



THE PSYCHOSOCIAL CONSEQUENCES OF INFERTILITY TREATMENT AND  
COPING MECHANISMS AMONG WOMEN UNDER TREATMENT IN  
SELECTED PRIVATE INFERTILITY TREATMENT CLINIC IN ADDIS ABABA.

MA Thesis

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June, 2025

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A Thesis Submitted to College of Education and Language Studies School of  
Psychology in Partial Fulfillment of the Requirements for the Degree of Masters of  
Art in Counseling Psychology.

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## APPROVAL PAGE

This is to certify that the thesis entitled: “THE PSYCHOSOCIAL CONSEQUENCES OF INFERTILITY TREATMENT AND COPING MECHANISMS AMONG WOMEN UNDER TREATMENT IN SELECTED PRIVATE INFERTILITY TREATMENT CLINIC IN ADDIS ABABA” submitted in partial fulfillment of the requirements for the degree of Masters of Art in Counseling Psychology by Betelhem Teklu Waji has been examined and approved by the following examination Committee.

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## DECLARATION

I, Betelhem Teklu Waji, hereby declare that this thesis entitled “The Psychosocial consequences of Infertility treatment and Coping mechanisms among women under treatment, selected private infertility treatment clinic” is my original work and has not been presented for a degree in any other university or institution. All sources of information used in this thesis have been duly acknowledged.

I further declare that this thesis was guidance and supervision of Daniel Tefera (PHD, Associate Professor of Applied Development Psychology).

This thesis is submitted to Addis Ababa University, College of Education and Language studies, department of Psychology, in Partial fulfillment of the requirement for the degree of Masters of Art in Counseling Psychology

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## **ACKNOWLEDGMENT**

First of all, I would like to thank God for granting me the strength and perseverance to complete this work.

Secondly, I would like to extend my sincere gratitude to Dr. Daniel Tefera, my thesis advisor, for all the guidance, continuous support and patience throughout the course of this research. His insightful feedback and encouragement were crucial to the successful completion of this study.

I am also grateful to the faculty members of the department of Psychology, Addis Ababa University, for their support during my academic journey.

I am deeply thankful to my Husband, my family and friends for their love, support and understanding during the challenging times of this research.

Lastly, special thanks go to Newleaf infertility center care providers and the participants of this study for their cooperation in this study and willingness to share their experiences made this research possible.

## **ACRONYMS/ABBREVIATIONS**

ART	Assisted Reproductive Technology
CBT	Cognitive Behavioral Therapy
GIFT	Gamete Intrafallopian Transfer
ICSI	Intra Cytoplasmic Sperm Injection
IPA	Interpretative Phenomenological Analysis
IVF	In Vitro Fertilization
IVF-ET	In Vitro Fertilization and Embryo Transfer
IUI	Intra Uterine Insemination
OS	Ovarian Stimulation
OS-IUI	Ovarian Stimulation and Intra Uterine Insemination
PCOS	Polycystic Ovary Syndrome
PID	Pelvic Inflammatory Disease
STIs	Sexually Transmitted Infections
WHO	World Health Organization
LMICs	Low- and Middle – Income Countries

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## ABSTRACT

*Infertility treatment imposes profound psychosocial burdens on women, particularly in sociocultural context where motherhood is central to female identity. This qualitative phenomenological study explores the psychosocial consequences of infertility treatment and the coping mechanisms adopted by women undergoing such treatment in selected private clinics in Addis Ababa. Focusing on their psychosocial challenges, coping strategies, and the interplay of cultural, relational, and economic factors. Six married women aged 29-39years, diagnosed with primary and secondary infertility and actively receiving assisted reproductive technologies (ART), were Purposively sampled. Data were collected through in-depth interview and analyzed thematically using Interpretative Phenomenological Analysis (IPA) to capture the core of participants' lived experiences. Participants reported high level of psychological distress, including anxiety, grief, and hopelessness, exacerbated by societal stigma that equates womanhood with fertility. Social isolation emerged as women concealed treatment to avoid judgment, while marital relationships fluctuated between solid and strained under financial and emotional pressures. The financial burden of treatments like IVF costing up to 700,000ETB forced participants to deplete savings, sell assets, or borrow funds, amplifying stress. Cultural norms intensified gendered blame, with women disproportionately bearing social scrutiny and familial pressures to pursue alternatives like traditional healing. Coping mechanisms were multifaceted, anchored in spiritual resilience, social support, and cognitive reframing. Faith in divine intervention provided emotional solace, while spouses and close family members offered critical, albeit inconsistent, support. Participants engaged in positive reframing, viewing treatment as a journey of personal growth, though secrecy and social withdrawal often deepened emotional isolation. Notably, the absence of standardized psychosocial support in clinics left women reliant on informal networks, online communities, and self-guided resilience. This research contributes to global discourse on reproductive health equity, advocating for holistic interventions in low-resource settings where infertility remains a silenced crisis. Future research is recommended to include the perspectives of men and couples, explore the long-term psychosocial outcomes of infertility treatment, and conduct comparative studies across different regions and socioeconomic groups in Ethiopia.*

**Keywords:** *Infertility treatment, psychosocial consequences, coping mechanisms, resilience, qualitative phenomenology*

# CHAPTER ONE

## 1. INTRODUCTION

### 1.1 Back ground

Infertility is a disorder with the reproductive system that makes it impossible to get pregnant after at least a year of regular, unprotected sex (World Health Organization [WHO], 2023). It can also be defined demographically as the lack of a live birth among sexually active women of reproductive age (15–49 years) who are not using birth control. The WHO divides infertility into two types: primary infertility, where a woman has never been pregnant, and secondary infertility, where a woman has been pregnant at least once, regardless of the outcome. Both men and women can be infertile, with female factors accounting for approximately 40-55% of cases, male factors for 20-30%, and the remainder due to combined or unexplained causes (Mascarenhas et al., 2012; WHO, 2023).

In Ethiopia, about 15–30% of couples are infertile. Secondary infertility is especially common because of untreated infections in the reproductive tract, unsafe abortion practices, and problems that come up during childbirth (Kassa et al., 2018). In Ethiopia, the main causes of secondary infertility are infectious diseases like pelvic inflammatory disease (PID) and sexually transmitted infections (STIs) (Gebresilase et al., 2021). In Western countries, infertility is often linked to waiting to have children and lifestyle factors. In Ethiopia, though, cultural stories often blame women for not having children, sometimes seeing it as a moral failure or punishment from God (Fledderjohann, 2012).

Women who use assisted reproductive technologies (ART) often say they feel more anxious, depressed, and tired, especially when the chances of success are low (Cousineau & Domar, 2007). Hormone injections and surgeries are examples of ART procedures that can make people worry about their body image and feel like they have lost their independence. These effects are stronger in cultures where being a mother is an essential component of a woman's identity and social status (Purewal & Chapman, 2018). In places with inadequate resources, like sub-Saharan Africa, limited access to

diagnosis and treatment makes the psychosocial burden even worse (Inhorn & Patrizio, 2015).

Despite advancements in ART, access to infertility care in Ethiopia remains uneven. Public health facilities are often overburdened with infectious disease and maternal health priorities, leaving specialized infertility services largely to private clinics in urban centers like Addis Ababa (Bekele et al., 2019). These private services, including in vitro fertilization (IVF) and intrauterine insemination (IUI) are expensive and can cost two to three times the average annual household income (Tiruneh et al., 2020).

Women receiving infertility treatment in private clinics face not only the physical demands of therapy but also psychological stress from repeated cycles, uncertain outcomes, and financial pressure. These challenges are compounded by societal expectations that equate womanhood with motherhood, exposing women to self-blame, marital conflict, and social isolation if treatments fail (Hörbst, 2020). Furthermore, the absence of standardized counseling services in private clinics means many women must navigate feelings of grief, guilt, and hope on their own (Gameiro et al., 2022). In Ethiopia, community-based organizations like *iddirs* and religious groups may provide informal support, although their effectiveness in addressing infertility-related trauma is not well documented (Tefera et al., 2021).

Qualitative research from countries such as Nigeria and Kenya indicate that women often internalize infertility as a lifelong burden, with marital instability and pressures toward polygamy increasing their distress (Umeora et al., 2008; Rouchou, 2013). However, little is known about how Ethiopian women in private clinics experience and manage these challenges, especially given the intersection of high treatment costs and the influence of Western medical models, which may conflict with traditional beliefs about healing and family.

While research has explored the psychological distress associated with infertility in various settings, few studies in Ethiopia have used a qualitative, phenomenological approach to examine the lived experiences of women undergoing ART in private clinics. Given the unique sociocultural and financial challenges faced by women in Addis Ababa, it is essential to understand their perspectives, experiences, and coping

strategies. This study seeks to address this gap by using a phenomenological lens to explore the psychosocial consequences of infertility treatment and the coping mechanisms adopted by women in selected private clinics in Addis Ababa.

## **1.2 Statement of the problem**

Infertility treatment while offering hope for conception, causes significant and multifaceted psychosocial consequences that go deeper than biological issues for women worldwide with significant differences based on social, cultural and economic factors (WHO, 2023). Due to the cyclical nature of treatment and societal expectations that associate womanhood with motherhood, women undergoing infertility treatment frequently experience severe psychological distress, including anxiety, depression, feelings of failure, guilt and hopelessness (Hasanpoor-Azghady et al., 2006; Yazdi et al., 2020).

According to studies conducted in Cameroon and other African countries, Strong cultural stigma exacerbates the psychosocial effects of infertility treatment in Africa which makes infertile women experience social marginalization, anxiety, sadness, fear of divorce, and even violence causes people to retreat from social connections and become secretive, (Nkengafac et al., 2024).

Although the effects of infertility and childlessness are severe and particularly so in low- and middle-income countries (LMICs), there is very little information available on infertile women in Ethiopia and other East African countries, despite the fact that most of the research in this area is presented from the context of industrialized countries (Cousineau et al., 2006).

Even if stress has effect on the success of infertility therapy, there is a lack of evidence regarding the reproducibility of strategies under field circumstances and how to integrate more affordable options for assisted reproductive therapy (ART) into existing infrastructures (Inhorn & Patrizio, 2015).

In Ethiopia, treatment for infertility causes significant psychological problems. According to a research, women receiving therapy have high rates of depression and their vulnerability is increased by variables including unemployment, low income, and unstable marriages (Fekadu et al., 2020). Women are still under pressure to hide their infertility and treatment status due to widespread societal stigma, which causes them to become isolated and receive less social support (Meskelu & Berhane, 2018).

Despite the considerable psychosocial and financial burdens, it imposes on infertile couples, infertility treatment and coping mechanism of women, often remains a neglected issue in many developing countries. Notably, resilience often coexists with vulnerability. Although official psychological support services are frequently limited, coping techniques that have been described include relying on religious faith, social disengagement, and asking close family members for help (Hasanpoor-Azghady et al., 2006).

Studies in Iran and India show how women alternate between hope and despair, finding strength in familial relationships while dealing with societal humiliation (Moghadam et al., 2021; Wirtberg et al., 2007). Whether similar dynamics exist in Ethiopia particularly among women investing scarce resources in private clinics is worth investigating. Existing research on infertility in Ethiopia has primarily focused on epidemiological trends, societal views, and cost of treatment (Kassa & Temesgen, 2020).

