Research Article

Ghana Social Science Journal
2022, Vol.19 (1): 32–54

Publisher: School of Social Sciences UG

Living in a man's world: An exploratory study of the experiences of Ghanaian women with infertility problems

Rosemond Akpene Hiadzi[1]

Abstract

In pronatalist Ghana, infertility is frowned upon, thus many married couples want children to meet societal expectations. Some couples, however, struggle with conception and childbirth. Over one out of 10 Ghanaians have challenges with fertility and may need In vitro fertilization (IVF) to become parents. Reaching the decision to opt for IVF may be challenging for some couples. Using a qualitative in-depth interviews, this study explored the experiences of 35 purposively selected married women with infertility challenges. The interviews were transcribed verbatim and analysed thematically. Women in such marriages often bear more due to the patriarchal society they live in. This study findings uncovers gendered discrepancies at every stage of the journey towards desired conception: commencing medically assisted reproduction, blame for infertility, social consequences of advancing age, and unpleasant treatment procedures. Some of these women survive in a difficult environment by relying on their inner strength and economic independence. The study shows the importance of male marital support for these women's psychological well-being and treatment effectiveness.

Article History: Received 12 May 2022 Accepted 08 August 2022

Keyword: Infertility, women, Ghana, patriarchy, qualitative approach

[1]Department of Sociology, University of Ghana, Legon, Accra, Ghana.
***Corresponding author:** Department of Sociology, University of Ghana, P. O. Box LG 65, Legon, Accra, Ghana
Email: rhiadzi@ug.edu.gh

Introduction

It is a challenging issue to accurately, estimate the prevalence of infertility on a global scale due to several factors, including definitional methods. However, according to the World Health Organisation (WHO, 2012), over 48.5 million couples experience infertility issues globally. Unfortunately, the latest statistics remains that there has not been a significant improvement over the years (WHO, 2022). Aside from having some of the highest rates of infertility, sub-Saharan Africa also has high rates of untreated reproductive tract infections (Arhin et al., 2019, Moll et al., 2022; Ombelet & Onofre, 2019). For instance, roughly one in four people in sub-Saharan Africa who are of childbearing age suffer from infertility (WHO, 2013).

Infertility has a wide range of effects on those who experience it. According to the literature (Alhassan et al., 2014; Hanson et al., 2017; Hoff et al., 2015), infertility is associated with indicators of physical, emotional, social, and psychological well-being. Hanson et al. (2017), for instance, show a strong positive correlation between infertility and prevalent mental health conditions, which include anxiety and depression. Due to attitudes that push women to have many children, infertility in the sub-Saharan African (SSA) countries has an additional negative socio-cultural effect on the mental health of women (Chimbatata & Malimba, 2016). Women with infertility issues in Africa experience high forms of communal mocking and stigma (Anokye et al., 2017; van Rooij et al., 2021; Nyasulu, 2020), family ostracization (Tabong & Adongo, 2013), witchcraft allegations (Dierickx et al., 2019), domestic abuse and intimate partner violence (Ozturk et al., 2017). In the context of SSA, there are financial repercussions for both singles and couples who are infertile due to the high cost of infertility treatment and the unavailability of state health insurance that covers infertility treatment especially Assisted Reproductive Technologies (ARTs) (Inhorn & Patrizio, 2015). It has also been asserted that the majority of couples seeking infertility treatments encounter severe financial instability in the process (Dyer & Patel, 2012). For these married couples, the ripple effects of such costs are frequently carried by the women, who are frequently held accountable for their families' financial struggles (Inhorn & Patrizio, 2015).

Additional studies (Moyo & Muhwati, 2013; Ochieng, 2019; Hiadzi & Boafo, 2020; Ofosu-Budu & Hänninen, 2021) show that illogical and frequently superstitious explanations for infertility in the local area are a major contributor to the unfavourable treatment and socio-cultural attitudes towards infertile individuals and couples. Many communities in SSA attribute infertility to supernatural causes due to a lack of knowledge and education about the causes of infertility, which can lead to the infertile person being mistaken for a witch or being bewitched. In the recent literature (Ofosu-Budu & Hanninen, 2020; Ofosu-Budu & Hänninen, 2021; Dierickx et al., 2021; Abebe et al., 2020), these unfavourable societal perceptions and treatment of women with infertility issues in Africa are still mentioned.

The introduction and development of technology in the field of medically assisted reproduction in the Western world are changing those cultures' responses to infertility in positive and significant ways (Brezina & Zhao, 2012). Available statistics from the International Committee Monitoring Assisted Reproductive Technologies (ICMART) reveal that sub-Saharan Africa had the lowest rate of adoption and use of ARTs in 2011, with a number of 71 cycles per million people per year (Fathalla, 2002). Additionally, local researchers claim that the usage of medically assisted reproductive technologies has been steadily increasing across Africa (Hiadzi et al., 2021; Sperm & Bank, 2019; Dyer et al., 2020; Gerrits, 2016). Increased information access, rising educational trends, and general globalization have all contributed to a growth in the use of these technologies and made the world a more open place for the exchange of information.

There are concerns about whether these advancements in knowledge and information exchange are altering attitudes and resulting in equivalent alterations in societal views and sociocultural responses to couples and, particularly, women who are experiencing infertility. Despite these reasonable concerns, there appear to be few studies that could offer any conclusive answers to these emerging issues. In the context of the gap in scholarship, this current study explored the experiences of women with infertility challenges seeking treatment in Ghana. It is envisaged that the findings of this study will help to design intervention and provide support services for such population.

Understanding the Ghanaian social structure – The interplay of patriarchy, urbanisation and agency

Although anthropological evidence indicates that there have always been gender disparities, with women typically having lower social standing than men in all societies throughout human history, recent studies have shown that these disparities have significantly decreased (Dill & Zambrana, 2020; Lorde, 2021). Developed nations like the United States, for example, make this even more clear (Crimmins et al., 2019). However, in other parts of the world, such as Africa, there are still cultural rituals and rites, such as marriage customs and puberty rites that put women in a position of subordination in comparison to men. In most facets of social life in African countries, there is a scenario of male dominance, or patriarchy (Ademiluka, 2018).

