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Comparative Hysteroscopic Profiles among Women with Primary and Secondary Infertility Followed at the Edith Medical Center of Lemba

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Abstract

Objective: To compare the clinical, obstetrical, and hysteroscopic characteristics of women classified as having primary or secondary infertility at the Edith Medical Center of Lemba. **Methods:** This single-center cross-sectional study included 140 women evaluated between January 1, 2020, and June 30, 2025. Sociodemographic, obstetrical, gynecological, and hysteroscopic data were obtained from medical records and patient interviews. **Results:** Primary infertility accounted for 53.6% of the analyzed sample. Mean age was similar between groups (37.0 ± 7.4 vs. 36.7 ± 7.0 years; reported p = 0.918). Uterine polyps were more frequent in the primary-infertility group (44.0% vs. 16.9%; reported p = 0.001), whereas hysteroscopic signs consistent with adenomyosis were more frequent in the secondary-infertility group (23.1% vs. 10.7%; reported p = 0.040). These estimates and all p-values require verification against the corrected participant-level dataset, particularly after auditing infertility classification. **Conclusion:** In this referred, single-center population, uterine polyps were more frequent among women classified with primary infertility, while hysteroscopic signs consistent with adenomyosis were more frequent among those classified with secondary infertility. These cross-sectional associations do not establish causality, diagnostic accuracy, treatment effectiveness, or subsequent pregnancy outcomes.

Subject Areas

Gynecology & Obstetrics

Keywords

Infertility, Hysteroscopy, Intrauterine Lesions, Kinshasa

1. Introduction

Infertility is a major reproductive health issue worldwide, affecting approximately 15% of couples of reproductive age, with a higher prevalence in low- and middle-income countries such as those in sub-Saharan Africa [1] [2]. In the Democratic Republic of the Congo (DRC), infertility remains a frequent reason for gynecological consultation, with significant social and psychological consequences, including stigma, marital instability, and marginalization of women [3].

Hysteroscopy plays a central role in diagnosing uterine abnormalities associated with infertility [4]. It allows direct and precise visualization of the endometrium, cervical canal, and tubal ostia, thereby facilitating the identification of endometrial polyps, submucosal fibroids, intrauterine adhesions, congenital malformations, and signs of chronic infection [5]. These intrauterine lesions represent significant etiological factors of infertility, potentially impairing implantation, disrupting tubal patency, or altering the endometrial environment [6].

Distinguishing between primary infertility (failure to conceive despite ≥ 12 months of regular unprotected intercourse with no prior pregnancy) and secondary infertility (inability to conceive following a previous pregnancy) is essential because their underlying factors may differ considerably [7]. Several studies have shown that hysteroscopic abnormalities vary according to the type of infertility: women with secondary infertility more frequently present adhesions, sequelae of infections, or postpartum complications, whereas women with primary infertility are more likely to have congenital malformations or primary endometrial abnormalities [8] [9].

However, in the DRC, data on the hysteroscopic profiles of infertile women remain limited. Few local studies have explored the prevalence and nature of intrauterine abnormalities in a modern clinical setting, even though risk factors such as genital infections, clandestine abortions, traumatic deliveries, and inadequate perinatal care are particularly common [10]-[12]. The Edith Medical Center of Lemba, located in a densely populated area of Kinshasa, receives an increasing number of infertile patients, making it necessary to better characterize the lesions encountered. Thus, the present study aims to describe and compare hysteroscopic profiles among women with primary and secondary infertility followed at the Edith Medical Center of Lemba. Such an analysis will not only improve local epidemiological understanding but also strengthen diagnostic orientation and therapeutic management of infertile patients in the DRC.

2. Materials and Methods

2.1. Study Design, Population, and Sampling

This descriptive cross-sectional study was conducted at the Edith Medical Center

of Lemba, Kinshasa, Democratic Republic of the Congo, from January 1, 2020, to June 30, 2025. The target population comprised women aged 15 - 49 years who were evaluated for infertility and underwent diagnostic or operative hysteroscopy at the center. Primary infertility was defined as failure to conceive after at least 12 months of regular unprotected intercourse with no previous pregnancy; secondary infertility was defined as failure to conceive after at least 12 months of regular unprotected intercourse following at least one previous pregnancy, regardless of its outcome. Women who were pregnant, had undergone hysterectomy, had an anatomical abnormality preventing hysteroscopy, had active pelvic infection or uncontrolled genital bleeding, or had incomplete records were excluded. The manuscript states that sampling was exhaustive and convenience-based and that 141 women were included. Specify whether recruitment was prospective, whether all consecutive eligible women or a convenience subset were included; and explain the difference between 141 initially included and 140 analyzed, including the exact exclusion.