Few studies use qualitative approaches to focus on women's lived experiences, and none specifically examine the psychological effects of treatment in private clinics and coping mechanisms that women adopt to manage the stress, anxiety, and emotional upheaval associated with infertility treatment. This gap is critical, as private healthcare users in Addis Ababa represent a growing yet under-researched demographic: urban, relatively rich and exposed to both modern medical practices and traditional cultural norms. Phenomenology, with its emphasis on subjective experience and meaning-making, offers a powerful lens to unpack how women interpret infertility, navigate treatment uncertainties, and harness coping mechanisms.

### **1.3 Research Questions**

- What are the range of psychosocial challenges experienced by women during infertility treatment?
- What coping strategies are utilized by women to manage the psychosocial impact of infertility and its treatment?
- How do social systems influence women's ability to cope with the psychosocial challenges of infertility treatment?
- How do women make sense of and find meaning in their experience with infertility treatment?

### **1.4 Objective of the study**

#### **1.4.1. General objective**

To explore the psychosocial consequences of infertility treatment and coping mechanisms of women undergoing infertility treatment.

#### **1.4.2. Specific Objectives**

- Describe the range of psychosocial challenges experienced by women during infertility treatment
- Identify coping strategies utilized by women to manage the psychosocial impact of infertility and its treatment.
- To investigate the influence of social systems on women's ability to cope with psychosocial challenges of infertility treatment.
- To explore how women, make sense of and find meaning in their experience with infertility treatments.

### **1.5 Significance of the study**

The findings of this phenomenological study will help the researchers and practitioners gain insight psychosocial consequences of infertility treatment and promote empathy

and understanding among healthcare and psychosocial service providers, policymakers, and the general public.

Understanding the psycho-social challenges faced by women undergoing infertility treatment can help health care and psychosocial service providers to address both the physical and psychological needs of women undergoing infertility treatments to improve overall patient well-being including mental health support services, insurance coverage, and access to reproductive healthcare.

Finally, It can also contribute to policy changes aimed at improving the overall experience of women seeking infertility treatment.

## **1.6 Delimitation of the Study**

This study is delimited to six married women aged 29–39 years undergoing infertility treatment at a single private infertility clinic (Newleaf Infertility Center) in Addis Ababa, Ethiopia, focusing exclusively on their psychosocial experiences and coping mechanisms. It excludes men, couples, and women outside this age range, as well as those not actively receiving assisted reproductive technologies (ART) such as IVF or IUI. The qualitative phenomenological approach prioritizes subjective lived experiences over quantitative analysis, and findings are contextualized within Ethiopia's sociocultural norms, limiting generalizability to public clinics, other regions, or global contexts. The study does not explore long-term outcomes post-treatment, male perspectives, or comparative analyses across socioeconomic or cultural settings.

## **1.7 Definitions of Key terms**

**Infertility:** Infertility is a disorder with the reproductive system among sexually active women of reproductive age (15–49 years) who are not using birth control but impossible to get pregnant after at least a year of regular, unprotected sex (World Health Organization [WHO], 2023).

**Infertility Treatment:** Any medical intervention of procedure that a woman is currently undergoing to enhance her chances of conceiving. This includes but not limited to, hormonal therapies, IUI, IVF and ART or surgical procedures.

**Psychosocial consequences:** Encompass the emotional, psychological, social and relational impacts experienced by women because of undergoing infertility treatment.

**Coping Mechanisms:** the specific strategies and behaviors that women employ to manage the emotional, psychological, and social challenges associated with infertility and its treatment.

**Social Systems:** The interconnected networks of relationships, institutions and structures (family, community, healthcare and religious groups) that influence women's experiences with infertility treatment.

**Well-being:** A women's self-reported perception of overall state of physical, emotional, psychological, and social health while undergoing infertility treatment.

## **1.8 Thesis Structure**

This thesis is organized into five main chapters, chapter one, Introduction provides background by highlighting the significance of infertility as a public health issue in Ethiopia and explains the rationale and justification for focusing on women receiving infertility treatment in private clinic Addis Ababa. It outlines the problem statement, research questions, objective of the study, the significance of the study and delimitation of the study. Chapter two, Literature review examines existing research related to infertility and infertility treatment, Psychosocial consequences, and coping mechanisms globally and within Ethiopian context. Chapter three, Methodology details the research design and methodology employed in the study. It explains the qualitative phenomenological approach, participant selection criteria, data collection methods and procedures for data analysis. Ethical considerations and measure to ensure trustworthiness and validity also discussed. In Chapter four, on the Result and discussion section the findings from the thematic analysis of interview data are

presented and the discussion part interprets the findings in relation to the research objectives and existing literature. It discussed the implications of the psychosocial burdens and coping mechanisms identified and also reflects on the significance of the findings for policy and practice. Finally, Chapter five, conclusion and recommendation's part summarizes the main conclusions drawn from the study and offers recommendations.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

This literature review examines the multifaceted psychosocial challenges faced by women undergoing infertility treatment and the diverse coping mechanisms they employ. It encompasses both the broad global context and specific circumstances of women in Addis Ababa, Ethiopia. It explores theoretical frameworks relevant to understanding women's experiences

#### **2.1 Introduction to Infertility and infertility treatment**

Infertility, defined as the inability to obtain a clinical pregnancy following a year of consistent unprotected sexual activity, affects millions of couples globally (WHO,2023). Although statistics indicate that 5% of heterosexual couples have unsolved infertility, more inclusive definitions that take temporary difficulties into account place the prevalence rates of infertility are estimated to range from 12% to 28% global (WHO,2023;Inhorn & Patrizio,2015). The etiology of this complex reproductive illness is varied, with 20 -30% of instances resulting from male factors,20-35% from female factors, and other cases resulting from combination of unknown reasons (Medscape, 2023).

Various factors can cause male and female infertility. Female infertility may arise from ovarian, tubal, uterine, cervical, or unknown causes. Polycystic Ovary Syndrome (PCOS), and ovarian disorder, has seen a marked increase in recent years (Setiawan et al., 2020). Male infertility can result from abnormal sperm production, ejaculation issues, sperm motility disorders, or low/ absent sperm counts. The causes of infertility are not only medical but also psychosocial. Although male and/or female factors are associated with infertility, the specific causes of infertility in a specific couple cannot be identified. (Setiawan et al.,2020; Medscape,2023).

Of couples experiencing infertility, up to 30% are diagnosed with unexplained infertility after a standard evaluation (ESHRE Capri Workshop Group, 2004; ESHRE

Guideline, 2023; Cleveland Clinic, n.d.). This evaluation would typically include the demonstration of at least one part of fallopian tube, documentation of ovulation of the female partner, and a semen analysis with an adequate number of motile sperm for the male partner (ESHRE Guideline, 2023; Medscape,2023). Since no treatable can be identified in the setting of unexplained infertility, treatment is by necessity empiric (ESHRE Guideline, 2023; Cleveland Clinic, n.d.).

The current treatment methods for infertility mainly include drug-induced ovulation therapy, hysteroscopic surgery, intrauterine insemination (IUI), in vitro fertilization and embryo transfer (IVF-ET), and third-party-assisted ART (with gamete donors) (ESHRE Guideline, 2023; Medscape,2023). Whether a drug treatment or surgical treatment, there is a certain treatment cycle, especially in IVF-ET, which is the core technology of ART. IVF-ET is an expensive and complicated process. The lack of correct understanding of related assisted reproductive technology can bring a certain level of public opinion pressure, have different degrees of psychological impact on patients, and produce negative emotions (ESHRE Guideline, 2023).

This kind of psychological stress and infertility can cause and affect each other and eventually form a vicious circle. Moreover, new technologies tend to increase the treatment confidence of infertile patients and give them a stronger willingness to give birth. The willingness has also aggravated the psychological pressure on patients to conceive to a certain extent (ESHRE Guideline, 2023).

Commonly used treatments include ovarian stimulation (OS) with oral medications or injectable gonadotropins with intrauterine insemination (IUI) (ESHRE Guideline, 2023; Medscape,2023). OS refers to pharmacological treatment with the intent of inducing development of multiple mature ovarian follicles and is the preferred term for treatment previously described as “superovulation,” “ovarian hyperstimulation,” and “controlled ovarian hyperstimulation”. Clomiphene citrate (oral medication to treat infertility for women who do not ovulate regularly), aromatase inhibitors such as letrozole, and gonadotropins are used to induce ovulation or for ovarian stimulation during in vitro fertilization (IVF) cycles (ESHRE Guideline, 2023; Medscape,2023). Adverse effects of gonadotropins include multiple pregnancy (up to 36% of cycles,

depending on specific therapy) and ovarian hyperstimulation syndrome (1%–5% of cycles), consisting of ascites, electrolyte imbalance, and hypercoagulability (ESHRE Guideline, 2023; Medscape,2023).

OS-IUI is believed to improve cycle fecundity by increasing the number of immature female egg cells that are available for fertilization while increasing the number of motile sperm in the uterus through IUI at the time of ovulation Other proposed treatments for unexplained infertility include IUI in unstimulated (that is, natural) cycles and OS with timed intercourse(ASRM Practice Committee, 2020;Wang et al., 2018). For couples with unexplained infertility, endometriosis (tissue similar to the lining of the uterus grows outside), or mild male factor infertility, an initial 3 to 4 cycles of ovarian stimulation may be pursued. IVF should be considered if these approaches do not result in pregnancy (ASRM Practice Committee, 2020; Wang et al., 2018). Because female fecundity declines with age, this factor should guide decision-making. Immediate IVF may be considered as a first-line treatment strategy in women older than 38 to 40 years. IVF is also indicated in cases of severe male factor infertility or untreated bilateral tubal factor (ASRM Practice Committee, 2020; Wang et al., 2018).

## **2.2 Psychosocial Consequences of Infertility Treatment**

The psychological consequences of infertility treatment are profound and multifaceted, affecting women’s mental health and emotional well-being throughout the treatment journey. Women undergoing infertility treatments commonly experience a range of psychological-emotional problems, including turmoil, frustration, anxiety, depression, hopelessness, guilt, and diminished self-esteem (Hasanpoor-Azghady, Simbar, & Vedadhir, 2014).

The treatment process itself, involving invasive procedures such as hormonal injections, egg retrieval, and embryo transfer, often triggers heightened anxiety and emotional fatigue, particularly during critical phases like waiting for pregnancy test results (Boivin, Takefman, & Braverman, 2022; Hasanpoor-Azghady et al., 2014).

Fear of negative outcomes and repeated treatment failures contribute to feelings of helplessness and grief, which may lead some women to discontinue treatment (Boivin et al., 2022). Moreover, hormonal medications used in treatment can exacerbate mood disorders, including anxiety and depression (Papadimitriou & Farmaki, 2021). Women generally report greater psychological distress than men, partly due to societal pressures and stigma that intensify feelings of guilt and inadequacy (Papadimitriou & Farmaki, 2021). The psychological toll of infertility and its treatment often results in social isolation, strained partner relationships, and decreased quality of life (Boivin et al., 2022; Mental Health America, 2023).

Despite this, many women lack access to adequate mental health support, which is crucial as psychological interventions like counseling and cognitive behavioral therapy have been shown to reduce anxiety and depression and improve fertility outcomes (Boivin et al., 2022; Mental Health America, 2023). Overall, the interplay between infertility-related stress and treatment outcomes forms a vicious cycle, underscoring the importance of integrated psychosocial care in fertility treatment programs (Boivin et al., 2022).

