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REVIEW

"Living with Silence and Shame": A Meta-Synthesis of Women's Lived Experiences of Infertility-Related Stigma

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Background: Infertility is a global reproductive health concern that imposes intense psychological and social burdens, particularly in cultural contexts where childbearing is integral to the construction of womanhood.

Objective: This qualitative meta-synthesis aimed to gain an in-depth understanding how women experiencing infertility across diverse settings experience stigma, and how they navigate its psychological and relational consequences.

Methods: A systematic search was conducted using six electronic databases (PubMed, CINAHL Plus with Full Text, JSTOR, ProQuest Central, Web of Science, and Ovid MEDLINE), supplemented by manual searches. Data quality was evaluated using the Critical Appraisal Skills Program (CASP) checklist. Fourteen peer-reviewed qualitative studies published between 2014 and 2025 were systematically synthesized through a qualitative meta-synthesis to derive integrated themes.

Results: Three overarching themes were identified: (1) Sources of stigmatization in the context of infertility, (2) Psycho-social consequences of infertility-related stigma, and (3) Coping strategies among women experiencing infertility-related stigma. Women experiencing infertility reported deep feelings of worthlessness, self-blame, and isolation, shaped by internalized stigma and societal expectations surrounding motherhood. These experiences often led to strained relationships, social withdrawal, and emotional distress. Nevertheless, many women demonstrated resilience through coping strategies such as acceptance, religious reframing, and caregiving roles. These strategies helped them reclaim their sense of identity and overcome the psychosocial impacts of infertility-related stigma.

Conclusion: Infertility stigma is not solely a personal burden but a culturally mediated social phenomenon. Effective interventions should be gender-sensitive and tailored to the sociocultural realities of women's lives. Mental health support and psychosocial services must consider these dynamics to adequately support women navigating infertility in resource-limited or culturally conservative settings.

Keywords: infertility, stigma, women's health, qualitative meta-synthesis, coping strategies

Introduction

Infertility, which affects approximately 72–80 million women of reproductive age globally, is clinically defined as the failure to conceive after one year of unprotected intercourse.[1] Traditionally framed as a biomedical issue, infertility carries significant social and psychological burdens, particularly for women in cultures where motherhood is tightly linked to feminine identity and societal values.[2] Studies indicate that over half of women with infertility experience stigmatization related to childlessness, often leading to diminished mental health, social isolation, and strained marital relationships.[3,4]

Infertility-related stigma is multifaceted, encompassing external discrimination and internalized shame. Women are frequently labeled as incomplete or blamed for their condition, reinforcing gendered stereotypes that equate women with reproductive success.[5] Cultural metaphors such as "trees of no fruit" in Turkey and "broken wings" in Jordan illustrate

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how stigma is embedded in societal narratives.[6] These experiences contribute to chronic psychological distress, including depression and anxiety,[1] and in some cases, lead to consequences such as abandonment or domestic abuse.[3]

Infertility stigma varies across cultures. In strongly pronatalist societies, especially in Asia, infertility is seen not only as a medical issue but also as a moral or social failure. For instance, in India and China, cultural norms often blame women, worsening psychological distress and strengthening familial and societal pressures.[1,5] In Japan, fear of rejection and family shame intensifies women's emotional burden.[4] These cultural dynamics underscore the need for a global synthesis including diverse perspectives, especially in underrepresented Asian contexts.

Over the past decade, qualitative studies have offered valuable insights into the lived experiences of women with infertility, revealing how stigma is navigated and negotiated. Coping mechanisms such as secrecy, avoidance, or alternative identity reconstruction are commonly reported.[2,6] However, the existing literature remains fragmented and lacks a cohesive synthesis that focuses on stigma. Previous reviews either prioritized quantitative outcomes (eg, mental health) or addressed stigma as a secondary aspect.[3] Even recent qualitative syntheses, such as that of Assaysh-Öberg et al,[7] have explored broader infertility experiences without fully capturing the complexity of stigma as a standalone phenomenon.

This study builds upon prior qualitative work by conducting a meta-synthesis that focuses explicitly and exclusively on infertility-related stigma as experienced by women. While previous reviews have explored various aspects of infertility—including emotional burden, treatment experiences, and social consequences—stigma has often been treated as one of many themes, rather than a central analytic focus. In contrast, the present review positions stigma as the core phenomenon of interest, examining how it is experienced, internalized, and negotiated across different sociocultural settings. This approach centers on women's voices and lived experiences, offering a nuanced understanding of the social dimensions of infertility. The findings aim to inform culturally sensitive interventions, contribute to theoretical discussions on reproductive stigma, and support future research and policy development.

Method

Design

A qualitative meta-synthesis was conducted, which is an important methodology for critically integrating the findings of multiple individual qualitative studies with a common focus on identifying shared meanings and generating new thematic insights.[8]

Search Strategies

A comprehensive literature search was conducted to identify qualitative studies that explored the stigma experienced by women diagnosed with infertility. The search included studies published up to February 28, 2025, using six electronic databases: PubMed, CINAHL Plus with Full Text, JSTOR, ProQuest Central, Web of Science, and Ovid MEDLINE.

The search strategy was developed in collaboration with a medical librarian and included both Medical Subject Headings (MeSH) and free-text terms combined using Boolean operators. Key search terms included variations in "infertility", "stigma", social stigma", "internalized stigma", and "qualitative research". Table 1 presents the inclusion and exclusion criteria applied during study selection.

The search was limited to peer-reviewed literature and the reference lists of the included studies were manually screened to identify additional eligible articles. The detailed search strategy, including Boolean operators and database-specific results, is provided in Supplementary Material 1: Search strategy for the included databases.

Study Selection

All search results were imported into EndNote X9 (Clarivate Analytics) for reference management and removal of duplicates. Two reviewers independently screened the titles, abstracts, and full texts based on the predefined inclusion and exclusion criteria. Discrepancies were resolved through discussions until a consensus was reached.

