**UNIVERSITY OF HEALTH AND ALLIED SCIENCES**

**SCHOOL OF ALLIED HEALTH SCIENCES**

****

**TRENDS AND PREDICTORS OF GHANAIANS’ ATTITUDES TOWARDS INFERTILITY: A SOCIO-BEHAVIOURAL CROSS-SECTIONAL SURVEY IN THE HO MUNICIPALITY IN 2022.**

**A PROJECT RESEARCH PROPOSAL**

**BY**

**APPIAH BAFFOE PRISCILLA UHAS20185121**

**SENOO GIFTY DZIFA AKU UHAS20181042**

**DEPARTMENT OF MEDICAL LABORATORY SCIENCES**

**JANUARY, 2022**

P. M. B. 31,

Ho, Volta Region,

Ghana.

January 30, 2022

The Chairman,

Research Ethics Committee (REC),

Research Operations Office, Institute of Health Research

University of Health and Allied Sciences

Dear Sir/Madam,

**LETTER OF INTRODUCTION:**

**APPIAH BAFFOE PRISCILLA (UHAS20185121)**

This is to introduce Ms. Appiah Baffoe Priscilla and Ms. Senoo Gifty Dzifa Aku, Medical Laboratory Science students from the Department of Medical Laboratory Sciences in the School of Allied Health Sciences, University of Health and Allied Health Sciences.

As part of their undergraduate study requirement, she shall be conducting a prospective cross-sectional study on the topic **“****Trends and predictors of Ghanaians’ attitudes towards infertility: A socio-behavioral cross-sectional survey in the Ho municipality in 2022”**

The study topic is approved by the supervisor, and the attached protocol has been admitted at the departmental review for onward submission to UHAS-REC for ethical review and approval.

We will therefore be most grateful if we are given the necessary assistance to enable us to conduct the proposed research.

Thank you.

Yours faithfully,

**HEAD OF DEPARTMENT SUPERVISOR**

Dr. Huseini W. Alidu Dr. Hamid A. Wahab Mawuko

Signature…………………… Signature……………………

Date………………………… Date…………………………

P. M. B. 31

Ho, Volta Region

Ghana.

January 30, 2022.

The Chairman

Research Ethics committee (REC)

Research Operations Office, Institute of Health Research

University of Health and Allied Sciences

Dear Sir/Madam,

**SUBMISSION OF PROJECT PROTOCOL FOR ETHICAL CLEARANCE:**

**APPIAH BAFFOE PRISCILLA (UHAS20185121)**

We are Appiah Baffoe Priscilla and Senoo Gifty Dzifa Aku, final year Medical Laboratory Science students from the Department of Medical Laboratory Sciences in the School of Allied Health Sciences, University of Health and Allied Sciences.

As part of our undergraduate study requirement, we shall be conducting a prospective cross-sectional study on the topic “**Trends and predictors of Ghanaians’ attitudes towards infertility: A socio-behavioral cross-sectional survey in the Ho municipality in 2022**”

We will therefore be most grateful if the attached study protocol is ethically approved to enable us to conduct our research.

Thank you.

Yours faithfully,

……………………… …………………..

Appiah Baffoe Priscilla Senoo Gifty Dzifa Aku

**RESEARCH OPERATIONS OFFICE**

**INSTITUTE OF HEALTH RESEARCH**

**UNIVERSITY OF HEALTH AND ALLIED SCIENCES**

**RESEARCH ETHICS COMMITTEE (REC)**

**NEW PROTOCOL SUBMISSION FORM**

**Requirements:**

1. A new protocol must be submitted to the REC **at least three months before** the proposed commencement date of the research to ensure you have clearance before the proposed start date.
2. All sections of this form must be completed and guidelines for submission strictly followed before the protocol can be considered for review.
3. **16 bound copies** of the application dossier (cover letter, completed protocol submission checklist, completed New Protocol Submission Form, the study protocol, and other documentation) should be submitted at the Institute of Health Research by the submission deadline for the month. Printing should be one-sided.
4. A soft copy of your application dossier (cover letter, completed protocol submission checklist, completed New Protocol Submission Form, the study protocol, and other documentation) **as one pdf file** should be emailed to [*rec@uhas.edu.gh*](mailto:rec@uhas.edu.gh)by the submission deadline for the month.





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| --- | --- | --- | --- |
| **1.1** **Title of Study:** | | **TRENDS AND PREDICTORS OF GHANAIANS’ ATTITUDES TOWARDS INFERTILITY: A SOCIO-BEHAVIOURAL CROSS-SECTIONAL SURVEY IN THE HO MUNICIPALITY IN 2022** | |
| **1.2 Principal Investigator (PI)** | | | |
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| **1.4 Proposed Study/Research Information** | | | |
|  | | | |
| Type of Proposal | | **☒** Student Research ☐ Grant Application  ☐ Faculty Research | |
| Student Status *(for student applicants only)* | | ☒ Undergraduate ☐ Masters ☐ PhD | |
| Type of Research/Study: | | ☐ Clinical Trial ☒ Biomedical/Epidemiological Study  ☐ Social Science Research ☐ Others (specify) | |
| Location of Research/Study:  *(Region, District, Towns)* | *Region: Volta Region*  *District(s): Ho Municipal*  *Towns: Ho* | | |
| Duration of Research/Study: | Study Start Date: November,2021  End Date: May,2022 | | |
| Source(s) of Funding:  *(Name, Postal Address, and Email)* | | Department of Medical Laboratory Sciences of University of Health and Allied Sciences | |



*As the Principal Investigator / Co-investigator / Researcher/ Student Investigator on this project, your signature on the proposal confirms that:*

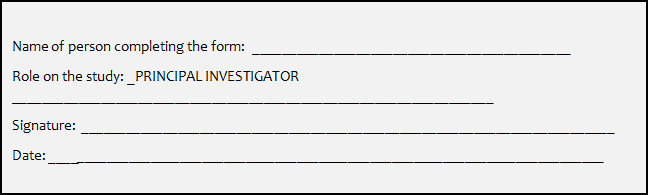
*You will ensure that all procedures performed under the study will be conducted in accordance with all relevant policies and regulations that govern research involving human participants.*

