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Lived experiences and coping strategies of women with fertility challenges in University of Calabar Teaching Hospital (UCTH), Nigeria

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ABSTRACT

Background: In many African cultures, pregnancy and childbirth are seen as proof of womanhood and productivity. The inability to conceive often leads to physical and psychological strain, affecting both marriages and families. This study aims to explore the lived experiences and coping strategies of women facing fertility challenges at the University of Calabar Teaching Hospital (UCTH), Nigeria.

Methods: A qualitative phenomenological research design was employed. Twenty-four women attending the Gynecological Clinic at UCTH were purposively recruited using the principle of data saturation. Data were collected through in-depth interviews and analyzed using thematic analysis.

Findings: Two major themes emerged: *Holistic Impact of Infertility* and *Coping Strategies*, with seven sub-themes: *Coming to Terms with Reality, Physical and Mental Exhaustion, Social Stigma and Isolation, Emotional Turmoil and Grief, Problem-Focused Coping Strategies, Emotion-Focused Coping Strategies,* and *Integrative Coping Strategies*. These themes highlighted the distress associated with infertility and the diverse coping mechanisms adopted by the participants.

Conclusion: Health practitioners, especially nurses, must provide comprehensive care addressing the biopsychosocial and spiritual needs of women experiencing infertility. Additionally, mental health support should be integrated into reproductive healthcare policies to better support these women.

Keywords: Lived experiences, infertility, women, coping strategies, Nigeria.

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INTRODUCTION

Infertility is defined as the inability to achieve pregnancy after at least 12 months of regular, unprotected intercourse.[1] It can be classified as primary, for those who have never conceived, or secondary, for those who previously achieved pregnancy.[1] In men, infertility often results from issues such as low sperm count, poor motility, or morphological abnormalities, while in women, it stems from endocrine or reproductive system dysfunctions, including complications with the ovaries, uterus, or fallopian tubes. However, infertility, whether primary or secondary, often leads to undesirable consequences, including stigmatization and social exclusion, with women typically bearing the brunt of the blame.[2] The psychological and relational challenges faced by infertile women, which are intensified in patriarchal and pronatalist societies.[3]

Globally, infertility affects about 15% of couples of reproductive age, with roughly one in six individuals experiencing infertility at some point in their lives.[1] In Africa, especially in the rural areas, the society grapples with high fertility rates, varying from 3.18 children per woman in South Africa; 4.74 in East Africa, 5.38 in West Africa, and 5.59 in Central Africa.[4] Variations also exist across economic categories, with fertility rates averaging 5.45 in low-income countries, 4.70 in lower-middle-income countries, and 3.80 in high-middle-income countries.[4] Nigeria, specifically, has a fertility rate of 5.009 births per woman as of 2024.[5] This figure is over and twice the replacement fertility level of 2.1, compelling governmental efforts to address population growth. Despite the high fertility rate, 11% of the population in Nigeria still faces fertility challenges.[6-7]

Studies indicate that infertility remains one of the most prevalent gynecological issues in Nigeria. According to WHO[1], many countries, including Nigeria, struggle with limited availability, accessibility, and quality of infertility-related interventions. Additionally, infertility diagnosis and treatment are rarely prioritized in national health policies or funded through public healthcare systems.[1]

Infertility is a universal challenge, affecting 10–15% of reproductive-aged couples across cultures.[8] Clinical studies conducted in northern Nigeria report infertility rates ranging between 14.5% and 30%.[9] In African societies, pregnancy and childbirth are deeply intertwined with perceptions of womanhood and, by extension, male virility.[10-11] Consequently, failure to conceive within a year of marriage often results in physical and emotional strain on individuals, their marriages, and their families. In many patriarchal societies[11], women are disproportionately blamed for infertility, regardless of whether the underlying cause lies with the male partner. This not only increases the emotional burden on women but also reinforces harmful gender stereotypes.

While infertility is a medical condition that can often be addressed with proper intervention[1], cultural beliefs in African societies frequently attribute it to divine disapproval, prolonged contraceptive use, or male impotence. Such misconceptions can harm both partners, eroding a man's sense of control and self-esteem while causing profound confusion and anxiety for the woman.[12] Sometimes women are often ostracized or subjected to material deprivation due to societal beliefs linking infertility to moral failings, such as promiscuity.[2] Recent research further demonstrates that the immense cultural and societal pressures surrounding fertility exacerbate mental health challenges, including depression, anxiety and psychological distress.[13-15]

In Nigeria and other parts of Africa, the societal expectation that defines womanhood through childbirth often leads to disrespect, domestic violence, ostracism, and a loss of rights for infertile women.[16] Infertility also affects marital relationships, creating tensions that can erode the emotional bond between partners. On the one hand, the shared experience of infertility can foster mutual support and understanding; on the other hand, it can result in conflict and resentment, particularly when couples face prolonged uncertainty and repeated treatment failures .[14] Cultural norms and beliefs around fertility further magnify these challenges, often dictating the social treatment of infertile women within their families and communities.[17-18]