The initial database search yielded 1689 records: PubMed (n = 505), CINAHL Plus with Full Text (n = 201), JSTOR (n = 196), ProQuest (n = 63), Ovid MEDILINE (n = 423), and Web of Science (n = 301). After the removal of 781

Table 1 The Inclusion and Exclusion Criteria

Category	Inclusion Criteria	Exclusion Criteria
P (Population)	Women diagnosed with infertility, or women with a history of infertility treatment	Studies focusing on male infertility or women who achieved pregnancy
I (Phenomenon of Interest)	Stigma experiences related to infertility (including internalized stigma, social discrimination, perceived stigma, or relationships with partners, families, healthcare providers, or community)	Studies not addressing stigma as a main focus, or only discussing treatment outcomes
C (Context)	Any cultural, social, or healthcare context in which infertility-related stigma is experienced	Studies addressing stigma from external perspectives only (eg, provider attitudes)
SD (Study Design)	Qualitative studies exploring lived experiences	Quantitative or mixed-methods studies, reviews, editorials, conference abstracts, and non–peer-reviewed articles

duplicate records, 908 studies remained. The initial exclusion removed 17 studies (n = 2 published after March 1, 2025; n = 15 non-English), leaving 891 records for title and abstract screening. Based on this screening, 844 records were excluded because of population mismatch (n = 537), irrelevant topics (n = 156), design mismatch (n = 32), methodology mismatch (n = 14), publication type mismatch (n = 93), nonoriginal research (n = 11), or incomplete publication information (n = 1). A total of 47 full-text articles were assessed for eligibility. Of these, 33 were excluded for reasons including irrelevant topics (n = 13), population mismatch (n = 15), methodology mismatch (n = 3), and full-text not retrievable due to paywall restrictions (n = 2). Ultimately, 14 studies were included in the qualitative meta-analysis (Figure 1).

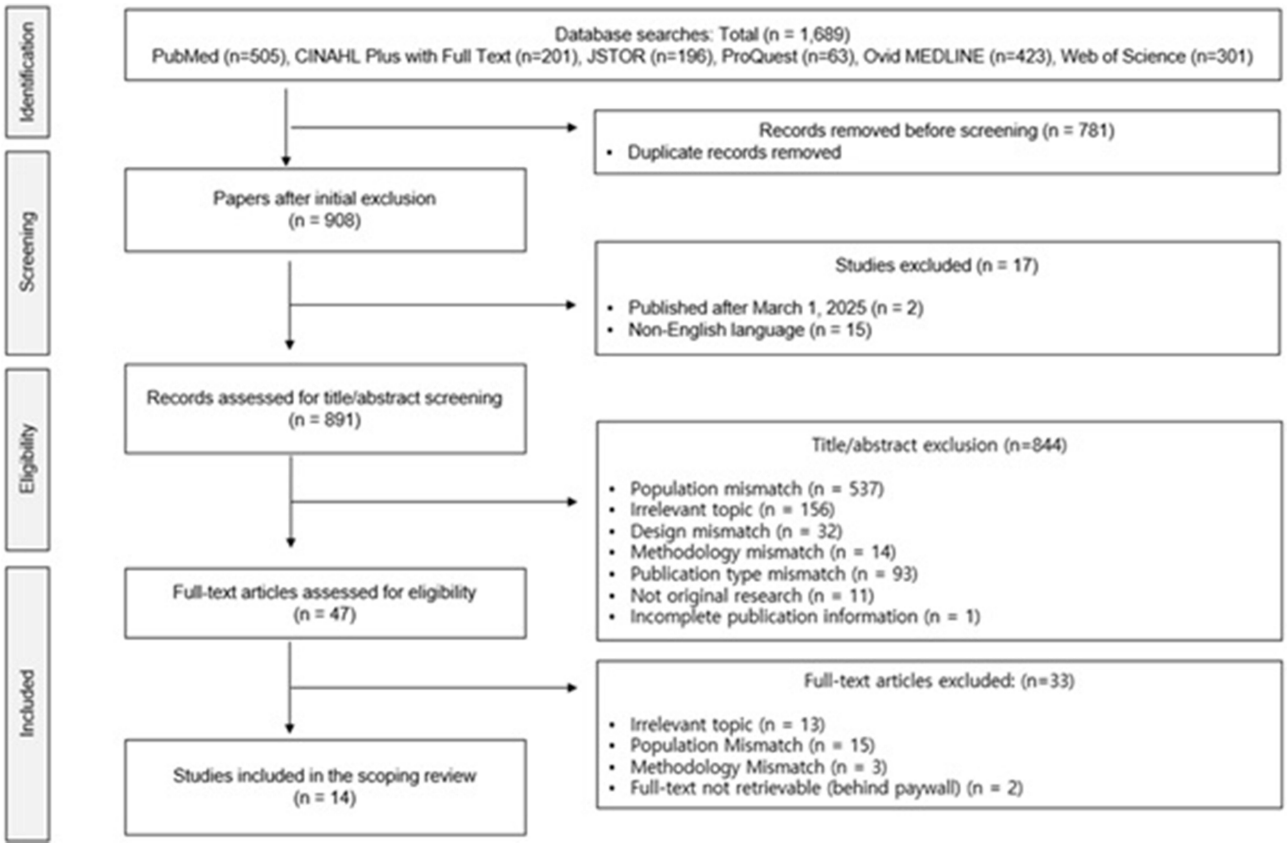

Figure 1 PRISMA flow diagram of study selection process.

Quality Assessment

The Critical Appraisal Skills Program CASP,[9] the tool most frequently used to appraise qualitative studies, was used to assess the quality of the literature. After independently assessing the quality of the literature, the two reviewers compared the appraisal results. Independently assessing the quality of the literature, the two reviewers compared the appraisal results. In accordance with the purpose of the CASP, studies were not excluded solely based on quality. Because excluding studies deemed to lack rigour may limit new insights into a phenomenon,[10] the evaluation of the included articles did not affect the inclusion or exclusion process. The quality of each study was assessed in terms of methodology, research design, recruitment strategy, and appropriateness of the analysis. Quality assessments were independently conducted by two reviewers, and any discrepancies were resolved through discussion for consensus. The detailed quality appraisal results, along with the information of the studies finally included in the synthesis, are presented in Supplementary Material 2: The studies finally included in the synthesis.