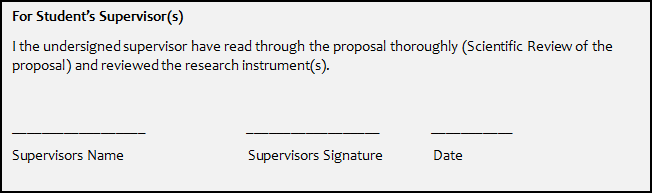
*You understand that if there is any change from the project as originally approved you must submit an amendment to the REC for review and approval prior to its implementation. Where you fail to do so, the amended aspect of the study is invalid.*

*You understand that you will report all serious adverse events associated with the study within seven days verbally and fourteen days in writing.*

*You understand that you will submit progress reports each year for review and renewal. Where you fail to do so, the REC is mandated to terminate the study upon expiry.*

*You agree that you will submit a final report to the REC at the end of the study.*

PP



**UNIVERSITY OF HEALTH AND ALLIED SCIENCES**

**SCHOOL OF ALLIED HEALTH SCIENCES**

**DEPARTMENT OF MEDICAL LABORATORY SCIENCE**



**TRENDS AND PREDICTORS OF GHANAIANS’ ATTITUDES TOWARDS INFERTILITY: A SOCIO-BEHAVIOURAL CROSS-SECTIONAL SURVEY IN THE HO MUNICIPALITY IN 2022**

**BY**

**APPIAH BAFFOE PRISCILLA (UHAS20185121)**

**SENOO GIFTY DZIFA AKU(UHAS20181042)**

**A PROJECT PROPOSAL SUBMITTED TO THE SCHOOL OF ALLIED HEALTH SCIENCES OF THE UNIVERSITY OF HEALTH AND ALLIED SCIENCES, HO, IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF THE BACHELOR OF MEDICAL LABORATORY SCIENCES DEGREE.**

**JANUARY, 2022**

# 

# DECLARATION

We hereby declare that this research proposal is the result of our original work and that no part has been presented for another degree in this university or elsewhere.

**NAME SIGNATURE DATE**

Appiah Baffoe Priscilla ……………………. ……………………..

(UHAS20185121)

Senoo Gifty Dzifa Aku ………………….. …………………..

(UHAS20181042)

Dr. Hamid Abdul-Wahab Mawuko …………………… ....…………………

(Supervisor)

# ABSTRACT

**Background:** Infertility, a condition where couples cannot conceive, continues to be a slow epidemiological sexual and reproductive health challenge. The apparent failure or inability to achieve pregnancy within one year of unprotected sexual intercourse attracts stigmatization on the couples which may result in psychosocial and psychological consequences, and may even lead to suicide. The public health strategies promulgated to prevent and control the sexual and reproductive challenges include public health education on the populance to appreciate infertility as a clinical condition that is treatable and manageable. Lack of baseline information on Ghanaians’ attitudes towards infertility in the Ho municipality makes it very impossible to evaluate the impart of those public health strategies in the Ho municipality. It is therefore essential to conduct a surveillance study on attitudes towards infertility among a cross-section of Ghanaians living in the Ho municipalities. Hence this study is to investigate the attitudes some group of people portray with regards to infertility.

**Aim:** To investigate the attitudes regarding infertility among residents in the Ho municipality regarding infertility**.**

**Methods:** The study is a socio-behavioral surveillance study, designed to cross-sectionally seek information on the participants’ attitudes towards infertility. The Ghanaians living in the Ho municipality shall constitute the study population. Using an online sample size calculator (Raosoft), about 382 study participants shall be recruited on the study through the convenient sampling method. A pretested questionnaire on attitudes shall be used for data collection from consented study participants. A Microsoft basic graphic interphase shall be used for visual data management. The data entry and management entry shall be quality controlled and the clean data shall be exported to STATA software for statistical analysis. The frequency, descriptive and logistic regression statistics shall be used to analyze and report the study outcomes.

**Expected Outcome:** The epidemiological situation on the socio-behavioral attitudes towards infertility among Ghanaians living in the Ho municipality shall be described. Specifically, the socio-demographic and socio-economic trends and predictors of participants attitudes from a scale of poor to excellent attitudes expressed by the participant shall be presented. The implication of the study outcome on policies, programmes and research shall be outlined and discussed. The outcome of this study shall serve as a baseline information on the socio-behavioral attitudes towards infertility among Ghanaians living in the Ho municipality.

# 

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# CHAPTER ONE

# INTRODUCTION

## 1.1 Background

The traditional Ghanaian society is pro-natal, where the ultimate purpose of marriage is to produce children who will continue the name of the family (Osei, 2016). The joy of couples is to have children after marriage since voluntary childlessness cannot be found in the dictionary of the people in Ghana. Childbearing and nurturing are essential events in one’s life span and are positively associated with the ultimate goals of completeness, happiness, and family integration. Therefore human existence can only reach completeness through producing children and fulfilling an individual’s need for reproduction (Eijk, *et.al*, 2015). Infertile couples are pressured strongly from cultural groups, the religion they belong to, and their societies to conceive; thus, making infertility to be taken as a life-threatening crisis (Sexty *et al*, 2016). In Ghana and other parts of Africa, reproductive failures have far social implications where the main reason for marriage is to bear children irrespective of whether they love each other or not (Hammarberg, *et.al*, 2017).

Infertility is the inability to conceive after twelve months of persistent unprotected sex (Abiona, 2015a). Infertility has a high prevalence of 15% to 20% worldwide of which half of the women and 15% of the men interviewed, infertility is one of the most disturbing challenges in their lives (Nguefack, *et al*, 2014). Infertility is a common health problem with devastating psychosocial consequences on the affected couples especially in Africa where women bear the brunt of these societal perceptions in most of the cases (Oladokun *et al*, 2009).

