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"Community members question me and flaunt their children before me": A call for psychosocial support for women with infertility in Northern Ghana

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ABSTRACT

Infertility is a major health issue that poses threats to women's lives, marriages, and health. Yet little is known about psychosocial support for women with infertility in Northern Ghana. This study aims to understand the psychosocial challenges faced by women with infertility and evaluate the availability and effectiveness of social support systems in East Mamprusi Municipality, Northern Ghana using a qualitative interpretive descriptive design. In-depth interviews were conducted using a semi-structured interview guide. Ethical approval was received from the Institutional Review Board of Ghana Health Service, Accra. Women who visited the health facility desiring to conceive were recruited and interviewed. Thirteen (13) women were interviewed, with each interview lasting 45 min to an hour. The interviews were audiotaped after obtaining permission from the participants, which were transcribed verbatim and analyzed using content analysis. The findings revealed that women faced numerous mental and social problems. Some of these problems include emotional, behavioural, marital instability, the high cost of infertility treatment, and a strong desire to have children. Although the women reported some social support from the community, they lacked strategies to sustain this support. Women with infertility face numerous mental and social challenges. They lack support systems to improve their mental and social health. Health professionals are required to constitute peer support groups for these women and advocate for external assistance to sustain these support groups.

Introduction

Infertility is a pressing global health concern, exceeding maternal mortality rates by a staggering 16-fold [1,2]. It poses a particularly significant threat to women's well-being, especially those yet to experience childbirth [3,4].

Infertility affects an estimated 80 million people globally, and 10 %-15 % of couples of reproductive ages are unable to conceive spontaneously after one year of unprotected sexual activity [5,6]. Also in the sub-Sahara Africa, the prevalence of infertility is estimated to be 21 to 30 %. In Ghana, secondary infertility rate is higher than that of primary infertility and subfertility, with an approximation of14 % and 2 % [7].

In African nations, infertility carries profound societal and psychological consequences. Motherhood is not merely an expectation but the most cherished identity for women in traditional societies, leaving those unable to conceive feeling existentially unfulfilled [8,9]. The perception of infertility as a curse in these societies compounds the suffering, primarily borne by women [10,11].

Infertility in African contexts lead to a range of social and psychological challenges. Socially, women are often ostracized and excluded from social groups, stemming from the belief that infertility is self-inflicted [12]. This isolation, coupled with stigma and strained relationships, adds to their distress [2,13].

Psychologically, infertility exerts a severe toll, manifesting as

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torment, despair, depression, humiliation, social isolation, and economic hardship[14,15]. The psychological pain is exacerbated by the loss of gender identity, with Rwandan women perceiving infertility as a stripping of their womanhood and gender identity, while men face a corresponding crisis of masculinity [10]. South African women experiencing infertility grapple with psychological distress, including disappointment, shock, and profound sadness [16,17].

In Nigeria, extensive studies have unveiled a host of psychological issues confronting women with infertility, encompassing stress, anxiety, and depression [18]. These burdens are compounded by self and social isolation, societal pressure, and marital conflicts [2,13]. Similar psychological challenges are documented in Mali, Zimbabwe, and Ghana, affecting both women and men [13,19–21].

Social support emerges as a pivotal mitigating factor for the psychosocial challenges faced by women with infertility. It encompasses physical and psychological resources offered by society to help individuals manage stress [22]. Social support is an effective stress management strategy, with individuals accepting assistance from others [23,24].

Despite these infertility predicaments, the availability and efficacy of social support systems for women with infertility in Ghana remain poorly understood. To address this gap, this study explored the psychosocial experiences and support among women with infertility at East Mamprusi Municipality of Northern Ghana.

Methods

The study used a qualitative research approach and interpretive descriptive design to explore the psychosocial experiences and social support for women with infertility at East Mamprusi Municipality of Ghana. The design was the best choice for the study because is well suited for studying subjective experiences, meaning, and interpretations, further allowing a contextual understanding of the phenomenon being study.

Inclusion and exclusion criteria

Women between 18 to 49 years old, who understood and spoke Mampruli, Frafra or English language, self-reported to have infertility and agreed to participate were purposively sampled. Women with infertility having obvious emotional crises were excluded to ensure data collected is accurate, reliable and free from potential biases, even though this might have limit generalization further limiting important information.