Data Extraction

A standardized data extraction form was developed in Microsoft Excel based on the purpose and scope of this review. Two reviewers independently extracted the following information from each study: first author (year), aim, country, study design, sample size, participant age range, data collection method, data analysis approach, and main themes derived. The form was pre-tested and refined prior to use. Discrepancies in the extracted data were resolved through discussion and consensus among the reviewers. The synthesized analytical results from the 14 included studies are summarized in Table 2.

Data Synthesis

Data synthesis followed the three-stage thematic synthesis approach proposed by Thomas and Harden,[12] which uses a narrative approach to integrate qualitative findings. The process was performed in three sequential stages. First, all included studies were thoroughly reviewed multiple times and verbatim findings were systematically coded line-by-line to generate a comprehensive set of conceptual codes. Second, these codes were examined for similarities and differences, allowing their systematic organization into descriptive themes that captured key patterns across the studies. Finally, each researcher independently engaged in an iterative review and synthesis to derive the final analytical themes. Thematic saturation was considered to have been reached when no additional themes emerged beyond those already identified. To facilitate this process, NVivo qualitative data management software[25] was used to generate potential theme titles and their corresponding definitions. Regular team discussions were held throughout the synthesis process to ensure consensus, enhance the reliability, and refine the emerging themes. These iterative synthesis processes deepen the analytical insights, resulting in the identification of three overarching themes.

Reflexive Considerations

The research team consisted of female academics in nursing and psychology, all of whom have engaged in clinical or academic work related to women's reproductive health. We recognize that our professional and cultural perspectives could influence the interpretation of the data. To address this, we engaged in regular reflexive dialogues throughout the synthesis process, critically examining our assumptions and ensuring that findings were grounded in the data rather than shaped by our preconceptions.

Findings

Three themes emerged from the meta-synthesis: sources of stigmatization in the context of infertility, psychosocial consequences of infertility-related stigma, and coping strategies among women experiencing infertility-related stigma. The overall themes and their corresponding subthemes are presented in Table 3.

Theme 1. Sources of Stigmatization in the Context of Infertility

The sources of stigmatization in the context of infertility encompass the following subthemes: self-directed internalized stigma, relational stigma, and gendered cultural expectations.

Table 2 Characteristics of the Included Studies

No	Author(s); Location	Purpose	Design; Data Collection	Participant Details	Method of Analysis	Stigma Experiences (Key Themes)	Cultural; Societal Context	Consequences of Stigma	Coping Strategies
A1	Adane et al.[11] Ethiopia	To explore the social and cultural challenges and coping strategies of women experiencing infertility in Bichena town, Ethiopia.	Descriptive phenomenological design; in-depth interviews, focus group discussions, key informant interviews	15 women experiencing infertility (age 18–49) and 15 key informants, selected via purposive sampling in Bichena town	Thematic analysis using NVivo 12; coding based on Cohen et al[12] procedures	Self-isolation, social isolation, social stigma (verbal, behavioral, dressing), perceived stigma, marital stigma	Pronatalist Ethiopian norms; motherhood as social identity; rituals around childbirth and death; community expectations	Low social status, psychological distress, marital problems, social rejection, public mockery, fear of being forgotten	Religious (holy books, prayer, vows), traditional (herbalists, wizards), medical (hospitals), informal fosterage
A2	Annan-Frey et al.[13] Ghana	To explore the lived experiences and coping strategies of women seeking treatment for infertility in the Kumasi Metropolis.	Descriptive phenomenological design; semi-structured interviews	19 married women with primary or secondary infertility (ages 21–50), recruited from 3 fertility clinics in Kumasi	Colaizzi's thematic analysis (7-step process)	Emotional distress, societal pressure, marital tension, mockery, social exclusion	Strong pronatalist culture in Ghana; marriage and childbirth tightly linked; stigma shaped by family and societal expectations	Psychological distress, social withdrawal, loss of happiness in marriage, strained family and peer relationships	Faith-based (prayer, fasting), biomedical care (fertility clinics), herbal treatment, rejection of child adoption due to cultural beliefs
A3	Asiimwe et al.[14] Uganda	To explore the experiences and coping strategies of women living with involuntary childlessness attending a fertility clinic in Uganda.	Qualitative phenomenological study; in-depth interviews	15 women with involuntary childlessness, aged 20–40+, recruited from Kawempe National Referral Hospital, Kampala	Thematic analysis using Braun & Clarke's six-step framework	Verbal and emotional abuse, internalized stigma, exclusion from decision-making, blame, social rejection	Pronatalist Ugandan culture; motherhood as source of social recognition and identity; lack of empathy from family and community	Marital instability, psychological trauma, sadness, hopelessness, loss of status, emotional pain, financial distress	• Positive: seeking treatment (biomedical, herbal, traditional), spiritual coping, optimism, acceptance, family support • Negative: social withdrawal, alcohol use, distraction, self-blame, hiding emotions, avoidance of gatherings
A4	Bawadi et al.[15] Jordan	To unravel the experiences of infertile women regarding societal violence in Jordan	Interpretative phenomenological study; in-depth semi-structured interviews	13 infertile women recruited from two IVF centers in Jordan (King Al Hussein Medical Center, King Abdullah University Hospital) using purposive sampling	Interpretative Phenomenological Analysis (IPA); NVivo 9 used for coding	Pity, interference, invasive questioning, blame, loss of status, verbal/emotional abuse	Strong pronatalist Arab culture; reproductive role central to women's identity; blame directed disproportionately to women	Social isolation, diminished self-esteem, distress, internalized shame, marital tension	Social withdrawal, concealment, religious practices (prayer, supplication), selective disclosure, emotional resilience through faith, family support (especially from natal family)
A5	Daibes et al.[16] Jordan	To explore women's responses to infertility and the impact of infertility in the Jordanian rural sociocultural context.	Descriptive qualitative study; semi-structured face-to-face interviews	14 infertile women aged 18–40+, with primary or secondary infertility, recruited from a fertility clinic in a military hospital in Northern Jordan	Thematic analysis based on Miles & Huberman,[16] using NVivo 10	Verbal stigma, emotional abuse, blame, self-perception as "incomplete", public scrutiny of sexuality, "aaqeem" label	Patriarchal and pronatalist norms; pressure from in-laws; motherhood tied to honor, status, and inheritance in rural Jordan	Psychological distress, social exclusion, marital conflict, inheritance deprivation, role loss, emotional pain	Submission and docility; self-isolation; internalising stigma; persistent treatment seeking (biomedical, herbal, spiritual); concealment; avoidance of gatherings