Recently two studies in Ghana reported on the mental health effect of infertility among Ghanaian women (Fledderjohann, 2012; Naab *et al*., 2013). According to these studies, infertile Ghanaian women experience many psychosocial consequences of childlessness such as social stigma, marital instability and many others. Psychologically, the infertile woman exhibits significantly higher psychopathology in the form of tension, hostility, anxiety, depression, self-blame, and suicidal ideation, thus, some individuals facing infertility who cannot withstand the high stigma on childlessness in Ghana also end up taking their own life. (Hammarberg *et al*, 2017). In some cultural settings in Africa, the infertile couples suffer from the conflux of personal, interpersonal, social, and religious

expectations thus bringing a sense of failure to them, and the heartbreaking and devastating aspect of the matter is that these infertile couples are even not allowed to take a lead role in important family functions and events (Oladokun *et al*, 2009). In some settings, the childless couples are often stigmatized, isolated, ostracized, disinherited, and neglected by the family and community which may result in physical and psychological abuse, polygamy, and even suicide (Hammarberg & Kirkman, 2013).

Even though research has highlighted that knowledge is a key factor associated with fertility self-care (i.e. knowledge about one’s fertility potential) and the initiation of treatment (when needed), concludes that education about fertility issues is needed to prevent fear and unnecessary delay in seeking help when faced with infertility problems and reproductive problems (Bunting & Boivin, 2008). Knowledge of fertility health issues will help prevent most infertility cases since more information and advice regarding curable sexually transmitted diseases could reduce the number of cases of infertility, especially in less developed countries where infertility in health issues is often due to infection(Hammarberg *et al*, 2017).

## 1.2 Problem statement

Infertility is a sexual and reproductive health challenge that ought to be elaborated on, to enable appropriate health interventions. In most developing countries, the situation is worse and it has been reported that up to 30% of the couples are infertile. In Africa, the prevalence is as high as 45% because of the high cultural premium placed on childbearing in many African countries including Ghana. Infertility often poses a serious social problem for both genders but women are mostly affected than men although the infertility problem may be caused by the male partner (Abiona, 2015).

Despite these challenges posed by infertility, it is often presumed that infertility is not a problem in resource-poor areas where fertility rates are high (Hammarberg & Kirkman, 2013). The adverse socio-cultural practices in rural communities and poor attitudes toward seeking clinical intervention may compromise any existing public health interventions. Although there is the availability of scientific knowledge on the cause of infertility, lack of model and affordable clinical services worsens the prognosis. Therefore, to effectively manage the high prevalence of infertility in our reproductive population, there will be a need to develop a locally-based tool within the context of public health strategy that is aimed at preventing and controlling infertility among the risk population. To achieve this, it is essential to assess the knowledge, attitude, and practices of infertility among the study population.

## 1.3 Justification

Infertility is a global reproductive health problem that affects both genders (Tabong & Adongo, 2013). The attitudes towards infertility vary based on socioeconomic and demographic distributions. Infertility is of public health importance in many developing nations including Ghana because of its burden within the context of social stigmatization toward people living with infertility. It is perceived and described as a manifestation of one or more pathological conditions either of female or male origin (Araoye, 2003 &Abiona, 2015). Apart from the share size of the problem, it is also well known that infertility in African countries has serious negative effects on women's reproductive health (Abiona, 2015).

This research seeks to explore the attitudes of the people in the Ho municipality about infertility. Effective management of prevalence and perception of infertility; need to develop a locally-based strategy that will aim at preventing and controlling infertility among the risk population. It is therefore essential to determine the level of attitudes of residents in the Ho municipality towards infertility. These shall contribute to an understanding of the public health strategy needed to protect and prevent the stigmatization associated with infertility.

## 1.4 Aim

To study the trends and risk factors associated with poor to excellent attitudes towards infertility among Ghanaians living in the Ho municipality

## 1.5 Specific Objectives:

1. To determine the trends of poor to excellent attitudes towards infertility by the socio-demographic status of the study participants.
2. To determine the trends of poor to excellent attitudes towards infertility by the socio-economic status of the study participants.
3. To determine the socio-demographic risk factors associated with poor to excellent attitudes towards infertility among study participants.
4. To determine the socio-economic risk factors associated with poor to excellent attitudes towards infertility among study participants.

## 1.6 Research Questions

1. What are the attitudes of people towards people with infertility problems?
2. What are the attitudes couples facing infertility portray towards their situation?
3. What are the treatment seeking behavior of couples toward infertility?
4. What are the negative effect of the attitudes towards infertility?

## 1.7 Definition of Terms

**Infertility**: When couples cannot give birth to children after one year of regular unprotected intercourse.

**Attitude:** People's behavior towards people with infertility issues.

**Trends:**

**Predictors:**

# CHAPTER TWO

# LITERATURE REVIEW

## 2.1 Introduction

The literature review entails the following sub-headings; general overview on infertility estimated rates, the attitude of couples facing infertility problems, complications, and treatments, and the effects of infertility among married couples.

## 2.2 General overview on Infertilty:

Infertility has been classified as primary and secondary with the latter being responsible for the majority of the cases in low-and middle-income countries (Sandall, 2007). Also, since reproduction requires the union of male and female gametes, the classification of infertility based on male and female factors has also been in use. Infertility affects millions of people of reproductive age worldwide and has an impact on their families and communities. Some doctors and researchers would say that infertility is becoming an epidemic. Estimates suggest that between 48 million couples and 186 million individuals live with infertility globally. The World Health Organization (WHO), estimates that 8-12% of couples around the world experience difficulty conceiving a child. (WHO, 2018).