According to Onwutuebe (2019), patriarchy is viewed as one of the primary causes of female disadvantage in society. At the moment, Ghana is a classic example of a patriarchal society, where male dominance is evident in decisions regarding reproductive health (Doghle et al., 2018), intimate partner violence (Doku & Asante, 2015) and the distribution of economic and political power both inside and outside the house. Doku and Asante (2015) further agree that patriarchy can occasionally take a form that causes the victim to embrace their submissive position and blame themselves for igniting or inciting any hostile behavior on the part of the man, leading them to accept the exercise of power over them by men. Low levels of education, unfavorable employment status, and

low-income levels are some of the causes of this (Salem & Yount, 2019). The difference between men and women in terms of power relations is anticipated to decrease in an urbanizing culture where women have increased access to education and employment. This is so that a woman can have some ability to act free from the stifling influence of the societal standards surrounding patriarchy. Economic independence and high educational achievement among others provide this agency.

Agency refers to a person's ability to act independently and make their own free decisions (Narayan, 2018). Thus, the woman's decision to have a medically assisted conception and her capacity to resist being held responsible for infertility will be considered (in this study) as indicators of the individual's power over her social environment. Without these, the woman in the infertile partnership is at the whim of the patriarchal society she lives in, which may lead to psychological suffering and treatment failures. Her biological responsibility for carrying the foetus (es) coupled with the ticking of her biological clock adds to the unfair burdens she already bears, which are made worse by the patriarchal society in which she lives. This study thus utilises the theories of patriarchy and agency in exploring the experiences of urban Ghanaian women with infertility problems.

Methods

Research design

The research design for this study is qualitative. Semi-structured interview guides were used to conduct face-to-face in-depth interviews with women accessing fertility treatment from fertility hospitals in Accra. The phenomenological approach was employed to understand the experiences of women with infertility issues from their own point of view. The interview guide, thus, solicited information about the experiences of women during their journey to achieving desired conception.

Research setting

The study was conducted in three hospitals in Accra, Ghana. The hospitals were purposively selected based on their varied approaches to solving infertility, and also due to the different categories (socio-economic and educational) of people that patronise the hospitals. One was a privately owned herbal clinic, the other was the obstetrics and gynaecology unit of the leading referral hospital in Accra (public hospital) and the third was a privately owned fertility hospital that offers assisted reproductive technologies (ARTs) to its clients.

Participants and participants selection

According to Saunders and Townsend (2016), 5 to 50 participants are sufficient for an interview. Hence, the current study's interview consisted of 35 women. These women

were chosen from the three Accra hospitals for this study. The hospitals and research participants were chosen using a purposive technique. This strategy was chosen because it allows the researcher to utilize their own discretion in selecting the study participants and hospitals. In total, the study included 15 respondents from the public orthodox hospital, 13 from the private orthodox hospital, and 7 from the private herbal hospital. All the 35 participants were married women in heterosexual unions experiencing either primary infertility (having no child) or secondary infertility (having one child but unable to have a subsequent one). The use of the purposive sampling approach was influenced by the need to understand the experiences of infertile married women from their own perspectives rather than achieving a representative sample. Their ages ranged between 24 and 56 years and they had been in their marital unions for between 2 and 30 years.

The respondents were approached after they arrived at the various hospitals in accordance with the initial request made to the hospitals that the researcher would like their patients to participate in the study. As a result, the patients were approached and asked if they would be interested in participating in an academic study after the reason for their visit to the hospital is resolved. The objectives of the study were clearly explained to the respondents, and they received guarantees that the information they provided during the interview would be kept private and used for academic purposes only. The interviews and interaction with the respondents were supported by the hospital personnel (nurses), who were nominated by the hospital administrator because the hospitals showed a lot of interest in the study. This approach was also employed to put respondents at ease around the researcher. In total, 68 participants were contacted, but due to the sensitive nature of the area of study, only 35 agreed to take part in the study. Those who chose not to participate in the study did so for a variety of reasons, such as lack of time due to obligations to their work and families and some reluctance of respondents to share their personal lives with a researcher.

Procedure

Data collection was made possible by the use of an interview because the study utilized a qualitative methodology. The interview questions that were used were open-ended because this type of questioning encourages greater discussion (Young et al., 2018). The areas that were discussed in the questions were the married woman's role regarding the choice of medical treatment, her experiences regarding the blame for infertility, and her experiences with treatment procedures. Questions such as "Which one of you decided to seek medical care?", "What kind of reaction do people have toward you concerning your inability to have a child?", and "What is the reaction of family members regarding your condition, and how do you deal with it?", to name a few, were used as examples of potential queries.

The interview lasted between one hour and one and a half hours. The researcher conducted the interview in-person (face-to-face) with the respondents while they were

in the hospital or, in some cases, in a convenient location that would protect their privacy. The interview was conducted predominantly in English, with a few respondents opting to speak in Twi or Ewe. As the researcher is fluent in both languages, it did not pose any challenge to the interview process. The duration of the data collection process was one year.

The following factors were considered when conducting the interviews with the participants: the interviewees were given a brief explanation of the interview's objective and structure; the interviewees were informed in advance that the interview would last between fifty minutes and an hour; and the interviews were recorded using a digital voice recorder, in addition to noting important points from the interview. This was required in addition to or instead of the recorder. The interviewees gave their permission before the interview was recorded, and the tape was halted when they made sensitive comments. The interviewers received assurances that the interview would be kept strictly confidential. Those who agreed to participate in the study gave written informed consent and those who were not able to read and write gave oral assent.

When an interviewee indicates they do not really want their comments recorded but they are willing to speak without being recorded, the recording is halted. Such interviewees usually claimed that they were worried with the ease with which information can now be shared and their concern that some familiar individuals could recognize their voices. The respondents' responses to whether they had children or not and the medical diagnoses underlying their inability to conceive naturally were regarded for the purposes of the interview as sensitive comments. To help the researcher learn more about the respondent in question and to accomplish the research goals, the comments for such a response were just documented and not recorded.

