

Male perspectives on infertility and assisted reproductive technologies (ART) in sub-Saharan contexts

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Abstract

To date social science studies on male views of infertility in developing countries are rare. Concerning treatment seeking, literature assessing men's behaviour from a biomedical point of view underlines bad male compliance with diagnosis and treatment, particularly if men are assumed to be the reason for unwanted childlessness. Summarizing the results of an anthropological research project on infertility and ART in Mali with regard to men this article shows that infertility is a complex problem configuration. Various factors such as the prevailing popular narrative to blame women for involuntary childlessness, alternative social solutions (polygyny), the double threat of demasculinisation by male factor infertility and the reproductive aim to continue the patrilineage prefigure which options seem better or worse for men. Given this Malian background, on the one hand, biomedical infertility care renders men vulnerable for public disgrace due to possible evidence of male infertility causes, and thus block avenues for social solutions. On the other hand, biomedical means especially ART increase hope for own biological children, but the outcome of these cost intensive options even if available are not at all certain. In such situations men may prefer not to be involved in biomedical treatments at all and to hide behind the stigmatization of their wives, in order to avoid the risk of being exposed to public disgrace and double demasculinisation in terms of sexuality and of authority over women.

Key words: Infertility, male infertility, assisted reproductive technologies, sub-Saharan Africa, Mali.

Introduction

Most developing countries are pro-natalist societies, where children are a necessity in order to be acknowledged as a full social adult being (van Balen, 2008). Infertility and childlessness are often looked at as a predominantly female problem. Yet, scarce literature on male infertility in developing countries shows that not only women, but also men are in need of own (marital legal) offspring to proof their bodily capacity to produce children and thus their manhood (Dyer *et al.*, 2004; Hadolt and Hörbst, 2009). In addition, both women and men need children for various other reasons, such as to support them when they are old and/or sick, to provide them with persons of confidence and trust and in order to guarantee the continuity of their family lineage (Inhorn and van Balen, 2002; Gerrits 1997).

To date social science studies on male infertility in developing countries, including studies on male perspectives, their experiences of their wives infertility and/or of male factor infertility, are rare (for

exceptions see e.g. Dyer *et al.*, 2004; Hörbst, 2008). Yet, a number of other studies, while not focusing on male infertility per se, have provided preliminary insights into the meaning and implications of infertility for men in various socio-cultural contexts and into the ways men are involved in seeking a solution for a couple's fertility problem (Bharadwaj, 2000; Bhatti *et al.*, 1999; Gerrits, 1997, 2002; Gerrits *et al.*, 1999; Inhorn, 1994, 2003, 2005, 2006; Mgalla and Boerma 2001; Nahar *et al.*, 2000; Nahar, 2007; Schuster and Hörbst, 2006, 2009; Sundby, 1997).

Literature emphasizes that main stream public narratives predominantly blame women for involuntary marital childlessness, while they hardly acknowledge male factor infertility (Sundby *et al.*, 1998; Nahar *et al.*, 2000; Nahar, 2007). Subsequently, the major and public part of the devastating infertility drama has to be shouldered by women, in terms of social ostracism, stigmatization, and social exclusion. Only few studies have shown that childless men are not treated equally like men with children and may suffer stigmatization and loss of

social status as well (Dyer *et al.*, 2004; Gerrits *et al.*, 1999; Hörbst, 2008; Inhorn, 1994; Mgalla and Boerma, 2001; Nahar *et al.*, 2000; Yebei, 2000).

Concerning treatment seeking, both in traditional and biomedical health care settings, women are found to bear the major part of the burden as well (see e.g. Inhorn, 1994; Gerrits, 1997; Nahar *et al.*, 2000; Nahar, 2007). Studies which assess men's behaviour from a biomedical point of view, underline the problem of bad male compliance with biomedical diagnosis and treatment, above all if men are assumed to be the reason for unwanted childlessness of the couple (Sundby *et al.*, 1998; Bhatti *et al.*, 1999). In particular, men are found not to be willing to hand in their semen for analysis, and in some cases this has to do with men's resistance to 'produce' semen by masturbation (see e.g. Dyer *et al.*, 2004). From the biomedical point of view, when thinking of setting up comprehensive infertility care in developing countries, major questions of concerns are threefold, namely: How to get men of infertile couples into the hospital? How to get them being diagnosed? How to get them to follow and support the treatment?

