UNSEEN CHOICES:
THE ROLE OF INFERTILITY STIGMA IN SHAPING REPRODUCTIVE AGENCY

Insights for Social and Behavior Change Program Design
from Formative Research in Cameroon and Kenya



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Contents

What will I find here? (click to navigate)

Background

Page 1

Program Opportunities

Page 71



Study Methodology

Page 7

Key Takeaways

Page 78

Formative Research Findings

Page 11

Background

RETURN
TO ROADMAP

STUDY RATIONALE

GLOBALLY, 1 IN 6 PEOPLE WILL EXPERIENCE INFERTILITY IN THEIR LIFETIME (1), THE MAJORITY OF THEM IN LOW-AND-MIDDLE INCOME (LMIC) COUNTRIES (2).

Infertility is a disease of the male or female reproductive system defined by the failure to achieve a pregnancy after 12 or more months of regular unprotected sexual intercourse (1).

There are two main categories of infertility: primary infertility, when an individual has never achieved a pregnancy, and secondary infertility, when an individual has achieved at least one prior pregnancy (2). The burden of infertility varies across and within regions, affecting more than 186 million people and 45 million couples worldwide (2, 3), and is widely considered a public health crisis (4).

INFERTILITY CONTINUES TO BE A NEGLECTED AREA IN GLOBAL HEALTH (5). TO SUPPORT REPRODUCTIVE AGENCY AND EMPOWERMENT OF ALL INDIVIDUALS, SEXUAL AND REPRODUCTIVE HEALTH RIGHTS PROGRAMS AND RESEARCH SHOULD HOLD SPACE FOR INFERTILITY.

Over 30 years ago, International Conference on Population and Development (ICPD), outlined numerous actions to advance sexual and reproductive health and rights, including infertility prevention and treatment (6). However, decades later, infertility has been consistently left out of sexual and reproductive policy, programs, and research (5,6).

Limited resources often make it challenging to justify investing in costly fertility treatments, especially in contexts where public health priorities focus on addressing high rates of infectious diseases and maternal mortality (1, 5, 6).

Continuing to neglect infertility will contribute to vast psychological and social consequences, in particular, in many LMICs where having children is deeply valued among cultures, tied to securing a marriage, ensuring property and inheritance rights, providing future income, and offering social support in old age (7).

WHILE A LACK OF DATA LIMITS ESTIMATION OF NATIONAL AND SUBNATIONAL BURDENS OF INFERTILITY, **THERE IS CONSENSUS THAT INFERTILITY RATES IN SUB-SAHARAN AFRICA ARE ELEVATED COMPARED TO OTHER REGIONS IN THE WORLD** (8).

The pooled estimate of lifetime infertility in sub-Saharan Africa is 13.1%, compared to 1.9% globally, while the pooled estimate of period infertility is 16.4% compared to 10.5%, respectively (2).

Causes of infertility in the region include 1) anatomical, genetic, endocrinological and immunological problems, and 2) preventable problems such as reproductive tract infections (e.g. STIs), risky healthcare practices, and exposure to toxic substances, either in the diet or environment (9). Pregnancy-related infections or bilateral tubal occlusion due to sexually transmitted infections (STIs) are the most common causes of infertility in Sub-Saharan Africa (9).

INDIVIDUALS LIVING WITH INFERTILITY EXPERIENCE A MYRIAD OF PSYCHOLOGICAL, INTERPERSONAL, AND FINANCIAL CONSEQUENCES THAT LOWER THEIR OVERALL QUALITY OF LIFE.

Across Sub-Saharan Africa, those living with infertility face numerous individual and interpersonal consequences, including:

- High levels of stress, depressive symptoms, loneliness, suicidal thoughts, and overall lower quality of life due to the increased pressure to bear children (10, 11).
- Divorce, separation, and overall martial dissolution due to children being regarded as essential for marriage stability (12, 13).
- Additional risks to women. Infertility is associated with increased rates of infidelity and polygamy, intimate partner violence (IPV), and increased risk of STIs (14).
- Financial strain, mainly from costly fertility treatments and divorce or property disputes due to marital deterioration (15, 16).

SOCIAL NORMS AND STIGMA SURROUNDING (IN)FERTILITY PERPETUATE MISPERCEPTIONS ABOUT THE CAUSES OF INFERTILITY, REINFORCE THE INDIVIDUAL AND INTERPERSONAL CONSEQUENCES OF INFERTILITY, AND CREATE CONDITIONS THAT CONSTRAIN REPRODUCTIVE AGENCY.

- Social norms and societal expectations around fertility place pressure on couples to bear children upon marriage (10, 14).
- Women are disproportionately blamed and seen as responsible for (in)fertility, to maintain the family lineage and reap the familial and social benefits derived from having children and further marginalize men from the discourse on infertility (17, 18)
- Because of the high social value on childbearing in Sub-Saharan Africa, there is pressure to prove fertility at an early age. Fear of infertility later in life—is a common justification for women's early marriage and childbearing to prevent ramifications such as gossip and speculation of infertility (19, 20, 21).
- The perception of infertility can affect contraceptive choices, as couples may avoid certain methods, fearing it can fuel stigma or doubts about their ability to have children (17, 22, 23).

OVERARCHING GOAL

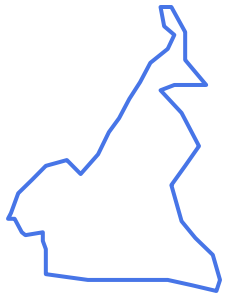
To address infertility stigma, and its impact on reproductive agency, this activity will **aim to design a context-specific social and behavior change (SBC) intervention that encourages a more supportive normative environment around infertility, towards the long-term goal of increasing the agency of men and women to take action on whether and when to have children.**

RESEARCH OBJECTIVE

To support this activity, formative research was conducted to understand infertility and infertility-related stigma more deeply in the contexts of Cameroon and Kenya, **to investigate individual, community, social and systems factors influencing women's and men's reproductive agency and behaviors, with particular focus on investigating (in)fertility-related knowledge and social norms and how they influence reproductive agency**. This information, in turn, will be used to inform the design of an SBC intervention that addresses fertility-related knowledge, attitudes, norms—including infertility-related stigma in 2024.

Cameroon and **Kenya** present unique settings to draw comparative parallels, deepen our understanding of the consequences of infertility and propose diverse intervention opportunities to improve the lives of women and men.

- Most of the research on infertility and its consequences has occurred in a small group of countries in Sub-Saharan Africa, including Ghana, The Gambia, Nigeria, and Malawi.
- Yet, in comparative studies across the region, both countries have high rates of infertility, cultural beliefs that stigmatize infertility, and limited access to and availability of infertility treatment (24). In both contexts, evidence suggests that individuals and couples also seek alternative non-biomedical care (e.g., religious and/or traditional healers and herbalists).
- Evidence indicates similar interpersonal and community-level stigma and isolation related to infertility in the two countries, these cultural norms may vary across both urban and rural settings in Cameroon and Kenya (25, 26).
- Taken together, understanding these similarities and differences will inform tailored interventions across both contexts, while also generating crosscutting learnings which can be applied in West Africa and East Africa, and build the evidence base for the broader region.



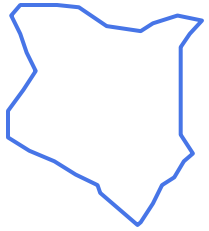
FAST FACTS
INFERTILITY IN CAMEROON

- Primary infertility ranges between 3.1%-7% and **secondary infertility between 18.9% - 26.3%** (2, 27), higher than global averages.
- While SRH programming and policies are oriented toward family planning, infertility is a growing concern in Cameroon (25).
- Cameroon has been recognized as an early leader in providing assisted reproductive technologies (ART) services in the Central and West Africa region(s). However, services and trained medical professionals remain limited and available only in city centers and costly (27, 28).
- As a result, there is evidence of using traditional medicine practitioners for treatment of infertility by use of natural plants and other remedies (29).

Within the context of such strong structural barriers to infertility services, **social and interpersonal interventions can be critical**.

Yet, there are **no evidence of existing interpersonal or social interventions to address infertility-related stigma** in Cameroon, despite the recognized need for such programming (25).

Interpersonal interventions to reduce rates of infertility-induced divorce and **community-based interventions** to address stigma for those experiencing infertility (in particular, women) (25) may be of utility.



FAST FACTS
INFERTILITY IN KENYA

- Primary infertility in Kenya is at about 3% (within a range of 0.3-5%), with **secondary infertility in the range of 35%-51%** based on mixed estimations (2), much higher than global averages.
- Kenya's National Reproductive Health Policy 2022-2032 names infertility as one of the ten priorities, calling out access to care, community awareness and male engagement (30).
- Kenya presents a more expanded environment for health service treatment for infertility, with several clinics and trained experts, yet they are costly (31).
- Despite these commitments, as within other contexts in the region, the issue of infertility has been overlooked as researchers and policy makers are focused on addressing other challenges, including those associated with rapid population growth (32).

Infertility stigma leads to **discrimination and marital problems,** as women may face blame and pressure from their partners and families; alongside the psychological distress they may feel (33).

In addition, the **high cost of treatment and lack of financial coverage** further exacerbates the burden of infertility on individuals and families (33).

With growing investment in service-level diagnoses and treatment efforts, **concurrent investments can be made to support increased awareness, education, and access to services on infertility** and build on momentum.

Study Methodology

RETURN
TO ROADMAP

STUDY METHODOLOGY
RESEARCH QUESTIONS AND METHODS

Three research questions:

1. What are local perceptions and conceptualizations of the causes, preventative measures, and social norms associated with infertility in Cameroon and Kenya?

2. How do infertility-related knowledge and social norms influence reproductive agency and contraceptive behavior in Cameroon and Kenya? What are the most trusted sources of information on infertility?

3. What are the priorities, opportunities, and gaps in the current landscape of infertility-related SBC programming in Cameroon and Kenya?

Overall study design:

- Exploratory qualitative study used as formative research.
- Conducted in multiple settings across two countries to compare findings by context, identities, and life course stages.
- Applied rapid qualitative methodology, to enable time-bound data collection and iterative analysis (34, 35).
- Included human centered-design and social norms identification activities.
- Used findings for a prospective intervention design to address infertility-related stigma.

IN-DEPTH INTERVIEWS

To understand infertility-related knowledge, and social norms influencing reproductive agency with women and men. Included a sub-sample of individuals with past or current experiences of infertility.

FOCUS GROUP DISCUSSIONS

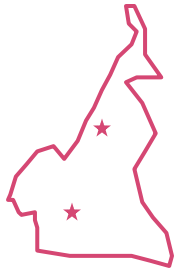
To unpack local perceptions, conceptualizations and norms around infertility that drive reproductive behaviors with women, men and influential individuals in the community.

KEY INFORMANT INTERVIEWS

To understand knowledge and attitudes around (in)fertility, and; identify priorities, opportunities, and gaps in the current programming with community health workers and non-biomedical healers and herbalists.

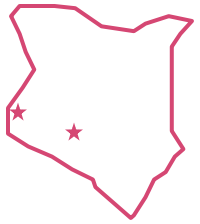
STUDY METHODOLOGY
SITES, TIMEFRAME, POPULATION

The study took place between August 2023 and February 2024 in Kenya and Cameroon. Data collection occurred concurrently in each country (September 2023 - October 2023), followed by data cleaning, transcription, and analysis (December 2023 - February 2024).



Cameroon

The urban setting of Yaoundé, located in the country's centre region, and in the rural community of Nganha, located in the country's northern region.



Kenya

Research was conducted in the informal settlement of Mukuru in Nairobi and the rural fishing community of Homa Bay.

The study included three broad study populations: (1) **Women and men** 18* to 49 years old who are sexually active (individual level), a small sample with direct experiences of infertility; (2) **Influential members of the community** who may uphold infertility-related norms and stigma (community level), and; (3) **Service providers** – both based within and outside of health facilities – who provide SRH, (in)fertility and family planning information, services and support to women and men (systems level).

Method	Gender	Age	Inclusion Criteria
In-Depth Interviews	Women Men	18-40 years 18-49 years	Individuals who have ever been sexually active or who are experiencing, or who have previously experienced, primary or secondary infertility for 12 months or more
Focus Group Discussions	Women Men	18-49 years	Women and men who are sexually active or are a part of a reference group influential in upholding norms around infertility and infertility-related stigma
Key Informant Interviews	Women Men	18+	Service providers in public and private health care facilities, Community health workers, Non-biomedical healers and herbalists

*In Cameroon, the age was 21-49 based on age of consent

STUDY METHODOLOGY
ANALYSIS AND INTERPRETATION

Data analysis occurred both during data collection, after IDIs using rapid analysis techniques to inform FGDs, and after all data collection using thematic analysis. The analysis team consisted of team members from each partner organization.

1

RAPID ANALYSIS

During data collection, a rapid assessment of social reference groups identified during the in-depth interviews was conducted to inform the focus group recruitment using the Social Norms Exploration Tool's 'My Social Networks' framework (36). Analysis matrices were later developed to identify the most prevalent reference groups for each study site to inform recruitment.

2

DEVELOPING AND PILOTING CODEBOOK

Full data analysis was conducted after all data collection activities were completed. All IDI recordings and FGD notes and records were cleaned, translated, and transcribed into English prior to analysis. In the first stage of full analysis, both deductive and inductive approaches were used to build and test a codebook. Codes emerged literature, and transcripts reiteratively throughout the coding process.

3

CODING PROCESS

Following codebook development, transcripts were piloted to test and revise the initial codebook. In the second stage, the team coded the remaining transcripts revising and adding new sub/themes to the codebook and coding tree as new themes and findings emerged. Coded excerpts and analytic memos were exported from Dedoose into Microsoft Excel and used to create separate data analysis tables in Microsoft Word.

4

THEMATIC ANALYSIS

In these data analysis tables by method of data collection (e.g., IDI, FGD, and KII), salient themes and sub-themes related to (in)fertility knowledge, attitudes and norms were extracted, with supporting excerpts. The themes exported informed country-based synthesis findings summaries used to inform dissemination and intervention design activities.

Formative Research Findings

RETURN TO ROADMAP

PARTICIPANT **DEMOGRAPHICS**

	IN-DEPTH INTERVIEWS	FOCUS GROUP DISCUSSIONS	KEY INFORMANT INTERVIEWS
CAMEROON	**28 IDIs** Women (n=10) Men (n=10) Women with infertility experiences (n=4) Men with infertility experiences (n=4)	**7 FGDs** **Yaounde**: Women (n=6-8) Men (n=6-8) Mothers (n=6-8) **Nganha**: Women (n=6-8) Men (n=6-8) Male Traditional Healers (n=4-6) Female Traditional Healers (n=4-6)	**12 KIIs** Nurse (n=5) Community Health Worker (n=2) Medical Doctor (n=1) Religious Leader (n=2) Traditional Healer (n=2)
KENYA	**28 IDIs** Women (n=10) Men (n=10) Women with infertility experiences (n=4) Men with infertility experiences (n=4)	**8 FGDs** **Mukuru**: Women (n=6-8) Men (n=6-8) Fathers (n=6-8) Mothers-in-law (n=6-8) **Homa Bay**: Women (n=6-8) Men (n=6-8) Fathers (n=6-8) Mothers-in-law (n=6-8)	**10 KIIs** Herbalist (n=2) Clinical Officer (n=1) Nurse (n=5) Community Health Officer (n=1) Child Protection Activist (n=1)

In **Cameroon,** most participants were married, and about one third of participants were either single or in a non-marital relationship. Less than one third of participants were between 18-29 years old and the majority between 30 to 49 years old. The older age structure is skewed by the age of key informants, who tended to be older participants. Among key informants, close to half were nurses, followed by community health workers, religious leaders and traditional healers, and one a medical doctor.