Ethical considerations

Ethical clearance was received from the Institutional Review Board of the Noguchi Memorial Institute for Medical Research, University of Ghana (Protocol number: CPN 037/12-13). The informed consent form was read out and explained to participants to ensure their full understanding. For those that were semi-literate, the contents of the consent form were explained to them in a local language. Thus, respondents who took part in the study signed the consent form with a few semi-literate ones thumb-printing the informed consent form to show that they willingly took part in the study. These were all done before the interviews were conducted. Furthermore, to ensure anonymity, the names used are all pseudonyms and all other identifying details of participants have been removed. In addition, verbal appreciation was expressed to all the participants of the study for their contribution to the study. The researcher confirmed the study's trustworthiness by using two coders, demonstrating confidence in the study's conclusions. Transferability and confirmability (neutrality of study findings) were also evaluated. The researcher

ensured the conclusions were based on participant replies, not prejudice or personal intentions. Finally, reliability was considered by providing adequate study material for other researchers to get similar results.

Data analyses

Thematic analysis of data was done manually following the guidelines provided by (Braun & Clarke, 2019), namely, getting to know the data, generating codes, searching, reviewing and defining themes, and, finally, writing up the findings. Audio recorded interviews (including those conducted in Ewe and Twi) were first transcribed verbatim into English. The transcripts were then read and reread several times to enable the researcher to be fully immersed in the data. Next, codes and themes were identified guided by the aims and objectives of the research. Identified codes and themes were then evaluated meticulously to ensure that the analysed data were exhaustive enough. In the final stage, the coded data were grouped under appropriate themes. Using (Noble & Smith, 2015) guidelines on improving the validity of qualitative research, the researcher obtained participant validation by summarising to participants what they said in order to validate their views. In addition, two separate coders were engaged to cross-validate the emergent themes. These coders were professional independent researchers best known for cross-validating recordings used in qualitative research. The coders constantly listened to the audio interviews and cross-checked that the transcripts were accurate. Furthermore, the themes that emerged were discussed with these independent coders to reach a consensus. This was done to reduce any subjectivity by the researcher. Where necessary, themes were modified to reflect the codes they contained and to reduce overlap.

Findings

The findings of the research revealed that women in infertile unions bore the bigger if not the sole brunt of family and other societal members in relation to their situation. Four predetermined themes in line with the study's objectives are discussed; namely, the decision to initiate medically assisted reproduction, blame for infertility, age and its related social factors and treatment procedures. However, in the midst of the unequal burden experienced by these women, a few were able to rise above the constraints and exhibited agency and control fueled by their economic independence and ability to withstand social stigma, and this forms the fifth theme.

The decision to initiate medically assisted reproduction

This theme describes the various circumstances that compelled women to initiate medical diagnosis and treatment in their infertile unions. These women initiated

treatment for three reasons: (1) cultural factors; (2) psychological distress; and (3) lack of co-operation from male partners.

Cultural factors: Some women felt it was their responsibility to bear children. They believed, as carriers of foetuses, they needed to ensure that they were medically fit to carry out this mandate. They expressed how being Ghanaian also meant being able to have children as illustrated in the narratives below:

> In Ghana, it is not normal for someone to have only one child. I need to have more and it's not coming. That is why I am here to see the doctor. (33 years old, married for 5 years, has one daughter)

> Well, to me, I think as a Ghanaian woman, you need to have a child. So yes, the 'white' woman will not care because most of them, even before they get married, they say they won't have babies but with me, I want to have a child… so I guess I'm a typical Ghanaian (married for 8 years, no child, been living in the UK for 10 years).

The narratives above show that both participants felt every (married) woman in Ghana is expected to bear children and this societal mandate is what drove them to seek medical care when they were having difficulty in conceiving naturally.

Psychological distress: These women in infertile unions reported feeling uneasy about the fact that they were not conceiving naturally. It was a source of worry for them that sometimes left them unhappy and unable to concentrate on their daily activities. To offset that, they believed seeking a medical diagnosis and treatment (where necessary) will lessen, if not completely remove, their woes. The narrative below supports the above mentioned sub-theme

> Left to me alone, I should have had three children by now. I have been waiting and hoping that I will get pregnant but nothing is happening. So, I decided to see a doctor to find out what the problem is. I am frustrated and disturbed because people keep asking me why I am not pregnant. I am tired of waiting and I am tired of having to answer questions from people…. I hope the doctor can help me because I am desperate for a child. (Cathy, 32 years, married for 3 years, without a child)

It can be deduced from the above quote that some women's desire to conceive naturally and subsequent inability to do so over the years or months following marriage is what pushed them to seek health care. The psychological pain of not achieving one's desires coupled with coping with societal pressures to conceive worked together to cause these women to initiate medical care.

Lack of co-operation from male partners: Some women expressed the difficulty in getting their husbands to accompany them to the hospital for diagnosis and subsequent treatment where necessary. Reasons given for this included the fact that husbands were often pre-occupied with work and did not make time for any hospital visit. According to Sylvia:

> It is almost impossible to get my husband to come with me to the hospital. He is always very busy with work and cannot find the time to do so. Besides, he is not very bothered about our childlessness because he keeps saying I am still young. (aged 32, married for 4 years without a child)

For others also, their unwillingness to go for a diagnosis from the hospital stems from the fact that they do not believe or think they are the cause of the infertility in the union. For example, according to Nyamekye:

> My husband refuses to accompany me to the hospital for a diagnosis because he does not think he has any reproductive disorder. He says, two of his past girlfriends got pregnant for him while he was dating them. So, it means he is capable of getting a fertile woman pregnant. I have told him that the doctor says everything is fine with me so he needs to also come and do some tests, but he has refused to come. Whenever I start talking about it, he gets annoyed, and it turns into a quarrel. (29 years, married for 2 and a half years without a child)

Furthermore, some husbands refuse to accompany their wives to the hospital because they have had a child or two out of wedlock from a previous marriage and thus do not feel the need to have children as much as their wives who have not had any child(ren). This selfish attitude of husbands also accounts for why they do not support their wives in the decision to visit the hospital for a fertility diagnosis and care. This situation leads to an increased burden for the woman. According to Ophelia,

> My husband is not worried about the fact that, I've not gotten pregnant. He already has 2 children (2 boys) with 2 different women…To me, I think it is because he already has children so he doesn't really care. Whenever I tell him that we should go to the hospital and go and check, he does not mind me. I keep saying it but still he does not mind me. It is as if I am talking to a stone. It's sad and frustrating…I just want to have children of my own. (45 years old, married for 20 years without a child of her own)

It can be deduced from the above quotes that men's lack of co-operation in seeking fertility diagnosis and treatment stemmed from the fact that they did not prioritise childbearing in relation to work demands; they did not believe they were the cause of the infertility in the union or they had successfully fathered children out of wedlock.

