Social Stigma and Health-Seeking Behavior among Women Experiencing Infertility in Ibadan, Nigeria: A Qualitative Exploration of Lived Experiences

Olaniyi Abimifoluwa Itunuoluwa*, Chinyere Chigerua

Department of Public Health, Babcock University, Ilishan-Remo, Ogun State, Nigeria, 121103

***Corresponding Author**

DOI: https://dx.doi.org/10.47772/IJRISS.2026.100500138

Received: 27 April 2026; Accepted: 02 May 2026; Published: 25 May 2026

ABSTRACT

Background: Infertility in Nigeria transcends biological impairment, constituting a profound social and psychological crisis, particularly within the pronatalist Yoruba context of Ibadan. While biomedical factors are well documented, the interplay between social determinants and their impact on health-seeking trajectories remains underexplored.

Objective: This study explores the lived experiences of women receiving infertility care and examines how social stigma shapes their health-seeking behaviour, while critically evaluating the applicability of Andersen's Behavioural Model in this context.

Methods: A qualitative design was employed, utilizing in-depth, semi-structured interviews with 24 women seeking fertility care at public and private clinics in Ibadan. Data were analyzed thematically, guided by an integrated framework combining Andersen's Behavioural Model, Goffman's Stigma Theory, and the Health Stigma and Discrimination Framework.

Results: Findings reveal infertility as a "crisis of identity" marked by the "naming burden" and emotional distress. Social stigma operates as a dynamic "triple threat" (enacted, anticipated, and internalised), creating a "seclusion barrier" that drives concealment and treatment discontinuation. Crucially, the study identifies deviations from Andersen's model: healthcare facilities are often perceived as "predatory" rather than neutral resources, and prolonged infertility triggers "treatment fatigue" rather than linear urgency, leading to care withdrawal.

Conclusions: Effective interventions must move beyond biomedical access to address the predatory nature of care markets and the cyclical dynamics of stigma. Policymakers are urged to integrate psychosocial support and foster culturally sensitive, stigma-free environments to improve fertility care utilization in Nigeria.

Keywords: Infertility, Health-seeking behaviour, Social stigma, Andersen’s Behavioural Model, Treatment fatigue

Word Count: 233 words

INTRODUCTION

Infertility is more than a medical diagnosis; it is a profound human experience shaped by emotion, expectation, and social relationships. Across societies, the ability to conceive represents continuity and social legitimacy. For many women, motherhood defines adulthood and marriage. When conception does not occur, the absence of children becomes a visible deviation from social norms, magnified through interactions and community rituals. Infertility unfolds within social environments where silence, blame, and economic strain intersect, intensifying women’s distress beyond biomedical dimensions (World Health Organisation [WHO], 2023). Globally, infertility affects an estimated 48 to 72 million couples, with prevalence rates ranging between 10% and 15%

(WHO, 2023). In low- and middle-income countries, consequences are disproportionately severe, exposing women to stigma and financial vulnerability. Research demonstrates strong associations between infertility and anxiety, depression, and reduced quality of life (Xie et al., 2023).

In developing countries, infertility is intertwined with gender inequality and cultural expectations prioritizing childbearing. In many African and Asian societies, infertility is framed as a moral failure, with women bearing a disproportionate share of blame irrespective of the medical cause (Dierickx et al., 2021). Sub-Saharan Africa carries one of the highest infertility burdens, with prevalence estimates ranging from 15% to 30% (WHO, 2023). A systematic review reported that up to 64% of women experiencing infertility encountered stigma, including discrimination and internalised shame (Roomaney et al., 2024).

Nigeria presents a complex context. National estimates suggest infertility affects approximately 20% of couples (Adeoye et al., 2023), with rates varmanuscript versionmanuscriptying between 10%-30% across zones (Esan et al., 2022). Both male and female factors contribute significantly; female factors like tubal blockage are common, while male factors account for 30–50% of cases (Oluwole et al., 2021). Among the Yoruba in Ibadan, fertility is embedded in cultural narratives where a woman's value is linked to conception. Prolonged childlessness exposes women to gossip and exclusion (Oluwole et al., 2021). Infertility is often seen as a punishment from supernatural forces, leading couples to turn to traditional remedies before biomedical care, causing delays (Okafor et al., 2019).

These experiences reflect enacted stigma, defined as direct discrimination. In Ibadan, this manifests through blame from in-laws or exclusion from ceremonies (Esan et al., 2022). Approximately 65% of Nigerian women report high levels of enacted stigma (Ekpor et al., 2025; Roomaney et al., 2024). Beyond overt discrimination, women internalise negative attitudes. Perceived stigma refers to the belief that others regard infertile women as incomplete, associated with emotional distress and withdrawal (Adeoye et al., 2023). Akinyemi et al. (2022) found that over 70% of women in Southwestern Nigeria attribute psychological distress primarily to community sanctions. Anticipated stigma involves expecting future discrimination, leading women to conceal clinic visits. This fear fosters secrecy, delaying formal care (Roomaney et al., 2024). Studies show women wait an average of 5.2 years before seeking clinical care (Amoo et al., 2021).

Stigma interacts with economic constraints and spousal dynamics. Cost is a significant barrier; fertility services are mostly private and financed out-of-pocket. The cost of Assisted Reproductive Technology (ART) can exceed 15 times the national minimum wage (Bello et al., 2021), leading to interrupted treatment. Spousal support is critical; in patriarchal settings, men control resources. Women with low spousal support are 3.5 times more likely to discontinue treatment (Amoo et al., 2021). Need-related factors also matter. Once infertility exceeds 5 years, social pressure shifts to ostracisation, paradoxically delaying engagement (Ren et al., 2022).

Despite increasing clinic availability in Ibadan, delays remain. Women postpone attendance due to stigma and cost (Esan et al., 2022). A recent study found women face severe stigma and marital challenges, often blamed even when male factors are involved (Adeoye et al., 2025). Access to ART remains limited to urban centres and high-income groups, contributing to low quality of life (Esan et al., 2022). Existing Nigerian studies have limitations. Bello et al. (2021) documented distress but did not explore how social factors influenced pathways. Adeoye et al. (2023) examined prevalence but provided limited insight into social processes. Ekpor et al. (2025) quantified stigma but did not examine how it is negotiated over time. This highlights the need for qualitative inquiry that centres women's narratives and situates health-seeking within broader social and relational contexts.

