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Research Article

Knowledge, Attitudes and Socio-Demographic Factors Associated with Males' Involvement in Fertility Treatment in Ghana

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ABSTRACT

Background: Infertility in developing countries often raises distinct and complex issues as compared to developed countries. Infertility affects an estimated 15% of couples globally with several socio-cultural implications. Many studies have reported that, males have poor health seeking behaviour when it comes to infertility treatment as they do not involvement themselves strongly due to varied factors. Therefore, this paper sets the pace by exploring how knowledge level, attitudes of men and their socio-demographic backgrounds influence their involvement in infertility treatment in Ghana. The paper was underpinned by the ancient Social Learning Theory which is still instrumental in modern social science research.

Methods: The study adopted a quantitative approach using a cross-sectional study design. The study population was married men selected using a simple random sampling technique from 8 clustered demarcation to obtain 423 respondents using the formula $N=z^2pq/d^2$. A structured questionnaire was administered and data were analysed using STATA 15. Statistical significance for all testing was set as $p<0.05$ with 95CI.

Result: The study found that, the mean age for the participants was 38.35 ± 0.48 and 92.67% were involved in monogamous marriage. Again, 57.45% had secondary/vocational education, 97.40% active employment with greater number of them earning less than GHC 600. It was noted that 84.16% of respondents agreed that, female partners are always the cause of childlessness in an infertile relationship. Misconceptions on infertility being caused by witchcraft, curses, or other supernatural powers were also noted (58.39%). It was also found that, married men in polygamous marriages were 6 times more likely to be involved in a fertility treatment than married men in monogamous marriages (Adjusted OR=6.210, 95%CI=3.153-7.232). Moreover, married men with primary and tertiary education were 0.517 less likely (Adjusted OR=0.517, 95%CI=0.319-0.819) and 0.597 less likely (Adjusted OR=0.597, 95%CI=0.153-0.732) to be involved in fertility treatment respectively as compared to those with secondary education. Again, married men who were employed were 3 times more likely (Adjusted OR=3.331, 95%CI=2.193-3.304) to be involved in infertility treatment as compared with those who are self-employed. Moslems were 4 times more likely (Adjusted OR=4.036, 95%CI=1.420-4.304) to be involved in infertility treatment as compared to Christians. Finally, traditionalists were 0.331 less likely (Adjusted OR=0.331, 95%CI=0.193-0.364) to be involved in infertility treatment as compared to Christians.

Conclusion: The study concludes that, fertility declines with age coupled with factors such as the consumption of excessive alcohol, use of anabolic steroids, untreated sexually transmitted diseases, excessive stress, and among

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others. Also, the general attitudes of men towards infertility treatment were good as majority of them perceive infertility treatment to be the responsibility of both couples. However, the ability to achieve this orientation is positively influenced by the males' socio-demographic factors such as marriage type, level of education, employment status and religious inclinations towards infertility issues.

Recommendation: The study recommends that, men should seek for infertility treatment together with their wives so that it can be wholly managed for the couples. Again, the National Health Insurance Scheme in Ghana (NHIS) should cover infertility treatment and the charges of Private Fertility Treatment Centres should be regulated to prevent them from charging exorbitant fees. Moreover, educational forum on issues related to infertility and fertility should be undertaken by the community health unit of District Hospitals to sensitize the public.

Keywords: Knowledge, Attitudes, Socio-Demographic Factors, Males Involvement, Fertility Treatment, Ghana

BACKGROUND

Infertility in developing countries often raise distinct and complex issues as compared to developed countries [1,2]. Several literature reviews have indicated that, research on fertility treatment focused solely on women and this has been attributed to the fact that women are generally perceived to be the centre of infertility causes [3]. Infertility affects an estimated 15% of couples globally, resulting to 48.5 million couples [4]. Infertility is defined by the WHO as "the inability of a sexually active couple, who are using no form of contraception, to conceive after one year of regular sexual intercourse" [5]. Several authors have revealed many findings on infertility studies [6,7]. Most of these studies identified that, socio-cultural factors such as cultural dominance and the generational gap among family members positively contributed to males' involvement in fertility treatment. Other authors have also reported on how males are involved in reproductive health services such as family planning and maternal health [8-10]. Even though men are strongly involved in decision-making regarding child birth and contraceptive choices other studies have reported that, men do not involvement themselves strongly when it comes to their own infertility treatments [11-13]. Remote underlying issues for this trend of non-involvement of males in infertility treatment is not known especially in Ghana. Therefore, this paper sets the pace by exploring how knowledge level, attitudes of men and their socio-demographic backgrounds influence their involvement in fertility treatment in Ghana.