Blame for infertility

This theme highlights the various social actors in the life of a woman in an infertile union who point fingers at her as being solely to blame for the infertility in the union. This blame comes along with stigma and labelling. The main actors were their spouses, in-laws, friends, and colleagues.

Male partners: For some of the women in this study, the blame for infertility came mainly from their spouses. For example, 24-year-old Desdemona reveals that throughout her one year of marriage,

> My husband has been giving me a lot of pressure. Every month, he asks me if my menses has come or not. Sometimes, I try to avoid answering the question because of the way he has been reacting when he finds out I am not pregnant. The way he is behaving…hmmmm…I am afraid It's as if it's my fault that the pregnancy is not coming. (24 years, married for 1 year without a child)

Extended family members: Other participants reported that the blame for infertility came from extended family members especially their in-laws (husband's relatives). According to 48-year-old Angela, her husband has been very supportive throughout their marriage and has never showed any indication of wanting to marry another woman as a result of their childlessness. However, according to her:

> ...The main problem is with my husband's family. Apart from his mum of blessed memory, the rest are not so helpful with their attitude towards the problem. There was actually an uncle of his that said that if I had not had a child by the end of the year, he'd have to marry someone else. (48 years, married for 16 years without a child)

Similarly, during her yearly Christmas visit to her husband's family home, Linda reports that:

> 'My mother-in-law told me that next year when you are coming to visit and you do not have a child, don't come.' (37 years old, married for 7 years without a child)

This blame for infertility from extended family members experienced by these women occurred without consideration for the fact that conception is a two way affair and both partners contribute equally to the success or otherwise of the process. As such, for those women who had received a clean bill of health from their doctor, it was more burdensome to cope with such false accusations from their in-laws. Twenty-nine-year-old Ethel's experience is a typical example of this scenario. According to her,

> My mother-in-law gives me no peace regarding my five-year childless marriage to her son. She is constantly pestering me with accusations and treatment suggestions which have created a tense relationship between the two of us. She feels I am the cause of the infertility in the union and thinks that I am not heeding her advice to go for treatment (married for 5 years without a child).

Friends and other colleagues: Other women also reported that the blame for infertility came from friends and work colleagues. It played out in the form of ridicule and contempt for their seeming lack of interest in their childlessness. This is illustrated in the following narratives:

> You have no idea … you have no idea [with more emphasis]. Someone can look you in the face and tell you that even when a man urinates here and I jump over it, I will get pregnant; those of you who have been wearing shorts to lie beside your husbands in bed, take them off, take them off … and these are people who are not even connected to you in anyway (Laureen, 36 years, married for 11 years without a child).

> I am a very fashionable person … So … sometime ago, I attended a wedding, and my friends told me that, this is not what is necessary (referring to the nice clothes, shoes, jewellery and other accessories I often wear). According to them, I should rather invest in finding a solution to my infertile union. I know that they often say that about me behind my back but that day, they said it to my face. Hmm … It was not pleasant! (Kafui, 39 years, married for 7 years without a child).

Age and related social factors

This theme describes how a woman's advanced biological age places her at a disadvantage in an infertile union due to the associated social consequences. As women age, their chances of natural conception and/or success with medically assisted conception decline drastically as compared to men. Here, two social consequences were identified: (1) loss of marital security and (2) loss of social security.

Loss of marital security: Some women expressed how they sometimes get worried about the stability of their marriages. According to one woman,

> My mother always reminds me that my marriage root is bare, there is no soil to cover it and hold it firm.

This feeling is exacerbated by the long years dedicated to service in the marriage with no child to show for it whereas their male counterparts can easily walk away or engage in an extra marital affair and have a child without suffering any form of social disapproval.

> After all these years of marriage, all the sacrifices … cooking, washing, cleaning and even sometimes financial support, your husband just gets up and says he is not interested in the marriage anymore and walks away simply because there is no child to tie you to him. At that age, who is going to marry you? With all the young girls walking around, my sister, forget it. And if you could not get pregnant in your 20s, 30s, what more when you are 45 going to 50? Meanwhile he has probably even impregnated one of his side chicks … hmm … If you were the one who had managed to get pregnant from an extra marital affair, all hell will break lose. Everyone will be saying bad things about you even your friends. It is an unfair society we live in. (47 years old, married for 18 years, without a child).

Loss of social security: For some women too, not having a child at their current age in their marriage also meant they risked losing any form of inheritance from their spouses. According to Agyeiwaa,

> I cannot stay with you for 13 years and then you tell me one day that I should go, and you expect me to go just like that. I will not accept it. I believe that, if I am able to have just one child for him, things will be a whole lot different. In that way, I stand to benefit from some of the properties he will give to the child I will have with him. I will also have someone to take care of me in my old age (48 years old).

The above voice implies that women who did not have children in their marital unions were at the losing end because it meant they may not get a share in their husband's property, and they may not have anyone to look out for them in their old age.

Treatment procedures

This theme describes the physical and emotional pain that are associated with treatment procedures that only women have to deal with. Whether it has to do with irregular menstrual cycles, fibroids, blocked fallopian tubes, hormonal imbalances and even in cases of male factor infertility, women had to bear the discomfort of fertility procedures especially assisted reproduction. This is because of their biological role as carriers of foetuses. However, the lack of support from spouses during the treatment period only heightens the already unpleasant experience. Some women expressed the fact that it has been a rather lonely journey for them. Whether the required treatment process was invasive or not, the absence of their spouses only made the experience worse. It is because of this that Charlotte, whom I met at the herbal clinic had made the choice to access such treatment since she felt it would not require as much support from her spouse as compared to the remedy she was being offered at the orthodox hospital. According to her,

> I went to Korle-bu and the doctor said I have to come for surgery so that he removes the fibroids then I can get pregnant. [exclaims] Me???…surgery??? No no no, I cannot do that. It is not my portion. I have told God that I don't want it. I am in this alone, the man does not care and has never accompanied me to the hospital. So, it means, if I am admitted right now for surgery, he will not come and visit me, and I will be here alone. I have no one to rely on. So as for surgery, and in this circumstance, hmmm…I will not wish it for even my enemy (34 years, married for 2 years without a child).