Ethical approval

The Institutional Review Board of Ghana Health Service reviewed the proposal and approved the study (GHS-ERC: 066/03/22) and permission was sought from the North-east regional health directorate for the data collection.

Tool for data collection

A semi-structured interview guide was designed based on the objectives of the study to conduct all the interviews. The process of data collection was also guided by a moderator using a semi-structured interview guide with key questions focusing on psychosocial experiences and social support of women with infertility.

The moderator was experienced in qualitative data collection and orientated about the research topic. The interview guide was reviewed by a qualitative researcher on infertility and pre-tested before the interviews.

Data collection

Data were collected between April and June 2021. Prior to data collection, the protocol and data collection tools were pilot tested with a small group of women with infertility to ensure feasibility and cultural appropriateness. On each day of data collection, the researcher met with each participant at a venue chosen by her. After explaining the content of the consent to participants individually, each participant signed two consent forms; one was kept by the participants and the other for the researcher team. To ensure cultural sensitiveness, participants were interviewed in their local dialect (Mampruli and Frafra) as well as English to ensure they understood the data collection process. Participants values and beliefs were respected throughout the process. Interviews lasted between 40 min to 1 h and audiotaped with permission from participants. Data was then transcribed verbatim for content analysis. Regular data quality checks were also performed to ensure accuracy, completeness, and consistency of data.

In each interview, the researchers were focused on the richness of the data rather than the sample size [25]. After collecting each participant's data, the researchers transcribed the data before proceeding to interview the next participant. Hence, interviews and data transcription occurred concurrently to identify areas that needed further probing. After interviewing and transcribing the 13th participant's data, it was detected that there was no new information. However, one more participant was interviewed to ensure all relevant data were collected for content analysis.

Data analysis

Content analysis guidelines by Miles, Huberman [26] were followed. Data was coded by the researchers themselves, and relevant phrases and sentences were captured to meet the purpose of the study. The statements identified were highlighted and labelled with a code. The passages that were coded were then compared for differences and similarities. Similar codes were categorized into main themes and subthemes.

These grouped themes and sub-themes were reviewed consistently to ensure clearness and relevance. Two (2) main themes were identified namely psychosocial experiences, and social support. Six (6) sub-themes were realized under the psychosocial experiences which include social pressure, emotional factors, behavioral factors, marital factors, strong desire to have children, and cost of treatment.

Three (3) subthemes were identified under the social support theme namely, received support, perceived support and access to support groups. To maintain confidentiality, participants were identified using pseudonyms (Ama, Serwaa, Akosua, Ofosuwaa and so forth). The researchers ensured they continually monitored and evaluated the analysis process to produce accurate and reliable results, whereas findings were validated by experts to certify they are culturally accurate and relevant.

Results

Demographic characteristics

The women who participated in the study were within the 18 to 49 years range. All the women involved were married with variations in the duration of marriages. Two women were in a polygamous marriage with the majority (n = 7) being Muslims and six (6) being Christians. Out of the thirteen (13) participants, seven (7) were childless, four (4) had one child each, and two (2) had two (2) children each but still complained of not being able to conceive. Concerning their educational background, three (3) did not attend school at all, three (3) completed senior high school and seven (7) completed tertiary education. With regards to employment, the majority six (6) were self-employed, five (5) were employed by the government, one (1) was employed in the private

sector and one (1) was a housewife. Details of the demographic characteristics of the participants are described in Table 1.

Two main themes were generated from the data: Psychosocial experiences associated with infertility and social support. The findings are illustrated with verbatim quotations in italics. To maintain confidentiality, participants were identified using pseudonyms (Ama, Serwaa, Akosua, Ofosuwaa and so forth). Details of the main themes and corresponding sub-themes are described in Table 2.

Theme 1: Psychosocial experiences associated with infertility.

Psychosocial experiences associated with infertility were recognized as a main concern among these women. The women experienced psychosocial challenges in the form of social pressure, emotional, behavioral, and marital problems as well as a strong desire to have children and the high cost of treatment as a barrier.

Social pressure

The women complained of the negative reactions that people in the society exhibited towards them. Unnecessary pressure is put on them in the form of negative utterances, questioning, and negative attitudes from the community. Below are few narrations shared by some participants:

Ama, a 34-year-old nurse with a child lamented that;

> *In an African Society, when a woman marries within a year, they expect her to have a child and when it does not happen after some time, people begin to question, gossip, and talk a lot about you.* **(Ama).**

Culturally, women without children are thrown out of the family after the death of their husbands, and this was the fear of these women, as narrated by a 25-year-old trader with no child.

