

Family Peculiarities, Social Support, and Acceptance of Child Adoption Among Women with Infertility Attending a Tertiary Hospital in Sokoto, Nigeria

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ABSTRACT

Background: Infertility remains a major reproductive health challenge with profound psychosocial and cultural consequences, particularly in sub-Saharan Africa, where family expectations and societal norms strongly influence women's experiences. Understanding family dynamics, social support, and attitudes toward child adoption is essential for improving infertility care. **Aim:** To assess family peculiarities, social support, and acceptance of child adoption among women with infertility attending a tertiary hospital in Sokoto, northwestern Nigeria. **Materials and Methods:** A hospital-based cross-sectional study was conducted among 156 women with infertility selected using systematic sampling. Data were collected using a structured interviewer-administered questionnaire and analyzed with IBM SPSS version 20. Descriptive statistics were used to summarize the findings. **Results:** The respondents had a mean age of 28.3 ± 6.4 years, and over half (51.9%) were in monogamous marriages. Among women in polygamous unions, fourth wives constituted the largest proportion (51.6%). Secondary infertility was more common than primary infertility (60.7% versus 39.3%). Most respondents reported that their husbands financed infertility treatment (81.1%), while relatives were the predominant source of social support (91.0%). Despite strong family support, the majority of respondents (71.3%) were unwilling to adopt a child, while only 25.4% expressed willingness to do so. **Conclusion:** Acceptance of child adoption was low among women with infertility despite substantial familial and spousal support. Integrating culturally sensitive counselling on child adoption into infertility care, strengthening family-centred psychosocial support, and implementing community-based awareness programmes may improve acceptance of child adoption and enhance the overall well-being of women experiencing infertility.

Keywords: Infertility, Child adoption, Social support, Family structure, Nigeria

INTRODUCTION

Infertility, defined as the inability to achieve pregnancy after 12 months or more of regular, unprotected sexual intercourse, remains a major global public health and reproductive health challenge. It affects millions of individuals and couples across all regions of the world, with the World Health Organization (WHO) estimating that approximately 17.5% of adults, about one in every six people globally, experience infertility during their lifetime. Primary infertility refers to the inability to achieve a first pregnancy, whereas secondary infertility denotes the inability to conceive following a previous pregnancy. Although infertility occurs in both high- and low-income countries, access to timely diagnosis, treatment, and fertility care remains substantially more limited in low- and middle-income countries, where the social and economic consequences are often more severe.¹⁻⁴ In sub-Saharan Africa, infertility continues to account for a substantial proportion of gynaecological consultations

and constitutes an important reproductive health concern. Female infertility is commonly associated with tubal disease resulting from untreated sexually transmitted infections, postpartum and post-abortion infections, while male factors, ovulatory disorders, endometriosis, uterine abnormalities, combined male-female factors, and unexplained infertility also contribute considerably to the burden of disease.^{1,5}

Recent advances in fertility care, increased public awareness, and expansion of assisted reproductive services have encouraged more couples to seek evaluation and treatment in tertiary health facilities, including Usmanu Danfodiyo University Teaching Hospital (UDUTH), Sokoto. Nevertheless, infertility remains associated with considerable psychological morbidity. A previous study conducted among women attending the gynaecological clinic at UDUTH reported that about

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one-fifth of infertile women experienced depression, underscoring the need for comprehensive infertility care that addresses both medical and psychosocial needs.⁶

Beyond its biomedical implications, infertility is increasingly recognized as a major psychosocial stressor that adversely affects emotional well-being, marital relationships, family functioning, and quality of life. Women and couples experiencing infertility commonly report grief, anxiety, depression, low self-esteem, social withdrawal, marital distress, and perceived stigma, with these effects often exacerbated in cultures where childbearing is closely linked to social identity and marital stability.⁷⁻¹⁰ Current evidence suggests that psychological distress is predominantly a consequence of infertility rather than its cause, although the relationship is complex and bidirectional, with emotional distress potentially influencing treatment adherence and reproductive outcomes.¹¹⁻¹⁵ Consequently, contemporary infertility care increasingly advocates an integrated, patient-centred approach that combines medical management with psychological support, counselling, and social interventions to improve overall well-being and treatment outcomes.^{7,11-15}

In many parts of northern Nigeria, particularly among the predominantly Hausa-Fulani Muslim population, childbearing is highly valued, and parenthood remains central to social identity, marital stability, and family continuity. Consequently, women experiencing infertility frequently face stigma, discrimination, social exclusion, marital instability, and pressure from spouses and extended family members. Family characteristics, including marital structure, position within a polygamous union, household socioeconomic status, and the quality of spousal and family relationships, may substantially influence women's coping experiences, access to treatment, psychological well-being, and reproductive decision-making. Likewise, strong social support from spouses, relatives, friends, and healthcare providers has been associated with better psychological adjustment and improved quality of life among women undergoing infertility treatment. In contrast, inadequate support is linked to greater emotional distress and poorer treatment experiences.¹⁷⁻²¹

