**ORIGINAL RESEARCH ARTICLE**

# The social and cultural consequences of infertility in rural and peri-urban Malawi

DOI: 10.29063/ajrh2022/v26i7.12

*Kristan Elwell*

Department of Health Sciences, Northern Arizona University

***For Correspondence:** Email: *kristan.elwell@nau.edu*; Phone: (928) 699-3443

## Abstract

Relatively little is known about infertility experiences among women in rural Malawi and the impact of infertility on women's marital and family relations. This article examines the perspectives of women and health care providers regarding women's concepts of reproductive health and attitudes toward infertility. The paper explores the supports and barriers to managing infertility at the individual, household, and community levels. The data presented was drawn from semi-structured interviews with health care providers and patients within a prevention of mother to child transmission program and focus group discussions with community men and women in four communities in Southern Malawi. Seventy-eight patients, 12 health care providers, and 32 community leaders participated in the study. The findings suggest that gender inequities and kinship relations intersect to produce infertility related stigma which exacerbates the social and cultural consequences of being infertile in these study communities. Social support from other women experiencing infertility is one strategy to help women manage the social and cultural burden of infertility in these study communities. These results shed light on the meaning of motherhood to women living in rural and peri-urban Sub-Saharan African communities and call for an expansion of infertility services, social services, and mental health services for both women and men who experience infertility. *(Afr J Reprod Health 2022; 26[7]: 112-126).*

**Keywords**: Reproductive health, infertility, gender Inequities, Malawi

## Résumé

On sait relativement peu de choses sur les expériences d'infertilité chez les femmes des zones rurales du Malawi et sur l'impact de l'infertilité sur les relations conjugales et familiales des femmes. Cet article examine les perspectives des femmes et des prestataires de soins de santé concernant les concepts féminins de la santé reproductive et les attitudes à l'égard de l'infertilité. Le document explore les soutiens et les obstacles à la gestion de l'infertilité aux niveaux individuel, familial et communautaire. Les données présentées ont été tirées d'entretiens semi-structurés avec des prestataires de soins de santé et des patients dans le cadre d'un programme de prévention de la transmission mère-enfant et de discussions de groupe avec des hommes et des femmes de la communauté dans quatre communautés du sud du Malawi. Soixante-dix-huit patients, 12 fournisseurs de soins de santé et 32 dirigeants communautaires ont participé à l'étude. Les résultats suggèrent que les inégalités entre les sexes et les relations de parenté se croisent pour produire une stigmatisation liée à l'infertilité qui exacerbe les conséquences sociales et culturelles de l'infertilité dans ces communautés d'étude. Le soutien social d'autres femmes souffrant d'infertilité est une stratégie pour aider les femmes à gérer le fardeau social et culturel de l'infertilité dans ces communautés d'étude. Ces résultats mettent en lumière la signification de la maternité pour les femmes vivant dans les communautés rurales et périurbaines d'Afrique subsaharienne et appellent à une expansion des services d'infertilité, des services sociaux et des services de santé mentale pour les femmes et les hommes qui souffrent d'infertilité. *(Afr J Reprod Health 2022; 26[7]: 112-126).*

**Mots-clés**: Santé reproductive, infertilité, inégalités entre les sexes, Malawi

# Introduction

## *Significance of children in sub-Saharan Africa*

Across all cultures, childbearing is a critical stage in a woman's life. Findings show that in most cultures, childbearing is a cultural ideal that marks a critical step in adult psychosocial development, reinforces social and cultural identity, and supports household production. In sub-Saharan Africa (SSA), children are valued for many reasons, serving a vital social, economic, and cultural role within the family, community, and broader society. Studies of fertility in African communities point to the social role fulfilled by primary fertility, or the ability to have at least one child in the family[1].

In many African societies, children fulfill a vital and economic social role by ensuring

continuity of the family and lineage[2]. As a result, high fertility is a marker of social status, social power, and social security, providing social and spiritual continuity within the family, community, and lineage, symbolizing social and material wealth to the kinship group[3]. Furthermore, in most social contexts, children are described as a spiritual "blessing"[4]. In many rural communities across Sub-Saharan Africa, children fulfill a vital economic function by helping with daily domestic tasks within the household and providing caregiving for young children and elderly relatives. For many men and women, high fertility is a marker of social status, social power, and social security, providing social and spiritual continuity within the family, community, and lineage.

## *Fertility rates and ideals*

Infertility affects 186 million people across the globe[5]. While in many countries in the Global North infertility is conceptualized as a medical condition, in many countries of the Global South infertility is conceptualized within a broader social and cultural context[6]. Countries in Sub Saharan Africa experience disproportionately high rates of infertility, where high rates of infertility 'co-exist' with high rates of fertility[5]. In Malawi, where fertility decreases with education level and socioeconomic status, the total fertility rate is six children per woman[3]. Coinciding with high rates of fertility, one in five Malawian women reports experiencing infertility[7]. While both primary and secondary infertility are decreasing overall, secondary infertility rates remain high, with over 10% of women of reproductive age experiencing secondary infertility and 60% of women aged 40-44.

Fertility ideals remain strong in Malawi where the average fertility rate is 4 children per woman, however access to services for diagnosing and treating infertility remains a challenge. In fact, the diagnosis and treatment of infertility are limited for many women living in Sub-Saharan Africa[5].

Malawian national policy on infertility mandates that secondary infertility prevention services be integrated into primary care; however, current data on the number of clients receiving services for primary infertility is unavailable and many women seek infertility services outside of the formal health care system[9]. As in most resource limited settings, infertility services are limited with few clinics offering infertility services to couples unable to bear children. Those facilities with infertility clinics, such as district-level hospital facilities, offer tuboplasty, a procedure which provides reconstruction of the fallopian tubes for the clinical treatment of infertility. However, assisted reproductive technique such as in vitro fertilization (IVF), are not available within the country and therefore not accessible to the majority of the Malawian population. In rural communities in southern Malawi, many couples experiencing infertility seek treatment from traditional healers. In one study of men and women living in rural Malawi, over 40% of women and men failed to seek clinical treatment for infertility[10]. For those who sought treatment, most (74.7%/80%) sought treatment for infertility from traditional healers[10].