Coping strategies are vital for navigating the emotional, social, and relational challenges associated with infertility. Identifying social support from partners, family, friends, or support groups as a key strategy for alleviating loneliness and fostering a sense of belonging has been reported.[19] There must be emphasis on the importance of problem-focused coping strategies[20], such as pursuing medical or alternative treatments, which can empower individuals by fostering a sense of control over

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their circumstances. In the African contexts, many women combine practical approaches with spiritual practices, such as prayer and fasting, as a means of coping with the emotional and social toll of infertility.[18] The role of spirituality in helping Nigerian women build emotional resilience and find solace in their faith during their fertility challenges has been underscored.[21]

Despite the growing body of literature on infertility, there is limited research focusing on the lived experiences and coping strategies of women facing fertility challenges in Nigeria. This study aims to explore fertility challenges and coping strategies as well as recommend ameliorative measures to comprehensively address the biopsychosocial and spiritual needs of women.

METHODOLOGY

Research Design

This study adopted a qualitative research approach, utilizing an Interpretive (Hermeneutic) Phenomenological design to explore and understand the lived experiences of women facing infertility. This design was chosen because it not only describes what women go through but also interprets how they make meaning of these experiences and how they cope emotionally, socially, and spiritually. Infertility is a deeply personal and culturally influenced phenomenon in Nigeria; thus, interpreting participants' narratives within the Nigerian context was crucial. The approach enabled the examination of both the subjective experiences and the meanings behind women's coping strategies, aligning with the interpretive phenomenological framework that emphasizes understanding human experiences from the perspective of those who live them.[22] Bracketing was employed to allow participants' voices to emerge authentically, with the researcher temporarily setting aside preconceptions.

Study Setting

The study was conducted in 2024 at the University of Calabar Teaching Hospital (UCTH), a tertiary healthcare institution established in 1979, located in Calabar Municipality LGA, Cross River State. UCTH serves as the primary government-owned tertiary healthcare provider for the state, with a population of approximately 4.4 million people. The gynecological clinic was selected because it manages women experiencing fertility challenges from diverse socio-economic, cultural, and religious backgrounds. The setting provided an ideal environment for exploring participants lived experiences and coping strategies, offering access to rich and varied narratives that reflect the multifaceted realities of infertility in the Nigerian context.

Study Population and Sampling

The study population comprised of women attending the gynecological clinic at UCTH who had been diagnosed with primary or secondary infertility. A purposive sampling technique was used to select the participants who could provide meaningful insights into their experiences. Participants were identified during clinic visits, and those meeting the inclusion criteria received an information sheet detailing the study's purpose, confidentiality measures, and their right to withdraw at any time. Those who voluntarily consented signed a written informed consent form prior to participation. A total of 24 participants were recruited, with the principle of data saturation guiding sample adequacy. In-depth interviews were conducted at private, mutually agreed-upon locations within the hospital to ensure comfort and confidentiality.

Key Concepts

The study focused on two interrelated concepts: lived experiences and coping strategies. Lived experiences capture the emotional, psychological, social, and spiritual realities of women living with infertility, including its impact on identity, marital relationships, and social interactions. Coping strategies refer to adaptive mechanisms employed to manage infertility-related stress, including spiritual coping, help-seeking, reliance on social support, and self-acceptance. Together, these concepts facilitated a holistic understanding of how women interpret and navigate infertility within their socio-cultural context.

Data Analysis

Data were analysed using thematic analysis to identify patterns and interpret meanings within participants' narratives. Audio-recorded interviews were transcribed verbatim, anonymised, and where necessary, translated. Participants were assigned unique codes ranging from FP1 (Female Participant 1) to FP24 to maintain confidentiality. The analysis followed an interpretive phenomenological approach, beginning with familiarisation with the data and reflexive memoing.

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Relevant codes were generated inductively and grouped into themes reflecting participants lived experiences and coping strategies. Themes were reviewed, refined, and defined to ensure coherence, with illustrative quotations selected to support interpretation.

