

AFRREV STECH

An International Journal of Science and Technology

Bahir Dar, Ethiopia

Vol. 3 (2), S/No 7, May, 2014:31-50

ISSN 2225-8612 (Print)

ISSN 2227-5444 (Online)

<http://dx.doi.org/10.4314/stech.v3i2.3>

INFERTILITY TREATMENTS AND COUNSELLING IN THE CONTEXT OF PATRIARCHY AMONG IJEBU, SOUTH WESTERN NIGERIA

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Abstract

Infertility, as a social and cultural problem affecting individuals and families, makes People Living with Infertility (PLWI) to seek solution through different pathways, but with little or no information on patriarchal barrier(s) militating against counselling in the course of treatment. The study, therefore, investigated infertility treatments and counselling in the context of patriarchy among Ijebu, south western Nigeria. The study utilized Ecology Model as theoretical guide and

cross-sectional survey design was adopted for data gathering. Two local government areas were purposively selected: Ijebu North and Ijebu-Ode LGAs. Infertile females were purposively selected in the churches and other care centres. Questionnaires were administered on snowball basis. Eight in-depth interviews (IDIs) were conducted for two medical doctors, two Traditional Birth Attendants (TBAs), two opinion leaders and two clergy. Quantitative data were analysed with simple percentage. Content analysis was used for qualitative data. Assisted reproductive technologies - ARTs were not acceptable. 62% agreed that government should intensify legislation, health education; legal and medical counselling centres that would provide level playing ground for PLWI. PLWI to have easy access to the treatments, social and financial costs should be de-emphasized and the need for counselling should be emphasized in case of ART

Key words: Patriarchy, Infertility, Health-seeking behaviour, Counselling, Gender inequality.

Introduction

The definition of infertility varies among clinicians, epidemiologists and demographers. Clinicians and epidemiologists use the concept infertility to mean having difficulties to conceive by a woman or to impregnate a woman by a man. That is, no conception after at least one year of attempting to achieve a pregnancy (Adegbola, 2007). Demographers define infertility as the inability of a non-contracepting, sexually active woman to have a live birth (Lone and Ægirsvej, 2006). Failure to have children is seen as a curse, which may lead to stigmatization, violence, battery and divorce. Infertility therefore, produces profound social and legal consequences for African women particularly in terms of economic deprivation, grief, powerlessness, frustration and other forms of psycho-social problems (Okonofua, Harris, Odebiyi, Kane, & Snow, 1997; Oladeinde, 2009). Nigerian Demographic and Health Survey (NDHS) (2008) reported that infertility of both primary and secondary types is very high in Nigeria. Primary infertility is when conception has never been

recorded. The Yoruba term for this is *agan* - bareness. Secondary type is when couples could not realize their desired number of children due to the inability on the part of the woman to conceive or the man to impregnate his wife/partner. This is called *Idaduro* i.e. waiting mother (Adegbola, 2007; (Akande, 2008; Okonofua, Harris, Odebiyi, Kane and Snow, 1997).). On the other hand, infertility has been categorized into four recognised types based on their causes (i) male Infertility (ii) female infertility (iii) Infertility in both male and female partners and, (iv) when both partners are individually fertile, yet they are infertile as a couple (Okonofua, 2002; van Balen and Inhorn, 2002).

Approximately four per cent of women aged 30 years and above have never given birth to a child. However, community based-data suggest that, up to 30 per cent of couples in some parts of Nigeria may have proven maternal health problems in achieving a desired conception after more than twelve months of uninterrupted sexual intercourse (Anate, 2006). Specifically, infertility cases have been on the increase in Ijebu division of Ogun state. This is evidenced in reported cases at General Hospitals in these areas from 2007 to 2010. In 2007, 25 percent of women that reported to hospital for maternal health were on infertility while, in 2008 19.2 percent cases of infertility were reported. In 2009 and 2010, 18.5 and 27.8 percent cases of infertility were reported respectively (Aluko-Arowolo & Aluko-Arowolo, 2012).