In the 21st century, developed countries have recorded lower infertility rate than developing countries. This is because in the developed countries, more light has been thrown on how to deal with infertility so infertility treatment has become more popular as couples looks for ways to start a family. In the developing countries, one in 4 couples in developing countries are affected by infertility. (Walsh, 2021). The notable difference in prevalence between developed and developing countries could be partly due to the poor attitudes and inadequate knowledge they have towards infertility. Also due to large disparities in resources for prevention, diagnosis and treatment of infertility, infertility has been attributed to the variations (Arhin *et al*,2019). Among the various regions in the world, South East Asia and Sub-Saharan Africa countries have the highest prevalence of infertility. (Bongaarts, 2020). In sub-Saharan Africa, the burden of infertility is as high as 30% in some countries (Dattijo *et al*, 2016). Also, estimates in Ghana project infertility as between 11.8-15.8% (Arhin *et al*, 2019). In Ghana, infertility is surrounded by many mistaken beliefs about its causes, such as, witchcraft and possession by evil spirits, and these beliefs negatively affects its management (Abolfotuh *et al*, 2019).

## 2.3 The attitudes of the society towards infertility problems:

Attitudes and awareness towards medical conditions are significant contributors to health-seeking behavior and possible determinants of health disparities. The traditional Ghanaian society is pro-natal where the sole reason for marriages is to produce children who will continue to perpetuate the name of the family (Osei, 2014). The members of the communities recognize childbearing and nurturing as a significant stage in human life but they have inappropriate knowledge about the causes, thereby rendering them to exhibit certain attitudes and as a result of that, it tends to hinder efficient treatment of infertility (Abiona, 2015b).

Various societal attitudes towards the childless were reported. Sometimes people are sympathetic and show concern towards the childless. In most cases, poor attitudes can be negative with all kinds of pressure from the family. Sometimes words and deeds from the childless person’s own family and in-laws might stress the couples. (Donkor, 2008). Current report shows that childless women are frequently stigmatized, isolated, ostracized, disinherited, and neglected by the family and the local community. This may result in physical and psychological abuse which may lead to suicide (Hammarberg & Kirkman, 2013).

Furthermore, infertile couples are often labelled as witches and considered useless and hopeless. In certain situations, some people insulted childless women with infertility especially when there has been a quarrel between them. (Donkor, 2008). Some cultures demand that, for a woman to be socially acceptable, she should have at least one child (WHO, 2010). It was pinpointed out that issues concerning children and parenting could not be discussed with the childless, society always feel that they have little experience in that regard (Donkor, 2008).

In our traditional society where children are indicators of a man’s wealth and prosperity in the community. Men without children therefore do not receive the same respect as fathers (Tabong & Adongo, 2013). Some men reported that they were excluded from leadership roles in their communities because they did not have children. To be able to perform such leadership roles the infertile man will have to undertake certain rituals, thereafter, an undertaker for clan members is allowed to impregnate the infertile man’s wife on the husband’s behalf. However, this does not take away the humiliation and stigma, as the biological fathers in such arrangements are not able to keep this contract secret. The biological fathers in such a partnership are also reported to abuse the women sexually in some instances (Sackey, 2008).

## 2.4 The attitudes of the victimized couples towards infertility:

It has been found out that the cause of a couple's failure to conceive is actually an equal proportion in the gender. In about 50% of cases can be related to either one of the sexes, but the social burden disproportionally falls on women (WHO, 2010). Men who are not conscious of their infertility sometimes divorce their wives, expel them from their houses and take up another if their culture permits polygamy. (Orji, Kuti & Fasubaa 2002). Between August 2013 and October 2013, the Ghana Statistical Service (GSS) and the Judicial Service jointly compiled data of divorce in the High Courts of the Greater Accra Region. The data confirmed our feeling that people hide behind childlessness situations and come out with other reasons to seek for divorce since infertility is not a good ground for Divorce in Ghana. Nevertheless, these data indirectly indicated that infertility and childlessness are probably the most important reasons for divorce in Ghana. (Osei, 2013).

Some couples also revealed that they were considering relocating from their current communities to reduce the insults, intense pressure, stress and stigma. Also, some women revealed maltreatment from their husbands and in-laws (Ofosu *et al*, 2020). Some are bodily harmed; they sustain bruises and experience other forms of domestic violence from their husbands. In other ways, others stated their husbands disclosed their fertility status to their own family members to avoid these family pressuring these women (Abolfotuh *et al*).

## 2.5 Attitudes of the victimized couples toward infertility treatment:

A study in Jakarta revealed that most participant agreed to treat infertile couples, while one in five participants considered that infertility does not need to be treated in East Sumba (96.0% vs 81.8%). Among those believing that infertility does not need to be treated, many stated that infertility is something genetic and congenital and the cause was attributable to God (Harzif *et al*, 2019). Also, majority of the participants in Jakarta answered with respect to treatment, both husband and wife should be investigated. One third of the participants in East Sumba thought that women should be investigated first. (Harzif *et al*, 2019). Again, in Jakarta, treatment options were given to consult medical doctors, witch doctors, self-medicate, or seek other alternative therapies. 36.4% (the majority), preferred to seek help from other alternatives which was traditional massage in lower abdominal and lower back area and only 1% preferred to consult medical doctors (Harzif *et al* 2019).

With respect to treatment sought by infertile couples, various sources of treatments were mentioned. According to Donkor and Sandall (2012), the study participants in Ghana sought to traditional healing including herbal treatments and spiritual medication (including churches). Others consult fetish and few consult to orthodox biomedicine for medical intervention. Some women are deeply convinced of supernatural causes, and so they patronize the services of traditional and religious healers for spiritual redress (Osei, 2013). At present it is very common in Ghana to see women form majority of attendants at prayer camps and other alternative health care sources in Ghana’s pluralistic health context with the aim of looking for a solution to their infertility (Osei, 2013). Several attitude items were also associated with the desire for treatment including the belief that infertility decreases a man's quality of life and that the condition should be treated (Harzif *et al*, 2019).