(*Continued*)

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Table 2 (Continued).

No	Author(s); Location	Purpose	Design; Data Collection	Participant Details	Method of Analysis	Stigma Experiences (Key Themes)	Cultural; Societal Context	Consequences of Stigma	Coping Strategies
A6	Dierickx,[17] Senegal	To provide a holistic understanding of the experiences of women with infertility in rural Casamance, with focus on both suffering and agency.	Qualitative study; life-story interviews, participant observation, informal conversations	11 women with infertility (varied marital, ethnic, and religious backgrounds); recruited through snowball sampling in Ziguinchor region	Thematic analysis using retroduction (inductive + theoretical comparison); NVivo 11 used	Emotional pain, gossip, witchcraft accusations, ridicule, blame, marital rejection, social exclusion	Pronatalist Islamic society; motherhood central to womanhood; spiritual beliefs (eg, jinn, kankurang); virilocal residence intensifying pressure	Depression, sleeplessness, marital conflict, pressure for polygyny/divorce, low self-worth, social withdrawal	Seeking biomedical and traditional treatment; turning to religion; support from family and kanyaleng groups; concealment; avoidance of conversations; emotional distancing
A7	Dierickx et al.[18] Gambia	To explore the implications of infertility on women's lives in urban Gambia and how this relates to gender and cultural norms as well as different social positions.	Qualitative research; 33 semi-structured interviews, 13 group discussions, 14 participant observations, 31 informal conversations	33 women, diverse in socio-economic status, recruited in the urban West Coast region (eg Bakau, Brufut, Banjul) between Sep 2017–Apr 2018	Thematic data analysis using NVivo 11; open and axial coding	Gossip, verbal abuse, accusations (eg, witchcraft, family planning), community exclusion, marital blame	Pro-natal and patriarchal society; strong gendered expectations; bride price; virilocal residence; polygyny	Emotional distress (crying, desperation, depression), violence, neglect, financial vulnerability, social suffering	Employment outside the household, emotional endurance, relying on God, women's saving organizations, remarriage
A8	Jiang et al.[19] China	Explore the experiences of Chinese women with infertility-related stigma in the context of their cultural environment.	Phenomenological study; Semi-structured in-depth interviews	12 female infertility patients from The First Affiliated Hospital of Gannan Medical University, recruited Mar–Apr 2024. Ages 26–43.	Colaizzi's phenomenological seven-step analysis	Emotional responses (anxiety, guilt, inferiority); Sources of stigma (self, family, environment)	Traditional Chinese culture emphasizing motherhood as women's role; societal; familial pressure	Emotional pain, self-isolation, social withdrawal, reduced life satisfaction, weakened mental well-being	Concealment, social withdrawal, spousal support, optimistic coping
A9	Mashaah et al.[20] Zimbabwe	To explore the psychological, sociocultural, and coping experiences of women with infertility who used traditional healthcare services in Harare Urban.	Phenomenological qualitative study; semi-structured interviews (2 rounds) with visual observation and field notes	5 women aged 27–56, recruited via THPs registered with Zimbabwe Traditional Medical Practitioners' Council; all had used traditional healthcare services	Simplified version of Hycner's five-step explication process	Labeling ("ngomwa"), emotional and verbal abuse, exclusion from family and society, ridicule, suspicion of witchcraft, undervaluation in community and church	Strong pronatalist norms; motherhood tied to social value and inheritance; fostering and adoption not widely accepted; women mocked for owning assets without heirs	Psychological distress, marital breakdown, diminished self-worth, loss of familial support, church exclusion, community gossip, isolation	Crying, self-isolation, multiple sexual partnerships, alcohol use, rebellious behavior, faith-based coping (church), emotional concealment, family support, fostering/adoption
A10	Naab et al.[21] Nigeria	To explore the psychosocial experiences of women with infertility in Zamfara.	Exploratory qualitative design; semi-structured in-depth interviews	12 married women with primary or secondary infertility, aged 22–45, receiving treatment at Federal Medical Centre in Zamfara	Content analysis; themes and sub-themes were developed through coding and comparison	Social stigma, perceived stigma, self-isolation, being accused of using family planning, being viewed as aggressive	Strong pronatalist and patriarchal expectations; value placed on childbirth for women's identity and status	Anxiety, depression, stress, social rejection, verbal abuse, marital conflict, polygamy, divorce	Self-isolation, withdrawal from social interaction, emotional suppression; no mention of formal psychological or community-based coping