In Kenya, most participants were married, and about one quarter of participants were either single or in a non-marital relationship. About one third of participants were between 18-29 years old, and the majority between 30 to 49 years old. This older age structure is skewed by the age of key informants, who tended to be older participants. Among key informants, half were nurses, followed by herbalists, and a mix of community health, clinical and child protection officers.

In the **FGD across countries**, participants had a mix of contraceptive history experiences, marital status, and education background. For men and women, they had a mix of contraceptive history and fertility knowledge, with possible experiences of infertility, and a range of marital status and education profiles. We were not able to capture other demographics. Reference group discussions were formed through screening participants who met the inclusion of being key influencers

KNOWLEDGE OF (IN)FERTILITY

CAMEROON KENYA

FERTILITY AWARENESS

Respondents in both Cameroon and Kenya demonstrated a general understanding of fertile days, menstruation, and fertility. However, there was mixed and often inaccurate understanding of when fertile days occur. In Cameroon, it was unclear whether people *actually* did not understand when fertile days occur, or if misunderstanding was due irregular menstrual cycles. In both settings, people understand that sexual intercourse between a woman and man, in the absence of contraception and within the fertile window, can lead to conception. In Cameroon, respondents expressed a lack of comfort about fertility and revealing knowledge.

People received information on fertility from:

- K C school
- K C women/wives
- K C parents
- K C TV/media
- K C personal experiences

K "A woman can become pregnant when she counts her ovulation very well. When she knows how to calculate her periods, it is always said that you can be fertile after the 11 days of menstruation period. After that, you are very fertile if you meet a man; you are going to gain a profit."
IDI, Woman, Age 36, Homa Bay

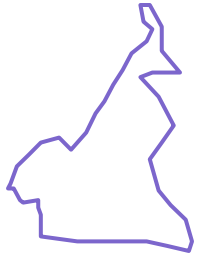
K "There are always high chances right after the period she will most likely become pregnant if he engages in sex. Two weeks after her periods she is more likely to be safe and chances are low to become pregnant."
IDI, Man, Age 36, Mukuru

C "A woman can become pregnant by only one means; it is just through unprotected sexual intercourse and perhaps at the time of her, How can I put it? her ovulation, or something like that. And that's what ruins some girls today because they don't really know how to calculate their period."
IDI, Man Aged 25-29, Nganha

C "The fertile period is after the woman's menses. (Hum, hum). Yes. After two, after one, after one day. Yes. Now she's in the fertile period. There, strongly, she gets pregnant."
IDI, Woman Aged 41-49, Yaoundé

C "A woman normally has a cycle and different women have different cycles and we have the fertile period of a woman during which, when she meets with a man, she gets pregnant. From the day that a woman starts menstruating till the, to me I calculate from the 11th day till the 19th or 20th day I know that I am not safe within those days if I meet with a man, it's possible that I can get pregnant. From the day a woman starts menstruating, to me, I calculate from the 11th to the 19th or 20th day, I know that I am not safe."
IDI, Woman Aged 30-35, Yaoundé.

FERTILITY AWARENESS
KEY FINDING FROM CAMEROON



While individuals seek support from traditional sources (e.g., healers, elders) in both Cameroon and Kenya, findings suggest they are more present and sought out in Cameroon, particularly in rural areas. In Cameroon, traditional healers who are especially influential and provide informal services and support to individuals and couples experiencing infertility noted that the ‘gait’, ‘strength’, physical structures of genitals and skin, ‘state of the lower abdomen’, ‘cowries in hair’, ‘using a hen as an ultrasound’, are indicative measures used to ‘know’ one’s fertility.

> When someone who can't have children comes to us, we ask them to buy a hen to do what we call an "ultrasound". We place the hen on the patient's belly and then open the hen's abdomen to see what the problem is that's preventing her from giving birth.”
>
> *–FGD, Female traditional healer, Nganha*

INFERTILITY KNOWLEDGE

People describe infertility as:

- K C "Being Barren"
- K C inability to "sire"
- K inability to "reproduce or conceive"
- K inability to "have" children
- C being "sterile"

The causes of infertility:

- C Incorrectly tracking fertile window
- C Being unwell, putting on weight, being sick or weak

How to know if you're infertile:

- K C Concerted attempts to conceive over long periods of time (one to several years) and being unsuccessful
- K Men can confirm fertility by "trying somewhere else"

How to know if someone else is infertile:

- K C "Knowing" someone else is infertile when they are married and do not have children after several years

K "I think infertility is the inability to have children between a man and a woman, and it can be on both sides; you can find that either the woman is the problem or the man."
FGD, Men Aged 18-49, Mukuru

K "But if you had not gotten a child in that other place and you have a wife here to… the measure that we use as Africans is trying somewhere else to see whether you will get children and if it fails twice or thrice you know that it is you."
FGD, Men Aged 18-49, Mukuru

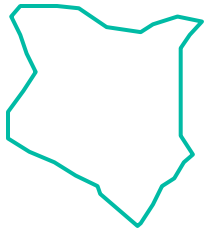
C "A woman who never bleeds can't give birth."
FGD, Women Aged 21-49, Nganha

C I think you can tell that by how long you've been married. Imagine a couple who have been married for two years, but don't always have a child. You're going to conclude that someone in this couple has a sterility problem." *FGD, Men Aged 18-49, Nganha*

C "For me, a woman who can't give birth shows signs. You'll see, for example, that she's putting on a lot of weight or that she's always sick. At the end of every month, she's always sick."
FGD, Men Aged 18-49, Nganha

C "A woman who doesn't give birth has menstrual problems; that's why she can't have children. If her periods are healthy, she can give birth, but if they have problems, she can't give birth. Tummy troubles, bad periods."
FGD, Male Traditional Healers, Nganha

INFERTILITY KNOWLEDGE
KEY FINDING FROM KENYA



Healthcare providers generally had a more accurate understanding of primary and secondary infertility than the general population. Some healthcare providers did not have the correct understanding of infertility causes. Among these providers, contraceptive use was commonly described as causing infertility and providers tailored counseling to reflect this.

> There are two different types of infertility, primary and secondary infertility. In primary fertility, someone has been actively having regular sex with her husband/wife and unable to have a child for more than 5 years. Secondary infertility, someone has been using a certain family planning and after removing it they struggle to get a baby. In family planning, one should be able to get a child immediately after stopping using a method. If a time of over 6 months passes, then one may have secondary infertility."
>
> *–KII, Male Healthcare Provider, Mukuru*

PERCEIVED CAUSES OF & **PREVENTATIVE MEASURES** FOR (IN)FERTILITY

CAMEROON KENYA

WOMEN MEN

CAUSES OF INFERTILITY: A MIX OF BIOLOGICAL, "LIFESTYLE", AND SPIRITUAL FACTORS

Across in-depth interviews and focus group discussions, participants shared a wide variety of real or perceived infertility causes. These varied across groups, with differences emerging between women, men, and key informants. Participants demonstrated a strong understanding of various causes of infertility, often linking biological, lifestyle, and spiritual factors rather than considering them in isolation.

Biological causes were widely recognized, but prior reproductive health behaviors, particularly contraceptive use and abortion, were frequently viewed as primary or contributing factors, especially for women.

Lifestyle-related factors such as diet, alcohol or drug use, and being overweight were also mentioned. Spiritual explanations, including beliefs in witchcraft or divine will, were cited equally by men and women, as well as by non-healthcare key informants.

By far, sexual and reproductive health behaviors were the most cited as contributors to causing delayed fertility or infertility, all of which placed a heavy burden on women's actions.

PERCEIVED BIOLOGICAL CAUSES OF INFERTILITY

BOTH

- K — "genetic" causes or "blockages" in the body
- K C — diseases
- K — hormonal imbalances
- K C — diabetes
- K C — chronic conditions
- K C — age

WOMEN

- K C — fibroids
- K C — cysts
- K — reproductive structural abnormalities
- K — polycystic ovarian syndrome
- K — cervical cancer
- C — previous ectopic pregnancies
- C — myomas
- C — ovarian failure
- C — endometriosis
- C — blocked fallopian tubes
- C — early onset menopause

MEN

- K C — Low sperm count
- K C — erectile dysfunction
- C — poor sperm "thickness" or quality

K C

Women understood causes among men and women while men only mentioned male causes.

K C

Key informants working in healthcare professions demonstrated accurate knowledge of leading biological causes.

K C

Traditional healers and religious leaders demonstrated mixed understanding of biological causes.

PERCEIVED BIOLOGICAL CAUSES OF INFERTILITY

K "In ladies there is something called fibroids, and then in men I can say low sperm count."
FGD, Men Ages 18-49, Mukuru

K "The man might have low libido, low sperm count, and these can cause infertility. Genetics also plays a critical role in infertility among men."
IDI, Male, Age 21, Mukuru

K "I believe that men are mostly because of the immaturity of the sperm. However, some are also born with infertility issues. The men with infertility issues cannot be reversed even if they go to the hospital."
KII, Male Herbalist, Mukuru

K "I think also age can play a factor on somebody being infertile."
FGD, Men Aged 18-49, Homa Bay

C "I think it's due to illnesses, because when you don't have any problems, you give birth until the menopause arrives. But, when you haven't reached menopause age, it's obviously linked to problems."
IDI, Woman Aged 36-40, Nganha

C "It is said that there are some men who lack good sperm and are unable to reproduce children... So even if they sleep with a woman, she can't get pregnant."
IDI, Woman, Aged 25-29 years, Nganha

C "Well, there are several reasons. The woman can have problems with the fallopian tube, with a blocked fallopian tube. Myomas, cysts. Yes. So, when a woman has these, cysts, both tubes are blocked. It's not easy for her to have.... Yes...babies."
IDI, Woman Aged 41-49, Yaoundé

PERCEIVED LIFESTYLE CAUSES: NON-SRH CAUSES

Lifestyle choices were commonly cited as causes of infertility among men, shared by all participants. These included drug and alcohol use/abuse, smoking, stress, poor diet, and being overweight or obese. K C In addition, some medicine was cited as a cause of infertility, such as erectile dysfunction drugs. C

These lifestyle factors were mentioned in both urban and rural areas. K C

While some participants mentioned drug or alcohol abuse as a factor for both women and men, it was more frequently associated with men's infertility. K However, in Cameroon, drinking and drug use were more often linked to women. C

In Cameroon, poor diet, for example, consuming unsafe foods like "maggi cube" or certain meats and over-exercising, were mentioned as causes of infertility. C

K "Young men nowadays like alcohol a lot. They also chew khat and I hear if you chew khat a lot, your sperm count becomes low [...]. The more they use the drugs the more the sperm count drops."
IDI, Male, Aged 28, Mukuru

K "Stress also plays a huge role in impacting the ability of the man to sire a child. The diet also plays an important role [...] we advise men to eat particular diets along with some herbal to improve their fertility."
KII, Male Herbalist, Mukuru

K "It can also be caused by lifestyle, if someone has habitual behaviors like things like smoking, I think can cause infertility."
FGD, Men Ages 18-29 Herbalist, Homa Bay

C "I did it mainly by advising against eating sugar, because it's not good for the sperm. The same applies to the maggi cube. If a woman consumes the maggi cube, she'll have problems getting pregnant."
FGD, Men Aged 21-49, Nganha

C "Excessive alcohol consumption, for example, among men, among young men, they drink alcohol excessively, they smoke tobacco, others even smoke hemp, all of this is a hindrance or a cause of infertility."
IDI, Man Aged 41-49, Yaoundé

C "Can we also say drug is a factor, drinking things like kitoco (a kind of whisky), that it destroys, the excess of alcohol and that is strong (many people talking at once) yes that is what I am saying, it can prevent pregnancy, people taking alcohol."
FGD, Women Aged 21-49, Yaoundé

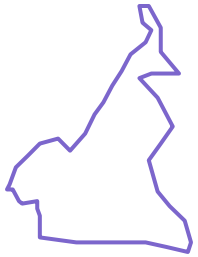
PERCEIVED LIFESTYLE CAUSES: **CONTRACEPTIVE USE**

CAMEROON

Women and men widely attributed contraceptive use, **particularly hormonal methods like implants, injectables, pills, and IUDs, as a major cause of infertility**. While many shared experiences of difficulty conceiving after contraceptive use, most could not clearly explain how it caused infertility. Beliefs about contraceptives causing infertility included disruption of menstrual cycles, prolonged use affecting natural fertility, and links to promiscuity, which were often blamed on women. Men frequently discussed these issues in focus groups, while women felt unfairly targeted and blamed. Key informants, including medical professionals and traditional healers, noted myths in the community about contraceptives causing infertility. **Some healthcare workers expressed the preference towards non-hormonal methods, while others blamed "uncontrolled" contraceptive use for fertility challenges.**

KENYA

Likewise, the most commonly cited causes of infertility among women were linked to their contraceptive and reproductive histories and behaviors, according to participants across all sites and groups. While distinct from the lifestyle factors attributed to men, **these reasons were often tied to women's lifestyle choices and reproductive health decisions. "Irresponsible contraceptive use" and "frequent abortion" were the two most frequently mentioned causes**. Prolonged contraceptive use, especially starting at a young age, was believed to cause "blockages in the female reproductive tract" leading to infertility, with pills, injections, and implants specifically cited. **Additionally, some healthcare providers and herbalists shaped their counseling based on their perceptions and knowledge of certain contraceptive methods.**



PERCEIVED LIFESTYLE CAUSES: CONTRACEPTIVE USE IN CAMEROON

- "Infertility also often affects couples who have already had one or two children, after which the woman decides to take contraceptives such as tablets or injectables. When she decides to stop using contraception, it becomes difficult for her to conceive again [...]. There are many cases like that here. That's why families don't like (injectable) contraceptives anymore, because it causes a lot of problems for couples afterwards."
  FGD, Men Aged 18-49, Nganha

- "Girls today use injectables. You see a little girl who isn't old enough to give birth yet, but she's already using injectables. That's the cause."
  FGD, Men Traditional Healers, Nganha

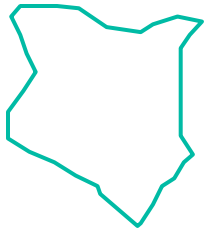
- "For me, there are several reasons. For young girls, it's usually contraceptives (injectables) that they take. When they get married, having children becomes complicated."
  FGD, Men Aged 18-49, Nganha