It can be deduced from the above quote that some women avoided some treatment procedures because it demanded hospitalisation and care which also meant reliance on their spouses to provide that care. Because they knew they could not rely on their spouses for such care, they avoided such situations.

For women accessing Assisted Reproductive Technologies (i.e., IVF, ICSI), they expressed how emotionally and physically draining the whole process was for them. After embryo transfers, these women had to take injections to thicken the lining of the womb to help in implantation of the transferred embryo(s). The injections are usually administered daily for two weeks and are very painful. They expressed the sentiment that this pain would have been somewhat more bearable if their spouses were supportive and present during those painful moments. As one respondent expressed:

> My sister, it's not easy ooo… the pain is just too much. Sometimes, I feel like running away. I mean, if I should think about it, I cannot go through with it. Whenever I have to take that injection, I wish my husband was around. It helps when they are around, you know. They get to experience what you are going through, and they can also appreciate better all that you are going through and that will make them more sympathetic. At least, he can encourage you or something. But he's never around … So, I just try my best to focus on the good side, and I think positive as well. I just imagine myself holding my baby one day; that's what keeps me going (Adzo, 48 years old, married for 18 years, childless).

Again, the fertility centre requires that these women stay on admission at the facility for five days after the embryo transfer. This is to encourage bed rest and allow the body to do it's work without the hustle and bustle of everyday life which may adversely interfere with the process. This period of bed rest has also been expressed by some of these women as a lonely period for them. For example, 29-year-old Ethel had this to say:

> Just lying down here… waiting… doing nothing… for five days, it's not easy. After all the painful treatments, now I have to go through this too. I'm bored and lonely. I don't pick some calls from friends because they will want us to meet, and I cannot go. And when you do not have anything to do, your brain gets filled with all kinds of things. Apart from my husband, no one else knows I am here for a procedure (IVF) because I don't want anyone to know. So, no one can come and visit. He too, he could not pass by yesterday or the day before. I don't even know if he will come today. It's a difficult period for me but I am hopeful that everything will turn out well and I can also have my baby (married for 5 years without a child).

Finally, the success rate of IVF procedures is about 40%. This poses another strain (psychologically, physically, and financially) on women experiencing intractable infertility and have no choice but to go in for IVF. A few respondents in this study had undergone the procedure more than once without success and expressed the difficulty associated with that.

> Hmmm… this is my 4th time of doing IVF. The last time I did it was about 2 years ago. It was difficult for me to decide at first because of all that is involved…

> the money, the time, the up and down, the pain, and after all that, one is not even guaranteed of success. But after a lot of analysis, planning and praying, I decided to go ahead with it again. I don't have much of a choice and I am not getting any younger so the earlier the better (Belinda, 42 years, married for 14 years without a child).

The narratives above show that the procedures involved in medically assisted reproduction, especially Assisted Reproductive Technology, require some amount of emotional support from spouses to make it more bearable. The absence of such support makes the women opt for less invasive procedures where the option exists. Where there are no options, the women experience psychological consequences such as loneliness, depression, and loss of self-worth.

Living above the constraints

This theme describes how, in the midst of all the challenges associated with being a woman 'living in a man's world', a few women are able to rise above the odds. Their ability to do so is hinged on two factors: (1) economic independence (2) resisting societal pressure.

Economic independence: A few women were highly educated and in well placed jobs, occupying high positions in these jobs. This gave them the economic power to take decisions regarding the use of IVF because they could bear the cost even if their husbands did not contribute to it. For example, according to Amanda (who holds a managerial position in her job), who does not rely mainly on her husband for financial support, the desire to have her own biological child even without the support of her husband was show According to her,

> It was a headache for me to get him to come with me to the hospital so that they can prepare him for the procedure (IVF). I even told him that, if it is about money, I have got the money to do it. He never gave me a pesewa on all my visits to the hospital. He did not even ask me how much it is costing. But thank God I can afford it, so… Even with that, it was with a lot of prayers that he finally came to the hospital to produce his sample for the procedure...then he started relaxing about the whole thing again… At that point I said to myself, why don't I just find another person to do this (referring to a donor for IVF). I don't think this marriage is going anywhere so what difference does it make? In fact, I was ready to get a donor to do it for me. But I thought about the implications of it - looking for a donor will delay the process, and he had already produced his sample for the procedure so it will be difficult for me to tell the doctor that I no longer wanted to use his sample… So, I decided to go ahead with his sample. What is more important is for me to have this baby (40 years old, married for 10 years without a child).

Resisting societal pressure: Again, a few women stated that it was their personal desire to have children and this 'child wish', although yet to materialise, would not make them tolerate any form of stigma from the people around them. This is illustrated in the following narratives:

> People make it seem as if you are the one that makes the baby… as if you are God. I don't allow what they say to affect me. I just encourage myself because I know my time will come.

> The last time I overhead some people talking about me at work … something about why I don't have a child … I just walked straight to them and told them my piece of mind. My family matters are not their business, and it is not part of their work demands so they had better find something better to do with their time, than gossip about me. I know they were shocked and since then, I have never heard such a thing again. As for me, I cannot tolerate such gossips and if I hear it, I won't spare you (Kafui, 39 years, married for 7 years without a child).

Others also resist societal pressures by avoiding specific social gatherings (e.g., church activities) that remind them of their childlessness.

> I am a regular church goer. I never miss church on Sundays if I can help it. But for some time now, I hate going to church on Mothers' Day because all mothers will be called to the front of the church for special prayers. Afterwards, an elaborate ceremony is held in honour of mothers. When this happens, I am reminded that I don't have a child yet and it is very painful. One time when it happened, I cried the whole day. Since then, I decided to stop going to church on Mothers' Day. So, I don't go anymore (Martha, 40 years, married for 11 years without a child).

It can be deduced from the above narratives that resisting social pressure was done either through speech or through actions. This gave the women some relief and served as a means of coping with the stigma they suffered from the society.