To ensure rigour, bracketing was employed to minimise bias, conducted peer debriefing, and used member checking with the selected participants. An audit trail and thick descriptions enhanced transparency and transferability. This process enabled a nuanced understanding of how women navigate infertility, revealing both shared patterns and individual meanings associated with their emotional, social, and spiritual coping mechanisms.[22, 23]

RESULTS

Demographic Survey

Demographic variables on age reveals that 3 (12.5%) participants were within the age range of 18 – 25 years, 5 (20.8%) were within the age range of 26 – 33 years, 7 (29.2%) participants were within the age range of 34 – 41 years and 9 (37.5%) participants were within the age range of 42 - 49 years. In reference to marital status, 2 (8.3%) participants were single, the majority 17 (70.8%) participants were married and 2 (8.3%) co-habited. Four (4, 16.7%) participants were housewives, 7 (29.2%) were Civil servants, the majority 10(41.7%) were businesswomen while 3(12.5%) were unemployed. With respect to educational qualification, 7(29.2%) participants had secondary education, the majority 9 (37.5%) had Higher Education while 8 (33.3%) had tertiary education. In assessing the type of infertility, the majority 19 (79.2%) participants had primary infertility while 5 (20.8%) participants had secondary infertility (Table 1). Figure 1 depicts the major themes and sub-themes of the study.

Table 1: The Socio-demographic data of respondents during the study

Data	Response option	Frequency	Percentage
Age	18 – 25 years	3	12.5
	26 – 33 years	5	20.8
	34 – 41years	7	29.2
	42 - 49years	9	37.5
	Total	**24**	**100.0**
Marital Status	Single	2	8.3
	Married	17	70.8
	Co-habitation	2	8.3
	Separated	3	12.5
	Total	**24**	**100.0**
Occupation	Housewife	4	16.7
	Civil servant	7	29.2
	Business	10	41.7
	Unemployed	3	12.5
	Total	**24**	**100.0**
Educational status	Secondary	7	29.2
	Higher Education	9	37.5
	Tertiary	8	33.3
	Total	**24**	**100.0**
Type of infertility	Primary	19	**79.2**
	Secondary	5	20.8
	Total	**24**	100.0

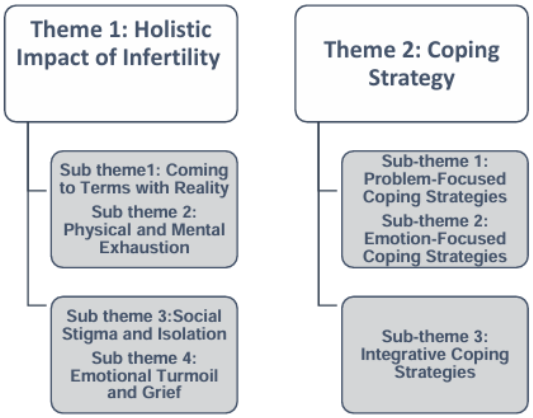

Figure 1: The thematic map elucidating the major themes and sub-themes of the study.

Theme 1: Holistic Impact of Infertility

This theme captured the wide-ranging effects of infertility, encompassing biological, social, and psychological dimensions. Four sub-themes emerged under this category:
(1.1) Coming to Terms with Reality, (1.2) Physical and Mental Exhaustion, (1.3) Social Stigma and Isolation and (1.4) Emotional Turmoil and Grief

Sub-Theme 1.1: Coming to Terms with Reality

This sub-theme highlighted the various stages participants navigated before accepting their diagnosis of infertility. Codes such as "denial," "harsh reality," "awareness," "acceptance," and "seeking solutions" captured the progression of emotions and actions.

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Participants described their experiences in their own words:
FP1 (Female Participant 1) shared:
"I *really found it difficult at first to accept that I was infertile. Initially, I didn't even want a pregnancy after marriage, I was focusing on regaining financial stability. I wasn't using contraceptives either; I just thought since I didn't desire it, that was the reason. But then my in-laws started probing, and I kept denying it… until I couldn't anymore."*
FP2 narrated:
"We don't have such issues [infertility] in our family, and it never crossed my mind that it could happen to me. Eight months after my wedding, it started bothering me, but I kept denying it. Then, after one year, I began thinking that something was definitely wrong."
For many participants, the harsh reality of their infertility became undeniable after one year of marriage.
FP3 recounted:
"Many people, including me, never understand the weight of being called 'barren' until you are labeled that way. It happened after a small misunderstanding with my brother's wife. She referred to me as barren. I felt so bad; I went into the house and realized that yes, I was barren. That's when I started thinking about how to help myself."
FP4 expressed the urgency of seeking help after coming to terms with her condition:
"As soon as I accepted that something might be wrong with me, the next morning, I was at the hospital. The worst thing is barrenness. It's better to get pregnant and have a miscarriage than to be barren."
And FP5 described her journey of opening up to her family:
"*I couldn't keep it to myself anymore. I called my mother, who had already been nursing inner fears that I kept denying. She suggested we meet at the hospital. I'm optimistic that we'll find a solution very soon.*"