The target population consisted of all women of reproductive age (15 - 49 years) followed for infertility and who had undergone diagnostic or operative hysteroscopy at the Edith Medical Center of Lemba. Inclusion criteria were as follows: women aged 15 - 49 years with primary infertility (no previous pregnancy) or secondary infertility (failure to conceive after at least one previous pregnancy); women who agreed to participate and provided informed consent. Exclusion criteria included: pregnant women at the time of the study, women with a history of hysterectomy or anatomical abnormalities preventing hysteroscopic examination, women with active pelvic infection or uncontrolled genital bleeding, and those with incomplete medical records. The sample size was exhaustive and based on convenience according to the inclusion criteria; a total of 141 infertile women were included in this study.

2.2. Data Collection and Hysteroscopy Procedure

Sociodemographic, obstetrical, gynecological, and clinical information was abstracted from medical records and supplemented by structured interviews with participants. Variables included age, marital status, occupation, husband's age, gravidity, parity, abortions, duration and type of infertility, menstrual characteristics, and relevant medical or surgical history. Interview-derived information was checked against records when available.

Clinical variables were collected through direct patient interviews and included:

- Type of infertility**:** •Primary: absence of pregnancy after ≥12 months of regular unprotected intercourse, with no previous pregnancy. •Secondary: absence of pregnancy under the same conditions but after at least one previous pregnancy (regardless of outcome).
- Duration of infertility**:** expressed in months or years.
- Relevant medical or surgical history**:** recorded dichotomously (yes/no), including tuberculosis (genital or other), cesarean section, myomectomy, uterine

curettage, pelvic infection (e.g., salpingitis), and abdominal or pelvic surgery.

Hysteroscopy was used to assess the uterine cavity and document visible intrauterine abnormalities. The current source manuscript does not provide sufficient study-specific information to reproduce the procedure. Timing in the menstrual cycle or relation to bleeding; hysteroscope type/diameter and imaging system; distension medium; outpatient or operating-room setting; diagnostic versus operative procedures; operator qualifications/experience; and the predefined visual criteria used to classify polyps, fibroids, synechiae, and features considered consistent with adenomyosis.

2.3. Statistical Analysis

Data were entered and analyzed using SPSS version 25. Categorical variables were summarized as counts and percentages, and continuous variables as means and standard deviations or medians and interquartile ranges, as appropriate. Comparisons between infertility groups used the chi-square test or Fisher's exact test when expected cell counts were small, and the independent-samples Student's t-test for continuous variables when its assumptions were met. Statistical significance was set at $p < 0.05$. The study was approved by the National Health Ethics Committee under approval number 239/CNS/BN/PMMF/2024 of 25/06/2024. Informed consent was obtained from all participants. Confidentiality and anonymity were strictly observed.

3. Results

3.1. Type of Infertility

Figure 1 illustrates the distribution of infertility types within the study population. Primary infertility represents 53.6% (n = 75) of cases, whereas secondary infertility accounts for 46.4% (n = 65).

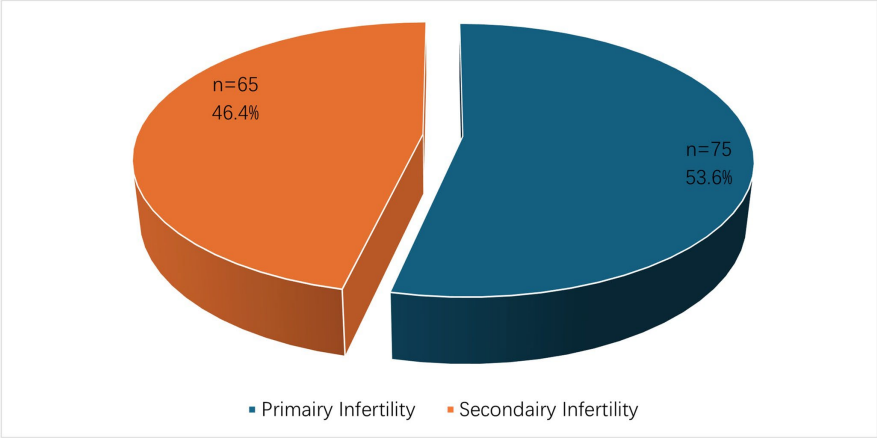


Figure 1. Distribution of infertile women according to the type of infertility.