### **2.3 Socio- cultural consequences**

The socio-cultural consequences of undergoing infertility treatment vary globally but share common themes of stigma, social isolation, and gendered blame, with particular intensities in sub-Saharan Africa and Ethiopia. Globally, infertility often leads to social scrutiny and stigmatization, especially in pronatalist societies where childbearing is a central social expectation; couples without children face heightened visibility and pressure, while in many high-income countries voluntary childlessness is more accepted, offering some social privacy but potentially increasing feelings of isolation (Greil, McQuillan, & Slauson-Blevins, 2010; Rebennack, 2000).

In developing countries, including much of sub-Saharan Africa, infertility is heavily stigmatized, especially for women who bear the brunt of blame regardless of medical cause, leading to marital instability, social exclusion, and sometimes domestic violence (Inhorn & Patrizio, 2015; Hollos, Larsen, Obono, & Whitehouse, 2022). Women may

be marginalized within their families and communities, excluded from social rituals, and subjected to accusations such as witchcraft (Elwell, 2022). The social consequences are often compounded by cultural practices such as bride price and patrilineal kinship systems, where childbearing is linked to family lineage and social status, intensifying pressure on women to conceive (Elwell, 2022; Hollos et al., 2022).

The socio-cultural consequences of undergoing infertility treatment in Ethiopia are profound and multifaceted, deeply affecting women's social roles, emotional well-being, and community interactions. Infertile women often face significant stigma and social exclusion, being blamed for childlessness and subjected to disrespect, neglect, and even abuse by husbands, in-laws, and the broader community (Meskelu & Berhane, 2018; Bekele et al., 2019). Cultural expectations strongly emphasize motherhood as central to a woman's identity and social status, and infertility can lead to exclusion from important cultural rituals and social gatherings, such as celebrations involving newborns (Fikre, Fekadu, & Girma, 2024; Meskelu & Berhane, 2018).

Many women conceal their infertility and treatment journeys due to fear of social judgment, which results in isolation and reduced access to social support (Bekele et al., 2019). These socio-cultural pressures are particularly acute; infertility and its treatment are framed within traditional and religious norms that emphasize motherhood as a woman's primary role, and women undergoing treatment in private clinics face the dual burden of modern medical expectations and persistent cultural stigma (Fikre et al., 2024; Aseffa, 2011). The secrecy surrounding infertility treatment, driven by fear of social judgment, often isolates women from support networks, exacerbating psychological distress (Bekele et al., 2019).

Additionally, religious and traditional healing practices coexist with biomedical treatments, influencing how women cope with infertility and its social consequences (Pennings et al., 2009). Across these contexts, socio-cultural factors shape not only the experience of infertility but also access to and acceptance of treatment, underscoring the need for culturally sensitive approaches in infertility care worldwide (Vayena, 2002; Inhorn, 2003).

## **2.4. Financial burden**

Treatment for infertility are frequently expensive, which puts heavy financial strain women having the procedures. The costs of these procedures can cause emotions of strain and increased anxiety. Various approaches are available to address infertility, including pharmacological treatments, surgical interventions, and assisted reproductive technologies (ART) such as in-vitro fertilization (IVF), intrauterine insemination (IUI), assisted hatching, gamete intrafallopian transfer (GIFT), and surrogacy (ESHRE Guideline, 2023; Medscape,2023).

Intracytoplasmic sperm injection (ICSI), a technique used alongside IVF, involves directly injecting a single sperm into each egg retrieved from a women to facilitate fertilization prior to embryo implantation in the uterus. IVF itself involves fertilizing an ovum in a laboratory setting before transferring the resulting zygote into the uterus (ESHRE Guidline, 2023;Medscape,2023).

Standardized psychological and psychiatric protocols to address mental health issues resulting from the diagnosis and treatment of infertility are lacking, despite the increasing use of ART (Bright et al.,2020). IVF, which was initially developed over 35 years ago to treat cases of obstructed fallopian tubes, remains inaccessible or prohibitively expensive for many infertile couples worldwide. In response, clinician-led efforts have sought to introduce “low-cost IVF” in resource-limited settings to address the scarcity of IVF clinics and the high costs associated with treatment in many regions (Malina et al., 2016).

## **2.5. Coping mechanisms of women undergoing infertility treatment**

Women undergoing infertility treatment employ a variety of coping mechanisms to manage the significant emotional and psychological stress associated with their condition and its medical interventions (Domar et al., 2000; Greil et al., 2010). Research shows that coping strategies broadly fall into problem-focused and emotion-focused categories (Lazarus &Folkman,1984).

Problem-focused coping, which involves actively addressing the causes of distress, such as seeking information, managing treatment logistics, and engaging in support groups or therapy, tends to be more effective in reducing stress and improving well-being (Domar et al., 2000).

Emotion-focused coping, including prayer, acceptance, distraction, and reframing infertility as an opportunity for personal growth, helps women handle negative feelings like anxiety, grief, and depression (Peterson et al., 2007; Geil et al., 2010). Religious and spiritual coping are particularly prominent in many cultural contexts, including Ethiopia and other African countries, where prayer and faith provide comfort and resilience (Dyer et al., 2004; Fikre et al., 2024).

Some women also use traditional healing methods alongside biomedical treatments (Fikre et al., 2024). However, avoidant coping strategies such as social withdrawal, denial, or substance misuse may worsen psychological outcomes and are generally discouraged (Peterson et al., 2007).

Studies highlight that women with higher education and longer infertility duration may adopt more adaptive coping mechanisms like positive reappraisal and acceptance, while younger or less educated women may struggle more with confrontational or avoidant strategies (Mpomaa Kyei et al., 2022). Importantly, therapeutic counseling, including Cognitive Behavioral Therapy (CBT), initiated before or during treatment, can enhance coping skills, reduce depression and anxiety, and improve treatment adherence and outcomes (Boivin et al., 2014; PMC, 2023).

Social support from family, partners, and friends also plays a critical role in buffering stress and fostering resilience (SCIRP, 2024). Overall, a combination of problem-focused strategies, emotional support, and professional psychological care constitutes the most effective approach for women coping with infertility treatment.

## **2.6 Theoretical Framework Empirical Perspectives**

The psychosocial consequences of infertility treatment and the coping mechanisms adopted by women can be understood through a multi-dimensional lens that integrates cognitive, emotional-affective, and social ecological perspectives.

### **Cognitive and Emotional-Affective Reactions Framework**

Hasanpoor-Azghady et al. (2014) identify four main psychosocial themes experienced by women undergoing infertility treatment; **Cognitive reactions to infertility and treatment**, including mental engagement, psychological turmoil, reduced self-esteem, and feelings of failure. These reactions involve how individuals perceive and interpret their experiences which can lead to **Emotional-affective reactions**, such as fear, anxiety, loneliness, guilt, grief, depression, fatigue, and hopelessness.

These reactions reflect the intense mental and emotional burden infertility and its treatment impose, often leading to psychological distress and diminished well-being. This framework highlights how infertility treatment is not merely a biomedical process but a profound psychological challenge that affects women's identity and mental health (Hasanpoor-Azghady et al., 2014).

### **Social Ecological Model (SEM)**

The Social Ecological Model (Bronfenbrenner, 1979) provides a useful structure for understanding how individual psychological experiences are embedded within broader social, cultural, and environmental contexts. Infertility treatment impacts women at multiple levels; Individual level encompass Psychological distress, coping strategies, and personal meaning-making. Interpersonal level includes Marital relationships, family dynamics, and social support or stigma and Community and societal level shows Cultural norms, societal expectations regarding motherhood, and healthcare accessibility.

This model emphasizes that coping mechanisms and psychosocial consequences are shaped not only by individual psychological processes but also by social interactions

and cultural expectations, which are particularly salient in the Ethiopian context (Bronfenbrenner, 1979).

### **Coping Strategies Framework**

The coping strategy framework elaborates how different coping mechanisms influence the stress and emotional well-being of individuals undergoing infertility treatment. It categorizes coping strategies into active-avoidance, passive avoidance, active confronting, and meaning-based coping. Research shows that women employ diverse coping strategies in response to infertility treatment stressors, including; Religious/spiritual coping which include Prayer, faith, and seeking divine intervention (SCIRP, 2023; Fikre et al., 2024). They also employ Traditional coping like use of cultural healing practices (Fikre et al., 2024). Medical coping also considered with the Engagement with ART and biomedical treatments (Fikre et al., 2024). and finally, Emotion-focused coping utilized which include Avoidance, acceptance, or reframing infertility experiences (SCIRP, 2023; Psychology iResearchNet, n.d.). These coping strategies influence psychological outcomes and well-being, and their effectiveness is moderated by cultural context and social support availability (SCIRP, 2023; Fikre et al., 2024).

### **Empirical studies on psychosocial consequences of infertility treatment**

Longitudinal research in the United States (n=1228 women undergoing IVF) discovered that 41% experienced clinically significant anxiety, while 32% fulfilled criteria for depression (Kian et al., 2023). Women experiencing treatment failure after three cycles 2.3 times more suicidal ideation than those who conceived (Kiani et al., 2023). Out of pocket costs over \$ 15,000 were associated with a 58% increase in depression scores (OR=1.58,  $p < 0.001$ ) (Kiani et al., 2023).

A meta-analysis of 27 studies (n=12450 women from 15 countries) found that stigma was the most consistent psychosocial outcome, mediated by cultural emphasis on parenting (Lee et al., 2022). In collectivist civilization (e.g., East Asia and sub-Saharan Africa) infertility stigma was substantially associated with social isolation ( $r=0.71$ ) and marital conflict ( $r=0.64$ ) (Lee et al., 2022).

In sub-Saharan Africa, the psychosocial consequences of infertility treatment are compounded by strong sociocultural pressures and stigma. Women frequently face blame, social exclusion, and marital instability due to infertility (Inhorn & Patrizio, 2015; Hollos et al., 2022). A mixed-method study in Nigeria found that women undergoing infertility treatment experienced frustration with medical procedures, anxiety about sexual relations being reduced to procreation, and fear of abandonment by spouses (Adeleye et al., 2022).

Social stigma leads to isolation and psychological distress, including suicidal ideation and sleep disturbances (Adeleye et al., 2022). To overcome these challenges, women employ various coping strategies such as seeking social support, religious faith, and acceptance, although access to mental health services remains limited (Adeleye et al., 2022; PMC, 2024).

A Nigerian study (n=350 infertile women) discovered that 68% were pressured by their spouses to enter polygamous marriages, while 22% experienced physical violence related to infertility (Odibo et al., 2021). Women undergoing IVF showed increased anxiety due to concerns about marital breakdown if treatments failed (Odibo et al., 2021).

In Kenya, 89% of women undergoing ART (n=412) sold assets or took out high-interest loans to pay for treatment (Mburu et al., 2023). Financial hardship predicted early treatment cessation (OR=4.2, 95% CI: 2.1-8.3), with 63% indicating cost as the main obstacle (Mburu et al., 2023).

A cross-sectional study at St. Paul hospital (n=206 women) using the PHQ-9 scale revealed that 42.1% experienced moderate-to-severe depression (Fekadu et al., 2020). Unemployment (AOR=3.1, p=0.002) and partner's poor education level (AOR= 2.7, p=0.01) were significant predictors (Fekadu et al., 2020).

Qualitative Interviews with 30 women in Addis Ababa found that 87% kept their infertility diagnosis hidden to avoid rumor (Meskelu & Berhane, 2018). Participants

acknowledged avoiding child-centric social engagements as their primary coping mechanism, which exacerbated loneliness (Meskelu & Berhane, 2018).

