Ghanaian Women in the Netherlands and Their Perceptions of Safe Childbirth

Submitted by
Shahannor Akter Chowdhury

Study Supervisors
Prof. Dr. Sjaak van der Geest
Prof. Dr. Anita Hardon

Amsterdam Master's in Medical Anthropology
Faculty of Social and Behavioural Sciences
Universiteit van Amsterdam
The Netherlands

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Summary

This is a case study of six Ghanaian (Akan) migrant women in the Netherlands and their perceptions of safe childbirth. The study aims to find out how Ghanaian migrant women perceive safety at childbirth, while being in a different country and a different culture. Many studies have been done on perceptions of safe childbirth, but little is known about migrant women’s views. Migration - voluntary or forced - inevitably means changes in the lives of people. On migrating to the Netherlands, Ghanaian women face changes in their environmental, social, political and/or economic situation. They adapt to these changed conditions and may have to give up previous lifestyles. While in a different country, Ghanaian women not only have to face their own ‘physical and psychological’ changes during pregnancy, but also problems of ‘cultural’ change.

The study, thus, aims to find out how Ghanaian migrant women perceive safe childbirth while being in Dutch society. The specific objectives of the study are to find out the socio-cultural factors which impact on the concept of ‘safe childbirth’, service and other related factors that contribute to making the choices of childbirth specifically the place of birth, decision-making process in choosing a safe birthplace and what the women perceive as conditions necessary for a ‘safe childbirth’.

This study is exploratory and descriptive in nature. It was carried out when little was known about the migrant Ghanaian women’s perceptions of safe childbirth (in the Netherlands). Due to time constraints, the research was conducted on a small-scale. It was also descriptive as it involved the systematic collection and presentation of data in order to give a clear picture of the particular situation being investigated. The fieldwork for my research was carried out in Kraaiennest, a large apartment block in the Zuidoost (Southeast) Amsterdam. I firstly used published and unpublished data on the particular issue as background information of the study, but the main method of data collection for this study was in-depth interviews. The data were collected through semi-structured interviews with a high degree of flexibility. Questions were open-ended and no restrictions were imposed as to how the respondents would answer. Focus group discussions were held among four Ghanaian midwives and one medical-assistant (they came from Ghana for a trip to the Netherlands) and migrant Ghanaian male participants. Some of the male participants were husbands of my informants. Observation was made between interviews. I joined one of my participants during her visit to the midwife. This gave me an
opportunity to gain first-hand experience of the consultation process. I also participated in Sunday church services of that particular group of Ghanaians.

Pregnancy and birth are universally considered as a special event. This event is potentially dangerous as it is a transition from one state to another both for the mother and the newborn child. For Ghanaian women, this transition is even more dangerous, because it relates to other aspects of their lives. They sense medical, social and spiritual dangers during childbearing. The Akan consider a human being a complex body-mind-spirit composition of maternal components, through which blood ties and kinship are gained, and paternal components, which are responsible for personality and temperament, and divine life-giving forces.

The meaning of safe childbirth among these Ghanaian migrant women in the Netherlands is associated with family and social support, income and living arrangements, traditional beliefs and practices, as well as knowledge and education on reproductive health. Their perceptions of safe childbirth are related to health and health care services provided to them. Gender relations, and role of men and women in decision-making play an important role in choosing a safe birthplace. The following are the factors that contribute to the perceptions of these Ghanaian migrant women on safe childbirth in the Dutch context.

Antenatal care has always been important to Ghanaian women. They expect that antenatal caregivers should provide sufficient time, information, medication and early detection and treatment of problems. Women feel safer when ultrasounds are made and to their babies’ heartbeat is checked.

The Dutch conceptions of pregnancy and delivery do not coincide with the views of Ghanaians on safe delivery. For Ghanaian women giving birth in the hospital is the safest place both in Ghana and in the Netherlands. The hospital staff are trained professionals and they believe they can offer immediate technical aid during delivery if necessary.