Discussion

This study was conducted to explore the experiences of infertile married women in their journey towards achieving medically assisted conception and subsequent childbirth. The study identified four main aspects of the journey where women bore an unequal burden as compared to their male spouses, namely: the decision to initiate medically assisted reproduction, blame for infertility, age and its related social factors, and treatment procedures. A fifth theme emerged where a few women were able to live above the constraints associated with living in a man's world as a result of their economic independence and ability to withstand societal pressure. In this study, it was found that

women in infertile unions often bear the sole responsibility of initiating medically assisted reproduction. This finding is consistent with research conducted in Gambia, Malawi and other parts of sub-Saharan Africa (Dierickx et al., 2019; Nyasulu, 2020; Serour et al., 2019) which highlight the existence of pronatalist attitudes as leading to a heightened experience of stigmatisation for women in these contexts. The findings contradict studies conducted in Western countries that have shown how decisions by the infertile to visit the hospital was, to a greater extent, a joint one made by both partners in the heterosexual union (Shreffler et al., 2020). As a result, this shared burden has been reported to have positive consequences for the marital union such as strengthening the bond, love and support for the couple while, for others, it has been an experience of personal growth for both partners (Allan et al., 2019; Pasch & Christensen, 2000).

The patriarchal nature of the Ghanaian society where man is the head of the household and takes decisions regarding the welfare of the home can explain some aspects of the findings of this research. Power comes with privilege and more specifically social privileges which inadvertently can lead to a situation where the one without power may suffer social oppression (Hunnicutt, 2009). In this case, as Ghanaian men enjoy the social privileges that come along with being the heads of households, they are to a large extent, absolved of blame for infertility and its associated burden of finding a remedy for it. Studies conducted in Gambia (Dierickx et al., 2019) and other parts of sub-Saharan Africa (Chimbatata & Malimba, 2016) corroborate the findings in this study where women experience disproportionate blame for infertility as compared to their male partners. In these studies, the blame for infertility experienced by women existed even prior to any form of health seeking. So far as the union was without a child/ren, the woman was the first to be blamed. However, this study adds on to what is already known in the literature based on the added dimension of biomedical health seeking where the 'blame game' persists irrespective of a medical diagnosis that absolves the woman of being biomedically responsible for the infertile union. Thus, these women, knowing very well that they are not to blame for the infertility in the union, still have to contend with extended family members, friends and colleagues who continue to point accusing fingers at them.

Age is an important determinant of fertility potential especially for women as their fertility declines faster (from age 35) as compared to their male counterparts (Macintosh, 2015). Women who are advanced in age and do not have a child thus have a double burden to deal with especially in pronatalist societies. Studies conducted in Ghana have highlighted factors such as marital and social security as factors accounting for the pronatalist Ghanaian culture (Tabong & Adongo, 2013). Others have also reported on how women in sub-Saharan Africa risk losing their marriages to extra-marital affairs or marital dissolution owing to their inability to have a child/ren with the men they are married to (Dyer & Patel, 2012; Dattijo et al., 2016). However, the findings of this research show the heightened effect that advanced age has on the risk of marital dissolution and

its associated consequences of the loss of time, energy, financial resources and the like and how advanced age makes it impossible to recoup any of these resources even in the event that these women find new partners at an advanced age. It highlights the social consequences of the ticking of the biological clock of a Ghanaian woman. Again, the loss of inheritance as a result of marital dissolution without childbirth has been reported as a consequence of infertility experienced by women in developing countries (Rouchou, 2013) without highlighting the double tragedy of advanced age associated with it which this paper reports.

The findings of this study also show that treatment procedures are physically and psychologically draining. This is exacerbated for some of the women in this study because they did not receive the much-needed emotional support from their spouses. This is inconsistent with findings from the developed world. In Australia, for instance, women accessing assisted reproductive technology treatment reported receiving psychosocial support from their spouses (Bell, 2012). Turkish women have been reported to enjoy spousal support irrespective of whether it is a male or female causal factor of infertility (Karaca & Unsal, 2015) . This made it easier for these women to cope with treatment procedures. The women in this study lacked such support thus making some of them even resort to less invasive treatment procedures which may not be as efficacious and in effect only delay their chances of conception further.

Finally, women in infertile unions are not always passive recipients of the blame and social stigma meted out to them by their spouses, family members, and other social actors around them. Being economically independent such that she does not have to rely on her spouse for financial assistance to be able to access medically assisted reproduction is one of the things that allowed women in the study to be able to overcome this. This finding resonates with that of Dierickx (2020) among the Casamance of Senegal. Again, a few women draw on their inner strength to empower them to withstand the social stigma from the people around them. They exhibit this resistance through their responses to people who question them about their infertile union, and by avoiding social gatherings that hinge on motherhood. This is similar to how women in Bangladesh confront stigma associated with infertility (Nahar & van der Geest, 2014).

Limitations of the study

Although the study explored the experiences of married women with infertility challenges on their journey to desired conception and childbirth, the were a few limitations. Respondents for the study were selected from hospitals and clinics that provide the assessed services. Therefore, care must be exercised when generalizing the results of the study. This is due to the exclusion of individuals who do not seek biological treatment for infertility, preferring instead to employ alternative treatments such as complementary and alternative medicine.

Conclusion

This study utilised qualitative methods to explore the experiences of urban Ghanaian women in infertile unions, given the increasing access to medically assisted reproduction and knowledge. It is found that women who experience infertility in Ghana continue to be blamed for the infertility in the union irrespective of a medical diagnosis that absolves them of blame. Men as heads in the marital union continue to enjoy the privileges that come along with this social position and, for that reason, are not actively involved in finding medical solutions to the infertile union. Although medically assisted reproduction has come to improve the chances of conception for many couples who otherwise would not have been able to bear children, advancing age continues to be a bane to the success of fertility procedures. This study, therefore, demonstrates the role of social forces in keeping women in a disadvantaged position when it comes to infertility and its treatment. However, few women exhibit agency and draw on their economic independence and inner strength to be able to resist the stigma that comes along with childlessness. Women who single-handedly carry the blame for infertility (whether rightfully or not), who bear the cost of treatment and go through treatment procedures single-handedly may experience an increased psychological and economic burden which does not auger well for fertility treatment. Such women require psycho-social counselling as well as increased spousal and family support to enable them to go through the process successfully. Policy makers and health workers need to intensify education on infertility in order to sensitize the general public about the equal role both males and females play in the process of (not) establishing fertility.

Disclosure statement

No potential conflict of interest was reported by the author(s).

