Seeking fertility treatment in Senegal: when tradition and modernity go hand in hand

Authors[1]*: Mame Soukeye Mbaye, Fatou Bintou Mbow*

For correspondence: mmbaye@popcouncil.org; fmbow@popcouncil.org.

Abstract

This study explores the knowledge, opinions and experiences of men and women seeking fertility services. Although biomedical fertility services are available in Dakar[2], they compete with the services of traditional healers. This qualitative study was conducted in Dakar. In-depth individual interviews were conducted with 15 women and men who had accessed fertility services, as well as with 12 providers of these services in health facilities. A further 47 participants took part in focus groups.

Traditional medicine was identified as the second most important healthcare alternative after modern medicine. There are two types of traditional medicine: private clinics offering treatments based on botanical products and 'marabouts'[3], who use mystical knowledge to 'consult' with women to determine whether they are possessed by a '*jinn*'[4], which may be the cause of their infertility. Opportunities for care reveal inequalities in financial accessibility: the most affluent have access to biomedical care and Assisted Reproductive Technology (ART). Traditional healers position themselves within the infertility market, gaining legitimacy from their clients.

Key words: infertility, fertility care, therapeutic pluralism, Assisted Reproductive Technologies (ART), Senegal.

Introduction

It is estimated that around 186 million couples worldwide suffer from infertility, which is a growing public health concern, especially in low- and middle-income countries. In Senegal, infertility has only recently been thoroughly recorded. Data from the District Health Information Software (DHIS2) shows that the number of reported cases increased by 15.7% between 2020 and 2021[5]. Despite its prevalence, infertility is still a socially stigmatized condition, it is also not considered a political priority. Regardless of the underlying cause, women are disproportionately affected by the social repercussions of infertility, often experiencing shame and blame. In addition to financial and practical obstacles, people seeking care face a complicated web of difficulties as a result of this stigma. In light of this, the current study examines the real-life experiences of people seeking reproductive services in Dakar, the capital of Senegal, where traditional and biomedical practices coexist and interact in unique ways.

Methods

[1] Population Council, Senegal, pubinfo@popcouncil.org

[2] Capital of Senegal. Most of the country's modern healthcare infrastructure is located in Dakar.

[3] People who use supernatural incantations, prepare decoctions, and know the secrets of plants for healing, exorcism, etc.

[4] Supernatural beings

[5] DHIS2, 2021, Senegal.

In order to investigate fertility service-seeking behaviors, this qualitative study used a multi-perspective design. Purposive sampling was used to recruit 74 participants in total. Six gender-segregated focus group discussions (FGDs) with 47 community members and 27 in-depth interviews (IDIs) with 12 health service providers and 15 individuals (11 women and 4 men) who had sought fertility treatment were used to collect data. Thematic content analysis was used to examine interviews and FGDs that were held in both French and Wolof. Key themes and sub-themes were identified by classifying and coding the transcripts. Understanding the gendered experiences of infertility, access dynamics, interactions with conventional and biomedical systems, and societal perceptions of fertility care were the main objectives of the analysis.

Results

Gendered disclosure of infertility status and decision-making

The data clearly showed that the extent to which infertility was disclod was gendered. Men tended to confide only in their parents, whereas women usually confided in close female relatives, such as mothers, sisters, or trusted friends.

> "*I first discussed it with a friend. She suggested that I see Dr G. D., who had previously treated her for similar issues*". 29-year-old female care seeker.

> "*I mostly talked about it with my mum. She suggested I visit a hospital to find a solution and try traditional medicine if that doesn't work".* 33-year-old male care seeker.

These disparities in disclosure patterns influenced the variety of care-seeking trajectories. Due to their larger social networks, women were frequently exposed to a greater variety of advice, including conventional and biomedical treatment options. Men sometimes engage in service and fertility care research activities more slowly or passively due to having fewer sources of input.

