The Arusha project: Accessible infertility care in developing countries – a reasonable option?

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Possible questions for our debate corner

1. How can we reduce the stigma of infertility and childlessness in DC?
2. Does the value of children and the motive for parenthood differ between developed and developing countries, and if yes, what can we do about it?
3. Is it necessary and/or advisable to introduce accessable low-cost infertility services in DC?
4. Is it reasonable and feasible to incorporate infertility care in 'Reproductive Health Care Centres' and what will be the hurdles?
5. Which geographical areas should have priority in developing ART in resource-poor economies and what have to be the selection criteria for accessible IVF in DC?
6. Is access to acceptable perinatal care an unconditioned requirement for the delivery of infertility care in DC?
7. Is access to antiretroviral therapy an unconditioned requirement for the delivery of infertility care in HIV-infected couples?
8. Although the need for single embryo transfer (SET) is obvious, which may be the best algorithm to follow in developing countries. Who should have double embryo transfer (DET)?
9. Can endoscopic surgery (diagnostic and therapeutic) be implemented in a project of low cost infertility care in DC?
10. How can Public-Private partnership assist in the development of simplified ART to the advantage of developing countries? Private versus Public or Public-Private?

Infertility and developing countries (DC): frequently asked questions
(ART = assisted reproductive technologies)

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