## *Infertility in sub Saharan Africa*

In most African communities, being unable to conceive a child can have severe consequences to women's social and cultural identity. Women who experience infertility are often marginalized within their marriage, family, and the broader community. The literature on infertility in SSA African communities reports a range of social and cultural consequences for women experiencing infertility, including: marital instability and divorce, domestic abuse, polygamy, stigmatization by family, stigmatization by community, social isolation, accusations of witchcraft, and limited rights of land and financial inheritance[2,12-14]. One study of fertility expectations among women in a small community in rural Malawi found that perceptions of infertility were influenced by waiting time to pregnancy[10]. Finally, several studies also suggest a direct relationship between infertility and mental health challenges where the social stressors of being infertile have significant consequences to women's emotional health and well-being[12-13]. Despite the existing literature, relatively little is known about how this social burden impacts women's social relations. Further, much of the research on

infertility in Africa centers on women's experiences in West Africa.

The current project examines infertility experience from the perspective of kinship structures within rural Malawian communities in relation to the gender norms within these communities. To the best of our knowledge, although previous studies have investigated infertility within some rural Malawian communities, domestic abuse, polygamy, stigmatization by family, stigmatization by community, kinship structures, and the socio-cultural pressures to conform to gender norms, no study to date has investigated the intersectionality of these topics[2,5,9,12-14].

## *Social and cultural consequences of infertility*

### *Infertility and marriage*

One common theme reported in the literature is the negative impact of infertility to a woman's marriage. These studies describe how women experience significant marital instability, and often divorce when fertility is unsuccessful[15]. In some sociocultural contexts, women experience emotional and physical abuse in the form of intimate partner violence[6]. Fledderjohann and colleagues conducted interviews to explore the social context of infertility among women living in urban Ghana, finding that marital instability, social isolation, and gendered experiences of infertility were identified as major social and cultural consequences of infertility[11]. This study of infertility among West African women found that the psychological distress from infertility often led to poor mental health. Studies suggest women experience the majority of negative socio-cultural consequences from infertility[6,15,16,17].

### *Infertility and family relations*

Relatively few studies examine the impact of infertility on women's family relations[14]. The impact of infertility on family relations is largely shaped by whether or not a woman has ties to a patrilineal vs. matrilineal family structure as children extend the matrilineal and patrilineal lines within the kinship group[17]. While in matrilineal communities, infertility may mean a smaller family size and loss of labor, within patrilineal communities, women may experience significant social exclusion because it is a new wife's social responsibility to contribute to the growth of the husband's kinship group.

In many SSA communities, a bride price, or payment given to the groom's family by the bride's family continues to be paid to ensure this highly valued growth within the family and lineage[2,18]. However, if a couple is unable to have a child, the bride price can be returned to the husband's family, thus weakening the marital relationship and linkages between the husband and wife's kinship group, and importantly, exerting pressure on the wife to produce children for the groom's lineage[19]. To the family and kinship group, children not only provide emotional fulfillment, they also serve a vital social and economic function[18]. In most rural communities in SSA, children, and in particular girls, are responsible for supporting the day-to-day functioning of the household by hauling water, gathering wood for fuel, and tending to young children while boys may assist the father with farming tasks and other manual labor.

### *Infertility and community relations*

Most studies suggest that stigmatization is relatively common for women experiencing infertility, and is most pronounced for women who experience primary infertility, or the inability to become pregnant[2,12,13,20,21]. These studies suggest that stigmatization is experienced as an overt demonstration of disrespect and social invisibility such as mocking and derision, barring infertile women from interacting with children, and socially excluding women from conversations with other fertile women[2,11,12]. In their study of infertility in urban Tanzania, Hollos and Larsen noted that experiences of stigmatization are directed primarily toward women with primary infertility[2]. These negative interactions were most likely to come from fertile women who looked down upon women experiencing infertility[2].

### *Infertility and women's mental health*

A growing body of literature suggests that psychological and sociocultural stressors are a common consequence of infertility in SSA[12-13]. Most of these studies focus on the psychological factors contributing to stress, with fewer studies focusing on stressors induced by socio-cultural pressures to conform to gender norms in these communities. For example, in a study of women from urban Nigeria, Upkong and Orgi find that depression is greater among women experiencing primary infertility[22]. Similarly, Fledderjohann found that mental health effects such as sadness, stress, and depression from infertility primarily stemmed from marital concerns and experiences with community-based stigma[11]. In Feldman's study of infertility among women in Cameroon, infertility imposed a severe psychological burden, particularly among wives within a polygamous household[14]. Co-wives unable to bear children experienced mocking and criticism from co-wives who were successful with fertility. In some instances, co-wives were accused of stealing an unborn fetus.

### *Infertility and gender*

A growing body of literature highlights the differences in the experience of infertility for men and for women. For example, Dyer describes how in most African societies, women's social identity is defined through her ability to secure marriage and produce children[18]. One of the few studies of infertility in Malawi found that the negative consequences of infertility were far greater for women than for men[6,10]. In some SSA cultures, a woman who has not had children experiences social exclusion whereas her husband may experience criticism from male peers and other threats to masculinities[23]. Few studies of infertility found that if a couple is found to be infertile, the husband can be blamed for the cause of infertility[11,17].

Despite this growing body of literature, to date there are few studies which have examined the social consequences of infertility among women living in rural and peri-urban Malawi and the potential impact on reproductive health inequities, particularly among women with low socioeconomic status[3,10]. The current study examines the social and cultural implications of infertility from the perspectives of women from rural and peri-urban Malawi. The research seeks to address the following questions - what are the social and cultural consequences of infertility among infertile women in this community? How are the experiences of women different from that of men?