- "... For example, women take these contraceptives [IUDs], but when they decide to have a baby, it becomes very difficult, and we don't understand why. For others who even take them, they keep having miscarriages. So, I do not really recommend these methods. I would rather recommend and go for the calendar method, which is ideal to me because even the condom is 80%, no 40% - 60% reliable."
  IDI, Man Aged 21-24, Yaoundé

- "I also wanted to know whether contraceptive methods can cause infertility in women, especially as our daughters today want to play the game of life, you see an eighteen-year-old girl who says she's going to school, but it's something else. If she starts using these methods at a young age one day or another, won't that cause them infertility one day?"
  FGD, Mothers, Yaoundé

- "I'd like to make it clear that we're living in a time when it's really difficult to have children. And what's causing this? It's because women are using injectables. Today, the majority of girls and women use injectables, and that's what's causing the difficulties of having children. There is no other cause. When the time comes to get rid of them because the woman now wants the child, she'll start bleeding profusely. And heavy bleeding will create problems in her body."
  FGD, Men Traditional Healers, Nganha

- "...normally contraceptive methods do not cause infertility but can lead to infertility if 'used in an abusive and uncontrolled manner without prescription from a doctor', this can have effects on the cycle such as cycle disorders which can prevent the woman from getting pregnant if this cycle is not regularized."
  KII, Man Medical Doctor, Yaoundé



PERCEIVED LIFESTYLE CAUSES: CONTRACEPTIVE USE IN KENYA

K "Respondent: Sometimes someone might have already had it or took medications when they were not yet married.
Moderator: Which medication?
Respondent: Family planning when they were young."
FGD, Mothers-in-Law, Mukuru

K "From what I have heard is that once a woman uses family planning for a while it can lead to a delay in getting a baby. The implants especially have a significant effect as they cause a delay in receiving the monthly menses after being used for a long period even though it's been removed. The arm injection also has adverse effects as it prolongs the wait for the ability to conceive even after removal. The majority of women complain about the lengthy delay after the use of various family planning methods, but implant has the most side effect."
KII, Herbalist, Mukuru

K "Most people especially our mothers and their children have family planning to prevent them from getting pregnant. When they learn about this they continue using contraception but remember you cannot live like this forever. After they get married they find out that the contraceptives they were using have affected them and they can no longer conceive."
IDI, Male Aged 25, Homa Bay

K "Prolonged or delayed return to fertility can be caused by certain family planning methods like the injection Depo-Provera. Especially for teenage girls, we recommend they explore other methods and delay the use of Depo-Provera until they've achieved their desired family size."
KII, Healthcare Provider, Homa Bay

K "I hear it is because of excessive use of family planning. The second reason is that some women are born that way."
IDI, Woman, Aged 33, Mukuru

K "Many women do not have children because of family planning. I remember a time when my wife after having our second born decided to use daily pills to help plan for our family and after some time we felt we needed another baby, but we couldn't even after she stopped using the pills…. When we visited the doctor, I was told that the daily pills were the cause of the fibroids. The doctor advised that if my wife got pregnant then the fibroids would disappear. Emergency pill (P2), destroys the reproductive system and this will impact the lady when she wants to become pregnant."
IDI, Male Aged 40, Mukuru

PERCEIVED LIFESTYLE CAUSES: **PROMISCUITY AND STIs**

Promiscuity and early sexual activity were seen as causes of infertility for women and men. K C Women were blamed for promiscuity due to frequent abortions, while men were believed to suffer from poor sperm quality. Early sexual initiation was also mentioned by traditional healers and religious leaders as a contributor to infertility. STIs, like Chlamydia, Gonorrhea, and HIV were accurately identified as causes of infertility K C , particularly when untreated. However, participants consistently referenced STIs alongside 'reckless' promiscuity, with women more frequently blamed, more frequently in Kenya. K

C "From what people say, sleeping with several men can also prevent a woman from giving birth. That's all I know."
IDI, Woman 25-29, Nganha

C "Yes, and I'd also say that from a social point of view, I could also talk about debauchery; by sleeping around with women, I tell myself that it has an influence. It can also have an influence on the man, it also has a negative effect. Sperm is wasted and all that. And in the end, even when he finds a woman, he decides to 'take responsibility', he marries a woman and now the woman has problems because he's already..., even socially the lifestyle too..."
KII, Woman Nurse, Yaoundé

C "I can say that infertility doesn't exist because God created all his children to be fertile. God didn't create anyone to be infertile. Now it's our actions that can lead us to be fertile or infertile. The things we do include abortions and sexually transmitted diseases."
FGD, Men Aged 21-49, Yaounde

C "Gonorrhoea and syphilis, for example, can prevent a person from having a child, especially a woman."
KII, Religious Leader, Nganha

K "There are instances of diseases such as syphilis … when taken to hospital and given a particular injection one will lose their fertility. I am just not certain if that injection directly impacts fertility, but that's the information I heard from one of my clients."
KII, Herbalist, Mukuru

K "First, if they were infected with STIs and did not get proper treatment. Gonorrhoea and when they are not well treated, they can lead to infertility."
KII, Healthcare Provider, Homa Bay

PERCEIVED LIFESTYLE CAUSES: **EXPERIENCES WITH ABORTION**

'Frequent' abortions were often cited as a cause of infertility, linked to poor lifestyle choices or reckless sexual behavior. K C Some believed abortions damaged reproductive organs, while others viewed infertility as divine punishment for immoral actions. Either the cited frequency of abortions or 'poor' execution of abortion procedures were mentioned, among men more, but also women, and importantly these narratives were reinforced by influential members of the community, such as mothers-in-law and fathers. These reflections often were loaded with judgement and assumptions of poor decision-making of the part of the woman.

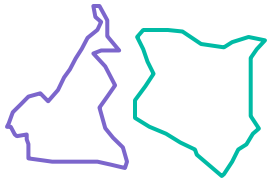
C "Young girls who have abortions and it affects the fallopian tubes. Those who do it in a precarious way, it clogs the tubes. Those who even ingest concoctions. They'll tell you this concoction will clean you up so that you give birth properly. It clogs the fallopian tubes. So that's also a cause of infertility and can lead to infertility afterwards."
KII, Religious Leader, Yaoundé

C "As I said before, in my community, you'll see that other people don't get pregnant. They lived a bad life when they were young, abortions."
IDI, Woman Aged 30-45, Yaoundé

K "What I know people do say let's say example my daughter in law. Some people do say maybe she's not giving birth maybe she aborted many times at home she did abortion so she is not able to give birth."
FGD, Mothers-in-law, Homa Bay

K "When you procure an abortion for example after every five months, when you are finally ready to get a child, you will miscarriage at five months because the womb is loose and has already been programmed that way."
IDI, Woman, Aged 28, Mukuru

K "You'll find that the child has already grown in the uterus and you end up aborting and destroying the uterus then later on the uterus cannot bear children."
FGD, Fathers, Homa Bay



WOMEN'S PAST BEHAVIORS SEEN AS DRIVERS OF INFERTILITY
KEY FINDING: CAMEROON + KENYA

In both Cameroon and Kenya, some lifestyle decisions were attributed to men, but by-in-large, **women's reproductive behaviors or 'lifestyle' choices were considered the drivers of infertility.** Together, past contraceptive use, 'frequent' abortions, early sexual initiation, promiscuity and STIs together paints a picture where women behave 'recklessly'. Women-blaming was not only common but accepted. Often women were described as engaging in not only one of the actions, but all of them. For example, women who were seen as promiscuous and would 'sleep around' with many partners, and in turn, would need 'frequent abortions'. These abortions were cited as causes of infertility. These behaviors were then tied back to spiritual causes described above, where women would have spells cast on them and need to 'pray for forgiveness' for past behavior if they wanted to overcome infertility. These narratives were as common in the general population as they were with influencers and healthcare providers and traditional healers.

C "These things happen every day. When it happens, it's mostly the man who's insulted for marrying a "whore" who's spent all her time taking contraceptives. That's why she doesn't give birth."
FGD, Men Aged 18-49, Nganha

C "I also wanted to say that some women, when they see that they're still young, when they're younger, when they get pregnant, they spend their lives having abortions…there are abortions, lots of them. And in the long run, when the person wants to have the child, there's no way to have the child."
IDI, Woman Aged 41-49, Yaoundé

C "First of all, from a religious point of view, God cannot send a woman into the world to be sterile. So, all women should give birth normally. Now, there are many things, many reasons why a woman might not be able to procreate… I'll take an example. First of all, there may be abortions. When a woman has already had a lot of abortions, this can lead to sterility in the long term."
KII, Man Medical Doctor, Yaoundé

K "Maybe she became pregnant and had an abortion, but the procedure wasn't done correctly or legally. If it was done improperly, it could have harmed her reproductive system, making it difficult for her to get pregnant."
DI, Woman, Aged 24, Homa Bay

PERCEIVED SPIRITUAL CAUSES: **WITCHCRAFT, SPELLS, CURSES**

CAMEROON

This theme was particularly common in Cameroon.

All participants – except Nurses and Doctors – cited curses and witchcraft as likely causes of one's infertility. These spiritual causes were mentioned equally across sites, but more often by women. These could be witchcraft practiced by the individual experiencing infertility or others casting 'spells'. They referred to it as "dérazou" in Fufulde.

Participants agreed that curses could be placed on people from ancestors preventing someone from conceiving. In those cases, people said those with curses against them could do nothing but 'pray to God'.

Another example stemmed from occultic practices, especially practiced by youth, where families may 'offer' their daughters (or someone else's) fertility in a spiritual curse or sacrifice for something else (e.g., money, property).

KENYA

Likewise, spiritual causes of infertility were often linked to witchcraft, spells, and hexes, typically directed at women and sometimes seen as social punishments for poor behavior.

Women often cited being "bewitched" as a common explanation for infertility, reflecting strong community beliefs in witchcraft as a major cause.

PERCEIVED SPIRITUAL CAUSES: **WITCHCRAFT, SPELLS, CURSES**

K "Some are just myths. Some will say that I'm bewitched, and they can't explain how they were bewitched. They'll say it's because my in-law doesn't want me. She has bewitched me; she doesn't want me to give birth."
KII, Community Health Worker, Homa Bay

K "When others are unable to get pregnant they now pin it to the fact that someone has bewitched them or 'looked at them in a bad way'. There are communities who believe someone talked about them in a bad way. "
KII, Healthcare Provider, Mukuru

K "For the women who are not able to get pregnant, I think they are cursed[Laughs]…, and even if you try until you are an old woman, you will try getting pregnant but you won't get it."
IDI, Woman, Aged 31, Homa Bay

C "The cysts are hidden, but the causes of sterility linked to witchcraft are known to everyone."
FGD, Women Aged 21-49, Nganha

C "Because there are other parents who spend their time cursing their children. 'You can be, you're never going to hear the kids. You'll never hear a child crying in your house'. But this is real. It does exist."
IDI, Woman Aged 41-49, Yaoundé

C "Some also can be a curse. Somebody can just look you and not want you to ever see the joy of the baby in your house. Then they take your name and go to witch doctor and then they destroy your body like that. So, you just be you…"
IDI, Woman Aged 31-40, Yaoundé

PERCEIVED SPIRITUAL CAUSES: (IN)FERTILITY IS "GOD'S WILL"

Religious beliefs suggested that conception—or the lack thereof —is all part of God's plan. Men, especially key informants, generally viewed these as myths, but women placed more importance on them. Many participants believed that prayer, guidance from religious leaders, and support from their faith community could improve their chances of conceiving. If these efforts failed, prolonged infertility was often seen as "God's will" or "fate," a perspective that shifted blame away from individuals and suggested the situation was beyond their control.

KENYA

In Kenya, this narrative was most common when no clear cause for infertility could be identified and was most frequently shared within the rural area of Homa Bay. Over time, if these were unsuccessful, and people were perpetually unable to have children for several consecutive years many participants rationalized this as "God's will", insinuating that infertility was out of one's control and should be accepted as 'fate' (a narrative that most commonly occurred in relation to other people's struggles). Many participants also turned to religion, believing that prayer, guidance from religious leaders, and support from their faith community could increase their chances of conceiving, offering hope for a different outcome.

CAMEROON

In Cameroon, many participants, including Traditional Healers, cited that infertility was caused by "God's will", often insinuating that infertility was out of one's control. Participants mentioned things you could 'try' to do to overcome infertility (such as prayer), but if those weren't successful it was ultimately because of God's will dictating a person's fertility. These sentiments were largely more common within the rural site of Nganha.

PERCEIVED SPIRITUAL CAUSES: (IN)FERTILITY IS "GOD'S WILL"

K "The solution is to relax and pray. If you are a Christian like I, I have seen God intervening in so many scenarios, when we read the bible, we get a story of Hannah and Peninnah, Hannah had no child. Hannah interceded with God and got pregnant; Samuel came forth. We have seen so many baren women in the bible like Sarah, Isaac came forth."
FGD, Men Ages 18-49, Homa Bay

K "God will take care of you."
FGD, Mothers-in-law, Homa Bay

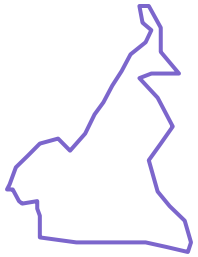
K "In many cases, people are encouraged to continue praying in hopes of having a child. That's the predominant advice given."
IDI, Woman, Aged 27, Homa Bay

C "I'd say the first thing is God's will. Then there are diseases. If you have sex with a sick man, he'll contaminate you and you won't be able to give birth."
FGD, Women Aged 21-49, Nganha

C "…God's will can also be causes. There are situations where someone can mystically block your uterus. No matter what you do, you won't be able to give birth."
FGD, Women Aged 21-49, Nganha

C "Not being able to give birth can be due to God's will too. And when it's his will, whatever you do, you won't have a child."
FGD, Women Aged 21-49, Nganha

C "I'm saying that if her problem isn't linked to God's will, which has condemned her to be unable to have children, she can be cured. But if God has written that she can't have children, we'll just treat the illness to at least relieve her of the pain."
FGD, Women Traditional Healers, Nganha



SPIRITUAL CAUSES OF INFERTILITY
KEY FINDING FROM CAMEROON

In Cameroon, in rural Nganha, Traditional Healers who are sought out as sources of knowledge, emphasize the beliefs that it's 'God's will' as the ultimate cause of one's challenges with fertility and conception and that prayer was helpful but could only control so much if it's not 'meant to be' and God 'designed them' that way. Conversely, healthcare providers who participated as key informants did not share the same perceptions of causes of infertility and expressed that they experience struggles in counselling clients to think otherwise.

"[For example], if my daughter is getting married and her husband fails to offer her something and I get angry, I speak badly this can hinder the pregnancy but as soon as she comes to my house, I take some water and make incantations on her saying that if it's because I spoke badly that she cannot get pregnant, she can go ahead and conceive and that will happen immediately."

–KII, Man Traditional Healer, Nganha

As concerns community beliefs, yes, you could say that. The hospital's role is this, we tell them what the problem is, but they can tell you it's something that was done to them in the village, a spell casted or prayer."

