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From Knowledge to Action: How Couples Navigate Plural Healthcare Systems for Infertility Care—A Qualitative Study in Ghana

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Abstract

Infertility affects 10–30% of couples globally, with significant psychological and social impacts in sub-Saharan Africa, where fertility is closely tied to identity and social status. To explore how couples' understanding of infertility causes influences their treatment-seeking behaviours and healthcare decision-making processes in Ghana, this cross-sectional qualitative study used in-depth interviews with 24 married participants (nine dyads and six individuals) experiencing current or past infertility in Greater Accra, Ghana, from August to October 2023. Data were analysed using thematic analysis with NVivo version 15. Couples demonstrated comprehensive knowledge of infertility causes spanning medical, spiritual, cultural, and lifestyle factors, although they lacked knowledge of clinical diagnostic criteria. Three main treatment pathways emerged: medical/orthodox, herbal, and spiritual interventions, pursued either sequentially or concurrently. Decision-making was influenced by internal factors (treatment effectiveness, financial constraints, and safety concerns) and external factors (family influence and peer testimonials). Four distinct navigation strategies were identified: informed notification, trial periods and evaluation, parallel relationship management, and strategic sequencing. Couples experiencing infertility are sophisticated healthcare consumers who skilfully navigate pluralistic healthcare systems through strategic decision-making. Rather than representing non-compliance, their multimodal approaches reflect rational responses to structural constraints and cultural values. Healthcare systems should recognise and accommodate these navigation strategies to improve therapeutic relationships and outcomes.

Keywords: infertility; healthcare-seeking behaviour; pluralistic healthcare; Ghana; qualitative research

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1. Introduction

Infertility is a significant global reproductive health challenge that affects individuals from diverse backgrounds. "Infertility is a disease of the male or female reproductive system defined by the failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse" [1]. It is estimated that 10 to 30 out of every 100 couples globally, and in sub-Saharan Africa (SSA) specifically, experience infertility [2–5]. The experiences of infertile couples are deeply influenced by their cultural context. In SSA, couples unable to conceive often face heightened rates of depression, suicidal ideation, personal attacks, marginalisation, diminished sexual desire, and reduced social acceptance [6]. The burden of infertility extends beyond individual women to encompass men, families, societies, and communities. These multifaceted challenges contribute to social segregation

and necessitate the development of effective coping strategies. The social significance of childbearing in African societies, where fertility is closely tied to identity and social status, underscores the urgency of addressing infertility as both a medical and social issue [7,8].

Beyond its social and psychological dimensions, infertility has significant implications for population dynamics and demographic change in sub-Saharan Africa. While infertility affects approximately 10–30% of couples, its population-level impacts extend beyond this prevalence rate. In contexts where desired fertility remains high and childbearing is central to social identity, untreated infertility contributes to a gap between desired and achieved fertility, affecting completed family size and overall fertility rates [9]. Moreover, the economic and social barriers to accessing effective fertility treatment create demographic disparities, where wealthier couples can overcome infertility while poorer couples cannot, potentially exacerbating existing inequalities in reproductive outcomes across socioeconomic groups [10,11]. Understanding how couples navigate healthcare systems for infertility treatment is therefore not merely a question of individual health-seeking behaviour, but has broader implications for reproductive health policy, healthcare system design, and ultimately population-level fertility patterns. As African countries continue their demographic transitions, improving access to and effectiveness of infertility care informed by understanding of how couples actually navigate these systems could meaningfully impact aggregate fertility outcomes and help couples achieve their desired family sizes.

Infertility emerges as an unforeseen event, precipitating a chronic crisis in individuals' lives [12] and engendering challenges from a multidirectional hierarchy both within and outside the marital union. While biomedical causes such as tubal disease and male factor infertility are well documented [13,14], many patients adhere to diverse explanatory models that incorporate supernatural and sociocultural factors [7,15]. Despite advances in assisted reproductive technology (ART), access remains limited, prompting many affected individuals to resort to a combination of traditional, faith-based, and biomedical treatments [16,17]. First, the cost of ART procedures; ranging from $2000–$5000 per cycle in Ghana, places treatment beyond the reach of most couples, particularly given that the national minimum wage is approximately $50 monthly [18,19]. Second, geographic accessibility is severely limited, with most ART facilities concentrated in major urban centres like Accra and Kumasi, requiring rural couples to travel long distances and incur additional accommodation and transportation costs [20]. Third, inadequate health insurance coverage means most couples must pay out-of-pocket for fertility investigations and treatments, with Ghana's National Health Insurance Scheme explicitly excluding ART services [19]. Fourth, knowledge gaps about ART availability, procedures, and success rates persist, with many couples unaware that such technologies exist or harbour misconceptions about their safety and religious acceptability [2,21]. Fifth, sociocultural and religious concerns about ART; including fears about the "naturalness" of conception, concerns about genetic parenthood, and religious prohibitions—create additional psychological barriers even for couples who can afford treatment [3,16]. Finally, the limited number of trained fertility specialists and inadequate infrastructure in existing facilities further constrain service delivery capacity [22]. These compounding barriers prompt many affected individuals to resort to a combination of traditional, faith-based, and biomedical treatments, often sequencing or combining multiple therapeutic approaches in their quest for conception [16,17].

Existing research highlights a knowledge gap regarding patients' fertility awareness and treatment-seeking behaviours, with reports indicating low knowledge and delayed care-seeking [21,23,24]. Controversies persist concerning the predominance of traditional versus biomedical treatment preferences and the role of gender in infertility experiences and care-seeking [25,26]. The consequences of this gap include inadequate treatment adherence, psychological distress, and unmet reproductive health needs [27,28]. The multi-

faceted impact of infertility, including psychological distress and economic burden, further underscores the importance of a comprehensive understanding and intervention [28,29]. Historically, research has evolved from epidemiological assessments of infertility prevalence and causes [13,16] to more nuanced explorations of sociocultural meanings and health-seeking behaviours [30,31]. This study contributes to the infertility literature by examining a diverse sample that includes individuals currently experiencing infertility and those who have navigated these challenges in the past, as well as cases of both primary and secondary infertility. This methodological approach provides a comprehensive understanding of infertility experiences across different stages and types, offering insights into both the immediate challenges and the longer-term impacts of fertility difficulties.