Knowledge of male infertility may include risk factors, prevention, signs of infertility, and available treatment option [14,15]. Good knowledge on male infertility may improve precaution through lifestyle changes. In a study conducted in Ghana, with a sample of 2000 respondents, 53.5% of the respondents could not identify any cause of infertility [6]. Similarly, Umelo et al., reported that only 9.5% of their 400 respondents had good knowledge of infertility [16]. Therefore, the problem of males' inadequate knowledge of infertility has been a social problem patterned across sub-regions [17-19].

Even though inadequate knowledge of males has been reported above, one contrary study results has been found. For instance, the study of Bassey et al., reports that, 90% of the 146 respondents in Nigeria had adequate knowledge on infertility and the various fertility treatments options available [20].

On the knowledge level, respondents have attributed infertility to supernatural causes, black magic, continued use of contraceptive pills, biological disorders and other lifestyle behaviours [18,21]. Equally, other respondents have good knowledge of infertility treatment options such as undertaking physical exercise, quitting excessive smoking, healthy dietary practices, reducing alcohol intakes, consulting fetish healers, surgery and among others [18,22].

In other studies, socio-demographic factors such as age, religion, educational status, type of marriage, ethnic orientation, systems of inheritance among others have been reported to influence the level of knowledge of married men, their attitudes and involvement in infertility treatment [23,24].

Theoretical framework

This study was underpinned by the Social Learning Theory (SLT) propounded by Bandura Albert in 1977 [25]. The SLT emphasizes the importance of observing and modelling the behaviours, attitudes, and emotional reactions of others coupled with motivation for an action to occur. Social learning theory explains human behaviour in terms of continuous reciprocal interaction between cognitive influences (knowledge, information flow, perceptions, misconceptions, among others), behavioural influences (attitudes, mannerisms, habits, actions, an among others), and socio-environmental influences [place of stay, social interactions, social-demographic factors (age, gender, marital status, wealth status, occupational status, religious affiliations, ethnic orientation, among others). The social learning theory is applicable for our study on knowledge, attitudes and social demographic factors influencing males' involvement in infertility treatment due to its strong manifestation of aggression, psychological disorders, and the need for motivation when couples are unable to bring-forth children [26]. The SLT therefore espoused that, behaviour modelling is very essential for an action to occur and that collaborates the efforts needed for males to get involved in infertility treatment.

Much important to this study is the 2nd principle of SLT. This principle states that, "Individuals are more likely to adopt a modelled behaviour if it can result in outcomes they value". Actions of men towards infertility have socio-cultural implications in some societies in sub-Saharan Africa including Ghana [27]. Males may begin infertility treatment when they are sure the outcomes would be the value they have cherished for in life (Children). The Social learning theory is therefore a useful tool for social workers, public health workers, psychologists, and among others to employ when assessing and assisting clients. This theory can often help identify and treat the identifiable causes of certain human behavioural tendencies such as males' orientation to sensitive issues like infertility.

METHODOLOGY

Study type and design

The study was quantitative using cross-sectional study design conducted in Ashanti Region of Ghana in the year 2020.

Study population

The study population involved males in their reproductive ages of 18 and 60 years who were married men or cohabiting with their partners living in eight (8) major communities in Ghana.

Inclusion and exclusion criteria

All men between 18-60 years of age and married or cohabiting with their female partners were included. The exclusion was made up of all females, males who were not married as well as males who were less than 18 years or more than 60 years of age.