Child adoption remains an important family-building option for couples who are unable to achieve biological parenthood. However, its acceptance remains limited in many African settings due to deeply rooted cultural, religious, and social beliefs that place a high value on

biological offspring, inheritance, and family lineage. In Sokoto, a previous study reported high awareness of child adoption (74.8%) but low adoption practice (1.2%) and limited willingness to adopt (27.2%). Women with longer duration of infertility, higher educational attainment, and no living children were more likely to accept adoption, whereas many respondents rejected adoption because they believed it could not fulfil their expected role as biological mothers.¹⁶ More recent studies from Nigeria and other low- and middle-income countries similarly report that misconceptions about adoption, concerns regarding family acceptance, inheritance, legal processes, and religious beliefs continue to limit its acceptability despite increasing public awareness.¹⁷⁻²¹ These findings underscore the need for culturally appropriate counselling and community engagement to improve understanding and acceptance of child adoption as a legitimate pathway to parenthood.

Despite increasing recognition of the psychosocial dimensions of infertility, evidence examining the combined influence of family peculiarities, social support, and acceptance of child adoption among women with infertility in northwestern Nigeria remains limited. Most previous studies have focused primarily on psychological distress, quality of life, or knowledge and attitudes toward child adoption without comprehensively evaluating how family dynamics and social support interact to influence adoption decisions within the sociocultural context of infertility.¹⁷⁻²¹ Addressing this knowledge gap is essential for developing culturally responsive interventions that complement biomedical infertility care, strengthen family support systems, and improve the overall well-being of affected women. Therefore, this study assessed family peculiarities, social support, and acceptance of child adoption among women with infertility attending the Gynaecology Clinic of Usmanu Danfodiyo University Teaching Hospital, Sokoto, Nigeria. The findings are expected to inform clinicians, counsellors, programme managers, and policymakers in designing holistic, culturally sensitive interventions that promote psychosocial well-being, strengthen family support, and facilitate informed decision-making regarding child adoption among women living with infertility.

MATERIALS AND METHODS

Study Design, Area, and Population

This hospital-based cross-sectional study was conducted among women with infertility attending the Gynaecology Clinic of Usmanu Danfodiyo University Teaching Hospital (UDUTH), Sokoto, Nigeria, in November 2016.

UDUTH is an 800-bed tertiary healthcare institution located in Sokoto metropolis in northwestern Nigeria. The hospital serves as a major referral centre for Sokoto State and neighbouring Kebbi and Zamfara States, as well as parts of the Republic of Niger. The Fertility Unit, where the study was conducted, is one of the four clinical units within the Department of Obstetrics and Gynaecology, alongside the Oncology, Urogynaecology, and Fetomaternal Units. The study population comprised women diagnosed with either primary or secondary infertility who attended the Gynaecology Clinic during the study period. Eligible participants included all women with infertility, irrespective of the type or duration of infertility or whether they were receiving fertility treatment. Only women who provided written informed consent were enrolled in the study.

Sample Size Estimation and Sampling Technique

The minimum sample size was estimated at 156 using the Cochran formula for a single population proportion for cross-sectional studies,²² based on a 10.9% prevalence of infertile women in a previous study,²³ a precision level of 5%, and an anticipated response rate of 95%. Participants were recruited using a systematic sampling technique. The Gynecology Clinic operates four times a week, with an average attendance of approximately 30 patients per clinic, for a total of about 120 patients per week. Based on the estimated number of eligible attendees and the required sample size, every second eligible woman presenting consecutively at the clinic was recruited over three weeks until the desired sample size was attained.

Data Collection and Analysis

Data were collected using a structured interviewer-administered questionnaire adapted from previously validated instruments.^{10,24,25} The questionnaire elicited information on participants' socio-demographic characteristics, family peculiarities, perceived social support, and acceptance of child adoption. Items assessing family peculiarities, social support, and acceptance of child adoption were rated on a four-point Likert scale ranging from 1 (strongly disagree) to 4 (strongly agree). Experts established the face and content validity of the instrument before the commencement of the study. Reliability was assessed using the test-retest method and demonstrated acceptable consistency. Four medical doctors (House Officers) were recruited and trained as research assistants. The training covered the study's objectives, principles of survey research, ethical conduct, interpersonal communication skills, and the

standardized administration of the study instrument. Following the training, the questionnaire was pretested among 20 women attending the Gynecology Clinic at the Specialist Hospital, Sokoto (another tertiary healthcare facility within the state). The pretest demonstrated that the questionnaire was clear, understandable, and appropriate for the study population; therefore, no modifications were required. Completed questionnaires were reviewed daily for completeness, consistency, and accuracy before data entry. Data were cleaned, coded, and analyzed using IBM Statistical Package for the Social Sciences (SPSS) version 20. Continuous variables were summarized using means and standard deviations, whereas categorical variables were presented as frequencies and percentages.