Given the limited research on how couples navigate plural healthcare systems in urban Ghana, where biomedical, traditional, and spiritual treatment options coexist this study focuses on an urban setting where couples have theoretical access to multiple treatment modalities, including proximity to a major teaching hospital. While this urban focus provides important insights into healthcare navigation in contexts where options are available, we acknowledge that findings may not be generalizable to rural or semi-urban populations who face different constraints and opportunities in their healthcare-seeking journeys. Understanding healthcare navigation patterns in this urban context, where access barriers are primarily economic and cultural rather than geographic, provides a foundation for future research comparing treatment-seeking across different geographic contexts. This study aimed to explore couples' knowledge and perceptions of the causes of infertility, identify the various treatment pathways pursued (medical, traditional, spiritual), analyse factors influencing couples' treatment decision-making processes, and understand how couples navigate plural healthcare systems.

2. Methods

This cross-sectional qualitative study utilised In-Depth Interviews (IDIs) conducted with married participants in the Ablekuma South sub-metropolitan area of the Greater Accra region of Ghana. This location was purposively selected because it is a major referral hospital area in Ghana. Korle-Bu Teaching Hospital, the primary healthcare facility in Ghana, is the largest tertiary hospital in the country and is affiliated with the Medical School of the University of Ghana. As part of a broader mixed-methods study, a structured quantitative survey was administered to 1000 households randomly selected from 50 Enumeration Areas (EAs) across six localities in the Ablekuma South Sub-Metro. The survey, conducted using KoboCollect electronic data collection software, was administered face-to-face in the respondent's preferred language (Twi, Ga, or English) by trained enumerators. The survey included questions on socio-demographic characteristics, marital history, pregnancy experiences, delayed fertility, attitudes about infertility, and willingness to participate in follow-up in-depth interviews.

From the 1000 households surveyed, participants for the qualitative in-depth interviews were purposively selected based on two criteria: (1) their affirmative response to a survey question regarding personal experiences with infertility, whether current or past, and (2) their expressed willingness and availability for follow-up interviews. This purposive sampling approach ensured that all interviewed participants had direct lived experience with infertility, enabling in-depth exploration of their knowledge, treatment pathways, and healthcare navigation strategies. When selected participants agreed to be interviewed, their spouses were also invited to participate. Spouses who consented were interviewed simultaneously by two different interviewers in separate locations to ensure privacy and candid responses. Spouses who did not consent were excluded from the interviews. This recruitment approach resulted in nine dyadic interviews (18 participants

interviewed as couples) and six individual interviews (6 participants), yielding a total sample of 24 married participants.

Data collection occurred from 3 August 2023 to 4 October 2023. The total sample size of 24 was determined based on data saturation, whereby no new themes or insights emerged from additional interviews. All interviews were conducted in the local language preferred by participants (Twi or Ga) and were audio-recorded with the participants' consent. The average duration of the interviews was 54 min. Inductive probing was used during interviews to explore issues raised by participants in greater depth.

Ethical approval was obtained from the Ethics Committee for Humanities at University of Ghana [ECH 198/22–23]. All participants provided written informed consent before participating in the study. The consent process was conducted in the participant's preferred language (Twi, Ga, or English), with the consent form read aloud by the interviewer to ensure full understanding of the study purpose, procedures, risks, benefits, and participants' rights, including the right to withdraw at any time without consequences. All participants in this study had at least basic formal education and were able to provide written consent after the verbal explanation. Participation in the study was entirely voluntary, with no financial compensation or incentives provided to participants. Privacy and confidentiality were maintained throughout the interview process, with all recordings and transcripts stored securely with unique identifiers rather than personal names.

Data were analysed using a thematic approach [32] with the assistance of NVivo version 15 software. The analysis was guided by the study objectives. Initial codes were generated through both inductive (data-driven) and deductive (theory-driven) means. The coding framework and emerging themes were discussed with colleagues who acted as peer debriefers, enhancing the credibility and trustworthiness of the analysis.

3. Results

Table 1 presents the demographic and reproductive characteristics of 24 study participants experiencing infertility, comprising nine couples (dyads) and six unpaired individuals from four urban communities in Ghana. The participants, all identifying as Christian, included 12 females (ages 34–50) and 12 males (ages 36–57), representing both primary infertility (never conceived) and secondary infertility (previously conceived but unable to conceive again) cases. Primary infertility refers to individuals or couples who have never achieved a pregnancy, while secondary infertility refers to those who have previously conceived (whether resulting in live birth, miscarriage, or abortion) but are currently unable to conceive again. The couples have been in their current unions for 3–23 years, having first married between ages 21–37 for women and 22–34 for men, with infertility delays spanning 2–19 years. The six unpaired participants included three females and three males from various communities who participated without their partners. Notably, some couples exhibit discrepancies in the reported number of children (ranging from 0 to 6), which may be attributed to differences between biological and social parenthood, instances of child loss, or children from different or previous unions. Additionally, six participants had never had children.

The analysis of participant responses identified three main themes, summarised with subthemes and examples of direct quotes in Table 2.

Table 1. Demographic characteristics of Participants.