–KII, Woman Nurse, Yaoundé

INDIVIDUAL AND INTERPERSONAL BURDENS OF (IN)FERTILITY

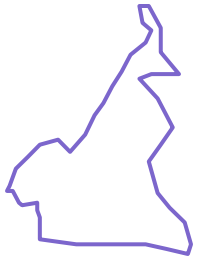
CAMEROON KENYA

THE INDIVIDUAL AND INTERPERSONAL BURDENS OF INFERTILITY ARE VAST, CONFIRMED BY THOSE WITH INFERTILITY EXPERIENCES AND WITHIN THE COMMUNITY.

Findings clearly indicate profound consequences of experiencing infertility (or being perceived as infertile) across sites in Kenya and Cameroon. Both women and men suffer deep **psychological and financial consequences of infertility**, which are commonly recognized within their communities.

Experiences of infertility significantly diminish the quality of relationships in both Cameroon and Kenya, and can result in **separation, intimate partner violence, (threats of or actual) divorce**, (threats of or actual) **infidelity**, **and/or (threats of or actual) forced polygamy**.

Notably, however, is that **women bear a disproportionate share of the burden, often being more widely blamed for infertility**. All participants groups, across all sites, shared reflections on how the individual and interpersonal consequences of being infertile compound together and blame women. These are largely driven by social norms and socially held beliefs surrounding women's fertility.



INDIVIDUAL LEVEL IMPACTS IN CAMEROON

Likewise, in Cameroon, individuals suffering from infertility reported **depression, anxiety, fear of social ostracization, and a deep loneliness stemming from their inability to have children**. This loneliness often led to feelings of anger, frustration, and embarrassment, especially when interacting with people who have children. **These mental health challenges were attributed to both internalized experiences of infertility and the unmet social and life expectations reinforced by prevailing social norms.**

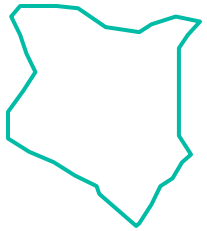
Women, in particular, were described as facing low self-esteem, phases of depression, and, in some cases, severe mental health breakdowns. Traditional doctors and religious leaders noted that some women experienced "hallucinations" or mental breakdowns due to their inability to meet personal, interpersonal, and community expectations. Interestingly, these mental health consequences were more often described by others than self-reported by women themselves.

For **men**, the mental health consequences were linked to stress and anxiety, which, in some cases, contributed to intimate partner violence, exacerbating the emotional toll of infertility on relationships.

C "She definitely cares about having a child. Because every woman's dream is to give birth and leave her offspring on earth. Some pray to taste the pain of childbirth; that is, even if they give birth and the newborn dies, she will at least have experienced childbirth."
IDI, Woman Aged 41-49, Nganha

C "I think that the difficulties in getting pregnant are the same for men and women. Even for men, they can't be at rest. Stress in a man leads to violence, he even becomes practically violent towards his wife."
KII, Woman Nurse, Aged 30-49, Yaounde

C "Some of them even develop imaginary pregnancies. Some even develop imaginary pregnancies, because sometimes when we go into more detail, we realise that some women develop imaginary pregnancies."
KII, Woman Religious Leader, Yaoundé



INDIVIDUAL LEVEL IMPACTS IN KENYA

Infertility was considered an incredibly taboo topic, often perceived as shameful, embarrassing, and stigmatized—a "bad" disease that is not openly discussed. People who experience infertility tend to share their struggles with only a few trusted individuals, as speaking about it can provoke significant anxiety.

Participants spoke freely about how children bring happiness into one's life– and that if you can't have children, it is assumed you can't be happy. Psychological and mental health consequences included **depression, self-hatred, isolation, low self-esteem and sense of self, and even suicidal ideation.**

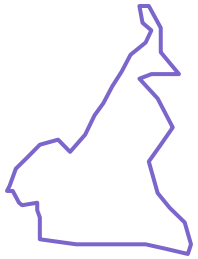
For **women**, these consequences were described as feelings of ostracization, depression, and deep loneliness.

For **men**, these consequences were described as feelings of stress, anxiety, and low self-esteem, largely from feelings as if their 'manhood' was threatened or in question.

K "Women who do not have children are very bitter, depressed, and lack peace because they are continuously thinking of how to get a child. Some of them may know of the things they did before such as abortion, drug abuse and this may be impacting them in the current relationship."
IDI, Man, Aged 40, Mukuru

K "And again self-esteem becomes lowered. You cannot even express yourself. You are withdrawn. I can't talk. As I do not have a child, who will listen to my opinion? There is none."
FGD, Mothers-in-law, Homa Bay

K "Most men have the ability and capacity to overcome depression because of not having children. However, some of the men may drown their stress and sorrows in alcohol to manage the pressure. The man also feels disrespected, isolated and rejected."
KII, Healthcare Provider, Mukuru



INTERPERSONAL LEVEL IMPACTS IN CAMEROON

In Cameroon, infertility was also frequently associated with deteriorating relationships, often leading to separation, divorce, and infidelity. Furthermore, it contributed to heightened conflict, tension, and blame, not only between couples but also between their respective families, exacerbating arguments and discord between the husband's and wife's families.

In both Nganha and Yaoundé, women implied that even if their husbands were infertile, they were still expected to bear children, leading some to seek covert solutions. These actions were rarely openly discussed but included turning to other family members to conceive, such as a brother-in-law, to "maintain" the bloodline.

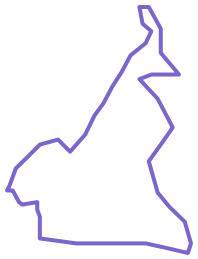
The extended family played a significant role in influencing such decisions, underscoring the weight of familial expectations. While women could take covert steps to address infertility, these actions were neither widely accepted nor openly supported. In contrast, men's actions to "solve" fertility issues—such as seeking other partners—were generally expected and accepted, with divorce looming as a consequence if a woman resisted. Adoption was mentioned as a potential option, particularly in urban Yaoundé, but not seen as common.

C "I'd say there are more negative consequences. As I said, sometimes it (experiencing infertility) leads them (partners) to do something like this, they lose their home for those who are already married. They lose their home."
KII, Woman Community Health Worker, Aged 21-29, Yaoundé

C "Yes, it can happen [that], you're in a relationship with a woman, she, is fertile, you the man you're not fertile. It can happen that the; her family, or one of the family members can advise her [the woman] to go outside and try. Then you realize that you're the problem. And now you'll have to deal with the in-laws."
IDI, Man Aged 25-29, Yaoundé

C "if my husband doesn't give birth, what am I going to do at home? I'm going to look for someone who can give me a child."
FGD, Women Aged 21-49, Nganha

C "Most mothers who haven't been able to give birth often try to take the children of their brothers and sisters as their own, and grow up with them."
FGD, Mothers, Yaoundé



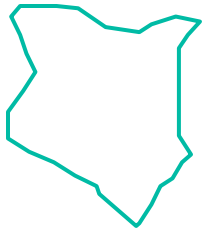
UNIQUE MARITAL CONSEQUENCES: KEY FINDING FROM CAMEROON

'**Forced polygamy**' was a common theme, and something widely accepted as normal. In these situations, community members agreed that men were permitted to take on 2nd, 3rd, or even 4th wives if their wife was infertile. Men interviewed expressed the idea that this is the only sure way to 'prove' your first wife cannot conceive. This was not seen as acceptable or normal for women to do. Male traditional leaders or healers were particularly supportive of men having as many wives as needed to procreate and for women to 'put up with it'.

"If it happens when we're having sex regularly, it means there's a problem with one of us. So we have to go to hospital. If at the hospital they say it's the wife who has the problem, I'll marry another woman."
–FGD, Men Aged 21-49, Nganha

"I don't chase her away, maybe even because I'm the one with the problem. And if it's established that she's the problem, I won't chase her away. But I'm going to take a second wife."
–FGD, Men Aged 21-49, Nganha

"I'm going to approach my wife to tell her that since we can't have children and Islam allows us to have 4 wives, I'd like to remarry. If she refuses, right now, I understand that she doesn't want my property. Then I can divorce her. But if she says, I agree. Either way, the child this woman will give birth to will also be my child. If she says so, then my love for her will increase even more."
–FGD, Men Traditional Healers, Nganha



INTERPERSONAL LEVEL IMPACTS IN KENYA

Divorce, separation, and marital disharmony were as common in Kenya. Men and women in Kenya noted examples of couples within their communities who, to avoid separation, mutually decided to bring another wife into the relationship. In some cases, where separation or divorce did not occur, men covertly initiate another committed relationship or remarry, often ceasing financial support for the wife perceived to be infertile—actions that disproportionately impact women, for whom such responses are either impossible or taboo.

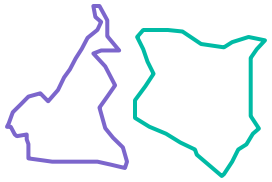
Infertility also affected relationships beyond the immediate family, impacting how individuals were seen by their community. In rural Homa Bay, for example, some men were discouraged from participating in or leading community meetings because they were unable to have children. This exclusion became more pronounced with age.

K "Some lead to separation, some lead to husbands marrying other wives who can bear children. Some complain that their husbands marry ladies who have already three children so that they can compensate."
KII, Healthcare Provider, Homa Bay

K "In the society they don't view a man's infidelity as an issue but if a woman commits such offense it's a taboo. I've lived with almost all these tribes and they all don't entertain that."
FGD, Fathers, Mukuru

K "They are abused, provision is cut. If you were being given money for upkeep, they now stop. The husband, for example, if he is working in Nairobi and you are at home, he will no longer send support because you are not having children."
IDI, Woman, Aged 33, Mukuru

K "Sometimes … the whole village they have called for a meeting … some people will talk and when it's his turn to talk, some people will say the ones without children should not speak…something like that."
IDI, Man, Aged 25, Homa Bay .



EXTENDED FAMILY AS INFLUENCERS
KEY FINDING: CAMEROON + KENYA

Infertility often led to significant **family tensions, causing conflicts, abandonment, and divisions within both nuclear and extended families**. Family members play a large part in influencing what actions people take within their marriages when facing challenges in conceiving. Participants described how a couple's inability to conceive could spark disputes, with some families even disowning their daughters-in-law if they failed to prove their fertility within a certain period of marriage. Family members frequently interfered, offering unsolicited advice or pressuring the couple to take specific actions, which often created discord between the couple and their families. In-laws were cited frequently in interfering and for placing the blame wholly on their daughters-in-law. These findings across settings highlight how deeply the ability to bear children impacts relationships, with infertility straining not just marriages but also ties with in-laws and extended family members.

C At the family level because the in-laws will sometimes incriminate them and perhaps want the husband to take a second wife, which creates tensions at the household level. We don't often have the mindset to investigate both sides, both partners."
KII, Man Medical Doctor, Aged 30-35, Yaounde

C When you don't have children, everyone talks about you. Even your partner sometimes, you don't understand his mentality, he turns against you. Your in-laws also stigmatize you. Your brothers-in-law and sisters-in-law criticize you all the time, telling you that you're worthless apart from eating. All because you haven't given birth."
IDI, Woman Aged 25-29, Nganha

K "There is an element of rejection and discrimination, especially by family. The family always advises the man to separate or leave the marriage... My first girlfriend left me because of my inability to have a child. This made me feel so lonely. You feel stressed, dejected and rejected."
IDI, Man, Aged 27, Mukuru

K "In most childless marriages, the mother-in-law (the groom's mother) will always blame the wife and even intimidate her. They will start saying negative things about the wife, saying she adds no value, she is useless and pressuring the man to look for another woman."
IDI, Man, Aged 40, Mukuru

(IN)FERTILITY **INFLUENCERS**

CAMEROON KENYA

COMMUNITY INFLUENCERS: WHO PROVIDES SUPPORT? WHO ENFORCES SANCTIONS?

In both Kenya (Mukuru and Homa Bay) and Cameroon (Yaoundé and Nganha), in-depth interviews explored whom women and men, including those with experiences of infertility, trust for advice, communicate with about reproductive health, and whose opinions matter most regarding (in)fertility. The interviews also examined who influences the enforcement of social norms or reinforces stigma at the community level.

Across all sites, the same groups often played dual roles, both as sources of support and as enforcers of social norms and stigma. However, some differences emerged: in Nganha (rural Cameroon), participants more frequently turned to traditional healers and elders for guidance, while this was less common across sites in Kenya.

TRUSTING AND COMMUNICATIVE SOURCES OF INFORMATION AND SUPPORT

KENYA

In Kenya, it varied by gender but not site.

Women their partner, mothers-in-law, mother or father, and religious leaders as most supportive. In addition to those primary groups, sisters, other members of the husband's family, medical doctors and community health workers were mentioned.

These were largely the same groups for **men,** except one notable difference: men turned to their peers more so than women to trust with information and discuss issues related to (in)fertility. Men also mentioned turning to village leaders.

CAMEROON

In Cameroon, it varied by site.

In **Yaoundé**, women and men turned to their doctors for advice and counsel on (in)fertility, followed by their partners who they could confide in to share concerns and approach challenges together.

In **Nganha**, in addition to doctors, they would turn to traditional healers and herbalists for support and counsel just as frequently. Sometimes participants in the community noted that they would turn to formal traditional healers, and others referenced going to 'older women in the community' who may informally have solutions for them (e.g., herbal remedies or just for emotional support).

‘POWER HOLDING’ PUNITIVE AND STIGMATIZING SOURCES OF INFORMATION

In Kenya, the same groups often enforced social norms and stigma around infertility while advising couples on actions to hide their struggles.

Mothers-in-law were most frequently mentioned as influential, followed by **fathers**, other family members (primarily the husband’s), and **close friends**.

Mothers-in-law and fathers often intervened to "assist" couples in maintaining lineage, suggesting options like adopting relatives' children, women procreating with their husband’s brothers, or, in extreme cases, fathers themselves stepping in.

Family members, especially aunts and grandmothers, openly questioned why couples hadn’t conceived, increasing pressure. Community elders were also noted as key sources of stigma.

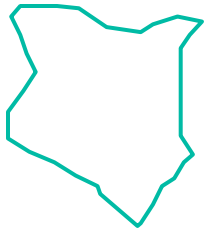
In Cameroon, **friends**, **peers**, **in-laws**, and **biological parents** were the most frequently mentioned groups by both women and men.

Friends and peers, in particular, were noted for sanctioning or rewarding actions taken by individuals or couples.

In Yaoundé, these groups were described more broadly (e.g., community peers or extended family), while in Nganha, they were more specifically identified as close peers, neighbors, or immediate family. Across sites, in-laws on both sides were especially influential, often pressuring couples to take drastic actions, such as divorce or remarriage.

