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Infertility in Malawi: exploring its impact and social consequences

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Infertility is a serious personal, social and public health issue in developing countries such as Malawi. Infertility is often a 'hidden' problem in this context as the policy and service emphasis is on issues like infant mortality and family planning. Social expectations can also contribute to the problem. This research briefing reports on the first in-depth qualitative study of infertility in Malawi. These findings aim to form a starting point for development of services and programs that are based on people's own views, local needs and go beyond family planning.

Key Points

- Infertility is a serious psychological, social and public health problem in many developing countries, including Malawi. Common interpretations of childbearing and infertility exacerbate the problem for infertile women
- Infertility has many serious psychological and social consequences, including social exclusion, verbal and physical abuse, and marriage breakdown
- Polygamy and extramarital affairs are often proposed as culturally required, reasonable and inevitable responses to infertility. This may lead to personal hardship and an increase in the incidence of sexually transmitted disease (STDs)
- Some men and women in this study minimised relationship troubles caused by infertility. This may limit their ability to access the support they need
- The cultural pressure to bear children is so strong that people with fertility problems feel they need to be seen to be trying to solve these problems. However, seeking help intensively may have financial and physical consequences, and places considerable demands on fragile health systems
- Some practitioners emphasize their ability to cure infertility, and some attribute problems to patients. This may give clients false hopes and obscure the role of health services
- Social rather than individual interventions are recommended. Efforts to discourage unhelpful attitudes and facilitate more empowering alternatives may be effective
- Infertility should be incorporated into existing policy and services, in particular those concerning HIV/AIDS

Background

Infertility is a significant public health problem in African countries like Malawi. Secondary infertility (ie infertility after the birth of a child) affects an estimated 17% of Malawian couples aged between 20 and 44 years (Larsen 2000). An additional 16% have had infertile periods (failing to conceive for 5 to 7 years) at some point in their life (Ericksen and Brunette 1996).

Infertility has many serious psychological and social consequences, including social exclusion, verbal and physical abuse, and marriage breakdown. Furthermore, infertility is intertwined with other major public health problems, in particular the transmission of STIs, including HIV/AIDS (Ericksen and Brunette 1996). STIs are amongst the main causes of infertility in Africa (Larsen 2000).

Infertility may contribute to the spread of STIs. Polygamy and extramarital affairs are seen as justified by the couple's fertility problems. This often leads to increased number of sexual partners (Gerrits et al 1999) and this contributes to the spread of STDs.

The number of infertility consultations is putting a strain on the limited resources of the health system. People with fertility problems tend to consult large numbers of practitioners (Gerrits et al 1999) despite the few medical solutions available in developing countries. Infertility clients take up precious resources in health systems, which could be used for more soluble problems (Rowe 1999).

Despite these issues, infertility has not been a priority for policy makers and practitioners in developing countries until recently. Traditionally, family planning

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and services to support women just before, during and after birth were seen as more urgent (UNFPA 1994). However in 1994, at the International Conference on Development and Population (ICDP), infertility was put on the international health agenda. Reproductive health was defined as a 'state of complete physical, mental and social wellbeing' (UNFPA 1994), a holistic notion of reproductive health that has been internationally accepted. Infertility is a physical, mental and social problem.

The study

Interviews were conducted with men (7) and women (14) who saw themselves, or were seen by others, as having a fertility problem; relatives of people with a fertility problem (7); indigenous healers (8); Malawian (28) and expatriate biomedical practitioners (4). Interviews were recorded and transcribed in detail. Sometimes interpreters were used: translations of the exchanges between interpreters and respondents were obtained in order to make them available for analysis.

The study looked at culturally shared ways in which people talk about infertility. It examined what interveiwees said about infertility's causes, consequences and solutions and how they said it. The study also looked at the effects of what they said; for instance how people may blame others or justify themselves.

The findings

Polygamy and extramarital affairs

Past research has shown that social expectations about bearing children are particularly strong in some developing countries in sub-Saharan Africa (Gerrits et al 1999). This study examined when and how people refer to such a cultural expectation and need to bear children. Lay people and practitioners interviewed for this study stated that this pressure explained why polygamy and extramarital affairs were often responses to infertility problems. The man interviewed below describes the cultural context as one in which a man must produce children, even if it means taking another wife.

> Man: And if African doctors fail then it is up to the man, if he feels it is not his fault – then you look for an alternative.
>
> Interviewer: What kind of alternative might he look for?
>
> Man: You need children. In our context, in our cultural beliefs, if you marry have no children then you are unfortunate, very unfortunate… [respondent mentions several problems of not having children]. So, if I've a alternative, what alternative can you have, if you love your wife you cannot divorce…automatically you will marry another wife…. So you automatically become a polygamist.
>
> Relative of someone with a fertility problem

Responding to fertility problems in this way may have a number of consequences:

- it provides a rationale for and normalises these practices, making them into understandable and reasonable, practical solutions to the problem
- it minimizes individual choice and responsibility for extramarital affairs or polygamy. They become practices that any member of the culture would 'automatically' do. Also 'culture', rather than individuals, becomes responsible
- it may lead to personal hardship (especially for women who are being 'replaced')
- it may have health consequences (unprotected sex with additional partners puts people at risk of STDs and HIV/AIDS)

Relationship troubles

Although the literature reports that infertility commonly affects people's spousal, family and community relationships (Dyer et al 2002), several people with infertility problems and their relatives interviewed depict their relationships as good. Others do mention relationship change or troubles, such as a husband having extramarital affairs, being told by parents-in-law to leave, or feeling shy in the company of friends. However, their descriptions of these events are remarkably neutral and lack explicit negative judgements of the situation and other people. Also, women minimise the seriousness of their husbands' extramarital affairs.