Therapeutic Pluralism

A distinguishing feature of services and care-seeking behavior was therapeutic pluralism. Most participants started their journey in the biomedical system, specifically in private clinics or public hospitals. However, they often explored traditional healing methods after becoming dissatisfied with treatment outcomes or receiving advice from peers. These included spiritual consultations, herbal remedies and marabout rituals. Importantly, these treatment choices were considered complementary rather than contradictory, as everyone uses treatment methods in parallel, moving back and forth between modern medicine and traditional medicine.

> "*As for traditional medicine, I went because people often recommend certain practitioners, saying that they're good and so on. You hear all sorts of things*." 27-year-old female care seeker.

This coexistence of biomedical and traditional healing methods demonstrates a practical approach to healing, whereby patients move between systems based on trust, perceived efficacy and financial constraints. Depending on the results of treatment and external recommendations, shifts between biomedical and traditional systems often occur in cycles.

Socioeconomic Disparities in Access

Notable socioeconomic disparities were observed in access to fertility services. Low-income couples were largely unable to access assisted reproductive technology (ART) services including intrauterine insemination or in vitro fertilization, due to the high costs in the private sector. As ART is not officially available in the public sector, . for many people, therefore, traditional healers filled the service gap.

> "*The cost of PMA is slightly higher than the resources available to the population... more stimulation is done outside IVF than PMA*." Gynecologist-obstetrician

Furthermore, the study found that many people could not afford basic fertility consultations or diagnostic tests. Some participants reported spending over 35,000 XOF ($62.00) on tests or medication. Traditional medicine offered clients who were economically vulnerable cultural familiarity and accessibility.

Male Engagement and Social Pressure

The level of male involvement in the service and fertility care seeking varied considerably. While some men distanced themselves from the treatment process, others provided their partners with financial and emotional support. Cultural views on masculinity and fertility further reinforced the gendered burden of infertility, dissuading men from undergoing diagnostic tests, especially sperm analysis. Women often began treatment independently and shouldered the emotional burden of social scrutiny and repeated failures.

> "*To be honest, I haven't done it, but I understand that she wants a child. I encourage it with God's help*." 38-year-old male care seeker

> *"My husband has a strong faith in God... Sadly, it's his parents who are treating me badly. Their goal is to get my husband to date another woman.*" 43-year-old male care seeker.

Influence of Social Networks

Care-seeking behavior was significantly influenced by social networks. Decisions were often influenced by peer groups and community leaders, who provided practical guidance and emotional support. Although their influence and reach varied by neighborhood, community-based health agents such as the *Bajjenu Gox*[6] played a crucial role in connecting people to medical facilities.

Discussion

This study clarifies how gender dynamics, institutional constraints and complex social norms influence infertility treatment in Senegal. Infertility is not an isolated experience; rather, it is viewed through the lens of societal norms that prioritize motherhood as a defining characteristic of femininity. Women bear a disproportionate amount of the burden of dealing with the psychological distress and social stigma associated with postponed or absent childbearing (Goffman, 1975; Giami et al., 2008), both when starting and navigating care.

The results emphasize the importance of therapeutic pluralism in the context of reproductive health. Addressing emotional, spiritual and accessibility gaps enhances biomedical care rather than undermining it (Brochard, 2014; Horbst, 2012). These two options reflect the formal health system's inability to address patients' needs holistically. Findings from other West African contexts, where pluralistic care patterns are ingrained in the sociocultural logic of health seeking, support the idea of pragmatic switching between systems (Inhorn, 2009).

[6] Female community workers trained to provide expert advice and support, help women with their SRH issues.

Male disinterest in the diagnosis and treatment of infertility is still a major problem. The reluctance to have sperm tested reflects broader social unease about questions surrounding male virility. According to Gueye et al. (2012), these gender norms limit the effectiveness of care, delay diagnosis and perpetuate stigma. To dispel the myth that infertility only affects women, public health messaging and service delivery models must be updated to promote and encourage male involvement.

