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UNIVERSITY OF GHANA
COLLEGE OF HEALTH SCIENCES
SCHOOL OF NURSING AND MIDWIFERY

TREATMENT SEEKING BEHAVIOUR AMONG WOMEN WITH INFERTILITY IN GREATER ACCRA REGION

BY

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THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF MPHIL NURSING DEGREE

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DECLARATION

I, Nana Semuah Bressey, do honestly affirm that this thesis titled: "Treatment Seeking Behaviour among Women with Infertility in the Greater Accra Region" is my private work with the excellent assistance of my supervisors and that this thesis has neither been submitted in whole nor in part for a degree or an award in this university or any other institution.

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ABSTRACT

Infertility is a significant public health issue with grave social consequences that seems to affect women more than men. Globally, 15% of couples in their reproductive stage of development are affected with infertility at an estimated prevalence of 48.5 to 70 million couples worldwide. The vulnerable impression of infertility makes women with infertility wander in circles not knowing exactly what to do to avert childlessness; worsening their plight, wasting time and increasing treatment cost. This study therefore explored the treatment seeking behaviour among women with infertility in Greater Accra Region, using the Theory of Reasoned Action as an organising framework. An exploratory descriptive design was employed. Semi-structured interviews were conducted on 14 women with infertility through purposive and snowball sampling technique. Data were drawn from women with infertility in the community who visited churches, hospitals, herbal clinics and prayer camps. Thematic content analysis was employed for data analysis after audio recorded interviews transcribed verbatim. Out of which seven major themes and twenty-two subthemes were derived. The findings revealed that women with infertility consult herbalists, seek hospital treatment, and engage in faith-based spiritual activities in addition to modification of their lifestyle in order to have children. However attention was drawn to the fact that financial limitation, religion, menopause, inadequate knowledge about infertility treatment, among others are possible barriers to seeking treatment. These findings have implications for Nursing practice, Nursing research, community sensitization and counselling. Recommendations are made to Ghana Health Service and fertility clinics to train frontline healthcare providers in the management of infertility in Ghana.

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DEDICATION

I bless the Almighty God for giving me wisdom for this research. With a heart of gratitude, I dedicate this great work to my adorable twins: Selli Afua Bressey and Aseda Kofi Bressey. You have motivated me to do this.

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TABLE OF CONTENTS

CONTENT PAGE

DECLARATION i
ABSTRACT ii
DEDICATION iii
ACKNOWLEDGEMENT iv
TABLE OF CONTENTS v
LIST OF FIGURES ix
LIST OF TABLES x
LIST OF ABBREVIATIONS xi
CHAPTER ONE 1
INTRODUCTION 1
1.0 Background 1
1.1 Problem Statement 8
1.2 Purpose 11
1.3 Specific objectives 11
1.4 Research Question 11
1.5 Significance of the Study 12
1.6 Operational definition of terms 12
CHAPTER TWO 13
LITERATURE REVIEW 13
2.0 Introduction 13
2.1 Conceptual framework 13
2.1.1 The theory of reasoned action 14
2.2 Literature review 17
2.2.1 Beliefs about treatment seeking 17
2.2.2 Attitude to seek treatment 21
2.2.3 Motivation to seek with treatment 23
2.2.4 Subjective norms about treatment seeking behaviour (cultural beliefs and perceptions) 25
2.2.5 Intention to seek treatment 29
2.2.6 Treatment seeking behaviour 31
2.2.7 Summary of Literature Review 34

University of Ghana http://ugspace.ug.edu.gh

CHAPTER THREE......36
METHODOLOGY......36
3.0 Introduction......36
3.1 study design......36
3.2 Research Setting......36
3.3 Target Population......38
3.4 Inclusion Criteria.......38
3.5 Exclusion criteria......38
3.6 Sample size and sampling technique......38
3.7 Tool for data collection......39
3.8 Piloting/ Pre-testing of tool for data collection......39
3.9 Data collection procedure......40
3.10 Data management and analysis......42
3.11 Methodological rigor......43
3.12 Ethical Considerations......45
CHAPTER FOUR......47
FINDINGS......47
4.0 Introduction......47
4.1 Demographic Characteristics of the Participants......47
4.2 Organization of Themes......47
4.3 Belief about seeking treatment......49
4.3.1 Conviction about seeking treatment......49
4.3.2 Trust in Hospital remedy......50
4.3.3 Confidence in seeking herbal remedy......51
4.3.4 Faith based spiritual treatment......51
4.3.5 Reliance in combined treatment......52
4.4 Motivating factors about seeking infertility treatment......53
4.4.1 Intrinsic......53
4.4.2 Extrinsic......54
4.5 Attitude about seeking infertility treatment......55
4.5.1 Positive attitude......56
4.5.2 Negative attitudes about seeking infertility treatment......57

University of Ghana http://ugspace.ug.edu.gh

4.6 Cultural beliefs and perceptions about seeking infertility treatment (subjective norms) 58
4.6.1 Influence from significant others about seeking treatment 58
4.6.2 Traditional views about treatment 59
4.6.3 Societal pressure on seeking treatment 60
4.6.4 Opinions about seeking infertility treatment 60
4.7 Intentions about seeking infertility treatment 62
4.7.1 Aim of infertility treatment 62
4.7.2 Plans to seek treatment 63
4.7.3 Target for treatment 63
4.8 Treatment seeking behaviour 64
4.8.1 Pursuing herbal treatment 65
4.8.2 Seeking hospital treatment 65
4.8.3 Engaging in faith-based spiritual treatment 66
4.8.4 Lifestyle change 67
4.9 Barriers to seeking infertility treatment 68
4.9.1 Possible obstacle to seeking infertility treatment 68
4.9.2 Inadequate knowledge about infertility treatment 69
4.10 Summary of Findings 70
CHAPTER FIVE 72
DISCUSSION OF FINDINGS 72
5.0 Introduction 72
5.1 Demographic Characteristics 72
5.2 Beliefs about seeking infertility treatment 73
5.3 Attitude about seeking infertility treatment 75
5.4 Motivating factors for seeking infertility treatment 77
5.5 Cultural beliefs and perception about seeking infertility treatment 80
5.6 Intentions about seeking infertility treatment 82
5.7 Treatment seeking behaviour 83
5.8 Barriers to seeking infertility treatment 86
5.9 Summary of discussion 88

University of Ghana http://ugspace.ug.edu.gh

CHAPTER SIX 91
SUMMARY, IMPLICATIONS, LIMITATIONS, CONCLUSION AND RECOMMENDATIONS 91
6.0 Introduction 91
6.1 Summary of the study 91
6.2 Implications of the findings 93
6.2.1 For Nursing Practice 93
6.2.2 For Nursing Research 94
6.2.3 For Community Sensitization 94
6.2.4 For Counselling 94
6.2.5 For Policy formulation 95
6.3 Limitations of the study 95
6.4 Conclusion 96
6.5 Recommendations 97
6.5.1 For Ministry of Health (MOH) 97
6.5.2 For Ghana Health Service (GHS) 98
6.5.3 For Fertility clinics 99
REFERENCES 100
APPENDICES 118
APPENDIX A: ETHICAL CLEARANCE 118
APPENDIX B: DATA COLLECTION INSTRUMENT 119
APPENDIX C: CONSENT FORM 123
APPENDIX D: PROFILE OF PARTICIPANTS 127
APPENDIX E: GHANA HEALTH SERVICE ETHICAL CLEARANCE 128
APPENDIX F: INTRODUCTORY LETTER 129

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LIST OF FIGURES

Figure 2.1 Theory of reasoned action 16

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LIST OF TABLES

Table 4.1: Organisation of themes and subthemes..48

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LIST OF ABBREVIATIONS

AMH	Anti-Mullerian Hormone
ART	Assisted Reproductive Technologies
CAM	Complementary and Alternative Medicine
GHS	Ghana Health Service
GSS	Ghana Statistical Service
HIV	Human Immunodeficiency virus
HSG	Hyrosalpinogram
ICSI	Intra Cytoplasmic Sperm Injection
IUI	Intrauterine insemination
IVF	In Vitro Fertilization
MOH	Ministry of Health
NMIMR-IRB	Noguchi Memorial Institute for Medical Research-Institutional Review Board
OPD	Out-Patients Department
SDGs	Sustainable Development Goals
STI	Sexually Transmitted Infection
TCAM	Traditional Complementary and Alternative Medicine
USA	United States of America
USG	Ultrasonography
WHO	World Health Organisation

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CHAPTER ONE

INTRODUCTION

1.0 Background

Infertility is a significant public health matter with grave social consequences (Sarkar et al., 2016). Globally, 15% of couples in their reproductive age are affected by childlessness at a projected prevalence of 48.5 to 70 million couples (Gerrits et al., 2017, Okhovati et al., 2015, and Solati et al., 2016). In Africa, the prevalence of infertility ranges between 30-40% of the global infertility rate with much negative social impact such as stigma, abuse, and economic challenges on women (Ombelet, 2014). Though the impact of infertility is great in Africa, its rate among member countries varies. The rates range from 9% in Gambia to around 10% in Togo and Rwanda and to nearly 32% in Nigeria (WHO, 2004). Infertility is a disorder of the procreative structure, characterised by the inability to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse (WHO-ICMART, 2018). Infertility causes women serious emotional pain and throws uncertainty on their ability to fulfil their purpose in society (Sternke & Abrahamson, 2014).

Parenthood is an anticipated goal of most couples after marriage especially in Africa. Nonetheless, not all couples achieve this dream due to infertility especially among women (Boivin, Bunting, Collins, & Nygren, 2007). Due to the marital and social challenges associated with infertility, women especially diligently seek health care for infertility (Dyer, Abrahams, Hoffman, & Spuy, 2002). In the low and middle income countries (LMICs) in Africa, children are valued and therefore, couples with infertility suffer divorce, stigma, isolation, and marital distress. Giving birth to children therefore is not just for continuity of family lineage but also for economic security, where parents in resource

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constraint societies depend greatly on their children for support during old age. Couples therefore after marriage, are always under pressure to produce children (Kaadaaga et al., 2014). The WHO (2010), ranked infertility 5th on the list of moderate-to-severe disabilities within the global population under the age of 60 years, after conducting a world disability study.

In Ghana, infertility rate ranges from 2% to 14% (Osei, 2016) but fertility had declined over the years from 6.9 children per woman in the 1960s and 1970s to 3.3 in 2010 (Ghana Statistical Service, 2014). Also, women who are childless aged 35 and above were 9.1% of the female population of reproductive age in Ghana (Ghana Statistical Service, 2014). An estimated 51% of couples with primary infertility and 22% with secondary infertility seek treatment (Donkor & Sandall, 2009).

The central identity and social value of women is motherhood (Inhorn & Van Balen 2002). Some women take the blame of the childlessness even when the cause is from the man (Omu & Omu, 2010). Hence, it is no surprise to see women spear-heading the solution for the couple's infertility. In Ghana, it is uncommon to find individuals who by their own free will have decided not to have children (Donkor, 2007). This due to the attitude of the Ghanaian society toward childbearing (Buor, 1996; Nukunya, 2003).

The behaviour of seeking treatments can take diverse forms and is not exclusively restricted to medical services. Also patients who wait too long before initiating infertility treatment can impede treatment success through advanced vital age and time.

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Some studies have established that the attitude of women who are childless are more positive (Gubernskaya, 2010; Koropeckyj-Cox & Pendell, 2007a, 2007b; Liefbroer & Merz, 2010; Sobotka & Testa 2008) to treatment, which has made it possible for most women with infertility to have their own children. There is mostly an inner yearning of most childless women to seek treatment. Anecdotal evidence from the Bible illuminates the idea that an empty womb is never satisfied, this drives women to engage in various treatment seeking behaviours to have children at all cost.

Different treatments available for infertility include lifestyle changes, invasive laparoscopy, ovulation stimulation alongside intra uterine insemination and In vitro fertilization (IVF) with or without Intra cytoplasmic sperm injection (ICSI) (Sonaliya, 2016). Other treatments options used include allopathic treatments, spiritual healers, visits to holy places and quacks doctors (Dyer, 2018). However, IVF has become a household name synonymous with infertility treatment. Some women with infertility will opt for the IVF disregarding the other treatment option after thorough examination.

Some women have the intention to avert infertility by preserving their eggs for later use. The negative impact of postponing parenthood is potentially the cause of infertility (Belasch, 2010). Also, an increment in the incidence of female subfertility is due to the reason that, the most fertile years of women’s life in starting a family is used in setting the groundwork for a successful professional career for economic emancipation (Meissner et al., 2016). A study in Rwanda reported that 11% out of 277 women visited a traditional healer (Dhont, Luchters, Ombelet et al., 2010) all in seeking treatment for difficulty to conceive. While in Nigerian 69% of couples with infertility were reported to seek care from a traditional complementary treatment expert (Ola, Aladekomo, & Oludare 2008).

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With respect to religion, religious Islamic beliefs concerning procreation could have a substantial impact on Assisted Reproduction Technologies (ART) user (Van Rooij, Balen, & Hermanns, 2004). Muslim women with infertility are expected to only receive sperm from their own husband, anything else is considered adultery (Harriet, 2011, Sallam, & Sallam,2016). In Iran some women with infertility rant spiritual prayers during intercourse believing that the behaviour will improve fertility. Others also believed that when they increase the number of times they engage in sexual intercourse in a day, the act increases their chances of getting pregnant. Nevertheless, some women with infertility believe that eating specific food could get them pregnant by improving the IVF success rate (Bokaie et al., 2016).

The cultural background of women with infertility influences the belief and their perception of treatment. According to Al-Jaroudi (2010), 60% of participants in a survey conducted in Saudi Arabia believed that childlessness was caused by evil eye or envy. The beliefs around the use of ARTs in Islam may influence the attitudes towards ART and restrict care options (Van Rooij, Balen & Hermanns, 2004). Undesirable beliefs around the safety, accessibility and cost of fertility treatment have been reported (Klonoff-Cohen & Natarajan, 2004; Benyamini et al., 2005) as well as the low probability of searching for care (Boivin, Bunting, Collins & Nygren, 2007). Naab et al., (2013) reported that beliefs about infertility affect the psychosocial health of women with infertility, impacting on the levels of depression, anxiety, stress, stigma and social isolation.

According to Bunting, Tsbulsky and Boivin (2013), treatment success rate may affect the attitude towards the start of seeking fertility care. In contrast, behaviour for seeking treatment can be affected by subjective norms and cultural perception (Sunby et al., 1998;

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Unisa, 1999; Ali et al., 2001; Dyer, 2008). More so, women in sub-Saharan Africa are demotivated to choose tubal surgery as an option to avert infertility due to its cost (Naab, 2013); though it has a success rate of 50 % (Sharma et al., 2009).

The belief of improving productivity made some women with infertility seek herbal medicine for their husbands to increase their sperm count (Bokaie et al., 2016). On the other hand, desperate and distress women with infertility use herbs as a traditional remedy for themselves (Inhorn, 1994).

According to Killeen (1981) in his incentive theory, individuals are motivated to engage in certain behaviours or even stop a behaviour due to the importance they place on the reward. In the United States of America (USA), private insurance cover for some specific treatment of infertility has motivated its usage (Bitler & Schmidt, 2012). The quest for alternative treatment for infertility is on the rise due to the unsatisfactory results of established treatments (Jiang, Li, & Zeng, 2017). Currently, Chinese medicine is in the lime light for the treatment and prevention of reproductive diseases, which infertility is part of because its counterparts like the IVF is expensive and emotionally laden (Ju-feng, Inagaki, & Jian-feng, 2017). Women with infertility patronise these herbs to treat endometrine receptiveness and fallopian tubal blockage among others (Jiang et al., 2017).

The cultural beliefs and perception allow women with infertility to adopt the treatment that suit their subjective norms. In the U. S. A and other more modernized states, the rise of infertility treatments also reflects a cultural emphasis on control over procreation (Koropeckyj-cox, 2018). In Sub-Saharan Africa, it appears that patient's cultural and religious beliefs and perceptions are the reason for the popularity of herbal medicine. They

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perceive it to be economical, readily available and it sits well with their culture (Bamidele, Adebimpe, & Oladele, 2009; Hughes, Aboyade, Beauclair, Mbamalu, & Puoane, 2015, Gari, Yarlagadda, & Wolde-Mariam, 2015). According to Sonaliya (2016), cultural perceptions restrict some women with infertility from engaging in religious and social activities. The perception of the cause of infertility evokes the needed treatment preference. Due to cultural orientation, majority of the couples with infertility in Iran would not inform others about their plan of seeking treatment. Especially pertaining to women, when there is the need for ARTs, it increases their anxiety thus they are not eager to share their feelings much more seek for social support. These anxieties may well lead to obsession (Yazdani et al., 2016) due to lack of information about the ARTs.

In Africa, studies has revealed that women seeking infertility treatments consult both traditional and modern treatments consecutively or concomitantly (Dyer, 2018; Leonard, 2002; Richards, 2002; Stenkelenburg, Jager, & Kolk, 2005). Also, treatment seeking related to infertility is influenced by social challenges such as neglect, social isolation, stigma and abuse (Dyer, 2018).

In Ghana, it is not bizarre to see a woman attesting in church of how God changed her childless state by prayers (Osei, 2016), fasting and receiving "Akwan kyere" (meaning; guidance). Osei (2016) also added that women form the bulk of members at the various prayer camps where majority of these women are childless.

As part of treatment of infertility, Bokaie et al (2016) revealed that most women keep their legs raised up after sexual intercourse to increase their chances of getting pregnant, but this attitude may not have any scientific basis. In another study, Crawford et al (2017),

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revealed that women with infertility who had a positive result for depression were not likely to begin treatment for infertility.

In Ghana, women with infertility sought treatment through word of mouth and testimonies of success stories in certain health facilities especially ones in the Greater Accra Region. This encourages others to travel far and near, including people from other countries (Gerrits, 2018). As stated above, the choice of clinic the individual seeks help from depends so much on testimonies and not necessarily the percentages of the success rate.

Diet and nutrition as well as other lifestyle habits such as smoking significantly reduces the chances of success from ARTs (Gormack et al., 2015). Women seeking treatment for infertility should adopt to healthy lifestyle as doing otherwise may add on to reduced chances of conception or affect the health of offsprings (Joelsson et al., 2016). In Ghana, women with infertility, engage in the habit of moving from one fertility clinic to the other as a result of other women who were satisfied with services rendered disregarding proximity (Gerrits, 2018).

Women with infertility also engage in yoga to improve their physiological and psychological states thereby helps them overcome challenges of infertility and increase the ART success rate (Darbandi et al., 2017). Sarkar and Gupta (2016), reported that in India about half of 80% of women with infertility received allopathic treatment. Mulgaonkar (2001) added that it is the first treatment couples sought for, followed by religious practices, either concurrently or afterward. Contrary to what has been stated earlier, various studies mentioned that women with infertility seek initial help from

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traditional healers and subsequently take advantage of medical services (June, Dimka, & Dein, 2018 and Tabong & Adongo, 2013).

According to Schaefer (2014), individuals have inborn and unique ways of reacting to their environment. The view of the reaction depends on the individual's age and how she is challenged by health issues. She added further that the distressfulness in reacting to a situation are based on specific inherent structures and environmental stimuli of social, cultural, spiritual, and experiential factors. Dembińska (2014) agrees to the fact that there are many and different ways people react to infertility. Assisted Reproductive Technologies (ARTs) have been widely recommended as successful and common treatments in most countries (Okhovati et al 2015) to an extent that if not properly regulated by policy, women with infertility might be exploited. Notwithstanding, there is a huge knowledge deficit about infertility and Assisted Reproductive Technologies (ARTs) and people including religious bodies may not always be in favour of the usage of these technologies (Gerrits et al., 2017). Ghana is a country of people with multi-tribal, social, cultural, economic and religious backgrounds. Despite the high burden of infertility globally coupled with the diverse social, cultural, religious and economic nature of Ghanaians, there is paucity of data on the treatment seeking behaviour of women with infertility in Ghana. The theory of reasoned action was used as an organising framework to explore the treatment seeking behaviour of women with infertility in the Greater Accra Region of Ghana.