Statement of problem

According to the World Health Organization (WHO), 30 percent of men have infertility problems just as 30 percent women do. An additional 30 percent of infertility cases are caused by either men or women, while the remaining 10 percent, can either be man or woman. Infertility is seen, apart from its biological element to have social implications. Socio-cultural notice is taken of childless couple as a liability and adding no value to society and therefore not fulfilling the ancestors' progeny purpose(s). However, in all this, man is hardly accused of infertility as this is seen to demystify patriarchal norms and punctures man's ego. The woman bears the stigmatization of

infertility as she is subjected to derogatory innuendos, which sometime leads to violence or battery. Categorically, a woman who is childless suffers social stagnation and matrimonial dislocation as she is not able to move from womanhood to motherhood. Thus, discussions about infertility brings to fore issues of impotency and other emasculating disruptions of family and a deflation of the husband's patriarchal 'ego'. In a general term, infertile or Couple Living with Infertility (CLWI) suffers serious stigmatization and integrity degradation more in patriarchal societies, such as Ijebu; with the wife at the receiving end than the husband and frequently, her past social life and fidelity are queried.

The challenges associated with infertility have necessitated different health/care seeking behaviours ranging from traditional/alternative health care to orthodox medical types such as Assisted Reproductive Technology (ART) and spiritual - including *syncretic* types, where she may be asked to sleep in holy place(s) and bathe in the open space beside the river bank. ART pertains to a number of advanced medical techniques that aid fertilization in men and women (Inhorn, 2002). ART and other methods of interventions are not without social, cultural, environmental and ethical encumbrances which are constraining their effectiveness. A major question that suffices therefore is, what are the ethical, social and cultural factors influencing the choice of the treatment of infertility? And how timely counselling can assuage the woman's motivation to follow the regimen of treatment to achieve conception.

Research questions

1. What are the social, economic and cultural factors influencing the choice of treatment for infertility?
2. To what extent have people embraced counselling during in the course of treating infertility?
3. How do patriarchal norms at home influence the acceptability of treatment?

4. What is the role of family support during treatment of infertility?

Objectives of the study

The main objective of the study is to investigate people's attitude towards infertility treatment and counselling in Ijebu division of Ogun State in South Western Nigeria.

Justification of the study

Though population policy in Nigeria points to the need for assistance to infertile couples who come to family planning clinics (Federal Government of Nigeria (FGN) 2004), infertility is yet to be addressed as a health and social issue. There is a lacuna between social science research and research in medical science on the subject of infertility as a reproductive failure. The differences are noticed in terms of gender inequality that borders on who takes the blame for the inability, who receives medical intervention in the course of treatment and how effective is the counselling before and during the treatment. There is a paucity of studies on this topic in the social sciences because of the strong anti-natalist policy thrust that favours the development of economic rationalism and related developmental strategies whereby a large population is considered to be inimical to socio-economic growth.

This study would enhance the existing body of knowledge on infertility, sexism, gender inequality and expand our analysis of various issues associated with counselling during infertility treatment in Nigeria.

Scope of study

The geographical location for the study is Ijebu Division of Ogun State in South Western Nigeria. The Ijebu division inhabits six out of the twenty Local Government Areas (LGAs) of Ogun State. The area occupies a total landmass of 5,690.02sq kilometres with estimated populations of 1, 0009814. This represents 35 percent of total land area of Ogun State. Quantitative data were gathered through

questionnaire among infertile women who were purposively selected through snow ball method in the churches and other care centres. While qualitative data were gathered through the instruments of In-depth Interviews (IDIs) and Key Informant Interviews (KIIs). The interviews for IDIs were conducted among medical doctors, Traditional Birth Attendants (TBAs), opinion leaders and clergy men/women.