Ethical Consideration

Ethical approval for the study was obtained from the Ethics Committee of Usmanu Danfodiyo University Teaching Hospital, Sokoto, Nigeria. Administrative permission to conduct the study was obtained from the hospital management. Written informed consent was obtained from all participants before enrolment, and confidentiality, anonymity, and privacy of the information provided were maintained throughout the study.

RESULTS

Respondents' socio-demographic and marital characteristics

All 156 questionnaires administered were adequately completed and included in the analysis, yielding a response rate of 100%. The respondents had a mean age of 28.3 ± 6.4 years, with the largest proportion (65; 41.7%) aged 18–25 years. Most respondents were Muslims (120; 76.9%), while the remaining were Christians (36; 23.1%). Regarding educational attainment, over one-third (59; 37.8%) had tertiary education, followed by those with secondary and primary education. Nearly half of the respondents were full-time housewives (66; 42.3%), while 62 (39.7%) were civil servants. More than half of the women (81; 51.9%) were in monogamous marriages, whereas the remainder were in polygamous unions. Among respondents in polygamous marriages, fourth wives constituted the largest proportion (39; 52.0%), followed by second wives (25; 33.3%), first wives (7; 9.3%), and third wives (4; 5.3%) [Table 1].

Table 1: Respondents' socio-demographic and marital characteristics

Variables	Frequency (%) n = 156
Age group (years)	
18-25	65 (41.7)
26-30	42 (26.9)
31-36	27 (17.3)
≥37	22 (14.1)
Religion	
Christianity	36 (23.1)
Islam	120 (76.9)
Level of education	
No formal education	43 (27.6)
Primary	21 (13.5)
Secondary	33 (21.1)
Tertiary	59 (37.8)
Occupation	
Unemployed	2 (1.3)
Student	13 (8.3)
Civil servant	62 (39.7)
Farming	4 (2.6)
Business	9 (5.8)
Full-time housewife	66 (42.3)
Type of marriage	
Monogamous	81 (51.9)
Polygamous	75 (48.1)
Position in polygamous marriage (n = 75)	
1 st	7 (9.3)
2 nd	25 (33.3)
3 rd	4 (5.3)
4 th	39 (52.0)

Type of infertility and willingness to adopt a child

Of the respondents whose infertility type was documented, secondary infertility was more common, affecting 74 (60.7%) women, while 48 (39.3%) had primary infertility. With respect to child adoption, the majority of respondents (87; 71.3%) reported that they were unwilling to adopt a child. Only 31 (25.4%) expressed willingness to adopt, while a small proportion (4; 3.3%) remained undecided [Table 2].

Table 2: Type of infertility and willingness to adopt a child

Variables	Frequency (%), n = 122
Type of infertility	
Primary	48 (39.3)
Secondary	74 (60.7)
Willingness to adopt a child	
Willing	31 (25.4)
Unwilling	87 (71.3)
Undecided	4 (3.3)

Payment for infertility treatment and sources of social support among respondents

Most respondents (99; 81.1%) reported that their husbands bore the cost of infertility treatment. Eighteen (14.8%) financed their treatment personally, while parents paid for 2 (1.6%) respondents and spouses shared costs for 3 (2.5%) respondents (Figure 4). Regarding social support, almost all respondents (111; 91.0%) identified relatives as their primary source of support during infertility management. A much smaller proportion received support from friends (8; 6.6%), while only 3 (2.4%) reported receiving support from other sources [Table 3].

Table 3: Payment for infertility treatment and sources of social support among respondents

Variables	Frequency (%) n = 122
Payment for infertility treatment	
Husband pays	99 (81.1)
Parents pay	2 (1.6)
By self	18 (14.8)
Cost shared with husband	3 (2.5)
Source of social support	
Relatives	111 (91.0)
Friends	8 (6.6)
Others	3 (2.4)

DISCUSSION

This study assessed family peculiarities, social support, and acceptance of child adoption among women with infertility attending the Gynaecology Clinic of Usmanu Danfodiyo University Teaching Hospital, Sokoto, Nigeria. More than half of the respondents were in monogamous unions despite the predominance of polygamy in the study setting. This finding may reflect the respondents' relatively high educational attainment and the urban, hospital-based nature of the study population. Nevertheless, a substantial proportion of respondents were in polygamous marriages, with many occupying later marital positions, underscoring the continuing influence of infertility on family structure within the sociocultural context of northern Nigeria. In settings where fertility is highly valued, infertility may increase the likelihood of marital strain, remarriage, or polygamy as families seek to achieve biological parenthood.^{17,26} Contemporary African evidence further indicates that women with infertility frequently experience diminished social status, marital instability, and pressure from spouses and extended family members, particularly where childbearing is regarded as an essential expectation of marriage.^{17,25}