A study revealed that up to 50% of infertility cases will involve a male factor, and a male factor is the only identifiable one in approximately 20% of couples. Despite this, men are less likely to seek for services and many men from infertile couples do not undergo a male evaluation but the 1% who are aware of their infertility condition generally have a good attitude towards infertility treatment as majority of them perceive infertility treatment to be the responsibility of both couples (Gerhard, 2014). In Africa, most women sought out to traditional sources and few sought to medical sources for help. Sometimes the few who sought to the prolonged period of medical treatment and perceive less benefits of that treatment frequently stop the medication and either change to another form or stop seeking for any treatment (Yakubu, 2015)

## 2.6 Effect of the negative attitudes towards infertility

Infertility could be disappointing and devastating for couples who desire to have a child. Infertility as a source of stress could threaten the mental health of infertile people (Gerhard, 2014). Infertility has psychosocial impacts on couples especially women. In African settings, Infertility is a socially unacceptable condition; leading most infertile couples on a relentless “quest for conception”. Studies have shown that women not only are harassed by the family members but face various forms of marital instabilities (Fehintola, *et al*, 2017). Also, Psycho-social effects of infertility recorded ranged from depression, low self-esteem, frustration, anxiety, hopelessness to actual suicidal attempt. (Hasanpoor-Azghdy *et al*, 2014). Also due to the negative attitudes the society portray towards infertility, it hinders most women from seeking for medical treatment.

# CHAPTER THREE

# METHODOLOGY

## 3.1 Study design:

The study is a socio-behavioral surveillance, and it is cross-sectionally designed to seek information on expression of poor to excellent attitudes towards infertility among Ghanaians living in Ho municipality

## 3.2 Study site

### 3.2.1 Location and Area

The Ho municipality is located between latitudes 6o 20” N and 6o 55” N and longitudes 0o 12’E and 0o 53'E. The Municipality shares boundaries with Adaklu and Agotime-Ziope Districts to the South, Ho West District to the North and West, and the Republic of Togo to the East. Its total land area is 2,361km2 thus representing 11.5 % of the region’s total land area (GSS, 2010).

## 3.3 Population size, structure, and composition

According to the 2010 Population and Housing Census, the population of the Ho Municipality Census is 177,281 representing 8.4 % of the region's total population. Females constitute 52.7 % and males represent 47.3 %. About 62 % of the population resides in urban localities. The Municipality has a sex ratio (number of males per 100 females) of 89.7. The youthful population (population less than 15 years) in the Municipality accounts for 31 % of the population with a small number of elderly persons (population aged 65 years and older). The total age dependency ratio (dependent population to population in the working-age) for the Municipality is 59.0, the age dependency ratio for males is higher (60.7) than that of females (57.4)(GSS, 2010).

 Source: Ghana Statistical Service

**Marital status**

About one-third (35.8 1%) of the population aged 12 years and older are married, 42.8 percent have never married, by age 45-49years, about seventy percent of females (69.6%) %) are married compared to a little below two-third of males (60.1%). At age 65 and above, widowed females account for as high as 57.8 percent while widowed males account for only 13.9 percent, among the married, 11.9 percent have no education while about 3.1 percent of the never-married have never been to school. About 8 out of 10 of the married population (79.3%)) are employed, 2.9 percent are unemployed6 and 17.8 percent are economically not active. A greater proportion of those who have never married (65.7%) is economically not active with 29.4 percent unemployed(GSS, 2010).

**Fertility, mortality, and migration**

The Total Fertility Rate (TFR) for the Municipality is 2.6. The General Fertility Rate (GFR) is 74.4 births per 1000 women aged 15-49 years for the region. The Crude Birth Rate (CBR) is 20.9 per 1000 population. The Crude Death Rate (CDR) for the Municipality is 8.3 per 1000. The majority of migrants (72.7%) living in the Municipality were born elsewhere in the region in Ghana. For migrants born in another region, those born in Greater Accra (38.3%) form the majority followed by Eastern (24.6%) and Ashanti (12.1 %) regions (GSS, 2010).

**Literacy and education**

Of the population, 11 years and above, 90.3 percent are literate whiles 9.7 percent are not literate. The proportion of literate females is higher (51.3%) than that of males (48.7%). 7 out of 10 people (73.8%) indicated they could read and write both English and a Ghanaian language (s). Of the population aged 3 years and above in the Municipality, 9.3 percent have never attended school, 39.4 percent are currently attending and 51.3 percent have attended school in the past (GSS, 2010).

**Occupation**

Of the employed population, about 21.4 percent are engaged as skilled agricultural, forestry, and fishery workers. 26.8 percent are engaged in service and sales while 22.6 percent are into a craft and related trade, and 15.8 percent are engaged as managers, professionals, and technicians (GSS, 2010).

**Employment status and sector**

Of the population 15 years and older, 58.5 percent are self-employed without employees while employees constitute 27.6 percent. Overall, men constitute the highest proportion in each employment category except self-employed (without employees), contributing family workers, and domestic employees. The private informal sector is the largest employer in the Municipality, employing 76.7 percent of the population followed by the public sector (16.1%) (GSS, 2010).

**Economy**

Although an urban area, agriculture is the mainstay of the Ho Municipality's economy. It employs about 70 percent of the economically active labor force. Nearly every household in the Municipality is engaged in farming or an agricultural-related activity. Farming in the Municipality is largely carried out on a small-scale or subsistence basis. The average acreage cultivated ranges between 4-6 acres for all crops. Despite its importance in the Municipality's economy, much of the agricultural potentials in the Municipality remain unutilized. For instance, out of a total of 62,261 hectares of arable land, only 23,167.6 hectares are currently being utilized. The Municipality's irrigation potential also remains untouched. The Municipality's economy is also characterized by a large number of small-scale commercial and industrial activities. These small-scale enterprises and industrial concerns are concentrated in the city center, making it the business hub of the Municipality. People are in various forms of employment both in the public and private sectors. The public service employs 9 percent of the workforce while the private sector (dominated by the informal sector) employs the remaining 91 percent (GSS, 2010).

## 3.4 Study Population

The communities of formal and non-formal sectors shall constitute the study population. While the formal population will be mainly health workers, educationists, and public servants, the informal population shall include both skilled and non-skilled manual workers in Ho municipality.