At the same time, the Dutch health insurance system has a great influence on making a decision at where the woman will give birth. In normal home deliveries, the national health insurance pays for the services of a midwife, which include all pre- and postnatal care. On the other hand, the health insurance covers hospitalisation only where there is some suspicion or evidence of a problem. This health service factor affects women’s ability to choose between home and hospital delivery. This delivery care arrangement in the Netherlands is very different from what Ghanaians have at home. There, they have choice, as long as they pay for the services.
Here choice is very limited by institutional guidelines and health insurance system. The immigration status of Ghanaians in the Netherlands also is a major factor in choosing a safe birthplace, because any illegal migrant lacks access to the national health services. This circumstance, when they also cannot afford costly private services, limits their choice of place of birth.

Sufficient income and good living arrangement are important factors for Ghanaian women to feel safe and secure throughout pregnancy and childbirth. This support means having a steady job, the opportunity to continue with one’s own studies, financial stability etc. Having enough money usually creates a sense of security; parents can always spend that money when it is needed.

Social support from women’s own networks and supports from their families also help them to cope with the stress of pregnancy and childbirth. This support can be of many forms like emotional and moral support, financial aid, advice and information about pregnancy and childbirth etc.

In the Netherlands, even in hospitals, most normal births are managed not by physicians but by midwives. Thus the decision-making of normal birth is separated from medical decision-making. Although many decisions, such as the location of the birth, who will be present, the question of medication and pain relief, and so on, are institutionally managed in the Netherlands, the Ghanaian women decide themselves where they would deliver and how.

Another most important factor to explain safe childbirth is the parity of women. If they are first-time mothers-to-be, they prefer to give birth in hospital for safety reason; these women feel safe enough in knowing that, in case of complications, they will always be able to get available medical services. Also prior experience with the Dutch maternal health care system affect their perceptions of safety.

Communication is another key factor in helping migrant women adapt to their new surroundings and through this they learn about the new health care system. Although Ghanaian migrant women speak English fluently, they find it difficult to communicate with their midwives and doctors. They think that they are taken less seriously and given less time by the health professionals. They prefer to deliver in Ghana, where they can easily communicate with their midwives and the midwives devote sufficient time to them.
The Ghanaian migrant women consider birth as a normal physiological state, as they do not want any medical intervention in their body during childbirth; but at the same time they do not want to deliver at home. It must be considered that high rate of home delivery is possible in the context of the Dutch situation. The Dutch obstetric system has highly qualified midwives, good prenatal and postnatal care, maternity home care assistants, and a careful system for high and low risk pregnancies. If complications suddenly occur during a delivery at home, rapid transport to a nearby hospital is easy because of the high density of hospitals and the absence of isolated rural areas.
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Chapter One
Introduction

Flowers are nice, but a new report from Save the Children suggests that schooling and basic health care would make better Mother's Day gifts for many of the world's women. In its fourth annual "State of the World Mothers" report, due out this week, the group documents disparities among the 117 countries it surveyed. In the lowest-ranking countries, women die in childbirth at roughly 600 times the rate of women in the most developed countries, and their babies are 27 times more likely to perish during the first year of life...(Newsweek May 12, 2003: 8)

According to the report Sweden, Denmark and Norway top the rankings this year. The Netherlands and Canada hold the sixth position among the 10 best countries to be a mother. The Index uses six indicators measuring the status of women: lifetime risk of maternal mortality, use of modern contraception, births attended by trained personnel, prevalence of anaemia among pregnant women, female literacy, and participation of women in national government. Four indicators covering the well being of children are: infant mortality, nutritional status, primary school enrolment and access to safe water. To a large extent, these statistics go far beyond mere numbers. The indicators exclude women's own experiences, their emotional states, their concept of physical and mental well-being etc. In case of the Netherlands, where it has been a multi-cultural, multi-ethnic society for decades, does this ranking say how the migrant women experience pregnancy and childbirth? As expectant mothers, do they also experience this country to be the sixth best in the world?