3.2. Sociodemographic Characteristics of Infertile Women

In the overall sample, the mean age of the women was 36.9 ± 7.2 years, with no

significant difference between those with primary and secondary infertility (p = 0.918). The age distribution was similar across groups: approximately 40% of the participants were between 25 and 35 years old, while about one-third were aged 40 to 49 years. No statistically significant variation in age categories was observed between the two infertility types.

Marital status did not differ significantly between the groups (p = 0.502). Most women in both categories were married (around 90%), reflecting the typical profile of women seeking infertility care in this setting. Regarding occupation, the proportions of women working in the informal sector, the formal sector, or without employment were comparable between the two groups (p = 0.558). About 45% of the overall sample were engaged in informal employment, while 14.3% reported no occupation. No occupational pattern appeared to distinguish primary from secondary infertility (Table 1).

Table 1. Sociodemographic characteristics according to the type of infertility.

Variable	Over all (n = 140)	Primary infertility (n = 75)	Secondary infertility (n = 65)	p
Age	36.9 ± 7.2	37.0 ± 7.4	36.7 ± 7.0	0.918
19 - 24 years old	4 (2.9)	2 (2.7)	2 (3.1)	
25 - 35 years old	56 (40.0)	28 (37.3)	28 (43.1)	
36 - 40 years old	35 (25.0)	20 (26.7)	15 (23.1)	
40 - 49 years old	45 (32.1)	25 (33.3)	20 (30.8)	
Marital status				0.502
Married	126 (90.0)	67 (89.3)	59 (90.8)	
Unmarried	14 (10.0)	8 (10.7)	6 (9.2)	
Occupation				0.558
Informal	64 (45.7)	33 (44.0)	31 (47.7)	
Formal	56 (40.0)	29 (38.7)	27 (41.5)	
No occupation	20 (14.3)	13 (17.3)	7 (10.8)	

3.3. Clinical Characteristics of Infertile Women

The reproductive-history results require an audit before interpretation. The manuscript currently reports that 72.0% of women classified with primary infertility were nulligravidas, implying that 28.0% had at least one previous pregnancy. This conflicts with the stated definition of primary infertility (no previous pregnancy).

Menstrual characteristics (including cycle type, cycle length, and duration of menstruation) do not differ significantly between the two groups (p > 0.05). A higher proportion of women with secondary infertility report a history of myomectomy (15.4% vs. 4.0% in the primary group), as well as a more frequent history of other abdominal or pelvic interventions (Table 2).

Table 2. Distribution of patients according to clinical characteristics.

Variable	Over all (n = 140)	Primary infertility (n = 75)	Secondary infertility (n = 65)	p
Parity				0.222
Nulliparous	99 (67.1)	56 (74.4)	38 (58.1)	
Primiparous	24 (17.1)	10 (13.3)	14 (21.5)	
Paucipara	16 (11.4)	7 (9.3)	9 (13.8)	
Multiparous	6 (4.3)	2 (2.7)	4 (6.2)	
Gestation				**<0.001**
Nulligravida	63 (45.0)	54 (72.0)	9 (13.8)	
Primigravida	25 (17.9)	8 (10.7)	17 (26.2)	
Multigravida	52 (37.1)	13 (17.3)	39 (60.0)	
Cycle type				0.788
Regular	99 (70.7)	51 (68.0)	48 (73.8)	
Irregular	29 (20.7)	17 (22.7)	12 (18.5)	
Unknown	12 (8.6)	7 (9.3)	5 (7.7)	
Cycle length	28.4 ± 4.0	27.9 ± 3.8	28.9 ± 4.2	0.551
Short	27 (19.3)	17 (22.7)	10 (15.4)	
Normal	96 (68.6)	49 (65.3)	47 (72.3)	
Long	17 (12.1)	9 (12.0)	8 (12.3)	
Menstrual period length	4.0 (3.0-5.0)	4.0 (3.0-5.0)	4.0 (3.0-5.0)	0.729
Hypomenorrhea	54 (38.6)	31 (41.3)	23 (35.4)	
Eumenorrhea	68 (48.6)	34 (45.3)	34 (52.3)	
Hypermenorrhea	18 (12.9)	10 (13.3)	8 (12.3)	
Surgical history				0.412
No	95 (67.9)	52 (69.3)	43 (66.2)	
Yes	45 (32.1)	23 (30.7)	22 (33.8)	
Type of history				**0.033**
Adhesions	5 (3.6)	4 (5.3)	1 (1.5)	
Appendectomy	10 (7.1)	7 (9.3)	3 (4.6)	
Laparoscopy	12 (8.6)	8 (10.7)	4 (6.2)	
Myomectomy	13 (9.3)	3 (4.0)	10 (15.4)	
Other	5 (3.6)	1 (1.3)	4 (6.2)	