1.1 Problem Statement

Despite the high population rate in Ghana which is estimated at 29,614,337 of which women form 49.1% (Ghana Statistical Service, 2014), infertility is penetrating deeply

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among women of reproductive age at 15% (Oti-Boadi & Oppong Asante, 2017). This is a worrying situation which must not be taken lightly. Women particularly suffer the negative social consequences such as abuse, stigma and economic deprivation (Dyer, Abrahams, Hoffman, & Spuy, 2002). Globally the degree of infertility affect women more than men (Bhardwaj, 2002; Phipps, 1993; Chimbatata, Malimba, & Chimbatata, 2016) in a union. Women with infertility become so worried and depressed to the extent of wanting to take their own life (Loke et al., 2012; Nieuwenhuis et al., 2009).

Move so, the treatment seeking behaviour towards allopathic or modern treatment makes women with infertility more vulnerable (Sarkar & Gupta, 2016). In Africa, family voice affect treatment seeking behaviour instead of the individual (James et al., 2018), endangering the individual's life by popular opinions. Women with infertility sell most of their valuable assets to enable them afford the cost of infertility treatment (Gerrits, 2018), rendering most of them poor. Treatment seeking increases as the wealth index increases (Singh & Shukla, 2015a) but might be too late to achieve a positive result as fertility decreases with age. Social stigma and ostracism (Fledderjohann, 2012; Tabong & Adongo, 2013) may even lead women with infertility to steal babies (though this information begs for documented evidence). Women with infertility may engage in extramarital relationship if the spouse is suspected to be the cause of the couple infertility, hence leading to the woman contracting sexually transmitted infection (STI) even Human Immunodeficiency Virus (HIV) (Ombelet et al., 2008; Morhason-Bello, 2014; Looker et al., 2015; Osei, 2016, Dhont et al., 2010). Nevertheless, 85% of infertility among women seeking infertility care are as a result of untreated genital infections (World Health Organization, 2015) which may lead to blockage of the fallopian tubes. It is not wrong to say that women with infertility are susceptible to mental illness (mentally challenged) as 53% of Ghanaian

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women with infertility seeking treatment are depressed (Naab et al., 2013). Women with infertility are mostly vulnerable and easy prey for traditional and spiritual healers, which worsens their plight and waste a lot of time as well as increasing the cost of treatments (Osei 2016). So far, not a great deal has been done currently in Ghana on infertility and treatment seeking behaviour, specifically in the Greater Accra Region.

Data on infertility are not easy to be estimated due to the various ways of evaluating the cause (Dyer, 2009; Sonaliya, 2016). In Ghana there is no data on the incidence and prevalence of infertility. The surge in the rate of infertility is alarming (Aleixandre-Benavent et al., 2015; Talmor, & Dunphy, 2015), hence professionalism should meet this specialised area of treatment so that women with infertility in their bid to seek care will not fall on quacks. Treatment legalities and regulations to protect most activities in most fertility clinics are not available. For instance in Poland (Dembińska, 2014) and Ghana (Hörbst & Gerrits 2016) no legal regulations regarding ART exist. Sarkar and Gupta (2016) postulated that treatment of infertility in public health care system is largely ignored and Ghana is not exempted from this assertion. Furthermore, Singh and Shukla (2015) added that a large proportion of rural couples who are totally dependent on government health facilities for treatment are not provided with adequate services. As it stands there are no official data records of women seeking treatment in most public hospitals in Ghana. An understanding of the treatment seeking behaviour among women with infertility is crucial in order to improve the medical care of childlessness and sustain strategies to improve society. Therefore, this study sought to explore the treatment seeking behaviour of women with infertility in the Greater Accra Region using the theory of reasoned action by Fishbein and Ajzen (1975) as an organizing framework.

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1.2 Purpose

The purpose of the study was to explore the treatment seeking behaviour of women with infertility in the Greater Accra Region.

1.3 Specific objectives

The specific objectives were to:

1. Assess the beliefs of women with infertility to seek treatment (personal beliefs).
2. Identify factors motivating women with infertility to seek treatment.
3. Describe the attitude of women with infertility about seeking treatment.
4. Assess the cultural beliefs and perceptions of women with infertility about seeking treatment (subjective norms).
5. Describe the intentions of women with infertility about treatment.
6. Describe the treatment seeking behaviour of women with infertility.

1.4 Research Question

1. What are the beliefs of women with infertility about seeking treatment?
2. What motivates women with infertility to seek treatment?
3. How do the attitudes of women with infertility influence seeking treatment?
4. To what extent do cultural beliefs and perceptions affect the treatment seeking behaviour of women with infertility?
5. What are the intentions of women with infertility to seek treatment?
6. What are the treatment seeking behaviours of women with infertility?

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1.5 Significance of the Study

The findings from this study gives the awareness of what women with infertility experience with seeking treatment and enhances the education for them to seek care geared towards their individual needs by a deeper understanding of the cultural connotation of infertility. It also serves as an important resource material for counselling. It would further add to the existing literature on infertility whilst enriching data. This study may also help women with infertility make informed decisions about the care they might receive. In addition to the above, the findings of this study gives women with infertility and their treatment seeking behaviour the special attention it needs for policy makers, feminists and health activists in general.

1.6 Operational definition of terms

Women: female from 18 years and above.

Treatment: anything a person does for cure.

IVF: assisted to conceive through invasive procedure.

Infertility: Inability to go through pregnancy and get a child.

Behaviour: the actions and intentions geared towards seeking treatment.

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CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter describes the theory that provided the philosophical underpinnings of the study and a review of empirical literature.

2.1 Conceptual framework

During the conceptualization of the study, the theory of stigmatization by sociologist Erving Goffman in 1963 was considered. This theory speaks to the issue of infertility as the diagnosis is stigmatizing by itself. The label and shame of childlessness are almost invariably on the woman as if she is almost less of a woman for not being able to conceive. Fertility is respected in many countries and the state of infertility is a seal of shame. According to Fledderjohann (2012) and Tabong and Adongo (2013), women who are childless suffer discrimination, stigma and ostracism in many cultures. The theory of stigma is relevant to infertility but this study considered the theory of reasoned action more appropriate for this study.

Another framework that was considered was Self-efficacy by Psychologist Albert Bandura in 1982, which says that an individual's belief in his or her innate ability to achieve goals define his/her personal judgement of how well the individual can execute action required to deal with likely circumstances. Self-efficacy deals with attitude and subjective norms (De Vries & Kijkstra, 1998) influencing the intention to a behaviour. The construct of belief impacting attitude and the motivation (Fishbein and Ajzen,1975) was not captured

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in the self-efficacy concept from Bandura's social learning theory hence was not considered appropriate for the study of treatment seeking behaviour.

2.1.1 The theory of reasoned action

Theory of Reasoned Action by Fishbein (1967) was developed to better understand relationships between attitudes, intentions, and behaviours. The constructs were developed from the attitude measurement theory. This measurement theory conceptualised an attitude being the expectation or belief concerning attribute or action or evaluations of those attribute. In psychology the concept of the expectancy-value has been applied in learning, attitude and decision-making theories (Rotter, 1954; Rosenberg, 1956).

The theory of reasoned action has gone through a lot of criticism (Greve, 2003, Liska, 1984, Miniard & Cohen, 1981; Ogden, 2003; Smedslund, 2000). Some previous research did not find agreement between attitude and behaviour (Abelson, 1972, Wicker, 1969). However, a lot of researchers have engaged this theory to predict behavioural intentions to health behaviours, including HIV/STD prevention behaviours and condom use, breastfeeding, and smoking. Findings from these research have been used for behavioural change effectively (Fishbein, 1990; Fisher, Fisher, & Rye, 1995; Gastil, 2000; Hardeman and et al., 2005; Jemmott, Jemmott, & Fong, 1992; Jemmott & Jemmott, 2000).

According to Ajzen (1991); Ajzen and Driver (1991); Ajzen and Madden (1986), it was not clear that the component of the theory of reasoned action was enough to predict a behaviour in which intention to do so was diminished. Thus the creation of the theory of planned behaviour to introduce perceived behavioural control to account for factors the individual has no control over that perhaps affects intention and behaviour.

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From Figure 2.1, the theory of Reasoned Action affirms that behaviour is as a result of behavioural intention. The belief of an individual impacts on their attitude whilst motivation affects the subjective norms of the individual. Belief, attitude, motivation and subjective norms influence on the individual's intention to engage in a behaviour. Belief is the conviction that behavioural performance is associated with certain positive or negative feelings (attitude) and the value attached to a behavioural outcome or attribute. Motivation to conform is whether or not the person's plans and behaviour will be affected by what others consider. It matters a lot to the individual what parents, associates, and teachers think of their plans to engage in a behaviour.

Subjective norms are directly determined by normative belief that is if the individual's significant others sanctions the behaviour coupled with the individual's motivation to comply to his or her significant others. Subjective norms are the personal belief toward how and what people think and consider as important, perception of belief about whether most people around us approve or disapprove of the behaviour. These include family, friends, colleagues and partners.

Behavioural intention are the perceived possibility of acting out a behaviour and attitude is the overall affective evaluation of the behaviour. Behavioural intention is directly determined by attitude towards an action and cultural beliefs and perceptions (subjective norms).

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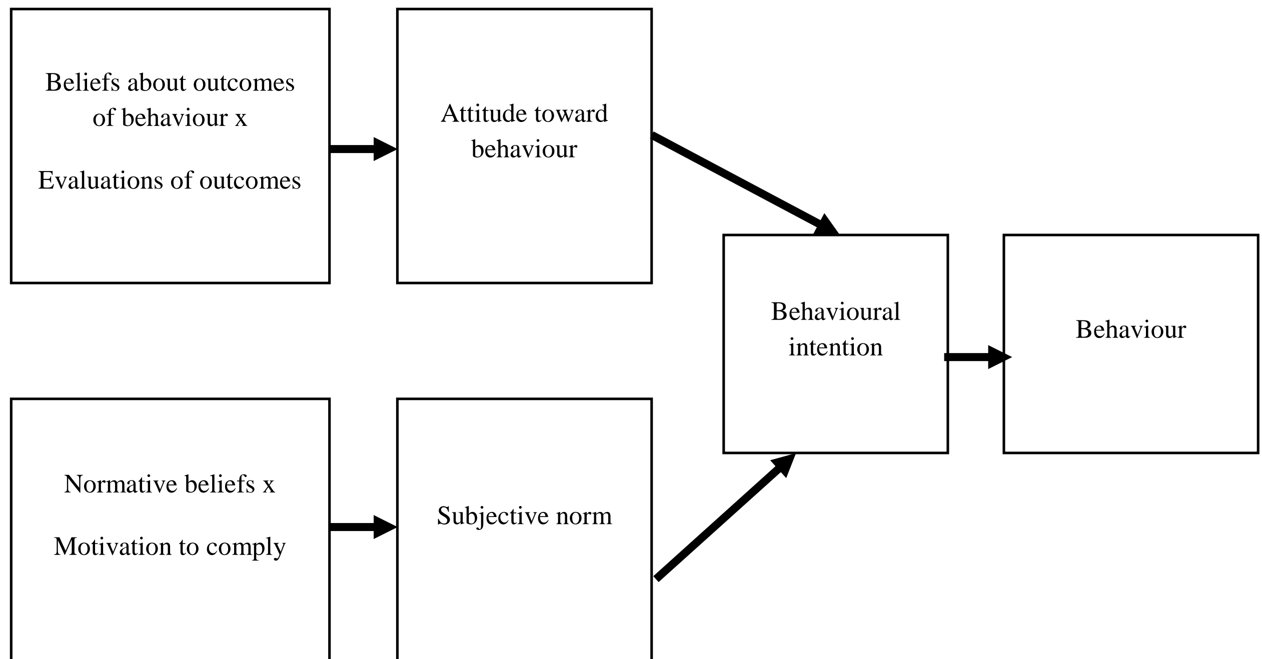

Figure 2.1: Theory of Reasoned Action

Source: Fishbein and Ajzen (1975)

The theory of Reasoned Action explains the treatment seeking behaviour among women with infertility.The ability to understand why people behave the way they do is crucial to researchers involved in health psychology. There are six constructs in the theory: belief, attitude, motivation, subjective norms, behavioural intention and actual behaviour (see Figure 2.1).The theory of reasoned action (Fishbein & Ajzen, 1975) posits that behavior is a function of behavioral intentions that are, in turn, a function of attitudes and subjective norms. Belief influences the individual attitude about a phenomenon whilst cultural belief and perception (Subjective norm) regulates what significant others think one should do and how much one is motivated to comply with those significant others (Trafimow, 2009). This theory is ranked among effective models in envisaging human behaviour and behavioural tendencies. Fishbein and Ajzen (1975) posited that the link between attitudes and behaviour might best be explained by an appeal to specific behavioural intentions. That is attitude in performing a behaviour would predict behavioural intentions to enact

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the behaviour, which in turn predict behaviour. Subjective norms about how to behave were also included as a predictor of behavioural intentions. Behavioral intentions is a predictor of behaviour (Albarracín, Johnson, & Fishbein, 2001).

Subjective norms is defined as the perceived social pressure to perform or not to perform the target behaviour. Subjective norms surrounding the behaviour are beliefs about whether others think women with infertility should seek treatment. Behavioural intention is defined as perceived likelihood of performing the target behaviour. The constructs of the theory are in line with the topic and objective for this study.

2.2 Literature review

The literature review sought to discover studies that have been carried out and documented on treatment seeking behaviour among women with infertility. A comprehensive search was conducted in PubMed, Google Scholar, Science Direct, Willey, Francis and Taylor as well as online libraries. The key words that were searched included: infertility, treatment seeking behaviour in Ghana, beliefs and infertility, and attitude to infertility treatment. The literature review accounted for the justification of the use of the theory of Reasoned Action in treatment seeking behaviour among women with infertility. Literature was reviewed according to the constructs of the model and objectives of the study.

2.2.1 Beliefs about treatment seeking

Beliefs are strong convictions people hold dear that influence their actions, reactions and attitude toward seeking infertility treatment. The beliefs in the conviction that an empty womb is never satisfied lead women with infertility to seek treatment. According to Nahar (2010), the belief of the cause of infertility provoke its corresponding treatment. This study

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was conducted both in the rural and urban settings of Bangladesh. The study revealed that most women with infertility believed the cause of their infertility was as a result of an evil spirit eating the foetuses in their womb so they consulted spiritualists and herbalists in their bid to conceive. These women in the study initiated the treatment sometimes alone or accompanied by their mothers and bore the cost of treatment. The gender of the spiritualist is as important to the receiver as the care is, as the study posited that women spiritualist were mostly available to them. In the urban setting the treatment of choice for the educated women with infertility was the ARTs due to their understanding of science and modern technology.

Also, Naab (2014) conducted a study from 15 participants from 8 African countries. The study revealed three components of beliefs which are the belief of the community about infertility, the belief of the family that influence women with couples' infertility and the reaction of the couple to infertility due to their belief of infertility. The findings of the study made known that, the belief of women with infertility to seek treatment from witch doctors presuppose that believe of infertility to be controlled by evil spirits, witchcraft activities and curses from voodoo which eat wombs. Women in such instances sought help from witch doctors who took advantage of their vulnerabilities. Treatment took the form of spiritual bathing and sleeping with the witchdoctors. Another study by Naab, Brown and Heidrich (2013) reported that 8.9% of women believed in traditional treatment for infertility.

Further, a quantitative study in Pakistan revealed that infertility is caused by evil spirits and black magic and therefore women will alternate medical treatment for infertility with faith healers and homeopathic practitioners. About 94% of the study participants believed

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that couples should seek treatment for infertility (Ali, Sophie, Imam, Khan, Ali & Shaikh 2011). Again, a study on fertility knowledge and beliefs about infertility treatment revealed that negative beliefs about the safety, accessibility and cost of medical treatment for infertility influenced the treatment seeking behaviour of women (Bunting, Tsibulsky & Boivin, 2013). More so, the belief of bewitching, poisoning and religious belief played a significant role in the treatment seeking behaviour of infertile couples (Dhont et al., 2010).

Religion plays a key role in the beliefs about illness and treatment. According to Dhont, Wijgert, Coene, Gasarabwe, and Temmerman, (2011); Hiadzi (2014) and Ray and Bhore (2017), women with infertility believe in spiritual treatment to have children. They belief in the will of God as the source of having children. In Iran, a correlational study with 204 childless women in their quest to seek treatment established that 76% believe in miracles, 72.5% belief in God's will and 71.1% express hope in the sovereignty of God to get children (Golmakani et al., 2019).

A study in Turkey on the use of complementary and alternative medicine for infertility revealed that women suffering infertility may consult religious healers and faith-based healers for help in order to enable them give birth (Edirne et al., 2010). Another quantitative study in the USA to examine the relationship between religion and fertility-related help seeking behaviour has been reported that, religious traditions such as encouragement for childbearing, emphasis on the importance of family provokes the non-acceptance of childlessness. This encourages the pursuit of various forms of infertility treatments available (Greil et al., 2010). Contrary to the above studies is a study in Bangladesh which revealed that women believed infertility is caused by themselves and

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blamed no one for their situation (Papreen et al., 2000). According to Adewunmi et al., (2012), 236 (representing 47.5%) of the study participants had beliefs about seeking infertility treatment and were of the conviction that treatment would yield desirable result and the majority (representing 79.9%) of the participants had faith in spiritual remedy for their childlessness.

The belief in seeking hospital treatment encouraged 3,239 couples to seek treatment for infertility in Nepal. In a retrospective study to find out about contributing factors of infertility Tamrakar (2019) revealed that these couples went through the various laboratory test and investigations to ascertain abnormalities impeding conception. It was further revealed that a total of 1578(48.8%) of these couples had female-factor infertility. In India, 80% of women with infertility had conviction to seek treatment, but quite a number of these women resorted to therapies other than advanced technology treatment due to lack of funds and inadequate information on infertility treatment (Sarkar & Gupta, 2016). In Nigeria, June, Dimka, and Dein, (2018) and Chethana (2016) asserted in their studies that people believed in herbs and herbalist as their first option in the treatment of infertility whilst others believe in its natural abilities to treatment neglected diseases including infertility (Gyasi et al., 2016). In the USA, 16% believed in herbal therapy as a complementary alternative management for infertility (Smith et al., 2010).

The belief in the combined treatment for infertility is to maximise the effectiveness of the various treatment sources. In Mali, due to the distress psychologically endured by childless women, a study reported that 71% of the study participants believe in combining infertility treatment and at times simultaneously (Hess, Ross, & Gilillandjr, 2018). In the health seeking behaviour of couples with infertility Tabong and Adongo (2013) reported that

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three outlets (that is; churches, traditional healers and hospitals) are used for the treatment of infertility in combination. A systematic review in sub-Saharan Africa revealed the confidence in the combine usage of traditional, complementary and alternative medicine (TCAM) with conventional medicine with a high prevalence mean of 54.9% (40%–63.7%) in the over-all populace (James, Wardle, Steel, & Adams, 2018).

2.2.2 Attitude to seek treatment

Using the health belief model, Ola (2012) found out in a study that the attitude toward fertility treatment choice resulted in 41.4% responding to faith healers, 22.4% orthodox treatment, 13.8% spiritualist, 7.9% traditional herbalist, 5.9% access traditional birth attendant and 2.6% referred to medicine seller for care. Also in the agreement to what Bista (2015) said, treatment seeking behaviour was influenced by their significant others and the perceived aetiology of infertility. Upon knowing they could not conceive, the first place participants chose was orthodox treatment. However, 53.8% completed orthodox treatment with faith healers. Though some studies have reported of inaccessibility of treatment centers, geographical location was not a hindrance to accessing treatment. Participants went the length and breadth to access fertility care.