Literature review

The epidemiology of infertility

Historians have discovered in the last 300 years that, infertile persons have sought different kinds of treatment in order to become pregnant. The treatments in the 18th century included advice about seeking mutual sexual satisfaction, visits to water springs and medical herbs prescribed by midwives and other caregivers. During the 19th century, infertile persons, especially women were advised to try different diets and to get more exercise, until late in the century when different surgical procedures to the uterus as well as donor insemination fertility treatments were included (Marsh and Ronner 1996, in: Lone and Ægirsvej, 2006).

Infertility is noted from the foregoing, as a situation of diminished or absence of being able to produce offspring biologically, either in male or female (Akande, 2008). This is often traced to disease(s) of the reproductive system that impair(s) the body's ability to perform basic reproductive functions. Reproductive issues in terms of fertility, family planning, and contraception technology and child birth have become a dynamic area of research for social scientists, medical anthropologists and reproductive health experts throughout the world. By contrast however, there is a noticeable neglect of such reproductive conditions, such as infertility, miscarriage, still births, etc, which are equally prominent and destructive to familial well being. Infertility on its own especially affects family structure more prominently with wives/female partners who are unable to bear children having to contend with the brunt of stigma, isolation,

deprivation and innuendos than their husbands/ male partners. Indeed, victims of infertility have little or no power of contest in the social space in Nigeria, especially South Western Nigeria. The man's agony is clearly obvious through his inability to continue his father's lineage. These problems in Nigeria and elsewhere in sub-Saharan Africa have proved to be quite volatile and polarizing as the society faces the challenges of infertility. To escape stigmatization, the woman goes through regimented medico-spiritual and bio-technology interventions - bio-technological type involved assisted reproductive technology (ART). All these are not without huge social, cultural, and financial costs – leading to all sorts of health deterioration and losses in finances and man hours to attend hospital/clinic.

Infertility is undeniably very significant among couples in Nigeria with the ratio of one to five (1:5) (Oladeinde, 2009). There is however, correlation between high fertility and high infertility due to apathy shown by the government and other non-governmental agencies to the problem of infertility. Westerners, policy makers, social scientists including demographers have historically seen most of countries in Africa as overpopulated and believed that a drastic reduction in population is *sine qua non* a viable way to socio-economic development (Okonofua, 1999; Adegbola, 2007; Lersen and Raggars, 2001). This view has contributed to sparse attention towards infertility and equally overshadowed the study of population in general in Nigeria and elsewhere in Sub Saharan Africa countries (SSA). But in Africa a woman's marital success and status are linked with her fertility. Indeed victims of infertility have little or no power of contest into social space in sub-Saharan African countries (Aluko-Arowolo, 2010). But infertility rates are rising, and medical interventions and assisted reproductive technologies in recent time have become veritable solution. It is estimated that in Nigeria 30 to 40 percent of women of maternal age bracket, i.e. 15 to 49 years are infertile (Anate, 2006). This is because governments and international donor agencies preoccupy themselves with the control of the high population growth rate through fertility reduction (Pennings, 2008;

Adegbola, 2007; Obono, 2004). Environmental and socio-cultural factors are particularly very peculiar as causative agents for infertility and at the same time they provide an elixir for its treatment

In furtherance of this, the ecology theory/model which situates biology, environment, social determinants and influences of family and significant others including organization to address public health problems was used as a guide to explain the inherent socio-cultural issues underscoring infertility treatment and the need for counselling.

Theoretical framework

Ecological model of public health

The Ecological model comprehensively addresses public health problems and the roles of individuals including organization for effective treatment. It highlights interaction and integration of biological, behavioural, environmental and social determinants, as well as the influence of organizations (e.g. workplace), significant persons (that is, family, friends and peers) and public policies as a fusion to help individuals to make choices concerning their daily lives and health (Craven and Hirnle, 2007). The model provides a complex web of causation and creates a rich context for intervention when the need arises. It can be used to map the key links in an event of health problem, such as infertility. The model also provides means of identifying latent failures (such as inadequate counselling, lack of support from the husband, family members during treatment) in case of any intervention to treat the health problem, along with the more obvious active failures which may be occasioned through interaction with the social environment.

