives, or the tolerance of marriage to infertile women, might be that post partum abstinence (which frequently lasts for up to two years after

giving birth) is practiced for varying lengths of time in the study area, as throughout much of sub-Saharan Africa. Whilst wives who bear children every two or three years experience prolonged periods of abstinence, infertile women are more sexually available. Indeed, choosing an infertile wife might be a strategy on a man's behalf to avoid increasing the size of his household further. One childless woman also joked that her husband preferred sleeping in her house every night rather than with his other wife who had six children, because he could not sleep with all the noise that the kids made.

A number of monogamous couples interviewed had been married for several years and women reported no problems with the marriage as yet. In these cases, husbands frequently 'over ruled' negative opinion from the extended family and reassured their wives that whether they had children was 'up to God', and that marriage was not just about having children. Without a longitudinal study it is not possible to know how long such marriages might fare in the future, but it is important to note that not all husbands behaved in the stereotypical negative way often portrayed: the quality of the relationship between a husband and wife is an important part of marriage, as undoubtedly are children, and infertility need not inevitably lead to divorce if the relationship is strong enough.

COMPARISONS WITH FERTILE WOMEN

If only infertile women had been interviewed, the reported frequency of marital disruption, husbands taking co-wives or girlfriends, and concern over treatment seeking for reproductive health problems might have seemed convincing evidence that infertility is strongly linked to these adverse health and social outcomes. However, 15 fertile women and three groups of women with children were also interviewed. We asked similar questions about their life histories, and asked about treatment seeking related to pregnancy and childbirth. Their answers revealed that fertile women are under many similar pressures to infertile women.

One woman had been bewitched by her uncle-in-law and was compelled to divorce her first husband due to the severe illness that the bewitchment had caused; the fact that they had just had a son together did not stop her from leaving him. Another woman described similar beatings and insults to those that infertile women had described, and yet she had two children with this husband. Family arguments over marital payments and disagreements over husbands taking new wives were familiar stories: having children was only mentioned on a couple of occasions as acting as a motivating factor to stay in a marriage. In one case, a woman was unhappy to find that she had

married a man who turned out to already have a wife (which he had previously denied), but when her family came to take her home, they found out that she was pregnant, so she stayed, in spite of being unhappy with living in a polygamous marriage.

Women who had had children also reported a range of reproductive health problems, issues about their husband's fidelity, and anxiety over diseases such as HIV and AIDS. Menstrual pain and irregularities, premature births, various ailments during and after pregnancy that caused disability and discomfort were all regularly reported and resulted in similar levels of treatment seeking to women looking for fertility treatments. Although infertile women suffer a particular set of health worries, they avoid many of these risks associated with pregnancy and childbearing. Additionally, having borne children was no guarantee of the longer term benefits that children can bring. Several women no longer lived with their children due to divorce, or children being obliged to go and live with other relatives, and if one or more children had died then women were left with no children or fewer than they desired.

Thus although fertile and infertile women differ in some of their precise concerns, ultimately they experienced a common set of structural factors that impacted upon their health and wellbeing. These include a poorly resourced medical health service, high levels of marital disruption, women generally having a low socioeconomic status, pressures to demonstrate fertility at a young age and early on in marriage, a heavy reliance on 'traditional' (chifipa) medicine and the understandings of health and physiology that this entails. Although the traditional medical sector is not a negative force in women's health per se (although there were some reports of negative side effects from certain treatments), the disjuncture between traditional and medical conceptions of health and disease, and what suitable treatments consist of, may mean that women do not always receive the optimal care available, particularly in the case of easily treatable STDs.

Discussion

This paper describes some of the effects that infertility had on women's marriages and health in rural northern Malawi. It finds a much more complex situation regarding fertility, infertility and marriage than commonly presented with regards to sub-Saharan Africa, alerting us to the fact that associations found in the epidemiological literature or anecdotal evidence from qualitative studies can prompt the rapid generation of stereotypes of infertile women. Commonly cited problems related to infertility were indeed found in this study area: these included social stigma, psychological distress and concern about the future, marital disruption and long-term quests for

effective treatment. However, we found few women who accorded with existing models of why infertile women might represent a 'risk group' for HIV and other STDs due to their sexual behaviour. It is easy to understand how dramatic stories like Mary's (p.8) become anecdotal and frequently reported by both local people and by social researchers, thus assuming greater importance as 'evidence' that infertility leads to risky sexual behaviour. However, in our sample, for every case like Mary's where she had been 'chased away' after a year of marriage due to her infertility, there were women who had been married for five years without getting pregnant and who still had the ongoing support of their husbands. A large proportion of fertile women also experienced marital disruption at some point in their lives. Additionally, It should not be assumed that the increased risk that infertile women may have for HIV infection is due to their own sexual behaviour: it could arise from their husband's sexual behaviour, as he might try to have a child outside of their marriage, as reported on several occasions in this study.

The prevailing view of marriage in sub-Saharan Africa in demography is also challenged: It has been written about some sub-Saharan African societies that infertile women are seen as useless as non-child-producing wives. But in this area, all the infertile women interviewed had re-married swiftly, or were receiving many offers of marriage which they turned down. Such women asserted that their marriages were based on 'love', and further reasons why infertile women may be attractive further wives for men who already have children are discussed: they may be more sexually available than child-producing wives, prevent further children being born if a husband feels he already has enough children, and can provide a quiet house to stay in for husbands who have many other children or have fallen out with co-wives. It may be that infertile women do not face the same discrimination as in the past, particularly in relation to the legitimation of a 'love' match based on the romantic model which may be indirectly associated with 'modern' low fertility. However, even if they are still 'in demand' as wives, infertile women are probably more vulnerable to marital disruption and disapproval from the wider family and community.

The perceived importance of supernatural influences on women's fertility is at odds with public health messages that are disseminated to women on the radio, at antenatal clinics, and at Under 5's clinics at the hospital. Although women are warned about the dangers of STDs, and in particular HIV and AIDS, most do not have a clear understanding about the causal link between STDs and infertility. In almost all interviews, women lacked of knowledge about both 'biological' and 'traditional' causes of infertility (both are specialised domains of knowledge that women do not

have easy access to), which led them feeling powerless about their condition and unable to negotiate or comprehend treatment in either sphere.

An opportunity exists to reduce acquired infertility in a tangible and resource efficient way that is complementary with current AIDS reduction and reproductive health programmes: through basic sex education, strategies for improving the status of women and gender relations, and provision of reproductive health services such as management of STDs. This recommendation has been made before in several other African settings following research into infertility, and findings from Malawi support this strongly. However, this places a further challenge to decide to the best way to protect women's reproductive health: condoms and abstinence are usually key messages in health promotion campaigns in Malawi, but in a situation where women want to get pregnant or do not want to abstain or use condoms for a host of other reasons, this might be impracticable advice. Policies and guidelines developed in response to new services or education programmes need to be sensitive to the fundamental importance of reproduction in women's lives.

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