Sample size and sampling method

A sample size of (423) people was calculated by using a general proportion of 50% with 95% Confidence interval and an allowable margin of error of 5%. The study used the sample size formula: $N=z^2pq/d^2$, Where, [(N=sample size, Z=is a constant, with 95% confidence level (1.96). Again, P=estimated prevalence of adults with the characteristics under study, q=(1-p) where the general proportion of 50%, was applied and transformed to Pq=[(0.5) (1-0.5)]. We also defined d=statistically tolerated error (0.05).

Sampling method

A multi-stage sampling technique was adopted for this study. At the primary stage, three Municipalities were purposefully selected. Then we used simple random method to select 1 out of the 3 Municipalities. Adopting a stratified sampling technique, the selected Municipality (Ejisu) was clustered into eight strata. Criteria for the strata were on the basis of the population of the town and closeness or farness from the Municipal capital (Ejisu). At the third stage, simple random sampling technique was used to select proportional number of men who meet the inclusion from each of the clusters. This was done by spinning a pen at the centre of the community, the household where the pen's head pointed to was the starting point for the research team where males who met the inclusion criteria were selected and interviewed. The same procedure was repeated in the other community till the required sample for each community was attained.

Data collection technique and tools

Primary data was gathered with the use of structured questionnaires and was administered to consented people during the field work session. The questionnaire was prepared in English and administered in Twi language, which is the most widely spoken and understood language in the communities.

Data handling and analysis

Data collected from the questionnaire was double-checked, cleaned, entered into an excel spread sheet and then was transferred to the statistical software (STATA)15. The descriptive data were presented using frequencies, percentages, tables and charts. Multivariate regression analysis was performed to establish reproductive characteristics of married men influencing male involvement in fertility treatment. Statistical significance for all testing was set as $p<0.05$.

Ethical consideration

Ethical approval was sought from the Committee for Human Research, Populations and Ethics (CHRPE), Kwame Nkrumah University of Science and Technology. Again, respondents' ethical issues such as consent, confidentiality, the right to withdraw from the interview process, the leverage of not answering uncomfortable questions and prior counselling of respondents due to the sensitive nature of the study (Infertility) were adhered.

Limitations

The study did not do prior listing and numbering of households with married men or cohabitation. This process would have had implications for the sampling frame. Therefore, the population of married men or men co-habiting with their partners in each community was unknown, hence the sample size (423) was divided amongst the eight communities. Again, the study focused on using quantitative approach only instead of adding qualitative approach to evaluate views of the participants and throwing more light on the quantitative variables. The qualitative variables could have offered explanatory notes on the quantitative outcomes.

RESULTS

Socio-demographic characteristics of participants

Table 1 clearly shows that the mean age for the participants was 38.35 ± 0.48 where majority of the respondents (92.67%) were involved in monogamous marriage. In terms of the educational background, more than half of the respondents (57.45%) had secondary/vocational education and 6.62% had no formal education. With respect to the employment status, majority of the respondents (97.40%) were employed with employment categories of 16. 70% and 83.30% in the formal and informal sectors respectively. With regards to the religion, majority of the respondents (82.03%) were Christians while 14.18% of them were Muslims, 2.13% of them were Traditionalists and 1.65% of them belonged to other religions. Most of the respondents (37.83%) received a monthly salary of less than GH 600 while 34.99% of them received between GH 600 and 1,000 with 1.89% of them receiving GH 3,0001 and above. Most of the participants, representing 63.59% belonged to the Asante ethnic group with the Nzemas being the least.

Level of knowledge on fertility treatment

As detailed in Table 2, majority of the respondents (89.83%) agreed that, untreated sexually transmitted diseases can affect fertility. Majority of the respondents (80.61%) were in agreement that frequent exposure to heat may affect sperm production. With regards to extreme exposure to environmental factors affecting fertility, majority of the respondents (73.52%) were affirmative. Majority of the respondents (72.10%) agreed that drinking of alcohol affects fertility. Moreover, 69.74% of respondents agreed that, anabolic steroids can influence fertility. Also, 64.30% of respondents admitted excessive stress may affect fertility. Majority of the respondents (63.12%) believed that tobacco and marijuana affect fertility. Moreover, about half of the respondents agreed that, fertility in men declines after 40 years and more than half (50.12%) knew the correct definition of infertility.