In case of infertility, among the factors that can contribute to both latent and active failures are cultural (such as belief, patriarchal norm, etc), occupational, income, religion, and educational factors). Others are environment (in terms of residence, ethnicity, etc.), public perception of the method of intervention and the will to adhere to medical regime, even if the duration would take longer period before fertility can be achieved. However, the model is useful in identifying

the most strategic links (leverage points) to ensure effective action (Black and Hawks, 2005).

A key feature of the model however, is that it highlights how health and wellbeing are affected by changes and interactions amongst all the environmental factors over the course of one's life; or, for the period the ailment (in this case infertility) lasts. In application of the model to explain further the causes and effects of infertility, for instance, three dimensions to this model can be identified as: the individuals (as the ones who are suffering from infertility) and behaviour they would exhibit to overcome the problem and the physical environment (acting as a determinant factor). Each dimension can then be analyzed at five levels: Intra-personal, Inter-personal, Organizational, Community and Society. The individuals and their behaviour is, metaphorically speaking, the tip of the iceberg as it is the most visible component, with important determinants of their behaviour and environmental risk hidden below the waterline. Infertility rarely occurs as a consequence of an isolated failure at one level only. Rather infertility results from a combination of latent failures which may be environmental, organizational or social (for example, fertility decisions made by the woman in the past, socio-cultural issues, lack of adequate medical attention, etc) along with behavioural responses of individuals (active failures) which may be counterproductive. Ecological model highlights how health and wellbeing are affected by changes and interactions amongst all social and environmental factors over the course of the treatment in one's life

Methodology

Research design

The research design for the study was both exploratory and descriptive which employed cross sectional design. The survey method was complemented with qualitative research method by using in-depth interviews on purposively selected opinion leaders, health workers including Traditional Birth Attendants (TBAs) and the religious leaders. Two local government areas were purposively

selected: Ijebu North and Ijebu-Ode LGAs. Due to peculiarity of the study respondents were selected purposive through snow ball sampling method. They were selected in the churches, orthodox and traditional maternity centres. The sample size was 110 infertile women between the ages of 15 and 49, who were currently (then) going through one fertility treatment or the other. As well as eight In-depth Interview (IDIs) respondents which included two medical doctor, two Traditional Birth Attendants (TBAs), two opinion leaders and two clergy persons. The key informants who responded to in-depth interviews were selected based on their experiences on gynaecology/fertility matters. The respondents were made to answer questions such as value attached to children – to elicit responses on peoples’ awareness and knowledge of infertility and the need for counselling during infertility treatment to achieve conception. Questions were asked on the cultural interpretation of infertility, attitude towards persons living with infertility and treatment intervention, social and cultural challenges of going through treatment regimen before conception. Others are problem of infertility and who is to blame: Causes of Infertility/Childlessness and health seeking behaviour for infertility treatment.

Data interpretation, results and discussion of findings

Percentage distribution of respondents by selected socio-demographic characteristic

Characteristic	Number	Frequency
Age	110	100
< 20 years	5	4.5
21-30	38	34.5
31-40	56	50.0
41-50	11	10.0
Marital Status	110	100
Married	102	92.7
Single	5	4.5
Separated	3	2.7
Religion	110	100

Muslim	17	15.5
Romans Catholic	25	22.7
Protestant(Including the White garment worshippers)	41	39.1
Traditional Worshipper	2	2.2
Pentecostal	25	22.7
Occupation	110	100
Traders	58	52.7
Teaching	20	18.2
Artisan	6	5.5
Civil Servant	16	14.5
Others	8	7.3
Level of Education	110	100
No Formal Education	3	2.7
Primary School Completed	30	21.8
Secondary School Completed	46	41.8
NCE/OND	25	22.7
HND/ 1 ST Degree	3	2.7
Adult Education	3	2.7
Post Graduate	6	5.5