This study addresses these gaps by exploring the lived experiences of women receiving infertility care services in selected hospitals in Ibadan and discovering how social stigma affects the health-seeking behaviour of women receiving infertility care services in selected hospitals in Ibadan, Oyo State.

METHODOLOGY

Research Design

This study employed a qualitative research design to explore the social determinants of health-seeking behaviour among women receiving infertility care services in selected hospitals in Ibadan, Oyo State. A qualitative approach was deemed most appropriate as it facilitates an in-depth understanding of participants' perceptions, lived experiences, and motivations regarding infertility care, nuances that quantitative methods often fail to capture. By prioritizing participants' voices, this design enabled the generation of rich, contextual insights into how social determinants shape health-seeking behaviours. Furthermore, the design facilitated the identification of recurring themes and patterns across narratives, which are essential for informing policies and interventions aimed at improving access to fertility care in Ibadan and similar settings. The study was grounded in Andersen’s Behavioural Model of Health Service Utilisation to frame the investigation of predisposing, enabling, and need-related factors.

Population of the Study

The study was conducted in Ibadan, the capital of Oyo State and the largest metropolitan area in Nigeria. Ibadan serves as a central hub for healthcare and commerce, characterized by a mix of densely populated inner-city areas and peri-urban communities. The socio-cultural context is strongly influenced by Yoruba pronatalist norms, where childbearing is highly valued, and infertility is frequently associated with social stigma, particularly for women.

The target population comprised women aged 18 years and above who were actively seeking fertility care at selected clinics in Ibadan. This included women undergoing consultation, investigation, or treatment for infertility, irrespective of their marital status or parity. Notably, the population included women aged 49 years and older. This inclusion was intentional, as health-seeking behaviour for infertility often extends beyond conventional reproductive ages due to persistent pronatalist expectations, delayed childbearing, remarriage, or continued societal pressure to conceive. Participants were required to be able and willing to provide informed consent and communicate effectively in either English or Yoruba. The study focused on two specific fertility clinics: a government-owned facility (Adeoyo Maternity Teaching Hospital) and a privately owned clinic (Vine Branch Fertility Centre), ensuring representation from diverse socioeconomic and healthcare contexts.

Sample Size Determination

The initial target for the study was a minimum of sixteen (16) participants, with eight recruited from each of the two selected clinics. However, the final sample size was determined by the principle of data saturation rather than statistical power. Data collection continued until no new themes, patterns, or insights emerged from additional interviews. In qualitative research, sample size is dictated by the richness and depth of the data required to answer the research questions. The final sample consisted of 24 participants, a number deemed adequate to enable an in-depth exploration of experiences while ensuring variability across public and private healthcare settings. This flexible approach strengthened the credibility and trustworthiness of the findings by ensuring that the data fully captured the complexity of the phenomenon under investigation.

Sampling Techniques and Bias Mitigation

This study employed a multi-stage sampling strategy combining purposive and convenience sampling techniques. At the first level, purposive sampling was used to select the two study sites based on ownership type (one government-owned and one privately owned). This deliberate selection ensured the inclusion of diverse service contexts, particularly regarding service costs, accessibility, and patterns of care, which are critical social determinants.

At the second level, participants were selected using convenience sampling within the chosen sites. This involved recruiting women who were actively seeking care and available during the data collection period. To mitigate bias and address the sensitive nature of infertility, the recruitment strategy was adapted based on the institutional culture of each site. In the government-owned clinic, an initial public invitation in the waiting area proved ineffective due to participants' fear of stigma. Consequently, the strategy was shifted to a private approach where nursing staff identified eligible patients, and the researcher approached them individually in private consultation rooms. In the private clinic, recruitment was integrated into the patient flow by clinic staff acting as intermediaries to introduce the study in a confidential manner. These adjustments minimized selection bias related to stigma and ensured that participants felt safe to disclose their experiences.

Instrument and Data Collection

Data were collected using in-depth, semi-structured interviews. This instrument allowed participants to express their experiences, perceptions, and feelings in their own words while providing the researcher with the flexibility to probe emerging issues. The interview guide was developed based on the study objectives and mapped to Andersen's Behavioural Model, covering four thematic domains:

- Predisposing Factors: Enacted, anticipated, and perceived/internalised stigma.
- Enabling Factors: Cost of fertility care and spousal support.
- Need-Related Factors: Duration of infertility and perceived severity.
- Health-Seeking Behaviour: Pathways to care, timing of visits, and adherence.

Interviews were conducted face-to-face in a private, quiet setting within the clinics to ensure confidentiality. Each session lasted approximately 10 to 25 minutes. With participants' consent, interviews were audio-recorded to ensure accurate transcription. Field notes were also taken to document non-verbal cues and contextual observations. Interviews were conducted in English or Yoruba, depending on participant preference. For Yoruba interviews, verbatim transcription and translation into English were performed with care to preserve the original meanings. Data collection proceeded concurrently with analysis until data saturation was achieved.

Method of Data Analysis

Data collected from the in-depth interviews were analyzed using thematic analysis, a method well-suited for identifying and reporting patterns within textual data. The analysis followed the six-step framework outlined by Braun and Clarke (2006):

1. Familiarisation: Audio recordings were transcribed verbatim, and transcripts were read repeatedly to gain a comprehensive understanding of the narratives.
2. Generating Initial Codes: Transcripts were coded line-by-line to identify meaningful segments related to social determinants. Deductive codes were applied based on Andersen's model (e.g., enacted stigma, cost of care).
3. Searching for Themes: Related codes were collated to form potential themes capturing broader patterns, such as "stigma-driven care avoidance."
4. Reviewing Themes: Identified themes were reviewed against original transcripts to ensure accuracy and coherence.
5. Defining and Naming Themes: Themes were clearly defined and linked to the research objectives and theoretical framework.
6. Producing the Report: The final analysis integrated thematic findings with direct participant quotations to illustrate experiences authentically.