3.4. Main Complaints of Infertile Women

Desire to conceive was the most frequently recorded reason for consultation (107/140, 76.4%). The reported group comparisons for amenorrhea and irregular menstrual cycles are provisional because these complaints were uncommon and the reported p-values must be verified using the underlying data and Fisher's exact test

where expected counts are small. The originally reported p-values for amenorrhea ($p = 0.045$) and irregular menstrual cycles ($p = 0.039$) should be treated as unverified pending reanalysis. Because these outcomes have small cell counts, Fisher's exact test may be more appropriate than the chi-square test. Interpret any confirmed associations as descriptive associations in this referred sample, not as evidence that menstrual disorders are caused by secondary infertility.

Other complaints, such as menorrhagia, pelvic pain, recurrent miscarriages, and other symptoms, were rare and showed no significant differences between the two groups (Table 3).

Table 3. Distribution of infertile women according to main complaints.

Main complaint	Over all (n = 140)	Primary infertility (n = 75)	Secondary infertility (n = 65)	p-value
Desire to conceive	107 (76.4)	60 (80.0)	47 (72.3)	0.596
Amenorrhea	11 (7.9)	5 (6.7)	6 (9.2)	**0.045**
Menorrhagia	5 (3.6)	3 (4.0)	2 (3.1)	0.239
Irregular cycle	6 (4.3)	1 (1.3)	5 (7.7)	0.039
Pelvic pain	5 (3.6)	3 (4.0)	2 (3.1)	0.597
Repeated miscarriage	3 (2.1)	1 (1.3)	2 (3.1)	0.098
Other	3 (2.1)	2 (2.7)	1 (1.5)	0.231

3.5. Hysteroscopic Lesions

Uterine fibroids and intrauterine adhesions were reported in both groups. The source table reports more uterine polyps in the primary-infertility group (44.0% vs. 16.9%; $p = 0.001$) and more hysteroscopic signs consistent with adenomyosis in the secondary-infertility group (23.1% vs. 10.7%; $p = 0.040$). These comparisons must be recalculated after the infertility-classification audit and the p-values verified against the source data. Hysteroscopic appearances alone should not be described as a definitive diagnosis of adenomyosis without confirmatory assessment (See Table 4).

Table 4. Hysteroscopic lesions according to infertility type.

Hysteroscopic lesion	Over all (n = 140)	Primary infertility (n = 75)	Secondary infertility (n = 65)	p
Uterine fibroid	49 (35.0)	25 (33.3)	24 (36.9)	0.395
Uterine synechia	37 (26.4)	21 (28.0)	16 (24.6)	0.398
Hysteroscopic signs consistent with adenomyosis	23 (16.4)	8 (10.7)	15 (23.1)	**0.040**
Uterine polyp	44 (31.4)	33 (44.0)	11 (16.9)	0.001
Other lesions	12 (8.6)	5 (6.7)	7 (10.8)	0.286

Note on this table: multiple lesions could be observed in the same patient.

4. Discussion

In this single-center, referred population, primary infertility accounted for 53.6% of the initially reported analytic sample. This proportion should be interpreted cautiously because the infertility classification requires an audit: the reported proportion of nulligravidas in the primary-infertility group is inconsistent with the study's own definition. The group distribution and all analyses affected by classification should therefore be updated before drawing substantive conclusions.

The sociodemographic profile showed similar patterns across infertility types. The predominance of married women (90%) reflects the characteristics of the population seeking fertility evaluation in this setting and aligns with findings from African surveys where marriage remains closely linked to the pursuit of childbearing [13]-[15]. Employment status did not differ significantly between the groups, suggesting that, in this sample, infertility type did not vary according to occupational category. This observation is compatible with reports indicating that infertility-related factors may be more strongly linked to clinical or reproductive histories than to immediate socioeconomic indicators [16] [17].