K “When it comes to a situation like that the elders plan for a meet between the wife and maybe brother to the husband and they meet and have a child and it remains as a secret in the family.”
FGD, Fathers, Mukuru

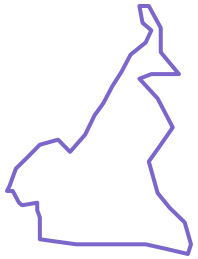
C “In general, when your wife doesn't give birth and we go to tell the mother-in-law, she asks her son to simply divorce his wife, then she asks him to remarry. That's what a lot of mothers-in-law do.”
FGD, Women Aged 21-49, Nganha



INSIGHTS ON SPECIFIC INFLUENTIAL GROUPS **IN KENYA**

PARTNERS Partners encouraged one another to seek help in the form of counselling or fertility services. While many reasons were provided for why relationships are strained as a result of infertility, some participants expressed that couples should come together as well to overcome problems.	*"Then also at that time it is very trying, they should just love each other. You come together, you know you are fighting a common enemy, you help each other out."* *FGD, Women Ages 18-49, Mukuru* *"The spouse always plays a big role in making the man seek help. The partner should be the first support."* *IDI, Male, Aged 21, Mukuru*
MOTHERS-IN-LAW Mothers-in-law were of great influence within the family to counsel their sons and daughters-in-law on actions to take when facing challenges conceiving.	*"Likewise, if the man is the one with fertility challenges, his mother will recognize the issue and work to foster a closer relationship with the daughter-in-law to find a solution."* *IDI, Woman Aged 41, Homa Bay*
FATHERS AND MOTHERS Parents – both mothers and fathers – counselled both women and men on how to cope with infertility and being trusting sources to listen to concerns and fears. Mothers were more frequently mentioned for women and fathers more frequently mentioned for men.	*"The parent can always encourage the man to go and find a solution to the fertility problem."* *IDI, Man, Aged 21, Mukuru* *"Parents are some of the people who can shield childless couples from experiencing the consequences."* *IDI, Man Aged 25-30, Mukuru*

RELIGIOUS LEADERS Religious leaders are a source of trust for individuals and couples providing support and comfort. Priests, Pastors, Imams and individuals working within religious institutions (e.g., within leadership structures) were frequently mentioned as a source of guidance.	*"Couples trust religious leaders more than anyone else. In the community, I will create the program within the church set-up. We can organize couples' therapy and groups after church to discuss reproductive health, and challenges with infertility and develop tailor-made solutions that can help the couples. These programs can have more impact than the hospital."* *KII, Healthcare Provider, Mukuru*
PEERS – FOR MEN ONLY Trusted friends and peers that understand their experiences and are often in the same life course stage (e.g., childbearing years) were great sources of comfort for men. These friends weren't just anybody – but described as those 'lifelong' friends who would never judge them when discussing issues related to infertility.	*"There are long-term friends with whom you share your problems, deep things and issues of life that each go through and you build confidence and trust. I believe the majority of other men would seek advice from such long-term friends"* *IDI, Man, Aged 45, Mukuru* *"What I can say so that a man or a friend can help is that they should be trust because even the friend I was talking about came to me, there is that confidence that they had in me because they did not share it with anyone else, because for them to come and tell you, "this is what I am going through". Then for us men even if you know your men, it is not easy for us to ask. You have to wait till they open up, that is when you can give your opinions and advice because if you start asking that is where your friendship can end or get worse." FGD, Men Aged 18-49, Mukuru*



INSIGHTS ON SPECIFIC INFLUENTIAL GROUPS **IN CAMEROON**

MEDICAL DOCTORS Doctors, were seen as the best option to make recommendations for individuals and couples to take – or to express concern to.	*"In my opinion, consulting a doctor is the first thing that can help; family and partners can also help." – IDI, Woman Aged 30-35, Yaoundé.*
PARTNERS Partners are trusted and reliable for providing help and support, such as contacting doctors on behalf of their partners, when dealing with infertility. Though in some cases, it seemed as if to get partner support, you need to have a strong relationship with your partner.	*"When you're having problems having children and your partner likes you, he can help you find solutions by taking you to see a gynaecologist, for example, to find out what's wrong." – IDI, Woman 25-29, Nganha.* *"And also as a couple you guys have to understand each other because if there is no understanding you people will not have a solution" – FGD, Women Aged 21-49, Yaoundé.*
EXTENDED FAMILY MEMBERS Parents, and siblings play a significant role in helping people dealing with infertility as well. Typically, this is gendered, with women seeking advice from their mothers and sisters - and men seeking advice from fathers or brothers.	*"It is the family that supports them and takes them to the various places where they can find a solution, whether in the hospital or traditionally." – IDI, Man Aged 21-24, Nganha.* *"Generally, if it is the woman [experiencing infertility], it is her mother or her mother-in-law who assists her, and if it is the man, it is his father or his relatives who assist him." – IDI, Woman Aged 30-35, Nganha.* *"It was one year before she got pregnant. So, I went to my big sister in Ngaoundéré, she gave me a remedy and when she took it, God answered our prayers and she became pregnant." – IDI, Man Aged 21-29, Nganha.*

IN-LAWS In-laws, and specifically mothers-in-law while supportive in some instances, were more frequently mentioned as those pushing individuals and couples to go outside of their marriages, divorcing, or punishing daughters-in-law for not conceiving.	*"They are scorned by their in-laws, mothers-in-law, sisters-in-law, who say, "Oh, your wife isn't giving birth, is that normal? Is it, is it a badly wrapped fruit, all that. They are often condemned negatively." – KII, Woman Community Health Worker, Aged 21-29, Yaoundé.* *"There are mother in-laws who drive away their daughter in laws"* *– FGD, Women Aged 21-49, Yaoundé.*
FRIENDS Friends who may have had similar experiences with infertility and who may have used a method to overcome any issues were good support systems for individuals.	*"Good. There is perhaps a friend who has experience in this area. She may have had to do in vitro fertilization and experienced success or an improvement in fertility."* *– KII, Man Medical Docter, Aged 30-35, Yaoundé.*
TRADITIONAL HEALERS/ELDERS - (*NGANHA ONLY*) Women, and individuals in Nganha, were more likely to mention turning to traditional healers – as well as were perceived by others to go seek such care – than men to solve their fertility challenges. This was sometimes described as turning to 'women in the community'.	*"Yes, you can go to a traditional practitioner. He gives you products to take, and when you take them, they heal you too." – FGD, Women Aged 21-49, Nganha*

SOCIAL NORMS, STIGMA, AND GENDERED EXPERIENCES OF INFERTILITY

CAMEROON KENYA

SOCIAL NORMS, STIGMA, AND GENDERED EXPERIENCES OF (IN)FERTILITY

Across countries, sites, and participants, a similar sentiment was consistently emphasized: **children are highly valued and those who cannot conceive are considered less than**. This was reinforced through different social norms – or the unspoken rules that govern behavior – driving multiple, compounding, consequences of infertility and consequently could be attributed to influencing certain mitigation, help-seeking, or broader reproductive behaviors (e.g., contraceptive use, early childbearing). Social norms often related to stigma and feelings of 'community acceptance' or 'peer approval'.

The findings indicate that being childless impacted not only one's individual happiness, but also one's ability to continue family tradition or protect their lineage, inherit property (e.g., wealth in general or land specifically). Therefore, one's familial or social standing was inherently threatened due to their real or perceived ability to procreate. Couples together, as well as women and men separately, experienced social consequences (sanctions) associated with the social norms that surround (in)fertility. However, women were most often blamed and seen as responsible for (in)fertility.

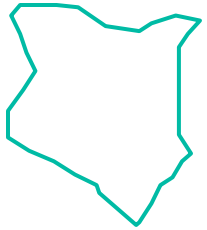
SOCIAL NORMS IN KENYA

The social norms could be broadly categorized into: **proving one's fertility, son preference, communication about fertility,** and **the responsibility of fertility.** Proving your fertility had to do with conceiving young, immediately upon being married, and has associated consequences if not demonstrated. Son preference was related to prizing having a son in order ensure family lineage and inheritance. Communication about infertility was gendered in nature: women could speak openly about experiences, but men could not. Responsibility for infertility was also gendered, where women were held responsible, even in cases when the source of infertility is proven to be male.

	EXAMPLE NORM(S)	QUOTES
PROVING FERTILITY	Members of this community expect all married couples to have children. Members of this community expect married couples to have children within the first years of marriage. If a couple cannot have children, husbands should seek separation, divorce, or another course of action against their wives (and inversely, not 'acceptable' for wives to pursue) In this community, those who have children are seen as 'wealthy' and 'prosperous.	*"The desire or need to be referred to as someone's mother... If you don't get children then it means that if you die, that is the end of your lineage. I agree, not having a child is stressful."* – ***IDI, Woman Aged 22, Mukuru***. *"They [men] also want to show off that they can get a woman pregnant."* – ***KII, Community Health Worker, Mukuru.*** *"It is okay because most people in the community get their first child at that age and if you are left behind, people will look down upon you."* – ***IDI, Man Aged 33, Homa Bay.*** *"In our community we have been brought up in communities whereby children are treated as successors or are a measure of prosperity and wealth to a family. So, if you have a child in the family, you are perceived differently that someone without children."* – ***FGD, Men Ages 18-49, Homa Bay***.
SON PREFERENCE	In this community, it is preferrable to have a son. If you cannot have a child, and especially a son, you risk losing your family assets, such as land.	*"In the community, people would want a woman to have the number of children she was destined to have, even if it is 12 or more…any child you bring into the world is valued, although there's a preference for boys because they typically stay with the family to carry on the name."* – ***IDI, Woman Aged 24, Home Bay.*** *"Yes, for example, if you have a boy child, if the father dies, he will inherit the property, …for those who have ladies, they will get married and other people will claim the land so you as a man your place will not be retained so in the Luo community a boy is regarded than a girl."* – ***IDI, Man Aged 40, Homa Bay.*** *"The community always believes that a man should have a child early with a preference for boys and this influences the age when men get their first child"* – ***IDI, Man Aged 25-30, Mukuru.***

SOCIAL NORMS IN KENYA

	EXAMPLE NORM(S)	QUOTES
COMMUNICATING ABOUT INFERTILITY	It is not normal to speak openly about infertility. It is more accepted for women to talk openly about infertility. It is less expected for men to talk openly about infertility. If men openly discuss infertility, taking blame on themselves, they will be regarded and less manly.	*"There are some things that are considered secrets like you cannot start telling someone the way you are struggling with infertility… Women talk and make it easy to discern the problem and offer solutions whereas men do not talk … making it difficult for them to be assisted."* – ***KII, Healthcare Provider, Mukuru.*** *"Men will not be approached on such issue, rather it is the wife who will be approached for such discussions."* – ***IDI, Woman, Aged 34, Mukuru.*** *"Mostly, it is women. I mentioned earlier that men are usually quite secretive. If they can't father a child, they won't admit to being infertile",* ***– KII, Community Health Worker, Homa Bay.***
RESPONSIBILITY OF INFERTILITY	If a married couple cannot conceive, women are held responsible. Women are expected to take responsibility for infertility, even if they know the cause of infertility is not their own.	*"It is always different because the blame is always placed on a woman. The inability to conceive is usually attributed to a woman's underlying issues. In the eyes of the husband's family, the woman is usually seen as the root of the problem."* – ***IDI, Woman Aged 36, Homa Bay.*** *"It is easy for a man to hide the fact that they are unable to get a woman pregnant. It's only the woman who knows whether his partner/husband has a fertility problem. If I know that my husband cannot get me pregnant, I will have sex with someone else and convince my husband that the child is his."* – ***IDI, Woman Aged 42, Mukuru.*** *"Men have egos and think they are powerful; they won't do anything that they feel will diminish their power. Men will also not want to feel defeated and expose themselves to embarrassments… yes that is embarrassing to them."* – ***KII, Healthcare Provider, Homa Bay.***



SANCTIONS, SUCH AS GOSSIP AND JUDGEMENT, CONTRIBUTE TO STIGMA **IN KENYA**

The social norms were often described as overlapping, to contribute to community perceptions and dynamics impacting women and men who experience – or are perceived as experiencing – challenges with infertility. Community dynamics such as gossip, rejection, mockery, judgement, social isolation, and loss of respect within the community lead women, men, and couples together great stress, anxiety, and emotional turmoil. These community perceptions increase and become more acute as individuals get older.

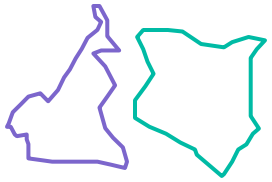
Key informants noted the stigma and shame from peers and family has forced many experiencing infertility to isolate themselves. Further, the stigma and shame due to infertility were even cited as reasons why women and men socially isolate and as a result hold less of a standing within communities and are discouraged from speaking in gatherings. Reference groups – such as mothers-in-law and fathers – were to anecdotes of a childless person being perceived as not 'knowing' things or have the right to weigh in on certain 'respectable' subjects – which was especially seen in the rural site of Homa Bay.

K "People are less interested in younger people. They only start to talk if you are older and not getting children. For example, they will be more concerned with a woman who is about 40 years."
IDI, Women Aged 42, Mukuru

K *"The elders will start telling you that you'll die childless"*
FGD, Fathers, Homa Bay

K "The society is not even supportive. They'll start saying that for those who don't have children, there is no need to have them in the meeting and I know very well you are the one who doesn't have children. They are abusive."
FGD, Fathers, Homa Bay

K "Then that man, in case they have a family meeting back home, they cannot speak because they do not have a child."
FGD, Women Aged 18-49, Mukuru



BLAMING WOMEN IS COMMONPLACE
KEY FINDING: CAMEROON + KENYA

Across countries, findings indicate that, women are the first to be blamed for infertility and in any rare cases where the male partner is known to be responsible for infertility, people would refuse to believe it. This was attributed to low levels of knowledge or understanding of the causes of infertility and due to the norms around how men should (or should not) communicate openly about infertility. Because women largely held the blame and men remain silent, stigma, other sanctions, and their rippling psychological effects impacted women more profoundly. As a result, women experienced a mix of internalized psychological, interpersonal and social consequences which would compound together and limit their ability to address any reproductive health challenges alone. Women are considered 'easy targets' for blame as women are physically responsible for childbearing. This underscores the reality that a women's "worth" is largely defined by her ability to bear children.

C "When I say it's different, women are blamed more than men. For men, it's not too bad, but for women, if a woman doesn't procreate, it's very frowned upon, it's very frowned upon by society, it's very frowned upon. So, it has a big influence on women."
KII, Woman Community Health Worker, Yaoundé

C "The first person to blame is the woman. The woman is the first person because uh, when a boy ..., the woman has an early sexuality compared to the man, we'll say she had to do the wrong things and now when she's in the home."
FGD, Men Aged 21-49, Yaoundé

K "Women often face more challenges than men, especially in cases where the man is infertile Men have this mentality that they cannot be barren. In such situations, blame tends to fall on the woman, particularly in cases of low socioeconomic status, where seeking medical attention is a challenge."
KII, Healthcare Provider, Homa Bay.

K "Another mentality is people have never known men can be infertile. That is what people really do not understand. It is always the women." *FGD, Women Ages 18-49, Homa Bay.*

SOCIAL NORMS IN CAMEROON

The social norms identified could be broadly categorized into: **early childbearing, proving one's fertility, son preference, communication about fertility, and the responsibility of fertility.** For some interviewed, they spoke to contexts (specifically Eastern Cameroon, or more rural settings) where girls are expected to be married young and have children young, and if they don't, they'll be seen as 'sterile'. Related social norms emerged in the context of early childbearing around the appropriate age of sexual initiation, where girls are perceived to engage in sexual activity earlier than boys, and within some context, expected to prove fertility if they are seen as being sexually active. Further, having children was widely considered a way to ensure your happiness as an individual and within your marriage. They are also important for continuing lineage and securing inheritance stays within immediate families as well as critical for caring of aging parents later in life. Son preference was a complementary social norm related to proving fertility, and linked to ensuring family heritage, considered as the ability to ensure one can multiply their family for generations (potentially with multiple partners). Some women expressed a preference for daughters to be able to 'help' within the house.