We reviewed the perspectives of women and health care providers regarding women's concepts of reproductive health and attitudes toward infertility. This paper explores the supports and barriers to managing infertility at the individual, household, and community levels. In addition to the key barriers and supports experienced by women, we describe the strategies employed by women and their families to manage the social consequences of infertility. The data presented in this article was drawn from interviews with health care providers and Prevention of Mother to Child Transmission (PMTCT) patients and focus group discussions with community men and women in four communities in Southern Malawi.

## Methods

The following study was conducted in four communities (two peri-urban and two rural) in Southern Malawi. Seventy-eight HIV-positive patients and fifty-one non-HIV positive health care providers and community leaders were included in the study. Data collection methods included semi-structured interviews and focus groups. Data were collected from PMTCT patients, health care providers, and community leaders including church leaders, teachers, village chiefs, and traditional birth attendants (TBAs) in 2012. Research questions were designed to explore community concepts of motherhood. Health care providers, HIV/AIDs patients, and community members were asked the following questions related to infertility in their community: What does it mean for a woman to be a mother in this community? What are women's roles and responsibilities in the household? In the extended family and kinship group? What happens if a woman is unable to have

a child? What role does the family and larger kinship group play in women's reproductive health care seeking (prenatal/postnatal care)?

Fifty-three patients participated in a total of seven focus groups (age range 20–44, mean 29). Twenty-five patients participated in interviews (age range 18–49, mean 28). Of these 78 total patients, most were married (82%) and between 26 and 40 years (70%). Thirty-five percent had at least primary school education. The most common occupations were housewife (35%), vegetable vendor/small-business owner (28%), and subsistence farmer (14%).

Nineteen healthcare providers (13 women, 6 men; ages 23–56) participated in interviews. Most were nurse-midwives (58%). Thirty-two community leaders (18 women, 12 men; ages 23–66) participated in interviews and focus groups. Most were teachers or church leaders (81%). An inductive approach to data analysis utilizing grounded theory was employed to identify key concepts that emerged from the interview and focus group data. This analysis consisted of identifying common concepts in the data, exploring relationships among the data to identify patterns, and grouping the data together into thematic categories. Emerging categories were compared to identify higher level themes, which were linked to form a theoretical model to explain patients' decisions to participate in the program[25-27]. Analysis focused on describing consequences of infertility to women's marriages, family, and community, exploring potential relationships between the consequences, uncovering barriers and supports not yet identified in the literature, and identifying additional themes important to women experiencing childlessness in the participating study communities.

# Results

## *Infertility and marital instability*

Motherhood is central to the identity of the majority of the women in our study communities. Participants described how a woman who has failed to reproduce does not have the social capital in which to enact her responsibilities within marriage, solidify social relations within the lineage or leverage respect within the community. Where family is central to the reproduction of society, women's inability to reproduce signifies a failure to fulfill their roles as wives, mothers, sisters and daughters. Women unable to provide children for their husband fail to fulfill one of the central tenets of wifehood—to provide children to carry the husband's name. In fact, women in many African communities who are unable to provide children for their uncle or older brother, fail to provide a *bvumwe* over which the uncle or brother may expand upon his social wealth. To other women in the community, women with reproductive capabilities may serve as social threats as they are known to have greater marital potential.

Men also experience the social pressure to reproduce and bear children. Participants in this study suggest that culturally, children enhance men's status by ensuring a family over which he may provide social and economic security. Informants claim that men who are unable to have children are labeled as "castrated," suggesting that both women and men experience social and cultural consequences from infertility in marriage. Gender norms related to local masculinities suggest men embody "ego strength" which manifests as physical strength and virility. "Ego strength" may lead some men to delay seeking medical treatment unless they are very ill. "Ego strength" may also signal a man's virility or the ability to demonstrate fertility by producing children for the family and lineage. In the following quote, a male health care provider confirms the pressure placed upon Malawian men to reproduce:

> "Culturally if you are a man, you should show that you have children. You should have children, it's just the way we are trained, brought up. That you should see some children... running around… (*Male health care provider*)"

## *Infertility and the kinship group*

In the study communities, fertility and reproduction contribute significantly to the social and economic power of the kinship system. Within the matrilineal

kinship system, a man's biological children belong to the matrilineage whereas within the patrilineal kinship system, a man's biological children belong to the patrilineage where the status and labor power of children is granted to the larger kinship system[25].

When asked about the meaning of reproduction, community members and health care providers equated having additional children with amassing greater social and economic wealth. As stated by one informant, having more children means social "richness." Several informants situated reproduction within a religious context, claiming that having children signifies a family has received a "blessing from God." When asked about family size and family planning, several informants employed religious discourse, claiming that whether they would have another child was "in God's hands." A current PMTCT patient stated,

> "It will depend on what God will offer me, if it's one, that will be the only one and if its twins then it will be those two, because I had one but it died." Another said, "I want to have two child(ren), I want to have two child(ren), but God gives this one… This is the last born. (PMTCT patient)"

Within communities adhering to matrilineal practices, the birth of a child confers greater status to the wife's family where children are likely to cultivate stronger familial bonds, expand the social wealth of the lineage and enhance the status of the uncle or avunculate. Within both the matrilineal and patrilineal kinship systems, children signify social and material wealth, and confer greater status to the lineage. Children do so by expanding the size of the lineage and by contributing the products of their labor to the kinship group with which they live. Within patrilineal kinship groups, the birth of children confers greater status to the husband's family where children are likely to cultivate stronger bonds with the father's kinship line[27].

In communities adhering to matrilineal practices, the birth of children confers greater status to the wife's family where children are likely to cultivate stronger familial bonds. Uncles within matrilineal kinship systems become more powerful as size of the lineage is equated with social, political and economic power. Therefore, the uncle's power grows as the size of his sister's family grows, for the uncle has expanded the lineage by expanding his clan[25]. These normative ideals suggest men achieve their status through the role of malume (uncle) rather than that of the husband[28]. The social status of the malume is then augmented by providing him with a *bvumwe* over which he exercises political, social and economic authority. The uncle exercises economic authority by providing for his sister's children, such as paying school fees and paying for wedding costs. Therefore, having children contributes to the social status of the household *banja* and lineage.