The length of time an individual has endured infertility gave the likelihood of opting for IVF as a choice of treatment. According to Jin et al. (2013), more than 50% of 460 women who participated in their study had a positive attitude towards IVF after 5 years of enduring childlessness. They further explained that women with infertility in China who had had university or college education were six times more enthusiastic about IVF as a treatment option than those with primary or high school level of education. The well educated women with infertility could afford the treatment cost of IVF than the less educated

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women. Also, Jin et al. (2013) reported that 68.6% of women with infertility 's attitude to seek treatment was as a result of family members pressure and influence.

In Nigeria, 460 women with infertility were evaluated for their knowledge, perception as well as their treatment seeking behaviour (Dattijo, Andreadis, Aminu, Umar & Black, 2016). They illuminated that, apart from the various causes of infertility by the participants, 50.2% had the mindset that only women should seek treatment for infertility whilst 29% had the assumption that hospital should be the first place of call when an individual realises she cannot conceive. However, 91% were of the view that infertility should be given priority in the public hospitals with the necessary government support.

Attitude towards the use of contemporary and alternative medicine in the USA was positive among couple (women) with 29% of 428 who were undergoing endocrinology (Smith et al., 2010). Participants also believed in engaging in healthy lifestyles to improve the possibility of conceiving, though it was not statistically significant. The study revealed that 23% used Acupuncture and 18%, herbal remedy for the treatment of infertility. Furthermore, it was identified by Koropeckyj-cox (2018) in a previous study that there is a positive attitudes toward infertility treatment. Whilst testimonies of successful results aggravated positive attitude to seek infertility treatment (Gerrits, 2018), the pleasant reception of care givers propelled a positive attitude to seeking infertility treatment (Gyasi, Asante, Yeboah, et al., 2016; Gyasi, Asante, Abass, et al., 2016; June et al., 2018; Abolfotouh, Alabdrabalnabi, Albacker, Al-jughaiman & Hassan, 2013). Nevertheless, negative attitude was reported, much due to lack of compassion of health care givers Pedro, Faroa, Pedro & Faroa (2017) and repeated unsuccessful infertility treatment (Hess et al., 2018).

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In low income countries, the stigma associated with seeking treatment for infertility may be a barrier to treatment access (Gerrits, 2012; Donkor & Sandall, 2007; Anne & Saint, 2015). Hence the likelihood to provoke negative attitude towards seeking treatment.

2.2.3 Motivation to seek with treatment

Though infertility treatment is difficult and exhausting, the joy of a healthy baby (Redshaw, Hockley & Davidson, 2006) motivates women with infertility to seek treatment. Redshaw et al. (2006) reported that infertility treatment was physically unimaginable to put up with, not to talk about the emotional aspect. Likewise the motivation to seek treatment for infertility is depended largely on the level of experiences of infertility. According to Alfred and Ried (2011), women with infertility are motivated to use traditional medicine due to the holistic individualised care of the practitioners they receive. Again, in a retrospective study on (N= 212) women with infertility, Bennett, Wiweko, Hinting, Adnyana and Pangestu (2012) reported that women were motivated to seek professional help from a biomedical provider due to proximity to the geographical location of the facility, though 40% were sceptical and afraid to access care because of the unimaginable diagnosis of infertility.

Additionally, certain factors motivated or demotivated treatment seeking behaviours of women with infertility. In a study in Malawi, de Kok and Widdicombe (2008) revealed that there was lack of enthusiasm to seek treatment for infertility in a biomedical facility due to financial constraints. That same study reported that women with infertility were demotivated to seek medical treatment in a biomedical facility as a result of the bad attitude of health staff, lack of support from husbands and the negative outcomes of long periods of fertility medications.

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Furthermore, abnormalities of the female reproductive system that obstruct conception, motivated women with infertility to seek treatment. According to Kessler, Craig, Plosker, Reed and Quinn (2013) in a study to evaluate infertility and treatment seeking in the USA, it was found that out of 623 women who sought infertility services, 2.7% searched remedy for uterine fibroids. What motivates women to seek infertility treatment is when there is a realization of a challenge of conception. According to Tamrakar (2019), 5.7 women had uterine fibroid when ultrasonography was done to investigate factors impeding conception. Also reported was 19 cases of uterine abnormalities which included sub mucosal fibroid when hysterosalpinography (HSG) was done. These factors warranted women with infertility to seek treatment. Testimonies of success rate of treatment accounted for a number of women with challenges to conceive to seek treatment (Adewunmi et al., 2012; Gerrits, 2018; Osei, 2016). They were motivated to strive for infertility treatment by experiences of others they had seen and heard from concerning a specific treatment option.

The motivation to seek infertility treatment emanated from the core mandate of a woman to conceive and have children (Kalaja, 2015; Yao et al., 2018; June, Dimka & Dein, 2018), anything else becomes a deviation from normal. God's words in the Bible and Koran to multiply and replenish the earth drives childless women to persevere in hope on treatment to get children (Tabong & Adongo, 2013). Previous studies of Yao et al. (2018); Kalaja (2015) and Tabong and Adongo (2013) indicated that women with infertility were inspired to procreate as to their drive to ensure continuity of the next generation and to enjoy their assistance, especially in their old age. It was added that the pressure of most parent asking to see their grandchildren also stirred the drive for women to seek infertility treatment. Similarly, in Rwanda, China, Mali and Albania, the negative consequences of infertility that threaten marital bonds prompts childless women to seek infertility treatment to save

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the collapse of their marriages in future (Yao et al., 2018; Dhont et al., 2011; Hess et al.2018., Kalaja, 2015).

Advertisement has a way of inducing prospective consumers to patronise a specific item, and infertility treatment is not left out. Although hospitals are not allowed to advertise themselves in the media, traditional and faith healers are allowed to do so (Osei, 2016). Advert proliferation in television, sign boards, internet and newspapers in Ghana of spiritual healing, prayer and healing sessions for people in search of the 'fruit of the womb' and women holding babies attracts women to seek treatment (Hiadzi, 2014). A study by Hawkins, (2013) reports that advertisement on the internet that sells infertility treatment, appeals to the emotions of women to seek that treatment. The study added that out of 372 (97.64%) clinics for infertility, 79.03% had images of babies on their home page to persuade patient instead of having their success rate to inform their customer on their decision to seek treatment.

2.2.4 Subjective norms about treatment seeking behaviour (cultural beliefs and perceptions)

Subjective norms are the cultural beliefs and perceptions about the expectations of important referent others to engage or not to engage in a behaviour they have sanctioned (Chiou, 1998). The perceptions about the cause of infertility impact treatment seeking behaviour. Meera, Guntupalli and Chenchelgudem (2004) found out in a study that women sought treatment from traditional healers due to the perceived cause of infertility from evil spirit, black magic, the heat of the woman's body, supernatural powers and God's curse on the woman for sinning. On the other hand, eating of the umbilical cord of a fertile woman who had given birth was perceived as a cultural belief to cure infertility. The belief

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was that the umbilical cord has special fertility juice. Similarly, 90% of the research respondents perceived the woman's body heat to be the cause of her infertility. Hence, the woman is made to eat food like lizard to reduce heat. By contrast, the study reported that herbal tea or paste made of medicinal roots, leaves or seeds had been the treatment of choice for most women with infertility who sought treatment from herbalist and medicinal men, at some point in their life. The perception about infertility and its treatment seeking behaviour are the collective experiences of individual's with infertility over the years that are expressed.

Pedro, Faroa, Pedro and Faroa (2017), in their study findings of 21 women identified that health care professionals were not empathetic during treatment, both doctors and nurses neglected the psychological and emotional needs of their patients. It was also mentioned that there was lack of adequate information from some health care professionals especially the nurses about ARTs. Nurses did not show confidence in that area. Lack of infertility counselling before, during and after treatment also emerged. Patient lived in limbo as to what to expect next from their treatments and most participants expected their care providers to refer them to professional counsellors or people who had gone through similar experience. However, some participants added that treatment for infertility was expensive (Mosalanejad, Parandavar & Abdollahifard, 2014, WHO, 2010). Redshaw et al. (2006) reported that the perception about treatment of infertility may be framed by experiences to care. In their study, women with previous infertility who had achieved their aim of pregnancy recounted their experiences to treatment as difficult, hurting and emotionally laden. Participants added lack of counselling especially follow-up counselling when treatment failed, inhumane treatment including lack of privacy, no empathy and dignity. Differences in perception to treatment emerged as some women described a number of

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care givers as not caring, not compassionate and exhibiting unprofessionalism. However contrary to what was reported earlier by Pedro et al.(2017), few women appreciated the professionalism and caring nature of the skilled staff.

Cultural norms cannot be over emphasised with the coping strategies of infertility (Naab, 2014). Cultural norms learnt from the community and the family includes marriage and having children. Any deviation from these assertion incur negative consequences. According to Naab (2014), based on the cultural belief and perception in Africa, women with infertility suffer pressure from in-laws, ostracised from occasions, prejudice of being jealous and mean to other people's children. Unfortunately these negative attitudinal reactions against women with infertility are emitted by other women in the family and community. Some women with infertility decline to attend certain events, others use herbs and combine religion, spiritual and traditional methods to avert childlessness. On the contrary, the study also reveal that cultural perception of seeking adoption as treatment was unacceptable in Africa (Naab, 2014).

The use of herbs in the Ghanaian culture has existed long before the introduction of the Whiteman's medicine. It has been used to cure a lot of illnesses including infertility (Gyasi, Asante, Yeboah, et al., 2016; Gyasi, Asante, Abass, et al., 2016). Women in Mali report popular usage of herbal remedy for infertility treatment (Hess, Ross, & Gililland, 2018). Traditional Chinese medicine (TCM) has gained a lot of awareness in the treatment of ailment and infertility. Treatment of infertility with TCM are considered efficacious when a conventional treatment failed (Alfred & Ried, 2011). In their study findings, 32% of the participants mentioned TCM as the first line of treatment to infertility, whilst 68% accepted the recommendation of TCM from acquaintance.

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The lived experiences of women with infertility can be demoralising (Bista, 2015). According to Bista (2015), the perception of significant others of women with infertility influenced their treatment seeking behaviour. However, some women were sceptical of traditional healers; they were motivated to comply because of their in-laws, relatives and husbands.

Donkor (2008) in congruence with other researchers reported that the social and cultural perception about women with infertility affect the type of seeking behaviour. Though some women use orthodox treatment at the various health facilities, others do not hesitate on the use of herbs for cure. Some of the perceptions and practice were dealings with shrines and spiritual churches. Nevertheless, the perceived origin and consequences of childlessness navigates the treatment modality; whereas treatment are perceived to be done concurrently for efficacy.

According to Id et al. (2019) and Ray and Bhore (2017), women in India and Gambia seeking infertility treatment were encouraged to initiate treatment by their social network impacting on the bond of their relationship. The support these women enjoyed were very instrumental and helpful; especially bearing costs of treatment (Obeidat, Hamlan & Callister, 2014). Contrary to the support most women enjoy during treatment, the impact of less support from family and friends resulted in treatment termination (Vassard, Lund, Pinborg, Boivin & Schmidt, 2012). Moreover, studies by Id et al. (2019), Gerrits (2012), Tabong and Adongo (2013) revealed that there is a possibility of some men to be the cause of infertility in marriage even though they claim they might be having children in past relationships.

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With the awareness of ARTs, religious beliefs may pose as a threat to seeking infertility treatment. In a study by Sallam and Sallam (2016), it was reported that any form of assisted reproductive therapy was prohibited. Besides, the invention of science does not make ART treatment right. Also, other religious sect have varying convictions about ART (Sallam & Sallam, 2016).

2.2.5 Intention to seek treatment

Intention to seek treatment was to increase the probability of achieving pregnancy (Fulford, Bunting, Tsibulsky & Boivin, 2013). The study posited that participants' intention to treatment were initially lifestyle modification but those who had already modified their lifestyles were more likely than not to go for medical help to advance infertility treatment. On the contrary, there was lack of preference to the participants who had tried non-medical method initially. Nevertheless, the study added that intention to seek treatment of infertility increase with knowledge about infertility, its causes and effect. In Otago and Southland, majority of women with infertility between 25 – 29 years (70.2%) had aims to have children in the future but as the age advanced (40-44years), there was decrease in their intention to conceive, a proportion due to unresolved primary infertility (Righarts, Dickson, Parkin & Gillett, 2015). In Portuguese, a cross sectional study conducted to validate a fertility tool found out that the intention of women with infertility to stick to treatment in a fertility center was as a result of how staff respected their views and preferences, provided them with information care and perceived competence of the health team (Pedro, Canavarro, Boivin & Gameiro, 2013).

From a national survey of fertility barrier's, Greil, McQuillan, Johnson, Slauson-Blevins and Shreffler (2010) reported that 63.2% of women with infertility considered the intention

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of seeking treatment. Whilst 49.8% went ahead to speak to a physician about infertility only 5.5% had ART because they had the financial means. The study findings also revealed that most women who had never conceived and were married had higher intention to get pregnant (45.4% and 69.1% respectively). Additionally, Joelsson et al. (2016) investigated the lifestyle habits and how women with infertility modify their everyday life when they intent to conceive. In their study, 48.2% were on folic acid supplement and these were women with infertility who had had higher education. The use of tobacco was low but 61.6% of the participants were ingesting alcohol. The study findings depicts that women with infertility do not make considerable lifestyle changes when trying to get pregnant.

In Nigeria, the increasing awareness of child adoption made childless women who experience infertility for a long time with procedures that threatens their lives, now express fulfilment in raising their adopted children (Ekwoaba, 2019). Positive intention about child adoption was also reported in previous studies (Ali et al., 2011) with 92% of the study participants accepting child adoption as infertility treatment option. Contradictory study in Nigeria indicated that the intention of women with infertility to agree to take adoption as a treatment preference was significantly low (Adewunmi et al., 2012). The findings suggested that, 97.2% of the study participants were cognisant of child adoption as a treatment of choice but only 47.0% were of the view that it should be accepted as a last resort for women with infertility. Contrary to this assertion, cultural and religious reasons made 57% of participants not keen to accept child adoption.

More so, most women who are childless are more willing to take care of a child from a family member or an acquaintance than go through the legalities of child adoption (Adewunmi et al., 2012). Adoption is illegal in Muslim laws and some Christians shun

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adoption since it translates into lack of trust and faith in God (Nachinab, Donkor & Naab, 2019). According to their study, women needed the approval of their husbands to consider ideas of child adoption. Nonetheless, an Islam husband would prefer a second marriage for a biological child than child adoption. Furthermore, Christian women with difficulty to conceive had hope to seek treatment no matter how long it takes to achieve biological child (Nachinab, Donkor & Naab, 2019).

Similarly, Fehintola et al. (2017) in their study findings had all participants voting against child adoption as treatment option. The reason was that the adopted children will in due course get to know they were adopted and these women may be mocked. The intended target for treatment for most women with challenges to conceive become an illusion. Most women go from hospital to hospital, go through painful IVF in addition to taking a lot of pills without positive outcome of having children resulting in psychological stress (Hess et al., 2018,Obeidat et al., 2014).

2.2.6 Treatment seeking behaviour

Treatments seeking behaviour are implemented fully to the later by women with infertility to avert adverse consequences. These women seek for hospital or medical treatment, consult herbalists and engage in religious activities to conceive and have children (Hess et al., 2018; Ambarish, 2013; Chimbatata & Malimba, 2016; Tabong & Adongo, 2013). According to Fatima et al. (2016), 30% of the study participants at the initial stages of infertility went to traditional healers, 36% conferred with both traditional healers and doctors whilst 32% dealt with general practitioners plus gynaecologist but only 2% of the participants consulted fertility centres directly. The findings of the study revealed that just

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32.37% accepted infertility treatment at the centre after they were physically assessed and confirmatory laboratories requested.

In Uttar, 700,000 household took part in a demographic and health survey (Singh & Shukla, 2015b). It was reported that women with infertility who were illiterate or had lower education attended temple, religious or traditional, astrologers and charlatans (Patel 1994; Unisa 1999). Also most rural couples relay on government health centers for treatment. The study also posited that 85% of the urban couple with infertility adopted allopathic treatment making treatment seeking higher in the urban setting than rural setting, for the most part due to availability and how close these treatment centers are.

In a study to explore infertility experience among low income Latinos Nachtigall et al. (2006) found that the difference between seeking infertility treatment were as a result of cultural background as to women raised in the USA and elsewhere. The study observed those raised in the USA to be assertive to seek treatment for infertility and persevering to get pregnant even in menopause. Biomedicine and humoral medicine were often combined as treatment of infertility, massaging the womb accompanied by keeping warm by staying indoors at home and drinking warm herbal tea. In Bangladesh and Jordan, childless women pursued herbal treatment for its effectiveness (Daibes, Safadi, Athamneh, Anees & Constantino, 2018; Nahar, 2010). Contrary study in Sierra Leone reported less than 2% of participants in agreement to the effectiveness of herbal medicine (James et al., 2018).

In Nigeria, Fehintola, Fehintola, Ogunlaja, Awotunde, Ogunlaja and Onwudiegwu (2017) conducted a mixed method study using 200 women with infertility. Their study advanced that women with infertility engage in numerous treatment seeking behaviour aside hospital care owing to the societal meaning of childlessness and its consequences. Most

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participants perceived infertility to be spiritual than somatic (medical or traditional) and with that mentality 50% consulted herbalists, 26% had taken herbal concoction, 30% engaged in prayers and spiritual cleansing whereas 56% attended churches in their bid to forestall infertility.

In other studies, it was revealed that most women seek faith-based spiritual remedy for their childlessness. These women attend churches, prayer camps and consult prophets whilst exercising their faith in God through fasting, praying, and performing rituals with anointing oil for 'Akwan kyere'(guidance) (Tabong & Adongo, 2013; Owusu-Ansah, 2011; Osei, 2016; Ray & Bhore, 2017). Most women feel embarrassed and stigmatized when prayed for openly; attracting unnecessary attention on them in the bid to help them conceive (Anne & Saint, 2015).

The usage of medical treatment have given women with infertility different experiences. These women travel far and wide to seek hospital therapy by undergoing test and procedures in anticipation to conceive (Hess et al., 2018; Datta et al., 2016). In a study by Malin, Hemminki, Räikkönen, Sihvo and Perälä (2001), they conveyed a picture of what women with infertility want during their management in the hospital facility. In their findings, 45% were pleased whilst 96% were dissatisfied. Gynaecologists at the private hospitals were preferred to those in the public facilities. Satisfaction was also due to successful treatment outcome, nurses' interpersonal relationship with client and thorough examination of the patient. By contrast, those who were not pleased with treatment experienced poor communication and relationship of the medical staff, treating them as objects (Tabong & Adongo, 2013). In their depressive state, childless women expect to be treated in a friendly and sensitive way. Women with infertility engage in the behaviour of

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increasing the number of times they have sexual intimacy with their partners. Mostly not for enjoyment but to increase their chances to achieve conception (Dhont et al., 2011; Bokaie, Simbar, Ardekani & Majd, 2016).

According to Sharma, Biedenharn, Fedor and Agarwal (2013), in reviewing the impact of lifestyle modification on infertility made an assertion that choosing the right nutrition, staying active through exercises, refraining from chemicals and refraining from radiation among others are vital for conception and overall health. These activities serve as a source of alternative treatment for infertility (Gaware, Parjane, Pattan & Dighe, 2009). On the other hand,contrary to the believe that menopause end the phase of reproduction for a woman, Banh, Havemann and Phelps (2010) in a study of reproduction beyond menopause asserted that, older female can have children through ART and IVF. They added that caution should be taken in the interest of maternal health since postmenopausal women are susceptible to cardiovascular conditions, cancer and older women may not have the physical and mental strength to take care of children.

2.2.7 Summary of Literature Review

Literature was reviewed based on the objectives of the study. The first section was the beliefs about seeking infertility treatment. It was evident that women had different forms of beliefs in their search for children. Their beliefs on the etiology of infertility directed the course of seeking treatment for their childlessness whiles some believed in herbal treatment and hospital management, others trusted in faith-based spiritual remedy. Many belief in the combination of efforts as well. Literature on attitude about seeking infertility treatment were both positive and negative attitude from both women with infertility and care givers. Proximity to treatment area, economic resources among others motivated

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women to seek a particular treatment course. Also, women with infertility were driven to pursue treatment due to their core mandate as women.