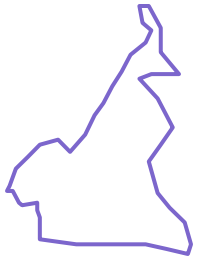
	EXAMPLE NORM(S)	QUOTES
PROVING FERTILITY	In this community, children are needed to maintain family harmony. In this community, children are essential to continue family lineage and pass inheritance to. In this community, a child (and only a child) can bring happiness to a couple. In this community, if a man doesn't produce an heir he won't be seen as a full man.	*"I like children for the joy they bring. We can also send them on errands."* – ***FGD, Women, Aged 21-49, Nganha*** *''A man who does not have children cannot have a positive consequence because every man needs to see his offspring, same with the woman."* – ***KII, Man Traditional Healer, Yaounde*** *If you refuse to give someone advice on how to have children. No one is going to give birth, and if no one can give birth, then who are we going to send to fetch us sugar from the store, for example. We have to give advice to those who ask for it. We're old and we're sick, so if there aren't any children, who are we going to send?* - ***FGD, Men Traditional Healers, Nganha*** *"We are living in a society where children for a man is a sign of virility and he is not considered as a woman."* ***– IDI, Man Aged 21-24, Yaoundé***

SOCIAL NORMS IN CAMEROON

	EXAMPLE NORM(S)	QUOTES
EARLY CHILDBEARING AND SEXUAL INITIATION	In some communities, girls are expected to have at least one child before the age of 20. In some communities, it is considered normal for girls to be sexually active at 16; whereas boys may not be sexually active until 18.	*"From a cultural point of view, I'd say that I already had a friend from the East, and she made me understand that in their culture, at 15, when a woman hasn't already had one or two children, it's not normal. They think maybe she's sterile. And even among the Bamileké, if a woman gets married and hasn't given birth for a year, she's already married, and the mother-in-law is already starting to wonder, "What am I saying? If things don't work out, you take a second wife. Well, those are the two cases I see. Both cases. As for the rest, well, particularly among us Bassas, on the women's side, certainly when the woman gives birth if she's not married, it doesn't look very good, it's not very well seen. But, when the child is born, the family takes it in, the parents forgive and embrace it. So, it's the three, even say more cultural."* – ***KII, Woman Community Health Worker, Yaounde.*** *"Men, often emancipate themselves a little later than women. Because a young girl at 16 years old, generally, she has already experienced sexual intercourse, her first sexual intercourse. (Yes). For the most part, in our community, a 16-year-old girl has already experienced her first sexual encounter. So, she is more likely to have her first child earlier than a young man who, sometimes, at 18 years old, has not even had his first sexual encounter yet, his first sexual encounter."* ***– IDI, Man Aged 30-35, Yaoundé.***
RESPONSIBILITY OF INFERTILITY	If a married couple cannot conceive, women are held responsible. Women are expected to take responsibility for infertility, even if they know the cause of infertility is not their own.	*In Africa, even if it's the man, we always blame the woman."* – ***FGD, Men Aged 21-49, Yaounde.*** *"Since then, we've been saying women, women! Even us men are just as guilty. But we only accuse women sometimes."* – ***FGD, Men Traditional Healers, Nganha.*** *"But generally it's the woman who has the problems, she's the one with the stomachache, bad periods, this and that. So it's the woman who's the problem."* – ***FGD, Men Traditional Healers, Nganha.*** *"...the woman is the weaker sex and she's the first one to be pointed at in case of infertility."* ***– FGD, Men Aged 21-49, Yaoundé.***

SOCIAL NORMS IN CAMEROON

	EXAMPLE NORM(S)	QUOTES
SON PREFERENCE	In this community, families prefer to have sons over daughters to continue their family lineage. Boys are expected to take care of family affairs and run the household in their parents' absence. Boys are perceived to be more resilient and physically strong and can care for their families.	*"Parents prefer to have more boys than girls so that they can be the pride of the family, such that it can be said of their family that they have many boys, and the boys will continue expanding the family."* ***– IDI, Male Aged 21-29, Nganha.*** *"You have to look for your heir, we're always looking for the heir. So, it has to be a boy, in any case."* ***– IDI, Male, Aged 30-49, Yaounde.*** *"Well, they believe the boy child would be the one to educate his siblings, as he can be more resilient, he can run the house in the absence of his parents, he can easily handle a recalcitrant sibling, he can give advice to his siblings, and he can handle sensitive issues among them without necessarily reporting to his parents."* ***– IDI, Man Aged 21-24, Yaoundé.*** *"Well, for a man; he'll preferably have a boy so he can be his heir tomorrow after tomorrow. This heir is an assurance for his future, in his weakness."* ***– IDI, Man, Aged 25-29, Yaoundé.***
COMMUNICATION ABOUT FERTILITY	In this community, it is not normal to openly and freely discuss infertility. In this community, men do not talk about fertility problems. In this community, if men openly discussed their infertility experiences, they would be cast out by their peers. Openly discussing infertility would bring you anxiety, shame, fear, isolation, and judgement from others in the community.	*"Moderator: Does society here in Yaoundé often talk about infertility in relation to the couple? Here in Yaoundé? Respondent: No….I think the word frustrates people. It's a bit of a taboo word. It's a difficult word to hear."* ***– FGD, Men Aged 21-49, Yaoundé.*** *"It's not easy to talk about sexuality in Africa, in Cameroon, but it's very difficult to talk about sexuality, how often infertility is serious because when sex is first taboo, how are you going to tell someone that I'm not giving birth? So you're going to lock yourself away."* ***– FGD, Men Aged 21-49, Yaoundé.*** *"The man himself is a problem, is a hindrance, because, the man himself being stigmatized, being frustrated, he finds it hard to confide in anyone in the first place: because, he even finds it hard to talk about it. I know some cousins who have this problem [experiencing infertility], but I'm the one who found out they had it. They never told me or anyone else that they had this problem."* ***– IDI, Man Aged 41-49, Yaoundé.***



PEERS AND FAMILY MEMBERS OSTRACIZE AND ISOLATE IN CAMEROON

Stigma around infertility or even being remotely perceived as struggling with infertility (e.g., if you have not proven your fertility in an appropriate timeframe), would cause pain, shame, gossip or rumors, rejection, judgement and social isolation or ostracization. As described elsewhere, a lot of public discourse and gossip blamed women, and women's behaviors (including contraceptive use, promiscuity, and abortions) as the causes of infertility.

Peers and neighbors were named as those who will gossip, judge, and ostracize you and your whole family (even extended family) for not having children.

As a result of the stigma, couples feel 'exposed', some of them become socially isolated from community activities and peer gatherings, others choose to abstain from such events to protect themselves from being stigmatized.

Family members played a central role in enforcing stigma and sanctions against infertile individuals, often insulting couples privately or publicly, causing shame and embarrassment. Childless individuals, especially women, faced rejection, with some being labeled as "men" due to their inability to bear children. Familial pressure, often tied to the desire for grandchildren, was consistent across both urban Yaoundé and rural Nganha.

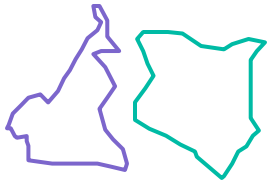
C Yes, people talk a lot. When you're married and you don't give birth, people talk [...] society mocks and even insults them. They say here's a couple who can't have children, and they make up things.
FGD, Men Aged 18-49, Nganha

C "Your brothers-in-law and sisters-in-law criticise you all the time, telling you that you're worthless apart from eating. All because you haven't given birth."
IDI, Woman Aged 25-29, Nganha

C Like we'll say, 'you're a sorcerer or you're a witch'; 'you spend your time eating other people's children'. In short, things like that, things that aren't exactly right. Unlike the ones who are fertile, uh, those ones only get good remarks.
IDI, Male Aged 21-29, Yaoundé

C What won't the neighbors say! These people have been married for 5 years and they don't have any children. What exactly do they even do as a couple? They'll say anything about this couple.
– FGD, Women Aged 21-49, Nganha

C "I can't share with the neighbours because they'll make fun of me."
FGD, Women Aged 21-49, Yaoundé



MASCULINITY AT RISK
KEY FINDING: CAMEROON + KENYA

Openly discussing infertility was taboo and not widely and explicitly spoken about, especially among men. However, men were also seen to suffer social stigmatization and its consequences, but this was much less frequently mentioned. They primarily referred to a lack of respect as loss of prestige within the community and standing within the family unit which mitigated opportunities for land inheritance and financial and leadership opportunities. When it emerged, shame and embarrassment was often mentioned as the trickle-down impact of the social stigma they would feel. However, in most cases, men expressed an ability to overcome those feelings by proving masculinity or being masculine in other ways – or by scapegoating women.

C "Yes, it's the same. For example, for a man who cannot get a woman pregnant if he scolds or hits a child, we can tell him that he is not a man if he cannot give birth to a child, and therefore, he has no right to correct a child. It's the same a man is considered worthless as long as he cannot get a woman pregnant." *IDI, Woman Aged 41-49, Nganha*

C "It is hard for men to be blamed. There's no single day men will be accused of infertility; it is always women. Blaming men is the last option. If I had a son and they were not getting a child, I would never agree it is my son who has a problem. I must side with my son. How would I even ask him if he is the one with a problem or low libido? It will always be the wife to be questioned and to carry the blame." *IDI, Woman Aged 34, Mukuru*

K "…for you to be considered as a man you need to be able to sire, if you are unable to sire kids no matter how rich you are no one can respect you." *FGD, Fathers, Mukuru*

SUPPORT SEEKING PRACTICES
FOR INFERTILITY

CAMEROON KENYA

TREATMENT AND SUPPORT SEEKING: A UNIQUE COMBINATION OF SERVICES, TRADITIONAL SUPPORT SYSTEMS, AND RELIGION

Across both countries, individuals and couples often sought multiple courses of action simultaneously, combining biomedical, traditional, and religious approaches without prioritizing one as ideal. In both countries, societal expectations and negative attitudes about infertility were widespread and led to judgment or discrimination against individuals in seeking treatment or support.

In both Cameroon and Kenya, **biomedical treatment** was seen as the primary and most 'trusted' option for dealing with infertility. Women and men with experiences of infertility described turning to biomedical intervention for fertility testing, drugs or medications to stabilize hormones, or surgery to remove fibroids/cysts. This was followed by going to a **traditional healer or practitioner**.

Findings also indicated that individuals and couples would seek multiple courses of action concurrently, such as seeking out biomedical help, but also turning to get counsel from others. Indeed, some participants shared that biomedical medicine and traditional medicine together should be complimentary approaches to solving or overcoming infertility.

In Cameroon (and to a less extent in Kenya), religious leaders and prayer was a prominent theme in 'dealing' with infertility. Religious prayer was perceived as mostly a given, something you'd do regardless of biomedical/traditional medicine intervention. Religion was prominent and prayer was cited as a treatment and action one can take to solve infertility.

BIOMEDICAL SERVICES

KENYA

In Kenya, all participants consistently expressed that biomedical clinical diagnosis and treatment were often the first course of action for addressing infertility to identify the root cause of infertility through testing, surgical removal of cysts or fibroids, or prescribed treatments such as medications or vitamins (e.g., folic acid) to address hormonal imbalances and improve fertility. Reference groups and key informants reinforced these sentiments, highlighting the critical role of biomedical services as an initial step or a pathway to referrals for more advanced testing and treatment at larger hospitals. These services were most frequently cited as the preferred first option, particularly in the urban site of Mukuru.

CAMEROON

In Cameroon, across sites participants consistently expressed that biomedical interventions were seen as the most trusted and preferred first option for addressing infertility. This trust stemmed from perceptions of advanced tools, reliable follow-up care, and the availability of prescriptions, medications, diagnostic tests, and surgical procedures. Many participants believed these interventions improved the likelihood of achieving fertility, and this sentiment was broadly shared across groups.

However, some notable differences emerged. Men, particularly in rural Nganha, were more adamant than women about biomedical care being the only viable option, often dismissing traditional or alternative support systems as more suitable for women. Mothers played a significant role in guiding individuals and couples, frequently advising them to begin their fertility journey at hospitals to better understand their situation and options.

SUPPORT SEEKING
BIOMEDICAL SERVICES

K "I think after finding out you are infertile; the solution can be to seek medication and use it for a while to see whether it can improve your hormones."
FGD, Women Ages 18-49, Homa Bay

K "I trust the doctor because they have the expertise and information on childbearing and reproductive health, especially the gynaecologist"
IDI, Male Aged 45, Mukuru

K "They get support when they go to the hospital or from Community Health Workers. I always urge them to get tested first before declaring that they are infertile…"
IDI, Woman, Aged 42, Mukuru

K "Mostly they go to hospitals. When you go to the hospital you will be checked and if you have a problem, you will be told. If you don't have a problem, you will also be told and advised on what to do next. It is only a doctor who will tell you if you can bear children or not"
IDI, Woman Aged 33, Mukuru.

C "… sterility can affect both men and women. The only solution is to go to the hospital for screening. There are many causes of infertility, but it's only the hospital that can say."
KII, Men aged 18-49, Nganha

C "I told you at the outset that I trust modern science a lot more. In other words, I trust the school, and it's out of the question for me to have a problem like that, or for someone close to me to go and see a traditional practitioner. I'm certainly going to send her to meet a gynaecologist in a gynaecology department that I consider reliable. Generally, issues related to infertility and reproductive health, mostly we trust the gynaecologist, we trust the medical staff and more specifically the gynaecologist."
IDI, Man Aged 49, Yaoundé.

SUPPORT SEEKING
COST AND AFFORDABILITY

Despite participants prioritizing biomedical care as the first option for addressing infertility, significant barriers to accessibility and affordability emerged as recurring themes in both countries, K C but these sentiments were more frequently shared in Cameroon. C All participants highlighted the limited availability of infertility services, the high costs associated with diagnosis and treatment, inadequate infrastructure at hospitals and health centers, and the scarcity of qualified medical practitioners. These challenges were not confined to rural areas but were reported across all sites.

Cost was a particularly pressing barrier – expenses associated with infertility tests, diagnoses, and treatments were prohibitively high, often preventing individuals and couples from pursuing care. Participants pointed out the absence of dedicated spaces or units for managing infertility within hospitals, unlike other reproductive health or contraceptive services. They expressed frustration over the lack of quality care and suggested that programs should expand access by providing more free or subsidized testing and diagnostic services, at a minimum, to address these gaps.