Knowledge on treatment options by participants

Figure 1 presents the various treatment options for infertility. A total of 341(80.61%) respondents agreed that they would undertake

Table 1: Socio-demographic characteristics of participants (Source: Authors' survey, 2020).

Characteristic	Frequency (n=423)	Percentage (%)
Age (Mean ± S.D)	38.35 ± .48	
Marriage Type		
Monogamy	392	92.67
Polygyny	31	7.33
Educational Background		
Primary	86	20.33
Secondary/ Vocational	243	57.45
Tertiary	66	15.6
No Formal Education	28	6.62
Employment Status		
Employed	412	97.4
Unemployed	11	2.6
Occupation		
Formal Organization (Public	68	16.7
Service Worker		
Informal Organization	355	83.3
Monthly Income		
Less 600	160	37.83
600-1000	148	34.99
1001-3000	107	25.3
3001 and above	8	1.89
Religion		
Christianity	347	82.03
Islamic	60	14.18
Traditionalism	9	2.13
Other	7	1.65
Ethnic Group		
Asante	269	63.59
Fante	37	8.75
Ewe	41	9.69
Nzema	4	0.95
Dagomba	10	2.36
Others	62	14.66

Table 2: General knowledge on fertility by participants (Source: Authors' survey, 2020).

Variables	Category (Yes Responses) [N= 423 (100 %)]
Correct definition of Infertility	212 (50.12%)
Fertility in men declines after 40 years.	221 (52.25%)
Fertility in women declines with increasing age.	311 (73.52%)
Tobacco and Marijuana affect fertility.	267 (63.12%)
Drinking of alcohol affects fertility.	305 (72.10%)
Extreme exposure to certain environmental factors can affect fertility.	311 (73.52%)
Frequent exposure to heat and long driving hours on a hot seat may affect sperm production.	341 (80.61%)
Anabolic steroids taken for bodybuilding or sporting purposes can affect fertility.	295 (69.74%)
Mumps in early childhood can affect fertility in males.	137 (32.39%)
Untreated sexually transmitted diseases can affect fertility.	380(89.83%)
Male partner can contribute significantly to the state of childlessness among couples.	356 (84.16%)
Excess stress contributes to fertility.	272 (64.30%)

regular examination and treatment of disorders, 279(70.38%) opted for home-made herbal concoction, 132(68.79%) respondents preferred usage of aphrodisiac drug, 162(38.30%) of respondents agreed to perform in-vitro fertilization, with 114(26.95%) respondents affirming the use of over-the-counter drugs.

Misconceptions on infertility by respondents

As shown in Figure 2, majority of respondents (84.16%) agreed that, female partners are always the cause of childlessness in an infertile relationship. As in family planning been the cause of infertility, 79.91% of respondents were affirmative. As a treatment option for infertility, majority of the respondents (61.23%) consented that they trust God's timing for their own children. Again, the study found that, 58.39% of respondents believed that, infertility is caused by witchcraft, curses, or other supernatural causes. Most of the respondents (81.32%) believed that, there is the need for one to seek for fertility treatment though they can perform sexually well. Moreover, 64.30% of the respondents asserted that, having a child in the past does not deny the fact that, infertility can exist in the man.

Attitudes of married men on fertility treatment

As detailed in Table 3, majority of the respondents (96.45%) agreed that males should be part of the fertility treatment when experiencing infertility. Majority of the respondents (95.98%) believed that, one should seek for medical help with regards to infertility and also from the table, majority of the respondents (85.11%) are of the view that they would consider infertility treatment as an option if they were unable to give birth naturally. Majority of the respondents (81.09%) agreed that they can have a child and may be infertile a year later. With regards to infertility been a concern to the man and the wife, majority of the respondents (82.03%) agreed that, it should be a concern to both.