A11	Nahar & van der Geest,[22] Bangladesh	To explore how childless women in Bangladesh experience and confront stigma, focusing on agency, resilience, and resistance.	Anthropological qualitative study; life history interviews, participatory rapid appraisal, group discussions	20 childless women (urban middle-class and rural poor); ages 17–62; plus two rural group discussions (10 participants each)	Thematic analysis guided by concepts of agency, resilience, resistance; comparative ethnographic method	Verbal abuse, exclusion, being called "deviant" or "unacceptable", surveillance, gossip, loss of privacy	Strongly pronatalist patriarchal society; Islam's flexible role; lack of national infertility policy; rural vs urban variations in stigma	Social exclusion, fear of abandonment/ divorce, economic insecurity, low self-esteem, emotional pain, restricted mobility	• Rural women: secret treatment-seeking, increased helpfulness, "tolerance", conflict avoidance • Urban women: persistent biomedical/spiritual treatment, avoiding social gatherings, pursuing education/employment, expressive defiance
A12	Ofosu-Budu & Hanninen,[23] Ghana	To explore the consequences of infertility.	Phenomenological qualitative study; in-depth interviews	30 married women with infertility (15 from each region); aged 19–43; recruited via snowball sampling through herbalists	Thematic analysis based on Saldana's coding manual	Insults, ridicule from co-wives and husbands, name-calling, blame, worthlessness, exclusion from rituals, verbal abuse	Strongly pronatalist; patriarchal norms; cultural beliefs linking infertility with curses, witchcraft, or immoral behavior	Depression, sleeplessness, emotional pain, self-isolation, low self-esteem, anxiety, reduced marital satisfaction	Concealment, relocation, pretending to have children, avoiding disclosure, remaining in marriage to retain respect, emotional suppression
A13	Sharma et al.[24] India	To explore the emotional and social lives of the women with infertility issues in the Northern States of India.	Hermeneutic phenomenology; semi-structured in-depth interviews (face-to-face and online)	17 married women, aged 28–40, with primary infertility; recruited via purposive sampling from Uttar Pradesh, Haryana, and Punjab	Thematic analysis using Atlas.ti software; hierarchical coding and code families	Blame, social labeling ("baanjh"), exclusion from rituals, pity, intrusive questioning, reputation damage	Strong patriarchal and pronatalist norms; low women's empowerment; marriage defined by childbearing	Psychological vulnerability, marital tension, self-blame, feelings of incompleteness, financial strain, emotional violence	Denial, religious coping (prayer, adopting deity), social withdrawal/isolation, acceptance and meaning-making
A14	Taebi et al.[2] Iran	To explore the concept of infertility stigma based on the experiences and perceptions of infertile women.	Qualitative conventional content analysis; semi-structured in-depth interviews	17 women with primary infertility at Isfahan Fertility and Infertility Center; ages and durations varied (mean age 32.88)	Graneheim and Lundman content analysis method	Verbal stigma, social stigma, same-sex stigma, self-stigma (negative feelings, devaluation)	Iranian cultural norms emphasizing motherhood; judgment from women; use of terms like "OjaghKoor"	Anxiety, social isolation, low self-esteem, fear of divorce, internalized inferiority	Defensive mechanisms: escaping from stigma, acceptance, secrecy ("infertility behind the mask"); empowerment through optimism, humor, peer and family support

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Table 3 Main Findings

Theme	Subthemes
Sources of stigmatization in the context of infertility	Self-directed internalized stigma Relational stigma Gendered cultural expectations
Psycho-social consequences of infertility-related stigma	Emotional and psychological distress Existential disruption Isolation, rejection, and the breakdown of social and relational ties.
Coping strategies among women experiencing infertility-related stigma	Silence and withdrawal Seeking meaning and acceptance Reclaiming identity through action.

Subtheme 1: Self-Directed Internalized Stigma

Women experiencing infertility often internalize the cause of failed attempts to achieve pregnancy as stemming from a flaw within themselves, rather than attributing it to external factors (A1, A2, A5, A11-14). Many interpret their inability to become pregnant as a reflection of physical inadequacy, leading to the internalization of stigma through doubts such as "Is there something wrong with my body?" or "Am I physically defective?" This internalized stigma is characterized by a range of negative emotions, including self-directed anger, guilt, inferiority, self-blame, and a profound sense of incompleteness. These internalized responses were particularly intense in contexts where there were implicit expectations from family members or social circles regarding pregnancy. In such cases, women tend to hold themselves solely accountable for failed ovulation or implantation, which further reinforces their emotional distress and sense of personal failure.

> We quarreled about this last week, sometimes I feel sorry for my husband, after all, it is my problem…. A8

> Sometimes I even wish that it was better if I was born blind than not to have a child… if I am blind and have a child, then my child will take care of me in old age…. A9

> I am always very careful when I carry a newborn baby; I avoid public places so that nobody can ask a question about the baby. A11

> I always think that, because I cannot get pregnant, cannot have children, I am lower than others. This idea really bothers me. A14

Subtheme 2: Relational Stigma

Relational stigma involves the internalization of negative perceptions held by others during interpersonal interactions. Women experiencing infertility often perceive themselves as inferior or defective because of their perceived failure to fulfill their expected maternal role, particularly within the context of familial, spousal, and community expectations (A1, A2, A4, A5, A7, A13, A15). In certain cultural settings, this perception leads to a deep internalized stigma, manifesting as a sense of being an incomplete person, or even a false or inauthentic woman. For women who experience relational stigma more intensely, the absence of children contributes to profound emotional suffering within the marital relationship, often resulting in deterioration of the partnership. In some cases, it also leads to discussions about divorce (A1, A7). Within familial contexts, implicit comparisons with siblings who have children, careless remarks, and culturally embedded expectations further reinforce and entrench stigma, exacerbating women's sense of social exclusion and emotional distress (A4, A5).