In this article I will summarize some of the findings on men's perspectives from a long-term anthropological research on infertility and assisted reproductive technologies in the capital of Mali, Bamako¹. From an anthropological point of view the problem of infertility has to be seen as complex problem configuration, where various socio-cultural and structural factors impact on what seems to be a better or a worse solution for men. This background serves as a basis to turn around the above noted questions and to analyse the situation along two alternative ones: What is at stake for men with regard to female or male factor infertility, what can biomedical treatments (including ART) offer to men and which avenues for solutions do such diagnostics constrain for men?

Infertility in Mali – a multiple problem configuration

To get children in Mali is a self-evident part of the anticipated biography and is neither for women nor for men a question of individual decision. The necessity to have children does not only derive from the couple or the single partners but also from the extended family as well as from society as a whole. After marriage the social pressure to procreate is high and if children fail to appear, first and foremost women are made responsible – due to the prevailing popular narrative in Bamako which blames women to be the cause of infertility. Although biomedical knowledge on male causes for infertility is increas-

ingly disseminated through national and accessible international media, male factor infertility causing marital childlessness is hidden from the public; it is equated with a source of shame and disgrace for a man. In consequence, foremost women are stigmatized to different degrees from members of their husband's extended families, but also from the wider social surrounding (neighbours and peers), e.g. at the frequently held baptisms and marriage ceremonies. To avoid shame, to maintain and to increase personal prestige are attributes highly valued by Malian men. In order to achieve these aims, they have to be treated with respect by other men and particularly by women. Children are essential for being acknowledged as a full social adult within Malian society – a quality which is predominantly connected to proof the bodily capacity to make children (Hadolt and Hörbst, 2009). The lack of children, as the socially visible sign of sexual capacity, is easily equated with impotence. Moreover, sexual potency and procreative ability are core factors for male authority over women (and other men). If children are missing, the respectful behaviour of women is endangered, too. To be taken for impotent and losing the authority over women equates a double threat for masculinity. Given this background, sub- or infertile men affirmed that they have no sexual problems and that no one in their social environment dares to insinuate them with regard to their or their wives' "infertility". Friends might tease them or make allusions such as "when will we go to a baptism in your house" or bother them with recommendations to marry another wife. The infertile diagnosed men stated that they enjoy enough respectability and authority in order to silence these voices quickly. Only a few men disclosed singular and shameful events to me, in which their family members or neighbours dared to directly accuse them as being the cause of their marital childlessness. The mainstream narrative which blames women in combination with men's higher position seems to shield men (at least in many cases) from being suspected or even accused for male-factor infertility. Nevertheless, some also told me that their

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marital childlessness stopped them from having a higher rank in the family hierarchy and/ or blocked them off from receiving a higher post in their job.

Social options for solution

As usually women are taken to cause childlessness, the ideal solution for many extended families is seen in polygyny. Polygyny is a widespread phenomenon in Malian society, where the majority of around 90 % at least officially is Muslim (Esposito, 2003), which allows men to marry up to four women. Thus men living in (yet) childless marriages are urged by members of their patrilineage to marry a second wife in order to find a solution. For men who didn't undergo biomedical diagnostics, this might be seen as a realistic solution. On the one hand, many men have internalized the public narrative to such a degree that they simply don't imagine they really could be the cause for marital childlessness, on the other hand, many seem to avoid diagnostics because they are afraid and they don't want to know it for sure. For some of these men as well as those whose wives are diagnosed as sub- or infertile, polygyny might become a realistic loophole in the end. Nevertheless, many men try to solve the problem with their first wife for several years. Whatever avenues for a solution are approached: if they are not successful in helping to conceive a child, the pressure and the attractiveness to marry a second wife will increase. But for those men who are themselves diagnosed as sub- or infertile, this pressure by family members and peers is complicating the situation tremendously. Besides creating in many cases problems with their first wives, a second wife would substantially augment the risk of disclosing the men's secrets in case a pregnancy of the second wife would not be achieved neither.