Sub-Theme 1.2: **Physical and Mental Exhaustion**
This sub-theme emerged with codes such as "circling on one point," "plague of infertility," and "fatigue." These codes illuminated the physical and psychological toll of infertility on women, as described in their narratives:
FP6 lamented:
"It is like my life and marriage circle around being pregnant. Family members are not interested in any other thing about my life, but having pregnancy. Greetings come with looking at my face for signs of pregnancy. I just feel tired of the whole affair."
FP7 added:
"I feel womanhood is tied up with pregnancy, and the whole essence of marriage is for children. Without pregnancy, as a woman, you lose your purpose in life. It is so frustrating; I just feel unhappy with myself and even being born in Africa."
FP8 narrated the societal meaning of infertility:
"Infertility connotes promiscuity and poor upbringing to the mother or parent. People look at you as a wayward woman or blame it on overuse of contraceptives. It is hard to prove your innocence, even to your husband, who may try to believe you but can act otherwise because of social pressure sometimes."
FP9 moaned:
"I try to stay away from women's gatherings and remain silent to avoid attracting attention to myself or outright insult. For some, I am not a woman because I have not proven to be one."
FP10 affirmed the perception that infertility connotes past promiscuity:
"Some men may personally try to lure a woman because they feel she is not faithful or a good woman. They think the husband just happened to marry a public woman as a wife. Men set traps to prove a point."
FP 11 muttered:
"You know, coming to the hospital actually brings hope that there will be a solution to my problem someday. But the continuous appointments and hormonal injections are tiring."
FP11 continued:
"The huge amount of money paid for IVF puts me under pressure and fear. You just can't think about what will happen if it doesn't work. The trauma was overwhelming when it failed. I was physically and mentally drained."
FP12 expressed her longing for even a brief sign of pregnancy:
"I wish I just missed my period, even if I miscarried after 8 weeks. It is still better than my current state of no pregnancy. At least I would make my husband feel like he is a man."
FP13 affirmed:
"Infertility comes with lots and lots of anxiety and low self-esteem. You are not counted among women. You can never inherit any property, no matter how good you were to your husband."
FP14 described how she sought relief from the humiliation:
"I left my home to stay in my Father's house to end the humiliation and anxiety. I am not obligated to anybody. Whether pregnancy comes or not, I don't owe anyone anything. I feel better not waking up every day with the guilt of something I don't have control over."
FP14 noted:
"I lost my appetite for food because of worry and unhappiness. I don't even like dressing because it attracts attention to me. I incur

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more hatred for spending my husband's money on food and irrelevant things."

Sub-theme 1.3: Social Stigma and Isolation

This sub-theme emerged with codes such as "pride of womanhood," "mockery," and "self-isolation." These codes illuminate the stigma associated with infertility and its impact on women.

FP15 narrated:

"The proof of womanhood in our community is pregnancy and delivery, then to crown it, the delivery of a male child. Without any evidence to show, I learned to keep my mouth shut in women's gatherings if I attend any. And it is not strange to hear someone saying, 'This gathering is for real women.'"

Similarly, FP16 affirmed the social impact, stating:

"Some associate my infertility with poor moral standards, saying it is my reward. Therefore, I stopped going to social gatherings. Even when I have to go, I remain silent, but generally, I just feel out of place most times."

FP17 added:

"I stay at home to avoid undue questioning."

Sub-theme 1.4: Emotional Turmoil and Grief

This sub-theme emerged with codes such as "hope and disappointment," "sporadic anguish," "strained relationships," and "occasional suicidal ideation." These codes illuminate the alternating and fluctuating emotions that study participants experienced.

FP18 described her experience:

"Each time my menses comes, I am not myself. My husband even gets irritated for nothing, I know he is not happy with me. I feel I have failed as a woman and a wife. I pray and cry when I am alone and hope that my story will change and there will be a happy ending."

FP19 lamented:

"You know, for me, the last thing I want is menses. The joy and hope it brings when I don't see it as at when due, then the shattered hope when it finally comes—this is how it is every month after marriage. Menses comes with sadness and grief."

Similarly, FP20 affirmed:

"Menses just remind me of my inability to conceive, my failure as a woman and a wife. It brings tears, a devastating experience. Even our marital relationship is strained—we remain distant from one another, and our silence speaks volumes. He really wants a child."

FP21 expressed suicidal ideation as narrated:

"Sometimes, the thought of ending it all clouds my brain, and I wonder: what is life if I cannot be and feel like other women do? I made up my mind when I was told of in vitro fertilization and the success story behind it. It provided a ray of hope because the woman in question was about 45 years old."

Theme 2: Coping Strategy

This theme emerged with three sub-themes: Problem-Focused Coping Strategies**,** Emotion-Focused Coping Strategies, and Integrative Coping Strategies, which illuminate the measures adopted by study participants to cope with the biopsychosocial impact of infertility in the Nigerian environment.

Sub-theme 2. 1: Problem-Focused Coping Strategies

This sub-theme involves taking proactive measures aimed at managing or mitigating the impact of infertility on their lives. Codes such as "gathering information," "medical treatment," "gaining spousal trust through communication," "financial empowerment," and "resilience" emerged.