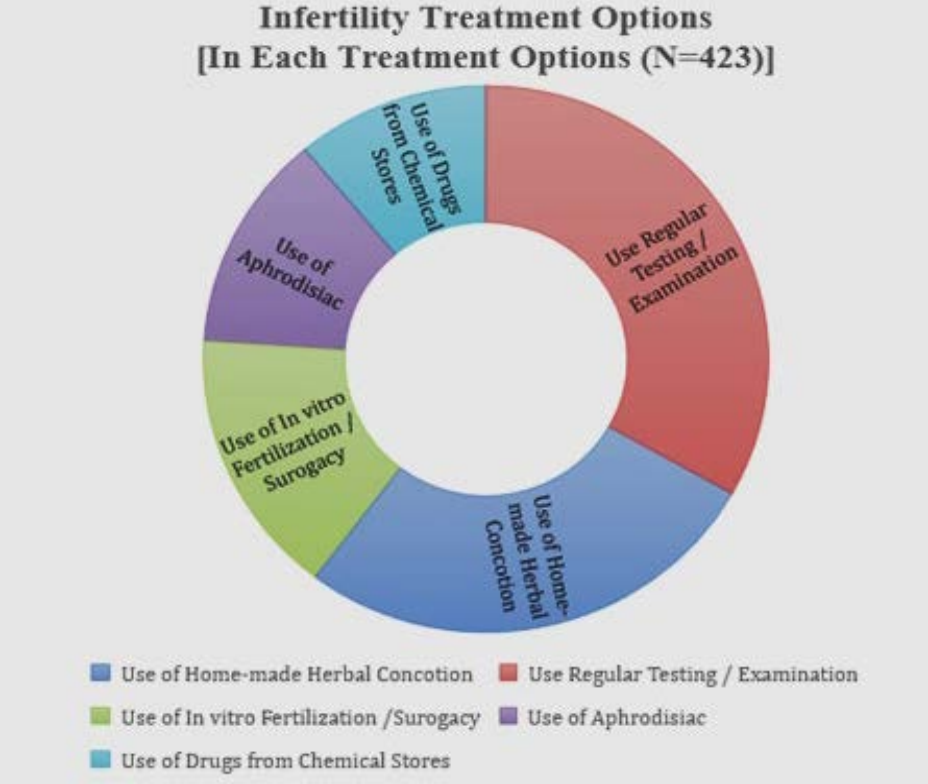

Figure 1: Knowledge on treatment options by participants (Source: Authors' survey, 2020).

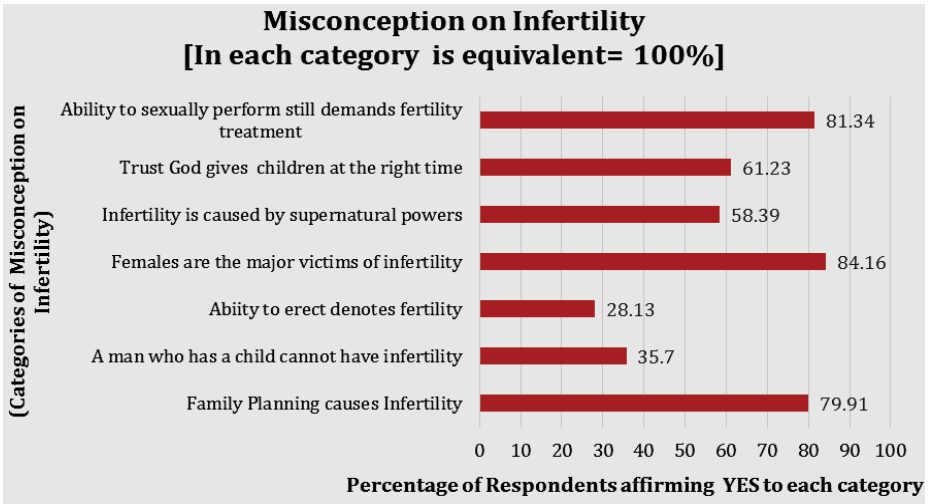

Figure 2: Misconceptions on infertility by participants (Source: Authors' survey, 2020).