ORCID

Rosemond Akpene Hiadzi https://orcid.org/0000-0001-9376-877X

References

Abebe, M. S., Afework, M., & Abaynew, Y. (2020). Primary and secondary infertility in Africa: systematic review with meta-analysis. *Fertility Research and Practice, 6*(1), 1–11. https://doi.org/10.1186/s40738-020-00090-3

Ademiluka, S. O. (2018). Patriarchy and women abuse: Perspectives from ancient Israel and Africa. *Old Testament Essays, 31*(2), 339–362. http://dx.doi.org/10.17159/2312-3621/2018/v31n2a5

Allan, S., Balaban, B., Banker, M., Buster, J., Horton, M., Miller, K., & Zegers-Hochschild, F. (2019). International Federation of Fertility Societies' Surveillance (IFFS)

2019: Global Trends in Reproductive Policy and Practice. *Global Reproductive Health*, 1–138. https://doi.org/10.1097/GRH.0000000000000029

Alhassan, A., Ziblim, A. R., & Muntaka, S. (2014). A survey on depression among infertile women in Ghana. *BMC Women's Health, 14*(1), 1–6. https://doi.org/10.1186/1472-6874-14-42

Anokye, R., Acheampong, E., Mprah, W. K., Ope, J. O., & Barivure, T. N. (2017). Psychosocial effects of infertility among couples attending St. Michael's Hospital, Jachie-Pramso in the Ashanti Region of Ghana. *BMC Research Notes, 10*(1), 1–5. https://doi.org/10.1186/s13104-017-3008-8

Arhin, S. M., Mensah, K. B., Agbeno, E., Badii, V. S., & Ansah, C. (2019). Pharmacotherapy of infertility in Ghana: retrospective study at the cape coast teaching hospital. *Journal of Pharmaceutical Policy and Practice, 12*(1), 1–10. https://doi.org/10.1186/s40545-019-0191-0

Bell, K. (2012). An exploration of women's psychosocial support needs in the context of assisted reproduction. *Social Work in Health Care, 51*(8), 695–709. https://doi.org/10.1080/00981389.2012.696086

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health, 11*(4), 589–597. https://doi.org/10.1080/2159676X.2019.1628806

Brezina, P. R., & Zhao, Y. (2012). The ethical, legal, and social issues impacted by modern assisted reproductive technologies. *Obstetrics and Gynecology International*, 2012. https://doi.org/10.1155/2012/686253

Chimbatata, N. B., & Malimba, C. (2016). Infertility in sub-Saharan Africa: a Woman's issue for how long? A qualitative review of literature. *Open Journal of Social Sciences, 4*(8), 96–102. http://dx.doi.org/10.4236/jss.2016.48012

Crimmins, E. M., Shim, H., Zhang, Y. S., & Kim, J. K. (2019). Differences between men and women in mortality and the health dimensions of the morbidity process. *Clinical Chemistry, 65*(1), 135–145. https://doi.org/10.1373/clinchem.2018.288332

Dattijo, L., Andreadis, N., Aminu, B., Umar, N., & Black, K. (2016). Knowledge of infertility among infertile women in Bauchi, Northern Nigeria. . *International Journal of Women's Health and Reproduction Sciences, 4*(3),103–109. http://dx.doi.org/10.15296/ijwhr.2016.25

Dierickx, S. (2022). 'With the kanyaleng and the help of god, you don't feel ashamed': women experiencing infertility in Casamance, Senegal. *Culture, Health & Sexuality, 24*(2), 268–283. https://doi.org/10.1080/13691058.2020.1833366

Dierickx, S., Balen, J., Longman, C., Rahbari, L., Clarke, E., Jarju, B., & Coene, G. (2019). 'We are always desperate and will try anything to conceive': The convoluted and dynamic process of health seeking among women with infertility in the West Coast Region of The Gambia. *PLoS One, 14*(1), e0211634. https://doi.org/10.1371/journal.pone.0211634

Dierickx, S., Oruko, K. O., Clarke, E., Ceesay, S., Pacey, A., & Balen, J. (2021). Men and infertility in The Gambia: Limited biomedical knowledge and awareness discourage male involvement and exacerbate gender-based impacts of infertility. *PLos One, 16*(11), e0260084. https://doi.org/10.1371/journal.pone.0260084

Dill, B. T., & Zambrana, R. E. (2020). Critical thinking about inequality: An emerging lens. In McCann, C., Kim, S. & Ergun, E. (eds.) Feminist Theory Reader (pp. 108-166). Routledge.

Doghle, K., King, R. S., & Akaabre, P. B. (2018). Legal establishments and gendered access to land in patriarchal societies of north-western Ghana. *African Journal on Land Policy and Geospatial Sciences, 1*(3), 77–99. https://doi.org/10.48346/IMIST.PRSM/ajlp-gs.v1i3.14289

Doku, D. T., & Asante, K. O. (2015). Women's approval of domestic physical violence against wives: analysis of the Ghana demographic and health survey. *BMC Women's Health, 15*(1), 1–8 https://doi.org/10.1186/s12905-015-0276-0

Dyer, S., Archary, P., Potgieter, L., Smit, I., Ashiru, O., Bell, E. G., & Network, A. (2020). Assisted reproductive technology in Africa: a 5-year trend analysis from the African Network and Registry for ART. *Reproductive BioMedicine Online, 41*(4), 604-615. https://doi.org/10.1016/j.rbmo.2020.06.021

Dyer, S. J., & Patel, M. (2012). The economic impact of infertility on women in developing countries-a systematic review. *Facts, Views & Vision in Obstetrics and Gynaecology, 4*(2), 102.

Fathalla, M. F. (2002). Current challenges in assisted reproduction. In G. P. E. Vayena, Rowe PJ (Ed.), *Current Practices And Controversies In Assisted Reproduction* (1st Edition, pp. 117–121). World Health organization.