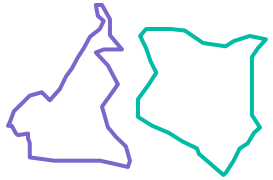
K "So, to seek medication for infertility is very expensive. Even that IVF plan is for rich people, 100 thousand and above […] it is very expensive and very few can access it."
FGD, Women Ages 18-49, Mukuru.

K "In Homabay County referral hospital, there is only one gynaecologist […] It would be good to get 3 or 4 gynaecologists. If we get 5 to 10 nurses who specifically deal with that, it will be helpful."
KII, Healthcare Provider, Homa Bay.

C "Sometimes we need to go to the hospital, but when we think of the cost of transport and medication we get discouraged."
IDI, Woman Aged 36-40, Nganha

C "Yes, it's too expensive. Not everyone can afford it. And yet there are some people who really need children and are willing to go down that route, but because of the very high cost, they prefer to stay at home."
IDI, Woman Aged 36-40, Yaounde

C "I think that first of all, we have to put this in all the structures, because there are hospitals. I'm talking about district hospitals perhaps, where you can't even find a gynaecologist. Small facilities, health centres, small clinics here too, really need to have well-trained staff. There's that too."
IDI, Woman Aged 36-40, Yaoundé

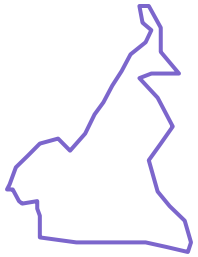


DESIRE FOR PUBLIC SECTOR SUPPORT
KEY FINDING: CAMEROON + KENYA

Government support was seen as crucial in improving access to infertility care. Many participants emphasized the importance of subsidies or financial assistance to make treatments more affordable. For example, one key informant, a woman nurse from Yaoundé, expressed that even partial government subsidies could significantly ease the financial burden, helping individuals access treatments they otherwise couldn't afford. This aligns with the perspectives of women in Homa Bay, who suggested that infertility care should be prioritized in a similar way to other public health concerns, such as cancer, with free services and programs introduced to reduce the barriers to testing and treatment. These reflections highlight a shared belief that government intervention, whether through subsidies or free services, could dramatically improve access to infertility care and reduce the financial strain on individuals and couples. Such support could be a vital step in making fertility services more accessible, equitable, and part of the broader public health agenda.

C "I would like us, as for example (look at the hospital) there are rooms only for FP; therefore, we should no longer talk about family planning, of course family planning includes all that. But not the infertility side, we didn't put too much emphasis on that side like the planning. You see, regarding planning, there are many spacing methods, but [to have the child now], yes, you see [it's not possible] . Until now the women who come with the [infertility] problems: we say that "it is the infections which prevent you from having children, the infections which prevent you". You treat, you treat. Always! You see a person is there, old enough to give birth, but she cannot give birth."
KII, Woman Nurse, Aged 30-25, Nganha.

K "... we don't have support from the government or an NGO supporting for sure. I have never come across such. We have partners supporting HIV, and adolescents, and we have partners supporting different cases but infertility I am sorry, I have not seen."
KII, Healthcare Provider, Homa Bay



TRADITIONAL TREATMENT IN CAMEROON

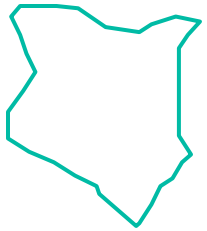
In Cameroon, participants frequently mentioned traditional medicine, particularly treatments offered by herbalists, as a common option for addressing infertility. Traditional medicine was often viewed as a complementary approach to biomedical care, helping individuals become "uncursed" or resolving perceived spiritual or cultural barriers to fertility. Women and men noted that these services were often easily accessible within their communities and provided quick answers and remedies, such as herbal treatments.

Traditional healers interviewed as key informants were passionate and detailed in describing their methods, which included unconventional practices like using a hen for an "ultrasound" by placing it against a woman and examining the hen's insides, as well as prescribing drinks, medicinal plants, herbs, and charms (e.g., "gris gris"). While there was broad trust in the effectiveness of these treatments—such as teas, ointments, and herbs—some participants expressed skepticism, noting that traditional healers might prescribe remedies without thoroughly diagnosing the root cause of infertility.

C "I end up going to see a traditional healer hoping that he'll find a safe way to give birth, so I just have to go. If I go and succeed in giving birth in the end, I'll be [full of] joy."
IDI, Woman Aged 30-35, Nganha

C "Now, if infertility is caused by a blockage, there's a gris-gris that's given to the person concerned. He then goes to the river and throws away the gris-gris. If the gris-gris passes between the two legs he's opened in the river, it means he's cured and can have a child. This is especially true for women.
FGD, Traditional Healers, Nganha

C "As I like flowers, there are certain flowers there, I go and pick the flowers. I come back and take them home. There's a white calabash and I put the flowers inside. This goes on for maybe 3 days, as women often go through their period [...] That means we've turned the tide. It's already in the past and washes everything out of her. And it goes. And then we're off to start having kids again." – *FGD, Traditional Healers, Nganha*



TRADITIONAL TREATMENT IN KENYA

Likewise, in Kenya, In addition to seeking medical services, individuals and couples experiencing infertility often turned to natural remedies, typically provided by local herbalists and traditional healers.

Two notable findings emerged regarding traditional remedies: First, these practices were often linked to perceptions that infertility resulted from witchcraft, voodoo, or hexes, particularly targeting women. Second, traditional healers and their remedies were more commonly recommended by older participants compared to younger ones. For younger individuals, traditional remedies were seen as a secondary option, whereas older generations often viewed them as the primary approach.

Herbalists who participated as key informants strongly advocated for the use of traditional remedies, and other key informants acknowledged their influential role in addressing infertility, often before individuals sought formal clinical care. These healers ranged from established practitioners to respected older women in the community, valued for their knowledge of herbal treatments.

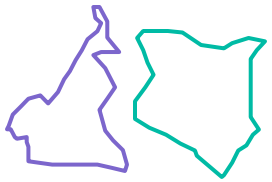
K "There are those who go to these old women in the community to get the traditional medicine. We also have these herbs people who treat. For most people, they just go to the old women not necessarily their relatives. You will even hear someone talking of someone in Kisii who has traditional medicine and treated an aunt."
KII Healthcare Provider, Homa Bay

K "... Some people have also sought the services of witch doctors to try and get a solution to their infertility challenges"
IDI, Man, Aged 27, Mukuru

K "The elderly mostly advise people on the witchdoctors, and not the doctors as they said. They tell you to try this one or go to this person to get this medication."
FGD, Men Ages 18-49, Homa Bay

K "Respondent: With cases like this I have only seen people being referred to the herbalist, not to the hospital. Those services are not available in these facilities.

Respondent: Adding on what he has said, there is a notion that infertility cannot be treated at the hospital [if] they believe it's witchcraft."
FGD, Fathers, Homa Bay



A COMPLEX AND COMPLIMENTARY INTERPLAY OF OPTIONS
KEY FINDING CAMEROON + KENYA

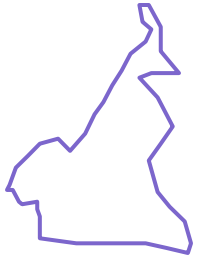
The approach to infertility treatment is often a blend of biomedical and traditional methods, with many participants emphasizing the importance of seeking both forms of care. Biomedical services are typically prioritized as the first step due to their diagnostic capabilities, with hospitals seen as more reliable for identifying and addressing infertility issues. Traditional medicine, however, is viewed as a complementary option, to be considered if biomedical treatments fail. Traditional healers often recommend that patients first seek medical consultations but also offer alternative remedies when conventional treatments fall short. **This reflects a shared belief in the value of both systems**.

In rural areas, where healthcare access can be limited, traditional healers remain a critical resource, but even they recognize the importance of medical diagnosis before proceeding with treatment. Some expressed a desire for collaboration with hospitals to better support infertility care. Ultimately, the interplay between biomedical and traditional treatments reflects a flexible approach to infertility care, where individuals navigate various options based on personal beliefs and available resources. While biomedical care remains the starting point, traditional medicine continues to play an important role, especially in areas with limited access to healthcare.

C "You see, among the traditional healers, there are many who have knowledge that helps the community. If we could get the healers to work with the hospital, it would work. That's what I'm proposing."
FGD, Traditional Healers, Nganha

C "As a traditional healer, I think that when a woman doesn't give birth, she should first go to the hospital and if necessary come back to us. Now, we want to collaborate with the hospital."
FGD, Man Traditional Healer, Nganha

K "Respondent: There are pastors who believe in prayers though prayers alone cannot solve the issue. You should visit the hospital and seek medical advice then start praying about it."
FGD, Fathers, Mukuru



FAITH, GOD'S WILL, AND PRAYER
KEY FINDING FROM CAMEROON

Many expressed that religious counsel provided emotional support and hope during a challenging time. For some, religious institutions such as churches or mosques were primary places to seek guidance, with pastors or marabouts offering spiritual solutions or advice. Some participants mentioned how they had heard stories of women who, after being diagnosed as infertile by doctors, **turned to church pastors or religious figures for help and subsequently conceived**. Despite the trust some placed in religious leaders, there were also concerns about the potential for exploitation. Participants expressed that certain religious figures, especially in churches, could take advantage of vulnerable individuals, particularly women, by offering false promises or unethical advice. Some participants described how individuals, especially women seeking fertility solutions, could fall prey to unscrupulous preachers who used their struggles to further their own agendas, sometimes making damaging claims, such as blaming husbands for infertility.



I've also heard stories myself. There are women who have been diagnosed as sterile or infertile in hospitals. But they went to churches like the revivalist churches, the pastor did his "abracadabra" there and then she conceived. Others know that the pastor (religious clergy) won't ask for anything apart from the tithe. Others know that if they go to hospital, it also depends on their status."

–KII, Woman Community Health Worker, Yaoundé

Okay, I'll give her the treatment. But I'm going to ask her to be patient while she takes the treatment. I'll also tell her to pray to God and she'll be fine. She'll have a child.

–FGD, Traditional Healers, Nganha

Program Opportunities

RETURN
TO ROADMAP

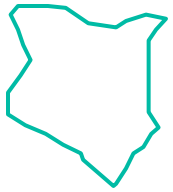
WHAT ARE THE **PROGRAM GAPS AND NEEDS ON INFERTILITY**?

To support an enabling environment where accurate fertility information is communicated, social norms related to (in)fertility can be shifted, infertility-related stigma can be reduced, and infertility services are more widely known, **we asked participants what kinds of investments and programs would be desirable to them and their communities.**

In both Kenya and Cameroon, participants emphasized the need for **comprehensive education and support systems** to address infertility-related stigma and misinformation. Key recommendations included **integrating psychosocial services within health settings** to provide emotional and mental support for individuals facing infertility challenges. Additionally, both groups highlighted the importance of co**mmunity-based activities, such as forums, school curricula, and local gatherings,** to share accurate information and combat myths.

While Kenya focused on communication education and sensitization activities to raise awareness and reduce stigma, Cameroon participants pointed to the value of addressing both the gendered impacts of stigma and the need for gender-sensitive health education.

Both countries also recognized the potential of **mass media as an underutilized tool.** While community members in Cameroon did not widely mention it, some saw mass media as an effective way to reach broader audiences and break taboos, offering a way to address misperceptions and raise awareness on a national scale. This overlap in recommendations suggests a shared understanding of the importance of diverse, multi-platform approaches to tackling stigma and supporting those affected by infertility.



PRORGAM OPPORTUNITIES IN KENYA: PSYCHOSOCIAL INTERVENTIONS

A combination of **formal counseling, community-based support, and religious guidance** was seen as an essential network to help individuals cope with the challenges of infertility, though such services were largely unavailable. Participants, particularly in the urban site of Mukuru, emphasized the value of counseling and emotional support for both men and women, with many believing that these services would be highly beneficial within the health system.

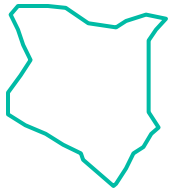
Counseling was suggested to be integrated into the healthcare process, particularly after an infertility diagnosis, to help individuals manage the emotional and mental challenges. Support for men was also highlighted, with suggestions for therapy and discussions on alternatives like adoption. Community-based support groups were viewed as invaluable, particularly for women, who could benefit from shared experiences and informal counseling on coping strategies and remedies.

Religious institutions, especially churches, were identified as key sources of support. Participants highlighted the potential of church programs, such as counseling and group therapy, to help individuals cope with infertility. The call for trained counselors in churches was echoed, with the belief that these professionals could provide empathetic, informed guidance to couples facing infertility challenges. As one participant noted, **"The church plays a huge role in influencing one's decision to seek support… We need trained counselors in the church to handle infertility issues"** (KII, Herbalist, Mukuru).

Additional support structures, such as community-based forums, were also suggested. "Barazas" (community meetings) were proposed, where people could gather to discuss infertility and share experiences. Women's groups were recommended to facilitate open conversations in a safe environment:

"Women fear to speak in the presence of their husbands, so forums like women's groups would allow them to share and discuss their challenges" (KII, Healthcare Providers, Homa Bay).

Finally, testimonies from individuals who had previously faced infertility were seen as a powerful tool in providing hope and support. **"Women who have overcome fertility issues and now have children can advise others facing similar challenges and show them that there is hope"** (KII, Herbalist, Mukuru). Such shared experiences were seen as vital in breaking the stigma surrounding infertility and providing emotional relief to those affected.



PROGRAM OPPORTUNITIES IN KENYA: COMMUNITY EDUCATION AND SENSITIZATION

The consensus among participants was that **integrating infertility education into schools, healthcare services, and community networks** could help individuals understand the issue and seek appropriate support. Community education and sensitization were viewed as crucial for raising awareness and reducing stigma. Both formal education and informal information-sharing were considered essential, especially for those hesitant to seek help. Schools, churches, and community gatherings were identified as key platforms for these efforts.

Healthcare providers, including community health workers, doctors, and nurses, were seen as pivotal in these educational efforts to engage the wider community. There was also a call for the Ministry of Health and local health departments to lead outreach programs, particularly for those without access to mass media.

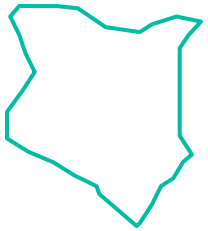
Participants suggested **leveraging community leaders, elders, and herbalists to spread awareness** through village meetings and loudspeakers. Gender-specific education was emphasized, with a focus on adolescents to prevent stigma and raising awareness among men, who were seen as key contributors to the perpetuation of misinformation and social norms around infertility.

Specific suggestions included integrating infertility education into school curricula, teaching the topic in churches, and using community gatherings, such as barazas (village meetings), to facilitate open conversations about infertility. As one participant noted, **"It should be introduced in schools so when people grow up, they grow up knowing... so that when they get to our age, there is no stigma"** (FGD, Women Ages 18-49, Mukuru).

There were also recommendations to enhance the knowledge of healthcare providers through capacity building, courses, and refresher training, to improve reproductive and sexual healthcare services. **"The Ministry of Health should create awareness... teach people about fertility... so when somebody has a problem, they can seek help"** (FGD, Women Ages 18-49, Homa Bay). Additionally, community health workers, using a door-to-door approach, were seen as key in spreading information about infertility and where to access support. **"The programs should create awareness... using the community health workers who often use the door-to-door approach"** (KII, Healthcare Provider, Mukuru).