## **2.7. Research Gaps**

While a growing body of research has examined the psychological and social impacts of infertility globally, most studies in Ethiopia have focused on epidemiological patterns, societal attitudes, the financial costs of treatment. There is a notable lack of qualitative research that explores the lived experiences of women undergoing infertility treatment, particularly within private clinics in urban settings like Addis Ababa. Existing studies rarely address how women navigate the complex interplay of psychosocial distress, cultural expectations, financial pressures, and the absence of formal psychological support in these private health care environments.

Moreover, the coping mechanisms employed by Ethiopian women shaped by unique cultural, religious, and social system remain unexplored, especially in the context of modern assisted reproductive technologies. The voice and perspectives of women who invest significant personal and financial resources in private infertility care largely missing from the literature.

This study uniquely contributes to the field by employing a phenomenological approach to deeply investigate the psychosocial consequences and coping strategies of women receiving infertility treatment in private clinics in Addis Ababa. By centering on their subjective experiences and meaning-making processes, this research provides nuanced insight into how these women interpret, endure, and adapt to the multifaceted challenges of infertility. The finding will not only fill a significant gap in the Ethiopian context but also inform culturally sensitive interventions and support systems for women facing similar challenges in comparable settings.

## **2.8 Conceptual Framework**

The conceptual framework for this phenomenological study centers on understanding the lived psychosocial experience of women undergoing infertility treatment in private clinics in Addis Ababa. At its core, the framework posits that infertility treatment exposes women to a range of psychosocial consequences including anxiety, depression, self-blame, marital conflict, and social isolation intensified by cultural expectations that closely link womanhood to motherhood. These challenges are compounded by the physical and financial demands of assisted reproductive technologies and the absence of standardized psychological support within private clinic.

Women respond to these psychosocial burdens through diverse coping mechanisms, such as relying on religious faith, seeking support from family or community, or withdrawing socially. The effectiveness and nature of these strategies are shaped by the broader social systems that surround each woman, including family networks, community organizations, and religious groups. These social systems can either provide critical support or reinforce stigma and isolation, thereby influencing both the severity of psychosocial distress and resilience women demonstrate.

Throughout this process, women engage in meaning making interpreting and finding personal significance in their infertility journey. This ongoing sense-making meditates how they experience treatment, respond to psychosocial challenges, and select coping mechanisms. The framework recognizes the interplay between individual experiences, social context, and cultural norms, providing a holistic lens through which to explore and interpret the subjective realities of women navigating infertility treatment in an urban Ethiopian setting.

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.1 Research design and approach**

Qualitative phenomenological design was employed. This allows to explore the consequences of infertility treatment and coping mechanisms by focusing on women's subjective experiences. The study design enables to gain rich, in-depth insights into the psychosocial problems they experience, their emotions, and coping strategies. The Phenomenology prioritizes understanding participant's subjective interpretations of their experiences, making it ideal for investigating complex psychosocial challenges. The approach aligns with the work of Smith and Osborn (2007), emphasizing the importance of capturing how individuals make sense of their realities.

#### **3.2 Study Area**

This study was conducted at Newleaf infertility clinic which is purposively selected private-funded infertility clinics in Addis Ababa. Newleaf is regarded as a leading fertility clinic in Addis Ababa, Ethiopia, specializing in advanced assisted reproductive technologies (ART) such as Vitro fertilization, intracytoplasmic sperm injection (ICSI) where a single sperm is directly injected into the cytoplasm of an egg to facilitate fertilization, and intrauterine insemination (IUI).

The clinic was selected for its reputation in providing compassionate care and its urban custom, which represents a growing demographic of women navigating both modern medical practices and traditional cultural norms, and emphasizes psychological support for infertility-related traumas.

The center reports a strong track record with 296 total pregnancies, 166 deliveries. The center is privately run with a team of 11-50 employees based in Addis Ababa.

### **3.3 Study Participants**

Participants included six married women aged 29-39 years.

- Diagnosed with primary or secondary infertility
- Actively undergoing or having completed ART (In vitro fertilization (IVF), intrauterine insemination (IUI), ovulation induction, or other assisted reproductive technologies) within the last six months.
- Who were receiving and have received medical treatment from fertility clinic and willing to share their personal experiences in an interview.
- From diverse age groups, educational backgrounds, and socio-economic status, though the study may prioritize specific subgroups based on availability and relevance to the research questions.

### **3.4 Sampling and Sampling techniques**

Purposive sampling was used to recruit six participants through collaboration with clinic staff, who identified eligible women during routine visits who were undergoing infertility treatment in the selected privately funded infertility treatment clinic in Addis Ababa Ethiopia. The sampling aligns with phenomenological norms, respects the vulnerability of the participants and ensures rigorous analysis of complex psychosocial experiences. This approach is validated by qualitative research standards and ethical considerations for sensitive topics. Similar phenomenological studies on sensitive topics often use comparable sample sizes (e.g., 5-8 participants) to balance depth and manageability (Creswell & Poth, 2018). Despite the small sample, saturation was achieved as recurring themes emerged consistently across interviews, indicating no new insights were likely with additional participants (Guest et al., 2006). Recruitment faced challenges due to stigma surrounding infertility; many women initially hesitated to share experiences. To address this:

- Staff emphasized the study's confidentiality.
- The researcher conducted informal pre-interview meetings to build trust.

- Participants were assured anonymity ( e.g using fictitious name like “ I-1, I-2”)

### **3.5 Eligibility Criteria**

#### **3.5.1 Inclusion Criteria**

- Married women (to capture the experiences of women within marital relationships)
- Women who have been unable to conceive after at least 12months or regular, unprotected sexual intercourse.
- Currently or recently undergoing infertility treatment at a selected private clinic.
- Able and Willing to participate in in-depth interviews

#### **3.5.2 Exclusion Criteria**

- Men and Couples
- Women who are unable to participate in interview due to emotional instability and unwillingness.

### **3.6 Data Collection tool and Procedure**

In line with the objectives of the study and in consultation with relevant literature, in-depth interviews were conducted focusing on participants’ experiences with infertility treatment, psychosocial challenges face during treatment and coping strategies employed to manage these challenges. The interview guides are with a series of prompts like ‘can you tell me more?’ and what else have you felt or experience?’ were used to encourage participants to clarify or expand on their responses. In addition to verbal communication, the participants’ nonverbal responses were noted.

All interviews were conducted by the researcher and the interviews were done in a private quite room arranged in the infertility clinic. Their duration ranged from 25min

to 55min. interviews were auto-recorded. Interviews were transcribed in the original language (Amharic) and then translated into English.

### **3.7 Data processing and Analysis**

The researcher employed Interpretative Phenomenological analysis (IPA) following Smith et al. (2009) to analyze the data collected from in-depth interviews. The process begins with transcribing the interviews exact and engaging in systematic familiarization with the transcripts. Initial coding involves systematically analyzing each line to identify relevant codes and meaning units, capturing the participants' perspectives and emotions. Subsequently, the researcher grouped these codes in to broader themes shaping women' experiences with infertility treatment. Finally, the findings were synthesized into a coherent narrative, balancing descriptive accounts with insightful interpretations and supporting them with illustrative quotes.

### **3.6 Trustworthiness and Rigor**

To ensure the trustworthiness and rigor of this phenomenological study, several strategies were employed throughout the research process.

**Credibility** was established through prolonged engagement with participants, allowing for in-depth exploration of their lived experiences and the use of member checking, where participants reviewed and validated the interpretations of their narratives.

**Transferability** was enhanced by providing descriptions of the research context, participant characteristics, and the setting of the private infertility clinic, enabling readers to determine the applicability of findings to similar contexts.

**Dependability** was addressed by maintaining a detailed audit trail of all research decisions, data collection procedures, analysis step, ensuring that the study's processes were transparent and could be replicated.

**Confirmability** was strengthened by practicing reflexivity, with the researcher regularly reflecting on and documenting personal biases, assumptions, and their potential influence on data interpretation. Peer debriefing with academic supervisors and colleagues further contributed to the rigor of the analysis.

Together, these measures ensured that the findings of this study are credible, dependable, and grounded in the authentic voices of the participants.

### **3.7 Ethical consideration**

**Approval:** Ethical clearance and approval of the research was Obtained from Ethical Review Board of Addis Ababa University. In addition, written permission was obtained from the selected study areas to conduct the study.

**Informed Consent:** Study participants were recruited on a voluntary basis after providing full information about the objective of the study

**Confidentiality:** the confidentiality of the data and after a verbal consent agreement is taken. To keep the confidentiality of the study subjects' information, personal identifiers (*name and card number*) were not included in the data collection format instead a code were used and all recorded data were kept in a very secure area.

**Emotional Safeguards:** A counselor was on standby for distressed participants (none required intervention).

### **3.8 Limitation of the study**

This study has several limitations that should be considered when interpreting the findings. First, the research was conducted at a single private infertility clinic in Addis Ababa, with a small sample of six married women aged 29-39 years. As a result, the findings may not be generalizable to women receiving infertility treatment in public clinics, other regions of Ethiopia, or different cultural contexts.

Second, the study focused exclusively on women's perspectives, excluding the experiences of men and couples, which may have provided a more comprehensive understanding of infertility's psychosocial impact.

Third, the phenomenological approach prioritized the subjective lived experiences of participants, which, while providing rich and in-depth insights, may not capture the full range of psychosocial challenges faced by all women undergoing infertility treatment.

Additionally, the study did not explore long-term psychological outcomes post-treatment or compare coping mechanisms across different socioeconomic groups. Finally, social desirability bias may have influenced participants' responses during interviews, potentially limiting the disclosure of sensitive or stigmatized experiences.

## **CHAPTER FOUR**

### **RESULT AND DISCUSSION**

#### **4.1. Introduction**

This chapter presents the findings of phenomenological exploration into the psychosocial consequences of infertility treatment and the coping mechanisms employed by women undergoing infertility treatment in privately funded clinic in Addis Ababa, Ethiopia. The analytical process was done through interpretative phenomenological analysis, superordinate themes and several subthemes were identified.

#### **4.2 Demographic Profile of Participants**

The study was conducted among Six women participants age range 29 to 39 years. Out of six respondents four of them had attended university/college and one of them is Master's degree holder. Two respondents completed secondary education. The duration of marriage ranges from 2 to 18years and the duration of treatment ranged 4month to 2year and 3month.

**Table 1: Participants Demographics**

Participant ID	Age (years)	Educational Level	Occupation	Religion	Marital Duration (years)	Previous pregnancies	Treatment Duration	Treatment Type
I-1	32	Degree	Private business	Protestant	18	None	1 year	IVF
I-2	31	Degree	Government office	Protestant	2	None	4 months	Hormonal Therapy
I-3	32	10+2	Hotel work	Orthodox	8	Yes (IVF child)	2 year including prior cycle	IUI
I-4	29	degree	Private business	Orthodox	6	Miscarriage	1 year and 3 months	IVF
I-5	39	Masters	Private business	Orthodox	14	Yes (2 children, 5 Miscarriages)	1 year and 2 months	IVF
I-6	30	10th grade	Private business	Orthodox	14	None	2 years	IVF

### 4.3 Emerged Themes

The analysis of participants' lived experiences revealed five interconnected themes that capture the multifaceted psychosocial journey of women undergoing infertility treatment. The themes in this study emerged through a systematic application of Interpretative Phenomenological Analysis (IPA) which involves carefully examining and understanding participants' personal stories, emphasizing common challenges they face as well as their unique ways of coping and showing strength. Psychosocial Challenges encompassed emotional strain, physical discomfort, and societal stigma, while Social and Relational Consequences exposed tensions within marriages and broader cultural expectations. Financial Burden underscored the economic strain of costly treatments, and Coping Strategies illuminated adaptive mechanisms such as

spirituality and social support. Finally, Finding and meaning revealed how participants reframed their journeys through hope and self-reflection.