	Years in Current Union	Number of Children	Age of Respondent	Age at First Marriage	Years of Delay	Type of Infertility
Female	11	2	38	27	5	secondary
Male	11	2	36	25	5	secondary
Female	7	0	35	28	7	Primary
Male	7	3	46	30	7	secondary
Female	13	3	42	29	2	Primary
Male	13	3	41	28	2	Primary
Female	23	3	50	27	5	secondary
Male	23	3	57	28	5	secondary
Female	4	4	39	26	10	secondary
Male	4	0	49	24	4	Primary
Female	3	0	42	24	5	Primary
Male	3	4	57		5	secondary
Female	13	0	40	27	13	Primary
Male	13	0	47	34	13	Primary
Female	20	6	41	21	9	secondary
Male	20	6	43	22	9	secondary
Female	6	2	36	30	2	Primary
Male	6	2	37	31	2	Primary
Female	6	1	34	28	6	secondary
Male	14	2	37	23	3	secondary
Female	23	2	47	21	7	secondary
Male	5	0	38	33	5	Primary
Female	3	2	40	37	7	secondary
Male	23	2	48	25	19	secondary

Table 2. Themes, sub-themes & direct quotes generated from the data analysis.

Main Themes	Sub-Themes	Examples of Direct Quotes
1. Understanding of infertility	Unexplained	*"And we have been to the hospital, and they said there is nothing wrong with us."*
	Medical	*"The test carried out on both of us reported that my egg or ovary was becoming weak, but I was assured it was not quite serious. In addition, my husband too was detected of low sperm count."*
	Physical	*"I know is that alcohol is likely to cause that and then smoking of weed."*
	Spiritual	*"In our African setting, it is believed that someone could bewitch you and that you would not be able to conceive. When it comes to the medical aspect, it could be due to low sperm count in men, tube blockage among women, and fibroids. So we can look at the causes from two angles, the spiritual and the medical."*
	Cultural	*"My uncle has advised me to officially marry my spouse because sometimes if the marriage rites have not been performed, the woman cannot give birth. During traditional marriage, depending on one's ethnicity, libation and prayer are offered to the new couple. And one of the prayers is for the fruit of the womb."*

Table 2. *Cont.*

Main Themes	Sub-Themes	Examples of Direct Quotes
2. Treatment pathways and Decision-making factors	Medical/Orthodox treatment and its determinants	*"Sometimes you could be scheduled for either the following week or month. So, let us assume you spend almost a thousand cedis every month; it is not a joke. The medication or drugs alone that are prescribed are expensive."*
	Herbal medicine and social influence	*"It is herbal, anytime I visit my mother, I get some herbal medicine to come and drink. So I have been taking herbal medicine most often."*
	Spiritual interventions	*"The only solution is God, any other thing I don't believe in it."*
	Sequential treatment pathways	*"Our initial start was with the medical, and after some time, we decided to use the herbal, and that worked. So we switched to the herbal, and between three and five months after the herbal medication I think I conceived."*
	Concurrent treatment pathways	*"So like the Bible teaches us that we should cast all our burdens on Him, so even when you go through procedures and you conceive, you still back it with prayers. They give you medication; you still pray over it before you take it. Some people have taken the medication and it has never worked, while others have taken it and it has worked. So you support all your medical procedures with prayers."*
3. Strategies for navigating plural health systems	Informed notification	*"When I told my doctor that I was going to seek a second opinion from a herbalist, he said no. But we went ahead with it and when it succeeded, then we started with the antenatal."*
	Trial periods and evaluation	*"Our initial start was with the medical, and after some time, we decided to use the herbal, and that worked."*
	Parallel relationship management	*"Herbs can also be used for treatment. When we consider the spiritual aspect, it is fasting and prayers."*
	Strategic sequencing	*"At that time, we were financially constrained, so I visited the herbalist for help. Many people have testified to the potency of her herbal medicines"*

Theme 1: Understanding of infertility

Most participants consistently defined infertility as an inability to conceive or give birth. However, their definitions lack critical clinical components, specifically the timeframe criteria and the requirement of unprotected intercourse for formal infertility classification.

> *"The inability of either the man or the woman to get pregnant. That is the delay in the woman to get pregnant and the delay in the man to make a woman pregnant."* Respondent 6M

Organising theme: Causes of infertility

All couples demonstrated comprehensive knowledge of the causes of infertility, identifying medical, physical, cultural, unexplained, and spiritual factors. Importantly, the participants acknowledged both male and female contributory factors. However, the prevalent association between abortion and infertility may perpetuate harmful misconceptions that disproportionately blame women for their fertility challenges.

Subtheme 1: Unexplained causes

Two participants described their infertility as unexplained, reflecting their physicians' conclusions after comprehensive testing revealed no detectable abnormalities. This diagnostic uncertainty appeared to influence their ongoing search for alternative explanations.

> *"I was not conceiving, so we went to see my doctor and . . . mine was unexplained. My infertility was unexplained."* Respondent 3F

> *"And we have been to the hospital and they said there is nothing wrong with us."* Respondent 5F

Subtheme 2: Medical causes

Some participants identified various medical factors affecting both partners, including male factors such as low sperm count and female factors ranging from tubal blockage and ovarian dysfunction to conditions such as fibroids and polycystic ovarian syndrome.

> *"The test carried out on both of us reported that my egg or ovary was becoming weak, but I was assured it was not quite serious. In addition, my husband too was detected of low sperm count."* Respondent 14F

Subtheme 3: Physical causes

Some participants cited lifestyle factors, including alcohol consumption, marijuana use, and dietary habits, as contributory factors to infertility.

> *"I know is that alcohol is likely to cause that and then smoking of weed."* Respondent 4F

Subtheme 4: Spiritual causes

Some participants attributed infertility to spiritual factors, including witchcraft or divine timing. Notably, some medical causes, such as abortion, were interpreted through spiritual frameworks, suggesting that couples integrate biomedical and spiritual explanatory models.

> *"Some are due to medical reasons, while others are spiritual. In our African setting, it is believed that someone could bewitch you and that you would not be able to conceive. When it comes to the medical aspect, it could be due to low sperm count in men, tube blockage among women, and fibroids. So we can look at the causes from two angles, the spiritual and the medical."* Respondent 7M

> *"Sometimes it is a result of lifestyle and behaviour; for instance, maybe someone is destined to have two or three children in her lifetime. Meanwhile, this person has had two or three abortions. Implying that, this person has aborted all three children she was destined to have in life."* Respondent 8F

Subtheme 5: Cultural factors

Participants identified cultural practices, particularly the completion of traditional marriage rites, as factors influencing fertility rates. These cultural ceremonies are viewed as spiritual gateways that unlock reproductive potential.