All infertile men in my research informed their wives about their diagnosis. Some also informed selected persons, mostly their fathers, family chiefs and/ or younger brothers. Their wives in turn informed either no one at all or only their mothers, a close friend or a younger sister. Most of the wives believe that their husbands would not stand the stigmatization and don't want to leave them over to public disgrace. The mainstream narrative to blame women for childlessness allows to weave a web of secrecy around the diagnosis and the situation, in order to protect the infertile man (and his patrilineage) from shameful situations, to hide his condition and to leave it to their wives to shoulder the bigger part of insinuations and marginalisation in daily life.

Whether the situation intensifies, disrupts or brings dramatic turbulences to the couples internal relations depend on many specific and individual

aspects like love and emotions, living situation as well as resources available, but also on such facts as who is diagnosed infertile, the length of time the problem is already persisting, the number of unsuccessful treatments already undergone and the amount of money already spent. With regard to infertile diagnosed men, to share such secrets and the search for a solution seems to intensify couple relationships and many couple try to protect their relation against interfering interests and influences of the extended patrilineage – at least as long as there is hope for both partners that one day they will achieve to get a child together. Most of the men are eternally grateful to their wives who accept the men with their deficit, keep their secret and grant them respect in public life.

Biomedical treatments

However, mostly the wives initiate biomedical treatment, as they shoulder the bigger part of the stigmatization, they fear family's pressure for a second wife and they are in need of getting pregnant, in order to achieve the socially visible sign of their bodily capacity to produce children and thus to end their stigmatization. Men will profit from pregnancy as all children of their wives count as their legitimate biological ones. But with making children men link the duty to guarantee the continuity of their patrilineage - an aspect which comes to the fore when this aim is disrupted by a male-factor infertility diagnosis. Otherwise, the mainstream narrative which declares women as responsible for infertility and the simultaneous fact that all children born by the wife are taken as the husband's biological children shields men eventual incapacity to continue the lineage. Even if the husband himself or a family member might doubt the children's biological origin, there is no clear proof (besides genetic testing) and thus, the possibility is always left that the children in question are in deed his biological children (Hörbst, 2008). Once biomedical diagnosed this aim to continue the lineage requires the transmission of male substances to the children in other ways. Therefore it is of central importance whether the cause for childlessness is diagnosed in the woman (which leaves social options as well as biomedical options open) or in the man, which closes alternative social options and requires the transmission of their substances in another way. All infertile men were open to homologue ART with the partners' gametes, but not for heterologue ART via sperm donation – except one. After two failed attempts with homologue IVF this man, belonging to a Christian denomination, had finally accepted IVF with sperm donation, as in his opinion it was the last option for his wife to get a

child within their marriage. The other men argued that such a child would not continue their patrilineage. Instead, they prefer to take foster children from a brother or a cousin. Although such a child would neither be their own biological offspring, it would be at least a child originating from the patrilineage via a family member (Hadolt and Hörbst, 2009). Many infertile men supposed to their wives to live as a couple without children, and all promised to never ever marry a second wife. But all wives regarded both propositions as being totally unrealistic for living in the Malian society. Instead, many wives of infertile diagnosed men at least try to pressure to achieve a biomedical solution. As neither foster children nor formal adoption allow the women to become pregnant, they are no appropriate solutions for them. Thus, in contrast to their men women in Mali were found to be more open for heterologous ART, even by ova donation - at least as a last means to overcome their childlessness. Nevertheless, they evaluated such an option as worse than sharing a common biological child with their partners.

These multiple and partially contradicting aspects, such as the need to get a child, contrasting gender specific aims, different available ways to achieve a solution are argued and/or negotiated within the couples. They potentially trigger despair and emotional turbulences adding to the already high burden of suffering from infertility, in particular in connection to financial feasibility.