Together, these themes provide a holistic understanding of infertility treatment’s impact and contextualizing individual experiences within Ethiopia’s unique sociocultural landscape. Direct quotes from participants present each theme, ensuring their voices remain central to the findings.

*Table 2: Summary of themes, subthemes, codes, and code descriptions*

<b>Theme</b>	<b>Subtheme</b>	<b>Code</b>	<b>Code Description</b>
<b>Psychosocial Challenges</b>	<b>Emotional Strain</b>	Anxiety	Persistent worry about treatment outcomes, fear of failure, and uncertainty.
		Grief	Sadness over unmet motherhood expectations or treatment failures.
		Hopelessness	Feelings of despair after repeated unsuccessful cycles.
	<b>Isolation</b>	Social Withdrawal	Avoiding social interactions to escape stigma or intrusive questions.
		Cultural Stigma	Shame due to societal blame for infertility
	<b>Physical Discomfort</b>	Hormonal Side Effects	Fatigue, mood swings, or pain from injections/medications.
		Procedural Pain	Discomfort from IVF procedures
<b>Social and Relational Consequences</b>	<b>Relationship with Partner</b>	Marital Strain	Tension due to financial stress, emotional distance, or blame.
		Partner Support	Spousal solidarity and shared decision-making during treatment.
	<b>Social and Cultural Expectations</b>	Gendered Blame	Societal pressure attributing infertility to women
		Intrusive Advice	Unsolicited suggestions
<b>Financial Burden</b>	<b>Treatment Costs</b>	High Expense	Stress over IVF/IUI costs exceeding average income
		Financial Sacrifices	Selling assets, taking loans, or prioritizing treatment over basic needs.
<b>Coping Strategies Utilized</b>	<b>Spiritual Support</b>	Prayer and Faith	Relying on religious practices for hope and acceptance
		Trust in Divine Plan	Framing infertility as part of a higher purpose or spiritual test.
	<b>Social Support Networks</b>	Partner/Family Support	Emotional reliance on spouses, siblings, or parents.

		Healthcare Provider Guidance	Valuing empathetic communication from clinic staff.
	<b>Positive Reframing</b>	Goal-Oriented Focus	Channeling energy into treatment goals
		Resilience Narratives	Emphasizing personal strength
<b>Finding Meaning in Experiences</b>	<b>Self-Reflection and Optimism</b>	Identity Reevaluation	Questioning self-worth or redefining womanhood beyond motherhood.
		Transformative Perspective	Viewing treatment as a journey of growth

### **Theme 1: Psychosocial Challenges**

Respondents were asked to describe how infertility treatment affected their emotional well-being and experience of feelings like anxiety, grief and hopelessness. From their responses, 7 codes were found and categorized into three subthemes; emotional strain, sadness and isolation and physical discomfort.

#### **Subtheme 1.1: Emotional Strain**

The emotional toll of infertility treatment was profound. Two respondents described anxiety, grief, and hopelessness tied to the unpredictability of outcomes and repeated cycles of treatment amplified these feelings, revealing the intense psychological toll for their fertility journeys.

It is clear that the uncertainty inherent in infertility treatment can amplify emotional distress, leaving women in a state of persistent worry and fear. for instance , one participant shared

*"At first, I was very anxious. My mind was filled with many thoughts. But my goal was clear: to try, whether it works or not." (I-2, 31 years old, married for 2 years.)*

This statement illustrate the inner conflict between hope and apprehension, as well as the determination to preserve despite emotional challenges. Another participant echoed similar feelings:

*“The first time was scary. I was worried, wondering what would happen” (I-4, 29years old married for 6years)*

Her words highlight the fear of the unknown that often accompanies the start of treatment

These accounts reflect findings in the literature, which indicate that women undergoing assisted reproductive technologies (ART) frequently experience heightened anxiety, and emotional exhaustion, particularly when success is uncertain and treatments are prolonged<sup>1</sup>. The cyclical nature of hope and disappointment can erode psychological well-being, especially in contexts where motherhood is closely tied to social identity and self-worth. Without adequate psychosocial support, women may feel isolated in their struggles, compounding the emotional impact of infertility treatment.

Overall, these reflections underscore the need for integrated mental health support within infertility care, as well as greater societal understanding of the profound and often invisible psychological challenges faced by women pursuing fertility treatment in Ethiopia.

As one respondent indicated, undergoing infertility treatment exposes you to experiences intense emotional stress often hidden due to social stigma. Support from family and partner helps to cope with this emotional strain.

*" when we first tried IVF, I was very worried. Then the doctor said we could try again. After that, I often cried alone. My sister supports me. I tell her about it. She cries with me. It's hard, but when you talk about it, it helps. My husband is a very good person, very empathetic. He thinks more about others than himself." (I-3, 32years old, married for 8years.)*

This statement reveals the profound vulnerability and isolation that can accompany fertility. The emotional burden is not only related to the physical and medical challenges but also to the uncertainty and repeated cycles of hope and disappointment. The respondent's experience of crying alone underscores how societal stigma around infertility can lead to internalized suffering, making it difficult for individuals to openly express their distress.

However, the respondent's narrative also highlights vital role of support from family and partners in coping with this emotional strain. She notes "My sisters supports me. I tell her about it. She cries with me. It's hard, but when you talk about it, it helps," emphasizing how sharing feelings with trusted loved ones can provide relief and validation. This kind of emphatic supports breaks the silence imposed by stigma and creates a safe space for emotional expression, which is essential for psychological resilience during infertility treatment.

Furthermore, the respondent's description of her husband as "a very good person, very empathetic. He thinks more about others than himself" illustrates the importance of a compassionate partner in this journey. Such empathy and selflessness likely foster a strong emotional bond and mutual support, which can buffer the stress associated with infertility.

### **Subtheme 1.2: Isolation**

From the six Participants two of them clearly experienced sadness and isolation, as infertility treatment is often stigmatized in Ethiopian society. Infertility, often considered a taboo or misunderstood condition, places affected individuals in a vulnerable position where emotional distress is compounded by societal judgment and silence. This stigma not only marginalizes those undergoing treatment but also discourages open discussion, leading to feelings of loneliness and alienation.

Two respondents further highlighted that their sadness and isolation were exacerbated by unfamiliarity with infertility options and the uncertainty surrounding the causes of their condition. One participant expressed this uncertainty and reliance on faith.

*"Since this is not common in our country, sometimes I feel isolated. But I keep my hope in God and move forward. There are a lot of feelings, but I rely on God." (I-6,30years old, married for 14years).*

This statement reveals how limited awareness about infertility and its treatment can leave individuals feeling lost and isolated, turning to spiritual faith as a vital source of

hope and coping. The reliance on God reflects a culturally grounded resilience mechanism that helps mitigate emotional distress and within uncertainty.

Among participant described the intangible nature of the emotional burden:

*"Sometimes you yourself don't even know why, but something bothers you. There's stress, and sometimes you feel like isolating." (I-3, 32 years old married 8years*

This quote captures the often ambiguous and pervasive nature of emotional suffering in infertility stress and sadness may not always have clear triggers but nonetheless profoundly affect well-being. The inclination to self-isolate can be both a symptom and a coping strategy, reflecting an internal struggle with feelings that are difficult to articulate or share, especially in a context where infertility is stigmatized.

This sense of isolation was compounded by societal expectations and unsolicited advice, which added to the emotional burden. A participant reflected on choosing loneliness as a protective response:

*"I stopped seeing my friends. Loneliness is what I choose" (I-6, 30years old, married for 14years."*

This deliberate withdrawal from social circles can be understood as an attempt to avoid judgment, pity, or intrusive questions, yet it also risks deepening emotional isolation and depriving individuals of potentially supportive relationships.

### **Subtheme 1.3: Physical Discomfort**

Physical discomfort, particularly from hormonal injections, was a recurring challenge for participants undergoing infertility treatment. while the pain was generally described as manageable, it was nonetheless impactful enough to affect daily functioning and emotional well-being. One participant shared:

*"The injections in the stomach are a bit painful, and as the eggs grow, there is some discomfort. I don't feel comfortable at work during this time, but it's manageable." (I-1, 32years old, married for 18 years.)*

This statement highlights how even moderate physical pain can interfere with routine activities, such as work, underscoring the pervasive nature of treatment -related side effects.

Two other participants emphasized the psychological negotiation involved in enduring physical discomfort, focusing on the trade-off between temporary pain and the hope for a successful outcome. As one explained,

*"At the onset of IVF treatment, the injections are administered into your abdomen. From the very start we tried to reassure ourselves; although I notice some discomfort in my abdomen, I tried not to dwell on it. The most important thing is making it to the completion of the process. Ultimately, though our central concern remains: we will achieve our desired outcome in the end."* — I-4, 29 years old, married for 6years.

Another participant echoed this sentiment,

*"I didn't like injections before, but now I am used to it because I want a child."* (I-6, 30years old, married for 14years).

These reflections reveal the resilience and determination that underpin participants' willingness to tolerate physical pain. The discomfort is reframed as a necessary sacrifice in pursuit of a deeply valued goal parenthood.

Beyond pain, hormonal treatments also induced fatigue and mood swings, which further complicated participants' ability to function normally. One participant described these emotional side effects succinctly:

*"You become irritable, your mood changes. Makes you get emotional."* (I-3, 32 years old, married for 8years.)

This acknowledgment points to the broader psychosocial impact of infertility treatment, where physical symptoms intertwine with emotional fluctuations, potentially affecting interpersonal relationships and mental health.

Despite these challenges, participants demonstrated remarkable focus and perseverance. Many attributed their endurance to a combination of personal strength

and faith, which served as vital source of motivation and coping. This interplay between physical hardship and psychological resilience illustrates the holistic nature of the infertility treatment experience, where managing bodily discomfort is inseparable from sustaining hope and emotional well-being.

## **Theme 2: Social and Relational consequences**

These themes go in to specifies how infertility treatment affected relationships with, partner, family and other community members including friends.

### **Subtheme 2.1 Relationship with partner**

The infertility journey serves as a significant test for marital relationships. For some participants, the shared experience of treatment fostered increased closeness and mutual support. Three participants reported that their husbands become more supportive throughout the process, strengthening their partnership. One participant noted,

*“My husband is very supportive, and we’re going through this journey together, just the two of us. There is no pressure from our families, which has made the process a bit easier emotionally. When we lived in the countryside, we faced more challenges and interference from family members, However, since moving to Addis Ababa, we’ve been able to focus more on ourselves and our treatment without external stress.” (I-1, 32years old, married for 18 years.)*

This highlights how reduced external interference can create a safer emotional space for couples to unite in their shared goal.

Similarly, another participant emphasized the privacy they maintain around their infertility, stating,

*"The main difference is with my husband. We started this together. He supports me a lot. Family is not involved. Socially, not having a child brings some stress, especially after six years of marriage. People ask questions, and it adds pressure. But we keep it private."(I-4, 29years old, married for 6years)*

This reflects a conscious strategy to protect the marital relationship from external pressures, underscoring the couple's solidarity amid societal expectations.