> *"My uncle has advised me to officially marry my spouse because sometimes if the marriage rites have not been performed, the woman cannot give birth. During traditional marriage, depending on one's ethnicity, libation and prayer are offered to the new couple. And one of the prayers is for the fruit of the womb."* Respondent 2M

Theme 2: Treatment pathways and Decision-making factors

The analysis revealed that the participants pursued three main treatment pathways: medical/orthodox medicine, herbal remedies, and spiritual interventions. These pathways align with the causal explanations identified earlier. Treatment approaches were either sequential, where couples progressed from one pathway to another (typically from orthodox to herbal medicine), or concurrent, where multiple pathways were pursued simultaneously. Multiple factors influenced these treatment decisions, including internal factors (treatment effectiveness, financial constraints, safety concerns) and external factors (family influence, peer testimonials).

Subtheme 1: Medical/Orthodox treatment and its determinants

Participants described accessing formal healthcare services, although their responses revealed gendered assumptions about fertility responsibility. Some participants believed that women should be evaluated first, with male partners only seeking medical attention if female testing revealed no abnormalities. This pattern reflects the gendered nature of infertility blame and responsibilities.

> *"They can go to the hospital for treatment; for instance, the woman has to go and check if everything is okay. If they find nothing wrong the husband would also go and have himself checked and if there is a problem he would be treated."* Respondent 6F

However, economic accessibility significantly influenced treatment choices. The cumulative financial burden of repeated medical consultations and expensive medications created barriers to sustained orthodox treatment, with couples often selecting alternative approaches because of prohibitive costs.

> *"Sometimes you could be scheduled for either the following week or month. So, let us assume you spend almost a thousand cedis every month; it is not a joke. The medication or drugs alone that are prescribed are expensive."* Respondent 2F

> *"I didn't see any effective result with the medication from the hospital that is why I proposed the herbal alternative."* Respondent 11M

Subtheme 2: Herbal medicine and social influence

Participants described accessing traditional herbal remedies, often through family networks and community recommendations. Family members, particularly in-laws and parents, played a significant role in directing couples toward specific treatment pathways.

> *"So we realised it has been delayed, so we have to find a solution to it. Therefore, we discussed the issue with my in-laws, who were aware that we were not using any form of contraception, but conception was not occurring. So my in-law directed us to a herbalist and my wife was given some medicine, she got pregnant after a month of drinking the medicine."* Respondent 1M

> *"At that time, we were financially constrained, so I visited the herbalist to help me. Many people have testified to the potency of her herbal medicines."* Respondent 1F

Some couples pursued herbal treatments despite medical advice against them, suggesting tension between biomedical and traditional healing systems. However, safety considerations influenced their preference for medically supervised treatments, despite other constraining factors.

> *"Some would want to go by the herbal way. However, sometimes, herbal medicines may complicate matters. You might not know what complications it might cause to your system. Therefore, it is sometimes safe to go to the hospital for a check-up. And the doctor will prescribe medication for you due to the diagnosis, and this makes things easier."* Respondent 6F

> *"On our own, in fact my mother-in-law spoke to somebody and the person said oh this our problem is not a problem. Let us go to my hometown. . . our traditional medicine, these herbs are good. They do not document it; that is the annoying thing. When I told my doctor that I was going to seek a second opinion from a herbalist, he said no. But we went ahead with it and when it succeeded, then we started with the antenatal."* Respondent 3M

> *"It is herbal, anytime I visit my mother, I get some herbal medicine to come and drink. So I have been taking herbal medicine most often."* Respondent 5F

Subtheme 3: Spiritual interventions

For some participants, prayer and divine intervention were the primary or sole pathways to conception. These couples demonstrated strong faith-based approaches to fertility challenges, with some fundamentally rejecting other treatment modalities.

> *"The only solution is God, any other thing I don't believe in it."* Respondent 13M

Subtheme 4: Sequential treatment pathways

Several couples described the following treatment pathways in sequence, typically beginning with medical treatment before transitioning to alternative approaches. Financial constraints and treatment fatigue often influence these transitions.

"Our initial start was with the medical, and after some time, we decided to use the herbal, and that worked. So we switched to the herbal, and between three and five months after the herbal medication I think I conceived." Respondent 3F

"We spent a lot on medical treatment. . . so for now, medical treatment is on hold. We are only using the spiritual means." Respondent 7M

Subtheme 5: Concurrent treatment pathways

Some participants simultaneously pursued multiple treatment approaches, integrating medical procedures and spiritual practices. This approach reflects their belief that different pathways can complement rather than compete with each other.

"So like the Bible teaches us that we should cast all our burdens on Him, so even when you go through procedures and you conceive, you still back it with prayers. They give you medication; you still pray over it before you take it. Some people have taken the medication and it has never worked, while others have taken it and it has worked. So you support all your medical procedures with prayers." Respondent 3F

Theme 3: Strategies for navigating plural health systems

To navigate the plural healthcare system, participants used four strategies such as informed consent, trial periods and evaluation, parallel relationship management and strategic sequencing.

Subtheme 1: Informed notification

Participants consulted their primary healthcare provider if they wanted to try other remedies. This consultation appeared to be an official way of informing the provider, as they acted as much as possible in their own way. This shows that couples maintained autonomy while showing respect for medical authority.

"When I told my doctor that I was going to seek a second opinion from a herbalist, he said no. But we went ahead with it and when it succeeded, then we started with the antenatal." Respondent 3M

Subtheme 2: Trial periods and evaluation

Couples established trial periods for each treatment approach, evaluating effectiveness within self-imposed timeframes before deciding to continue, switch, or add alternative treatments to their regimen. They utilised existing social networks to gather information on alternative solutions during these evaluation periods.