> *I am considered a stranger and not recognized in the family. In this house that I am living in, I will not stay there when my husband passed on and I do not have a child. I just must pack my things and leave the family* ***(Asantewaa)***.

Negative labels were also problems for these women as many complained that they were labeled "infertile women", insulted, teased, and not considered in decision-making since they do not have biological children, a 25 year trader with no child reported that.

> *They label me with the statement "infertile person". Someone mocked me by saying that I am not a woman yet until I go for antenatal or postnatal. No matter how well dressed you are so far as you do not have children, you are not a woman"* **(Asantewaa).**

The narratives above confirmed that women with infertility face a lot of social pressure in the community.

Table 1
Demographic characteristics of participants.

Demographic data	Category	Frequency N = 13	Percentage (100 %)
Age(years)	21–30	5	38
	31–40	7	54
	41–50	1	8
Ethnicity	Mamprusi	6	46
	Dagaaba	1	8
	Talensi	2	15
	Kusaasi	1	8
	Hausa	1	8
	Komkomba	1	8
	Ashanti	1	8
Education	Tertiary	7	54
	Senior High	3	23
	Junior High	0	0
	Primary	0	0
	Not schooled	3	23
Employment status	Private employment	1	8
	Government employment	5	38
		6	46
	Self-employed	0	0
	Student	1	8
	Unemployed		
Duration of Marriage (years)	1–5	7	54
	6–10	4	31
	11–15	1	8
	16–20	0	0
	21–25	1	8
Duration of infertility (years)	1–3	6	46
	4–6	3	23
	7–10	3	23
	11 and above	1	8
Parity	None	7	54
	One	4	31
	Two	2	1 5
Religion	Islamic	7	54
	Christianity	6	46

Table 2
Main themes and corresponding sub-themes.

Main Themes	Sub-themes
1. Psychosocial experiences associated with infertility	Social pressure
	Emotional problems
	Behavioral problems
	Marital factors
	Wishful thinking / Desire to have children
	Cost of treatment
2. Social Support	Received support
	Perceived support
	Access to support group

Emotional problems

The women experienced a lot of mental health problems both at home and in the community as a result of infertility-related stress. Most of the participants experienced anxiety which affected their sleep as communicated by a 38-year-old seamstress with two children;

> *This challenge of not conceiving keeps me thinking and gets me worried. It sometimes creates panic, and sleepless nights because I am busy thinking over the situation* **(Serwaa).**

Aside from the anxiety, the women experienced sadness. Some of these participants complained that aside from battling to conceive, some people's attitudes toward them worsened making them inferior in society. A 34-year-old nurse having one child with the ex-husband lamented that;

> *I feel extreme sadness when they behave that way toward me. Sometimes they will make me feel like I am less of a human. I do not feel good anytime they behave that way with me.* **(Ama).**

Some women had to share how low their sex drive has become an issue. They claim it will be a waste to have sexual intercourse since they will not be able to conceive. This is what a 30 years old nurse with no child had to share in that regard;

> *Sometimes, he even wants to have sexual intercourse, and I think it will be a waste of time. Because I nothing will come out of it. It is better not to do than to do and waste it* ***(Kyewaa)***.

These findings suggest that these women go through emotional problems including sadness, anxiety, and low sex drive which affect health in diverse ways.

Behavioural problems

People portray certain negative attitudes towards women with

infertility by flaunting their children and using negative comments to remind them of their inability to conceive. These make the women withdraw themselves from others and social activities. A 30-year-old trader with no child narrated that;

Community members question me and flaunt their children before me. Some will just come and give their child to me to keep. All these just to let me feel bad for not having my own. **(Nana Aba)**.

Most participants were accused by Community members and husbands of using family planning and committing abortion making them not conceive. Maafia, a 40-year-old housewife having one child with her current husband shared their worries;

It is a problem between myself and my husband. I have been injured several times with the excuse that I have been aborting children. ***(*Maafia)**.

Some women with infertility were accused of being cursed, using their wombs for rituals, and labelled as witches, hence their inability to have biological children. A 40-year-old nurse with one child narrated that;

They told me that I had used my womb for ritual to build this house. If you are a woman and you are still seeking a child, they will say you are a witch and that you have sacrificed your children. ***(Adom)***.