Another participant shared a more cautious approach to disclosure,

*“The treatment hasn't affected my interactions with others. Both my family and my husband's family are aware of the treatment I'm undergoing, and they've been very supportive—they ask about the process and keep me in their prayers. However, I haven't shared this with my friends yet. Given the uncertainty surrounding the outcome, we've decided not to talk about it widely until we see how things progress.” (I-2, 32years, married for 2years)*

This illustrates the delicate balance couples maintain between seeking support and guarding their privacy in a culturally sensitive context.

In another way one participant mentioned that after starting infertility treatment procedure, because of the cost and unexpected sacrifices to have a child there were disagreements and unusual conversations which affects their relationship which leads to stop the procedure.

*“At first, both of us were happy when we started. Then, fear of failure started to creep in. After that, I waited until they told me to stop. I came here, went back and forth, and was told it wouldn't work. I felt pain. I stayed home, didn't want to talk to my husband. He also seemed to feel it was his problem. After the first round, I didn't come for a whole year.” (I-6, 30years old, married for 14years).*

This account reveals how infertility can evoke feelings of blame, despair, and communication breakdown, sometimes leading to pause or cessation of treatment.

### **Subtheme 2.2 Social and Cultural Expectations**

Societal norms around motherhood added pressure, particularly in cultural contexts where a woman's identity is closely tied to her ability to bear children. Once women experience social and cultural pressure due to infertility, they will start to predict their experience of social and cultural pressure in the future because of undergoing infertility treatment. so, participants decided not to share that they have started infertility

treatment to prevent the social consequences and the inclusive nature of their family plays a great role

One participant discloses that she started infertility treatment and suffered from pressure because of their expectations as she shared her experience:

*“when I go to family, they see my belly and think something has happened. There is a lot of process. There is a program for families, but I prefer to stay alone. I feel isolated from my family. When I go, everyone asks questions. Before, my husband and I would go freely, but now, since starting this process. Now, I prefer being alone” (I-6, 30 years old, married for 13 years)*

This illustrates how infertility and its treatment can disrupt familiar relationship and increase feelings of loneliness.

Participants also encountered unsolicited advice that add to their emotional strain, such as suggestion to adopt try alternative methods. One noted:

*"Not directly, but people do ask questions like, 'Why don't you adopt?' or 'Why don't you try something else?' There's often an assumption that the issue always lies with the woman. (I-1, 32 years old, married for 18 years).*

Another reflected on professional advice:

*“I have visited health professionals several times for treatment, and during those visits, some of them suggested that, since I already have children, I could consider adoption if I still wish to expand my family. Although the idea of not being able to have another biological child due to my medical condition is difficult to accept, it has led me to reflect deeply and consider all possible options, including adoption.” (I-5, 39 years old, married for 14 years).*

These experiences highlight the complex interplay between cultural expectations, medical advice, and personal desires, which can create additional emotional challenges.

### **Theme 3: Financial Burden**

The financial strain of infertility treatment emerged as a significant challenge. Participants highlighted the high cost of procedures such as IVF, that they spend a lot of money and the cost is unaffordable which doesn't consider the living standard and income of Ethiopians. participants explained that:

*“The greatest challenge for me is the financial cost. IVF is very expensive, ranging from 600,000 to 700,000 birr, and payments are made in stages. If you don't have the means, it can be overwhelming. Fortunately, I have a job and can afford it, but it still feels like a heavy burden.” (I-4, 29 years old, married for 6 years.)*

Another participant emphasized the sacrifices involved and how they manage the cost:

*“When I started the treatment during my first cycle, I had to stop once because of the cost. Now, I have learned a lot from past. Now, I save up each month and wait. The medicine is always needed. I save up and pay as needed. Sometimes I have to borrow. I think about how much it will cost, maximum and minimum”. (I-6, 30 years old, married for 14 years)*

### **Theme 4: Coping Strategies Utilized**

#### **Subtheme 4.1: Spiritual Support**

Spirituality and religious faith have been identified as essential coping mechanisms for individuals facing the emotional and physical difficulties associated with infertility treatment. in setting such as Ethiopia, where religion is deeply integrated in to everyday life and cultural identity, turning to spiritual practice offers a significant source of solace, optimism, and inner strength. This reliance on faith-based support helps individuals endure the challenges of treatment by fostering hope and resilience throughout their journey

Faith played a central role in helping participants cope with the challenges of infertility treatment. Many relied on prayer and religious beliefs to maintain hope and resilience. One participant expressed this connection vividly:

*“I came here praying, asking God for help. I give everything to God and try to accept whatever comes. If you don’t, even the medicine can harm you. You have to treat yourself, keep away from stress, and focus on the goal.” (I-1, 32years old, married for 18 years.)*

This statement reflects a holistic understanding of healing- where spiritual well- being is seen as inseparable from physical health. The participant acknowledges that faith not only sustains hope but also actively protects her from detrimental effects of stress, which can undermine treatment outcomes. This perspective highlights how spirituality functions as both a psychological anchor and practical coping mechanism.

Another participant similarly emphasized the sustaining power of prayer and positive focus:

*“I pray for strength and resilience. After that, I focus on the main thing-having a child. That’s my goal. I don’t let myself dwell on negative thoughts. Sometimes I lose sleep, but I remind myself that I have to keep going to reach my goal.” (I-4, 29 years old, married for 6 years.)*

Here, faith is intertwined with goal-directed perseverance, helping to regulate emotions and maintain motivation despite setbacks. The participant’s conscious effort to redirect attention away from negativity toward hope illustrate a dynamic coping process supported by spiritual belief.

The centrality of spiritual support in coping with infertility treatment underscores the culturally embedded nature of resilience in this context. Faith provides not only existential meaning but also practical psychological benefits- offering hope, reducing anxiety, and fostering acceptance of uncertainty. This aligns with broader literature on the role of spirituality in health, which identifies religious coping as a significant factor in managing chronic illness and medical stressors.

Health care providers working with infertile patients in such cultural setting should recognize and respect the importance of spiritual coping. Integrating spiritual care – whether through chaplaincy services, culturally sensitives counseling, or simply acknowledging patient’s faith- can enhance holistic care and improve psychological

well-being. Encouraging patients to draw on their spiritual resources may also empower them to manage stress and maintain hope throughout their treatment journey.

In conclusion, spiritual support is a vital coping strategy that helps individuals navigate the multifaceted challenges of infertility treatment. It fosters resilience by providing meaning, emotional regulation, and a helpful outlook, all of which are essential for enduring the physical and psychological demands of this journey.

#### **Sub theme 4.2 Social Support Networks**

Social support from family and partners emerged as a fundamental resource for participants undergoing infertility treatment, offering emotional sustenance during a challenging and often isolating journey. However, the nature and quality of this support varied among individuals, influenced by personal relationships and social contexts. While some participants received consistent encouragement and understanding, others experienced mixed reactions, including well-meaning but sometimes unhelpful advice.

One participant highlighted husband's and families' role while undergoing their treatment:

*“Both my family and my husband’s family are aware of the treatment I’m undergoing, and they’ve been very supportive—they ask about the process and keep me in their prayers.” (I-2, 31years, married for 2years).*

This example illustrates how open communication and shared awareness within families can foster a nurturing environment that alleviates feelings of isolation and reinforces emotional resilience. The act of family members actively inquiring about the treatment and offering prayers reflects a culturally significant form of support that combines emotional care with spiritual solidarity.

In addition to family and partners, sibling support was highlighted as particularly meaningful.

As one participant shared how her sister supported her during her difficult time:

*“I was feeling lonely, but my sister was there for me; we even cried together. During a period of frequent medical appointments, I became overwhelmed with emotion and began to cry, as I discovered my own strength as a woman. She was the one who gave me comfort.” (I-3, 32 years old, married for 8years.)*

*This distressing account underscores the power of emphatic companionship and shared vulnerability. The sister’s presence provided not only emotional relief but also a space for the participant to explore and affirm her inner strength, illustrating how close familial bonds can serve as a vital source of psychological support.*

*The experience shared by these participants highlight the critical role that social support networks play in buffering the emotional strain of infertility treatment. support from family and partners provide a sense belonging, reduce feelings of loneliness, and offer practical and spiritual encouragement. However, the variability in support also points the complex dynamics that individuals face- while some receive unwavering care, others may encounter misunderstanding or unsolicited that can add to their distress.*

Some participants underlined the relevance of support systems and even joined online support groups. One participant stated:

*“The first time was scary. It was very frightening. I was worried, wondering what would happen. I used to search on Google a lot about IVF. I saw others who succeeded. Being part of a support group has been life-changing ” (I-4, 29years old, married for 6 years.)*

*And another participant advises not to be alone:*

*“Not everyone will help you, but if you find someone, share your thoughts. Sometimes, being alone is hard, but sharing helps. I talk with others who have gone through this, and it helps.” (I-6, 30 years old, married for 14 years)*

Health care providers and Staffs of the health institution has enormous role in the treatment process as participants explained.

*“They have been very supportive and treated me well throughout the process. I also feel comfortable asking the doctors questions, and they provide detailed explanations about the treatment. From the moment I enter the clinic to the end of my visit, I receive excellent care. Their support, both emotional and medical, has been invaluable, and I am truly satisfied with the treatment I’ve received.” (I-2, 32years, married for 2years)*

### **Subtheme 4.3 Positive Reframing**

All participants demonstrated remarkable resilience as they navigated the multifaceted challenges of infertility treatment. this resilience man faceted challenges of infertility treatment. this resilience manifested through perseverance, faith , adaptive coping strategies, hope, emotional strength, and an unwavering focus on their goal of parenthood. Their narratives reveal a dynamic process of managing loss, isolation, and uncertainty while maintaining inner strength and determination.

one participant encapsulated this resilient mindset by encouraging persistence and positivity:

*“Don’t give up. Try everything you can. Don’t let fear hold you back. Even if it doesn’t work, at least you tried. Keep your faith and stay positive. I keep myself busy with work and try to stay positive, because I am here to have a child. There’s no challenge here, only good things you have to focus”(I-1, 32 years old, married for 18years).* This statement reflects a proactive and hopeful approach, where resilience is not merely enduring hardship but actively engaging with the process, reframing challenges as opportunities for growth and focusing on positive aspects. The participant’s emphasis on faith and staying busy also illustrates the use of both spiritual and behavioral coping mechanisms to regulate emotions and sustain motivation.

Another participant highlighted the interplay between hope, trust, and acceptance:

*“After starting treatment, I felt hope. I trust in God and the doctors. If it doesn’t work, there are other chances, and I will try again.” ( I-2, 31years, married for 2years).* This demonstrates spiritual resilience intertwined with realistic optimism, where trust in both divine support and medical expertise fosters a balanced outlook. The willingness to try

again despite setbacks exemplifies adaptive coping, reflecting flexibility and persistence.

Participants consistently emphasized the necessity of maintaining strength amid the profound challenges posed by infertility treatment. Their narratives illustrate the intense emotional strain they endure, yet simultaneously reveal a deep well of resilience and determination to persist despite setbacks.

One participant expressed the importance of internal strength and selective disclosure, saying

*“You have to be strong. There are many challenges. To be real, you don’t have to listen to others. Sometimes, you don’t even tell your own mother. It’s better to find your own solution inside. I pray for strength and resilience after that I focus on having a child.”* (I-4, 29 years old, married for 6 years). This statement highlights the emotional isolation that can accompany infertility, where external pressures or unsolicited opinions may exacerbate distress. The participant’s strategy of turning inward and relying on prayer underscores the role of spiritual resilience as a vital source of emotional fortitude. It also reflects a conscious effort to protect one’s mental health by filtering external influences and focusing on personal goals.