Throughout the process, the researcher engaged in reflexivity to monitor personal assumptions and biases, ensuring that the findings were grounded in participants' experiences.

Ethical Considerations

This study adhered to the highest ethical standards for research involving human participants. Ethical approval was obtained from the Babcock University Health Research Ethics Committee (BUHREC 1037/25/1516) and the Oyo State Health Research Committee (OYREC/NHREC/OYSHRIEC/10/11/22). Formal permission was also secured from the management of the participating clinics.

Informed Consent: Participation was entirely voluntary. Written informed consent was obtained from all participants after a detailed explanation of the study's objectives, procedures, and their right to withdraw at any time without affecting their clinical care. Confidentiality and Anonymity: Given the sensitive nature of infertility stigma in Yoruba culture, strict confidentiality protocols were implemented. Recordings were coded with unique ID numbers, and consent forms were stored separately from data. Findings were reported in aggregate to prevent the identification of individuals or specific clinics. Minimising Distress: Recognizing that discussions on infertility could evoke emotional distress, interviews were conducted in a supportive, non-judgmental environment. Participants were offered the option to pause or terminate the interview, and referrals to clinic counsellors were facilitated when necessary. Cultural Sensitivity: The researcher demonstrated sensitivity to local beliefs regarding the causes of infertility, gendered expectations, and family dynamics to ensure respectful engagement with participants.

RESULTS

This session presents the findings derived from in-depth interviews with 24 women receiving infertility care services in selected hospitals in Ibadan, Oyo State. The data were analyzed thematically to address the study's two primary objectives: exploring the lived experiences of these women and examining how social stigma affects their health-seeking behaviour. Participants ranged in age from 24 to 54 years, with the majority (n=17, 70.8%) falling between 30 and 49 years. Most participants (n=16, 66.7%) experienced primary infertility, while the remainder (n=8, 33.3%) sought care for secondary infertility. The findings are organized into two main sections corresponding to the research objectives.

Table 4.2: socio-demographic characteristics of participants.

Variable	Category	Frequency (n=24)	Percentage (%)
Age Group	20–29 years	6	25.0
	30–39 years	8	33.3
	40–49 years	9	37.5
	50 years and above	1	4.2
Type of Infertility	Primary infertility	16	66.7
	Secondary infertility	8	33.3
Duration of marriage	1-5 years	8	33.3
	6-10years	11	45.9
	Higher than 11 years	5	20.8
Occupation	Fashion designer	6	25.0
	Teacher	5	20.8
	Civil servant	3	12.5
	Self-employed	3	12.5
	Entrepreneur	2	8.3
	Lecturer	1	4.2
	Business woman	1	4.2
	Trader	1	4.2
	Hair stylist	1	4.2

Lived Experiences of Women Receiving Infertility Care

The first objective sought to understand the lived experiences of women navigating infertility in Ibadan. The analysis revealed that infertility is not merely a biological condition but a pervasive social and emotional burden. The majority of participants (n=20, 83.3%) described their journey as a "tug of war" between despair and hope, characterized by profound emotional distress. Menstruation was frequently cited as a recurring trauma, serving as a monthly confirmation of childlessness. Participants reported feeling "insufficient and inadequate" when observing younger peers or siblings who had completed childbearing. This emotional toll was compounded by the absence of the traditional Yoruba identity marker, where women are often addressed by their children's names.

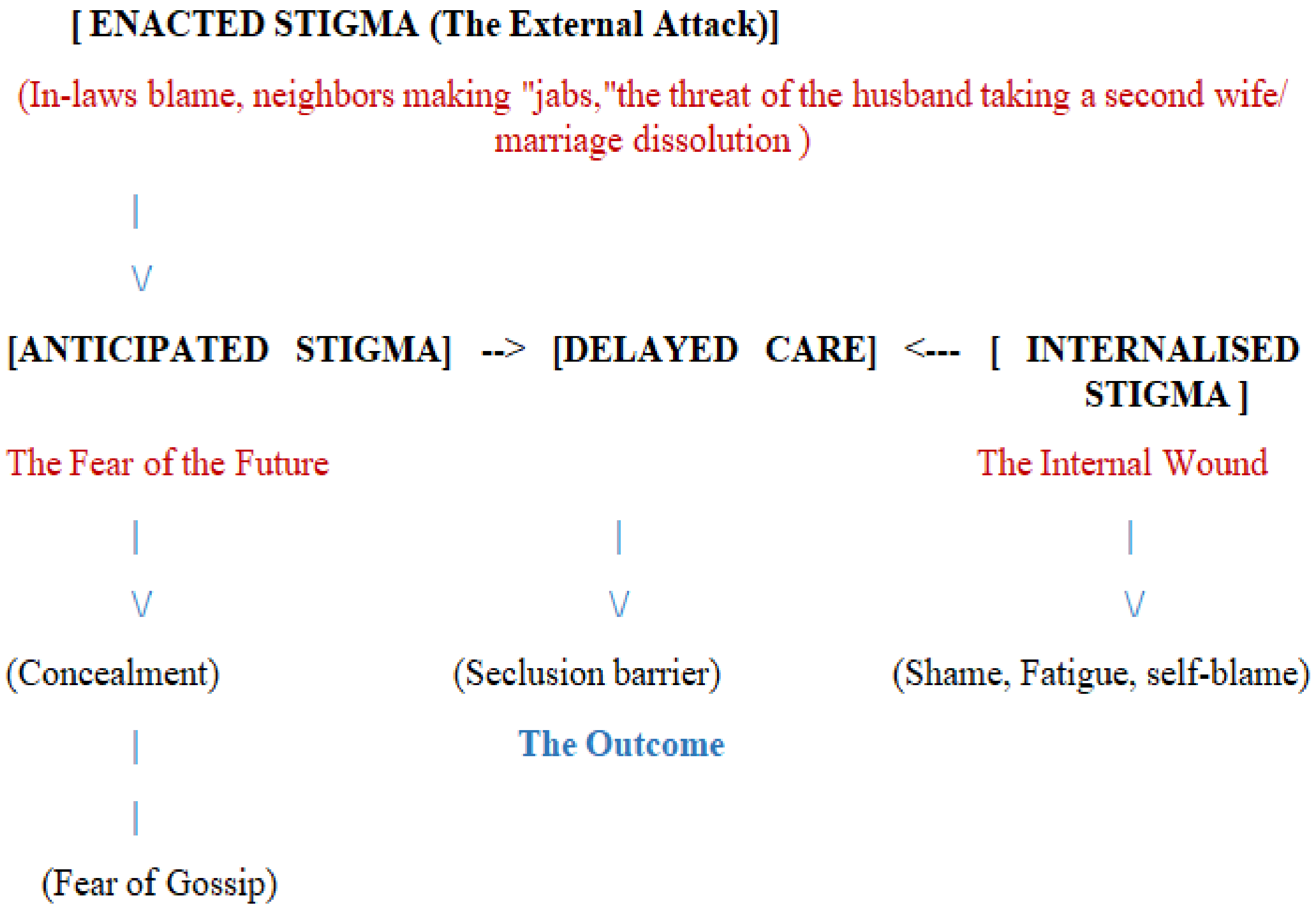
Family dynamics played a critical role in shaping these experiences. Over half of the participants (n=14, 58.3%) reported significant pressure from in-laws, particularly mothers-in-law, who monitored their fertility status closely. These pressures often manifested as comparisons with other women in the family or direct questioning about delays. Additionally, community interactions were described as sources of "jabs" and "digs," where neighbors would make insensitive remarks or assume the women were practicing family planning. This constant social scrutiny created an environment where women felt constantly judged and marginalized. The quotes below supports the issues being summarized:

“It is heart-wrenching, it's heart-breaking and quite saddening... You see your younger sisters and brothers already done with childbearing and feel insufficient and inadequate.” (Participant 1B, 42 years old)

“Someone called me by name and called my younger sister Iya lagbaja (Mother of someone)... because they have given birth. So I can call them by their children's name but you, have you given birth? They call you by name because you don't have a child.” (Participant 10B, 44 years old)

Social Stigma and Health-Seeking Behaviour

Figure 1. The “Triple Threat" of Stigma



(Note: Instead of viewing stigma as a single problem, this study shows it operates in three simultaneous layers that reinforce each other, which directly or indirectly explains why women in Ibadan delay, hide, or stop seeking fertility care (shaping health-seeking behavior among women in Ibadan)).

The second objective investigated how social stigma influences health-seeking behaviour. The analysis revealed that social stigma operates not as a singular barrier, but as a multifaceted 'Triple Threat' comprising enacted, anticipated, and internalised dimensions. These components interact dynamically to create a 'seclusion barrier' that dictates health-seeking trajectories (see Figure 4.2). The findings indicate that stigma acts as a powerful predisposing determinant, shaping when, where, and how women seek care. Three dimensions of stigma emerged: enacted, anticipated, and internalised. Enacted stigma, experienced by most participants (n=19, 79.2%), involved direct discrimination such as blame from in-laws and threats of marital dissolution. This often triggered urgent, sometimes desperate, help-seeking, driving women toward traditional remedies before biomedical care. However, for some, enacted stigma led to withdrawal, delaying clinical engagement to avoid further conflict.

Anticipated stigma was a significant barrier to open health-seeking. Approximately two-thirds of participants (n=16, 66.7%) reported concealing their clinic visits and infertility status to avoid gossip. This fear of judgment led to "hidden" health-seeking behaviours, where women traveled to distant facilities or avoided follow-up appointments if they risked being recognized. This secrecy often resulted in fragmented care and increased financial burdens due to travel costs. Conversely, a minority of participants (n=4, 16.7%) adopted transparency, believing that sharing their struggles would facilitate solutions.

Internalised stigma profoundly affected self-perception and motivation. Many women (n=15, 62.5%) reported feelings of shame and moral questioning, viewing themselves as "incomplete." This internal burden often reduced the motivation to persist with treatment, leading to discontinuation when progress was slow. However, spousal support emerged as a protective factor; women with supportive partners reported lower levels of internalised stigma and greater adherence to treatment plans. Ultimately, the interplay of these stigma dimensions dictated the trajectory of care, often prioritizing social safety over medical optimization. The quotes of participants below are true reflection of the situation of women faced who pointed out that:

“I don't even talk about it because I hate pity. Even at work, people don't know I don't have children, only my close friends & family know.” (Participant 2B, 29 years old)

“I feel responsible because I should have explored orthodox means first because then we went for more like quack treatment... I should have known better considering my level of education.” (Participant 1B, 42 years old)

The thematic analysis clearly reveals a complex landscape where cultural norms and structural barriers intersect. Social stigma emerged as the dominant predisposing determinant, encompassing enacted discrimination, anticipated judgment, and internalised shame. Nearly 80% reported direct blame, while two-thirds concealed clinic visits to avoid gossip, promoting secrecy and delay. Internalised stigma eroded motivation, often leading to treatment discontinuation. Economic constraints constituted the primary barrier to sustained engagement, causing interruptions and reliance on substandard alternatives due to prohibitive high out-of-pocket costs. Spousal support moderated these effects; supportive partners buffered external pressure and improved adherence, whereas conflict exacerbated distress. Prolonged infertility eventually induced treatment fatigue. In summary, women’s experiences are deeply entrenched in emotional distress and marginalization. Stigma significantly alters health-seeking behaviour, while economic barriers also fragment care continuity. Effective interventions must address these key psychosocial and economic determinants beyond biomedical solutions to improve current access to fertility care in Ibadan, Nigeria.