The most important structural constraint is possibly financial. Most people still cannot afford ART, particularly in settings where even basic diagnostics are expensive. Without expanded public ART services or subsidized care, reproductive health disparities will continue to exist. As Mbow and Diop (2019) argue, the privatization of infertility care exacerbates social inequalities and undermines the principle of reproductive justice.

Furthermore, the covert nature of ART procedures and the invisibility of male infertility compromise accountability and transparency in fertility care. Senegal's lack of national policy and regulation regarding ART services necessitates immediate change.

This study also highlights how underutilized community actors are in influencing health-related behaviors. Involving former patients, community health workers and religious leaders in initiatives may help to dispel the stigma surrounding infertility and make it less mysterious. It is equally important to strengthen psychosocial support networks in the public and private sectors to help patients through what is frequently a drawn-out and emotionally draining journey.

Conclusion

Infertility care pathways in Senegal demonstrate the intricate interplay of therapeutic pathways, gender dynamics, social expectations, and systemic injustices. Women, in particular, bear heavy social, economic and psychological burdens as they negotiate pluralistic healthcare environments. The results stress the need for systemic changes including gender-transformative approaches to care, culturally sensitive communication and the inclusion of infertility in public health priorities. To achieve reproductive equity, access to high-quality, reasonably priced ART services must be expanded, and comprehensive, gender-inclusive care must be offered.

References

Bajos N. et Ferrand M., 2006, L'interruption volontaire de grossesse et la recomposition de la norme procréative, *Sociétés Contemporaines*, n°61, pp. 91-117.

Giami et al, 2008, "Representations, metaphors and meanings of the term handicap in France", *Scandinavian Journal of Disability Research*, 9 (3–4) (2007), pp. 199-213

Goffman E., 1975, *Stigmate. Les usages sociaux des handicaps*, Paris, Les Éditions de Minuit.

Gueye SM, Ndoye M et Ouattara A. Aspects Spécifiques de La Prise en Charge de l'homme Infertile. Reproduction Humaine et Hormones, décembre 2012 ; 25 (3–4).

Horbst, V. (2012) "You Need Someone in a Grand Boubou" Barriers and Means to Access ARTs in West Africa. Infertility, 21, 46-52.

https://knowledgecommons.popcouncil.org/cgi/viewcontent.cgi?article=3010&context=departments_sbsr-rh.

Inhorn M. C., 2009, Fertility regulation, Right to assisted reproductive technology: Overcoming infertility inlow-resource countries, *International Journal of Gynecology and Obstetrics*, Department of Anthropology, Yale University, New Haven, CT, USA.

Marie Brochard. Normes reproductives, infertilité et nouvelles technologies de reproduction au Sénégal., Sciences de l'Homme et Société. Université Paris Descartes, 2014. Français. ffNNT : ff. fftel01148641f.

Mbow Fatou Bintou, Diop Isseu Toure. 2019. "Développer des approches pour comprendre, caractériser et adresser l'infertilité et ses conséquences pour les individus et les familles en Afrique subsaharienne : Le cas du Sénégal." Dakar: Population Council, 2019

Organisation mondiale de la Santé, and Banque mondiale. Rapport Mondial Sur Le Handicap 2011. 2012, https://apps.who.int/iris/handle/10665/44791.

Prioux F., Mazuy M., 2009, « L'évolution démographique récente en France : dix ans pour le Pacs, plus d'un million de contractants », Population, 64(3), p. 445-494.

Rowe, Patrick J, Comhaire, Frank H, Hargreave, Timothy B, Mahmoud, Ahmed M. A & World Health Organization. (2000). WHO manual for the standardized investigation, diagnosis and management of the infertile male / Patrick J. Rowe ... [et al.]. World Health Organization. https://apps.who.int/iris/handle/10665/42437

Schütz, A. (1972), *The Phenomenology of the Social World* (Chicago: Northwestern University Press).

WHO. Définitions et terminologie de l'infertilité. Available from: https://www.who.int/teams/sexual-and-reproductive-health-and-research/key-areas-of-work/fertility-care/infertility-definitions-and-terminology