## 3.5 Sampling Methods

The sampling techniques and procedures shall include;

1. Stratification of study population into respective sections: Here the study population will be divided into different subgroups or strata based on their occupations, then conveniently select the final subjects proportionally from the different subgroups (column 1, Table2)
2. Determination of sample size per section by Raosoft calculator; the Raosoft calculator will be used to calculate the sample sizes of the respective subgroups before the convenient selection of the final subjects is done (column 2, Table 2).

The selection of potential subjects and administration of the questionnaire shall be done conveniently. Thus, the selection of participants shall not be on a random basis, but who (potential study subject) ever pass the inclusion criteria, and he/she is present at the time of sample collection shall be recruited to participate in the study. This is a surveillance kind of study that is okay to use a non-probability method using convenient sampling to obtain the estimated sample size needed to achieve the desire statistical power.

## 3.6 Sample Sizing:

An online sample size calculator with an inbuilt formula (See figure 1) called Raosoft sample size calculator was used to determine the study sample size. The settings in column *‘expected Input’* in table 1 are readjusted to have a 95% confidence interval, 5% margin of error, 50% response distribution, and a population of 80,458, the minimum sample size will be 383.

X= Z(C/100)2r(100-r)

n= Nx/((N-1)E2+x)

E= Sqrt[(N-n)x/n(N-1)]

**Figure 1:** the inbuilt formulae on which the Raosoft calculator operates. Where N is the population size, r is the fraction of responses that you are interested in, and Z(c/100) is the critical value for the confidence level c.

|  |  |  |
| --- | --- | --- |
| Table1: Raosoft sample size calculator interphase (Raosoft, 2004) | | |
| **Raosoft Elements** | **Expected Input** | **Rationale** |
| What margin of error can you accept? | 5% | i\* |
| What confidence level do you need? | 95% | ii\* |
| What is the population size? | X\* | iii\* |
| What is the response distribution? | 50% | iv\* |
| Minimum recommended sample size? | Y\* | v\* |

**Key**

* *X\* = This is where the population size for the group captured in the second column of Table 2 was entered.*
* *Y\*= This is where the calculated minimum sample size will display after entering the population size was inputted.*
* *i\* = The margin of error is the amount of error that you can tolerate. If 90% of respondents answer yes, while 10% answer no, you may be able to tolerate a larger amount of error than if the respondents are split 50-50 or 45-55. A lower margin of error requires a larger sample size.*
* *\*ii= The confidence level is the amount of uncertainty you can tolerate. Suppose that you have 20 yes-no questions in your survey. With a confidence level of 95%, you would expect that for one of the questions (1 in 20), the percentage of people who answer yes would be more than the margin of error away from the true answer. The true answer is the percentage you would get if you exhaustively interviewed everyone. A higher confidence level requires a larger sample.*
* *\*iii= How many people are there to choose your convenient sample from? The sample size doesn’t change much for populations larger than 66,135..*
* *\*iv= If the sample is skewed highly one way or the other, the population probably is, too. If you don’t know, use 50%, which gives the largest sample size.*
* *\*v= This is the minimum recommended size of the survey.*

## 3.7 Sampling strategy

In a previous pre-tested data, the main socio-economic class, known to drive the ‘*awareness’, ‘perception’, and ‘enlightenment’* on sexual and reproductive health issues in our society include health workers, educationists, spiritualists, skill manual and non-skilled manual, and public servants (Lamisi & Mwini-Nyaledzigbor, 2017)**.** To enable us to do comparative analysis among these sections of our society, the study population shall be stratified into four main groups including group 1(informal society); group 2 (Health care providers), and group 3 (Educationist).

|  |  |  |  |
| --- | --- | --- | --- |
| Table 2: Sample size calculation by sections of the study population for Ho municipal | | | |
| Study groups | Estimated population | Percentage %  population | Sample  size |
| 1. Informal Society |  |  |  |
| 1. Skilled manual | **11077** | **16.75** | **64** |
| 1. Mechanics/fitters/welders | 3719 |  |  |
| 1. Construction | 4445 |  |  |
| 1. Transportation & storage | 2913 |  |  |
| 1. Non-skilled manual | **39735** | **60.08** | **229** |
| 1. Farmers (Agric, forestry fish) | 16267 |  |  |
| 1. Wholesale & Retail | 19,749 |  |  |
| 1. Elementary occupation | 3,719 |  |  |
| 1. Health care providers | **6,525** | **9.86** | **38** |
| 1. Physician | 91 |  |  |
| 1. Nurses | 3700 |  |  |
| 1. Public health | 576 |  |  |
| 1. Others | 2158 |  |  |
| 1. Educationist | **5,495** | **8.31** | **32** |
| 1. Lectures (University) | 116 |  |  |
| 1. Tutors (Secondary) | 163 |  |  |
| 1. Teachers (basic) | 5216 |  |  |
| 1. Social & public security | **3,303** | **5** | **19** |
| 1. Public servants | 1651 |  |  |
| 1. Spiritualist/counselors | 551 |  |  |
| 1. Judiciary & associate s | 1101 |  |  |
| Total | **66,135** | **100** | **382** |

## 3.8 Inclusion and Exclusion Criteria

### 3.8.1 Inclusion

The inclusion criteria shall include, individuals ≥18 years of age who are willing to participate in the study voluntarily. These will include both Formal sector workers (Health workers, educationists, security personnel), and Informal sector workers (Farmers, traders, and drivers, etc.).

### 3.8.2 Exclusion

The following category of people shall not be included in the study; people under 18 years of age, people who do not want to participate voluntarily, and individuals who are 18 years and above but not mentally sound**.**

## 3.9 Data collection/ Procedure

Data will be collected using a pretested and structured questionnaire which will contain parameters such as demographic characteristics, socio-economic parameters, and the knowledge participants have on infertility. It will also include parameters on participants' perceptions and beliefs that drive their attitude and practice respectively towards infertility. The main languages for communication will be English language, Ewe, and Twi in the interview and administration of the questionnaire. However, where necessary, other languages aside those already mentioned will be used in which case help will be sought from the appropriate interpreter.