"I took the herbal mixture for a while, but there was no improvement. Therefore, I decided to visit the hospital for treatment. I took the herbal mixture for approximately three months, and since I did not see any improvement, I halted the treatment and opted for medical treatment. So I could tell that the medical treatment was good". Respondent 9F

"Our initial start was with the medical, and after some time, we decided to use the herbal, and that worked". Respondent 3F

Subtheme 3: Parallel relationship management

Couples maintained relationships with multiple providers simultaneously, justifying these approaches as complementary rather than contradictory, all working toward the shared goal of conception.

"So for instance God has given doctors the knowledge to provide solution to our illnesses and sicknesses, so while you are trusting God you should also visit the hospital for assistance". Respondent 14F

"Herbs can also be used for treatment. When we consider the spiritual aspect, it is fasting and prayers". Respondent 7M

Subtheme 4: Strategic sequencing

Couples made strategic decisions regarding treatment sequencing based on multiple factors, including financial constraints, social recommendations, diagnostic outcomes, and personal beliefs. Rather than random selection, these decisions reflect careful consideration of the available resources and social influences.

> *"At that time, we were financially constrained, so I visited the herbalist for help. Many people have testified to the potency of her herbal medicines".* Respondent 1F

> *"However, apart from helping the person pray, at my place of worship, the person is advised to seek medical help".* Respondent 4M

> *"Some seek herbal treatment, while others seek medical treatment. The problem is identified, and treatment is prescribed. In the end, there is victory".* Respondent 12F

These navigation strategies reveal that couples experiencing infertility exercise considerable agency as sophisticated healthcare consumers. Rather than being passive recipients of care, they actively orchestrate multiple treatment approaches while maintaining autonomy in decision-making.

4. Discussion

This study reveals a complex landscape of infertility experiences among Ghanaian couples that challenges conventional assumptions about healthcare-seeking behaviours and patient agency. Through four interconnected objectives, the study's findings reveal the knowledge and knowledge gaps that couples who have experienced infertility in the past or are currently experiencing infertility have, and how these nuances influence their treatment choices or pathways. The progression from knowledge to action revealed in this study demonstrates that couples possess a wide-ranging understanding of infertility causes spanning medical, physical/lifestyle, spiritual, and cultural domains, yet strategically adapt this knowledge to navigate practical constraints and social expectations. Most significantly, couples employ four distinct navigation strategies: informed notification, trial periods and evaluation, parallel relationship management, and strategic sequencing, which reflect adaptability and challenge healthcare providers to recognise and accommodate multidimensional approaches to fertility care.

4.1. Knowledge and Misconceptions

The study findings reveal a gap between couples' conceptual understanding of infertility and clinical diagnostic criteria, consistent with previous research in Sub-Saharan Africa [23,24]. While participants accurately identified infertility as the inability to conceive, their definitions lacked critical components, specifically the 12-month timeframe for unprotected intercourse required for clinical diagnosis. This gap has important implications for timely healthcare-seeking, as couples may delay medical consultation or, conversely, seek treatment prematurely based on unrealistic expectations regarding conception timelines.

However, the findings also demonstrate that couples possess adequate knowledge of infertility causes, identifying factors across medical, lifestyle, spiritual, and cultural domains, as documented in similar studies in the African context [7,16,33] which contrasts with Dyer et al. [21], where respondents had poor fertility knowledge. Interestingly, participants who have experienced infertility also attribute spiritual causes to infertility; however, this multifaceted understanding reflects the pluralistic healthcare environment in which they operate and suggests that knowledge deficits may be less about breadth of experience and more about specific clinical criteria.

4.2. Treatment Pathways and Decision-Making

This study identifies sequential and concurrent treatment approaches, providing empirical evidence for healthcare pluralism in fertility care, extending beyond previous studies that have documented the use of traditional medicine alongside biomedical care [16,17]. The strategic nature of these approaches, rather than random or desperate switching between modalities, demonstrates couples' sophisticated understanding of different therapeutic systems and their complementary potential. Sequential approaches typically followed a pattern from biomedical to traditional treatments as documented in similar studies [20,34]. This finding is also in contrast to the studies [35–37] which depict biomedical care as the last resort following traditional failure. In our study, the pathway was often driven by financial constraints or treatment fatigue rather than a lack of faith in medical care.

Concurrent approaches, characterised by integrating medical procedures with spiritual practices, reflect couples' ability to maintain multiple explanatory models simultaneously without experiencing cognitive dissonance. The seamless integration of biomedical, traditional, and spiritual explanations observed in our study demonstrates couples' flexibility, viewing different treatment modalities as complementary rather than contradictory approaches to achieving conception. The finding that couples view divine intervention as working through medical knowledge ("God has given doctors the knowledge") illustrates sophisticated theological reasoning that reconciles faith with science.

Treatment effectiveness emerged as the primary driver of pathway decisions, with couples employing evidence-based evaluation strategies despite operating outside the formal clinical trial frameworks. Their assessment of effectiveness was based on observable outcomes within the self-imposed timeframes. Financial constraints significantly shaped treatment choices, with couples often selecting herbal alternatives because of prohibitive biomedical care costs. The economic burden of fertility treatment, documented extensively in resource-limited settings [38], creates equity issues that force couples to pursue potentially less effective treatments based on affordability rather than clinical appropriateness. The findings of monthly costs approaching 1000 Ghana cedis (approximately $200 USD) represent substantial financial burden for couples in a country where minimum wage is approximately $50 monthly. Safety concerns, particularly regarding herbal medicines, demonstrate couples' awareness of treatment risks and their preference for medically supervised care when possible challenging stereotypes regarding uncritical acceptance of traditional remedies.