These narratives prove that women with infertility went through a lot due to the negative attitude of people towards them.

Marital factors

Most of these women suffered conflicts and pressure from their husbands for not conceiving. The husbands were restricting some of the participants from taking some soft drinks, preventing some of these participants from roaming, quarrelling with them and comparing them to other women who conceived. A 26-year-old hairdresser with no child had this to share;

Any word that comes out of my mouth, be it good, he will see the bad aspect of it and pick a quarrel with me. I cannot go to visit a friend or take part in certain activities, or else we will quarrel ***(Esi)***.

Some husbands of these women felt hurt because they claimed much money was spent on treating their wives' infertility, causing financial constraints, without achieving their goal of having children. A 40-year-old nurse with one child shared her concerns as follows;-

My husband wants children and they are not coming so a little thing, he becomes annoyed. It is like he is wasting his resources. Sometimes he becomes angry and shouts at me ***(Adom)***.

On the contrary, some of the quarrels were caused by these women because they thought the fault was coming from the husband or the husband was not putting effort enough into the treatment. Even some of these women threatened to leave the marriage but the husbands still showed them love and care. A 34-year-old nurse having one child with her current husband verbalised that;

Upon fighting and telling him (my husband) a series of times we should part ways, he is still there for me. I have never seen someone who cares and loves me like he is doing. No matter how much I tried to walk away after we fought, he was still there for me ***(Ama)***.

Wishful thinking/ desire to have children

Most of the women revealed that they always wished to have children. It was confirmed that their desire for children is reflected in occasions like outdooring and marriage ceremonies. A 30-year-old trader with no child has this to say;

On naming ceremonies, mostly I do not feel comfortable, sometimes I will hold the child, and be thinking, wishing that the child was mine and that it was supposed to be my child's outdooring. ***(Nana Aba)***.

Some participants' desire for children becomes stronger when they see a pregnant woman or newborn resulting in them crying. A 40-year-old nurse with one child confirmed in her statements below;

Sometimes what makes me cry is when somebody just gives birth or when I see somebody who is pregnant, it makes me think about it and I cry a lot. It affects me a lot. ***(Adom)***.

Some participants' desire for children manifested when they viewed other children's pictures on social media making them feel sad, question themselves, and sometimes become jealous. A 25-year-old trader with no child lamented that;

When I see some people dressing with their kids and husbands, their children's birthdays taking pictures, and putting on social media, I get very worried and feel sad ***(Asantewaa)***.

These findings confirmed that these women had a strong desire to have biological children due to so many reasons.

Cost of treatment

Most participants reported that much money was spent on their treatment. Some reported that they had to sell out their food storage to treat infertility. While others had to take salary advance to seek infertility treatment, all these affected their livelihood.

A 40-year-old nurse with one child narrated that;

All my money remains in searching for pregnancy. Sometimes they will tell me to buy certain drugs that will boost my immune system. I have to go for a salary advance for the treatment. ***(Adom)***.

These women with infertility later realized that they needed to divert the resources to care for the few children they had in school since they were not getting positive outcomes from their spending. A 47-year-old trader with one child shared the following;

For eight years now I have not gone for any treatment, so I advised myself that it is better to use the money to support my only child at school than to keep wasting money ***(Gyamfuwaa)***.

Theme 2: Social Support.

Although some of the women received some form of financial, material, emotional, companionship, or informational support to relieve them from infertility-related stress, some reported not receiving support from the community. They received little support from their husbands, families, spiritual leaders, co-workers, peers, the institution where they work, and society as a whole of which was not adequate. Social support is categorized into received support, perceived support, and support systems available for women experiencing infertility.

Received support

Some of the women revealed that their husbands gave little or no financial support for their infertility treatment.

Financially I do not get support from anybody. Because of that, I started working not now, but I do not have savings. All my money remains in searching for pregnancy.

Also, participants stated that the husband's families were not assisting them in any way including treating infertility, providing for upkeep, and general well-being

With my husband's family, I do not know whether because the relationship has reduced between myself and them, I do not know the kind of help they give, maybe they talk to my husband.