Globally, women with infertility attract unpredictable source of support from family, husbands, mothers-in-law, friends and other social network that affect they seeking infertility treatment. The literature indicated how childless women benefited from close relation in seeking treatment and how some negative treatment also triggered stimuli that drove them to seek treatment at all cost regardless of its negative consequences. The literature on cultural beliefs and perceptions across the globe revealed mixed preferences about seeking infertility treatment.

The literature review also covered the intentions of women about seeking treatment for infertility. The literature had it that women with infertility had strategies to achieve motherhood through IVF and child adoption although some religion and countries frown on child adoption due to their cultural disposition. Majority of the findings of the treatment seeking behaviour were those activities women with infertility engaged in to have children. Women sought treatment from hospitals, churches and traditional remedy including herbalists, fetishes, and witch doctors among others. They engage in various activities even those detrimental to their health with inadequate knowledge on treatment measures that are geared towards their individualised infertility need and remedy. Most studies on infertility were on the causes, beliefs and perception of infertility of both fertile and childless women with a few on treatment seeking behaviour thus the question: what is the treatment seeking behaviour among women with infertility?

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CHAPTER THREE

METHODOLOGY

3.0 Introduction

Methodology is how a research is conducted (Taylor, Bogdan & DeVault, 2015). This chapter outlines the Research design, Research setting, Target population, Sampling technique, Sample size, Procedure for data gathering and Data analysis. Ethical considerations and methodological rigor were also highlighted**.**

3.1 study design

A qualitative research approach using an exploratory descriptive design was employed to elicit responses from women on their treatment seeking behaviour through interviews and were interpreted accordingly. The interpretation reflected the participants' point of view. Interviews were conducted in the natural settings of the participants (Gergen, Josselson & Freeman, 2015). Rallis and Rossman (1998) added that qualitative research gather information on what is seen and read from people, places, event to bring to existence new insight. Qualitative research explore deeply into a phenomenon to build further knowledge but not to be generalised to other people or setting (Thomas & Magilvy, 2011).The focus of the study was on the treatment seeking behaviour among women with infertility.

3.2 Research Setting

The study was conducted in the Greater Accra region. According to GSS (2013), the Greater Accra Region is the smallest of the ten regions in Ghana and situated in the southern central part of the country. The region has the highest population in Ghana with 4,010,054 people and spans an area of 3,245 square kilometres or 1.4 percent of the total

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land area of Ghana. It shares boundaries on the north with Eastern Region, the south is the Gulf of Guinea, the east is the Volta region and the Central Region is on its west. The Greater Accra Region is predominantly urban and cosmopolitan (Alhassan et al., 2015) and most ethnicities are adequately represented in the region hence rich experience of treatment seeking behaviour of women with infertility. The major ethnic groups include 39.8% Akans, 29.7% Ga-Damgbes, 18% Ewes and a good proportion of the people from the Northern regions. The Greater Accra Region is blessed with a lot of sites which include the National Theatre, Independence Square, Markola Market and Kotoka International Airport just to mention few. It has an ultra-modern Regional Hospital with 420 bed capacity and a hub of ultra-modern equipment and specialised staff. It has a lot of public and private health facilities. The people of the Greater Accra Region are mostly religious and according to the 2010 population and housing census, 83.3% of the people in the Greater Accra are affiliated to Christianity of which 44.6% are Pentecostal/Charismatic, 22.3% Protestant, 8.9% other Christian, and 7.5% are Catholics. 11.8% are Muslims, 0.5% are traditional people and 3.4% are not affiliated to any religion. A colourful festival called Homowo (meaning hooting at hunger) is celebrated annually in the month of August by the natives of the region. It is characterised by sprinkling a festive food and a procession of twins in the principal streets of the capital.

The Greater Accra contains the Tema municipal area, Accra metropolitan area, Ga West District, Ga East district, Dangbe West district and Dangbe East District. In the study, the researcher drew sample from the population of women with infertility who sought treatment from prayer camps, churches, consulted the herbalists (herbal centres) and who patronised the drug peddlers at the market places through purposive and snowball

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sampling in the Greater Accra Region. There are a lot of churches, fertility clinics and prayer camps scattered all over the region.

3.3 Target Population

The target population for the study were women with infertility in Greater Accra Region.

3.4 Inclusion Criteria.

The research included women who had experienced infertility for 12 months and above. Women with infertility who live in the Greater Accra Region were included as well as women with infertility who could express themselves in English and Twi.

3.5 Exclusion criteria

Women with infertility below 18 years of age were not included in the study due to lack of rich experience of treatment seeking behaviour of infertility. Men were also excluded from the study because in our setting women are mostly blamed for infertility and women therefore are left to seek treatment and find solution for their problem. Hence it becomes a women's problem instead of collective problem.

3.6 Sample size and sampling technique

Qualitative enquiry requires that responses are elicited from a number of participants to the point where subsequent participants seem to be giving the same responses without the emergence of new information (Bernard, 2011). Data saturation is crucial in qualitative research for the study to be credible. Polit and Beck (2014), explains data saturation as the state where there is no new information sprouting at a stage of interviewing such that the participants keeps iterating same information.

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The sample size for the study was fourteen (14) and by the time the fourteenth person was interviewed the study reached its saturation. The researcher employed purposive and snowball sampling techniques for this study. Purposive sampling technique is a non-probability sampling method to recruit the participants who have the specific knowledge and experience in the phenomenon under study (Marshall & Rossman, 2014) whilst snow ball sampling is a technique whereby research participants will direct the researcher to other people with the knowledge and experience in the phenomenon under study (Polit & Beck, 2013). Snowball sampling method is also well-known as chain-referral sampling and it is based on referrals from initial subjects to generate additional participants for the study. Issues of infertility are sensitive and people do not openly speak about it. In view of this, the researcher obtained sufficient data saturation for all facet of the phenomenon after the interview of the fourteenth (14th) woman with infertility.

3.7 Tool for data collection

A semi-structured interview guide was used to conduct a face-to-face in-depth interview with each participant to enable them recount their treatment seeking behaviour. It also allowed the researcher to redirect participants' responses when out of context (Creswell, 2014). The interview guide (see Appendix B) captured information on the demographic characteristics of participants and questions guided by the objectives of the study, theory of reasoned action and the literature reviewed. All interviews were transcribed verbatim to ensure accurate data collection.

3.8 Piloting/ Pre-testing of tool for data collection

The tool for data collection was piloted with four (4) known women with infertility who met the inclusion criteria. The data used for piloting was not included in the main data for

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the study. The piloting was done to rectify any ambiguities of questions. Some questions were revised and restructured to improve the tool. This also helped to improve the interview skills of the researcher.

3.9 Data collection procedure

The Institutional Review Board of Noguchi Memorial Institute for Medical Research of the University of Ghana and Ghana Health Service, ethic committee gave ethical clearance for this research study. Multiple visits were made to some prayer camps and churches to seek permission from the spiritual leaders. Also, two herbalists were consulted for some of the participants. Several visits were made to some local medicine sellers at the market places. A visit was paid to a fetish priest who confirmed that he had helped women to conceive but none was willing to participate in the study. All these visits allowed the researcher to understand the complexity of the research questions, allowed access to participants and also help establish rapport then a trusting relationship between the researcher and the participants. Due to the sensitivity of the research area, this was very crucial.

The first seven (7) participants were identified through a herbalist upon discussion of the research questions and all the research was about. Phone numbers of participants was given to researcher willingly for their involvement in the study. After that snow balling technique was used to recruit subsequent participants till the data was saturated. No participant was recruited from any healthcare facility, the prayer camps churches or the market place though researcher made several visits to these places. All participants were taken through the study process for voluntary participation. Before commencement of the interviews, the researcher established rapport with each participant to ensure trust.

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Eligible women with infertility who gave their consent participated in the study (refer to appendix C). Participants signed the consent form to indicate their willingness to participate in the study after the nature of the study explained to them in simple language. The in-depth interviews were conducted from December 2018 to February 2019 through purposive and snowballing sampling techniques. The duration of the interview was approximately 45 minutes to 1 hour. The interview was recorded and transcribed verbatim (Mayan, 2009) with the permission of the participants. Short notes were written to keep track of ideas for further exploration, including observation for verbal and non-verbal behaviour (Musante & DeWalt, 2010). Useful observations that could not be captured by digital recording like the demeanor, body language, humour, and some informal conversation that took place before or after the interview were captured in the field diary notes. The interviews were conducted at the participants' place of choice for privacy and confidentiality. The researcher developed a trusting relationship with all the participants. A trusting relationship between the researcher and the participants is very important in a qualitative research. Individual participants were given pseudonyms. The researcher was courteous, respectful and professional during all the interviews. Participants were allowed to respond, express their views and opinions freely and at their own pace during the interview. They were neither rushed nor pushed to respond to answers or were they interrupted unnecessarily. Interruptions were done to direct participants to stay on track with the subject being discussed and also for deeper clarification. Participants were allowed to ask questions before the interview commenced and when the interview was over. Events that were not recorded with the audio tape during the interview were typed immediately after each session into the researcher's computer and secured with a password. The recordings of the audio tape were given pseudonyms and kept under lock

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with my supervisors after the research period which will be destroyed and discarded after five years if nothing comes up on the study.

3.10 Data management and analysis

Data in qualitative study is derived from participant's interview. It can produce meaningful findings if managed properly (Miles & Huberman, 1994; Richardson 1998; Richards 2002; Bazeley, 2009). Each interview was transcribed immediately as possible to get deeper understanding of the phenomenon. Each audio recording was replayed to ensure accurate transcription. Pseudonyms were used for each participant and transcripts were saved in a folder with unique identification. Hard copies of the interview were securely kept with the supervisor under lock and key, whilst soft copies kept with a password on the researcher's computer to ensure the security and safety of the data.

Data analysis reveals how raw data, that is the transcription from the audio taped interview, field notes and other written materials are processed and interpreted to answer the research questions (Ulin, Robinson, Tolley & Mcneill, 2002). The data collected was coded under emerging themes in line with the research objectives to reveal the findings of the study. A code is a word, phrase or a sentence that capture the idea or essence of the data collected to enhance analysis. Codes and themes are developed considering each line, sentence, paragraph or phrase to summarise what the participant is saying. Thematic analysis is an interpretive process, whereby data are systematically explored to identify patterns within the data in order to offer an informative description of the phenomenon (Smith & Firth, 2011). A thematic analysis can yield truthful and insightful conclusions when the researcher has been laborious with the process (Braun & Clarke, 2006). After writing the response of participants in a word, it was grouped under similar themes based on the

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objectives and the constructs of the theory. Emerging ideas were further grouped under subthemes.

3.11 Methodological rigor

Rigor is a way to establish trust and confidence in the results of a qualitative research by being exhaustive, thorough or accurate and consistent. In qualitative inquiry, rigor is a key element (Speziale, Streubert & Carpenter, 2011). According to Aroni et al. (1999), rigor is the process of demonstrating reliability and proficiency in a qualitative study and a demonstration of the validity of the inquiry procedure. It allows a study to be replicated by establishing consistency. According to Lincoln and Guba (1985), the model of trustworthiness in qualitative research addresses four relevant component comprising credibility, transferability, dependability and confirmability. Encompassed in these were other methodological strategies such as audit trail, member checks when coding, categorizing or confirming results with participants and peer debriefing to ensure rigour in this study (Guba & Lincoln, 1982). These criteria were used to ensure trustworthiness in the study.

Credibility is how reliable the findings of a study are to reality (Guba & Lincoln 1985). To attain this, the researcher engaged participants who met the inclusion criteria. Iterative questioning and probing were employed to elicit detailed information from participants. The transcripts were also reviewed for similar views across the research participants. A study is said to be credible when an individual with the same experience can identify with the shared experiences. Strategies like reflexivity, member checking, and peer debriefing or peer examination can be used to establish credibility. These strategies used allowed the researcher to collect and confirm data documented during the course of the research process.

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According to Jootun and McGhee (2009), reflexivity is a helpful tool that increases the rigor of a research method by endorsing the understanding of the phenomenon under study and the researcher's role. Also, Clancy (2013) describes reflexivity as an active process in which the researcher becomes mindful of his /her own preconceptions, opinions, assumptions and experience that may persuade the research procedure.

Transferability describes how using the findings of a study can have relevance or be applied in some other settings (Guba & Lincoln, 1981). The extent to which other participants with the same data collection methods and inclusion criteria can be applied to a study findings to create similar results, make the study research transferable. The study setting, the design, the sample size and the method of data collection, the inclusion and exclusion criteria were described adequately to ensure transferability.

Dependability according to Thomas et al (2011), is when some other researchers can come after the decision trail by another researcher. Dependability describes whether the subject area can be repeated by another researcher (Guba & Lincoln, 1981). The researcher should be able to give a detailed audit into the specific purpose of the study, selection of participants, data collection procedure and how long it lasted, how data were managed and analysed, discussions and findings of the study as well as communicating techniques used. Detailed information gathering and processing methods were used to assess the ability to replicate results in similar research contexts. The research design and strategic choices which were made throughout the study in addition to other occurrences that were observed during data collection, and evaluation of the study design were described effectively

Confirmability occurs when credibility, transferability, and dependability have been established and reflective, maintaining openness of unfolding results of the study. The data should represent participants' information and interpretation not the bias or personal views of the researcher.

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3.12 Ethical Considerations

Ethical clearance was obtained from the Noguchi Memorial Institute for Medical Research- Institutional Review Board. The researcher ensured that there was no emotional, physical, professional, or financial harm to the participants when they agreed to speak. Necessary arrangement for a counsellor to step in when needed was done. Clinical psychologist, Dzifa Monu Awudi (telephone number 02442116677) who works at the Korle-bu Teaching Hospital was briefed about this study and she was on standby for referrals. But all participants were comfortable and did not need the assistance of the clinical psychologist. Risks and discomforts for participating in this study were minimised. Participants had the right to withdraw their consent or stop participating at any time if they wished to. Some participants decided not to continue with the study after the researcher explained the study to them and their decision was respected.

Every effort was made to maintain the privacy of the study participants and to protect confidentiality of data, no personally identifying information was used. The results used in reports, presentations, or publications had pseudonym, and none of the participants' information had their real names. All electronic files of observation notes, interview transcripts, and audio files were kept in physically secured locations by the researcher and supervisors using password-protected files and locked drawers.

In a research of any kind participants have the liberty to partake in the study or not. They are not under any obligations to continue with the study regardless of their consent at the initial stage of the research. Participants' right to human dignity were respected. The right to know the purpose, nature of the study and what was expected was communicated to all the participants. Nevertheless in situations when divulge specific information to participate can mar the study, the researcher may require period of time to tell the overall purpose

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including detailed information of the study to the participant (Morse, 2016; Tolley, Ulin, Mack, Succop & Robinson, 2016).

Interviews were done at a place convenient for the participants and at the cost of the researcher. Each participant was compensated during the interview process by the researcher with twenty Ghana cedis worth of call credits. The researcher was fair to all participants and they were all treated equally. The principle of justice requires that the values and interests of the whole population are balanced (Manda-Taylor, Mndolo & Baker, 2017). The same level of information was given to each of the participants of the study. Privacy and confidentiality was also maintained throughout the study. Participants were reassured that all information they gave, were purely for the purpose of the study. Recruitment of participants started after ethical approvals from the Institutional Review Board of the Noguchi Memorial Institute for Medical Research (NMIMR) and the Ghana Health Service, Ethics Committee were obtained in December 2018.

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CHAPTER FOUR

FINDINGS

4.0 Introduction

Chapter four elucidates the research findings. The findings were put under six main themes and twenty two subthemes emerged from the data.

4.1 Demographic Characteristics of the Participants

The research participants were all women who were having challenges to conceive. Their ages ranged from 26 to 40 years. All except one (1) participant was a Muslim. Two (2) were divorced as a result of infertility. The remaining participants were still married, with the number of years of marriage between 1 year and 14 years. With regards to educational background, five (5) participants had attained post graduate education and one (1) pursuing PhD, two (2) participants with junior high school certificates, one (1) participant with senior high school certificate, one (1) participant with Ordinary level certificate, two (2) participants had also attained their first degree, one (1) participant with a diploma and another participant had attained certificate course in health. Three (3) of the participants had suffered miscarriages at the early stages of their marriages. Thirteen (13) of the participants though reside in the Greater Accra region, had their hometowns in different parts of Ghana. The broad summary of the participants have been provided in appendix D.

4.2 Organization of Themes

The thematic findings have been grouped into six major themes from the model guiding the study and under each of these major themes were sub-themes. The themes and their corresponding sub themes are presented in table 4.1 below. Also, a new emerging theme that emanated from the data was added.

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Table 4.1: Organisation of themes and subthemes

Themes	Subthemes	Codes
Beliefs about seeking treatment	• Conviction about seeking treatment • Trust in hospital remedy • Confidence about herbal/ natural/traditional remedy • Faith based in spiritual/ religious remedy • Reliance on combination of treatment	BEL
Attitude about seeking infertility treatment	• Positive attitude to treatment • Negative attitude to treatment	ATT
Motivating factors for seeking infertility treatment	• Intrinsic • Extrinsic factors • Procreation drive • Testimonies on seeking treatment	MOT
Cultural beliefs and perceptions	• Influence from significant others about seeking treatment • Traditional views about infertility treatment • Societal pressure on seeking infertility treatment • Opinions about seeking infertility treatment	CUL BEL & PER
Intentions about seeking infertility treatment	• Aim of infertility treatment • Plans to seek treatment • Target for treatment	INT
Treatment seeking behaviour	• Pursuing herbal treatment • Seeking hospital treatment • Engaging in faith-based spiritual treatment • Lifestyle change	BEHVR
Barriers to seeking infertility treatment (additional theme)	• Possible obstacles to seeking fertility treatment • Inadequate knowledge about infertility treatment	BAR

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4.3 Belief about seeking treatment

The salience of the belief of the individual precipitates an appraisal. All the participants had a belief of what to do to avert childlessness. It was found from out that participants had conviction about seeking treatment, trust in hospital remedy, and confidence about herbal or natural or traditional remedy. They also had faith in spiritual or religious remedy and also relied on a combination of treatments.