FP22 narrated:

"I know how people look down on those with infertility, so immediately after I started receiving unnecessary questions from in-laws, I started looking out for solutions before it got too late. I went to the hospital to confirm if anything was wrong with me. I also visited the community traditional birth attendant, who also checked me."

FP23 affirmed:

"I was told about this medical treatment, in-vitro fertilization (IVF), but I learnt that it was really costly. Yes, I know that will be the last resort. I have to gather money; if nothing happens, I will go for that one."

Participants also approached the issue of infertility by gaining spousal trust through communication, as FP24 narrated:

"The last person I wanted to be against me was my husband. At first, I was annoyed that he was listening to others, so I silenced him, and it was not helping issues. I decided to explain things to him and even my feelings. He started supporting me, and we started visiting the doctor together and making plans. My husband's trust is what matters the most to me."

FP5 and FP11 spoke about seeking financial support:

"The medical treatment is really challenging, but I am determined to raise that money to remove this shame from my face. My family members, especially my mother, are very supportive, so we will raise enough money next year for IVF."

Resilience was another strategy employed, as affirmed by FP11:

"I don't allow anybody to put me down. Though I feel bad, I talk back to anybody that makes any gesture (insinuation) at me. You won't even land, and they now think I insult people."

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Sub-theme 2.2: Emotion-Focused Coping Strategies

This sub-theme emerged with codes such as "seeking emotional support," "praying," "changing outlook to life," and "avoiding triggers." These codes highlight how individuals manage their emotional distress rather than addressing the problem itself. Women experiencing infertility often use these strategies to cope with the emotional toll of their condition, including feelings of sadness, frustration, guilt, and social pressure.

FP12 shared:

"I try my best when I really feel down to talk to my husband. Sometimes I meet my friend who has not been able to conceive for five years now. We often encourage each other."

FP12 and FP22 affirmed the power of prayer:

"I believe that there is nothing God cannot do. I believe this problem brought me closer to God, and I know a solution will come. Generally, I have peace of mind, and even my husband now prays, seeking supernatural intervention."

FP15 expressed a change in perspective about life:

"It depends on how you look at life. If you see infertility as a problem, then it is for you. What of those who don't want children in their marriage—are they not human? I changed the way I see it. If my husband chooses to take a new wife, then it is OK for him. I will not kill myself for something that I cannot help."

FP15 avoided stressors, as narrated:

"I don't want problems with anybody. I enjoy my peace of mind. So, anybody that will remind me of this problem, I remove them from my heart. Really, I stopped visiting my husband's family house to avoid problems."

Resilience was also emphasized by FP12:

"I keep telling myself I will be pregnant and will have children. Don't worry Mary (not real name), it will soon come to pass. I believe that and tell myself repeatedly."

Sub-theme 2.3: Integrative Coping Strategies

This sub-theme illuminates a combination of elements of both problem-focused and emotion-focused coping to provide a holistic approach to managing infertility. Codes include "spiritual and practical approaches," "balancing acceptance and action," and "developing resilience through integration." These codes highlight how participants, even when emotionally challenged, still seek practical solutions that foster resilience, hope, and adaptability in the face of uncertainty.

FP18 shared:

"It has not been easy. Although I cry sometimes, I don't give up hope. I make sure I seek solutions, even when what I tried did not work out. I don't give up; I try something else."

FP12 added:

"I go for prayers and fasting. I make sure I follow up on medical appointments. I believe God can help with medicine. Whatever I do, my trust is in God."

FP22 spoke about handling mockery and finding inner peace:

"When I am mocked, I don't mind. I just turn it over to God. Before, I used to get sad, but now I don't let what somebody thinks or says disturb me. I hand it over to God."

DISCUSSION

In assessing the lived experiences of women with infertility, the study findings reveal holistic impacts which captures the emotional and psychological journey that women navigate before accepting the diagnosis of infertility. The participants' narratives revealed distinct stages of denial, awareness, acceptance, and solution-seeking, highlighting the complex interplay of personal, social, and cultural factors.

Coming to terms with reality: The results revealed initial reaction to infertility by many participants was characterized by denial. This stage often stems from societal and cultural expectations that equate womanhood with motherhood, leading individuals to suppress or rationalize their reproductive challenges. As one participant noted, "We don't have such issues (infertility) in our family," which reflects the deeply ingrained belief that infertility is an anomaly that "should not happen" to them. This finding aligns with previous study[234] that identified denial as a common coping mechanism in the early stages of infertility and diagnosis. The study revealed that, the realization of infertility became undeniable after one year of marriage, often catalyzed by external triggers such as probing from family members or derogatory remarks. One participant recounted how being labeled "barren" during a family misunderstanding was a turning point: "*I felt so bad... I knew that yes, I was barren.*" This highlights how societal stigmatization and negative labeling exacerbate the emotional burden of infertility. These findings revealed that social stigma surrounding infertility is a significant source of distress, particularly in cultures where childbearing is a marker of social status and familial acceptance.