Perceived support

Participants evaluated or perceived the support offered to them as either positive or negative depending on the quality and satisfaction of the support given to them. Some of the women reported that they received physical support in the form of medication. The medicine received improved their reproductive health and prepared them for conception, hence very important to their health. Adepa, a 29-year-old nurse with no child has this to say;

> *The first time I conceived that was when I realised the importance of folic acid so I can say it is helpful. The support group has helped me a lot, even though I have not given birth.*

The women also explained that they perceived the support offered to them gives them hope of conception, improves their well-being, and lifts their mood. Ama, a 34-year-old nurse has one child with her ex-husband and no child with her current husband confirmed that;

> *The support given to me affects my well-being a lot in the sense that when am too down and they give me emotional and moral support, it lifts my mood.*

However, few participants perceived the support given to them as not satisfactory. Although they benefitted from the support, it is not adequate to treat infertility and minimize infertility-related stress.

> *Though the support I received from the people is good, I still worry, the thing that will help me to please and improve my health is when I get help to conceive and have another child.*

Access to support group

Most of the participants disclosed that infertility support groups are not available in their community, and they have never seen, they have never heard and they are not aware of such support groups.

> *I do not receive assistance from any support group and I have never heard of support groups that assist people with this problem.*

However, few participants admitted that they have met and been involved in an infertility support group on social media such as Facebook, WhatsApp, and TikTok.

> *I met support groups from WhatsApp, TikTok, and Facebook. We share information like the food and drugs that will help us to conceive, calculate the ovulation period, best time to meet.*

Discussion

The psychological and social challenges confronted by women experiencing infertility include societal pressures, emotional, marital issues, the financial burden of treatment, behavioural challenges, and a strong desire to have biological children.

Women with infertility face significant social pressure, negative reactions, and exclusion from their communities, leading to fears of being ostracized or labelled negatively, especially after the death of their husbands. They endure derogatory remarks, questioning, and exclusion from decision-making due to their lack of biological children.

The findings of this current study reinforce other studies on the societal pressures women with infertility face, including the risk of divorce and polygamous marriages, coupled with diminished recognition and ridicule [4,27–30].

Numerous studies, including the present one, have been conducted in societies that place a high value on biological children. In these cultures, married women who cannot have children often face poor treatment and lack recognition. The societal emphasis on biological offspring leads to the perception of women with infertility as abnormal, resulting in their maltreatment. However, few participants in this study, particularly those whose husbands' families included health professionals, faced less pressure and received more understanding.

The persistent social challenges these women endure can negatively impact their physical and psychological health, potentially leading to suicide and increased maternal mortality. Therefore, it is essential to empower women through education and employment opportunities to help them withstand these pressures and achieve independence. Additionally, educating the people around these women about infertility is crucial to minimize societal pressure and create a more supportive environment.

Emotionally, women in this study reported anxiety, sadness, and decreased libido [31]. These emotional struggles resulted in sleep disturbances, lower self-esteem, and impaired daily functioning. Numerous studies have shown that women dealing with infertility often experience anxiety, stress, and depression [14,15,28,32]. Fear of divorce, polygamy, and derogatory comments exacerbated these emotional challenges.

The findings suggest that nearly all women with infertility endure psychological trauma, leading to decreased attention and productivity. This reduction in productivity among women, who form a substantial part of the workforce, can significantly impact the country's overall productivity and economy. Furthermore, the study indicates that counselling services are not sufficiently available or accessible in workplaces and homes, and many women are unaware of existing counselling institutions for psychotherapy. To address this, it is crucial to decentralize counselling services, making them accessible to low-income women in rural areas, and to increase public awareness about these services.

The above finding corroborates with other studies in Ghana where the researchers revealed how women with fertility problems expressed numerous desires for psychosocial management, and yet was not readily available to them [33,34]. This lack of psychosocial support system significantly affects these women emotionally, socially, and physically further leading to a reduced quality of life.

Constant reminders of infertility through flaunting children and negative comments exacerbated the distress. This study aligns with others that found that these women are reminded of their infertility through exposure to children, insults, confrontations, menstruation, child-related events, pregnant women, and hearing children call for their parents [4,35–37]. These reminders result in feelings of helplessness, sadness, jealousy, loss of appetite, and sleepless nights.

These experiences can have detrimental effects on their health. To better manage infertility triggers, women should engage in diversionary activities, find employment, consider adopting children, and avoid specific reminders. Furthermore, professional counselling is essential to support them through these challenges and assist in coping with unavoidable reminders.