Finally, a focus **on educating men when they're young** (e.g., in school) was emphasized, as they were often the least likely to seek help. **"Most of the men do not seek help, especially when they are the ones with the problem. I would urge you to create more awareness among men to increase their uptake of infertility services"** (KII, Healthcare Provider, Mukuru).

KEY FINDING FROM KENYA
PROGRAM STRATEGY: USING MEDIA



Participants were unaware of any existing mass media programs in Kenya addressing infertility, yet there was strong support for using media as a powerful tool to raise awareness. Across both sites, men and women emphasized the potential of media campaigns, drawing parallels to the successful HIV/AIDS awareness efforts. Television and radio were noted as key platforms, but social media emerged as the most frequently cited tool, seen as both a standalone approach and a complementary strategy alongside traditional mass media and community outreach. Suggestions included using designated health days to distribute infertility-related information and launching comprehensive awareness campaigns to spark important conversations among couples, families, and entire communities.

"It is like when AIDS came, it was acted and all over social media and billboards explaining everything. I think this is something that people should know."
–FGD, Women Aged 18-49, Homa Bay

"So, for me all I can say is that you can sensitize people even by using media like TV, Facebook, internet, to tell people how to get information because so many people are suffering but now because of the current problems they fear."
–FGD, Men Aged 18-49, Mukuru

"The majority of the people can access online platforms hence they can share contractive information on what's up groups, social media, Facebook and Instagram."
–IDI, Man Aged 25-30, Mukuru

"We would like to see an awareness campaign. That this this is real they can use these social platforms to talk boldly with family because bit could be an issue within the family and no one is talking."
–FGD, Fathers, Homa Bay



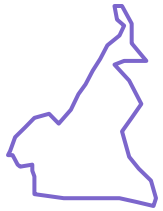
PRORGAM OPPORTUNITIES IN CAMEROON: **PSYCHOSOCIAL INTERVENTIONS**

Psychosocial support activities were not commonly suggested, as they are typically seen as relevant only for individuals or couples already experiencing infertility or in the early stages of diagnosis. However, participants emphasized the importance of integrated health services that include psychologists or psychiatrists within the treatment pathways, particularly in hospital settings. Person-centered or couple-centered counseling was recommended, with support tailored to the specific health and psychological challenges each individual or couple faces.

Community health workers were highlighted as critical, with many suggesting that they receive broader training on referral systems and how to engage with those experiencing infertility. Participants also proposed the creation of support groups—such as women-only, men-only, or mixed couples groups—to provide safe spaces for individuals to share experiences and reduce stigma. These groups were particularly seen as vital for those who may feel isolated due to infertility.

In urban Yaoundé, psychosocial support was mentioned more frequently, with some participants calling for better training of healthcare professionals to ensure they are equipped to support individuals and couples dealing with infertility. One participant suggested, **"If there was psychological support [programs]... where the couple know that when they go there, we'll be listened to... it will save a lot of lives"** (IDI, Woman, 36-40, Yaoundé). Others emphasized the need for specialized services and awareness-raising campaigns, particularly within the community: **"We need to organize seminars... and train people on how to talk to couples... in the community"** (FGD, Men, 21-49, Yaoundé).

Additionally, participants recommended that the government establish a specialized service for fertility-related issues and that awareness efforts be integrated into school programs, targeting adolescents early on to reduce stigma and provide accurate information. One participant noted, **"Young people should really prepare themselves, become familiar with these practices, it should no longer be a taboo"** (IDI, Man, 21-24, Yaoundé).



PRORGAM OPPORTUNITIES IN CAMEROON: **COMMUNITY EDUCATION AND SENSITIZATION**

Education campaigns, both formal and informal, were the most frequently suggested intervention to address infertility. These campaigns could take various forms, such as conferences bringing together people with and without infertility experiences, integrating infertility education into school curricula, or organizing community talks through local health workers and traditional healers. In rural Nganha, the importance of informal spaces and local language messaging was emphasized, with traditional healers already playing a significant role in supporting couples and reducing stigma. Participants suggested that the government could formalize these efforts through national health campaigns.

Targeted education should focus on adolescents, parents, and local influencers, providing accurate information about infertility's causes—both biological (e.g., low sperm count) and lifestyle-related (e.g., untreated STIs)—while dispelling prevalent myths.

The content should also cover available treatment options and alternatives, such as adoption. Emphasis was placed on crafting stigma-reducing messages and using a variety of communication channels to reach as wide an audience as possible.

Some participants also highlighted the need to address the broader social impacts of infertility, particularly its connection to early and forced marriages in rural areas like Nganha. Efforts should specifically target parents. One participant noted, **"The government can educate parents to understand that marrying a girl before the age of 18 causes harm to her health... they should let girls be at least 20 years old before marriage"** (IDI, Man, 21-24, Nganha). Another remarked, **"We must focus more on raising awareness... I tell people that adoption is a valid option, and we should make the process easier for those who choose it"** (KII, Woman Nurse, 49, Yaoundé).

Additionally, participants stressed the importance of reaching rural communities, where awareness is limited. **"In rural areas, where there are no social media or easy access to information, we need to carry out awareness campaigns to educate people"** (IDI, Man, 21-24, Yaoundé). Traditional healers were seen as key in educating and supporting their communities: **"We need to sensitize and counsel people, especially about preventive methods and how to behave"** (KII, Traditional Healer, Yaoundé).

7 Key Takeaways

RETURN
TO ROADMAP

1 **Fertility knowledge, myths, and misperceptions all influence** health behaviors and social expectations, and contribute to stigma.

KNOWLEDGE GAPS

Limited understanding of infertility's causes—both biological (e.g., low sperm count) and behavioral (e.g., untreated STIs)—leads to delayed help-seeking and reliance on ineffective remedies.

PERPETUATION OF MYTHS

Misconceptions, such as infertility being caused by certain methods of contraception or curses, fuel stigma and harmful social norms.

DRIVERS OF BEHAVIOR

Myths and misinformation heighten blame and discrimination, discouraging open discussions and creating barriers to accessing healthcare.

GENDERED DIFFERENCES

Women and men have different perceptions of the causes of infertility, differing sources of information or trusted individuals to exchange information with.

INFLUENCE OF TRUSTED FIGURES

Community leaders, elders, and herbalists play dual roles—either spreading myths or serving as potential advocates for accurate information on fertility.

2 The impact of infertility on individuals and couples is multidimensional.

EMOTIONAL AND PSYCHOLOGICAL CONSEQUENCES

Infertility leads to deep emotional distress, including feelings of shame, inadequacy, and hopelessness, often exacerbated by societal pressures and personal expectations.

RELATIONSHIP STRAIN

Infertility creates tensions within marriages and families, with some relationships breaking down under the strain of unmet expectations.

GENDERED IMPACTS

While women are often blamed and bear the brunt of stigma, men also experience emotional stress, though they may suppress their struggles.

FINANCIAL STRESS

Individuals face significant financial burdens when seeking treatment, often compounding their emotional and social challenges.

3 **Infertility isn’t solely an individual or couple-level challenge.** It disrupts the larger family unit.

RELATIONSHIP STRAIN
Infertility often causes tension, blame, and even dissolution of marriages, with women disproportionately facing accusations and mistreatment by in-laws.

EXTENDED FAMILY PRESSURE
Families, particularly in-laws, frequently exert pressure on couples to have children, leading to additional stress and strained relationships.

ECONOMIC IMPACT
Costs associated with seeking treatment or alternative paths (like adoption) can financially burden the entire family.

SOCIAL ROLE DISRUPTION
In settings where childbearing defines familial and social roles, infertility can erode a person's perceived value within the family, impacting collective dynamics.

CULTURAL EXPECTATIONS
Failure to produce children affects lineage continuation and disrupts the family’s ability to fulfill cultural and generational obligations.

4 **Social norms and social sanctions are the driving force** for stigma surrounding infertility.

GENDERED EXPECTATIONS

Cultural norms often tie a woman's worth to her ability to bear children, leading to disproportionate stigma and blame, even when infertility is male-factor.

SANCTIONS FROM FAMILY AND COMMUNITY

Infertility can lead to exclusion, ridicule, or even ostracism from family and community networks, with women particularly vulnerable to mistreatment by in-laws or co-wives.

REINFORCEMENT OF MYTHS

Misperceptions and cultural beliefs about infertility (e.g., attributing it to curses or personal failings) perpetuate stigma and discourage open dialogue.

MEN'S RELUCTANCE TO SEEK HELP

Norms around masculinity and male dominance discourage men from acknowledging infertility or seeking care, shifting blame largely to women.

PRESSURE TO CONFORM

Couples face intense pressure to adhere to traditional milestones like childbearing; failure to do so challenges their social standing and acceptance.

NORMALIZATION OF STIGMA

Social norms that frame infertility as shameful or taboo fuel discriminatory practices, reinforcing stigma and preventing collective action.

5 **Women experience consequences** of infertility more profoundly.

HEIGHTENED STIGMA
Women are often the first to be blamed for infertility, regardless of its cause, reflecting entrenched gender norms that equate femininity with motherhood.

SOCIAL ISOLATION
Women perceived as infertile frequently face exclusion from family and community gatherings, particularly those centered on parenting and childbearing.

DOMESTIC INSTABILITY
Infertility can result in severe consequences within marital relationships, including neglect, verbal abuse, or the threat of abandonment or polygamy.

ECONOMIC DEPENDENCE
In contexts where childbearing secures women's roles within families, infertility may lead to diminished access to financial support or inheritance.

EMOTIONAL AND PSYCHOLOGICAL TOLL
Women face significant emotional burdens, including feelings of shame, guilt, and low self-worth, exacerbated by persistent societal blame.

MORAL JUDGMENTS AND BLAME
Women and girls' infertility is often attributed to their perceived moral failings, such as promiscuity or engaging in "poor behavior," intensifying the stigma they face.

PRESSURE TO SEEK REMEDIES
Women bear the majority of the burden to pursue medical treatments, alternative remedies, or religious interventions to address infertility, often at great financial and emotional cost.

6 **Psychological impacts, interpersonal constraints, and social norms significantly limit reproductive agency,** influencing a range of behaviors as well as access to fertility care.

CONSCIOUSNESS OF CHOICE

Infertility stigma limits individuals' recognition of their reproductive choices. In both Kenya and Cameroon, many participants initially did not view fertility treatment or alternatives like adoption as viable options, due to myths, inaccurate information, and norms. Internalized stigma, especially among women, impairs perceived control over one's reproductive health. Additionally, the emotional and psychological toll of infertility diminishes self-worth, creating barriers to recognizing viable reproductive options. Shame, fear of judgment, and anxiety about social repercussions suppress the awareness that individuals have choices.

GOAL SETTING AND DECISION-MAKING

The ability to make decisions about reproductive health is shaped by both barriers and facilitators. Many individuals face obstacles like lack of accurate information, financial constraints, and limited healthcare access. For women, social norms often influence their choices, with societal pressure to prioritize family and motherhood over personal health needs. Decisions about fertility and family planning are often made in consultation with male partners or family members, reducing women's autonomy. Support from healthcare providers and community groups can help, but these resources are limited.

TAKING ACTION

Even when individuals decide to pursue fertility treatment or family planning, practical and social barriers often prevent them from acting on their decisions. Financial constraints, geographical barriers to healthcare, and cultural expectations can all limit the ability to follow through on reproductive choices. For many women, societal expectations around marriage and childbearing create significant pressure to conform, often leading them to delay or abandon their decisions to seek medical treatment. Fear of judgment or stigma associated with infertility also makes it harder to take action, as individuals worry about the consequences of stepping outside societal norms.

NAVIGATING PUSHBACK

Social norms and familial pressure play a major role in influencing reproductive decisions. In both Kenya and Cameroon, individuals often face resistance from extended families or community leaders when they pursue non-traditional reproductive choices, such as delayed marriage, fertility treatments, or adoption. This resistance, frequently rooted in entrenched gender norms, can discourage individuals from following through on their reproductive choices. Women, in particular, face more intense resistance, as their reproductive decisions are often scrutinized more closely due to traditional expectations about marriage and childbearing.

IMPACT OF INFERTILTIY STIGMA ON **REPRODUCTIVE AGENCY**

Multiple, crosscutting factors constrain an individual or couples' ability to assert their reproductive agency and strive toachieve a desired reproductive health goal. For example, one's knowledge of (in)fertility or belief in myths and misperceptions regarding infertility causes can undermine an individual's confidence to seek care. Rigid social norms often place blame for infertility solely on women, limiting their ability to make and act upon goals. Interpersonal constraints, such as fear of family judgment, further restrict decision-making. A lack of accessible fertility services and insufficient information compounds these challenges. However, supportive factors—such as social and family support, open communication with partners or peers, and psychosocial support can help individuals and couples navigate and overcome these barriers, enabling them to exercise their reproductive agency.

CONSCIOUSNESS OF CHOICE → GOAL SETTING AND DECISION-MAKING → TAKING ACTION → NAVIGATING PUSHBACK → **SELF-DETERMINED REPRODUCTIVE GOALS**

CONSTRAINING FACTORS

- Inaccurate knowledge on fertility
- Myths and misperceptions around fertility
- Lack of availability, affordability, and access to mental and physical health services
- Psychological toll
- Social norms related to fertility
- Gender norms related to fertility
- Stigma and social sanctions
- Financial barriers
- Partner, peer, family pressure

Example RH behaviors:

- Seeking infertility diagnosis and treatment
- Choosing pregnancy timing and spacing
- Contraceptive use and method choice
- Seeking STI diagnosis and treatment
- Communicating fertility challenges to partners, family members or peers

7 **Programs should leverage trusted platforms, and tailor approaches** to meet the diverse needs of individuals, families, and communities.

HOLISTIC SUPPORT SYSTEMS
Programs should look to integrate psychosocial approaches, such as counseling and support groups, to address the emotional and mental health needs of individuals facing infertility.

COMMUNITY-LED SOLUTIONS
Involve community leaders, elders, and herbalists in outreach efforts to provide culturally relevant education, reduce myths, and foster acceptance of modern infertility interventions.

GENDER TRANSFORMATIVE APPROACHES
Design interventions that address the unique challenges faced by women, including societal blame and stigma, while also engaging men to counteract harmful norms and misinformation and meet their unique needs around infertility.

EDUCATIONAL CAMPAIGNS
Develop awareness programs that challenge myths, normalize conversations about infertility, and promote accurate information through schools, churches, and local community forums.

MASS MEDIA STRATEGIES
Leverage mass media to amplify outreach efforts, using relatable storytelling to reach broader audiences and break taboos surrounding infertility.

ACCESSIBLE SERVICES
Ensure that health services are affordable, and include comprehensive infertility care, including diagnosis, treatment options, and emotional support.

LONG-TERM NORM SHIFTING
Programs should directly address the social norms driving stigma or embed infertility education into other ongoing social norms change programs, emphasizing shared responsibility and community support to mitigate stigma over time.

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