## 3.10 Ethical considerations

Theresearch study protocol would be submitted for ethical clearance from the Research Ethics Committee (REC) of the University of Health and Allied Sciences. Individual consent would also be sought from each participant. The purpose of the study will be explained to each participant who will be encouraged to ask questions so that they would be able to understand the nature of the study and how findings will be disseminated.

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# WORKING PLANS AND SCHEDULE OF ACTIVITIES

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Activity** | **September–November-2021** | **December–January 2022** | **February 2022** | **March-2022** | **April-2022** |
| Proposal Writing |  |  |  |  |  |
| Data Collection |  |  |  |  |  |
| Data Entry and Analysis |  |  |  |  |  |
| Thesis Writing |  |  |  |  |  |
| Thesis Submission |  |  |  |  |  |

# PROPOSED BUDGET

|  |  |  |  |
| --- | --- | --- | --- |
| **ITEMS** | **COST PER ITEM** | **QUANTITY PER ITEM** | **TOTAL** |
| Questionnaire Printing | GH 0.2 | 1500 | GH 300.00 |
| Transportation to study site | GH 5.00 | 5 | GH 25.00 |
| Feeding of researchers on the field | GH 10.00 | 5 | GH 50.00 |
| Workforce | GH 10.00 | 10 | GH 100.00 |
| Internet service | GH 50.00 | 2 | GH 100.00 |
| Chapter Printing | GH 2.00 | 50 | GH 100 |
| Typing | GH 20.00 | 5 | GH 100 |
| **Total** |  |  | **GH 775** |

# QUESTIONNAIRE

**FORM 1: SURVEY QUESTIONNAIRE**

**A: THE PARTICIPANT'S PERCEPTION THAT DRIVES ATTITUDES TOWARDS INFERTILITY**

**CODES**

1. How many children do you have?

None

1

2-3

>3

**ATDI**

2. What is the sex of your child?

Male

Female

Male & Female

Not applicable

**ATD2**

3. Are you under pressure to have a child or more children again?

Yes

No

**ATD3**

4. Do you know any person(s) who suffers from infertility issue?

Yes

No

**ATD4**

5. If question 4 is 'Yes', what is your relationship?

Family

Friend

Others

**ATD5**

**6. WHICH ONE OF THE FOLLOWING WILL YOU CONSIDER THE MOST RISK FACTOR FOR INFERTILITY?**

***choose one only***

Spiritual/Rituals/Curses

Hereditary

Disease (infection, abnormal organs, etc.)

Life style (smoking, alcoholism, hard drugs, poor nutrition, luck of adequate exercise)

**ATD6**

Exposure of occupational hazard and stress

Marrying under age

History of unprotected sex and unsafe abortions

Having under/overweight partner

**7. WHICH ONE OF THE FOLLOWING WILL YOU CONSIDER A MAJOR PROBLEM ATTRIBUTABLE TO INFERTILITY ISSUE?**

***choose one only***

Societal pressure

Family pressure

Blame game

Stigmatization

**ATD7**

**8. WHICH ONE OF THE FOLLOWING LABELS ON INFERTILITY IS MOST ASSOCIATED WITH YOUR COMMUNITY?**

**choose one only**

Victims are labeled as normal people

Abnormal people

Irresponsible

**ATD8**

Spiritually infectious(witches/wizards)