One health care provider expands upon this social process, emphasizing the desirability of a larger clan to a matrilineage, stating:

> "It means… the uncle is a bit more powerful. The tribe is growing bigger. That man has got a clan… *Aphwanga*. So he has more status.
> How about if she has only one child? (Interviewer)
> He will look inferior. He doesn't have any power. (Female health care provider)"

The following health care provider describes the social wealth attributed to having children for the Chewa, the largest ethnic group in Malawi. The provider links marriage and reproduction as an opportunity for female children to amass bridewealth within the matrilineage*:*

> "Other parts of Malawi they would take that as a wealth. And more especially female children. And they would say if it's female children, once they are grown up, that's why they will make little children and get married quickly. Because they expect that girl to go get married and then give bridewealth to the family. This is for the Chewas. (Female health care provider)"

Within patrilineal communities, the birth of a child confers greater status to the husband's family where children are likely to cultivate bonds with the father's kinship line. The health care provider goes on to explain the social value of male children within the patrilineal kinship structure of the Ngoni where a significantly greater social value may be

placed on males who can inherit the wealth of their fathers:

> "But now we have one for the Ngoni's. The head of the family is like a son, so if the woman is giving birth to only girls then the husband has to go find another woman for him to have a boy. That when the father dies the boy should inherit the wealth. I'm half Ngoni. The very same thing happened in my family. We are three. We are all girls and now my Dad is looking for a boy. (Female health care provider)"

### *Kinship strategies to manage infertility*

> "She is saying sometimes, God created us but sometimes it happens that there are other problems that can make us not to have the gift of a child. We are married okay, but the gift of a child is not there. For such people, what do they do? (Female health care provider)"

The social significance of a woman's reproductive potential to marital and kinship relations is made clear in the multiple strategies employed by spouses and kinship groups to ensure that a couple will reproduce. Study participants suggest the couple and the extended family may employ a range of strategies to ensure the reproduction of the family when a couple is believed to be infertile. Strategies reported include use of a male surrogate, appropriating the reproductive capabilities of the wife's younger sister, use of multiple wives, divorce, use of drugs/medical treatment, traditional medicine, or prayer.

Participants report a gendered response to infertility in women and men. For example, in some rural communities in Malawi, if the husband is suspected to be infertile, the family will secure a surrogate to provide a child for the couple. However, if the wife is suspected of being infertile, the family will call for the husband to divorce her. Given that women are most likely to be blamed for infertility, the risk of losing marriage is particularly high for them.

*Fiisi* is a cultural practice in which a male member of the community is asked to impregnate a woman who has not become pregnant in her marriage. These men serve as surrogate fathers so that a couple may have children. While discussing the social practice of *fiisi*, some community members framed the social practice as a means for women to "prove her fertility." *Fiisi* was actively practiced in one study community, but was more commonly referred to as a cultural practice that took place "only in the north."

> "They will just look for any woman. And some there are some other cultural practices. They'll be like the father… the husband—the wife is not becoming pregnant. They don't know what's the reason. They wouldn't go to the hospital. They would just go to another man whom they have seen that in his family he has children. They will call him, come heal my family. You should sleep with my wife and then you should impregnate my wife. They call it as a fiisi. If they do the sex unprotected, definitely they will do it unprotected because they want a child. If that man is HIV-positive, and this one if she's not, then it's infected. Those are some other bad cultural practices. (Female health care provider)"

As previously discussed, in Malawi bearing children is essential to the foundation of family and the construction of local masculinities and femininities. Therefore, seeking pregnancy outside of marriage may be a coping strategy by which women preserve the stability of their marriage.

Female teachers interviewed within a focus group discussion claim that infertile women living in patrilineal societies have considerably less decision-making power in marriage and must negotiate greater social challenges. These women are more likely to have the husband find a replacement for the wife's infertility than to have the wife find ways to compensate for her infertility, or to be divorced:

> "In the patrilineal type of marriage, they will tell them that the woman has contributed to that and they will ask for a second marriage. Usually they will ask for a separate marriage, maybe the sister of the woman provides the

**Table 1:** Study participants

| Participant | Number Sampled |
|---|---|
| HIV-positive patients | 78 |
| Healthcare providers | 19 |
| Community leaders | 32 |
| Total Number of Participants | 129 |

> children for the family. Sometimes it might not be a sister. They may look for somebody else to carry it. Sometimes the other family, they have a baby, and it becomes difficult for them to let you hold the baby. (Female teacher)"

As noted in the example above, husbands seek other fertile women if his wife fails to provide a child early in the marriage. These younger siblings either serve as a surrogate or join the marriage as a second or third wife. Husbands may also take on a second wife if the first wife is unable to provide children.

For many of the participants in this study, husbands often decide where a woman will give birth—whether it is at home with a traditional birth attendant (TBA), or at the hospital. Husbands also strongly influence decisions about family size. This was not the case, however, for women with higher socioeconomic status. For many of the professionals and nurses in the study, husbands and wives shared the decision-making authority when making family planning decisions, suggesting that social and economic power largely shape the social and cultural consequences of infertility.

Decisions related to family size are not only made by husband and wife, they are also made by the kinship group. Kinship group responses to a woman's infertility may be severe, placing a woman at risk of losing her marriage. Informants claim that these pressures most often come from "in-laws," mothers-in-law in particular. Pressure from in-laws is most pronounced in patriarchal kinship systems where the social and material value of children weighs more heavily on a woman experiencing infertility. The following informant situates the meaning of infertility beyond the household to the larger kinship system:

> "She can't bear babies. And the woman has a really tough time with the relatives at the man's side. Because the mother in law—*aphongozi*. So when you are married they are looking forward that you should have a baby in some time and when you're not producing, they are asking you, or they even ask the man to leave you, that you should go to somebody else who can have babies. So it's really like a mockery. Being infertile is not good here in Malawi. (Female health care provider)"

> "They can tell the son to look for another woman. Would he get a new wife? Yes, he would get a new marriage. You can even be in the house while another is having an affair. [Why do they want babies?] They just want babies. They want babies. They want children in this house. Why are children important? They are a big asset. A house without a child in Malawi is useless. (Female health care provider)"

The social and economic value of the child to the lineage is evident in the following example of a failed delivery recounted by a female health care provider in which the mother-in-law seeks to control the outcome of her daughter in law's pregnancy. Ultimately the mother-in-law deploys her power within the lineage to force a pregnancy on a young woman who is viewed as withholding a child from the family and patrilineage with a failed pregnancy.