DISCUSSION

Lived Experiences: The Crisis of Identity and the "Naming Burden"

The findings of this study reveal that infertility in Ibadan transcends clinical delay, manifesting as a fundamental "crisis of identity." Consistent with Labinjo (2022), the inability to conceive is experienced as a biological betrayal within a pronatalist society where childbearing is a rigid mandate. A novel contribution of this study is the identification of the "Naming Burden." In Yoruba culture, a woman's social elevation is contingent upon adopting a teknonym (for instance, Iya Ayo). The persistence of addressing women by their birth names in their 30s and 40s functions as a continuous "public jab," reinforcing a "spoiled identity" (Goffman, 1963). This aligns with Kuug et al. (2023), who posit that motherhood is the primary source of "matri-potency" in West Africa; its absence renders women perpetual adolescents regardless of professional achievement. Furthermore, the "Pity Gaze"—sympathetic yet intrusive monitoring—acts as a subtle mechanism of exclusion. As noted by Ekpor et al. (2025), this "sympathetic stigma" can be more damaging than overt abuse, fostering the "stigma of silence" described by Amusan et al. (2021), where women withdraw from social spaces to escape the emotional weight of communal observation.

Social Stigma as a Predisposing Determinant of Health-Seeking Social

Stigma operates as a multifaceted barrier, creating a "seclusion barrier" that delays clinical intervention.

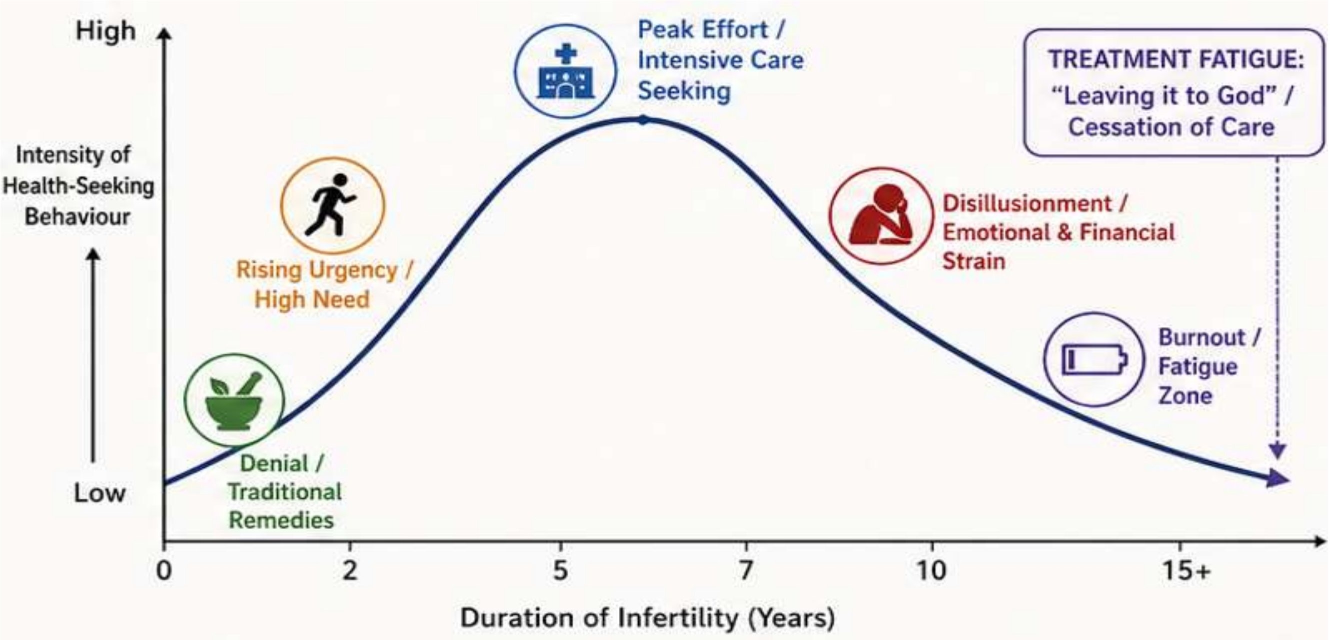
Enacted stigma transforms the marital home into a "battlefield," where in-laws act as "fertility monitors." The threat of polygyny serves as a coercive "cue to action" (Olowokere et al., 2023); however, rather than facilitating timely biomedical care, this pressure often drives women toward desperate, substandard traditional remedies. Anticipated stigma emerges as the most significant barrier to service utilization. The fear of being "spotted" at a clinic leads to "protective concealment" (Amoo et al., 2021), where women travel to distant facilities or avoid follow-ups, inadvertently losing access to support networks. Finally, internalised stigma results in "biographical disruption" (Esan et al., 2022), where women absorb societal devaluation, leading to moral self-blame and a loss of life purpose, as confirmed by Roomaney et al. (2024). Conversely, the study highlights the "spousal shield," where supportive partners neutralize external judgment, reinforcing Kuug et al.'s (2023) assertion that positive spousal dynamics are a potent protective factor.

As illustrated in Figure 1, the 'Triple Threat' of stigma functions as a dynamic feedback loop rather than a static predisposing factor. This finding challenges the traditional application of Andersen's model, which often treats stigma as a discrete variable. Instead, our data suggests that enacted discrimination fuels anticipated fear, which in turn deepens internalised shame, creating a self-reinforcing cycle of care avoidance. Regarding our findings which reveal that social stigma is not a single barrier but a "Triple Threat" that dynamically shapes health-seeking behaviour. As illustrated in Figure 1, this framework comprises enacted, anticipated, and internalised stigma. Enacted stigma involves direct discrimination, such as blame from in-laws. Anticipated stigma is the fear of future judgment, leading women to hide clinic visits. Internalised stigma occurs when women accept negative beliefs, feeling incomplete. Crucially, these elements form a continuous feedback loop rather than existing in isolation. Enacted discrimination fuels anticipated fear, which deepens internalised shame, creating a self-reinforcing cycle of care avoidance. This challenges the traditional application of Andersen’s Behavioural Model, which often treats stigma as a static predisposing factor. Instead, our data suggests stigma actively transforms the enabling environment, making clinics feel unsafe and reducing motivation through treatment fatigue. Consequently, women face a "Seclusion Barrier" where even those with financial means may delay or disengage from care. This dynamic understanding highlights the urgent need for interventions addressing all three layers simultaneously, rather than focusing solely on access or cost. Policymakers must recognize that fear and shame are as critical as financial barriers in determining fertility care utilization in Nigeria.