The significant role of family members and social networks in treatment decisions reflects the communal nature of fertility concerns in Ghanaian society, where reproductive challenges extend beyond the couple to affect extended family systems. Family recommendations carried considerable weight, particularly from in-laws and parents, reflecting respect for elder authority and recognition of their experiential knowledge of fertility treatments. The influence of religious counsellors who recommend both spiritual and medical interventions illustrates how social networks can facilitate rather than impede biomedical care access, challenging the assumption that traditional authorities discourage the use of modern medicine.

4.3. Navigation Strategies

The four distinct navigation strategies identified–informed notification, trial periods and evaluation, parallel relationship management, and strategic sequencing–provide novel insights into how couples actively manage complex healthcare environments. These strategies reveal patients as sophisticated healthcare consumers who exercise considerable agency within structural constraints, challenging the traditional focus of medical anthropology on structural factors that limit patient choice. The strategic nature of these behaviours,

characterised by careful planning, risk assessment, and relationship management, contradicts assumptions about "non-compliant" or "traditional" patients who supposedly reject modern medicine. Instead, couples demonstrate remarkable adaptability, maintaining relationships with multiple providers, maximising therapeutic options, and preserving autonomy in decision-making processes.

The strategy of informed notification, which tells providers about alternative treatments while maintaining decision-making autonomy, reveals a sophisticated understanding of medical authority and patient rights. Parallel relationship management, where couples maintain simultaneous relationships with multiple providers while justifying these as complementary approaches, reflects advanced social skills and cognitive flexibility. These navigation strategies suggest that apparent "non-compliance" or "treatment discontinuation" may actually reflect sophisticated healthcare management, rather than passive resistance or lack of understanding. Healthcare providers who recognise and work with these strategies may achieve better therapeutic relationships and outcomes than those who insist on exclusive biomedical engagement.

4.4. Implications

4.4.1. Clinical Practice and Provider Training

Healthcare providers should recognise couples' multimodal treatment approaches as sophisticated healthcare behaviours rather than non-compliance or lack of education. Training programmes should emphasise cultural competency skills, including asking non-judgmental questions about other treatments being used, providing accurate information about treatment interactions without dismissing traditional approaches, and working collaboratively with couples to coordinate care across different therapeutic systems. Providers should also address the knowledge gaps identified in this study by providing clear information about infertility diagnostic criteria and correcting misconceptions correct misconceptions about abortion-infertility associations while remaining sensitive to the spiritual and cultural interpretations. The informed notification strategy employed by couples suggests openness to dialogue about multiple treatments, creating opportunities for providers to offer guidance while respecting patients' autonomy.

4.4.2. Health System and Policy Design

Policy approaches that accommodate rather than compete with traditional and spiritual healing systems should be adopted. This may include referral pathways between biomedical facilities and qualified traditional healers, insurance coverage that recognises herbal medicine costs, and facility designs that accommodate spiritual practices within medical settings. Financial barriers to biomedical fertility care require urgent attention, with policy options including subsidised fertility services, insurance coverage for infertility treatment, and sliding fee scales based on income. The economic burden documented in our study effectively excludes many couples from accessing evidence-based treatments, creating equity issues that demand policy interventions. Quality assurance mechanisms for traditional healing practices could help couples make informed decisions about herbal treatments while maintaining respect for traditional knowledge systems. Economic analyses comparing the costs and outcomes of different treatment pathways can inform policy decisions regarding resource allocation and insurance coverage, considering not only direct medical costs but also indirect costs of transportation, time, and family involvement.

4.4.3. Counselling and Support Services

Fertility counselling approaches should address the multidimensional nature of couples' infertility experiences by incorporating spiritual and cultural dimensions alongside biomedical concerns. Counsellors should be trained to work with couples' existing be-

lief systems rather than attempting to replace them with purely biomedical frameworks. Family-inclusive counselling models may be appropriate, given the significant role of extended family in treatment decisions. Support services should help couples navigate conflicting advice from multiple stakeholders while maintaining autonomy in their decision-making processes. Group counselling or peer support programmes could harness the positive aspects of social network influence while providing accurate information and emotional support, helping couples share navigation strategies and learn from others' experiences across different treatment modalities.

4.4.4. Population and Demographic Implications

From a population studies perspective, this research contributes to understanding the complex relationship between reproductive health services, healthcare accessibility, and fertility outcomes. The sophisticated navigation strategies employed by infertile couples reveal high motivation to achieve desired family sizes, yet the substantial financial and structural barriers documented suggest that many couples may be unable to overcome infertility, creating a gap between desired and achieved fertility that disproportionately affects lower-income populations. This has implications for understanding population dynamics in Ghana and similar contexts, where improving access to effective infertility care could meaningfully impact aggregate fertility rates and reduce demographic inequalities in reproductive outcomes. As African countries continue their demographic transitions, the role of infertility treatment in enabling couples to achieve their desired family sizes may become increasingly important for understanding actual fertility trajectories and population-level change. Intervention studies testing approaches to improve integration between biomedical and traditional healing systems, along with comparative studies across different cultural contexts, could provide evidence for policy development and identify which navigation strategies are universal and which are context-specific.

4.5. Study Limitations

Several limitations should be considered when interpreting the findings of this study. The sample was drawn from people in the broader survey and in an urban area near a major teaching hospital, which may have facilitated access to biomedical care and influenced couples' treatment choices. Rural couples may exhibit different navigation patterns and face different constraints and opportunities.

The cross-sectional design captured couples' experiences at a single time point, potentially missing how navigation strategies evolve over time or how prolonged infertility experiences might influence treatment approaches in the future. Longitudinal studies would provide a better understanding of how couples adapt their strategies based on treatment outcomes and changing circumstances.

The sample included both couples currently experiencing infertility and those who had successfully conceived, which provided diverse perspectives but may have introduced recall bias among those reflecting on their past experiences. Additionally, some interviews were conducted with individuals rather than couples, which may have missed the dynamics between partners in the decision-making process.