In the following example, control of the young woman's birth process begins with the kinship group's decision to seek medical care from a traditional birth attendant (TBA) rather than a hospital delivery. After two failed deliveries, the mother-in-law co-opts the assistance of the TBA to ensure a successful pregnancy. The quote provides a poignant example of the less common, more severe reproductive pressures that may be experienced by women whose mother-in-laws exert control over their reproductive health to ensure the social and biological reproduction of the lineage. By ensuring reproduction, the aphongozi seeks to reinforce her status within the family when the son has contributed children to the lineage.

> "I have one example. This patient, she came from (name of village). This was the third

**Table 2:** Major themes

| Theme | Category |
|---|---|
| Gendered responses to infertility | Both men and women experience the social pressure to reproduce and bear children. While men who are unable to have children are labeled as "castrated," women experience stigmatization, ridicule and social isolation. Participants suggest that women are more likely to be divorced by husbands when the couple experiences infertility. |
| Negative impact of infertility to a woman's marriage | Most participants described how infertility posed a unique challenge to marital stability, placing a significant strain on a woman's marriage which often leads to marital strife, and in some cases, divorce. |
| Negative impact of infertility to women's family relations | Within communities adhering to matrilineal practices, the birth of a child confers greater status to the wife's family where children are likely to cultivate stronger familial bonds, expand the social wealth of the lineage and enhance the status of the uncle. |
| Kinship group strategies to manage infertility | The extended family may employ a range of strategies to ensure the reproduction of the family when a couple is believed to be infertile. Strategies reported include use of a male surrogate, appropriating the reproductive capabilities of the wife's younger sister, inclusion of multiple wives, divorce, and utilizing traditional medical practices or employing prayer. |
| Community stigmatization | Community members enact stigma toward infertile women. Stigmatization brings attention to deviance from cultural norms through a range of strategies that reinforce local gender norms: mocking and community gossip, excluding women from gendered social spaces in the village, and in some communities, accusing women of witchcraft. |

> pregnancy. The first pregnancy she started labor. She wanted to go to the hospital. The mother-in-law said no you will not go to the hospital. You will go to the traditional birth attendant. They went there, the labor was not progressing. A stillbirth. The second pregnancy, the same thing. Now the third pregnancy, they were like, 'You are not giving us babies, we will chase you.' Now she was pregnant… each and every time she is pregnant her mother-in-law takes her to the birth attendant. Next time around she went there, she labored, she labored, nothing. And then the descent was high. The mother-in-law and the TBA took an mpanga (knife), they inserted it into the vagina, it will bring the baby down like this (demonstrates) but they failed and then the woman had ruptured the uterus. She bled. They went to the hospital because the woman was gasping. She arrived here with offensive discharges of the uterus. We kept her for almost two months. The mother-in-law didn't come even a single day. She didn't come to see her. The husband didn't come to see her. They sent a message saying, 'When you are back, we don't want you coming here because you are not giving us babies. We gave MK 5000 to your mother and to your brother, but because you are not giving us babies, we will take your younger sister.' Now, this girl was only nineteen years. The younger sister was thirteen years. I asked, 'Why is it that you can't give back the MK 5000?' They said, 'We don't have money.' I asked, 'Why can't you take this issue to court?' They said, 'No, according to our culture we don't have to do that, this is a marriage issue.' So I think ignorance also leads to some of these problems. (*Female health care provider*)"

In the above example, fertility becomes a social commodity to be exchanged between lineages. When the fertility of a woman is not achieved, it is replaced by a younger sister whose fertility repays a social and economic debt. This "commoditization of reproduction" illustrates the social and material value of fertility for the continuity of the lineage and of society[29]. The reproductive value of the anticipated birth goes beyond the 5000 kwacha, to the social and material power of the family and lineage, transacted through the exchange of one reproductive body for another. Forced delivery was not a common experience among the women in this study. However, it illustrates how societal and kinship pressures to reproduce interact with gender inequities and poverty, situating the young woman in a social context in which she has little agency to assert control over her own social and reproductive power.

### *Infertility and community stigmatization*

Women's reproductive successes and failures are often the subject of social commentary by the local community. In the discussed study communities, the community monitors which women have achieved infertility and which women have not, thus exercising control over community social relations and bringing attention to social deviance through a range of strategies that reinforce gender norms: mocking and community gossip, excluding women from gendered social spaces in the village, and accusing women of witchcraft were some of the strategies discussed by study participants[31]. As noted by Foucault, "Mechanisms of power are exposed around the abnormal individual to brand him, alter him"[31].

Women with children were also involved in stigmatization. Informants report that those most likely to deride women for not having children are their female peers. Community responses to women's infertility include various forms of gossip with often disparaging comments, claiming that community members "Talk a lot… a lot." Women unable to bear children are often shamed when deviating from these gender norms and assigned to the margins of society, although there is variation in this as the following statement from a health care provider illustrates. Below, the health care provider asserts class status by constructing those who mock infertile women as lacking in education:

> "They are mocked by their fellow women that they can't have children. It depends on the educational level of the people you are living with because when you are living with people who have gone to school, at least they understand. But in Malawian communities we have a lot of people that are not well educated so they MOCK at the woman saying she can't produce. She can't bear babies. And the woman has a really tough time with the relatives at the man's side. (Female health care provider)"

One female health care provider states "Others laugh at them when they are there and make fun of them, like when women are chatting they may laugh at you indirectly." Another health care provider conflates the social risk of infertility with the biological risk of HIV transmission, suggesting the cultural pressure to reproduce places men and women at greater risk of contracting HIV:

> "They will be shouted everywhere they go. Even small children will be pointing at them, saying, 'this one doesn't give birth, this one doesn't have a child.' And this is one thing promoting HIV infection being highly transmitted because the husband will look for a child. They don't know why the woman is not having a child and then they will keep on searching for other women and they'll keep on spreading HIV if they are HIV-positive. (Female health care provider)"

### *Infertility and gender*

In many parts of the world, women are most likely to be blamed for infertility[30]. In this study, informants suggest that women, rather than men are most likely to be blamed for infertility. This gendered experience of infertility constructs women's bodies as weaker while men's bodies are constructed as embodied with "ego strength," reflecting the inequalities in gender relations between men and women.