Secondary infertility was more common than primary infertility among the respondents, consistent with previous reports from northwestern Nigeria and several other low- and middle-income countries.²⁷ The predominance of secondary infertility has largely been attributed to the persistent burden of reproductive tract infections, postpartum and post-abortal complications, sexually transmitted infections, and limited access to quality reproductive healthcare.^{15,17} Although advances in infertility diagnosis and management have improved reproductive care globally, preventable reproductive tract pathology continues to contribute substantially to infertility in many resource-constrained settings.^{17,26} This finding reinforces the importance of strengthening preventive reproductive health services, early diagnosis, and timely management of reproductive tract infections to reduce the burden of secondary infertility.

One of the most important findings of this study was the high proportion of respondents who were unwilling to adopt a child despite experiencing infertility. Although child adoption provides an important pathway to parenthood for couples unable to achieve biological conception, its acceptance remains limited in many African societies.^{16,28} Recent evidence suggests that deeply rooted sociocultural beliefs regarding biological parenthood, inheritance, family lineage, religious expectations, and concerns about acceptance by spouses and extended family members continue to influence attitudes toward adoption.^{17,28} Women frequently perceive biological motherhood as essential to their identity and marital security, while fears of discrimination and limited family support further reduce willingness to consider adoption.^{16,28} These findings are consistent with recent African literature demonstrating that infertility-related stigma extends beyond the inability to conceive and often influences acceptance of alternative family-building options, including child adoption.^{17,25}

Most respondents reported that their husbands financed infertility treatment, while relatives constituted the principal source of social support. These findings emphasize the central role of spouses and extended family in infertility management within the Nigerian sociocultural setting. Financial support from husbands may facilitate access to fertility care; however, emotional and social support are equally important determinants of psychological well-being and treatment adherence.^{15,25} Recent African studies have shown that supportive spouses and family members enhance coping, resilience,

treatment adherence, and quality of life among women with infertility, whereas inadequate support contributes to depression, anxiety, social isolation, and poorer treatment experiences.^{17,29} Nevertheless, family involvement may also become a source of pressure when expectations regarding childbearing are not fulfilled, highlighting the need for family-centred counselling during infertility management.^{25,29}

These findings highlight the complex interplay between sociocultural context, family structure, and social support in shaping reproductive experiences and decisions among women living with infertility. In many parts of sub-Saharan Africa, including northern Nigeria, childbearing remains central to marital stability, family continuity, and social identity. Consequently, infertility is frequently associated with stigma, psychological distress, social exclusion, and family pressures that disproportionately affect women irrespective of the underlying cause of infertility.^{15,17} Recent reviews have similarly demonstrated that women with infertility in Africa experience considerable emotional, social, and marital challenges driven by cultural expectations regarding motherhood, gender norms, and misconceptions surrounding infertility.^{17,25}

The findings of this study have important implications for clinical practice and public health. Infertility management should extend beyond biomedical treatment to incorporate routine psychosocial assessment, counselling, and culturally sensitive education on infertility and child adoption.^{15,29} Healthcare providers should actively involve spouses and, where appropriate, influential family members during counselling sessions to improve understanding of infertility, reduce stigma, and strengthen supportive family relationships.^{17,25} Community-based awareness programmes addressing misconceptions surrounding infertility and child adoption may also improve acceptance of adoption while reducing discrimination against affected women. Such holistic, patient-centred approaches are increasingly recommended within contemporary reproductive health frameworks to improve the overall well-being and quality of life of individuals and couples living with infertility.^{15,17}

STUDY LIMITATIONS

The findings of this study should be interpreted in light of certain limitations. As a hospital-based study conducted in a single tertiary healthcare facility, the

findings may not be generalizable to all women with infertility in the community or other settings. In addition, the use of self-reported data may have introduced recall and social desirability biases, particularly regarding attitudes toward child adoption and perceived social support. Despite these limitations, the study provides valuable insights into family dynamics, social support, and acceptance of child adoption among women with infertility in northwestern Nigeria, and it also offers a foundation for future multicentre studies in similar settings.

CONCLUSION

This study found a high level of unwillingness to accept child adoption among women with infertility attending a tertiary hospital in Sokoto, despite substantial support from relatives and financial support from spouses for infertility treatment. The findings also highlight the potential importance of family structure and social support within the sociocultural context of infertility management in northwestern Nigeria. Integrating culturally sensitive counselling on child adoption into infertility care, strengthening family-centred psychosocial support, and implementing community-based awareness programmes to address misconceptions surrounding infertility and child adoption may help improve the overall care and well-being of affected women.

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Conflict of interest

None declared.

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