Costs of ART treatments in Mali

Without a comprehensive health insurance system in Mali, biomedical treatments for most infertility ailments are quite cost intensive for the patients. Besides quite low fees in public hospitals, treatments, drugs and materials needed (e.g. needles, anaesthetics for operations etc.) have to be paid by them and cases of under-desk fees are reported. Concerning ART, which are particularly expensive, these interventions are only provided in a private clinic. No nationally nor internationally supported fund is (partially) taking over the costs for ART. For the patients in Mali one attempt for IUI roughly adds up to between 1,100 to 1,800 Euros (400 Euro for doctoral attainment, 200 Euros for analysis etc, between 500 to 1,300 Euros for pharmaceuticals); one IVF cycle costs in between 2,400 and 2,900 Euros (doctoral attainments 1,300 Euros, around 200 Euros monitoring and 900 to 1,400 Euros for medication); and for one attempt of ICSI expenses range between 3,000 to 3,600 Euros (1,900 Euros for doctoral attainment, 200 Euros for monitoring, 900 to 1,400 for medication). Although the fees for these interventions are in general lower compared to costs in

Europe², and the local availability of ART makes these interventions feasible for a broader part of society, as travel and accommodation dispenses for two persons do not have to be reckoned, regular employment (to get credit) and/or good (additional) income from activities in the informal sector, as well as good relationships to affluent family members or to migrants abroad, who eventually contribute to manage costs, are necessary to undergo ART even when carried out in Mali. Beyond, even if couples have considerable financial sources at their disposition, whether such high amounts are spent on ART is influenced and linked to various competing needs and demands in the extended family (like paying school fees or health treatments for family members, lending money for investing in business etc.) The majority of Malians suffering from involuntary marital childlessness cannot afford ART treatments.

Conclusion

As the Malian situation outlined shows, infertility is a field of specific problem configurations where various socio-cultural, structural and economic factors prefigure what for men seems a better or a worse option to handle their situation. Although to get a child forms the ostensible key problem, this problem is intimately linked to diverging constellations, in which involuntary childlessness forms part of other problems (such as social respectability, position in family hierarchy, popular narrative, proof of sexual capability, family pressure for a second wife, social solutions, costs) and vice versa. These constellations prefigure those objectives affected men (and women) try to achieve simultaneously when trying to have a child. These purposes are multiple and appear as a meshwork or network of aims (Hadolt and Hörbst, 2009), and, in a synoptic way, attribute some solutions as better and some as worse at a specific time and situation. Based on this background, the question what is at stake from men's point of view with regard to biomedical diagnostics and what biomedical treatments (including ART) offer to men's problems configurations can be approached.

² For comparison in Germany an attempt for IUI (if not covered by health insurance) costs on average between 650 and 1,600 Euros (600 to 850 Euro for doctoral attainments, between 50 and 750 Euro for pharmaceuticals); for one IVF attempt an average of 4,600 Euro (3000 Euro for doctoral attainments and 1,600 Euro for pharmaceuticals) while one attempt of ICSI will cost on about 7,200 Euro (5,600 doctoral attainments and 1,600 Euro for pharmaceuticals), information given by the *Bundesverband Repromedizinischer Zentren* of Germany, 22.03.2010.

On the one hand, biomedical infertility care renders men more vulnerable, as the predominant narrative of female responsibility of marital childlessness is broken up. When undergoing analysis, men have to reckon with the possibility of being indeed diagnosed with male factor infertility. Although they know it is not true, many men have internalized the prevailing narrative that only women are the cause for involuntary childlessness to such a degree that receiving a divergent diagnosis is an emotional shock for them. Many have to struggle hard with this internally felt devaluation of their manhood and being robbed of what seems for many men a normative right. Moreover, via biomedical diagnostics men run a higher risk for public disgrace and shame, which includes a double demasculinisation, concerning sexuality and authority over women. Such a diagnosis bounds them to their wives' capacity and willingness of keeping the secret maintained. Thus the option to hide their handicap from getting publicly known is weakened.