Gerrits, T. (2016). Assisted reproductive technologies in Ghana: transnational undertakings, local practices and 'more affordable' IVF. *Reproductive Biomedicine & Society Online, 2*, 32-38. https://doi.org/10.1016/j.rbms.2016.05.002

Hanson, B., Johnstone, E., Dorais, J., Silver, B., Peterson, C. M., & Hotaling, J. (2017). Female infertility, infertility-associated diagnoses, and comorbidities: a review. *Journal of Assisted Reproduction and Genetics, 34*(2), 167-177. https://doi.org/10.1007/s10815-016-0836-8

Hiadzi, R. A., & Boafo, I. M. (2020). Quest for conception: exploring treatment patterns associated with infertility in Ghana. *African Journal of Reproductive Health, 24*(2), 27-39. https://doi.org/10.29063/ajrh2020/v24i2.3

Hiadzi, R. A., Boafo, I. M., & Tetteh, P. M. (2021). 'God helps those who help themselves'… religion and Assisted Reproductive Technology usage amongst urban Ghanaians. *PLos One, 16*(12), e0260346. https://doi.org/10.1371/journal.pone.0260346

Hoff, H. S., Crawford, N. M., & Mersereau, J. E. (2015). Mental health disorders in infertile women: prevalence, perceived effect on fertility, and willingness for treatment for anxiety and depression. *Fertility and Sterility, 104*(3), e357. https://doi.org/10.1016/j.fertnstert.2015.07.1113

Hunnicutt, G. (2009). Varieties of patriarchy and violence against women: Resurrecting "patriarchy" as a theoretical tool. *Violence against Women, 15*(5), 553-573. https://doi.org/10.1177%2F1077801208331246

Inhorn, M. C., & Patrizio, P. (2015). Infertility around the globe: new thinking on gender, reproductive technologies and global movements in the 21st century. *Human Reproduction Update, 21*(4), 411-426. https://doi.org/10.1093/humupd/dmv016

Karaca, A., & Unsal, G. (2015). Psychosocial problems and coping strategies among Turkish women with infertility. *Asian Nursing Research, 9*(3), 243-250. https://doi.org/10.1016/j.anr.2015.04.007

Lorde, A. (2021). Age, race, class, and sex: Women redefining difference. In Arthur, J & Shapiro, A (eds.) *Campus Wars (pp. 191-198)*. Routledge.

Macintosh, K. L. (2015). Teaching about the biological clock: Age-related fertility decline and sex education. *UCLA Womens Law Journal, 22*(1), 1-40 https://doi.org/10.5070/L3221026365

Moyo, S., & Muhwati, I. (2013). Socio-cultural perspectives on causes and intervention strategies of male infertility: a case study of Mhondoro-Ngezi, Zimbabwe. *African Journal of Reproductive Health, 17*(2), 89-101.

Nahar, P., & Van Der Geest, S. (2014). How women in Bangladesh confront the stigma of childlessness: Agency, resilience, and resistance. *Medical Anthropology Quarterly, 28*(3), 381-398. https://doi.org/10.1111/maq.12094

Narayan, U. (2018). Minds of their own: Choices, autonomy, cultural practices, and other women. In Antony, L. & Witt C. (eds.) *A mind of one's own (pp. 418-432)*. Routledge.

Noble, H., & Smith, J. (2015). Issues of validity and reliability in qualitative research. *Evidence-based Nursing, 18*(2), 34-35. http://dx.doi.org/10.1136/eb-2015-102054

Ochieng, E. (2019). Constructing the Meaning of Childlessness within the Luo Community of Western Kenya. *Journal of African Interdisciplinary Studies*, 3(3), 14-35.

Ofosu-Budu, D., & Hanninen, V. (2020). Living as an infertile woman: the case of southern and northern Ghana. *Reproductive Health, 17*(1), 1-9. https://doi.org/10.1186/s12978-020-00920-z

Ofosu-Budu, D., & Hänninen, V. (2021). Explanations for infertility: The case of women in rural Ghana. *African Journal of Reproductive Health, 25*(4), 142-152. https://doi.org/10.29063/ajrh2021/v25i4.15

Ombelet, W., & Onofre, J. (2019). IVF in Africa: what is it all about?. *Facts, Views & Vision in Obstetrics and Gynaecology 11*(1), 65.

Onwutuebe, C. J. (2019). Patriarchy and women vulnerability to adverse climate change in Nigeria. *Sage Open*, *9*(1), 2158244019825914. https://doi.org/10.1177%2F2158244019825914

Ozturk, R., Taner, A., Guneri, S. E., & Yilmaz, B. (2017). Another face of violence against women: Infertility. *Pakistan Journal of Medical Sciences, 33*(4), 909. https://doi.org/10.12669/pjms.334.12862.

Rouchou, B. (2013). Consequences of infertility in developing countries. *Perspectives in Public Health, 133*(3), 174-179. https://doi.org/10.1177%2F1757913912472415

Salem, R., & Yount, K. M. (2019). Structural accommodations of patriarchy: Women and workplace gender segregation in Qatar. *Gender, Work & Organization*, *26*(4), 501-519. https://doi.org/10.1111/gwao.12361

Saunders, M. N., & Townsend, K. (2016). Reporting and justifying the number of interview participants in organization and workplace research. *British Journal of Management, 27*(4), 836-852. https://doi.org/10.1111/1467-8551.12182

Serour, G. I., Serour, A. G., El Faysal, Y., & Islam, Y. (2019). The place of ART in Africa. Global Reproductive Health, 4(2), e27. https://doi.org/10.1097/GRH.0000000000000027

Shreffler, K. M., Gallus, K. L., Peterson, B., & Greil, A. L. (2020). Couples and infertility. *The Handbook of Systemic Family Therapy, 3*, 385-406. https://doi.org/10.1002/9781119438519.ch76

Tabong, P. T. N., & Adongo, P. B. (2013). Infertility and childlessness: a qualitative study of the experiences of infertile couples in Northern Ghana. *BMC Pregnancy and Childbirth, 13*(1), 1-10. https://doi.org/10.1186/1471-2393-13-72

van Rooij, F. B., Bos, H. M. W., Gerrits, T., Hiadzi, R. A., & Donkor, E. S. (2020). The relationship between stigmatisation and quality of life in Ghanaian women and men with fertility problems: mediating role of coping strategies. *Facts, Views & Vision in Obstetrics and Gynaecology, 12*(4), 257.

Young, J. C., Rose, D. C., Mumby, H. S., Benitez-Capistros, F., Derrick, C. J., Finch, T., & Mukherjee, N. (2018). A methodological guide to using and reporting on interviews in conservation science research. *Methods in Ecology and Evolution, 9*(1),10–19. https://doi.org/10.1111/2041-210X.12828