5. Conclusions

This study reveals that couples experiencing infertility in Ghana are sophisticated healthcare consumers who navigate complex therapeutic landscapes through strategic decision-making and adaptive relationship management. The integration of biomedical, traditional, and spiritual approaches represents not confusion or non-compliance, but rational responses to structural constraints and cultural values within pluralistic health-

care systems. The four navigation strategies identified–informal notification, trial periods and evaluation, parallel relationship management, and strategic sequencing–demonstrate remarkable patient agency and challenge healthcare providers to recognise and accommodate multidimensional approaches to fertility care. Healthcare providers need training in cultural competency and collaborative care approaches that respect patients' expertise in managing their healthcare journeys. Health systems require policy frameworks that accommodate rather than compete with traditional and spiritual healing systems, while addressing financial barriers that force couples to choose treatments based on cost rather than clinical appropriateness. From a demographic policy perspective, investments in accessible infertility care informed by an understanding of how couples navigate healthcare systems represent not only improvements in individual reproductive health but also potential influences on population-level fertility patterns and reproductive justice. Most importantly, this study calls for a fundamental reconceptualisation of patient agency in healthcare settings. Couples experiencing infertility demonstrate that patients are not passive recipients of medical interventions but active agents who strategically orchestrate multiple therapeutic approaches while maintaining their autonomy within structural constraints. Healthcare systems that recognise and support this sophisticated healthcare behaviour are likely to achieve better therapeutic relationships, improved patient satisfaction, and ultimately better health outcomes for couples navigating infertility's complex challenges outcomes that may aggregate to meaningful demographic impacts at the population level.

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Data Availability Statement: The datasets used and/or analysed in this study are not available in a public repository because they contain identifiable and sensitive information, making it impossible to protect the participants' confidentiality. However, the datasets are available from the author upon request.

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References

1. WHO. Factsheet, Infertility. Available online: https://www.who.int/news-room/fact-sheets/detail/infertility (accessed on 3 December 2025).
2. Naab, F.; Brown, R.; Heidrich, S. Psychosocial health of infertile Ghanaian women and their infertility beliefs. *J. Nurs. Scholarsh.* **2013**, *45*, 132–140. [CrossRef] [PubMed]
3. Oti-Boadi, M.; Asante, K.O. Psychological health and religious coping of Ghanaian women with infertility. *Biopsychosoc. Med.* **2017**, *11*. [CrossRef]
4. Esan, D.T.; Nnamani, K.Q.; Ogunkorode, A.; Muhammad, F.; Oluwagbemi, O.O. Experiences and Health-seeking Behaviour of Couples in Ekiti State, Nigeria, towards Infertility. *Research Square* **2020**. [CrossRef]
5. Hiadzi, R.A.; Boafo, I.M. Quest for conception: Exploring treatment patterns associated with infertility in Ghana. *Afr. J. Reprod. Health* **2020**, *24*, 27–39. Available online: https://www.ajrh.info/index.php/ajrh/article/view/2263 (accessed on 20 October 2025).
6. Ofosu-Budu, D.; Hänninen, V. Explanations for infertility: The case of women in rural Ghana. *Afr. J. Reprod. Health* **2021**, *25*, 142–152. Available online: https://www.ajrh.info/index.php/ajrh/article/view/2868 (accessed on 20 October 2025).
7. Dimka, R.A.; Dein, S.L. Cultural Construction of Infertility in Nigeria. *Afr. J. Reprod. Health* **2013**, *17*, 102–117.
8. Fehintola, A.O.; Fehintola, F.O.; Ogunlaja, O.; Awotunde, T.O.; Ogunlaja, I.; Onwudiegwu, U. Social meaning and consequences of infertility in Ogbomoso, Nigeria. *Sudan J. Med. Sci.* **2017**, *12*, 63–77. [CrossRef]
9. Larsen, U. Primary and secondary infertility in sub-Saharan Africa. *Int. J. Epidemiol.* **2000**, *29*, 285–291. [PubMed]