The table above shows the socio-demographic characteristics of the respondents. Socio-demographic characteristics are significant in situating, explaining and understanding patterns and structure of associations existing in society and how these relationships may influence the outcome of social relations. Majority of the respondents were within the ages of 21 – 40 years and above. While only 10% were above 40 years. This helped to demonstrate that in the South-West Nigeria, a particular emphasis is placed on maturity in age before going into marital relationship (Adeshina, 2004). Age at marriage is noted to be one of proximate factors underscoring fertility and procreation issues in Nigerian societies (Isiugo-Abanihe, 2003). But from 21-30 and 31-40 years, where 34.5 and 50.9 percent of the total respondents were seeking various types of healthcare, infertility is considered a very sensitive issue and therefore needed medico-spiritual intervention(s). However, from 41 years and above, the percentage nosedived because, at these ages, menopause has set in and

the hope of having children is decreasing. Hence, few respondents within this age bracket claimed to be trusting God. With respect to religious persuasion, Roman Catholic adherents were 22.7 percent, the protestant (including the *aladura* sect, i.e. white garment worshippers) and Pentecostals were 39.1 and 22.7 percent respectively, while Muslims were 15.5 of the total respondents. This shows that majority of the respondents were Christians. The result is not unconnected with the early acceptance of western education by Christians which paved the way for the wholesale acceptance of western lifestyle (Obayan, 2003). However, the percentage of the Muslim respondents could be attributed to early contacts with Muslim traders from the Northern regions coming through Ilorin, and then, Ibadan (Falola and Adediran, 1986). But, the percentage of the traditional believers can be explained with what Ogunba (1973) described as resilience of traditional religion and the belief system among the Ijebu people (Akintan, 2001) which is noted to be a major plank for cultural stability and suzerainty of people with traditions.

Respondents' occupation was largely a reflection of their levels of education. More than half (52.7 percent) of the respondents were in one trading venture or the other. Teachers and civil servants stood at 18.2 and 14.5 percent respectively. Self-employed respondents like farmers, artisans, etc stood at 1.8; 5.5 and 7.3 percent respectively and those who were educated beyond first school leaving certificate, but, not up to tertiary education (NCE) or Ordinary National Diploma (OND) were 22.7 percent. Barely educated ones were 5.4 percent.

Interpretation

Data revealed that majority of the respondents have knowledge of different medico-spiritual interventions to treat infertility. They also attributed the causes of infertility to biological factors, infidelity or promiscuity on the part of the women especially during the growing up period. Illicit sexual intercourse and abortion were mentioned often as prime causes of infertility. Only a few subscribed to spiritual activities of the wicked relatives/in-laws, witches, and wizards.

Majority (67.8%) believed that contraception to control fertility contributes to the misfortune of infertility. More than half (56.5%) of the respondents said it is an erroneous belief that infertility is only of the woman. Infertility is not limited to women alone. Less than one third (32.2%) of the respondents said that the counselling in the hospital care centre was enough, while, more than two third (67.8%) said counselling was not adequate.

On the question of values attached to children and Motherhood:

Qualitative data revealed that children are highly valued as their arrival to the community is highly celebrated. Male children, in particular, are celebrated more than the females especially where the arrival of a male child interrupts long string of female births. Apart from this, people are happy when they have new born in all ramifications. The woman who has a positive pregnancy outcome is highly celebrated. While the woman without children may be castigated and sent out of her matrimonial home. On the other hand, whenever arguments ensue between a woman living with infertility (WLWI) and other category of women, they are mocked, stigmatize and subjected to opprobrium. As noted by a WLWI,