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It is interesting to know that once participants acknowledged their reproductive challenges, they transitioned into a phase of awareness and active problem-solving. For instance, one participant stated, "*As soon as I came to that conclusion that something maybe wrong with me, in the morning I was in the hospital.*" This proactive approach reflects the transition from emotional denial to practical action, a shift that is critical for psychological adjustment and coping. These findings corroborated with who previous report[25] that seeking medical assistance is a vital step in regaining a sense of control and hope, as it allows individuals to actively engage in addressing their infertility.

Family support also emerged as an essential component and underscored the pivotal role of family support in facilitating acceptance and action. One participant shared how her mother encouraged her to seek medical care, demonstrating the importance of familial encouragement in breaking through denial and fostering optimism. This finding resonates with existing literature, which emphasizes the positive impact of social and familial support in buffering the emotional impact of infertility and promoting help-seeking behavior.[26]

The journey of coming to terms with infertility is laden with profound emotional challenges, including shame, guilt, and fear. The participants' experiences reveal the deep psychological toll of societal expectations and personal aspirations. One participant remarked, "*It is better that I got pregnant and it aborted than bareness*," illustrating the extreme emotional pain associated with infertility and that women experiencing infertility navigate five stages of grieving process.[27]

Physical and Mental Exhaustion associated with infertility: Participants lived experience also illuminated the "Physical and Mental Exhaustion" which reflects the profound and multifaceted toll infertility takes on women's lives.

Infertility as a Central Life Focus: The narratives demonstrate that infertility often becomes the focal point of women's lives, particularly in cultures where motherhood is a key determinant of identity and social status. One participant remarked, "*My life and marriage circle around being pregnant.*" This reflects the societal obsession with reproduction, where women are primarily valued for their ability to conceive. In patriarchal societies like many parts of Africa, the pressure to conceive is amplified by cultural norms that equate a woman's worth with her fertility.[28]

Psychological Impact of Stigma and Misconceptions: Study revealed stigma and misconceptions surrounding infertility, is often linked to moral judgments. Statements such as, "Infertility connotes promiscuity and poor upbringing," reveal the cultural narratives that associate infertility with moral failings. Women described feelings of shame, isolation, and frustration as they navigated societal blame. Recent report[29] confirmed that stigma is a universal challenge for infertile women, exacerbated by gender norms that place the burden of infertility squarely on women, even when male factors may contribute. Misconceptions about infertility, such as its link to promiscuity or contraceptive use, deepen the psychological distress, as women feel compelled to defend their innocence.[30]

Social Isolation and Avoidance: Study also revealed that participants lived experiences are characterized by social isolation and withdrawing from social gatherings to avoid scrutiny and judgment. One participant shared, "*I try to stay away from women gatherings and remain silent to avoid attracting attention to myself.*" Social isolation, while being protective in the short term, often worsens mental health outcomes by reducing access to support networks. This is similar to another report[31] that infertile women frequently experience social alienation due to societal attitudes, which negatively impacts their psychological well-being. The avoidance of social interactions may also hinder access to shared experiences and coping strategies that could alleviate feelings of loneliness.

Financial, Physical and marital Strain: The financial burden of infertility treatments, such as IVF, emerged as a key stressor. Participants described the physical exhaustion of continuous medical appointments and hormonal treatments, compounded by the fear of financial loss if treatments fail. One participant noted, "*The huge amount of money paid for IVF puts me under pressure and fear.*" Similarly, a recent report[32] stated that the cost of fertility treatments is a major barrier to care in low and middle-income countries, where affordable options are limited. Additionally, the physical toll of treatments, including side effects of hormonal therapies, contributes to fatigue and emotional distress.[33] Moreover, infertility's impact on marital relationships and social

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standing was another dominant theme. Participants described marital tensions stemming from societal pressure, with one noting, "*I wish I just missed my period, even if I miscarried after 8 weeks. At least it will make my husband feel like he is a man*." This reflects the gendered nature of infertility, where women bear the emotional labor of sustaining their marriage and managing societal expectations. Infertility often disrupts marital dynamics, leading to blame, tension, and, in some cases, abandonment. In many cultures, women are disproportionately held responsible for childbearing, intensifying the strain on their mental health and relationships.