This study focuses on the Ghanaian migrant women's perceptions of "safe childbirth" in the Netherlands. The perception of 'safe childbirth' has been studied from many different viewpoints. There have been studies done on this or similar topics but little has been done particularly among Ghanaians living in the Netherlands. Although in Amsterdam, Ghanaians are the third largest immigrant group, there has been hardly any anthropological study among them on this particular issue. On migrating to the Netherlands, Ghanaian women face changes in their environmental, social, political and/or economic situation. They adapt with these changes which affect their previous lifestyles. While in a different country, Ghanaian women not only have to face their own 'physical and psychological' changes during pregnancy, but also problems of
'cultural' change. For instance, the Dutch obstetric system can be very different from the one in Ghana.

The study, thus, aims to find out how Ghanaian migrant women choose their 'place of birth', having safety in mind, in a wider Dutch context. Many factors may contribute to choosing birthplace among this migrant group. While choosing between home and hospital, socio-cultural, religious, economic, health and service related factors might influence the choice. This study intends to explain all those important and possible factors, which shape their decision making in choosing a safe birthplace.

1.1 Background of the Study:

Before going to a further discussion of the study, I would like to present some of my personal experiences, which I think, are related to this.

I came to the Netherlands in September 2001 to participate in Amsterdam Master's in Medical Anthropology. It had always been a dream for me to go abroad and pursue my study. When I heard that I had received a fellowship from the Dutch government, my joy was boundless. Some days after this news, I discovered that I was pregnant. The confirmation of the pregnancy was indeed the happiest news in my life. Unfortunately, both of the happy news put me in a real dilemma. On the one hand, I definitely wanted to continue with my pregnancy but on the other hand I did not want to miss the opportunity to come here. At the same time, as I was quite worried about being pregnant for the first time and not knowing anything about it, I did not dare to come here alone. My husband and my friends gave me moral support and assured me that I could do both. Believing in my inner strength, I decided to come to the Netherlands, alone, with the hope that my husband would join me soon.

Before coming here, I already heard many stories about the Netherlands saying it is one of the most 'child-friendly' countries in Western Europe having the best of medical care. Soon after I encountered the health care system here, I encountered a different story. It first started with the health insurance. As my funding agency contributed for my health insurance, I never imagined that it would not cover my pregnancy costs. It took some time for them to agree that I could stay here, give birth and complete my study, but then I would have my 'own risk' coverage, which means a certain amount of money would be paid by myself. Being not familiar with the system, I just agreed with their proposal. Having settled this matter, I started to visit a polyclinic in one of
the hospitals in Amsterdam. Although I knew my pregnancy was going well, every moment of my stay in the Netherlands was full of insecurity and anxiety. I was lucky enough to be surrounded with friends who took great care of me, but I felt truly helpless to be away from my family, especially from my husband at this crucial stage of life. Nothing could help me get rid of the insecurity. For me, my country would be the best place to deliver, where my family would be around. If anything goes wrong, there would always be instant support. Thinking about all these, I decided to go back to Bangladesh, during the third trimester of my pregnancy.

M.N. Srinivas, a distinguished anthropologist from India who has studied his own society, coined the term *thrice born* for what he called the ideal anthropological journey (Nanda & Warms 1998). First, we are born into our original, particular culture. Then, our second birth is to move away from this familiar place to a strange place to do our fieldwork. In this experience, we are eventually able to understand the rules and meanings of other cultures and the “exotic” becomes familiar. In our third birth, we again turn toward our native land and find that the familiar has become exotic. We see it with new eyes. In the same vein, I started to have the ‘thrice born’ experience in Bangladesh right after I first met my doctor. I had already been informed by the Dutch midwifery system and I was quite interested to deliver at ‘home’ with the presence of my husband. When I shared my feelings with my doctor, she reacted in such a way that I felt I had committed a crime. She bluntly told me "you are no more in Holland. You are now in Bangladesh, so behave like a Bangladeshi woman." I must mention here that, firstly, in Bangladesh it is forbidden (religious and cultural) for a husband to be present during the delivery of his wife (except in some private hospitals). Secondly, staying in the capital city, where most of the births happen to be in hospitals, giving birth at home was simply impossible for me. Although I stayed at home during the first twenty-four hours of pain, I finally ended up in a hospital with a caesarean section.