In seeking for fertility treatment together with wife, majority of the respondents (66.67%) agreed that they wouldn't seek for fertility treatment together. Also, the study found that only few respondents 34(8.04%) agreed that cultural practices were hindrance in seeking for infertility treatment in men. Majority of the respondents (84.40%) believed that religion is not a hindrance in seeking for fertility treatment for infertile men.

Attribution, concern and health seeking behaviour for infertility

As shown in Figure 3, more than half of the respondents (55.56%) agreed that infertility is firstly attributed to both couples whereas the rest of the respondents (38.30%) and (6.15%) believed that it is attributed to the wife and to the male respectively. More than half of the respondents (55.56%) agreed that the couple should seek for fertility treatment. Interestingly, majority of the respondents (89.19%) agreed that infertility should be the concern of women rather than males.

Socio-demographic factors influencing males' involvement in fertility treatment

In univariate and multivariate regression analysis, the results depict that socio-demographic characteristics such as marriage type, level of education, employment status, religion, income status, and ethnic orientation were more likely to be determinants for males' involvement in fertility treatment as indicated in Table 4. For instance, married men in polygamous marriages were 6 times more likely to be involved in a fertility treatment than married men in monogamous marriages (Adjusted OR=6.210, 95%CI=3.153-7.232). Also, married men with primary and tertiary education were 0.517 less likely (Adjusted OR=0.517, 95%CI=0.319-0.819) and 0.597 less likely (Adjusted OR=0.597, 95%CI=0.153-0.732) to be involved in fertility treatment respectively as compared to those with secondary education. Again, married men who were employed were 3 times more likely (Adjusted OR=3.331, 95%CI=2.193-3.304) to be involved in fertility treatment as compared with those who are self-employed. Moslems were 4 times more likely (Adjusted OR=4.036, 95%CI=1.420-4.304) to be involved in fertility treatment as compared to Christians. Finally, traditionalists were 0.331 less likely (Adjusted OR=0.331, 95%CI=0.193-0.364) to be involved in fertility treatment as compared to Christians.

Table 3: Attitudes of married men on treatment (Source: Authors' survey, 2020).

Variables	*Yes Answer Category [N= 423 (100 %)]
Cultural practices as a hindrance in seeking for fertility treatment for infertility in men	34 (8.04%)
Religion as a hindrance in seeking for fertility treatment for infertility in men	66 (15.60%)
One should seek for medical help with regards to infertility	406 (95.98%)
Males should be part of the fertility treatment when experiencing infertility	408 (96.45%)
Would you consider infertility treatment as an option in case you are unable to give birth through natural means?	360 (85.11%)
You can have a child and may be infertile a year later.	343 (81.09%)
If No does it means you won't seek for fertility treatment together with your wife?	50 (66.67%)
Infertility should be a concern to both man and wife	347 (82.03%)