Some of these women were accused of using family planning methods, having abortions, being cursed, or practicing witchcraft, which allegedly made them unable to conceive, leading to physical assaults [2,38–42]. All these reminded these women of their inability to conceive. However, this contradicts an earlier study by [43], which posits that infertility is caused by witchcraft, with others bewitching couples to make them infertile.

In contrast, a study by [44] claims that infertility is not due to witchcraft but is instead caused by hormonal disorders and other factors that can affect both men and women.

The current study is conducted in the Northern part of Ghana where most of the people are not educated up to the tertiary level. People lack adequate knowledge of infertility. This highlights the need for cultural education to dispel harmful stereotypes about infertility. These accusations stem from individuals with limited knowledge of infertility. Health professionals need to address these misconceptions by educating the public about infertility through social media, community gatherings, and house-to-house meetings. This will help reduce ignorance and alleviate the pressure on affected women. This study identified marital

factors affecting women with infertility, highlighting the problems they face in their marital homes due to their inability to conceive. [21] noted that having children benefits parents, especially women, through societal recognition, family inheritance, and support from their husbands and families. The current study found that husbands restricted these women's freedoms, such as drinking soft drinks and visiting friends, and expressed anger and frustration over the perceived waste of money due to infertility.

These findings align with [45], who reported that women with infertility often face embarrassment, humiliation, and social restrictions. The negative attitudes of husbands led to women's isolation from family and community [46] and denial of financial support, causing them to struggle with basic needs and resulting in starvation [29]. In contrast, [47,48] found that in China and other countries, husbands often accompany their wives to clinics, share household responsibilities, and care for them at home.

The variation in findings may stem from sociocultural differences, with some societies placing higher value on women regardless of children, while others see children as essential for a woman's recognition. In the current study, children are highly valued, and women are primarily recognized based on their ability to have children.

Some women blame their husbands for infertility, believing they have no issues with conception themselves, while others, despite evidence that men may be the cause, still face accusations of infertility [13,42,49,50]. Women often internalize the blame for infertility, even when the husband's issues are identified [51].

Discrepancies in these experiences may stem from differences in educational levels and sociocultural contexts. The current study's participants, who are mostly educated at the tertiary or secondary level and include many health professionals, are more aware of their rights and assertive in seeking answers about infertility. Additionally, their urban residence and exposure to Western culture may influence their willingness to challenge traditional rural practices and advocate for themselves.

The study found that women with infertility had a strong desire for biological children, which intensified their distress when seeing children, pregnant mothers, and neglected children. This desire aligns with other studies showing that women feel jealous and continue treatments despite not conceiving [52]. They also seek children for companionship [53], to achieve motherhood, fulfil sociocultural norms, meet divine obligations [39,54], and to reduce family pressure [55,56].

Contrarily, some studies indicate that some women with infertility are "child-free" by choice or lose the desire to conceive after counselling [57,58]. These differences may stem from varying sociocultural norms. In this study, societal pressure and the high value placed on children drive women to strongly desire biological children. This and other pressures from people in the community forced women to desire children.

The study highlighted that the financial burden of infertility treatment has a significant impact on women's socioeconomic status. Many women experience financial difficulties due to the high costs of treatment, which can lead them to reallocate funds from other areas, such as caring for their existing children. Some participants reported selling their agricultural products to fund infertility treatments without achieving pregnancy. This finding is consistent with other studies indicating that women with infertility often face severe financial strain [41,59,60]. [61] also, noted that some women sold significant assets in their pursuit of pregnancy but still did not conceive.

Most of these studies including the current study were conducted in Africa; developing countries where poverty is predominantly high. This reflects the financial crises of these women and their families and subsequently affects the support offered to them. The financial crisis among these women typically stems from a lack of support from their partners and others and the high cost of treatments, which often do not result in successful conception

In the study, social support includes different forms of assistance financial, emotional, informational, and companionship given to women to help them manage and reduce stress related to infertility. The analysis of social support will focus on the support received, the perceived adequacy of support, and the availability of support groups. Some women reported that both their husbands and their husbands' families provided minimal or no financial support for infertility treatment and general well-being.

The study's findings align with those of [60] and [28], which noted that women with infertility in the Upper East region often lack spousal and family support, leading to severe financial difficulties and challenges in managing their condition. [29] Highlighted that these women struggled with basic needs due to insufficient support from their husbands. [46] and [62] also found that infertility led to loneliness, sadness, and depression due to negative treatment from spouses and a lack of companionship.