As I did not finish my study, I was again preparing myself to come to the Netherlands and decided to finally complete the course. Just before coming to Amsterdam, fortunately or unfortunately, I found myself being pregnant again. I decided to continue this pregnancy as well. Although I knew that staying in the Netherlands without my daughter and husband would be even more difficult than before, I had no other choice but to go. I wanted to complete my MA. As usual, I again encountered problems with the health insurance, medical services, etc. Every moment I spent here was full of worries and insecurity. I realized it twice that being pregnant was
not at all easy, while being away from home, away from the family. As I had wanted to do my research on something, which was much related to my own life experience, I decided to do it on pregnancy and childbirth experiences of other women. As I myself had been pregnant in the Netherlands, which is quite different from my own country, I wanted to conduct my research among the group of non-native Dutch women. I chose Ghanaian migrants for a pragmatic reason: they speak fluent English so that I did not need any Dutch interpreter. I wanted to see how Ghanaian women in the Netherlands perceive safety at delivery, being between two cultures and two medical systems.

1.2 Ghana: A Brief Profile

Ghana is situated on the south-central coast of West Africa. It is bounded on the north, east and west by the Republic of Burkina Faso, Togo, and La Cote d’Ivoire, respectively. To the south lies the Atlantic Ocean. The country covers an area of 238,540 square kilometers and a coastline exceeding 539 km. The climate is tropical-warm and dry along the southeast coast, hot and humid in the southwest, and hot and dry in the north.

Accra is the capital of Ghana and among the major cities are Kumasi and Tamale. Ghana is primarily an agricultural country. Its major exports include cocoa, timber, coffee, and palm oil. In addition, gold, diamond, manganese, and bauxite are exported in fairly large quantities.

English is the official language, but many Ghanaians speak other African languages as their mother tongue. The people of Ghana can be divided roughly into five language groups, each of which approximates to a geographical area. These are the Akan, the Ga-Adangme, the Ewe, the Guang and the Gur language groups. The Akan, who are the dominant ethnic group in Ghana, live predominantly in the Ashanti, Brong Ahafo, Central, and Western and Eastern Regions. They include the Ashanti, Kwahu, Akim, Akwapim, Fanti, Nzima, Wassa, Brong, and Ahafo. The Akan dialects spoken in Ghana may-be divided into two groups: Twi and Anyi-Baule. Twi is the commonest among the Akans in Ghana as a whole and has almost become Ghana’s lingua franca.

The main religions in Ghana are indigenous beliefs, Muslim and Christian.
1.3 Ghanaians in Amsterdam:

Between 1971 and 2000 the number of migrants in the Netherlands has increased from 200,000 to more than 2.6 million accounting for 17% of the total population (Statistics Netherlands, May 2000). In some cities, nearly half of the population is composed of migrants. In the Netherlands, migrants are defined as people born abroad with at least one parent born abroad and people who are born in the Netherlands but with at least one parent born abroad. Migrants in the Netherlands are composed of different groups from many different parts of the world. The four main groups are Moroccan, Turkish, Surinamese and Antillean migrants.

There are several factors that encourage Ghanaians to immigrate to the Netherlands. Firstly, Ghanaians have a high level of education, which enable many of them to speak good English. Knowing an international language helps them to communicate easily abroad. Secondly, their cultural socialization also encourages pursuit of economic success allowing for separation from their initial environment and adaptation to a new one. Unfavourable political and economic factors are among those, which have caused the migration too (Ter Haar 1998). The Ghanaian women migrate for the same reasons as men do. Some come to the Netherlands to join their husbands, some to join their families, but, generally, the main reason is to improve their economic status in Ghana.