Mental Health Consequences: This report also revealed significant mental health challenges, including anxiety, low self-esteem, and persistent unhappiness. One stated, "*Infertility comes with lots and lots of anxiety and low self-esteem. You are not counted among women*." This highlights the intersection of infertility, cultural norms, and mental health. On the other hand, infertility is strongly associated with depression and anxiety, particularly in societies where motherhood is central to female identity. The psychological toll of infertility is exacerbated by societal marginalization, financial stress, and repeated treatment failures. Despite the overwhelming challenges, some participants demonstrated resilience by making choices to reduce their stress. For example, one participant shared, "*I left my home to stay in my father's house to end the humiliation and anxiety*." This aligns with previous findings[32] that women often adopt various coping strategies, including seeking alternative support systems, to navigate the emotional toll of infertility.

Social Stigma and Isolation: Social stigma emerged as a profound theme in this study, highlighting how societal norms and cultural expectations place immense pressure on women to prove their womanhood through childbirth. Participants narrated how infertility leads to exclusion, mockery, and social isolation, as societal constructs often equate a woman's worth to her ability to conceive and deliver, particularly male children. The notion that infertility undermines the pride of womanhood reflects the deeply entrenched gender roles and cultural beliefs. This finding is consistent with the report[27] that in many patriarchal societies, infertility is often seen as a failure of a woman's primary role, leading to stigmatization and exclusion. Similarly, infertile women in sub-Saharan Africa[34] are frequently ostracized and excluded from social gatherings and labeled as "*lesser women*." Such stigma results in self-isolation, as women avoid situations that could subject them to judgment or ridicule. The association of infertility with moral failure or promiscuity, as noted in this study, exacerbates the social stigma. Participants reported avoiding social gatherings to escape undue questioning or insults. It has been reported[35] that cultural and religious beliefs often link infertility with past sins or poor moral character, further deepening the societal rejection of infertile women. The isolation that arises from this stigma takes a toll on mental health. Infertile women often feel alienated, ashamed, and unworthy, leading to withdrawal from social networks[36]. This self-imposed isolation is both a coping mechanism and a consequence of societal rejection.

Emotional Turmoil and Grief: Infertility induces significant emotional distress, as seen in the study participants' experiences. The alternating hope and despair associated with delayed or failed conception were common themes. Participants described the emotional pain of menstruation, which served as a monthly reminder of their inability to conceive. The psychological impact of this recurring disappointment is well-documented in the literature. The anticipation and subsequent disappointment of infertility often lead to grief, low self-esteem, and depressive symptoms.[32] The strain on marital relationships was another significant finding. Participants expressed feelings of failure as wives and women, which strained their relationships with their husbands. This aligns with previous report[33] that infertility often creates marital discord, with both partners struggling to navigate unmet expectations and societal pressures. The stress of infertility can lead to emotional distance, as couples grapple with feelings of blame, guilt, and inadequacy.

Some participants in this study revealed experiencing suicidal ideation due to the emotional weight of infertility. The lack of emotional support and the societal emphasis on motherhood contribute to this psychological distress. However, participants also highlighted how hope was rekindled through access to treatments like *in vitro fertilization* (IVF). Success stories of other women provided a ray of hope, emphasizing the role of assisted reproductive technology in mitigating emotional distress. Similarly, it has been noted that ART

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interventions[30] offer psychological relief and hope, serving as a vital coping mechanism for women facing infertility.

Coping Strategies: Study participants experienced a biopsychosocial burden, therefore women adopted various coping strategies to navigate the associated challenges such as problem-focused, emotion-focused, and integrative coping strategies. These strategies reflect proactive, adaptive, and holistic approaches to managing infertility in the Nigerian sociocultural context.

Problem-Focused Coping Strategies: This involved actively addressing the causes or consequences of infertility. These include gathering information, seeking medical treatment, building spousal trust, financial empowerment, and demonstrating resilience. Activity included seeking for medical care, including consultations with traditional birth attendants and exploring advanced options like IVF. This aligned with the study[37] that individuals experiencing infertility often seek diverse solutions, including medical interventions, alternative therapies, and lifestyle changes. Access to fertility treatments like IVF is often limited in resource-constrained settings, yet women remain determined to overcome financial barriers.

Study also revealed the building of spousal trust through communication, and this emerged as a significant coping mechanism, with participants emphasizing the importance of aligning with their partners. A study[33] revealed that open communication between partners strengthens marital relationships and reduces stress during infertility treatment. Spousal support fosters emotional stability and shared responsibility, which is crucial in navigating infertility challenges. Participants also demonstrated resilience, confronting societal stigmatization and refusing to succumb to pressure. Of course, resilience, characterized by assertiveness and optimism, enables women to manage the social impact of infertility effectively.[38]

Emotion-Focused Coping Strategies: This strategy focused on addressing the emotional toll of infertility rather than solving the root problem. These strategies included seeking emotional support, praying, changing perspectives on life, and avoiding triggers. Study revealed that participants leaned on supportive relationships, such as friends or spouses, to manage their distress. This is consistent with a previous report[35] which highlighted the importance of social support in reducing feelings of isolation and sadness among infertile women. Emotional support from others experiencing similar struggles fosters a sense of solidarity and shared understanding.