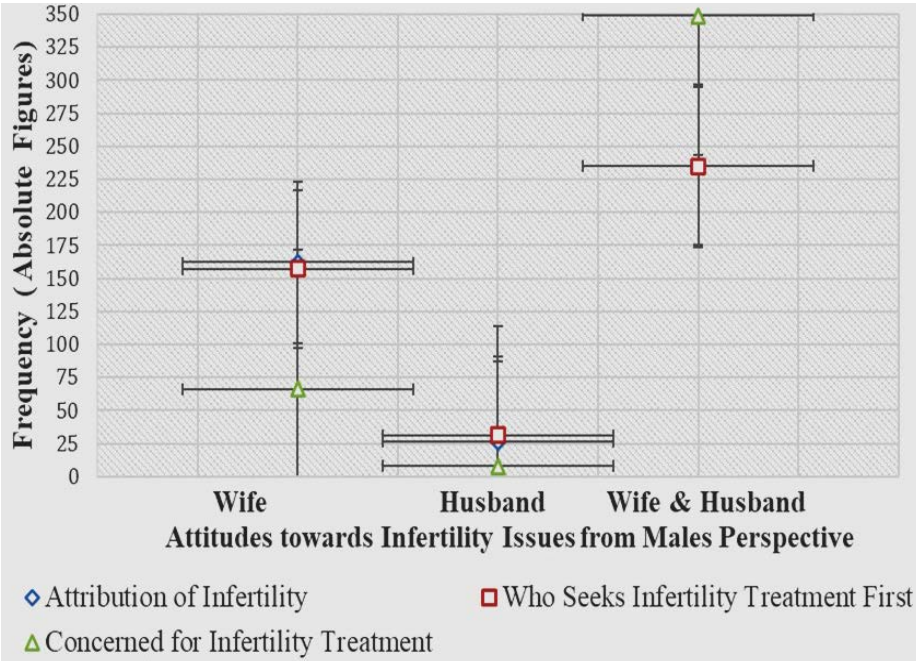

Figure 3: Attribution, concern and health seeking behaviour for infertility (Source: Authors' survey, 2020).

Table 4: Socio-demographic factors influencing male involvement in fertility treatment (Source: Authors' survey, 2020).

Variables	Univariate Logistic Regression			Multivariate Logistics Regression		
	Odd Ratio	95% Confidence Interval	p-value	Adjusted Odd Ratio	95% Confidence Interval	p-value
Marriage Type			[0.00]			0
Monogamy	Ref			Ref		
Polygyny	6.194	(3.114 – 7.201)	0.02*	6.21	(3.153 – 7.232)	0.04
Highest Level of Education			[0.01]			
Second/Voc.	Ref			Ref		
Primary	0.392	(0.113 – 0.418)	0.01*	0.517	(0.319 – 0.819)	0.02*
Tertiary	0.429	(0.332 – 0.720)	0.01*	0.597	(0.153 – 0.732)	0.02*
Employment Status			[0.04]			
Self-employed	Ref			Ref		
Employed	4.118	(2.097 – 4.230)	0.00*	3.331	(2.193 – 3.364)	0.00*
Occupation			[0.09]			
Public Service	0.284	(0.091 – 1.323)	0.04*	0.369	(0.197 – 1.005)	0.03*
Worker						
Trading	0.403	(0.042 – 1.007)	0.02*	0.569	(0.338 – 1.702)	0.01*
Monthly Income			[0.12]			
Less than 600	Ref			Ref		
3001 and above	0.121	(0.058 – 1.388)	0.04*	0.345	(0.147 – 0.446)	0.04*
Religion			[0.03]			
Christianity	Ref			Ref		
Islamic	4.022	(3.041 – 5.117)	0.02*	4.036	(1.420 – 4.304)	0.00*
Traditionalism	0.118	(0.097 – 0.230)	0.00*	0.331	(0.193 – 0.364)	0.02*
Ethnic group			[0.29]			0.1
Asante	Ref			Ref		
Ewe	0.648	(0.332 – 0.720)	0.01*	0.697	(0.153 – 0.232)	0.00*
Nzema	0.792	(0.413 – 0.818)	0.02*	0.817	(0.319 – 0.819)	0.00*

Note: *$p < 0.05$; OR significant at 95% CI; OR (95% CI), unadjusted odds ratio from simple logistic regression with Accompanying 95% confidence interval; aOR adjusted odds ratio determined using multiple regression. –n2 log likelihood = 144.231; Cox & Snell $R^2 = 0.170$; Nagelkerke $R^2 = 0.314$.

DISCUSSIONS

The mean age for participants was 38.35 ± 0.48 with most of the participants involved in monogamous marriage. Most of the respondents were in their middle adulthood stages (31-45) years per the age classification of Erickson [28]. The formal education obtained by the participants guaranteed their perceived heightened knowledge in fertility issues. Majority of the respondents are in the informal sector because more than half of the participants have their education up to the secondary level and most of them make an income within the range of 600-1000 Ghana cedis.