These similarities may stem from the studies being conducted in northern Ghana and Iran, developing countries where education and socioeconomic status are generally lower. In contrast, the current study found that educated and health-conscious relatives provided significant financial, emotional, informational, and companionship support, with less pressure to conceive. This suggests a need for increased public awareness about the stress of infertility and its broader societal impacts.

Perceived support in the study was viewed positively by most women with infertility. They felt that the support improved their health, alleviated financial and starvation issues, and assisted with infertility treatment. Additionally, it enhanced their mood, reduced worries, prevented divorce, and supported medical care.

These findings align with other research, such as [63], which showed that emotional support helps couples manage marital conflicts, enhance quality of life, and reduce stress. [60] noted that women with infertility see social support as crucial for maintaining a positive self-image and buffering against life's challenges. Family support helps reduce stress, anxiety, and depression [64–66] and fosters feelings of acceptance and love [67]. [68] found that support boosts self-confidence and optimism, while [69] emphasized that emotional support provides hope and reduces feelings of isolation and depression. The similarities suggest that most women appreciate and find social support beneficial, although some dissatisfaction may reflect societal attitudes or low awareness about infertility.

Most women in the study reported not having heard of or met with infertility support groups but expressed interest in joining if such groups were available. This finding contrasts with other research, such as [70], which found that women with endometriosis formed support networks to share experiences and build trust and self-esteem, and [71], which reported that women join voluntary childless forums to find a sense of belonging.

From the previous studies, most of the women with infertility access support groups through social media, which requires electronic devices, internet access, and knowledge of the use of these devices. The discrepancies may be due to lower literacy rates and limited access to online resources in rural areas, which hinder the use of support groups.

Additionally, the scarcity of research on infertility in the current setting might contribute to the lack of established support systems. There is a need for NGOs and government agencies to assist these women to be oriented in the use of these devices and possibly procure and establish the devices at certain centres for easy access by these women.

This current study provided more insights into the cultural and social factors influencing the experiences of women with infertility and the differences in psychosocial support needs in Northern Ghana, a region with limited research in this area. This study would further inform the development of culturally adapted interventions for women with infertility in Northern Ghana, addressing a significant gap in existing healthcare services. Lastly, the findings would promote and create awareness on the need for policy formation and the integration of clinical psychologists, and professional counselors in infertility clinics to

relieve them from infertility-related stress.

Limitation of the study

This study had some limitations. Firstly, a local dialect, was used for some of the interviews and were translated and transcribed into English. In as much as the researchers used words nearer in meaning to those in the local dialect, and the fact that the transcriptions were read before participants to ensure the same meaning of the words as spoken, during the translation and transcription, some of the statements may not reflect the exact meaning of participants verbatim. The second limitation of this study was that the women experiencing "obvious emotional crises" that were excluded in the study may provide unique perspectives or insights that could be valuable to the research, hence excluding them might have mean missing important information. Lastly, due to the small sample size, findings may not be transferred to other populations or contexts, as the research is often conducted in a specific setting or within a specific group.

Conclusion

Infertility poses a significant health challenge that negatively impacts women in society, causing a range of psychosocial issues such as societal pressure, emotional distress, behavioral and marital difficulties, and financial burdens due to the expensive nature of treatments. The women in this study reported receiving minimal support emotionally, financially, and socially from their spouses and families. While this support was insufficient, it still had a noticeable effect on their well-being. The lack of support groups was identified as a major shortfall. Thus, it is crucial for the Ghana Health Service, in partnership with clinical care teams, to establish social support systems in communities to assist these women in better managing infertility and improving their overall health. Furthermore, educating families about infertility and the importance of providing support can enhance these women's well-being and potentially help them in their pursuit of motherhood.

CRediT authorship contribution statement

Ignatius Anabila Adda: Writing – original draft, Methodology, Investigation, Conceptualization. **Florence Naab:** Writing – review & editing, Supervision, Methodology. **Deborah Armah:** Writing – review & editing, Supervision, Methodology, Investigation. **Josephine Kyei:** Writing – review & editing, Supervision, Methodology, Investigation. **Abdulai Yahaya:** Methodology, Investigation, Data curation. **Theodore Wuni Bobtoyah:** Methodology, Investigation, Data curation.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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