Prayer and faith were central to many participants' coping mechanisms. Participants described how spirituality offered hope, peace, and a sense of control amid uncertainty which is similar to a previous report[39] that religion and spirituality play pivotal roles in infertility coping, particularly in African settings where faith-based interventions are culturally significant. Praying and fasting not only provided emotional comfort but also reinforced optimism for eventual success.

Changing perspectives on life, such as accepting infertility as part of life's uncertainties, helped some participants manage their emotional burden. Cognitive reframing that is, shifting one's mindset to find meaning or reduce the perceived severity of infertility, have been found to enhanced psychological resilience.[40] Moreover, some chose to avoid triggers, such as hostile family environments or judgmental individuals, to maintain emotional stability suggesting that avoiding stressors can protect mental health, although it may limit social interactions.[41]

Integrative Coping Strategies: Integrative coping combines problem-focused and emotion-focused approaches, offering a holistic strategy to manage infertility. Participants utilized spiritual and practical approaches, balanced acceptance and action, and developed resilience through integration. This approach becomes all-embracing and keep participants optimistic of positive outcome.

Participants expressed strong will in combining medical treatments with prayer and fasting, indicating a belief in the synergy between spiritual and scientific interventions. This dual approach[42] emphasizes how integrating spiritual practices with medical care provides hope and emotional stability. Another strategy included balancing acceptance and action was another strategy, as participants pursued solutions while preparing for uncertain outcomes. Integrating acceptance with active coping strategies reduces emotional distress and raises adaptability of the individual. Developing resilience

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through integration emerged as a vital coping mechanism. Participants managed societal mockery and emotional challenges by adopting a pragmatic outlook and refusing to dwell on negative experiences. But emphasis that resilience, bolstered by both internal strength and external support, is essential for managing infertility in challenging sociocultural contexts.[35]

Implications for Nursing Practice

Nurses, as key healthcare providers, have a vital role in addressing the emotional and psychological needs of women, this can be achieved through providing infertility counseling, helping women and their partners navigate emotional distress, manage societal pressures, and access available treatments. Nursing practice should incorporate cultural competence by addressing spiritual beliefs, traditional practices, and societal norms while providing evidence-based care for infertility. For a prolonged and sustainable health care services to women with infertility challenges, it is recommended that:

1. Health practitioners, especially nurses, should provide comprehensive care that addresses the biopsychosocial and spiritual needs of women with infertility. This includes creating support groups to foster peer support and reduce stigma.
2. Governments and policymakers should implement subsidized or low-cost fertility treatment programs, including *in-vitro fertilization* (IVF), to ensure affordability for women in resource-constrained settings.
3. Public health campaigns should address societal stigma and misconceptions surrounding infertility, emphasizing it as a medical condition that affects both genders, not a moral failure or punishment.
4. Nurses should receive training on counseling and emotional support techniques to assist women in managing the psychological burden of infertility.

Further studies can investigate the influence of infertility on marital relationships, focusing on how couples navigate challenges and build resilience together.

Strengths and limitations of the study

Strengths

Employing an interpretive phenomenological design enabled a comprehensive and insightful exploration of the lived experiences of women facing infertility. The use of in-depth interviews allowed participants to share their feelings, beliefs, and coping mechanisms in their own words, yielding rich and contextually grounded data that would be difficult to obtain through quantitative approaches. Conducting the research in a Nigerian tertiary hospital provided an opportunity to understand infertility within its unique sociocultural framework, where factors such as cultural beliefs, gender norms, and spirituality influence women's experiences. This enhances the study's significance for public health and nursing practice in Nigeria.

Limitations

Given that the study utilized a qualitative approach with purposively selected participants (n = 24) from a single institution, the findings may not be generalizable to all women experiencing infertility in Nigeria. Nonetheless, the results offer valuable and transferable insights applicable to similar sociocultural contexts.

CONCLUSION

Infertility remains a significant biopsychosocial challenge for women, particularly in Nigeria, where societal expectations and cultural norms strongly emphasize motherhood as a defining aspect of womanhood. The findings of this study underscore the multifaceted impact of infertility, including physical, emotional, and social challenges, and highlight the coping strategies women adopt to navigate these difficulties. From problem-focused strategies such as seeking medical treatment and financial empowerment to emotion-focused and integrative approaches like prayer, resilience, and emotional support, women demonstrate a remarkable ability to adapt and persevere. Addressing infertility requires a holistic approach that integrates medical, psychological, and social support, ensuring that women feel empowered, valued, and supported in their journey toward achieving reproductive health and well-being. With continued research, education, and policy reform, society can create an inclusive and supportive environment for women navigating the challenges of infertility

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