Another participant shared a narrative marked by both hope and fear, shaped by previous losses:

*“I am hopeful that the treatment will be successful. However, since I have had five miscarriages before and I am afraid of the outcome but I focus on my work and share the stress with my husband.”* (I-5, 39 years old, married for 14 years). This account reveals the tension between optimism and trauma, illustrating how past experiences of loss complicate emotional responses to treatment. The participant’s coping mechanisms of engaging in work and confiding in her husband demonstrate adaptive strategies that help manage anxiety and foster resilience through social support and purposeful distraction.

Another participant emphasized the importance of mutual support and sharing emotions:

*“Sometimes people give you good advice, sometimes not. We should support ourselves and share with our husbands. If you find someone, share your thoughts. Being alone is hard, but sharing helps.” (I-6, 30 years old, married for 14 years).* This reflects the critical role of social connectedness in mitigating feelings of loneliness and emotional burden.

### **Theme 5: Finding Meaning in Experiences**

Participant reveals the profound inner journey that often accompanies infertility treatment. a journey marked by self -reflection, emotional struggle, and a search for meaning. One participant’s account offers a window into the depths of this experience:

*“It’s difficult to feel like I’m enough. I often deprive myself, feeling like God won’t provide what I need, despite my prayers. There are times when I’ve exhausted my ability to cry, yet I still find myself weeping in church. My husband lives abroad,, and while we’ve previously lived outside the country and the distance is a struggle. Sometimes, I feel like I’m constantly battling myself internally.” (I-6, 30 years old, married for 14 years).* This reflection underscores the intense feelings of inadequacy, spiritual doubt, and isolation that can arise during infertility treatment. the physical separation from her husband adds another layer of loneliness and emotional burden, intensifying her internal conflict.

Despite challenges, participants demonstrated a remarkable capacity for optimism and goal-directed focus. One participant acknowledged the societal association between femininity and motherhood but consciously chose not to let it define her:

*“These things come to mind, but I haven’t let them affect me deeply. My main focus is to try everything possible to have a child.” (I-4, 29years old, married for 6years).*

This statement highlights a resilient mindset recognizing external pressures while maintaining personal agency and determination. It reflects the ability to compartmentalize societal expectations and Prioritize one’s own goals, a key aspect of adaptive coping

Another participant emphasized the importance of autonomy in decision-making, especially in a context where advice from others can be overwhelming or misaligned with personal needs:

*“To be real, you don’t have to listen to others. Sometimes, you don’t even tell your own mother. It’s better to find your own solution inside and make your own decisions.” (I-3, 32years old, married for 8years).*

This approach illustrates the value of introspection and self-reliance, empowering individuals to define their own paths and find meaning in their unique experiences.

#### **4.4 Discussion**

The findings of this phenomenological study on the psychosocial consequences of infertility treatment and coping mechanisms utilized by women undergoing treatment in a private clinic in Addis Ababa. The discussion is organized thematically and aligned with the study’s central research questions, allowing for a comprehensive exploration of the participants’ lived experiences. In understanding how Ethiopian women navigate infertility treatment within unique cultural, social, and economic contexts, the discussion will put the findings within identified five organized themes: psychosocial challenges, social and relational consequences, financial burden, coping mechanisms, and meaning in experience. Each theme is examined in relation to participant narratives and bridges gaps in global infertility literature, emphasizing context-specific challenges and resilience strategies. The expanded analysis integrates recent empirical studies and policy recommendations to strengthen academic and practical contributions.

##### **1. Psychosocial Challenges During Infertility treatment**

Participants described infertility treatment as a cyclical ordeal marked by grief, anxiety, and feelings of inadequacy. Each failed treatment cycle reignited despair, mirroring global findings that relate infertility-related stress to chronic illness (Cousineau & Domar, 2007; Boivin et al., 2022). However, Ethiopian women uniquely framed their distress through communal and spiritual lenses. For instance, participants described,

crying alone, feeling overwhelmed, and relying on close family members for emotional support. One participant recounted feeling reduced to a reproductive function within her marriage, echoing Adeleye et al. (2022), who found that women undergoing infertility treatment in Nigeria experienced distress with medical procedures, anxiety about sexual relations being reduced to procreation, and fear of abandonment by spouses and Social stigma leads to isolation and psychological distress, including suicidal ideation and sleep disturbances (Adeleye et al., 2022).

These challenges are magnified within the Ethiopian sociocultural context, where motherhood is tightly linked to a women's identity and social value. Inhorn (2015) and Abebe et al. (2022) highlight how patriarchal societies often place the burden of infertility solely on women, reinforcing gendered expectations and internalized blame. Two participants reported fears of marital instability and social judgment, particularly from in-laws and community members. Some withdrew from social activities or concealed their treatment to avoid shame; a finding echoed in studies by Meskelu and Berhane (2018), which documented secrecy as a common coping mechanism among Ethiopian women.

The emotional burden was compounded by feelings of social exclusion and stigmatization. Participants frequently reported that community members viewed infertility as a personal failing. This stigma led to isolation, which in turn deepened psychological distress. Unlike Western contexts where clinical depression is often emphasized (Kiani et al., 2023), Ethiopian women framed their distress through spiritual, relational, and communal lenses. This difference highlights the importance of culturally agreed psychosocial interventions. Domar et al. (2012) support this by noting that infertility treatment, particularly when prolonged and unsuccessful, intensifies stress, depression, and isolation.

Motherhood in Ethiopia is central to female identity, and childlessness often invites public scrutiny. Extended family members, particularly mothers-in-law, frequently pressured women to seek traditional healers or accept polygamous marriages, exacerbating emotional isolation (Mekonnen et al., 2023). This societal hostility aligns

with Goffman's (1963) theory of stigma, where deviations from cultural norms result in social exclusion.

In addition to psychological and social burdens, financial stress emerged as a significant challenge. The high cost of assisted reproductive technologies (ART)—particularly IVF, which can reach up to 700,000 ETB (approximately \$12,000)—was well beyond the average household income in Ethiopia. Four participants reported taking out loans, selling assets, or saving for extended periods to afford treatment. This financial strain mirrors findings from Kenya, where Mburu et al. (2023) found that over 60% of women undergoing ART sold belongings or borrowed money to continue treatment.

These economic pressures often led to emotional distress, a sense of powerlessness, and treatment discontinuation. Boivin et al. (2021) argue that financial constraints amplify psychological challenges for women in low-resource settings, a finding clearly reflected in this study. Unlike women in high-income countries who may benefit from insurance coverage, Ethiopian women relied almost exclusively on personal savings. This limited access to care, increased treatment-related anxiety, and deepened social vulnerability especially for those with low education or unstable employment, as noted by Fekadu et al. (2020).

## **2. Coping Mechanisms Utilized**

The second objective of this study was to identify the coping mechanisms women employed to manage the psychosocial impact of infertility and its treatment. The findings revealed that women in Addis Ababa relied on three primary strategies: spiritual faith, social support, and cognitive reframing. These strategies were deeply influenced by Ethiopia's cultural, religious, and socioeconomic context.

Spirituality emerged as the most dominant coping mechanism among participants. Nearly all women emphasized the importance of prayer and trust in God as essential to coping with the emotional toll of infertility treatment. Faith provided a sense of meaning, comfort, and hope amid uncertainty, repeated failures, and stigma. This aligns with previous studies showing that religious coping significantly reduces psychological

distress among women undergoing infertility treatment (Luk et al., 2011; Aflakseir & Mahdiyari, 2016; Oti-Boadi & Asante, 2017; Dyer et al., 2004; Fikre et al., 2024).

Spiritual coping was not only a source of inner strength but also a culturally sanctioned way of navigating adversity. In a context where formal mental health services are limited, prayer and religious belief systems function as key emotional resources. These findings reinforce the need for culturally sensitive psychosocial interventions that incorporate or respect spiritual practices.

Support from spouses and family members played a crucial role, though the level and quality of support varied. Some women described their husbands as emotionally supportive and actively involved in treatment decisions, which helped buffer against stress. Others, however, reported marital strain, often triggered by financial pressures or unspoken blame. One participant described distancing herself from her partner after a failed treatment cycle, echoing similar concerns raised in studies from Nigeria and Iran (Odibo et al., 2021; Hasanpoor-Azghady et al., 2014). This dual dynamic is consistent with findings by Inhorn and Patrizio (2015), who noted that infertility in sub-Saharan Africa can both challenge and strengthen marital relationships.

Support from extended family also varied. While some participants received encouragement from parents and siblings, others chose to withhold information to avoid judgment or gossip. These experiences highlight how collectivist social structures common in Ethiopian society can both provide comfort and exacerbate stigma, depending on the level of openness and acceptance within the social network.

Many participants chose to conceal their treatment from others to avoid stigma, unsolicited advice, or intrusive questions about adoption and surrogacy. This coping strategy of secrecy mirrors findings from Fikre et al. (2024), who describe it as a survival mechanism in Ethiopian society, and from Nkengafac et al. (2024), who document similar gendered blame in Cameroon. These experiences underscore how cultural expectations surrounding motherhood intensify the emotional burden of infertility. Unlike Western societies, where voluntary childlessness is increasingly normalized (Greil et al., 2010), Ethiopian women are often judged for not having children, regardless of medical or personal reasons.

In the absence of formal psychological support services, a participant turned to informal networks and online platforms. Internet forums and virtual support groups served as spaces for emotional expression and information-sharing, particularly among women hesitant to discuss infertility publicly. This finding is supported by Malik and Coulson (2010), who observed the role of online communities in enhancing resilience among women facing infertility.

However, the lack of integrated mental health care in fertility clinics left many women dependent on these informal sources. This gap stands in contrast to international recommendations such as those by Gameiro et al. (2022), who advocate for psychosocial services as a core component of infertility care.

Though not a coping strategy in itself, the financial burden of treatment significantly shaped women's coping experiences. Participants frequently cited the high cost of procedures like IVF reaching hundreds of thousands of Ethiopian birr as a major stressor. In a country where most fertility services are privatized, access is limited to those with sufficient financial means. Some women had to borrow money, sell property, or delay treatment to save up, adding to their emotional distress.

These findings align with Boivin et al. (2021), who argue that women in low- and middle-income countries face disproportionate barriers to assisted reproductive technologies due to economic constraints. Addressing these financial obstacles through policy interventions such as subsidized treatment or expanded public services—could improve both access and emotional outcomes for women.

### **3. Influence of Social Systems**

The third objective of this study was to examine how social systems influence women's ability to cope with the psychosocial challenges associated with infertility treatment. In the Ethiopian context, societal expectations and cultural narratives that equate womanhood with motherhood significantly contributed to emotional distress. Many participants reported facing unsolicited advice, judgmental comments, and gendered blame from their communities reflecting a broader cultural tendency to hold women solely responsible for infertility. These findings support Elwell (2022), who noted that

stigma in many patriarchal societies disproportionately targets women, regardless of the medical cause of infertility.

Despite this, the study also revealed positive aspects of social influence. Several participants described receiving strong emotional support from their spouses, which provided a sense of partnership and shared burden during treatment. This contrasts with findings from Nigeria (Odibo et al., 2021), where infertility often resulted in marital conflict, emotional abandonment, or polygamous arrangements. In the present study, supportive partners played a crucial role in helping women remain resilient in the face of repeated treatment failures and social pressure.