Moreover, through biomedical diagnosis of male factor infertility different social solutions (wives conceiving via extramarital sex (with a family member), marriage of a second wife) are rendered more difficult. These avenues for solutions ask for an atmosphere of uncertainty, a situation of not exactly knowing, and not having a proof at hand. When the men know their own inability to produce children, it becomes more difficult for them to accept such means, as they contradict personal emotions and moral or religious values concerning female faithfulness and adultery. Further on, extramarital sex with a non-family member contradicts also the men's aim to continue the patrilineage.

On the other hand, biomedical treatments offer men hope for curing bodily and social impairments (e.g. increase of sperm quality and quantity via hormonal treatments). Sophisticated biomedical treatments, IUI (in combination with hormonal increase of sperm quality) and particularly ICSI heighten the hope to achieve an own biological child in the future. But the knowledge that biomedical doctors in principal could provide treatments for achieving a solution is rendered merit less, when many men hear the prices and know that the financial means necessary for such interventions won't ever be achievable for them. Thus, biomedical potentials can become a bitter and frustrating pill. Even if an IUI or ICSI is affordable, yet the outcome is highly uncertain, as success rates of ART are in general relatively low (around 35 % per cycle at its best and around 20% in sub-Saharan Africa). Moreover, highly featured accumulating effects can only develop its benevolence if several cycles are feasible and affordable. If only homologue IVF or ICSI are

offered, the chance to realize the reproductive aim of continuing the lineage via own biological/genetic offspring is less achievable for many men diagnosed with azoospermia. Other options, such as taking foster children of a brother, might seem then more adequate to men, even if they do not allow their wives to achieve their reproductive aims (Hadolt and Hörbst, 2009). Increased commodification and commercialisation of biomedical health care in the last decades add to the fact that biomedicine is seen similar to other economic negotiations where money is exchanged for a specific product. In case of attempts without success many feel being "robbed" money without having received the "paid for" product.

In such situations, some men hand their fate over to Allah, some take after years a second wife, waiting for 'Abraham's miracle', others seem to compensate their handicap by various extramarital partners, rendering them vulnerable for acquiring sexual transmitted diseases. If confronted with the possibility to stay without children for the rest of their lives – even when ART are offered - men may prefer not to be involved in biomedical treatments at all. Men may rather hide behind the social stigmatization of their wives in order not to risk to be exposed to demasculinisation. Without financial assistance by the Malian state or by trans- and international organizations, only a rather small minority of the Malian population can benefit from locally provided ART. The great majority of infertile Malian couples rests without these options. Most of them keep on beating the traditional and classical biomedical ways to find conception, while taking the risk to even exacerbate their condition through incompetent treatment or poor hygienic handling – both in traditional and biomedical spheres. For less affluent sufferers from infertility the lack of own adequate financial means for a solution in combination with no help from the Malian state and the international community triggers frustration and desperation which in turn enhances loss of confidence concerning the state's power to care for the health of its citizens.

Perspectives

From the complex constellation which infertility presents for couples and from men's perspectives in Mali it can be generalized that bad male compliance with regard to biomedical infertility diagnosis and treatments is part of this specific problem configuration. Even so men might undergo biomedical diagnostics, the treatments necessary might be out of reach for them, due to lack of financial means. The mere existence of biomedical diagnosis and promising treatments not necessarily makes men's aims easier achievable for them, but even might

diminish them in their view. To the contrary, it might render for many men their emotional and social lives as well as their relationships more complicated, and, in cases their aim to biologically continue the patrilineage might get questioned, biomedical diagnosis and treatment might fundamentally contradict their objectives. While further social science research, focusing on male views with regard to infertility and its treatments (including ART) in different socio-cultural contexts is necessary, the concept to understand infertility as being a complex problem configuration might be a fruitful approach. Together with the outlined risks for men in Mali, it has the potential to advance the understanding for non-complying men. To see men and their doings embedded in complex social, structural and economic entanglements may serve as a starting point for further attempts to increase male compliance with biomedical infertility care in developing countries.

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