In this study, it was identified that, participants had good knowledge on infertility. Participants agreed to the fact that, fertility declines with age, consumption of alcohol and anabolic steroids, untreated sexually transmitted diseases, excessive stress, frequent and extreme exposure to hot conditions. However, participants had poor knowledge with the fact that, the contraction of mumps at early childhood could affect the fertility in men. Findings are similar to that identified by Bassey et al., who found that married men have good knowledge in fertility issues [20]. On the contrary, findings are inconsistent with that identified by Geelhoed et al. and Umelo et al., who recorded that 46.5%, and 9.5% respectively have some level of knowledge on infertility [6,16]. Having knowledge on male infertility goes a long way to helping individuals preserve their fertility [15]. Good knowledge on male infertility therefore encourages for lifestyle changes and taking precaution to prevent male infertility.

With regards to treatment options for fertility, participants in the current study had good knowledge on the treatment option to undertake when facing infertility with the choice of hospital being the most preferred as reported. However, respondents asserted they would settle on home-made concoctions if the hospital treatment was expensive or ineffective. Usually, in our part of the world, inability to meet health care cost without health insurance compels people to opt for unorthodox means for accessing health care services. The fertility treatment options usually adopted by married men are physical exercises, practicing rugia, quitting smoking, eating certain kinds of food, attending to fetish priest [18] and the results of the current study is in consonance.

Our study found that, respondents have misconception of family planning causing infertility and this finding corroborates that of other researchers [9,29]. This finding may be due to the limited and inadequate knowledge on family planning methods among Ghanaians. Witchcraft, curses and other supernatural causes were also identified as misconceptions toward infertility among couples. Due to the believe of supernatural causes of infertility, most people wait on God's appointed time for pregnancy and this finding is consistent with finding of Alabdrabalnabi et al., and Ali et al., who

identified supernatural and black magic issues as the major causes of infertility among couples [2,17]. Apanga & Adam, were right in mentioning that, superstitious beliefs such as evil forces and supernatural powers affect the attitude of the men towards fertility treatment in Northern Ghana [29]. It may not be too remote to assert that, associating infertility to spirituality and black magic are significantly conspicuous within the African regions than the European regions. Admittedly, respondents admitted infertility demand mutual treatment and couples jointly seeking for treatment were the best option but the practice of seeking for treatment at the same source was a problem as identified by Gerhard et al., [22].

A significant relationship existed between males' involvement in fertility treatment and marriage type, level of education, employment status, and religious affiliation. Therefore, it can be deduced that, the type of marriage, level of education, employment status, and religious affiliation of an individuals has an influence on involvement in fertility treatment. Similar findings were identified in the study carried out by Tao et al., where education, employment status, and religious affiliation of an individual's significantly determines the person's involvement in fertility treatment [30]. From our findings, higher level of education did not increase males' involvement in fertility treatment. This finding is contrary to the findings of Anderson et al., who found that education increased health-seeking behaviour including reproductive health among men [31]. Individuals with higher levels of education were more likely to give accurate responses and believed less in myths about infertility [6]. Educated participants gave more biologically correct explanations to causes and subscribed to the modern explanation for infertility. It is believed that marital status, age and religion also affect the various perceptions about male infertility and the treatment options available for men [32].

CONCLUSION

The mean age for the participants was 38.35 ± 0.48 with majority of them involved in monogamous marriage, obtained formal education, self-employed and from Christian religion. The study concludes that, fertility declines with age. Again, consumption of excessive alcohol, use of anabolic steroids, untreated sexually transmitted diseases, excessive stress, frequent and extreme exposure to hot conditions affects fertility. Also, the general attitudes of men towards infertility treatment were good and agreed to the fact that infertility treatment is a responsibility of both couples. However, the ability to achieve this orientation of couples jointly treating infertility is positively influenced by the males' socio-demographic factors such as marriage type, level of education, employment status, and religious inclinations towards infertility problem.

RECOMMENDATION

The study recommends that, men should seek for infertility treatment together with their wives so that it can be wholly managed for the couples. Again, to alleviate the high cost involved in infertility treatment, it is recommended that, the bundle of services in the National Health Insurance Scheme in Ghana (NHIS) should cover infertility treatment. With this idea, the charges of Private Fertility Treatment Centres should be regulated to prevent them from charging exorbitant fees. It is also recommended that, period educational forum on issues related to infertility and fertility should be undertaken by the community health unit of District Hospitals to sensitize the public.

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