Wicked/evil incarnates

Cursed and bad luck people

**SEXUAL AND REPRODUCTIVE HEALTH STUDY**

**DEPARTMENT OF MEDICAL LABORATORY SCIENCES-UHAS, HO**



**FORM 2: SURVEY QUESTIONNAIRE**

**B: PARTICIPANT'S BELIEF THAT DRIVES ATTITUDE TOWARDS INFERTILITY**

**CODES**

**9. WHO WILL YOU BLAME FOR INFERTILITY IN YOUR COMMUNITY?**

Women

Men

Both couple

Socio-cultural practices

Other

**ATD8**

**10. WHICH ONE OF THE FOLLOWING WILL YOU CONSIDER A BEST OPTION FOR TREATING INFERTILITY**

***choose one only***

To increase sexual frequency

To ensure productive life style & good nutrition

Spiritual consultation & cleansing

To visit a herbal center for herbal medicine

**ATD10**

To visit hospital for medical attention

Others

**11. WHICH ONE OF THE FOLLOWING WILL YOU CONSIDER A BEST WAY TO MANAGE ISSUES OF INFERTILITY?**

***choose one only***

Polygamy

Divorce

Showing compassion to victims

Isolation and neglect

**ATD11**

Public education

Cultural incarceration before and after death

**SEXUAL AND REPRODUCTIVE HEALTH STUDY**

**THE KNOWLEDGE, ATTITUDES AND PRACTICES TOWARD INFERTILITY AMONG**

**GHANAIAN COMMUNITIES**

**DEPARTMENT OF MEDICAL LABORATORY SCIENCES-UHAS, HO**

***Choose one only***



**FORM 3: SURVEY QUESTIONNAIRE**

**C. SOCIO-ECONOMIC INFORMATION**

***choose only one***

**12. EDUCATION**

None

Basic

Secondary

Tertiary

**EDU**

**13. EMPLOYMENT**

Formal

Informal

Studentship

Not-employed

**EMPL**

***choose one only***

**14. FORMAL EMPLOY**

Civil servant

Public servant

Service/Trainee

**FORM**

**choose one only**

**15.PROFESSION**

Health

Educationist

Scientist

Engineering

Clergy/Imam

Accountancy

Law& order

Others

**PROF**

***choose one only***

**16. OCCUPATION**

Physician

Nursing

Allied Health

Public Health

Researcher

Lecturer

Teacher

Skilled manual

Administrative staff

Accountant & clerk

Sale & services

Unskilled manual & Agric worker

**JOB**

***choose one only***

**17. MARITAL STATUS**

Married

Divorced

Single

Other

**MAR**

**SEXUAL AND REPRODUCTIVE HEALTH STUDY**

**DEPARTMENT OF MEDICAL LABORATORY SCIENCES-UHAS, HO**



Other

**FORM 4: SURVEY QUESTIONNAIRE**

**D. SOCIO-DEMOGRAPHIC INFORMATION**

**CODES**

**18. RESIDENCY**

*(I.e., Name of your permanent dwelling place)*

**RESD**

**19. STUDY LOCATION**

*(i.e., where the questionnaire is being administered)*

**LOCA**

**20. GENDER**

Male

Female

**GEND**

**21. AGE. YEARS**

**AGE**

**22. NATIONALITY**

Ghanaian

Not a Ghanaian

**NATI**

**23. IF GHANAIAN, REGION OF ORIGIN**

**REGI**

**24. TOWN OF ORIGIN**

**TOWN**

**25. COMMUNITY LEVEL**

Rural

Sub urban

Urban

**COMI**

**26. ETHNIC ORIGIN**

Akan

Ewe

Ga- Adangbe

Mole Dagbon

Others

**CULT**

**27. RELIGION**

Islam

Christian

Traditional

Others

**RELIG**

**28.PARTICIPANT'S CONTACT NUMBER**

**FONE**

**29. DATE**

**30. STUDY IDENTIFICATION NUMBER**

SRH

**SEXUAL AND REPRODUCTIVE HEALTH STUDY**

**DEPARTMENT OF MEDICAL LABORATORY SCIENCES-UHAS, HO**

*Note: The contact information is to confirm that the study questionnaire where respondent by*

*a true participant and the information provided is not concocted by the field worker.*

*Therefore, your phone number will not be used for any purpose other than for quality control*



# APPENDIX II: PROTOCOL CONSENT FORM

**RESEARCH OPERATIONS OFFICE**

**INSTITUTE OF HEALTH RESEARCH**

**UNIVERSITY OF HEALTH AND ALLIED SCIENCES**

**RESEARCH ETHICS COMMITTEE (REC)**

**PROTOCOL CONSENT FORM**

Section A- **BACKGROUND INFORMATION**

|  |  |
| --- | --- |
| Title of Study: | **THE ATTITUDES OF GHANAIANS LIVING IN THE HO MUNICIPALITY TOWARDS INFERTILITY: A SOCIO-BEHAVIOURAL SURVILLANCE STUDY** |
| Principal Investigator: | **APPIAH BAFFOE PRISCILLA** |
| Certified Protocol |  |

Section B– **CONSENT TO PARTICIPATE IN RESEARCH**

**General Information about Research**

I am a student investigator from the School of Allied Health Science (SAHS), University of Health and Allied Sciences (UHAS). In partial fulfillment for the award of a bachelor's degree in Medical Laboratory Science. I am conducting a project research on the topic: **The attitudes of Ghanaians living in Ho municipality towards infertility: A socio-behavioural study**.”

The study aim is to ascertain the attitudes of the study participants towards Infertility and the effects of these factors on people suffering from Infertility. It is expected that the outcome of the study shall be added information on the existing public health strategy to control and prevent stigmatization associated with infertility. I shall therefore be most grateful if you will participate in this study.

**Expected duration of participant’s participation:**

It is anticipated that it will take you 15 minutes to answer the questionnaire. Permission for the study has been given by Ho Municipal Health Directorate.

**Questionnaires will be used for data collection by the convenience sampling method**

**Benefits/Risks of Benefits**:

Your participation in this study is voluntary, therefore, there shall be no compensation and financial benefits to you as a participant in the study. However, you have the opportunity of sharing your knowledge, and experience which will help improve our understanding of the knowledge, attitude, and practices towards infertility to improve sexual and reproductive health in Ghana. There is no anticipated risk involved in participating in the research. You have the right to withdraw from the study without penalty.

**Confidentiality**

The information that will be collected from you shall be given unique numbers that no one can know that this information is from you. All information taken from you will be used for the study only. If there is a need to use your information for any other purposes, I will come back to you for permission. I cannot also give your information to anyone without your permission or without the permission of those who ensured that will not cause harm to anyone taking part in this study, known as the Research Ethics Committee. Having completed the study, all documentations including the questionnaires that contain your information shall be kept in a cabinet under key and locked for about 10 years after the study. Only the researchers shall have access to your information. To anonymize your identity, your name and other information traceable to your identity shall be removed from the database. Only a study number that shall be known to only the study team shall be maintained throughout the study processes. All information traceable to you shall be kept under lock and key. This information shall neither be disclosed nor transferred to a third party without prior permission from you.

**Compensation**

There shall be no compensation in this study.

**Withdrawal from the study**

Participation is voluntary and participants may withdraw at any time without penalty. No effect if the participant withdraws from the study. Information will be provided to the legal representation of the respondent if it becomes necessary. If the participant voluntarily discontinues the process or become violent during the cause of administering the questionnaire.

**Contact for Additional Information**

In case of any questions or clarifications on this study, you can contact the principal investigator below,

In case of any questions or clarifications on this study, you can contact the principal investigator below,

1. Appiah Baffoe Priscilla, P.O.Box 194, Koforidua, 0551746930, appiahpriscilla093@gmail.com
2. You can also contact the supervisor, Dr. Hamid .A. Wahab Mawuko, P.O Box 31, University of Health and Allied Sciences, 0549032136, [whamid@uhas.edu.gh](mailto:whamid@uhas.edu.gh)

If you have any questions about your rights as a research participant in this study you may contact the Administrator of the Research Ethics Committee, IHR, University of Health and Allied Sciences at rec@uhas.edu.gh or +233- 362-196-193.

**Participant’s agreement**

I certify that I have read or have had someone read all of the above to me. I have had the opportunity to ask questions about all areas of the study I did not understand and I have received answers to my satisfaction. I am willing to give consent to participate in this study. I understand that I have the right to withdraw myself from the study at any time without my decision affecting me in any way.

Participant’s name: ----------------------------------------------------------------------------------

Telephone no. of participant…………………………………………

Signature/Left thumbprint of participant----------------------------------

Date: --------------------------- [dd /mm /yyyy]