I called one of my colleague children to help me run an errand to very close by, but her mother prevented her from going; instead result into abuse – **eniti ko bimo kole mo iyi omo** – that is, a woman without a child cannot appreciate its importance (IDI on 14th Jan. 2010)

Children in Yoruba morphology are considered very important to keep the wife in her matrimonial home, that is, the one with ability to have children is the legitimate owner of the husband “*Olomo loni oko*”. The respondents stated, “*Bi ina ba ku, afi eru boju, bi ogede ba ku afi omo re ropo*” that is “when fire dies, it is survived by ash, when banana plant dies, it replaces itself with its sucker”. Generally children are highly valued and celebrated irrespective of the sex.

Traditionally, it becomes imperative to note that the essence of motherhood is to be able to produce and give birth to younger ones.

**On the question of the nature of health seeking behaviour
between the husband and wife:**

More than 25 percent of the respondents believed that it is the wives that are having problems and that they should seek medical assistance. Only 2.7 percent said the husband should be the one to seek for help. But 28.2 percent were neither here or there. But 49.1 percent of the respondents claimed that their husbands are not going through any treatment with them. On the question of why the problem of infertility and blame rests squarely on the women, majority of the respondents (57 percent) claimed that they are on one medication or other; but only 14 percent said that their husbands were also attending to give them moral and emotional support. However, contrary to the claim above by the majority, according to an orthodox medical doctor:

...there was this case we handled that almost resulted into an ethical issue. This woman was coming for treatment without her husband, but, for a couple of years she could still not conceive. This prompted the husband to marry a second wife probably to prove his potency. This second wife also purportedly have infertility problem and started fertility treatment with us... Yet, none of these women had conception. We then appealed to their husband to commence treatment. To one dismay the man was the one who was infertile not the women (IDI on 16th Jan. 2010).

Even in the case where men feel as concerned about the situation as evidenced in their high frequency of attendance of church programs organized for WLWI, it was usually not because they thought that they were infertile, but rather to share and give emotional support for the women, not necessarily to pray for themselves. However, this

stereotype belief was debunked by a Traditional Birth Attendant (TBA):

Males are major victims of infertility from some of the cases we have attended to. Infertility is more common now among the men than the women because men are taking to too much drinking and smoking and when you take alcohol into excess without nutritious meal or balanced diet it can lead to watery sperm and smoke taints the sperm therefore not performing to optimum. I suggest male and female should be made to undergo infertility treatment. That a man is virile today is not to suggest that he cannot be impotent tomorrow” (IDI on 18th Jan, 2010).

Regarding the issue of family dynamics and transformation of marital role between the husbands and wife, 62.7 percent of the women claimed that their husbands are the ones paying the medical bills for treatment. Another 8.2 percent share payment with their husbands; while a negligible 10.9 percent said they are responsible for the payment alone. However, majority said that their husbands made decision on the type of health care facility to patronize for infertility treatment.

On the question of social and cultural interpretations of infertility treatment and the need for counselling

A significant number of respondents said that infertility should not be discussed openly especially as children are extremely valued. Particularly when the infertile woman is within an earshot as the discussion may be misinterpreted to mean different things to her from genuine patriotic concerns of the discussants. Treatment options especially assisted reproductive technologies - ARTs are not culturally acceptable. And if any treatment including ART should be embark upon it is imperative to counsel the sufferer to understand the social and biological consequences and prepare for such consequences in all

ramifications. Divorce may be an extreme option for couples with children, but not so with the one without children, divorce as the consequence of infertility is subtly welcome especially if both are not having any biological failures that hinder conception. This is because the couple may not be compatible; especially, if it is “found out” that the woman or man in question when coming from heaven had chosen to be childless. This points to preternatural or destiny causes of infertility. This is because it is only God who gives children. In this respect, majority of the respondents (62%) agreed that government should intensify legislation, health education, legal and medical counselling centres that would enable infertile persons (male and female) to have equal access to treatment; equality in terms of treatment costs and in the case of the death of the husband, the childless wife must have access to the husbands’ properties. The burden of litigation on the other hand, if the matter reaches court should be borne by the government. 24% agreed that increases in the level of education attained by the women are necessary to make the women skilful, employable and independent to make decision on their healthcare.