Finally, some place the blame for tensions in relationships on the person with fertility problems rather than social attitudes. For instance, one person explained his infertile brother's isolation from friends as follows:

> It's not that those people will be avoiding you, but it's you [the brother] who would be avoiding them.
>
> Brother of a man with a fertility problem

This explanation portrays the brother as responsible for his social isolation, rather than his friends.

Playing down the seriousness of affairs, not complaining about, or blaming others for relationship troubles, may make it harder for people with fertility problems to get the help and support they need.

'I really tried hard': intensive and exhaustive search for a cure

The social pressure to have children also leads people with fertility problems to feel they need to be seen to be actively trying to solve their problem. It appeared important to avoid being seen as not motivated to do something about their fertility problem. A woman with fertility problems explains in the following quote that she put a lot of effort in trying to remedy the situation, but was prevented from doing so by external factors, namely her husband:

> (…) I went again to the hospital. I went to the hospital there, they told me to bring, I really tried hard, so that there is even a book there at the hospital. After giving [it] to me, they told me to bring my husband, I told my husband, he refused. I told him, he refused! Ah, ah, me, to the hospital, I went!
>
> Woman with fertility problem

People interviewed frequently reported an endless search for a cure. The study suggests that local reaction to perceived inaction may be unhelpful for a number of reasons:

- it appears to facilitate intense health-seeking behaviour, which may give rise to financial troubles
- it may even facilitate additional health problems, for example when medical interventions lead to secondary infections (Inhorn 1994)
- it can raise false expectations as the chance to find a cure is small due to limited treatment options

Practitioners creating false expectations

Several practitioners portray themselves as successful and competent in dealing with infertility problems. Indigenous healers portray their success as more widespread than biomedical practitioners. This may be because their income is dependent on their ability to attract patients.

When acknowledging problems in helping infertility patients, some practitioners deny responsibility for any failures. They do this in a number of ways:

- by suggesting that there is no problem with the medical care they provide
- by attributing failure to achieve a cure to patients' behaviours
- by attributing communication problems to patients' limited knowledge or intelligence, or the interpreter used

Claims of widespread success may give patients false hopes, pushing them to continue taking action. In addition, it could be argued that suggesting that a problem is due to patient characteristics makes patients unjustifiably responsible. It also may hinder reflection on how care provided may both contribute to and prevent problems.

Conclusions

This study examined shared ways of talking about and interpreting childbearing and infertility in Malawi, and the effects of these descriptions. Some of these descriptions appear to have problematic effects. Changing the social meanings of childbearing, infertility, its consequences and solutions by getting people to describe and frame these matters in more helpful, empowering ways may address these problems.

While this study was conducted in Malawi, some of the insights may be transferable to other developing countries, especially those in sub-Saharan Africa.

It is important that any interventions are relatively inexpensive and take up few human resources. For example, using volunteers in communities, such as people who have or had suffered from a fertility problem themselves, or their relatives.

Proposed interventions are innovative and will have to be carefully evaluated. (see below) However, they are in line with health promotion principles of community development and empowerment advocated by the World Health Organization (1986).

Facilitating new ways of talking about an issue is one way to empower people: 'Everyone has stories, but some stories actively devalue people and other stories are not recognized as valuable at all. Some stories empower people and other stories disempower people' (Rappaport 1995). Developing social interventions to alleviate the burden of infertility is important, and an essential addition to the few individual interventions, such as counselling, currently on offer for those who fail to bear (enough) children in developing countries.

Policy implications

- Social interventions could be developed which address shared ways of talking about and interpreting infertility and childbearing. For example, discussions could be held in the media (radio, newspapers), health institutions, churches, or in discussion groups (in communities, hospitals/health centres). They could be triggered by plays in communities or soap operas on the radio
- Critical discussions could be held about:
  - the reasonableness, normality and inevitability of affairs, polygamy and divorce as a response to infertility
  - health or religious arguments
  - the effectiveness and impact of intense health seeking behaviour
  - health practitioner's claims of success and explanation of failures
  - expectations of society and practitioners about those seeking help for infertility
- People could be invited to share stories of relationship troubles, and reflect on who (spouse, relatives, community member) could be seen as co-responsible for the relationship strains, and for solving them
- Ideas for addressing the negative impact of infertility should be incorporated into existing policy and services, in particular those concerning HIV/AIDS

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