4.3.1 Conviction about seeking treatment

Most of the women had a conviction that women with infertility should seek treatment when there are challenges in conceiving. Regardless of the exact action to take, most women were of the view that it was very crucial to 'do something' to have children. A 33 year old woman, married for 4 years expresses her views about seeking infertility treatment as:

> *"Hmmmm. I think everybody who is not having children will definitely look for ways or would want to find out why they aren't getting pregnant. As in, you get married and you're not getting pregnant. With time, you start worrying. You start looking for ways and means of, first, you would want to know why, as in, you will do some investigations about you and your spouse, whether you can be pregnant or not". (ABBA)*

A 29 year old woman with infertility, married for 1 year 2 weeks shared her thoughts about seeking treatment as:

> *"I think it is needed, it is necessary, because you don't wait till things get worse or the pressure is too much you cannot take so the earlier the better. Well I think as early as possible even six months is enough to seek treatment to get pregnant. Because if you know you are having unprotected sex and you want to get pregnant and there is no sign of it, as a lady in an African setting you should be alarmed." (AFIA)*

Another woman who was with the conviction that women with infertility should seek treatment shared her views as:

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"Ok I think that it is something that is err mm is a bit unpleasant if you are experiencing infertility or going through it can be difficult and it can be frustrating because you wonder what is wrong what is happening but I am a strong believer that, it is important to seek infertility treatment because you can't just, you know stare in the air and not know actually what is happening within you or whether the problem is with you or your husband or it is a health challenge that the doctors can guide you to rectify. So I think that seeking infertility treatment is something that is very important for any couple or any person that is trying to have a child." (MODA)

4.3.2 Trust in Hospital remedy

Due to the perceived aetiology of childlessness and the educational background of some the women with infertility, they share their views about their trust in hospital treatment for infertility. A 40 year old nurse with a master's degree, experiencing infertility for 8 years articulates her opinion about her trust in hospital treatment as:

"So I think the first point of choice for any couple who are childless for a year or two years, is to go to the hospital and they do test and see where the problem is."(AKUA)

Likewise a 37 year old counsellor trusts in hospital remedy as:

"So I think that seeking infertility treatment is something that is very important for any couple or any person that is trying to have a child. It is important to go and seek infertility treatment from the right place, a hospital, an accredited hospital where you know that there are qualified doctors, gynaecologist to treat you, to investigate and then address your infertility issues. Well, (laughing) well, like I said earlier I think first of all the couple or the lady trying to get pregnant should first do what she needs to do, in terms of her part of what needs to be done, knowing cycle, you know you're doing the right things, you having sex frequently and doing the things that naturally should lead to pregnancy but if after doing that let's say for 2 years it doesn't work for you, the best place to go is the hospital because they have the required training, they have the experts who will do proper investigations."(MODA)

A 37 year old banker, who is divorced, shares her views about hospital treatment:

"I know the fertility hospitals, homoeopathic clinics and fertility facilities are the common ones I know of. I believe in the fertility clinics. Because the fertility clinics have well-trained gynaecologist. They are specialists so they understand that part of the human anatomy very well so they are able to take your case, your history

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and really look deep into it and see whether with medical science what they have learnt will bring out a solution." (DAPAA)

4.3.3 Confidence in seeking herbal remedy

Most of the participants had a feeling of certainty about herbal /natural/traditional medicine in the treatment of infertility. They had self-assurance that they will win infertility through herbal remedy. A 34 year old seamstress, with 4 years accounts of seeking infertility treatment, had confidence in herbal treatment and expresses her view as:

> *"For me I really have a lot of belief in natural medicine. I really believe in the traditional medicine than medicine from the hospital to treat infertility."(BIRAGO)*

A 31 year old psychiatric nurse, shares her views:

> *"I believe in herbal drugs because most of the medications that have been packaged nicely in pill, capsules and those things are herbal too. I thought the medication was really working. I am very happy with the treatment. I have tune my mind that it is going to work. It is just a matter of patience. My husband believe that since I am doing the herbal it is going to work so we need time for it to work out. With the treatment we still enjoy ourselves, we have our fun. (AKOSUA)*

A 30 year old hair dresser who was identified through a local herbalist, expresses her confidence in herbal remedy for infertility as:

> *I did natural medicine (bibidro) for a long time. I believe in it. If I had more money I will still go for herbal medicine like I am doing now. (AMA)*

4.3.4 Faith based spiritual treatment

Spirituality cannot be overemphasised in the treatment of infertility. Most of the women expressed their faith in God to bless them with children. Some verbalised that children are only given by God. A 36 year old Muslim woman with infertility, expresses her faith in spiritual treatment as:

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"I'm also in waiting, I'm waiting for God to give me children perhaps it is God who said it will take me all this while to have children. God gives to whom he wants to give to, He gives one to somebody, and He gives two to another person so I don't know, I'm waiting. God will give me children, I know, one day. Perhaps God is testing me. To me, I believe God will give me children, if He gives me one I'll be grateful." (MIRA)

Another view on faith-based spiritual remedy was shared by a woman with infertility with 14 years of marriage. Her believe was deeply in God to avert her childless status. She emphasized her thoughts as:

"Ooooo it's because I believe that God gives children and He will give me if He wants to. I believe that even if you hold Heaven and earth, go to all the hospitals, go to all the prayer places and you do all of that and God does not will that you should have a child you will not have it."(LADII)

Another participant believed that if the cause of childlessness was as a result of a sin she has committed so the only way to avert the situation to have a child is to pray and believe that God will forgive and bless her with a child.

"If you have sinned and it is causing you to be childless and you pray to God, He will have mercy on you and forgive you." (ABBA)

4.3.5 Reliance in combined treatment

Most of the participants also relied on combined treatment. They depended on faith-based and hospital, faith-based spiritual remedy and herbal remedy, and herbal with hospital treatment respectively. A 31 year old health worker was of the view that it was better to combine treatment for effective results:

"People have their babies but only a spiritual intervention, I think it doesn't help. Yes for me my view is that we should combine both rather than I mean, sticking to one: the spiritual aspect and the hospital treatment. Also, I think both hospital and herbal are the best but from accredited persons. Some people are not accredited, when it is accredited they know that their works are being judged so the will do the right thing to help you conceive." (AKOSUA)

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Another woman was also of the belief that faith based spiritual remedy should be backed with hospital treatment. She shares her views as:

> *"With the churches, you know you can't tell me you are only praying without doing anything. No it does not work that way. You have to support. Yes we know children come from God. It is a gift from God. So you have to also pray and also go to the hospital. They do not have to sit at the church premises, sometimes it can happen. Miracles do happen. But not all the time so you have to also go to the hospital. So for me I think we should go to the hospital. We have to pray and at the same time go to the hospital. That is the best." (BUBBLE)*

Nevertheless, though most women combined treatment, a major influence was due to their educational background. A 37 year old counsellor had a different view as:

> *"For me, I am not just in favour of traveling to prayer camps, taking herbs, I feel like herbalist they may not have done much research as the orthodox doctors, I mean medicine. The research evidence based research that drives the kind of treatment that doctors, I mean qualified doctors and physicians will give, will not be the same as these herbalist will give you. So I stand by going to the hospital then of course you back it with prayer trusting that God Himself will also make a way for you and resolve your infertility issue." (MODA)*

4.4 Motivating factors about seeking infertility treatment

This theme considers the energy, impulse, and enthusiasm that compelled participants to seek infertility treatment which includes the intrinsic and extrinsic factors for seeking treatment.

4.4.1 Intrinsic

There was a fundamental mandate that was observed among all the participants to seek infertility treatment. That was because they felt the need to have children as women. Also, some of the participants were moved to seek treatment as a result of some abnormalities that affected their core obligation pertaining to reproduction. A 39 year old woman, in a childless marriage for 14 years shares her feelings as:

> *"Ohhhhh once you are a woman you have to give birth. Because in the Bible God said we should go and multiply, He didn't say you should go and come back like that." (AJO)*

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A participant was motivated to seek for infertility treatment as a result of the difficulty in conceiving. She responded as:

> *"For me what I went through when I got married I conceived first, I conceived second. I had a miscarriage so after that I went to the hospital and they told me it is fibroid. So then you see I had to seek for I mean hospital treatment." (AKOSUA)*

A participant was inspired to seek infertility treatment as a mandate to impact the next generation. She explains her views as:

> *"I believe that honestly having children is a blessing and a gift from God and it is an opportunity to impact the next generation. Because these are people you take care of life from the time they are born right till they get to an age where they move out. When they are all about to start life long after you are gone, the things you instilled in them; the godliness, the training, all these things will be passed on to the next generation and also because the opportunity to give birth through your children I think for me is one, people can nurture to the next generation," (MODA)*

4.4.2 Extrinsic

Though all the women indicated an internal desire to have children of their own, this desire was greatly powered by outer stimuli for a need for them to conceive. These outer stimuli were also related to the good testimonies that other women gave of treatments that worked for them to conceive, unfavourable treatment from close associates and unstable union. Mira, Bubble and Ama share their views as:

> *"I will be very happy that, me too I have children. My mother wants her grandchildren (crying). She wants to see her grandchildren. She has to carry her grandchildren. I need to have children. My marriage will be stable when I get pregnant and have my own children I will be very happy if I get one. I am growing. Day in and day out the body is changing. And as a Muslim woman without children is suicidal. Your husband may go for another woman." (MIRA)*

> *"My kid brother is having two children, one girl and one boy. In fact they are just my photocopy. And when we go to a salon or go to market place or go to somewhere, the people will say madam your children resemble you and before you realise it the children will be crying ' I want to go to my mother'. And one day too, I got sick seriously all of a sudden. My brother's first born came to me and in fact the boy was entertaining me. So when I got used to this boy and immediately I heard a knock on my door. And it was my brother's wife, errrmmmm sister I came for my son. In fact it really got to me. It hit me like a stone. So when the boy left in*

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fact I found myself alone. That was the very first day I got to decide to go to any length to get children." (BUBBLE)

"Sister, it is very sweet to have your own children. No matter how it is to raise somebody else's child, that child cannot be as your own child. No matter what you do, even if the child's mother is dead and you have to raise that child, somebody will one day tell the child that the woman who raised you is not your mother. It is a joy to have your own child, even when the child is stubborn. You will be happy to point to your child as your own." (AMA)

Another participant shares her testimony driven experience to seeking treatment as:

"People I knew around had conceived and they motivated me to go to the lady herbalist I am seeing presently. I was introduced by someone who also wanted a baby and have now conceived by the woman's medicine. So through that I decided that ok if it has made like someone gotten something out of it, because it is more like a testimony, I too should go and experience it." (AKOSUA)

"For the religion by the testimony that people come out to testify. It gives you hope. You see people who are testifying that they went to this place, they gave me this medication and I took it even on the television there is testify on the television and you are compelled to go to all these place. So that one too by the testimony of people it makes you think that if I go to these places, I will get pregnant." (AKUA)

The authenticity of treatment is made evident through what some participants saw and heard from others. A 34 year old woman, married for 5 years added her opinion as:

"The herbalist told me his own daughter had fibroid but did not go for surgery but took the herbal medicine throughout and when she was still on the herbal medications she conceived and had a child. The herbal medicine shrank the fibroid and allowed her to conceive. She got pregnant and had another child. I heard a lot of testimonies of how successful their treatment are from a lot of people who consult the herbalist." (BIRAGO)

4.5 Attitude about seeking infertility treatment

The approach exhibited by participants to seeking infertility treatment were different. These demeanours were either positive, negative and some of them had the outlook of 'doing nothing' as a result of hope failing in each treatment. Also, during the interviews it was observed that the disposition of the care givers brought out the positive aura to seeking treatment.

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4.5.1 Positive attitude

Most of the women with infertility were optimistic about treatment as a result of their belief about the choice of treatment they were engaged in. Confidence about seeking infertility treatment was also as a result of witnesses of others.

A participant with high hope in faith-based spiritual remedy exhibited her feelings as:

> *"I believe in my God. If even I am very old and it's even just one I will have it. God didn't say some women would give birth and others won't. He didn't say that so definitely it will come. It will definitely come. I will call you hahaha. You make sure you focus on the treatment very well and believe, you pray to God. That's all." (AJO)*

A 34 year old psychiatric nurse, shares her likeness and exhibited positive outlook for seeking herbal remedy:

> *"The herbalist is a woman and she received me very nicely. She is in this wooden structure and she cooks her medicines there. That was how I just went and she received me nicely, asked of my problem and I just told her everything and she started with treatment. I don't know for them if they go through training like someone who is working in her own field so she needs to give you a comfort zone for you to express yourself so she can help you. When I went the reception was very good." (AKOSUA)*

> *"But for me I am determine to have children at all cost." (AMA)*

Some participants demonstrated assertiveness about treatment as exhibited by Birago:

> *"But I'm very optimistic my current herbalist will help me get pregnant. If you have a lot of faith in the treatment you will get good result. I don't think anything will be a barrier for me, unless I try try try and I still do not get pregnant, then I may decide but so far as I am alive, I will persevere. Some have persisted and it worked. Some went through childlessness and treatment for 15years." (BIRAGO)*

Akua expresses her hope about seeking treatment with good account of others:

> *"……….because of what my friends say, what my doctor told me and he has showed me people that he has helped and I know them and they have children so I know that where I am attending right now I will see results that is the believe I have that ok people have gone there and they have conceived so me too when I go there backed by my faith, I will also see some results. Me I'm very aggressive and passionate about having children. I was aggressive about taking action" (AKUA)*

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4.5.2 Negative attitudes about seeking infertility treatment

From the interview most women with infertility demonstrated undesirable attitude about treatment due to reactions from some care givers.

One participant narrated her encounter:

> *"When he (the doctor) finished with the thing, he (the doctor) touched my tummy and it was paining me and I held his hand, he said 'don't touch me' and he just shout on me. In your own small way that you can make the person feel like, ')nusu y3 nipa' (you are also a human being) you could have done it. It's not his fault. If I wasn't sick, he would not put his hand there." (ABBA)*

> *"And then the treatment in Ghana here is like you can start like one month if you are not seeking anything then you stop but it's not like that; you have to continue. I myself I am giving you an example of myself. I started the operation and I went for review for one year and did not want to go again." (AJO)*

When most participants were asked about their views about infertility treatment in Ghana, it was observed the stigma attached to seeking infertility treatment elucidate an adverse attitude about seeking treatment.

One of the participants demonstrated her undesirable attitude to treatment:

> *"I think that for us here in Ghana, seeking infertility treatment is shrouded, people do not want to talk about it. And also because people do not want others to see that they are doing this kind of treatment we tend to hide. We want to go to a place where when we get there nobody knows you. I don't want to go to a place and someone will say I went to this place and I met this person doing this kind of treatment. So we tend to hide." (AKUA)*

A 36 year old participant with 8 years experience in marriage had a learned helplessness attitude about seeking infertility treatment with unsuccessful results:

> *"They did it for me. I started with the IUI and it did not work out. The second time same, third same. I got friends there-the embryologist. So he advised me to go for the IVF. So we started the procedure and it did not end anywhere. I started having severe abdominal pains and I started bleeding so they took me to the theatre. I had distended abdomen, my tummy became big. They said hyper something something. So they had to tap and withdraw some of the fluid. It did not work out and I came home to prepare myself for the second one. For the second one, it did not even get anywhere, that day I started bleeding and yes that one too did not work out. I decided not to go there again." (PIPI)*

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4.6 Cultural beliefs and perceptions about seeking infertility treatment (subjective norms)

Cultural beliefs and perceptions have a great deal of influence on women with infertility about seeking treatment, which was revealed by the interviews. These cultural beliefs and perceptions were categorised into influence from significant others about seeking treatment, traditional views about seeking treatment, societal pressure about seeking treatment and opinions about seeking treatment.

4.6.1 Influence from significant others about seeking treatment

Influence from significant others were evident in the interviews. Though most women had their own innate drive about treatment, the choice of the treatment and the initiation were inspired by friends and family who took interest in their childlessness. Most of the women were grateful for the support rendered by friends and family to seek infertility treatment. The influence to initiate a particular choice of treatment was inspired by important people in one participant's life and she explains that:

> **"** *I think it was my husband, my husband told me that someone also advised him to seek health assistance as it stands before relying on God if everything is ok. That is why I went to the hospital to check. In fact my pastor himself recommended we seek medical treatment, if we are that worried."(AFIA)*

Treatment seeking involved the people around the participant and Ajo got the support of her family as:

> *"Hmmnnnn they (my family) support me in prayer and sometimes if they hear any medicine they bring it that I should take it." (AJO)*

Akosua reported the support she usually receives from her family and explains that:

> *"When it comes to support, let me say I have 98% of support, from my husband, from my family, from his families, from I mean my friends and my church members. Sometimes the 2% out of the 98% is from me. I think the rest are in support even though they have not made it known to me that they are not in support. The steps*

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they are taking in helping me I can see they are in support. Some comes with medication and say oh you can you try this, I have a friend who will say, can you go or let me take you there. Even my in-laws, some even come in and tell me they will take me to a gynaecologist and take care of all the expenses."(AKOSUA)

4.6.2 Traditional views about treatment

Traditions and customs are also instrumental in the treatment of infertility. Almost all the participants come from places other than the Greater Accra, the capital of Ghana. All the participants had to recall how infertility issues were tackled from their various traditional areas.

Akua threw more light on what pertains to seeking infertility treatment from her traditional area (hometown) as:

"From where I come from when people are not getting pregnant, number one is to go to the herbalist. There are a lot of herbalists there. The number one place I know that they go to seek infertility treatment is Mampong. When I got there something prompted me to ask about infertility treatment. I know that even when I was young I know that when people do not have children they go and see the herbalist and then they give them medicine. I know Mampong, they have medications there that it is good for infertility."(AKUA)

Though some participants mentioned that some people in their tradition areas seldom attend hospital, the cultural belief in herbal therapy for treating infertility was high. A 34 year old woman with infertility narrated:

"There are a lot of places people go in search for treatment. But most people prefer the herbalist. These natural medicines are taking over now. Because a lot of people go to the herbalist for medicines. Because their drugs are very good. If only you take the pains to drink them and adhere to the instructions, then it works. There are a lot of herbal medicine in my hometown. My own father's cousin is a herbalist in my hometown. Because in my home town herbal medicine is common. Nobody will tell me to go to hospital for infertility." (BIRAGO)

Also Pipi added her views as:

"Where I come from, they do not believe in the orthodox medicine. They believe in the herbal medicine. So where I am coming from, they do not know anything like

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IVF and all that. They know you go to see the herbalist, they give you herbal treatment." (PIPI)

4.6.3 Societal pressure on seeking treatment

During the interviews, it was noticed that almost all the participants were pressurized to seek infertility treatment from their social network of family, workplace, church, and friends. They verbalized these societal pressures as:

"Also there is pressure from society I have to admit because, if you don't have kids everybody is looking at you, everybody will be asking and it can be frustrating. I think is societal pressure yeah I think from family and even society. That is the reason why I want to have children, there is too much pressure from the society. Like everybody wants to tell you what to do. This person says go here, this person says take this, another person says you're not trying hard enough, you're doing this, you're not doing that. People will say we are waiting for my grandchildren, what you are waiting for, I want to carry my grandchildren." (MODA)

To most of the participants, society places a lot of demands on them out of being concerned about their infertility. According to Akosua:

"Some people go as far as to places they have not been before because they want to avoid the stress and pressure from the society just to get pregnant. So anywhere the person thinks is appropriate to get pregnant the moment they know there would be pregnancy the person has to be there. Society is pressurizing you. If not for society I don't think it would be more of a pressure to go length and breadth to seek treatment." (AKOSUA)

The pressures from society sometimes become daunting to the extent that they prescribe infertility treatment against their wishes. Birago narrated her experience this way;

"When they see you they say "you are wasting too much time', 'Hurry up and have children', 'today we don't sit down and waste time in having children'. They show you places to seek treatment even against your wish. If you follow the societal pressure you will go where you are not supposed to go even consulting fetish. Society will push you to consult the fetish to get a fetish child."(BIRAGO)

4.6.4 Opinions about seeking infertility treatment

Opinions about seeking fertility treatment were numerous. These thoughts from participants emanated from their own world views about infertility treatment.

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A 40 year old woman with infertility had a different interpretation to seeking treatment at the early phases of her childlessness as a result of her world view, but she became cognizant of other methods of seeking infertility treatment as she advanced in age:

> *"Initially, when I saw that I could not get pregnant, I said God gives it freely and why should I have to pay to get a child? So initially that was my close up perception, then as time went on I don't know if I read about it, or I was told by some of my gynaecologists , then I started thinking about ART(IVF). For me I think number one is age, because I did not marry early. So because anywhere you go to, they ask, how old are you? Because of my age, when we did the AMH (Anti-Mullerian Hormone), my ovarian reserves were very low. I think that it is my age which has not helped me. I think my age is the number one thing. So now my perception has changed. I know that if I am not conceiving naturally, the best option is that one (IVF). Initially I was bent on challenging God because He gives it freely, even to people who do not want it. Now my perception has changed greatly. IVF is a lot of money that you have to start somewhere." (AKUA)*

Another opinion from a participant indicated the need for men to collaborate with their partners in seeking treatment for their childlessness. She shared her opinion as:

> *"In Africa, when a couple is childless, everybody turns an accusing finger on the woman. Since women carry pregnancies, they are mostly accused of barrenness. Men should also go to the hospital for checks. The doctor I saw made it known to me that he dealt with a couple who were also childless for so many years…it was revealed through tests and labs that the man was the cause of the couple's childlessness. He never had sperms. So the children the man thought he had years ago, were actually not for him. So I think men should always go to the hospital for the couple's infertility tests." (BIRAGO)*

Moda, a 37 year old with five and a half years marriage experience had this to say when asked about her view on seeking infertility treatment in Ghana:

> *"I have this perception, that in terms of investigation regarding infertility, possibly, the hospitals abroad may have better resources and better technology to address some of these things faster than what our doctors have here in Ghana, I wouldn't mind flying out just to go and do investigation for like a year to see if I could get pregnant." (MODA)*

All the participants asserted that women with infertility consult several treatment modalities and the perception of Mira about seeking infertility treatment was not different

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from all the participants though she was sceptical about some places women with infertility consult for treatment:

> *"People go to plenty places. Some go to the churches, some go to the mallams, and some go to the fetish, some go to places and these pastors sleep with them, telling them they will get children. Some sleep with other people to get children. When they get pregnant they can't tell their husband. Some go to the riverside to ask for children so when they get pregnant perhaps the children may not be good they may be mentally ill. What would you do with such children? Such children become problematic for you. I do not believe in so many places who profess they give children. Some places will not give you a good child, then you regret later. Some take these children and suffer." (MIRA)*

4.7 Intentions about seeking infertility treatment

The forethought of all the participants was to seek treatment one way or the other in anticipation for a child. Three categories of intentions emerged; aim of infertility treatment, plans to seek treatment and target for treatment.