The reported differences in gravidity and surgical history cannot be interpreted confidently until the participant-level data have been checked. In particular, the presence of previous pregnancies among women classified as having primary infertility suggests possible coding or classification errors. Any associations with surgical history should also be recalculated using verified counts and appropriate tests, including Fisher's exact test when expected cell counts are small.

The original analysis reported differences in amenorrhea and irregular menstrual-cycle complaints between groups; however, these findings are provisional because the outcomes are uncommon and the p-values require verification. They should be retained as statistically significant only if the reanalysis of the corrected dataset supports that conclusion.

The reported hysteroscopic findings suggest that uterine polyps were more frequent in the primary-infertility group, whereas hysteroscopic signs consistent with adenomyosis were more frequent in the secondary-infertility group. These are observed associations in a selected population referred for hysteroscopy. Hysteroscopic findings should not be equated with confirmed adenomyosis or endometriosis unless supported by an appropriate confirmatory assessment.

Study Limitations: This study presents several limitations that should be considered when interpreting the findings. First, its monocentric design limits the generalizability of the results to the broader population of infertile women in the Democratic Republic of Congo. Second, although the sample size allows for certain comparisons, it remains relatively modest for exploring in depth the relationships between clinical variables, particularly less frequent hysteroscopic lesions. Third, the cross-sectional design prevents causal inference; it is not possible to determine whether the observed lesions are a cause or a consequence of infertility. Since the results are based on a bivariate analysis, the reported associations are unadjusted and potentially confounded.

Additionally, much of the data was obtained from medical records and patient self-reports, which may introduce classification or recall bias, especially regarding obstetric, surgical, and clinical histories. Finally, the study did not include certain potentially determining factors in infertility, such as male parameters, detailed hormonal markers, or environmental exposures, which could limit the overall understanding of the etiological profile.

5. Conclusion

Among women referred for hysteroscopic evaluation at one medical center in Kinshasa, uterine polyps were reported more frequently in women classified with primary infertility, whereas hysteroscopic signs consistent with adenomyosis were reported more frequently in those classified with secondary infertility. These findings describe associations in a selected clinical population and should not be generalized to all women with infertility. The results require confirmation after an audit of infertility classification and reanalysis of the underlying data. Because this study did not assess diagnostic accuracy, treatment effectiveness, or subsequent pregnancy outcomes, it cannot establish hysteroscopy as an "essential tool" or demonstrate improved reproductive outcomes. Multicenter studies with clearly defined recruitment, standardized hysteroscopy protocols, and longitudinal pregnancy outcomes are warranted.

Availability of Data and Materials

The datasets analyzed during this study are available from the corresponding author on reasonable request.

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Author Contributions

JEM designed and organized the work. ANN and ADO drafted the manuscript. PM, HM, and SLE obtained the data. ANN performed the statistical analyses and interpreted the results. JEM and JPDD coordinated the project. All authors approved the final, revised version of the manuscript.

Conflicts of Interest

The authors declare no conflicts of interest.

References

[1] Mascarenhas, M.N., Flaxman, S.R., Boerma, T., Vanderpoel, S. and Stevens, G.A. (2012) National, Regional, and Global Trends in Infertility Prevalence Since 1990: A Systematic Analysis of 277 Health Surveys. *PLOS Medicine*, **9**, e1001356.

https://doi.org/10.1371/journal.pmed.1001356

[2] Inhorn, M.C. and Patrizio, P. (2015) Infertility around the Globe: New Thinking on Gender, Reproductive Technologies and Global Movements in the 21st Century. *Human Reproduction Update*, **21**, 411-426. https://doi.org/10.1093/humupd/dmv016

[3] Ekpor, E., Brobbey, S.S., Kumah, C.Y. and Akyirem, S. (2025) Experience of Infertility-Related Stigma in Africa: A Systematic Review and Mixed Methods Meta-Synthesis. *International Health*, **17**, 903-913. https://doi.org/10.1093/inthealth/ihaf060

[4] AAGL (2019) AAGL Practice Report: Practice Guidelines for the Diagnosis and Management of Intrauterine Pathology. *Journal of Minimally Invasive Gynecology*, **26**, 179-193.