10. Inhorn, M.C.; Patrizio, P. Infertility around the globe: New thinking on gender, reproductive technologies and global movements in the 21st century. *Hum. Reprod. Updat.* **2015**, *21*, 411–426. [CrossRef]
11. Bell, A.V. *Misconception: Social Class and Infertility in America*; Rutgers University Press: New Brunswick, NJ, USA, 2014.
12. Roudsari, R.L.; Allan, H.T.; Smith, P.A. Iranian and English women's use of religion and spirituality as resources for coping with infertility. *Hum. Fertil.* **2014**, *17*, 114–123. [CrossRef]
13. Madziyire, M.G.; Magwali, T.L.; Chikwasha, V.; Mhlanga, T. Causes of infertility in women presenting to gynaecology clinics in Harare, Zimbabwe: A cross-sectional study. *Fertil. Res. Pract.* **2021**, *7*. [CrossRef]
14. Oriji, P.C.; Kiridi, E.K.; Ubom, A.E.; Okoye, C.N.; Oriji, V.K.; Awotundun, B. Patterns of infertility among infertile couples in a tertiary health institution in Bayelsa State, South-South Nigeria. *Int. J. Sci. Rep.* **2022**, *8*, 136–141. [CrossRef]
15. Iwelumor, O.S.; Suraya, S.S.J.; Babatunde, S.K.; Hayat, M.F. Sociocultural perceptions of infertility. *Asia Proc. Soc. Sci.* **2019**, *4*, 165–167. [CrossRef]
16. Dyer, S. nfertility-related reproductive health knowledge and help-seeking behaviour in African countries. *ESHRE Monogr.* **2008**, *2008*, 29–33. [CrossRef]
17. Whittaker, A.; Gerrits, T.; Hammarberg, K.; Manderson, L. Access to assisted reproductive technologies in sub-Saharan Africa: Fertility professionals' views. *Sex. Reprod. Health Matters* **2024**, *32*. [CrossRef]
18. Ombelet, W.; Cooke, I.; Dyer, S.; Serour, G.; Devroey, P. Infertility and the provision of infertility medical services in developing countries. *Hum. Reprod. Update* **2008**, *14*, 605–621. [CrossRef] [PubMed]
19. Gerrits, T.; Van Rooij, F.; Esho, T.; Ndegwa, W.; Goossens, J.; Bilajbegovic, A.; Jansen, A.; Kioko, B.; Koppen, L.; Migiro, S.K.; et al. Infertility in the Global South: Raising awareness and generating insights for policy and practice. *Facts Views Vis. ObGyn* **2017**, *9*, 39–44. [PubMed]
20. Hiadzi, R.A.; Woodward, B.J. Infertility treatment decision-making in Ghana and contestations that may arise: A prospective sociological study. *Glob. Reprod. Health* **2019**, *4*, e32. [CrossRef]
21. Dyer, S.; Abrahams, N.; Hoffman, M.; van der Spuy, Z.M. Infertility in South Africa: Women's reproductive health knowledge and treatment-seeking behaviour for involuntary childlessness. *Hum. Reprod.* **2002**, *17*, 1657–1662. [CrossRef]
22. Gerrits, T. Assisted reproductive technologies in Ghana: Transnational undertakings, local practices and 'more affordable' IVF. *Reprod. Biomed. Soc. Online* **2016**, *2*, 32. [CrossRef]
23. Dhont, N.; Luchters, S.; Ombelet, W.; Vyankandondera, J.; Gasarabwe, A.; van de Wijgert, J.; Temmerman, M. Gender differences and factors associated with treatment-seeking behaviour for infertility in Rwanda. *Hum. Reprod.* **2010**, *25*, 2024–2030. [CrossRef]
24. Enwuru, C.A.; Iwalokun, B.; Enwuru, V.N.; Oparaugo, C.T.; Ezechi, O.; Oluwadun, A. Fertility knowledge, care-seeking behavioural patterns, and attitudes of infertile men in Lagos, Nigeria. *Int. J. Res. Med. Sci.* **2020**, *8*, 901–907. [CrossRef]
25. Dyer, S.; Abrahams, N.; Mokoena, N.; van der Spuy, Z. "You are a man because you have children": Experiences, reproductive health knowledge, and treatment-seeking behaviour among men suffering from couple infertility in South Africa. *Hum. Reprod.* **2004**, *19*, 960–967. [CrossRef]
26. Moyo, S.; Muhwati, I. Socio-cultural perspectives on causes and intervention strategies of male infertility: A case study of Mhondoro-Ngezi, Zimbabwe. *Afr. J. Reprod. Health* **2013**, *17*, 89–101. Available online: https://www.ajrh.info/index.php/ajrh/article/view/274 (accessed on 20 October 2025).
27. Arhin, S.M.; Mensah, K.B.; Agbeno, E.K.; Azize, D.A.; Henneh, I.T.; Agyemang, E.; Ansah, C. Pharmacotherapy of infertility in Ghana: Why do infertile patients discontinue their fertility treatment? *PLoS ONE* **2022**, *17*, e0274635. [CrossRef] [PubMed]
28. Olowokere, A.E.; Olowookere, O.; Komolafe, A.O.; Oyelade, O.O.; Olajubu, A.O.; Aladegboye, M.K. Psychological, and social effects of infertility on women: A mixed-methods study. *Gynecol. Reprod. Health* **2022**, *6*, 1–12.
29. Nieuwenhuis, S.L.; Odukogbe, A.-T.A.; Theobald, S.; Liu, X. The impact of infertility on infertile men and women in Ibadan, Oyo State, Nigeria: A qualitative study. *Afr. J. Reprod. Health* **2009**, *13*, 85–98.
30. Okonofua, F.; Harris, D.; Odebiyi, A.I.; Kane, T.T.; Snow, R.C. The social meaning of infertility in southwest Nigeria. *Health Transit. Rev.* **1997**, *7*, 205–220.
31. Tabong, P.T.-N.; Adongo, P.B. Infertility and childlessness: A qualitative study of the experiences of infertile couples in Northern Ghana. *BMC Pregnancy Childbirth* **2013**, *13*. [CrossRef] [PubMed]
32. Attride-Sterling, J. *Qualitative Research*; Sage Publications: Thousand Oaks, CA, USA, 2001.
33. Usman, N.; Tlagae, C.; Grace, B. P-716 What do Africans know about their fertility? A systematic literature review exploring fertility knowledge, attitudes, and behaviour among African population groups. *Hum. Reprod.* **2024**, *39*, deae108.1043. [CrossRef]
34. Mohammed-Durosinlorun, A.; Adze, J.; Bature, S.; Abubakar, A.; Mohammed, C.; Taingson, M.; Airede, L. Use and pattern of previous care received by infertile Nigerian women. *Fertil. Res. Pract.* **2019**, *5*, 14. [CrossRef] [PubMed]
35. Chimbatata, N.B.W.; Malimba, C. Infertility in Sub-Saharan Africa: A Woman's Issue for How Long? A Qualitative Review of Literature. *Open J. Soc. Sci.* **2016**, *4*, 96–102. [CrossRef]

36. Dierickx, S.; Balen, J.; Longman, C.; Rahbari, L.; Clarke, E.; Jarju, B.; Coene, G. "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* **2019**, *14*, e0211634. [CrossRef]
37. Odek, A.; Masinde, J.; Egesah, O.; Irungu, C.; Mulinge, M.M. Socio-cultural beliefs and practices associated with infertility in Kenya: A case study of Kisumu County. *Afr. Multidiscip. J. Res.* **2016**, *1*, 96–120.
38. Njagi, P.; Groot, W.; Arsenijevic, J.; Dyer, S.; Mburu, G.; Kiarie, J. Economic costs of infertility care for patients in low- and middle-income countries: A systematic review protocol. *BMJ Open* **2020**, *10*, e042951. [CrossRef] [PubMed]