4.7.1 Aim of infertility treatment

All the participants had the goal of having children with their various treatments of choice. For some participants, their goal of seeking treatment was to experience the blessing that a child brings:

> *"(Laughing) everybody wants to enjoy the blessing of having kids. They are a blessing. So I really want to have one (Child)."(AFIA)*

> *"To know that my husband and I, God has blessed our union with this beautiful gift of another human being, you know. Sometimes you have all these dreams and ideas of how you would braid the baby's hair , you will play with the child, when you see other couples I mean handling their new-born babies you desire that when probably get one, I will try and take care of that child." (MODA)*

Akua, a 40 year old had a goal to have a child of her own child. She says:

> *"Whatever options are there for me to have a child. By all means I have to have a child. Even if I get one, I know this is mine." (AKUA)*

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4.7.2 Plans to seek treatment

Almost all the participants had their own strategy to pursue infertility treatment. Most of them had tried other methods without success and they had ideas to embark on another to seek treatment. Though child adoption is not a treatment option in Ghana, most participants had plans for child adoption.

> *"I will go in for adoption first and continue seeking treatment because I don't want to be depressed of not having a child. I wouldn't mind adopting a child from the social welfare people, the children's home. Even if I have my own children, I will still adopt. It is something I have planned to do." (AFI)*

> *"If pregnancy does not happen and still things are how they are with no baby… well we have conditioned our minds, I and my husband we sat down... Because we have positive and negative. We will go in to orphanage and pick a baby then we take care of the baby as our own. For the ART, that one too we are making enquiries, and so (voice breaking) of course we are going to do that one too. So any of it either IVF or adoption." (AKOSUA)*

Due to complications from failed IVF treatment, Pipi had this to share:

> *"I have decided in my mind even yesterday because of what I have gone through; everyday taking me to the theatre, so I get frightened. I don't know what will happen anymore. Maybe I might lose my life in the name of having a child so I have decided on going in for adoption. That was what I have decided but my husband and I have not come to that conclusion yet." (PIPI)*

4.7.3 Target for treatment

Although the ultimate mark of seeking infertility treatment for almost all the participants was to achieve pregnancy, most care givers could not give them timelines to conceive.

> *"I have not been given any time duration for conception but it depends on the treatment. He (herbalist) told me that people come for treatment and will not get to three months and they conceive. Everybody and their body makeup." (BIRAGO)*

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The target of all participants were not achieved yet. None of the participants had a child. Some of them recounted several failed attempts to treatment. Nevertheless, they were ready to forge ahead with treatment to have children:

> *"I have been married for about 14 years now. 1st September this year will be 14 years. So 14 years of marriage without children. And we are on the medicine. We have gone to so many places: herbalists, hospitals, wherever we hear the place is good, we go there. We have taken medicine upon medicine. So I don't sit down, I keep going to the hospital, also taking the herbal too small small. Right now I even have some medicine in my bag. It is also from the hospital." (AJO)*

> *I have decided not to give up. I will fight on. I will go for another one-IVF. I have tried three times. I know some people have tried severally and it was a success for them, so I will also try it and get what I want. But with prayers. (PIPI)*

4.8 Treatment seeking behaviour

All the participants were engaged in activities to help them conceive and have children. It was observed that participants consulted herbalists, fetish, purchased medicine from drug peddlers, attended prayer camps and churches to either pray on their own or consulted prophets to aid them in prayers. Some participants initiated seeking infertility treatment with hospital treatment, others started with prayers whilst others commenced with herbal remedy. The various courses of action each participant took was greatly supported by their views about the treatment, what motivated them to seek treatment, and their intention to work on the available options for them. Therefore, their treatment seeking behaviour involved pursuing herbal treatment, seeking hospital treatment, engaging in faith-based spiritual treatment, employing combinations of treatment and having a changed lifestyle as treatment seeking.

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4.8.1 Pursuing herbal treatment

Some of the participants utilised herbal remedy for their childlessness. In the case of two participants, their use of herbal treatment was the confidence in herbal medicine for infertility. In the narratives, they put it this way:

> *"I will continue to do the herbal. I have seen a lot of change in my body since I started taking the herbal medication. Because, my lower abdomen used to feel firm but it is no longer hard. My treatment with this particular herbalist has not been long. It is nearly two months." (BIRAGO)*

> *"I started with herbal medicine, I went to my village upon hearing that there is a women who helps people to get pregnant as fast as three months. I was given herbs for enemas, inhalation. I was given clay 'shiley' and herbs. (AMA)*

Akosua, a nurse by profession expressed her use of herbal medicine. In a confident look she narrates:

> *"I had to seek herbal medicine so I sought out herbal treatment. When I got there, she (herbalist) advised that I had to comply with the treatment irrespective of how it is. She started giving me medication. She first gave a medicine like a seed. To insert into my vagina. I did but didn't know it was so painful, I had abdominal cramps after the pain subsided I had chills, severe headache, felt feverish, then I was sweating, I became very weak. I called her but she told me that was how the medicine is. I started discharging watery substance like brownish, yellowish liquid for weeks, the amazing thing about the seed is that when you insert it, 3 days it will come out by itself, so it came out in 3 days but the watery discharge took like a week. Then she gave me medicine to drink and for enema, which I did." (AKOSUA)*

4.8.2 Seeking hospital treatment

The urge of seeking hospital treatment was as a result of the participants' educational background and their confidence in hospital treatment.

A 39 year psychiatric nurse, shares her views as:

> *"I have received infertility treatment both in Ghana and in the UK. I have done IVF twice to conceive but they all ended in miscarriage." (AFI)*

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Another 36 year old psychiatric nurse added her thoughts as:

> *"We went to the women's hospital for the first time they made me run a few test. I did series of test but it came out that I did not have a problem. The problem is from my husband. He has azoospermia. I always use donor sperm." (PIPI)*

Another participant, a 37 year old banker with a master's degree but divorce also asserted that:

> *"I went to the fertility centre because I thought I was married over three years and I did not have a child. Till 3 years after the pressure was becoming too much then I decided to go to the hospital for treatment."(DAPAA)*

4.8.3 Engaging in faith-based spiritual treatment

All the participants were religiously inclined. Though they all did one thing or the other to get a child, most of them were deeply engaged in faith-based spiritual remedy by consulting churches and prophets. They engaged in some spiritual activities like 'akwan kyere' (guidance by a spiritual leader), praying and fasting to enable them conceive.

A participant with 6 years experience in marriage, explains that:

> *"I sought treatment each month from pastors, drinking anointing oil, eating apples that has been blessed by these spiritual leaders. I buy apples to church...I have gone to a lot of churches. I spend time in these churches to fast, looking forward into the months. Some pastor asked me to buy milk so they tell me what to do 'Akwan kyere'. When you are given 'akwan kyere' when you do it and it goes well for you then you come back to thank God. Most of them do not take money but those who will take money will sell anointing oil to you. That was when I saw red anointing oil. At a place I was given anointing oil that I should bath with it at 12 midnight whilst I was naked. (AMA)*

Mira, although a Muslim had to consult prophets out of desperation to get children. She asserts that:

> *"I consulted two prophets. I've only been to these two prophets at Adabraka and Kpone. I am a Muslim but I go to see a prophet because I heard these prophets*

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help people get children. I have to do what I need to do to get children. I'm going there because I believe I will get children." (MIRA)

Contrary to the enthusiasm some of the participants had seeking faith-based spiritual remedy, one participant was not pleased with the deeds pertaining to that treatment of choice.

".... it is even affecting the way I go to church, as at now I am someone who used to go to church a lot. Anytime I go to church they will call you that sister come, let's pray for you....one baby... just to conceive so every time you will be called to the pulpit to be prayed for and I felt in a way they are stigmatising me."(AKOSUA)

4.8.4 Lifestyle change

Almost all the participants stated that they had made some modifications in their everyday life to help them get children. Some indicated healthy eating, dieting, exercising, reducing stress, increasing the number of times to have sex and taking of vitamin supplements to assist them increase their chances to conceive.

A 37 year old counsellor, shares her story of how she reduces stress and increases the frequency of sex to help her conceive:

"First of all, on my part, my husband and I we have made a conscious effort to slow down on work and do things to bring down the pressure. We tried to work on that to bring down the stress level and also to increase the frequency of sex, because we felt that to be a factor." (MODA)

Akua tells how she uses exercise and other dietary change to modify her life:

"I try to control my weight so I exercise. I go for walks. I tried to control my weight I do not want to put on a lot of weight and I take supplements. Currently I am taking Vitamin E, I'm taking folic acid and sometimes I do take Vitamin C. I do some kind of crazy diet. I check what I eat. I do not eat sugar because I have fibroids and I know the sugar helps the fibroids to grow fast."(AKUA)

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Another participant indicated she checked her fertility period in addition to taking supplements. She narrates it this way:

> *"Because I knew definitely I will get pregnant, I was taking folic acid and vitamins because it improves fertility and I was also checking my ovulation. I have it on my phone. He (my husband) also has it on his phone. So during that time the phones will give us the alert then we have increased sex just to improve our chances." (PIPI)*

In the case of Afi, in addition to exercising, she also practice relaxation, keeps well hydrated and avoids any form of harmful substances.

> *"I eat healthy and well, I exercise and go for massage and learnt all these things will help you conceive. I drink a lot of water. I do boxing all in the name to make me fit. I keep away from chemical, I tried to get organic stuff, I have stop doing my hair, and I do not perm my hair anymore. I just want to avoid chemicals so I tried to minimise the use of microwave because of the radiation." (AFI)*

4.9 Barriers to seeking infertility treatment

A theme that emerged outside the conceptual framework after the interviews and analysis is the barriers to seeking infertility treatment. The two subthemes that emerged are possible obstacles to seeking infertility treatment and inadequate knowledge about infertility treatment.

4.9.1 Possible obstacle to seeking infertility treatment

Emanating from the data were factors that could be hindering elements for the participants. Financial restraint, religion, painful infertility procedure and lack of spousal involvement in seeking infertility treatment were a likely blockade. Almost all the participants verbalised that the cost of seeking infertility treatment was expensive regardless of the type of treatment. According to some participants the consultation fees to see the spiritual leader for guidance, buying of items for guidance, giving of special offerings among others depleted their finances as they sought faith-based spiritual remedy. Early menopause,

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attitude of staff and long waiting time at the clinics were also reported by some participants to be a possible stumbling block to treatment. Afi, Akosua and Ama shared their sentiments:

> *"I am catholic and they don't allow infertility treatment. They prefer everything natural. I remember that my last divorce was as a result of my husband then refusing to do IVF because it was against his religion, he is also a catholic. My religion does not believe in fertility treatment." (AFI)*

> *"I was spending much money in these clinics and hospital which was draining me so I decided to 'chalk' for a while. The only thing that will hinder me will be financial restraint." (AKOSUA)*

> *"What will hinder me is when I get early menopause." (AMA)*

4.9.2 Inadequate knowledge about infertility treatment

Another contributing factor that negatively affected treatment seeking behaviour among women with infertility was inadequate knowledge about treatment. Some participants confessed that they would have advanced in seeking treatment if they knew what to do or where to go when they realized they could not conceive. Most participants did not have any clue about advance treatment of infertility like the ARTs (IVF) and those who had heard about it did not have the right information.

Akua elaborated on inadequate education about infertility treatment:

> *"People do not have enough knowledge too about treatment so when people are facing problems when they are married they do not want to go out to seek infertility treatment. So it will take a very long time; so by the time they seek for infertility treatment, then it has taken, I mean maybe, if you are a woman, looking at the age and all those things, it would have been late. You would have wasted a lot of time not seeking the treatment when you had wanted to seek the treatment."(AKUA)*

Akosua also articulates her sentiments as:

> *"I think that the education is low about seeking infertility treatment. Because a lot of people do not know what to do. I think that something must be done about the education. We should lift that aspect up and tell women that there is help out there.*

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You need to go and seek for help. If you know that you are married for a year, or six months and you're not getting pregnant, ask why am I not getting pregnant? There should be education of where to go. There were some places I pass by all the time but I did not know they were fertility centers. They may have had it there but if not for a doctor who will refer you there you may not know." (AKOSUA)

Moda expresses her worries about inadequate education on infertility treatment during pre-marital counselling. She described the situation as frustrating:

"So sometimes it can be very frustrating but I think that there should be more education on infertility. What to do, especially for people who are entering marriage I think. Even though yes I was given some information on infertility, I feel like I should have been given more detailed information by the counsellors so that I wouldn't wait too long to seek infertility treatment because sometimes I think what the counsellors told me made me more a bit to relax at the beginning that oohh 2 years is nothing keep waiting. When I could have made progress or started the process of treatment earlier because now I am growing older. I think education is something that we should also look at, at the premarital counselling and where we can educate people so that should they encounter infertility they start treatment earlier than later."(MODA)

4.10 Summary of Findings

In summary, this chapter was about treatment seeking behaviour of 14 participants with the age range between 26 years and 40 years. In seeking infertility treatment, most of the women had the expectation of conceiving with any action towards conception they engage in. On the contrary, their expectations were not met as all the participants were childless. From the interviews some participants after several failed attempts at treatment had given up and were grossly involved in other activities like furthering their education and developing their personal businesses.

The desire of all the participants was to conceive and have children. All the participants had their beliefs about seeking infertility treatment. They were of the conviction that women with infertility should not sit and do nothing about their childlessness. Some participants had trust in orthodox treatment, whilst other participants had confidence in

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herbal or natural remedy. A number of the participants exercise a lot of faith in spiritual remedy making them hop from one prayer camp to the other, likewise churches and seeking 'Akwan kyere' from spiritual leaders.

Participants were motivated to seek infertility treatment by their inner yearning that aggravated their core mandate as women, in addition to testimonies by other people on seeking treatment. Some participants exhibited positive attitude to treatment whilst others had an indifferent attitude to seeking treatment due to past experience of failed treatment. Culturally, the traditional views and opinions of where most participants hailed from did not influence their treatment choice much due to urban socialization. Influence from significant others and societal pressure impacted greatly on participants seeking for infertility treatment.

Furthermore, the intention of all the participants were to aim at conceiving and having children of their own. Most participants had their own plans to seek treatment to meet their targets. On the other hand, inadequate knowledge about infertility treatment, staff attitude, long waiting time, lack of spousal support among others may pose as a barrier to seeking infertility treatment. Socially, medically and economically there should be measures that will improve the treatment seeking behaviour among women with infertility. Though they have their own beliefs about seeking treatment, there should be enough education to boost their choice of treatment.

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CHAPTER FIVE

DISCUSSION OF FINDINGS

5.0 Introduction

This chapter discusses the findings of the study. The discussion covers the demographic characteristics, beliefs about seeking infertility treatment, motivating factors to seeking infertility treatment, attitude about seeking treatment, cultural beliefs and perceptions about seeking treatment, intentions about seeking infertility treatment and treatment seeking behaviour

5.1 Demographic Characteristics

This current study reported 14 women with infertility with the age distribution ranging from 26 to 40 years, representing women within their reproductive age. This signifies that infertility is not age discriminatory. The age range falls in the range of participants in similar studies of Yao, Chan and Chan, (2018) and Datta et al., (2016). The age group of these participants are the marriageable age group and majority of them were married within a range of 1 to 14 years, suggesting the duration of their infertility, with the exception of two participants who were divorced due to infertility. This suggests that infertility may impact marriages negatively or strengthen the union as reported in previous studies (Dhont, Wijgert, Coene, Gasarabwe & Temmerman, 2011; Yebei, 1999; Oti-Boadi & Oppong Asante, 2017; Kalaja, 2015).

All participants had formal education. More than half of the participants had tertiary level education with the highest pursuing PhD which is consistent with a previous study in Ghana (Oti-Boadi & Oppong Asante, 2017). On the contrary, participants in a previous

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study by Kalaja (2015) who resided in rural areas had gained not as much as high school level of education. Their level of education had an impact on the period and choice of the infertility treatment. This conforms with previous studies by Sarkar and Gupta (2016), Dhont et al., (2018) and Sarac and Koc (2019) where the period of infertility was significantly associated with educational level, thus the peril to seeking treatment. They were all urban settlers seeking infertility treatment from different rural traditional areas.

Majority of the women in this study were Christians with the exception of one woman who was a Muslim. All these women were engaged in various activities in search of having children regardless of their religious background. This suggests that their religious affiliation did not affect their treatment seeking behaviour as reported in a similar study by Roudsari and Allan (2011).

5.2 Beliefs about seeking infertility treatment

Beliefs about seeking infertility treatment are the strong philosophies of the woman to do something about their childless state. The findings of the study revealed that the women had conviction about seeking treatment, trust in hospital remedy, confidence in herbal/ traditional/natural remedy, faith-based in spiritual/religious remedy and reliance on combination of treatments. The conviction these women had to seek treatment was as a result of the belief that if a woman realises she cannot conceive, she should not sit down and leave it to chance by 'doing nothing' about her childlessness. The current study findings revealed that most of the participants had the conviction in seeking treatment for infertility as reported in previous studies (Singh & Shukla, 2015; Sarkar et al., 2016; Dhont et al., 2010 ; Ali et al., 2011). Most of the women felt it was very necessary to seek infertility treatment if you are having unprotected sex to get pregnant and there is no sign

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of it, especially in an African setting. Also, the women in this study believed that it was important to seek infertility treatment because experiences of infertility are unpleasant, difficult and frustrating to wonder what might have gone wrong with them (Ray & Bhore, 2017).

Most of the women expressed the belief in hospital treatment as a treatment of choice. These women were found to have above secondary school education. They were of the strong believe that the hospitals had the expertise to test and diagnose the infertility issue and it should be the first point of call. This is contrary to what was reported in a previous study by June, Dimka and Dein (2018) that the belief in seeking hospital treatment is done when other treatment modalities had failed. Again, these women believed that doctors at the hospital understood the human anatomy better and they are able to delve deeper to bring out a solution to their childlessness. Tamrakar (2019) and Ali et al. (2011) reported similar findings about the outcome of hospital remedy for infertility. In this present study it was observed that higher level education could be the reason why these women trusted the hospitals for infertility as also testified by women in Pakistan (Ali et al., 2011).

Conversely, findings of this study established that some of the women believed in natural/herbal/traditional remedy for their childlessness. It was obvious that due to the socialisation of these women, there was the belief that herbal treatment was natural as compared to hospital treatment. This finding agrees with findings by Naab, Brown and Heidrich (2013); Smith et al., (2010), Chethana (2016) and Gyasi et al. (2016) on recognition of herbal/traditional remedies as prominent in the treatment of choice and perhaps the first point of call (June et al., 2018).