> My colleagues at work are very gossipy. They ask me every month if I'm pregnant… I feel a lot of psychological pressure. A8

> Right now, it is my mother who sometimes advises me to stop working and focus on getting a child. A12

> When you have no child, you are not considered as a wife to their brother…up to now they have never taken me as a wife to their brother ….A3

Subtheme 3: Gendered Cultural and Structural Expectations

The subtheme gendered cultural and structural expectations subtheme illustrates that the stigma and psychological distress experienced by women with infertility are not merely the result of individual shortcomings but are deeply rooted in broader sociocultural structures and norms (A1, A4, A5, A7, A10, A11, A13, A14). Specifically, it encompasses traditional expectations imposed on women, such as the enforcement of motherhood as a normative role, and culturally embedded beliefs that view pregnancy and childbirth as a woman's essential duty. These expectations often lead to discrimination, internalized guilt, and ritual exclusion (A4, A10, A12, A14). In certain sociocultural contexts, when pregnancy is delayed or fails, women are perceived as having failed to fulfill their familial responsibilities or are labeled incomplete wives, which results in significant psychological pressure. Furthermore, cultural practices may exclude them from family and community rituals (eg, holidays or traditional ceremonies) or symbolically position them as inferior.

> I must be present at their house in the morning to help with cooking food and other household chores because I do not have children… It is forbidden to complain that you are tired or busy. A4

> Since everyone is just waiting for you to give birth or get pregnant, the moment you say you are ill or they see certain changes in you they think you are pregnant. A14

> … the only way for you to be useful is to give birth … without one child … no one will respect you and won't even include you in their affairs. A12

Theme 2. Psycho-Social Consequences of Infertility-Related Stigma

The consequences of stigma experienced by women include emotional and psychological distress, existential disruption, isolation, rejection, and breakdown of social and relational ties.

Subtheme1: Emotional and Psychological Distress

Women experiencing infertility were found to experience significant negative emotional distress related to infertility. This distress is characterized by persistent distress and anxiety due to the prolonged duration of infertility and uncertainty surrounding pregnancy (A1-14). Feelings of depression, sadness, and guilt are commonly reported and are often triggered by repeated treatment failure. These emotional responses formed a cycle of psychological struggles that deeply affected their daily lives. Amid these emotional challenges, emotional support from spouses, family members, or other women facing similar infertility challenges helps alleviate emotional distress and provides strength. In contrast, lack of support from families or spouses leads to severe depressive symptoms (A4, 14).

> Preparing for pregnancy together… Why is it so difficult for me to handle this matter, and my mentality has collapsed. A8

> Sometimes I cannot eat, I cannot even be able to sleep. A10

> I feel as if they were referring to me… I will stop work and send my ear towards them… although sometimes I realize they were not referring to me. A1

> I think a lot. I'm desperate. It is more like many others who married after me have given birth. I'm not happy. Sometimes I'm moody. A2

Subtheme 2: Existential Disruption

The existential disruption subtheme reflects the deepening psychological responses of women experiencing infertility, highlighting how prolonged emotional distress can escalate into an existential crisis (A2, A4, A10-13). Infertility is portrayed not only as a medical issue but also as a condition that profoundly affects a woman's life. For those who view pregnancy and childbirth as central life goals or sources of identity, the inability to conceive is devastating. These women often experience intense negative emotions and confront existential questions such as, "What do I live for now?" This inner turmoil was marked by feelings of emptiness, loss of direction, and profound helplessness. In some cases, this necessitates psychological restructuring, including a redefinition of life's meaning.

People say you are so successful, but I tell you this life is hollow… It doesn't matter how much a woman makes progress… this life is incomplete. A13

Infertility is a curse in life. this life is hollow… It doesn't matter how much a woman makes progress with her life, she is only born to produce kids… Kids fill your life with a joy I'm unable to experience. A13

Life is not fair; I sometimes feel God shouldn't have created me. A2

People around me make me feel like I am nothing … half a woman, half a man. When I look at myself in the mirror, I cry and ask myself 'why me? … I curse my destiny… A[15]

Subtheme 3: Isolation, Rejection, and the Breakdown of Social and Relational Ties

Women described a growing sense of emotional strain as repeatedly facing unsuccessful treatment attempts. Rather than seeking support, many began to withdraw—emotionally and socially (A1, A2, A4, A7, A8, A10, A11, A13, A14). Relationships with spouses, family members, and others gradually deteriorate, not always through open conflict, but often through silence, distance, and unspoken resentment. Feelings of blame and stigma, sometimes internal and sometimes perceived by others, surface in both marital and extended family dynamics. This manifested as strained communication with partners, emotional disconnection from in-laws and birth families, and escalating tensions within couples. Many chose to avoid relatives or friends who had children, skipped social gatherings, and were disengaged from conversations centered around pregnancy or parenthood. Over time, these patterns contributed to a sense of isolation and deepened their emotional burden.

Now I avoid most of my work friends and neighbors. I don't want to see anyone.A4

In the past, I used to go out with my friends every weekend… Now I'd rather stay at home alone than hurt myself.A8

Yes, I used to feel shy. Some will say about me… and if there is naming ceremony, they would not inform me.A7

A participant cited by Sharma et al, described: I don't want to talk to people… I don't even go to weddings or social gatherings. A13

Theme 3. Coping Strategies Among Women Experiencing Infertility-Related Stigma

The theme of coping strategies among women experiencing infertility-related stigma encompasses both positive and negative approaches, including silence and withdrawal, seeking meaning and acceptance, and reclaiming one's identity through action.

Subtheme1: Silence and Withdrawal

The subthemes of silence and withdrawal capture women's tendencies to conceal their infertility and avoid related conversations to escape negative perceptions and stigma (A1, A2, A4, A5, A10, A12, A14). Some chose not to disclose their condition to close family or friends, hide their treatment schedules, and suppress their emotions. Avoidance has also emerged as a form of self-protection against emotional pain caused by stigmatizing experiences. Women often withdrew from social situations centered on pregnancy or childbirth such as weddings, first-birthday celebrations, and family gatherings. These actions were aimed at shielding themselves from comparisons or intrusive questions.