> "In men—in Malawi, when it comes to these reproductive issues, the woman is mostly the one to blame. The man is infertile, the woman can be fertile, but if there are no babies in the family, the first one to be suspected is the woman. (Female health care provider)"

> "Unfortunately, the Malawian community tends to blame the woman and not the man—they say that the woman cannot have children. So it's not a nice experience. Some people tend to look down at you like you are a failure because you aren't able to have children. You have patients who are forty who are still hoping that one day they are going to have a baby. You cannot really offer them much... they still have to prove to the community that they can have children. They would never believe that infertility is a male's problem. (Male health care provider)"

Current PMTCT patients, health care providers, and community members link a woman's infertility to normative ideals of womanhood. In their own words, these individuals describe infertile women as "lacking in womanhood" or "not a lady." Particularly in rural areas, these women are conceptualized by members of the family and community as "girls" who have not experienced those sociocultural rituals marking critical transitions in the life cycle of women. Such local constructions are reproduced in community sanctions that forbid women from holding a child until they have fulfilled this social role, thus marking social spaces that include and exclude, and reinforcing gendered experiences of infertility.

Other informants frame infertility as a woman's failure to enact her ultimate social responsibility—the biological and social reproduction of Malawian society. When asked to describe how the community responds to women who don't have children, one PMTCT patient framed these women as lacking in purpose and social value. She reiterates the comments of other informants when I asked her what it meant to be infertile claiming, "It's not a nice experience. … I mean… what's the use for you being there for? Being a woman for? Things like that".

## Discussion

The above results demonstrate that children in Sub Saharan Africa serve a vital social, cultural, and economic role. Husbands and wives seek to have a family for emotional wellbeing, to achieve status in within the kinship group and lineage and the wider community, and in many rural communities, to ensure household labor. In our study communities, we found that the social and cultural consequences of infertility are severe, particularly in rural communities where women experience a range of responses that revolve around social exclusion and stigmatization. In addition, infertility in patrilineal communities can be particularly challenging where women experience social isolation from their families. The above quotes from women, providers, and community members revealed that a main priority in a woman's life and in her marriage, is the birth of children, and for those women unable to have children, there are multiple social and cultural consequences.

### *Infertility in marriage*

The majority of participants in this study mentioned the negative social and cultural consequences of infertility to marriage. Most participants described how infertility posed a unique challenge to marital stability, placing a significant strain on a woman's marriage which often leads to marital strife, and in some cases, divorce. Participants in this study community described how a woman who has failed to reproduce does not have the social capital in which to enact her responsibilities within marriage, solidify social relations within the lineage or leverage respect within the community. These findings align with the work of researchers who studied infertility in other Sub Saharan and West African contexts[2,11,12,18]. For example, in one study of infertility in Nigeria, 40% of women divorced because of infertility[33]. Reasons for divorce included domestic abuse, polygamy, and accusations of witchcraft. In another study of infertility among women in urban Tanzania, Hollos and colleagues found that women with both primary and secondary infertility/no children, partners changed frequently, and marriage was not socially and culturally conceptualized as "complete" until a child was born[2]. Overall, infertility exposes women to marital discord and the chance of being replaced by another more fertile partner. In these study communities, this fear of "being chased" was a common experience for those study participants living with HIV/AIDs.

### *Infertility and the kinship group*

An additional finding suggested that the kinship group clearly benefits from the birth of a child and in some instances will seek to control the fertility outcomes of a couple. When experiencing infertility, the marital couple has failed in their kinship responsibilities and are likely to experience social pressure from the in-laws. Similar to our findings, other studies have found that the husbands' family may exert the most social and cultural pressure to produce. For example, in one

study of infertility in Mali, West Africa, in-laws exerted the most pressure on women to conceive, demanding that husbands seek another wife or divorce if the wife was infertile[12]. Hollos' study of infertility in urban Tanzania had similar findings where in-laws often demanded that husbands seek a second wife or end the marriage through divorce[2]. An unexpected finding in this study was the degree to which the members of a kinship group would manage the infertility of a couple. While in this study in-laws were more likely to be the source of maltreatment, Feldman found that co-wives rather than in-laws were most likely to mistreat a woman unable to have children[14].

### *Infertility and community stigmatization*

According to study participants, stigma towards women with infertility manifests in several forms which center on derision or name calling, and social exclusion. Women experience mocking and community gossip, and exclusion from gendered social spaces in the village. In one rural community, women are asked to not enter the labor ward at the local clinic. Participants in this rural community described how women who experience infertility are accused of witchcraft. Another key finding that was particularly striking was that such derision often came from other women who were able to have children. This same response from fertile women occurred in a study of women living in urban Tanzania[2]. Women who have "proven" infertility enjoy a higher status and may be leveraging their social power against infertile women whose social power is weakened by the infertility status. Following intersectionality theory, these infertile women experience multiple forms of stigmatization from other women in the community through multiple social positions of gender, social class, and fertility status[34].

### *Infertility and gender*

We found in our study communities that women rather than men are most likely to be blamed for infertility in the marriage. This is not atypical, as similar findings were discussed by Hollos *et al*. whose work in urban Tanzania suggested that women bear the majority of the burden of stigma towards infertility while men have other opportunities through polygamy and greater opportunity to remarry to ensure fertility[2]. Similarly, Fledderjohann found that respondents suggested men were most likely to be blamed for infertility because fertility is made visible on women's bodies[11].