Critical Analysis of the Integrated Theoretical Implications

This study integrates Andersen’s Behavioural Model with Goffman’s Stigma Theory and the Health Stigma and Discrimination Framework (HSDF) to explain health-seeking trajectories. While Andersen’s model effectively categorizes predisposing (stigma), enabling (cost/spousal support), and need factors, our findings reveal critical deviations when applied to the Nigerian context, echoing critiques of behavioral models in low-resource settings (Ronsmans et al., 2021). First, the study challenges the classification of healthcare facilities as neutral "Enabling Resources." Instead, participants perceive both medical and spiritual sites as "predatory," exploiting desperation through arbitrary pricing and questionable efficacy. This transforms enabling resources into sites of trauma, breeding distrust that leads to service withdrawal—a nuance Andersen’s model, which focuses on resource availability, fails to capture. This aligns with recent scholarship on the commodification of reproductive health in Africa, where financial exploitation by providers creates a "trust deficit" that discourages utilization (Okafor & Eze, 2023; Adebowale, 2022).

Figure 2. The Non-Linear Journey: From Urgency to Fatigue



Second, the study identifies a non-linear relationship (see Figure 2) between "Need" and utilization. Andersen's model assumes a linear progression where increased duration of infertility heightens the urgency for care. However, our data reveals a "treatment fatigue" phenomenon. After years of exhausting cycles, many women reach a state of burnout, ceasing medical intervention to "leave it to God." This suggests that extreme duration and repeated failure can trigger a cessation of care rather than persistent seeking. This finding resonates with literature on chronic illness management, where prolonged treatment failure leads to "therapeutic nihilism" and disengagement (Mills et al., 2020; Chibanda, 2021), a psychological dimension often overlooked in standard behavioral frameworks.

Furthermore, the integration of Goffman and HSDF enriches Andersen's framework by explicating how stigma translates into behavioral outcomes. While Andersen identifies stigma as a predisposing factor, Goffman's concept of "spoiled identity" and the HSDF's focus on structural power relations clarify the mechanisms of "seclusion" and "concealment" (Link & Phelan, 2001; Stangl et al., 2019). The findings demonstrate that stigma is not merely a static belief but a dynamic social process that actively reshapes the enabling environment (e.g., by making clinics feel unsafe) and distorts the perception of need (by framing infertility as a spiritual failure rather than a medical one). This dynamic interaction supports the argument that behavioral models must account for structural violence to fully explain health disparities in pronatalist societies (Farmer, 2004; Nyblade et al., 2019).

Finally, while Andersen's model provides a robust structural skeleton, the lived realities of women in Ibadan necessitate a more nuanced understanding where stigma acts as a pervasive force that can convert enabling resources into barriers and transform need into exhaustion. Future models must incorporate the emotional and predatory dimensions of the healthcare landscape to accurately predict fertility care utilization in similar sociocultural contexts, moving beyond the assumption of rational actor behavior (Knaul et al., 2018).

CONCLUSION

Infertility in the Nigerian context, particularly within the Yoruba setting of Ibadan, transcends biological limitations to become a profound social and psychological crisis. This study explored the lived experiences of 24 participants, revealing how the "Naming Burden" and "Pity Gaze" enforce a spoiled identity, driving secrecy and delayed care. While Andersen's model offers a structural basis, findings indicate that healthcare resources are often perceived as predatory and prolonged need triggers "treatment fatigue" rather than urgency. Spousal support remains a vital protective shield. Consequently, this synthesis underscores the urgent need for public health policies that improve accessibility, affordability, and cultural sensitivity. Recommendations include integrating psychosocial support into fertility services and creating stigma-free environments to empower women to access sustainable care. At the policy level, the State Ministry of Health and other stakeholders should promote subsidised fertility care, including basic infertility tests and assisted reproductive technologies (ART), through the state health insurance schemes.