I avoid taking part in their conversation because I don't want someone to say a word that will hurt me or affect me negatively.A10

I don't like anybody to know anything about this at all. I don't like to be looked on with pity. … I come to the center for treatment, but I don't tell anybody. A14

Sometimes, I become very quiet and really very sad … The kind of things she says while patting, adoring, and pampering her children or child will make you sad. A12

Even if they gather I don't put myself among them. I will be doing my things alone. A10

Subtheme2: Seeking Meaning and Acceptance

In the context of infertility, many women turned to religious or spiritual beliefs as a way to find emotional stability, hope, and meaning (A2, A3, A4-6, A9, A13). Practices such as prayer, temple visits, pilgrimages, reading scriptures, and church services have helped ease feelings of anxiety and helplessness. For some, these practices serve as cognitive strategies to reframe their situation as part of a divine plan. Faced with the reality that infertility may not be resolved, some women have begun to accept their circumstances and search for new sources of meaning. Through emotional regulation, relationship healing, and self-care, they strengthened their psychological resilience and sought to create a fulfilling life, even without children.

> Having no child is not the end of the world, I have come to accept it…. I concentrate on my Job… and I am happy…A3

> I don't talk about my emotional pain. I just have faith in God, and I know that it is the will of God.A6

> …. mostly I put my trust in God… I usually go to Church and when I am from there my hopes of getting a baby are always high… they usually counsel us and by the end of it you have hope… A3

> Some people in the community gave me courage and made me active by telling me to have faith in God, with the will of God I will have a child. They really gave me a steady mind. A6

> I had accepted my fate.A9

Subtheme3: Reclaiming Identity Through Action

Women often pursued multiple treatment paths for infertility, combining traditional remedies with modern medical interventions such as IVF and ovulation induction (A1, A2, A4, A5, A11, A13, A14). As infertility became increasingly stigmatized, many felt more pressure to succeed. Rather than following a single path, some patients moved from one treatment to another, driven by a sense of urgency and pressure to achieve pregnancy. Simultaneously, some women pursued alternative paths to parenthood by adopting caregiving roles, including fostering care and adoption (A1, A2, A13). Through this, they experienced a sense of maternal fulfillment, which helped ease the pain of childlessness and supported their sense of self-worth and identity.

> I knew the chance of getting pregnant was very low and the treatment is costly. But still I gave it a try. I didn't believe that God had given me this fate. God also advises us to take action for any problem.A11

> During this period… eating Chinese medicine, pulling my husband to test semen vitality, trying various recipes… A8

> My aunt has born nine children… she has given one of her last daughters to me… I and my husband love her and seen as our biological child… she makes my life good and I am better than childless women.A1

> I've adopted Krishna as my child. He keeps me busy whole day… Now he is my child. A13

> For me, I think adoption will be okay because if the person does not know his or her parents but will call me mother or will come and meet me when I am returning from work, I will be fine with it. A2

Discussion

Sources of Stigmatization in the Context of Infertility

Across diverse cultural settings, infertility is consistently constructed as a socially deviant state primarily because womanhood is culturally defined in relation to fertility and motherhood. In pronatalist societies, infertility is not just a medical condition, but also a social identity marked by perceived failure. Many women internalize this status and experience intense shame, guilt, and feelings of personal inadequacy. For example, in Iran, women reported being labeled "Ojagh-Koor" or "cold house", a metaphor that stigmatizes the infertile woman as a source of emotional and spiritual emptiness in the home.[2] Similar symbolic constructions were found in Turkey and India, where women were viewed as "incomplete" and often bore full responsibility for the couple's inability to conceive.[24] Stigmatization was reinforced

through family structures, especially by in-laws who imposed psychological pressure or initiated marital dissolution. In Nigeria, a woman's mother-in-law forces her husband to divorce her, citing infertility as a justification.[18] Public scrutiny has played a major role in this process. In Jordan, women likened social pressure to "suffocation", describing constant questioning and surveillance as forms of emotional violence.[26] These findings highlight how infertility stigma is embedded within the structural and cultural norms that regulate gender, reproduction, and social status. The centrality of childbearing and parenthood in many societies cannot be overstated when examining the origins and mechanisms of infertility-related stigma. In numerous cultural contexts, motherhood is positioned not only as a desired personal goal but as a fundamental marker of adult female identity, marital success, and familial honor. Parenthood serves as a socially sanctioned transition into full societal participation, and childlessness disrupts this expected life trajectory. As such, infertility is not merely experienced as a private biomedical condition but as a visible deviation from a socially mandated life course. This deviation becomes grounds for stigma, reinforcing societal narratives that equate reproductive capacity with feminine worth. Thus, infertility-related stigma is best understood not only as an interpersonal or psychological burden, but as a culturally embedded response to a perceived failure to fulfill gendered social roles.

Psycho-Social Consequences of Infertility-Related Stigma

Because of this deeply embedded stigmatization, women across all studied contexts reported experiencing profound emotional and psychological distress. Feelings of worthlessness, chronic sadness, depression, and anxiety have been commonly described. In The Gambia, a woman captured this internal turmoil by stating, "I am always crying on the inside".[16] In many cases, the stigma extends beyond the individual, damaging marital relationships and disrupting family dynamics. In Uganda and Ghana, women reported experiencing neglect, verbal abuse, and polygamous remarriage initiated by their husbands due to their inability to conceive.[11,20] In certain cultural settings, infertility can lead to divorce. Conversely, there have been instances of spousal support, such as in Ghana, where husbands shielded their wives from external blame and provided crucial emotional support.[26] In countries like China, stigma is internalized and hidden; women often keep their condition a secret to avoid social shame and gossip, which in turn deepens their isolation and psychological burden.[19] The cumulative effect of infertility stigma, both overt and internalized, results in diminished mental health, social withdrawal, and erosion of self-esteem across contexts.