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On the part of faith based remedies, these women believed that God is the only source of children. As similarly perceived in other studies, women in the present study expressed their faith in the will of God to bless them with children (Dhont et al., 2011; Hiadzi, 2014; Nelson et al., 2018; Ray & Bhore, 2017). Correspondingly in Iran, Golmakani et al., (2019) found the belief in conceiving miracle babies. The findings may imply that women with infertility believe in supernatural abilities to make them conceive. Furthermore, some of the women believed in combined treatment for infertility (James et al., 2018). These women believed that the best way of treating infertility is to combine various treatment options for maximum benefits. Participants believed that it was less productive to only go to church or seek the favour of God without 'doing anything'. Consequently, seeking hospital and herbal treatments was beneficial to them. The belief in combining treatment was also reported in a previous study in Ghana that women believe in combined treatment outlets for infertility management (Tabong & Adongo, 2013). These combined treatments were used concurrently for lack of patience and fast results as indicated by Hess, Ross and Gililland (2018).

5.3 Attitude about seeking infertility treatment

Regarding attitudes, the findings of this study ascertained that women with infertility exhibited both negative and positive attitudes towards seeking infertility treatment. The attitude of all the participants to seek infertility treatment were their own approach towards their treatment of choice and also that of the care givers. Smith et al., (2010) and Koropeckyj-cox, (2018) reported in previous studies that positive attitude toward the treatment of choice increases the likelihood of having children. In this present study, it was found that most of the women were optimistic about the various treatment they were seeking. These women demonstrated high trust in treatment due to their beliefs about that

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particular management and perceived benefits. Most women were ready to persevere and stay focus till they conceive. This demonstration of positive attitude was also reported in Iran and UK (Roudsari et al., 2011).

The positivity about seeking treatment also came about because they had seen people who engaged in a particular treatment method and had succeeded in getting children. These women were sure that if other women with several years of infertility were able to conceive then it was also possible for them to have their own children. Gerrits (2018) indicated that testimonies of positive outcome aggravated positive attitude of participants to seek a particular treatment of infertility.

In Ghana (Gyasi et al., 2016) and Nigeria (June et al., 2018), it is reported that the pleasant reception of traditional care givers (herbalists) appeal to treatment seekers. In the present study, the women demonstrated positive attitude for traditional care. For instance, women indicated the nice reception, follow-up calls, listening to their problems, cooking herbal medicine for them and the overall eagerness of traditional healers to help them. These gave these women in need of children hope in the treatment. Similarly, in Saudi Arabia, Abolfotouh, Alabdrabalnabi, Albacker, Al-jughaiman and Hassan (2013) reported positive attitude of women during infertility treatment as reaction to the care givers' actions. On the other hand, negative attitude of health care providers towards these emotional laden women with infertility was reported by these women. Some women reported that doctors treated them less of human, shouting at them and portraying no empathy towards them during treatment, compounding their challenges. Similarly, Pedro, Faroa, Pedro and Faroa (2017) reported on the poor attitude of care givers demonstrating lack of compassion with participants whilst they were seeking treatment.

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The findings further revealed that the women were found to have experienced perceived stigma and they tend to hide as they seek treatment. They do not want other people to see them seeking treatment and do not even talk about it. They described seeking infertility treatment as being shrouded in secrecy. This signifies the negative perception the public has towards infertility as reported in similar studies to have an influence on treatment seeking behaviour (Donkor & Sandall, 2007; Gerrits, 2012).

This study also found that women exhibit lackadaisical attitude towards seeking treatment due to the unsuccessful results of conceiving. They go through several failures in their quest to get children. This gives them the learned helplessness attitude to back out of treatment and consequently jeopardising their dreams of having children of their own. Similar assertions have been reported in Mali (Hess et al., 2018).

5.4 Motivating factors for seeking infertility treatment

Factors that motivates women with infertility to seek treatment were linked with their intrinsic and extrinsic stimuli. The intrinsic stimuli are the innate determination of a woman to conceive and have children. Similar to the findings by Kalaja (2015); Yao et al.,(2018) and June et al., (2018), the current study found that women with infertility had the feelings that once you are a woman, you have to give birth as a core mandate on earth. Most of them were strongly motivated by God's command of proliferation on earth. They added that God did not ask only some women but all women to 'go and multiply'. This suggests that the innate determination to procreate gives childless women hope and motivates them to continue to seek treatment.

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Again, the difficulty to conceive prompted the awareness that something was not right, in so doing motivated participants to seek treatment. This assertion was also reported in other studies (Tamrakar, 2019; Kessler et al., 2013).

Although participants believed that children are blessings from God, they were also inspired to seek treatment to have children. The reason is to impact the next generation with knowledge and godly training and their own children perpetuating their generation to care for them when they are old. Yao et al., (2018); (Behboodi-Moghadam et al., (2013) and Kalaja, (2015) had similar findings in their studies where women seek infertility treatment faithfully for the continuity of generations and for their offsprings to assist them in their old age.

The extrinsic stimuli that motivated these women in this study to seek treatment were their procreative drive and the enticing testimonies from other women on treatment that worked for them. The study found that women with infertility were motivated to have children to enable their parents have grandchildren. They added that most of their mothers asked of their grandchildren which gives them that drive to always be on the move in seeking infertility treatment which is consistent with other studies (McQuillan, Greil, & Shreffler 2011; Tabong & Adongo, 2013; Yao et al., 2018).

The negative consequences of a childless marriage motivated most participants to go far and wide in search for pregnancy. The unfavourable treatment from family, friends, the society and the threat of unstable marriage gave most women the motivation to seek treatment at all cost. One Muslim married woman reported that it was suicidal not having children. Similarly in Rwanda, China, Mali and Albania, women with infertility are

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threaten in their marriages with the likelihood of their husbands going in for another woman (Dhont et al., 2011, Yao et al., 2018; Hess et al., 2018; Kalaja, 2015).

This study found that women with challenges to conceive were moved to seek treatment by virtue of testimonies. The women were introduced to the various therapies by social network who have had success with their treatment and also word of mouth propelled their treatment seeking behaviour as reported in previous studies (Gerrits, 2018; Osei, 2016; Hess et al., 2018). Media advertisement motivated most participants to visit certain places for help as they got to know of women who had also endured childlessness but eventually with babies in their hands. To reach a larger number of women with infertility, treatment centers often use advertisement of their product through the internet, newspaper, radio and bill boards to advertise infertility treatment (Hawkins, 2013; Osei, 2016); which seems to be attractive to these women.

Most herbalists and other care givers gave testimonies of their infertility treatment as indicated by participants, which encouraged them to seek their treatment. Other women with infertility also get to know about treatment through their social networks. Given that, most childless women do not talk much about their treatment seeking behaviour, they are left with the option of close ties and social networks as motivating factors to seek treatment. This situation does not allow women with infertility to explore treatment method that will suit the cause of their childlessness. It was reported in The Gambia that social networks of the women with infertility were significant resources in their motivation to seek treatment (Id et al., 2019).

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5.5 Cultural beliefs and perception about seeking infertility treatment

Another important practice found in this study was cultural beliefs and perceptions from the community of origin of these women that influence their treatment seeking behaviour in the area of influence from significant others, traditional views, societal pressure and opinions about seeking infertility treatment. Women in this study were found to initiate a particular choice of treatment by the encouragement of important people in their lives. The most mentioned were husbands and mothers (Id et al., 2019). Influence from significant others to seek infertility treatment was consistent with a previous study by Ray and Bhore (2017) in India where treatment was influenced by the relationship of husbands, family members and caregivers. This study indicated that most of the women had support from their significant others, influencing treatment seeking behaviour positively. The support was demonstrated in prayer, treatment recommendation and taking care of expenses of infertility treatment (Obeidat, Hamlan & Callister, 2014). However, contradictory views of low support of women seeking infertility treatment was found, that resulted in the termination of treatment (Vassard et al., 2012).

Women were faced with challenges that imposed pressure on them to seek infertility treatment. These undue pressures came from their social network of family, workplace, church and friends (Obeidat, Hamlan, & Callister, 2014). These women verbalised that it was frustrating to be childless with a lot of close associates putting pressure on them on what to do and where to go for treatment. This suggested that some women perhaps sought treatment against their wish.

Opinions differ from person to person, as made known by the participants in this study. Some women in this current study were of the opinion that men should collaborate with

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their partners to seek infertility treatment. The perception zoomed in on what they had heard about some men who do not go for treatment instead abandon their partners to seek for treatment alone. The men believed they had children in the past therefore may not be the source of the couple's childlessness. Similar findings were reported by Id et al. (2019), Gerrits (2012), Tabong and Adongo (2013) that most husbands may not be the fathers to some pregnancies they claim ownership for in their previous relationships. This suggests the need for men to be encouraged to seek for assessment and treatment for the couples' infertility.

Furthermore, the findings revealed that some participants had the perception that infertility treatment was better outside their home country (Ghana). They believed that other hospitals abroad may have better facilities to address their infertility issues which is contrary to a study by Gerrits (2018) that Ghana attracted infertility travels, where people with infertility from abroad and neighbouring countries sought advance infertility treatment with successful results of live births.

Although all the participants were urban dwellers, their traditions and customs of where they originate from were instrumental in the treatment seeking behaviour. This study indicated that the cultural beliefs in the traditional area of these women in relation to infertility, settled on herbal/natural/ traditional remedy. The participants in this current study narrated that herbal medicines were used for all illnesses including infertility. Also, when women eventually conceive, these herbs are used to manage the pregnancies. This is consistent with the study by Gyasi et al.(2016) who reported on the effectiveness of traditional treatment on ignored diseases such as infertility among others. In the same vein, other studies in Mali added that women with infertility in their traditional area were

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comfortable with herbal remedy for infertility instead of “Whiteman’s” medicine (Hess, Ross & Gilillandjr, 2018). This suggests that Herbal medicine is part of the Ghanaian culture which existed before the introduction of orthodox medicine. It has been used from generation to generation and it is believed to be efficacious for the purpose of its usage. Though there is reasonable awareness of herbal treatment, higher education and influence of foreign culture has reduced its usage.

All participants’ views about seeking infertility treatment showed that they had the perception that women with infertility consult several treatment modalities including consulting mallams, fetish priests and others sleep with pastors in the quest for children. But none admitted consulting these sources for assistance.

5.6 Intentions about seeking infertility treatment

The current study revealed that the intention of all the women for seeking treatment was to have children, though none of them had children of their own yet. The aim of all the participants was to have their own children with whatever treatment option they were embarking on (Righarts, Dickson, Parkin & Gillett, 2015). This is because of the harsh treatment society emits to women without their own biological children.

Child adoption was another discovery from this study. Some of the participants expressed their plans to go in for child adoption when all other measures fail or when treatment threatens their lives (Ekwoaba, 2019). In Pakistan, a study indicated that participants were positive to child adoption as a treatment of choice (Ali et al., 2011). This suggests that there is a lot of awareness on child adoption due to the level of exposure of these participants and their educational levels. But contradictory report of previous studies from

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Adewunmi et al. (2012); Naab (2014), Nachinab, Donkor & Naab (2019) and that of Fehintola et al. (2017) indicated that child adoption is not a common option for infertility in African. Formal child adoption in Ghana has a lot of administrative protocols with its legalities thus little is heard about it.

Although the target set by the women for infertility treatment were not met, they were ready to forge on and fight infertility. These women were unable to meet their benchmark due to several failed attempts of treatment. This finding supports the findings of Obeidat, Hamlan & Callister (2014) and Hess et al. (2018). The women in this current study had gone far and wide, from hospitals to herbal places, taking a lot of pills, gone through IVF without positive results but they were poised to get their target for treatment one day.

5.7 Treatment seeking behaviour

Treatment seeking behaviour was those activities undertaken in an effort to achieve conception. In the present study, participants attended hospitals and consulted herbalist. Other participants engaged in various spiritual activities such as visiting prayer camps, churches and consulting prophets. This revelation was congruent to previous studies (Hess et al., 2018; Ambarish, 2013; Chimbatata & Malimba, 2016;Tabong & Adongo, 2013) in three different countries that women with infertility consult herbalists, seek for hospital or medical treatment and engage in religious actions and deeds to conceive and have children..

This study noted that most women with infertility pursued herbal treatment for their childlessness (Fatima et al., 2016; Daibes, Safadi, Athamneh, Anees & Constantino, 2018; Nahar, 2010). Similarly, the women were happy with the evidence of changes they

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experienced in their bodies as a results of the use of the herbal medicine. However, a contrary finding in Sierra Leone indicated that less than 2% of the study participants agreed to the effectiveness of herbal medicine (James et al., 2018).

In relation to seeking hospital treatment, this study reported that some women go through series of tests, laboratory investigations and artificial insemination. This could be due to multiple factors such as educational status, economic status and confidence in hospital treatment. For some of the participants the only treatment of choice was the hospital therapy. For instance, a participant reported using donor sperm due to azoospermia. This backs the submission of Hess et al. (2018) and Datta et al. (2016) who reported how childless women travel far and wide to seek hospital treatment and medical test and procedures they have undergone in anticipation to conceive.

Furthermore, women in the present study had faith in God as the giver of children. Some of the women attended churches, prayer camps and consulted individual prophet or spiritual leaders to help them have children. These women spend hours or days at these places for 'Akwan kyere' (guidance) to fast, pray, purchasing and performing rituals with anointing oil to desperately get children. This finding was found to be true in similar studies in Ghana and India (Osei, 2016; Tabong & Adongo, 2013; Owusu Ansah, 2011; Ray & Bhore, 2017) that participants engaged in spiritual activities, fasting, praying and trusting God to get children.

Contrary to the joy of seeking faith-based spiritual remedy, stigmatization was reported. Some participants found it stigmatising when they are called out of the congregation to be prayed for as they go to privately seek spiritual favour to get children. They said this action made new members who did not know about their childlessness get to know, affecting

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their preferred choice of treatment negatively. This finding agrees with Tabong and Adongo (2013) who had related findings of stigma as participants with infertility who reported at facility were openly called out to go to a particular consulting room for treatment and attracting needless attention (Anne & Saint, 2015).

The act of increasing the number of times to have sex to improve the chances of getting pregnant was another important finding in this study. These women felt the need to have more sex as a duty and a matter of compulsion as compared to enjoying their intimacy. They saved monthly alerts of their ovulations on their phones as reminders for duty call. This is consistent with the findings in Rwanda that couples without children partake in having more sexual encounter in the aim of increased chances of conception (Dhont et al., 2011). Furthermore, the previous work of Bokaie, Simbar, Ardekani and Majd (2016) in Iran established that, the number of sexual intercourse of participants increased with some particular positions as reason to increase chances of conceiving.

Additionally, women in this study engaged in a seeking behaviour of changing their lifestyle to enhance conception. The behaviour of exercising, eating healthy and organic foods and drinking a lot of water, taking supplements and vitamins were all actions geared toward enhancing the reproductive organ to conceive as reported in this study and similar to the findings of Sharma, Biedenharn, Fedor and Agarwal (2013) where it was suggested that conception may well be impacted with the right nutrition, weight controlling and exercise. Correspondingly, the finding of this study supports the study of Gaware, Parjane, Pattan and Dighe (2009) where participants of the study used massages, refraining from chemicals , radiation among others as a means to avert infertility. It was perceived by some of the participants that relaxing the natural hair with hair relaxers may cause infertility, thus they had stop perming their hair to wear natural hair.

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5.8 Barriers to seeking infertility treatment

This study pointed out some barriers to seeking infertility treatment which included financial limitation, menopause and religion among others. This study revealed how costly most infertility treatments were and how they have financially drained the pockets of women with infertility, leading to a halt or possible termination of treatment. Previous studies also reported that participants put up with expensive costs of infertility treatment inhibiting their treatment seeking behaviour (Cui, 2010; Mosalanejad et al., 2014; Pedro et al., 2017).

Religious disapproval of some types of infertility treatment affected some participants to seek infertility treatment. Some religious sect do not allow advance technologies like ARTs/IVF in the treatment of infertility purporting it to be unnatural with some side effects. This study found that a participant's husband refused a specific treatment that was suitable for her, on religious grounds which agrees with previous study of Mohammed-Durosinlorun et al. (2019). They established that some study participants did not find ART acceptable, reasons given that it was not natural, may have side effect, husband would not agree, and religion. The report on the Religious aspects of assisted reproduction by Sallam and Sallam (2016) found that ART was immoral and illegal to practice with the catholic sects.

Although studies show that menopausal women may conceive and have children with advanced technology infertility care (Banh et al., 2010), most women in this study said early menopause will be the only hindrance to seeking infertility treatment. This assertion may be due to lack of knowledge on ARTs. The findings in a study by Banh et al. (2010)

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in USA talked about menopause being a hindrance to natural way of female procreation as similarly put forward in this present study.

Inadequate knowledge about infertility treatment was reported in the current study as a possible barrier to seeking for help. Participants indicated that they had kept too long to access treatment that was suitable for their cause of infertility owing to deficiency of knowledge on infertility treatment. It was reported in South Africa (Pedro et al., 2017) that participants complained of inadequate knowledge as a result of some care givers who lack information for treatment of infertility. Also, a previous study in Indonesia found a general lack of knowledge for infertility treatment among study participants, with some participants not having any idea at all for infertility treatment (Rae et al., 2015). Prolong abstinence from treatment increases failure rate since infertility is associated with advance age. Most participants did not know much about the advance treatment of infertility like ARTs/IVF. They all admitted education on infertility was low and not much on treatment too. They pleaded that there should be education on where and what to do if you realised you are not conceiving after six months to a year of marriage. They added that premarital counselling should include detailed information on infertility and treatment seeking behaviour to avoid waste of time and money plus psychological distress associated with seeking infertility treatment.

This little knowledge was a possible hindrance to these women with infertility and frustrating in spending longer periods in seeking treatment that were not suitable and ending in unfavourable results. Ray and Bhore (2017) reported similar findings about women with infertility getting frustrated at long periods of treatment without success. Participants in this present study wished there was increased education about infertility

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and possible treatment especially before marriage. This assertion is not different from findings in South Africa by Pedro et al. (2017) who reported the desire of participants that education about infertility in the initial junctures are essential. Some of them did not have any clue about advance infertility treatment which resonate with previous studies (Ali et al.,2011; June et al., 2018) that inadequate knowledge about infertility treatment could obstruct seeking timely medical care and increase misconceptions.

5.9 Summary of discussion

Women with infertility seek infertility treatment by engaging in activities to avert childlessness. They had belief in the conviction that it was crucial to seek treatment for infertility. It was revealed that childless women believed in hospital, herbal, faith-based spiritual remedy and also having that believe in combining any of the above mentioned remedy for effective benefits.

Women in this study were intrinsically motivated to seek treatment by reason of their core mandate as women who were created to give birth and multiply. Some women felt that their innate drive to have children was to impact the next generation with godly training. Furthermore, some women with the challenge to conceive would not have attempted to seek treatment if not for several miscarriages they experienced. The threat of an unstable marriage and fear of partner going in for another woman drove childless women to seek infertility treatment which studies elsewhere did not report differently. Similarly, insensitivity of close social network towards childless women with their children motivated them to go any length to have children of their own. Testimonies of how previous childless women conceived and had children motivated women to follow that same pathway to achieving pregnancy by visiting specific places they have been.

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Additionally, care givers (herbalists) also give testimonies of their success stories to motivate women to seek specific treatment of choice against the others.

The general attitude about seeking infertility treatment was positive with participants convinced in their beliefs to have children at all cost whilst staying focus on treatment. The pleasant reception by care givers (herbalist) coupled with follow-up calls stirred a positive attitude for these women to seek treatment for infertility. They were positive to the fact that if somebody with 15years challenge of conceiving eventually had children then if they do same, they were sure to get same result of having children. Nevertheless, the poor attitude of some care givers (doctors) produced negative attitudes towards seeking treatment was also reported by previous studies. These women also felt stigmatised so they tend to hide their treatment seeking behaviour eliciting negative attitude about seeking infertility treatment.

The cultural beliefs and perceptions impact childless women to seek infertility treatment with influence from significant others encouraging initiation of seeking for help and backing up support to seek treatment to get children. This study found the demands society places on these women to seek treatment.