This dual experience highlights the complex influence of the microsystem, as theorized by Bronfenbrenner (1979), wherein immediate social environments such as intimate relationships and family structures shape emotional and psychological outcomes. In households where partners and close family members offered understanding and encouragement, women reported greater emotional stability and hope. Conversely, those facing criticism or pressure from extended family, particularly in-laws, experienced heightened distress and isolation.

Support networks also extended beyond the household. Some participants mentioned receiving emotional reinforcement from siblings and, to a lesser extent, from healthcare professionals. Online forums and virtual support groups served as valuable emotional outlets, offering anonymity and connection with others facing similar struggles. These findings echo Malik and Coulson's (2010) study, which identified online communities as effective platforms for sharing experiences and coping with the emotional toll of infertility.

Participants also demonstrated personal agency and psychological endurance through positive reframing and emotion-focused coping. Many spoke of "doing everything possible" and "not giving up," despite years of unsuccessful treatments and financial hardship. These responses illustrate adaptive coping mechanisms that align with Lazarus and Folkman's (1984) stress and coping theory, which emphasizes the role of internal resilience and cognitive strategies in managing chronic stressors.

#### **4. Finding Meaning in the Experience**

The fourth objective of this study examined how women made sense of their experiences and derived meaning while undergoing infertility treatment. Despite facing emotional, social, and financial hardships, almost all participants exhibited remarkable resilience. Rather than being defeated by their circumstances, they framed their experiences as pathways to personal growth and emotional maturity.

This ability to reinterpret suffering aligns with Park's (2010) theory of meaning-making, which suggests that individuals can reframe adverse events in ways that restore purpose and promote psychological resilience. Participants consistently expressed a deep commitment to hope, optimism, and perseverance even after repeated treatment failures and miscarriages. These expressions reflect the transformative potential of adversity when it is processed through a personal or spiritual lens.

A significant number of women drew strength from their spiritual beliefs, viewing infertility as a test of faith or part of a divine plan. For example, one participant spoke about her inner strength despite experiencing multiple miscarriages, emphasizing how the experience had reshaped her sense of womanhood. This narrative echoes findings by Hasanpoor-Azghady et al. (2014) in Iran, where women undergoing infertility treatments often discovered a renewed sense of self-worth through redefined life purposes.

However, this process of meaning-making did not occur in a vacuum. Participants continued to face societal pressure to conform to dominant ideals of womanhood, which are closely tied to motherhood in Ethiopian culture. These cultural expectations often created tension between their personal efforts to find meaning and the external judgments they received from family and community members. As noted by Meskelu and Berhane (2018), such pressures can deepen emotional distress, even as women try to reframe their experiences positively.

## 4.5 Implications

The findings also carry important implications for healthcare providers and policymakers. First, it is essential to prioritize the psychological and emotional well-being of women undergoing infertility treatment. Integrating psychological counseling into fertility care can help women manage the stress, grief, and uncertainty that often accompany the treatment process. Second, economic counseling and support could alleviate the financial burdens that contribute to emotional strain, particularly in contexts like Ethiopia, where treatment is largely self-funded. Third, the development and promotion of public awareness campaigns can play a vital role in reducing stigma and reshaping societal attitudes toward infertility and womanhood.

Importantly, incorporating religious and cultural values into patient-centered care may enhance treatment outcomes and emotional support. Dyer et al. (2016) emphasize the importance of culturally sensitive approaches, particularly in low-resource settings where formal mental health infrastructure is often lacking.

This study's thematic analysis reveals that psychosocial challenges, financial burdens, and coping strategies are intricately connected to Ethiopia's sociocultural fabric. While global research often focuses on clinical outcomes and depression management, this study highlights the central role of spirituality, familial support, and community dynamics in shaping women's emotional resilience. The absence of institutional mental health services in many private clinics, as noted by Gameiro et al. (2022), underscores the urgent need for a more holistic and integrated approach to fertility care.

## CHAPTER FIVE

### CONCLUSIONS, AND RECOMMENDATIONS

#### 5.1 Conclusion

The psychosocial challenges faced by women undergoing infertility treatment in Addis Ababa were multifaceted and deeply rooted in cultural, economic, and gender-based dynamics. The findings emphasize the urgent need for integrated support systems addressing not only the emotional toll of treatment but also the social stigma and financial barriers women face. Public awareness campaigns, affordable treatment options, and culturally sensitive mental health services could significantly alleviate the burden for women navigating the complex landscape of infertility.

women utilized a combination of spiritual belief, social support, secrecy, and online communities to manage the emotional and psychological burden of infertility. These coping mechanisms were shaped by the broader cultural and economic context of Ethiopia, where infertility remains highly stigmatized and access to care is limited. The findings highlight the urgent need for integrated, culturally sensitive psychosocial support systems that consider the intersecting roles of gender, religion, and financial hardship in shaping women's infertility experiences.

While cultural norms often contribute to stigmatization and emotional pain, strong interpersonal relationships and support networks whether familial, medical, or virtual can serve as critical buffers. The data underscore the importance of strengthening these support systems and promoting inclusive, stigma-free environments for women navigating infertility treatment.

Despite the adversity associated with infertility treatment, women demonstrate a profound capacity to find meaning and strength in their experience. Their stories reflect a dynamic interplay between individual resilience and cultural context, offering important insights for improving the emotional and psychological care provided to women facing similar challenges.

### **5.3 Recommendations**

Ministry of Health and policy makers are recommended to establish culturally sensitive psychological counseling within fertility clinics, create standardized protocols that incorporate psychosocial support, ethical counseling and follow-up, particularly in private facilities to support women's emotional well-being throughout treatment. And It is also recommended to develop policies that reduce the cost of infertility treatments (e.g. IVF), making them accessible through public-private partnerships, insurance schemes, or government subsidies.

Infertility treatment centers are recommended to have a special unit to provide counseling service and health care providers should provide emotional support and train clinic staff including doctors, nurses, and counselors on the psychosocial dimension of infertility, cultural competency and promote couple-based counseling and treatment approaches that strengthen spousal support and reduce marital strain.

Civil society is recommended to establish peer support networks that facilitate in person and online support groups where women can share their experiences in safe, non-judgmental spaces. And the public health campaigners & media should initiate national and community-based campaigns to promote accurate information about reproductive health and treatment options

Researchers are also recommended to conduct further research into the long-term psychosocial impacts of infertility and on the experience of women undergoing treatment in low-resource setting and also women who finished their treatment and has a child through ART.

Future research is recommended to include the perspectives of men and couples, explore the long-term psychosocial outcomes of infertility treatment, and conduct comparative studies across different regions and socioeconomic groups in Ethiopia.

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## **ANNEXES**

### **Annex – I: Information sheet for participants in the research study**

**Title of the research:** A Phenomenological study of the psychosocial consequences of infertility treatment and coping mechanisms among women under treatment.

**Name of investigator:** Betelhem Teklu

**Name of the organization:** Addis Ababa University College of Education and Language Studies, School of Psychology.

**Purpose of the research:** This study aims to explore the psychosocial consequences of infertility treatment and the coping mechanisms of women undergoing infertility treatment

**Procedure|:** Women who met the inclusion criteria are welcomed in this study. If you are willing to participate in the study, you will be chosen as one of the participants, and I kindly extend my invitation to you.

#### **Benefits, Risks, and /or Discomfort**

You might find it uncomfortable to describe your pain and feelings when taking part in this study. However, your participation is crucial to study the consequences of infertility treatment and coping mechanisms. Participating in this study carries no risk and offers no immediate advantages.

#### **Right to Refusal or Withdraw**

You have the complete right to decline taking part in this study. Additionally, you have full permission to leave this study whenever you like. And you are welcome to get in touch with me at any time if you have any questions.

## **Annex II: English version of the Interview Questions**

Interview questions are prepared to explore the psychosocial consequences of infertility treatment and the coping mechanisms of women undergoing infertility treatment.

Dear participant,

My name is **Betelhem\_Teklu** I am a graduate student at Addis Ababa University, College of Education and Language Studies, School of Psychology, studying counseling Psychology. I am conducting a study entitled the *psychosocial consequences of infertility treatment and coping mechanisms of women undergoing infertility treatment*. These interview questions are designed to collect data for the indicated research title. The information gathered will be used only for academic purposes in the partial fulfillment of Master of Arts degree in Counseling Psychology. Your response will be kept private and confidential. The study findings should provide a valuable contribution to intervention efforts. Your open and sincere responses are highly appreciated.

I thank you in advance for taking the time to answer these questions

Would you be willing to participate in the study?

\_\_\_\_\_ 1. Yes      \_\_\_\_\_ 2. No

**Name of Researcher: Betelhem Teklu**

**Address: Addis Ababa University, College of Education and Language Studies, School of Psychology.**

**Phone No: +251913657660**

**Email: [teklu.betty@gmail.com](mailto:teklu.betty@gmail.com)**

## **Consent form**

I have been informed, and understand that this study is going to be conducted to explore the psychosocial consequences of infertility treatment and the coping mechanisms of women undergoing infertility treatment. I am informed that the information I give will be kept confidential and will only be used for academic purpose. I am also conscious that I have the right not to respond to any question without my interest. Hence, I agree to participate in the research voluntarily.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### **Part I Socio-Demographic and personal characteristics of the participants**

1. How old are you? (age in years)
2. What is your highest level of education|?
3. What is your occupation or source of income?
4. What is your religion or spiritual affiliation?
5. Duration of marriage?
6. Have you ever been pregnant before? (yes/no, if yes please specify)
7. How long have you been undergoing infertility treatment?
8. What type of infertility treatment are you currently receiving?  
(e.g IVF, hormonal therapy, other)

### **Part II**

#### **Challenges experienced by women undergoing infertility treatment**

##### **Section 1: Emotional and Psychological Consequences**

1. Can you describe how infertility treatment affected your emotional well-being?

2. Can you describe how undergoing infertility treatment has affected your sense of self-esteem, identity, or personal purpose?
3. How do you manage the uncertainty of treatment outcomes (e.g., fear of failure after cycles of IVF)?

## **Section 2: Social and Relational Consequences**

4. In what ways has undergoing infertility treatment influenced your interactions and relationships with your partner, family, or friends? Can you describe any experiences that you have encountered as a result of your treatment?
5. Have you experienced any social and cultural pressures to consider alternatives to infertility treatment? How have these expectations or suggestions from others affected you emotionally or psychologically?
6. Have you found yourself withdrawing from or avoiding certain social events or gatherings because of your experiences with infertility treatment? How has this avoidance impacted your emotional well-being and daily life?

## **Section 3: Financial and Practical Challenges**

7. The cost of infertility can be overwhelming. How has financial strain influenced your decisions about continuing or stopping treatment?
8. Have frequent clinic visits, hormonal side effects disrupted your work, education, or daily routines?

## **Section 4: Coping Mechanisms**

9. What strategies have you used to cope with the stress of treatment?
10. Have you worked with a therapist or counselor to manage emotional distress? If yes, what aspects of support were most helpful?
11. How do you balance hope for success with the possibility of treatment failure?

## **Section 5: Healthcare Experiences**

12. Have healthcare providers addressed your emotional needs during treatment (offering counseling)? If not, what support do you wish they provided?

13. How do you feel about the physical demands of treatment (e.g., hormonal injections, invasive procedures)?

### **Closing Questions**

14. If you could advise healthcare providers on improving infertility care, what changes would you suggest?

15. Is there anything about your experience with infertility that you feel is misunderstood or overlooked?

16. What advice would you give to other women facing similar challenges?