We found that infertility for men challenges their gender identity and threatens local understandings of masculinity. In short, the social consequences of infertility for men means that they will be *chided* by other men. As discussed earlier, infertility for women challenges a woman's gender identity as it suggests that she has failed to fulfill her obligations as a woman in marriage, the kinship group, and the wider community.

In many stages of the study, we attempted to recruit men for interviews. However, only two focus group discussions and three in depth interviews were conducted with male community leaders to reflect men's perspectives on gender relations in marriage. The meaning of infertility to masculinities is shown in a study by Kaler who found that men in this study asserted an HIV positive serostatus and cited the number of sexual partners to assert their virility[23]. Interestingly, women's negative interactions were most likely to come from other women-- fertile women-- who looked down upon women experiencing infertility. This may demonstrate the power imbalance between women with children and those women without children. According to intersectionality theory, asserting one's fertility status in the presence of an infertile woman may be an opportunity to leverage social power when faced with multiple forms of discrimination[35]. Cornwall found a similar pattern among women competing for husbands in Nigeria where single women were conceptualized as threats to getting married[36]. Women who constructed themselves as "respectable wives" constructed single women as "wayward" and misbehaving, hoping to minimize the competition for male "helpers" (lovers) who can "spend money" on a limited few[35].

### *Infertility and mental health*

While our study participants did not discuss the impact of these experiences on women's mental

health, other studies have found infertility to have a significant negative impact on women's mental health. For example, Fledderjohann's study of infertility found that women experience anxiety and depression when facing infertility[11]. Similarly, Donkor and colleagues' study of infertility in Southern Ghana found that length of the infertility period was associated with greater stress[13]. As in many resource limited settings, in Malawi community psychological services are limited to men or women experiencing mental health concerns.

## Conclusions

We examined infertility experience from the perspective of kinship structures within rural Malawian communities in relation to the gender norms within these communities. To the best of our knowledge, although previous studies have investigated infertility within some rural Malawian communities, kinship structures, and the socio-cultural pressures to conform to gender norms, no study to date has investigated the intersectionality of gender, infertility and kinship structures[7,8,10,36-41]. We found that gender inequities in the household, family and community exacerbate the social and cultural consequences of being infertile in these study communities. The findings of gender inequities have several ramifications. These in-depth interviews revealed the importance of social and psychological support for women experiencing infertility. Given that the primary social and cultural purpose of marriage is to have children and continue the lineage, the failure to fulfill this marital responsibility results in disrespect, social isolation, and maltreatment for many women experiencing infertility. To date, there are few studies which have examined the social consequences of infertility among women living in rural and peri-urban Malawi and the potential impact on reproductive health inequities among women living with infertility. The findings of this study are not generalizable and must be interpreted with restraint. Given our relatively small sample size, study findings cannot be generalized to other communities across Sub Saharan Africa. As in many countries across the Global South, infertility services such as IVF are not available to Malawian women and their spouses. The closest available fertility services are in the country of South Africa which would require a 2500-kilometer trip using public transportation. Therefore, such services are available only to those who can afford airplane travel, and not accessible to the majority of the Malawian population whose poverty rate is 51.5%, Overview – Malawi, available at https://www.worldbank.org/en/country/malawi/overview#1.

Finally, given power differentials in marriage, women who experience marital instability will likely experience economic consequences if the marriage does not last. Education and employment opportunities are gendered in Malawi and therefore limited. Further, in rural areas where household income is often controlled by husbands, women have limited access to household income. Therefore, in addition to social psychological support, women experiencing infertility may benefit from economic support. In conclusion, in addition to greater access to infertility services for members of the study community, there is a need for enhanced social services for these women. This research highlights the need for community sensitization campaigns and gender transformative interventions that challenge gender norms and attitudes toward infertility in the study communities. Until there is equity in access to fertility services where women of low socioeconomic status are able to access fertility treatment, psychological support and contextually and culturally relevant peer mentoring may mitigate the social, cultural, psychological and spiritual consequences of infertility. Social support from other women experiencing infertility is one strategy to help women manage the social and cultural burden of infertility in these study communities. These results shed light on the meaning of motherhood to women living in rural and peri urban Sub-Saharan African communities and call for an expansion of infertility services, social services, and mental health services for both women and men who experience infertility.

## Acknowledgement

This research was made possible through generous support from Michigan State University International Studies and Programs (ISP) the Michigan State University Department of Anthropology. The author is grateful for all those who participated in study interviews.