[5] Stamenov, G.S., Vitale, S.G., Della Corte, L., Vilos, G.A., Parvanov, D.A., Nikolova, D.N., *et al.* (2022) Hysteroscopy and Female Infertility: A Fresh Look to a Busy Corner. *Human Fertility*, **25**, 430-446. https://doi.org/10.1080/14647273.2020.1851399

[6] Bosteels, J., van Wessel, S., Weyers, S., Broekmans, F.J., D'Hooghe, T.M., Bongers, M.Y., *et al.* (2018) Hysteroscopy for Treating Subfertility Associated with Suspected Major Uterine Cavity Abnormalities. *Cochrane Database of Systematic Reviews*, **2018**, CD009461. https://doi.org/10.1002/14651858.cd009461.pub4

[7] Zegers-Hochschild, F., Adamson, G.D., Dyer, S., Racowsky, C., de Mouzon, J., Sokol, R., *et al.* (2017) The International Glossary on Infertility and Fertility Care, 2017. *Fertility and Sterility*, **108**, 393-406. https://doi.org/10.1016/j.fertnstert.2017.06.005

[8] Hussein, H.I., Kessy, S.A., Luvakule, A.D., Katembo, B.S., Khatib, S.S., Chandika, A., *et al.* (2025) Comparative Hysteroscopic Profiles among Women with Primary and Secondary Infertility at Benjamin Mkapa Hospital: A Cross-Sectional Study. *BMC Women's Health*, **25**, Article No. 438. https://doi.org/10.1186/s12905-025-03988-6

[9] Behjatnia, Y., Mohammad, K., Dabirashrafi, H., Zandinejad, K. and Maghadami-Tabrizi, N. (1996) Comparative Hysteroscopic Findings in Women with Primary and Secondary Infertility. *The Journal of the American Association of Gynecologic Laparoscopists*, **3**, S3-S4. https://doi.org/10.1016/s1074-3804(96)80137-x

[10] Kaseso, D., Valyananzighu, J., Mulisya, O., Munyanderu, B., Matumo, P., Posite, C., *et al.* (2023) Hysterosalpingographic, Ultrasonographic and Clinical Profile of Infertile Women in Butembo, Eastern Democratic Republic of Congo. *The Pan African Medical Journal*, **46**, Article 105. https://doi.org/10.11604/pamj.2023.46.105.39834

[11] Maindo Alongo, M.A., Otuli, N.L., Sihakiyolo, J.J., Agasa, S.B., Mayindu, S.M., Ilongosi, B.A., *et al.* (2025) The Burden of Infertility in North-Eastern Democratic Republic of Congo, a High-Fertility Region: A Cross-Sectional Study. *Reproductive Health*, **22**, Article No. 182. https://doi.org/10.1186/s12978-025-02111-0

[12] Ombelet, W. (2011) Global Access to Infertility Care in Developing Countries: A Case of Human Rights, Equity, and Social Justice. *Facts, Views & Vision in ObGyn*, **3**, 257-266.

[13] Dhont, N., van de Wijgert, J., Coene, G., Gasarabwe, A. and Temmerman, M. (2011) 'Mama and Papa Nothing': Living with Infertility among an Urban Population in Kigali, Rwanda. *Human Reproduction*, **26**, 623-629. https://doi.org/10.1093/humrep/deq373

[14] Bell, S.O., Larson, E., Bittle, D., Moreau, C., Omoluabi, E., OlaOlorun, F.M., *et al.* (2024) Care-Seeking for Difficulties Conceiving in Sub-Saharan Africa: Findings from Population-Based Surveys in Eight Geographies. *Human Reproduction*, **39**, 1712-1723.

https://doi.org/10.1093/humrep/deae084

[15] Bell, S.O., Moreau, C., Sarnak, D., Kibira, S.P.S., Anglewicz, P., Gichangi, P., *et al.* (2024) Measuring Non-Events: Infertility Estimation Using Cross-Sectional, Population-Based Data from Four Countries in Sub-Saharan Africa. *Human Reproduction*, **39**, 2848-2860. https://doi.org/10.1093/humrep/deae218

[16] Ericksen, K. and Brunette, T. (1996) Patterns and Predictors of Infertility among African Women: A Cross-National Survey of Twenty-Seven Nations. *Social Science & Medicine*, **42**, 209-220. https://doi.org/10.1016/0277-9536(95)00087-9

[17] Gurunath, S., Pandian, Z., Anderson, R.A. and Bhattacharya, S. (2011) Defining Infertility—A Systematic Review of Prevalence Studies. *Human Reproduction Update*, **17**, 575-588. https://doi.org/10.1093/humupd/dmr015