REFERENCES

1. Adeoye, B. D., Adebayo, O. A., & Adeyemi, O. E. (2025). PERCEPTION OF WOMEN’S INFERTILITY AMONG THE YORUBAS IN IBADAN, OYO STATE, NIGERIA. Gusau Journal of Sociology, 4(3), 173–191. https://doi.org/10.57233/gujos.v4i3.10
2. Al Sabbah, S., Tantry, A., & Bayliss-Pratt, L. (2025). Do perceived social support mitigate the influence of infertility stigma on fertility quality of life? Frontiers in Global Women’s Health, 6. https://doi.org/10.3389/fgwh.2025.1577951
3. A.O., A., & C.O., A. (2021). Knowledge, Perception, Myths and Health Seeking Behaviour on Infertility Among Men and Women Attending Selected Hospitals in Ogun State, Nigeria. African Journal of Health, Nursing and Midwifery, 4(4), 86–100. https://doi.org/10.52589/AJHNM-FFPNCD90
4. Atekoja, O. E., Adeniyi, O. E., Ogundare, T. T., & Olaleye, B. F. (2025). Perceived Causes and Psychosocial Consequences of Infertility among Women in a Nigerian Tertiary Hospital. In Review. https://doi.org/10.21203/rs.3.rs-7780796/v1
5. Ayorinde Olugbenga, A., & Catherine, A. (2021). Knowledge, Perception, Myths and Health Seeking Behaviour on Infertility Among Men and Women Attending Selected Hospitals in Ogun State, Nigeria. African Journal of Health, Nursing and Midwifery, 4(4), 86–100. https://doi.org/10.52589/AJHNM-FFPNCD90
6. Babitsch, B., Gohl, D., & von Lengerke, T. (2012). Re-revisiting Andersen’s Behavioural Model of Health Services Use: A systematic review of studies from 1998–2011. GMS Psycho-Social-Medicine, 9, Doc11. https://doi.org/10.3205/psm000089
7. Bell, S. O., Larson, E., Bittle, D., Moreau, C., Omoluabi, E., OlaOlorun, F. M., Akilimali, P., Kibira, S. P. S., Makumbi, F., Guiella, G., Mosso, R., Gichangi, P., & Anglewicz, P. (2024). Care-seeking for difficulties conceiving in sub-Saharan Africa: Findings from population-based surveys in eight geographies. Human Reproduction, 39(8), 1712–1723. https://doi.org/10.1093/humrep/deae084
8. Beyond The Wound: Nigerian Women Bearing The Weight Of Infertility Stigma—Daily Trust. (n.d.). Retrieved 23 March 2026, from https://dailytrust.com/beyond-the-wound-nigerian-women-bearing-the-weight-of-infertility-stigma/
9. Cox, C. M., Thoma, M. E., Tchangalova, N., Mburu, G., Bornstein, M. J., Johnson, C. L., & Kiarie, J. (2022). Infertility prevalence and the methods of estimation from 1990 to 2021: A systematic review and meta-analysis. Human Reproduction Open, 2022(4), hoac051. https://doi.org/10.1093/hropen/hoac051
10. Ekpor, E., Brobbey, S. S., Kumah, C. Y., & Akyirem, S. (2025). Experience of infertility-related stigma in Africa: A systematic review and mixed methods meta-synthesis. International Health, 17(6), 903–913. https://doi.org/10.1093/inthealth/ihaf060
11. Elumalai, R., Jaisankar, S., Bagepally, B. S., Vembu, R., & Bhatnagar, T. (2025). Health-seeking behavior for infertility: A systematic review and meta–analysis. European Journal of Obstetrics & Gynecology and Reproductive Biology, 315, 114777. https://doi.org/10.1016/j.ejogrb.2025.114777
12. Esan, D. T., Nnamani, K. Q., Ogunkorode, A., Muhammad, F., & Oluwagbemi, O. O. (2020). Experiences and Health-seeking Behaviour of Couples in Ekiti-State Nigeria towards Infertility. In Review. https://doi.org/10.21203/rs.3.rs-46818/v1
13. Esan, D. T., Nnamani, K. Q., Ogunkorode, A., Muhammad, F., Oluwagbemi, O. O., & Ramos, C. G. (2022). Infertility affects the quality of life of Southwestern Nigerian women and their partners. International Journal of Africa Nursing Sciences, 17, 100506. https://doi.org/10.1016/j.ijans.2022.100506
14. Gedef, G. M., Taye, E. B., Mohammed, O. Y., Abegaz, M. Y., Asratie, M. H., & Andualem, F. (2025). Prevalence of infertility and its risk factors in Sub-Saharan Africa: A systematic review and meta-analysis. Contraception and Reproductive Medicine, 10(1), 73. https://doi.org/10.1186/s40834-025-00411-1
15. Goffman, E. (2009). Stigma: Notes on the Management of Spoiled Identity. Simon and Schuster.

16. Hayat K., Chaudhary, D. A., Batool, D. Z., & Mahmood, D. B. (2025). The Social Stigma of Infertility Causes & Consequences. Review Journal of Social Psychology & Social Works, 3(1), 44–56. https://doi.org/10.71145/rjsp.v3i1.73
17. Helen, O. A. (2025). Variations in Online Health Information-Seeking Behaviour of Individuals Experiencing Infertility: A Literature Review. https://doi.org/10.5281/ZENODO.15092509
18. Ihebunezie, K. (2025). Fear of Infertility Among Women in Africa: A Scoping Review of Qualitative Evidence. In Review. https://doi.org/10.21203/rs.3.rs-7919584/v1
19. Isiyaku, A. G. (2019). Health Seeking Behaviour of Women with Infertility in Sokoto State, Nigeria [University of Ghana]. http://ugspace.ug.edu.gh/handle/123456789/35904
20. Jia, H., Han, X., Aderemi, T. A., Ifekwem, N. E., & Al-Faryan, M. A. S. (2025). Out-of-pocket expenditure and human welfare in Nigeria: Evidence from a fully modified ordinary least squares regression. African Journal of Reproductive Health, 29(2). https://ajrh.info/index.php/ajrh/article/view/5270
21. Kiani, Z., Simbar, M., Hajian, S., & Zayeri, F. (2021). The prevalence of depression symptoms among infertile women: A systematic review and meta-analysis. Fertility Research and Practice, 7(1), 6. https://doi.org/10.1186/s40738-021-00098-3
22. Kusuma, B., Harzif, A. K., Maidarti, M., Saroyo, Y. B., Winarto, H., & Meutia, A. P. (2025). Infertility misperception and improper health-seeking behavior between urban and rural areas. PLOS ONE, 20(4), e0312456. https://doi.org/10.1371/journal.pone.0312456
23. Kuug, A. K., James, S., & Sihaam, J.-B. (2023). Exploring the cultural perspectives and implications of infertility among couples in the Talensi and Nabdam Districts of the upper east region of Ghana. Contraception and Reproductive Medicine, 8(1), 28. https://doi.org/10.1186/s40834-023-00225-z
24. Labinjo, T. (2022). A qualitative synthesis of the impact of infertility on the mental health of African women. African Journal of Reproductive Health, 26(12), 49–57. https://doi.org/10.29063/ajrh2022/v26i12.6
25. Labinjo, T. O. (2025). Infertility in Nigeria as portrayed in movies: The role of cultural beliefs and societal attitudes. Culture, Health & Sexuality, 0(0), 1–10. https://doi.org/10.1080/13691058.2025.2582740
26. Mashood, L. (2021). Fertility Determinants among Reproductive Age Women in Nigeria: Evidence from Some Modelling Techniques. International Journal of Health and Medical Sciences, 7, 25–39. https://doi.org/10.20469/ijhms.7.30005
27. Naab, F., Lawali, Y., & Donkor, E. (2025). Coping Strategies and Health-Seeking Behaviour of Women With Infertility at Zamfara. Journal of Humanistic Psychology, 65(6), 1271–1289. https://doi.org/10.1177/00221678211027036
28. Nnagbo, J. E., Ugwu, G. O., Eze, M. I., Agu, P. U., Nnagbo, C. L., Ezugworie, J. O., Dim, C. C., Ugwu, E. O., Nwagha, I. U., & Odoh, G. U. (2024a). Son Preference among Infertile Couples at the Fertility Clinic of Two Tertiary Hospitals in Enugu, Nigeria. Annals of African Medicine, 23(3), 474. https://doi.org/10.4103/aam.aam_173_23
29. Nwosu, I. A., Njemanze, V. C., Ekpechu, J. O., Eteng, M. J., Ukah, J. A., Eyisi, E. C., Ohuruogu, B., Alo, C. A., Ordu, G. E. O., & Ezeali, T. C. (2022). Prevalence and determinants of use of traditional methods of infertility treatment among women attending infertility clinic in Southeast Nigeria. African Journal of Reproductive Health, 26(3). https://www.ajrh.info/index.php/ajrh/article/view/3264
30. Odeigah, L. O., Owolabi, B. O., Obalowu, I. A., Mutalub, Y. B., Agede, O. A., & Jimoh, A. A. G. (2024). Epidemiology and Sociodemographic Predictors of Infertility among Women in Ilorin, North-central Nigeria: A 5-Year Retrospective Longitudinal Study. In Review. https://doi.org/10.21203/rs.3.rs-4551360/v1
31. Okonofuaa, F. E., Harrisb, D., Odebiyic, A., Kaned, T., & Snowb, R. C. (n.d.). The social meaning of infertility in Southwest Nigeria. Health Transition Review.
32. Olowokere, A. E., Olowookere, J. O., Komolafe, A. O., Oyelade, O. O., Olajubu, A. O., & Aladegboye, M. K. (2022). Psychological and Social Effects of Infertility on Women: A Mixed-Method Research. Gynecology & Reproductive Health. https://doi.org/10.33425/2639-9342.1193
33. Oluwole, E. O., Fakayode, D. O., Olufela, E. O., Akinsola, O. J., & Ojo, O. Y. (2021a). KNOWLEDGE AND PERCEPTION OF INFERTILITY AMONG ADULT MALES IN IBADAN, NIGERIA. Annals of Ibadan Postgraduate Medicine, 19(2), 131–139.