The intention to go in for adoption as a treatment of choice when all treatment failed was found in this study. It was revealed in other studies that women with infertility engage in various activities, consulting herbalist, attending church, prayer camps and seeking hospital management for infertility which was in agreement with findings in this present study.

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Financial limitation, religious restraints and menopause coupled with inadequate knowledge about infertility treatment were compelling barriers to seeking help to avert childlessness. Women with infertility expressed how expensive infertility treatment was, be it the hospital, church or at the herbal centers. Menopause was reported to be a possible obstacle to treatment owing to lack of knowledge to advance treatment like ARTs. Studies elsewhere yielded similar findings. It was evident that inadequate knowledge about seeking treatment increased their frustrations.

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CHAPTER SIX

SUMMARY, IMPLICATIONS, LIMITATIONS, CONCLUSION AND RECOMMENDATIONS

6.0 Introduction

This section discusses the summary of the study, implications of findings, limitations of the study, conclusion and recommendations.

6.1 Summary of the study

Treatment seeking behaviour is the activities women with infertility engage in to conceive and have children. Although women experiencing childlessness go the length and breadth in quest for children, not much is known about the treatment seeking behaviour among women with infertility in the Greater Accra Region. The Theory of Reasoned Action was used as a guiding framework to explore treatment seeking behaviours among women with infertility. Both quantitative and qualitative studies in the related area of treatment seeking behaviour was used to review relevant literature.

This research employed an exploratory descriptive design for the phenomenon under study. Ethical clearance was given by the NMIMR-IRB (Appendix A). A total of fourteen (14) participants were recruited through purposive and snowball sampling techniques. A semi structured interview guide was used for data collection (Appendix B). Participants were interviewed for 45 minutes to 1 hour. All interviews were audio taped and transcribed verbatim and thematic content analysis was used to group the data into seven (7) main themes namely; belief about seeking treatment, motivating factors for seeking treatment, attitude about seeking infertility treatment, cultural beliefs and perception about seeking

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infertility treatment, intentions about seeking treatment, treatment seeking behaviour and barriers to seeking infertility treatment.

The participants were between the ages of 26-40years with 1 to 14 years experience in marriage. Two (2) were divorced. Thirteen (13) of the participants were Christians in different religious sects and one (1) was a Muslim. All participants had beliefs about seeking treatment to enable them get pregnant and have children. The belief was in hospital, herbal, faith-based spiritual remedies as well as belief in combination of treatments.

Intrinsically, most participants were motivated to seek treatment by their inner yearning that provoked their core mandate as women to conceive. Most of them had no choice than to seek treatment as a result of their inability to maintain conception through miscarriages. Other participants were also motivated to seek a particular choice of treatment due to the perceived diagnosis of their infertility. Most of the participants were inspired to seek treatment by the recommendations and testimonies of their social networks.

The attitude about seeking treatment were both positive and negative. The positive attitudes were influenced by nice reception of the care giver and faith in God. On the other hand, the negative attitude of care givers, societal sanctions and unsuccessful treatment results precipitated lackadaisical attitude to seek medical infertility treatment.

Culturally, the influence to seek treatment from significant others were beneficial to most of the participants. Most of them verbalised the support of family and friends that was helpful and for some participants friends and family gave them undue pressure to go the 'length and breadth' to seek treatment.

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The intention of the participants about seeking treatment was their plans for future treatment, what their aims are for the treatment they are engaged in and what targets to achieve with seeking treatment. In total, all participants were engaged in either hospital, herbal, faith-based spiritual remedy and lifestyle change to conceive.

Barriers that pose threats to seeking infertility treatment included financial limitations, religious constraints to advance technologies and inadequate knowledge about infertility treatment.

6.2 Implications of the findings

The findings of this study have implications for Nursing practice, Nursing research, Community sensitization, Counselling and finally Policy formulation.

6.2.1 For Nursing Practice

The study established that women with infertility have beliefs in hospital treatment. It was also known that these women may either start seeking hospital treatment but stop intermittently or midway along the line due to alleged less benefits and stigmatisation. Similarly, they may start hospital remedy when all other therapies have failed. It is therefore imperative on nurses and midwives in the medical team to take their time and understand the individual women with infertility and educate them on the treatment regime and what to expect so they stick to treatment. Nurses and midwives should be sensitive to the needs of women seeking treatment to ensure continuity of care. Lack of knowledge about seeking infertility treatment may be the grass root failure to achieve pregnancy. There is also the need for nurses and midwives working with the fertility specialist team to stay abreast with knowledge about infertility treatment.

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6.2.2 For Nursing Research

One of the reliable approaches to the acquisition of valid knowledge for evidence based practice is research. Nurses and midwives should be research inclined to enable them recognise the major concerns of women with infertility. It is important for nurses and midwives to conduct further research in the area of infertility to explore the major limitations in treatment seeking behaviour. The phenomenon could be quantitatively studied to establish relationship between the constructs of the conceptual framework.

6.2.3 For Community Sensitization

The findings of this research brought to fore that most women with infertility isolate themselves to seek treatment because they did not want 'people' to see them. Which meant that society is harsh on them. The general population should be sensitized about infertility and its treatment through the mass media and health workers. Since infertility treatment is difficult as some participants put it, the general public need to have thorough idea or understanding about it. People should be able to talk about seeking infertility treatment freely and not be judged.

6.2.4 For Counselling

From the research, most participants did not know what to do when they realised they had a challenge to conceive. Some participants verbalised that they heard something about infertility during their premarital counselling but they were told by their counsellors to relax. Some participants were of the view that if only they had sought treatment early, they would have avoided the complexity of their current treatment. Most participants also said it was good to pray to God but were of the conviction that they consult either the herbalist

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or go to hospital for treatment. The onus lie with spiritual leaders and counsellors to encourage women with infertility to take that step of faith to seek hospital treatment.

6.2.5 For Policy formulation

The study has provided insight to the treatment seeking behaviour and some of the possible obstacles that will hinder women with infertility to seek out for treatment. Though SDGs has policy on women's health, there is none for infertility. There should be a clear policy on infertility and treatment because the prevalence rate of infertility is alarming. The precious time and energy these women waste moving from one place to the other can be channelled for productivity. This will also reduce the divorce rate related to infertility. There should also be policy and regulations in the various fertility centres to protect the vulnerabilities of these women. There should be policy on infertility services as a special unit at the various government hospitals and half of the cost of treatment taken care of by the National Health Insurance Scheme (NHIS) to ease the financial pressure on women with difficulty to conceive. There should also be policies to protect their vulnerabilities at the prayer camps, herbal clinic, hospitals and with the local herbalist. Sensitization of the public about infertility and treatment should be done by public health personnel to create awareness through the various mass media, hence reduce the stigma to seek for early intervention.

6.3 Limitations of the study

The study was limited to women with infertility who lived in the Greater Accra Region of Ghana. The sensitivity of the subject area made most women with infertility not want to participate.

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Though most women asserted that people consult fetish to get children, none of the participants admitted consulting a fetish priest for help. Some prayer camps hesitated for the researcher to draw sample from their jurisdiction. Most spiritual leaders were mostly unavailable to seek their permission as the gate keepers to have access to the women with infertility who patronised their services. This limited the researcher, since the researcher had to visit these places several times.

The study was also limited by the period of time for data collection. The researcher was limited in the time to draw participants from the market place and modern herbal clinics. Another limitation for the study was difficulty getting participants from Greater Accra Regional hospital. Most women with infertility reported to the gynaecological unit with abdominal pains and menstrual disorders, so most of them were not identified by the nurses through documentation. Even with documentation, contacts of patients were not stated. Also at the consulting room, when requested to go and do investigations some did not return. This made it very difficult to access more women with infertility to participate in the study considering the time frame.

6.4 Conclusion

Women with infertility in the Greater Accra Region of Ghana are influenced by their personal belief to seek treatment from three major outlets: herbal /traditional /natural, hospital and faith-based spiritual remedies for their infertility. The belief in these outlets gave the attitude to seek treatment, whiles the motivation to seek treatment for infertility were both intrinsically and extrinsically driven. Similarly, the cultural beliefs and perceptions of these women to seek treatment were the influences from their social networks whiles their perceptions about seeking treatment were information gathered in

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their environment. The intentions of these women about treatment were their aims to achieve motherhood. Although there is little awareness on child adoption in Ghana, participants had the intention to accept child adoption when all avenues of treatment failed. Therefore, infertility needs to be seen as a psychosocial health issue rather than a pure medical condition. Women with infertility in Greater Accra Region patronised medical/hospital, herbal and practice faith-based spiritual treatment for solution to their problems. However, they frequently would stop a particular treatment as a result of perceived less benefits and prolonged duration of the treatment. Therefore, health workers at the various obstetric and gynaecological units, including fertility hospitals should have deeper understanding of the treatment seeking behaviour of women with infertility to meet their sensitive needs.

6.5 Recommendations

The following recommendations are made based on the findings to this study to the Ministry of Health (MOH), Ghana Health Service (GHS) and Fertility clinics.

6.5.1 For Ministry of Health (MOH)

The MOH should:

- Train frontline nurses, midwives and doctors on infertility management in order to function effectively in the specialized but sensitive area.
- Formulate policies to protect the vulnerabilities of women with infertility at the various hospitals, herbal clinics and fertility centers.
- Collaborate with other stakeholders and train local herbalists on standards of practices, hygiene, and infection prevention measures since a lot of women with infertility consult local herbalists. There should be guideline protocol for their

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practice. Most of herbalists are not educated but got their inspiration from God and some too understudied their parents or grandparents.

- Ensure ethical practice at the various health facilities are duly followed by periodic checking.
- Enact policies to increase awareness of infertility, education on lifestyle and reproductive health to prevent STIs.
- Legislate policy to improve infertility seeking behaviour and where to go when the need arises to reduce complications with treatment. There should be more investment in the area of infertility treatment.

6.5.2 For Ghana Health Service (GHS)

GHS should:

- Create infertility-friendly services to encourage hospital attendance and ensure proper documentation of childless women who visit the various health facilities under its jurisdiction to inform policy makers on the structures to improve infertility services.
- Ensure job satisfaction and improve conditions of service for all health care professionals for excellent delivery of care.
- Collaborate with stakeholders, nurses and midwives in the area of infertility to train their staff to offer comprehensive and sensitive infertility treatment including counselling and effective communication skills.
- Promote health education of infertility in all its facilities.

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6.5.3 For Fertility clinics

Fertility clinics should:

- Provide patients with adequate information for them to make their informed decision on the choice of treatment suitable for them.
- Establish an empathic clinic environment for patients, since treatment may have physical and psychological weight on them.
- Employ health practitioners with specialisation in women health issues especially infertility.
- Liaise with funding agencies to reduce the cost of infertility treatment to enable more women have access to infertility treatment.
- Embark on awareness programmes on infertility to spread knowledge on treatment options which are available.

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APPENDICES

APPENDIX A: ETHICAL CLEARANCE

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Your Ref. No:

7th November, 2018

ETHICAL CLEARANCE

FEDERALWIDE ASSURANCE FWA 00001824 **IRB 00001276**

NMIMR-IRB CPN 023/18-19 **IORG 0000908**

On 7th November 2018, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting reviewed and approved your protocol titled:

TITLE OF PROTOCOL : **Treatment seeking behaviour among women with infertility in Greater Accra Region**

PRINCIPAL INVESTIGATOR : **Nana Semuah Bressey, MPhil Cand.**

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 6th November, 2019. You are to submit annual reports for continuing review.

Signature of Chair: ....
Mrs. Chris Dadzie
(NMIMR – IRB, Chair)

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APPENDIX B: DATA COLLECTION INSTRUMENT

DATA COLLECTION INSTRUMENT

Interview Guide

Introduction

My name is Nana Semuah Bressey, MPhil nursing student at the University of Ghana Legon. I am conducting a study on the treatment seeking behaviour among women with infertility in Greater Accra Region. I will be asking you some questions as part of my data collection for the study on the various treatment seeking behaviour women with infertility engage in to conceive. Please take your time to answer the questions and you are free to ask for clarification if some of the questions are not clear to you. You may also skip any of the questions if you are not comfortable to respond to them. You will not be judged, so answer the questions with all the honesty it deserves. Your responses to the questions will not be identified with you but may be of great importance to this study. Thank you.

SECTION A

Demographic/Background information

Tell me about yourself

Probes

Are you a Christian, Muslim or traditionalist?

What work do you do?

What work does your spouse do?

Did you go to school? What level did you complete?

How long have you been married?

1

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Have you been divorced, if yes, why? How many times?

Where do you live?

How old are you?

SECTION B

Beliefs about seeking infertility treatment

1. What are your views about seeking infertility treatment?
2. Can you tell me the various things or places people go in search for pregnancies? What is your belief about these places? What informed your choice of the place you have been to?
3. What do you think are the reasons for your being childless?
4. How did you decide to look for treatment?
5. What has influenced your choice of treatment?
6. Why did you wait this long to seek treatment?

SECTION C

Motivation to seek treatment

1. Who or what propelled your choice?
2. Why do you desire to have children?

SECTION D

Attitude to seek infertility treatment

1. What are your views about infertility treatment in Ghana?
2. What will you do when you get pregnant?
3. What will you do if pregnancy does not happen?

2

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SECTION E

Cultural beliefs and perceptions to seek infertility treatment

1. What are the thoughts of people in your traditional area about seeking infertility treatment?
2. Do you have adequate support from friends and family to seek infertility treatment?
3. Does your religious background have any inferences on your treatment of choice?
4. Will your treatment of choice change if you had financial means? And why?
5. Can you share any cultural beliefs you have in relation to seeking treatment?
6. How does the public perceive seeking treatment for infertility?
7. Can you share any traditional beliefs you have with regard to seeking treatment?
8. What is your perception about seeking treatment for infertility?

SECTION F

Intentions to seek infertility treatment

1. How did you decide to seek treatment?
2. Have you tried anything to conceive?
3. What prompted you to seek treatment?

SECTION G

Treatment seeking behaviour

1. Where do you seek treatment for infertility?
2. How often do you seek treatment?
3. Describe your course of action when you realized you could not get pregnant after 12months of marriage?

3

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4. How are you coping with your present choice to conceive?
5. Does the reception at the various places of treatment influence your choice of seeking treatment?
6. Describe your experience during seeking treatment for infertility?
7. Can you describe any barrier that hinder your decision to seek treatment

Do you have anything to add?

Thank you

4

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APPENDIX C: CONSENT FORM

Title: treatment seeking behaviour among women with infertility in the Greater Accra Region

Principal Investigator: Nana Semuah Bressey

Address: University of Ghana

School of nursing and midwifery

Telephone number: 0244683209/0507008886

Email: semuah2003@yahoo.com

General Information about Research

You are being asked to take part in this work which is about treatment seeking behaviour among women with challenge to conceive. Your experiences in searching for treatment will help with this study. Please read this form carefully and ask any questions you may have before agreeing to take part in the study. The reason for this study is to understand your beliefs, attitude, and motivation towards looking for help to get pregnant. How does your traditional beliefs affect your search to find treatment and plans to help you to get pregnant? Also, this study is to fulfil the requirement for the award of a master's degree at the University of Ghana. At the end of it all this research will be published in international journals. If you agree to be in this study, an interview will be conducted with you. The interview will take about 30 to 60 minutes to complete. With your permission, I would also like to tape-record the interview.

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Possible Risks and Discomforts

There is no anticipated risk to you in this study, though some of the questions will not be comfortable.

Possible Benefits

There will not be direct financial benefits to you but this study will assist in policy making in future and also assist women in search for treatment to get pregnant.

Confidentiality

The records of this study will be kept private. In any sort of report that is made public will not include any information that will make it possible to identify you. Research records will be kept safe in a locked cabinet in the supervisor's office and only the researcher and the supervisor will have access to the records. All electronic information will be coded and secured using a password protected file. Audio recorded interview will be destroyed after 5 years it has been transcribed.

Compensation

There will be no compensation for participating in the study. 20 cedis call credit will be given after the interview sessions

Voluntary Participation and Right to Leave the Research

Taking part in this study is entirely voluntary. You may skip any questions that you do not want to answer. If you decide not to take part or to skip some of the questions, you are at liberty to do so. If you decide to take part, you are free to withdraw at any time.

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Contacts for Additional Information

If you find the need for counselling, please do not hesitate to contact clinical psychologist, Dzifa Monu Awudi (telephone number 02442116677) who works at the Korle Bu Teaching Hospital.

Your rights as a Participant

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, you are also encouraged to feel free at any time to contact me. If you have any other concerns about your rights as a research participant that have not been answered by me, you may contact the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB) through landline 0302916438 or between the hours of 8am – 5pm**.**

University of Ghana http://ugspace.ug.edu.gh

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title: treatment seeking behaviour among women with infertility in Greater Accra Region has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer

__________________________ __________________________

Date Name and signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here.

I was present while the benefits, risks and procedures were read to the volunteer. All question were answered and the volunteer has agreed to take part in the research

__________________________ __________________________

Date Name and signature of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

__________________________ __________________________

Date Name and Signature of Person Who Obtain Consent

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APPENDIX D: PROFILE OF PARTICIPANTS

Participant Pseudonyms	Age / years	Religion	Occupation	Level of education	Years of marriage
ABBA	33	Christian	Teacher	First degree	Four
AFI	39	Catholic	Psychiatric nurse	Diploma	Divorced
AFIA	26	Christian	Caterer	First degree	One year, Two weeks
AJO	39	Catholic	Teacher	'O' level	Fourteen
AKOSUA	31	Christian	Psychiatric nurse	Diploma	Three
AKUA	40	Christian	Lecturer	Pursuing PHD	Eight
AMA	30	Christian	Hair dresser	JHS	Six
BIRAGO	34	Christian	Seamstress	JHS	Three
BUBBLE	33	Christian	Security officer	Master's degree	Four
DAPAA	37	Christian	Banker	Master's degree	Divorced
LADII	34	Christian	Social worker	Master's degree	Ten
MIRA	36	Muslim	Orderly	SHS	Three
MODA	37	Christian	Dietician/counsellor	Master's degree	Five and half years
PIPI	36	Christian	Nurse	Certificate	Eight

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APPENDIX E: GHANA HEALTH SERVICE ETHICAL CLEARANCE

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the
number and date of this
Letter should be quoted.

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Tel: +233-302-681109
Fax + 233-302-685424
Email: ghserc@gmail.com
14th December, 2018

MyRef. GHS/RDD/ERC/Admin/App 18/463
Your Ref. No.

Nana Semuah Bressey
University of Ghana
School of Nursing and Midwifery
P.O. Box LG43
Legon-Accra

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	**GHS-ERC028/11/18**
Project Title	Treatment Seeking Behavior among Women with Infertility in the Greater Accra
Approval Date	14th December,2018
Expiry Date	13th December 2019
GHS-ERC Decision	**Approved**

This approval requires the following from the Principal Investigator

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report **after completion** of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED...
DR. CYNTHIA BANNERMAN
(GHS-ERC CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra

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APPENDIX F: INTRODUCTORY LETTER

UNIVERSITY OF GHANA
DEPARTMENT OF MATERNAL AND CHILD HEALTH
SCHOOL OF NURSING

Ref. No.:...SON/A.12............................ October 9, 2018

The Chairman
NMIMR - IRB
P.O. Box LG 581
Univ. of Ghana
Legon.

Dear Sir/Madam,

LETTER OF INTRODUCTION

I write to introduce to you Bressey Nana Semuah, an MPhil second year student of the School of Nursing and Midwifery.

The Scientific Review Committee of the School has approved the thesis topic **"Treatment Seeking Behaviour among Women with Infertility in Greater Accra Region"**.

I hope that the Institutional Review Board will approve the proposal to enable her collect data.

Counting on your usual co-operation.

Thank you.

Yours faithfully,

Dr. Florence Naab
Head, Dept. of Maternal and Child Health

INTEGRI PROCEDAMUS

COLLEGE OF HEALTH SCIENCES

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• Email: mch.son@chs.ug.edu.gh • Website: www.nursing.ug.edu.gh