## References

1. Larsen U. Primary and secondary infertility in sub-Saharan African. *Int J Epi*. 2000 Apr 1;29(2):285-91.
2. Hollos M and Larsen U. Motherhood in sub-Saharan Africa: The social consequences of infertility in an urban population in northern Tanzania. *Moth Cul, Health, & Sex*. 2008 Feb 1;10(2):159-73.
3. Sennott C and Yeatman S. Stability and change in fertility preferences among young women in Malawi. *Int Per on Sex and Repro Health*. 2012 Mar 1;38(1):34.
4. Dyer SJ, Abrahams N, Hoffman M and van der Spuy ZM. 'Men leave me as I cannot have children': Women's experiences with involuntary childlessness. *Hum Reprod*. 2002 Jun 1;17:1663-8.
5. Inhorn MC and Patrizio P. Infertility around the globe: New thinking on gender, reproductive technologies and global movements in the 21st century. *Hum Repro Update*. 2015 Jul 1;21(4):411-26.
6. Husain W and Imran M. Infertility as seen by the infertile couples from a collectivistic culture. *Jr of Comm Psychology*. 2021 Mar 1;49(2):354-360.
7. Bornstein M, Huber-Krum S, Norris AH and Gipson, JD. Infertility, perceived certainty of pregnancy, and contraceptive use in Malawi. *Stud in Fam Plan*. 2021 Apr 25;52(2):143-63.
8. Yeatman S and Trinitapoli, J. "I will give birth but not too much": HIV-positive childbearing in rural Malawi. In: Liamputtong, P, ed. Women, motherhood and living with HIV/AIDS. Springer: Dordrecht, 2013.
9. Bornstein M, Gipson JD, Failing G, Banda V and Norris A. Individual and community-level impact of infertility-related stigma in Malawi. *Soc Sci & Med*. 2020 Apr 1;251:112910.
10. Barden-O'Fallon J. Unmet fertility expectations and the perception of fertility problems in a Malawian Village. *Afr Jr of Repro Health*. 2005 Aug 1;9(2):14-25.
11. Fledderjohann JJ. 'Zero is not good for me': implications of infertility in Ghana. *Hum* Repro. 2012 May 1;27(5):1383-90.
12. Hess RF, Ross R and Gililland Jr JL. Infertility, psychological distress, and coping strategies among women in Mali, West Africa: A mixed-methods study. *Afr Jr of Repro Health*. 2018 Apr 18;22(1):60-72.
13. Donkor ES and Sandall J. The impact of perceived stigma and mediating social factors on infertility-related stress among women seeking infertility treatment in Southern Ghana. *Soc Sci and Med*. 2007 Oct 1;65(8):1683-94.
14. Feldman-Savelsberg P. Plundered kitchens and empty wombs: Fear of infertility in the Cameroonian grassfields. *Soc Sci and Med*. 1994 Aug 1;39(4):463-74.
15. Ties BJ and Mgalla Z. Women and infertility in sub-Saharan Africa: A multi-disciplinary perspective. *Repro Health Matt*. 1999 May 1;7(13):183-188
16. Fido A. Emotional distress in infertile women in Kuwait. *Int Jr of Fert and Wom Med*. 2004 Jan 1;49(1):24-28
17. Gerrits T. Social and cultural aspects of infertility in Mozambique. *Pat Ed and Couns*. 1997 Feb 9;31(1):39-48
18. Dyer SJ. The value of children in African countries–insights from studies on infertility. *Jr of Psyc Obst and Gyn*. 2007 Jan 1;28(2):69-77.
19. Mbaye LM and Wagner N. Bride price and fertility decisions: Evidence from rural Senegal. *Jr of Dev* Stud. 2017 Jun 3;53(6):891-910.
20. Okonofua FE, Harris D, Odebivi A, Kane T and Snow, RC. The social meaning of infertility in Southwest Nigeria. *Health Trans Rev*. 1997 Oct 1;7:205-20.
21. Yebei VN. Unmet needs, beliefs and treatment-seeking for infertility among migrant Ghanaian women in the Netherlands. *Reprod Heatlh Matt*. 2000 Nov 1;8:134-41.
22. Upkong D and Orgi EO. Mental health of infertile women in Nigeria. *Türk psikiyatri dergisi*. 2006 Dec 1;17(4):259-65.
23. Kaler A. "My Girlfriends Could Fill A Yanu-Yanu Bus": Rural Malawian men's claims about their own serostatus. *Demo Res*. 2003 Sep 19;1:349-72.
24. Aerback C and Silverstein LB. Qualitative data: An introduction to coding and analysis. Vol 21. NYC: NYU Press; 2003, 197 p.
25. Bernard HR, Wutich A and Ryan, GW. Analyzing qualitative data: Systematic approaches. 2nd rev. ed. Thousand Oaks: SAGE; 2016, 551 p.
26. Crehan KAF. The fractured community: Landscape of power and gender in rural Zambia. 1st ed. Berkley: University of California Press, 1997. 238 p.
27. Mbonu NC, van den Borne B and De Vries NK. Stigma of people with HIV/AIDS in Sub-Saharan Africa: A literature review. *Jr of Trop Med*. 2009 Aug 16;2009:145891–14.
28. Mtika MM and Doctor HV. Matriliny, patriliny, and wealth flow variations in rural Malawi. *Afr Soc Review*. 2002;6(2):71-97.
29. Chapman RR. Family secrets: Risking reproduction in Central Mozambique. 1st ed. Nashville: Vanderbilt University Press, 2010. 280 p.
30. Lock M and Nguyen VK. An anthropology of biomedicene. 2nd rev. ed. Sussex: Wiley-Blackwell, 2010. 545 p.
31. Stoler AL. Race and the education of desire: Foucault's history of sexuality and the colinail order of things. 1st ed. Durham: Duke University Press, 1995. 256 p.

32. Connell R. Gender, health and theory: Conceptualizing the issue, in local and world perspective. *Soc Sci & Med*. 2012 Jun 1;74(11):1675-1683.
33. Orji EO, Kuit O and Fasubaa OB. Impact of infertility on marital life in Nigeria. *Int Jr of Gyn and Obst*. 2002 Oct 1;79(1):61-2.
34. Cho S, Crenshaw KW and McCall L. Toward a field of intersectionality studies: Theory, applications, and praxis. *Signs: Jr of Wom in Cul and Soc*. 2013 Jun 1;38(4):785-810.
35. Cornwall A. Spending power: Love, money and the reconfiguration of gender relations in Ado-Odo Southwestern Nigeria. *Amer Ethno*. 2002 Nov 1;29(4):963-80.
36. Kerr RB. Food security in northern Malawi: gender, kinship relations and entitlements in historical context. *Jr of South Afr Stud*. 2005 Mar 1;31(1):53-74.
37. Phiri KM. Some changes in the matrilineal family system amont the Chewa of Malawi since the Nineteenth Century. *Jr of Afr His*. 1983 Apr 1;24(2):257-74.
38. Peters P. Against all odds: Matriliny, land and gender in the Shire Highlands of Malawi. *Crit of Anth*. 1997 Jun 1;17(2):189-210.
39. Baylies C. "Perspectives on Gender and AIDS in Africa." In: Baylies, C, Buira, J, eds. AIDS, sexuality, and gender in Africa: Collective strategies and struggles in Tanzania and Zambia. New York: Routledge, 2000.
40. Conroy AA. Gender, power, and intimate partner violence: A study on couples from rural Malawi. *Jr of Inter Vio*. 2013 Mar 1;29(5):866-88.
41. Oyewumi O. African gender studies: A reader. 1st ed. London: Palgrave Macmillan, 2005. 433 p.