Patriarchy underscores the type and interpretations given to infertility as well as the type of treatment adopted. Culturally, women were noted to be the culprits to be stigmatised and punished for the couples’ inability to have offspring. In Ijebu, women are noted to be carrying the burden of infertility disproportionately than the male counterpart due to what the respondents described as spiritual attacks, preternatural or mystical factors, illicit sexual engagements, lack of access to health facilities, poor health education. Infertility in this respect may not be unconnected with high rate of sexual transmitted infections (STIs) and lower rates of treatment and possibly exposure to industrial wastes, occupational/workplace toxins and other carcinogenic substances; therefore, there is the need for adequate counselling on where, when, how to go about suitable medical, technology and spiritual interventions.

Discussion of findings

Men are seldom considered to be the cause of infertility in Ijebu as against the World Health Organization (WHO) findings. This is because empirical evidence has equally found men to be culpable of family inability to have children/offspring. While women are forced to go through rigorous medical testing for infertility which in some cases may not be the proper diagnosis based on insufficient evidence. The data indicated that women suffer more from the medical and social consequences of infertility than their men counterparts. These findings strongly attest to the need for counselling for the women living with infertility during treatment. Women living with infertility (WLWI) were also subjected to ridicule, stigmatization and innuendoes of diverse types. Majority believed that contraception to control fertility contributes to the misfortune of infertility. This notion was attributed to the low patronage of contraceptive technology. This assertion was confirmed by Isiuguo-Abanihe (1994) and Adegbola (2007) studies of South Eastern and South Western Nigeria respectively on why scepticism still persists on contraception for fertility control. However, 13 percent said that their husbands are equally subjected to the treatment. However, husbands' health seeking behaviour in terms of treatment of infertility is highly noticed in the church, where 43.6 percent of the women claimed that their husbands followed them to the church to support them in prayer. This indicates that for the WLWI, the husbands give emotional support, as data equally revealed that majority of men also pay for their wives treatments. But counselling to help persons who are suffering from infertility is noted to be inadequate.

Concluding remarks

These results as obtained from this study helped to illuminate certain cultural issues that are salient on sexuality, gender differentiation, and who should take responsibility for the inability of the wife to reproduce children for the family. Gender differences point to a compendium of social life where there is an unequal relationship

between men and women. This relationship, without exception, defines the way of life of the Ijebu women in general and particularly the infertile ones among them in south western Nigeria and elsewhere in Sub-Saharan Africa. This study has demonstrated that culture, social and ethical factors such as gender inequality, decision making on health care pattern of infertile woman, family support and the position of the child through ARTs have been a major deterrent to health seeking behaviour of individuals who are experiencing infertility. This, on the other hand, without adequate counselling, may have consequential effects on the infertile women. However, there is hope that the findings of this study will have profound implications for reproductive health and right of infertile women in Ijebu and other similar patriarchal societies.

It is therefore recommended that government, leaders, religious organizations, non-governmental organizations (NGO), and other stakeholders should develop programmes in the areas of reproductive health education and counselling to educate men on their fertility status and to also undertake fertility treatment if need be after a year of uninterrupted sexual intercourse during which time their wives have not had conception. Measures such as this will significantly help to provide institutional support to mitigate the adverse consequences of infertility, its diagnosis and treatment.

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Acknowledgements and Tribute

I acknowledge the contribution of Late Mr 'Bosun Senbanjo, who was the anchorman to all the white garment churches visited in the course of this study and my research assistants - Tosin Ilori, Seyi Osilaja and Benjamin Oluwaloni - and others who played very prominent roles.