34. Ombelet, W., & Lopes, F. (2024). FERTILITY CARE IN LOW AND MIDDLE INCOME COUNTRIES: Fertility care in low- and middle-income countries. Reproduction & Fertility, 5(3), e240042. https://doi.org/10.1530/RAF-24-0042
35. Oriji, P. C., Kiridi, E. K., Ubom, A. E., Okoye, C. N., Oriji, V. K., & Awotundun, B. (2022). Pattern of infertility among infertile couples in a tertiary health institution in Bayelsa State, South-South Nigeria. International Journal of Scientific Reports, 8(6), 136–141. https://doi.org/10.18203/issn.2454-2156.IntJSciRep20221316
36. Panti, A. A., Ugonna, A. K., Garba, J. A., Eze, U. A., Yakubu, A. I., & Mayana, A. U. (2025). Psychological Well-being of Women with Infertility: A Study at a Gynaecological Clinic in North Western Nigeria. Nigerian Journal of Medicine, 34(2), 112. https://doi.org/10.4103/NJM.NJM_9_25
37. Patra, S., & Unisa, S. (2022). An exploration of treatment seeking behavior of women experienced infertility and need for services in rural India. Frontiers in Reproductive Health, 4, 978085. https://doi.org/10.3389/frph.2022.978085
38. Exploring the cultural perspectives and implications of infertility among couples in the Talensi and Nabdam Districts of the Upper East Region of Ghana. (n.d.). ResearchGate. https://doi.org/10.1186/s40834-023-00225-z
39. Polis, C. B., Cox, C. M., Tunçalp, Ö., McLain, A. C., & Thoma, M. E. (2017). Estimating infertility prevalence in low-to-middle-income countries: An application of a current duration approach to Demographic and Health Survey data. Human Reproduction, 32(5), 1064–1074. https://doi.org/10.1093/humrep/dex025
40. Roomaney, R., Salie, M., Jenkins, D., Eder, C., Mutumba-Nakalembe, M. J., Volks, C., Holland, N., & Silingile, K. (2024a). A scoping review of the psychosocial aspects of infertility in African countries. Reproductive Health, 21(1), 123. https://doi.org/10.1186/s12978-024-01858-2
41. Roomaney, R., Salie, M., Jenkins, D., Eder, C., Mutumba-Nakalembe, M. J., Volks, C., Holland, N., & Silingile, K. (2024b). A scoping review of the psychosocial aspects of infertility in African countries. Reproductive Health, 21, 123. https://doi.org/10.1186/s12978-024-01858-2
42. Sarkar, S., & Gupta, P. (n.d.). Socio-Demographic Correlates of Women’s Infertility and Treatment Seeking Behavior in India.
43. Stangl, A. L., Earnshaw, V. A., Logie, C. H., van Brakel, W., C. Simbayi, L., Barré, I., & Dovidio, J. F. (2019). The Health Stigma and Discrimination Framework: A global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. BMC Medicine, 17(1), 31. https://doi.org/10.1186/s12916-019-1271-3
44. Taebi, M., Kariman, N., Montazeri, A., & Alavi Majd, H. (2021). Infertility Stigma: A Qualitative Study on Feelings and Experiences of Infertile Women. International Journal of Fertility and Sterility, 15(3). https://doi.org/10.22074/ijfs.2021.139093.1039
45. Tilde, B. Y. (2020). Perceived Causes of Infertility and Health Care Seeking Behaviour of Women of Child-Bearing-Age in North-Eastern Nigeria.
46. Whittaker, A., Gerrits, T., Hammarberg, K., & Manderson, L. (2024). Access to assisted reproductive technologies in sub-Saharan Africa: Fertility professionals’ views. Sexual and Reproductive Health Matters, 32(1), 2355790. https://doi.org/10.1080/26410397.2024.2355790
47. Xie, Y., Ren, Y., Niu, C., Zheng, Y., Yu, P., & Li, L. (2023). The impact of stigma on mental health and quality of life of infertile women: A systematic review. Frontiers in Psychology, 13, 1093459. https://doi.org/10.3389/fpsyg.2022.1093459