Coping Strategies Among Women Experiencing Infertility-Related Stigma

Despite the psychological burdens and social consequences of infertility, women across all cultural settings demonstrate resilience through various coping mechanisms. Religious and spiritual coping strategies were particularly prominent. In Northern India, women often interpret infertility as part of God's will and turn to prayer as a primary coping method (Sharma et al, 2024).[24] Similar patterns emerged in predominantly Muslim societies such as Bangladesh and Senegal, where women viewed their condition as a test from God and adopted a posture of patient endurance.[18,22] Many women seek help from traditional healers and herbal remedies, particularly in Ethiopia and West Africa, before or alongside biomedical interventions.[11,18] Formal and informal social support networks are crucial. In Senegal, *kanyaleng* support groups offer a collective space for emotional healing and cultural resistance, often combining rituals, music, and prayer to help women reclaim their dignity.[18] Peer networks in hospitals and communities provide shared understanding and solidarity, as seen in Ghana and Nigeria.[13,22] Women also employ pragmatic strategies, such as fostering relatives' children to fulfill motherhood roles or relocating to escape community scrutiny.[23] Others have redirected their focus toward personal development, pursuing education or income-generating activities, to regain agency and value.[17] Notably, many women exhibited strategic agency in navigating stigma. For instance, Iranian women have described selective disclosure and role balancing as mechanisms for preserving their self-worth.[2] In Bangladesh, women engage in both overt and covert resistance to social exclusion by asserting their roles in family and community settings.[22] These coping strategies highlight that, even in environments marked by strong structural stigma, women can negotiate spaces for self-affirmation and resilience.

While this meta-synthesis primarily synthesized studies from Asia and Africa, qualitative research from Western countries such as Italy also reveals resonant themes. In a recent study Italian women undergoing medically assisted reproduction described their bodies as "fragmented" and themselves as "incomplete", reflecting deeply internalized

shame and a perceived failure to fulfill culturally ingrained expectations of womanhood.[27] Despite Italy's increasingly secular social climate, family-centered cultural norms and the moral weight placed on motherhood continue to shape women's emotional responses to infertility. These findings suggest that while the intensity and narrative framing of infertility stigma may differ across regions, core themes—such as identity disruption, social inadequacy, and gendered expectations—transcend cultural boundaries. Including such perspectives enhances the cross-cultural validity of this meta-synthesis and affirms the global relevance of infertility-related stigma.

Together, these findings underscore the fact that infertility stigma is a globally pervasive phenomenon shaped by gendered cultural norms and reproductive expectations. Although the nature and intensity of stigma varies across settings, its psychosocial impact is profound. These insights suggest that interventions must address both the structural and individual levelsby challenging harmful societal narratives around motherhood and supporting the diverse coping resources that women already mobilize. Programs that create safe, stigma-free spaces, integrate spiritual and cultural frameworks, and foster empathetic engagement among family members are critical for improving the well-being of infertile women. Most importantly, focusing on women's agency and lived experiences is essential for transforming infertility from a narrative of shame and exclusion to one of dignity, resilience, and support.

Implications for Practice

Programs that create stigma-free spaces and strengthen social support are essential to improve psychological outcomes for affected women.[23] The findings of this meta-synthesis highlight the need for stigma-aware reproductive healthcare. To reduce infertility-related stigma, healthcare providers should receive training in culturally sensitive communication, enabling them to address patients' psychosocial distress with empathy and without implicit bias. Community-based peer support groups may also help mitigate the isolating effects of stigma by fostering solidarity and shared experience. In settings with strong pronatalist norms, collaboration with religious leaders or community influencers can facilitate public education efforts that deconstruct harmful stereotypes about infertility. Policymakers should integrate infertility stigma-reduction into broader reproductive health programs by ensuring mental health resources are embedded within fertility services and by creating protective policies that discourage discriminatory practices, such as blame or forced divorce due to infertility.

Study Limitations

This study had several limitations. First, only English-language peer-reviewed studies were included, which may have led to the exclusion of relevant research from non-English-speaking regions. Although our search strategy imposed no geographic restrictions and covered six major databases, all included studies originated from Asia and Africa. This geographic concentration, while reflective of regions where infertility stigma has been explored in depth, may limit the generalizability of findings to other sociocultural contexts, particularly in Europe and North America.

Second, while our inclusion criteria ensured thematic consistency by focusing on studies that explicitly addressed infertility-related stigma, they also resulted in the exclusion of potentially insightful qualitative research—particularly from Western countries (eg, Italy and the UK)—that examined infertility without using stigma-specific frameworks or validated stigma scales. Some of these studies were identified during screening but were excluded due to not meeting our predefined criteria, such as lacking a central focus on stigma, relying solely on content analysis of online forums, or targeting populations outside the scope of this review (eg, voluntarily childfree women or single mothers by choice). Future reviews may consider broader conceptual and methodological frameworks to capture the full complexity and cultural diversity of infertility experiences.

Third, methodological heterogeneity among the included studies—such as variations in sample size, analytic approach, and depth of reporting—may have limited cross-study comparability and influenced the consistency of theme development. Additionally, three studies were excluded during synthesis due to conceptual misalignment or a lack of direct focus on stigma.

Future Research Directions

Further studies are required to explore how stigma interacts with healthcare access and outcomes, particularly in low-resource settings. Cross-cultural comparative research can provide deeper insights into how social, religious, and policy environments influence the perception and management of infertility stigma.

Intervention studies assessing the effectiveness of culturally adapted stigma-reduction strategies are warranted.

Conclusion

This review synthesized findings from 14 qualitative studies to explore how women in diverse cultural contexts experience and respond to infertility stigma. Despite variations across countries, infertile women consistently faced social blame, exclusion, and emotional hardship linked to gendered expectations of reproduction. Cultural narratives that equate womanhood with motherhood placed significant psychological and relational pressure on these women. However, the findings also illustrate how women adapt and resist stigma using culturally informed strategies such as social withdrawal, silence, spiritual coping, and informal support networks. These insights affirm that infertility cannot be separated from its sociocultural context and must be approached as both a medical and social issue. Effective reproductive health support requires not only clinical solutions but also community-level understanding and psychosocial care that reflect the lived realities of affected women. Future work should explore how intersecting social factors, including religion, marriage systems, and socioeconomic conditions, shape stigma and coping mechanisms in infertility.

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Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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