The influx of Ghanaians into the Netherlands before 1974 was negligible (Arhinful 2001). The significant migration that started from 1974 may be categorised in two phases as subtle and massive (Nimako 1993). The subtle phase took place between 1974 and 1983. The massive phase took place after 1983 came as a natural response to the economic crisis and drought in Ghana between 1981 and 1983 as well as the repatriation of nearly a million Ghanaians from Nigeria in 1983. Available statistics indicate that by 1990, more than 5000 Ghanaians had settled in the Netherlands. In 1992, the official Ghanaian population in Amsterdam alone stood at 4197 of which 60% lived in Amsterdam Southeast making Ghanaians the third largest ethnic minority group in that community (Nimako 1993). Present estimates put the population of legal Ghanaian migrants in the Netherlands at about 10,000.

To find a home away from home and to find identity, Ghanaians in Amsterdam have developed strategies of ‘survival’ as a cultural group. There are, for instance, Ghanaian foundations for health and social issues. They have Ghanaian Churches, radio broadcasts, food and clothing shops, videos etc. Furthermore, they are becoming more ‘closed community’ by
building a strong sense of Ghanaian identity and social network to help them survive in the Netherlands (Yebei 1999). Although they had this strong sense of Ghanaian identity, when I talked to them, most of the time, they referred themselves as African. I felt that their identity as African went far beyond than own identity as Ghanaians.

1.4 Migrants and Health Care in the Netherlands:

Accessibility to adequate medical facilities is a fundamental and universal human right, although it is universally acknowledged that the economically weak country, the under-privileged as well as poor areas in rich countries, have great difficulty in benefiting from such services (Vulpiani 2000). The immigration status of Ghanaians in the Netherlands is a major factor in getting access to health care. In 1998, a new Dutch law, the *koppelingswet* was established. It permits the linking of databases in order to ensure that immigrants who have legal documents would benefit from basic social services such as health care. A research project carried out in 2000 showed that people who do not have legal permission to stay in the Netherlands, so-called illegals, have only limited access to health care. They are only entitled to medically necessary care and are mainly dependent on a relatively small group of ‘illegal-friendly’ doctors and midwives, whom most find through networking (www.nivel.nl).

In the 1994 ICPD Programme of Action, it was explicitly mentioned that “migrants and displaced persons in many parts of the world have limited access to reproductive health care and may face specific serious threats to their reproductive health and rights. Services must be particularly sensitive to the needs of individual women and adolescents, and responsive to their often powerless situation, with particular attention to those who are victims of sexual violence” (PoA 1994 7.11). Although in theory, the prospects for good provision of reproductive health care are bright, because this Programme of Action for the coming two decades places women’s reproductive health and rights at the top of the overall population and development agenda (Ascoli 2001), it is not always the case in the Netherlands. Especially for women without legal authorization to stay in the Netherlands, insecurity, and often bad socio-economic conditions, lack of information and lack of access to available services may explain their distrust in the Dutch health care system, particularly maternity care services.

For foreigners, including migrant women, there are also more cultural specificities of the Dutch (reproductive) health care system. It is of course hard to generalize on this issue, but the
Dutch medical ‘philosophy’ seems to show a reluctance to prescribe drugs, to make less use of routine check-ups and tests (instead people are encouraged to come when they have a problem), and a rather specific culture of communications (doctors provide patients with little medical information unless patients ask for it, though doctors are open to questions) (Ascoli 2001).

Reporting on the quality and accessibility of sexual and reproductive health care in the Netherlands, Boschman and Verheul (1997: 9) noted the following barriers, especially for foreigners or people not familiar with the system:

- Financial barriers in the form of fees (own contributions) and own risk coverage - a restriction in the basic provisions of the national health insurance scheme;
- The complexity of the organization of health care - for many foreigners it is difficult to know what kind of care can be received where;
- Communication problems between patients and service provider - because of problems with language, differences in culture, sex, expectations of care provision, views on health and disease;
- Lack of trust between health care provider and patient, related to insecurity, prejudices, lack of knowledge and insight into the cultural background, on both sides;
- Lack of adequate methods of diagnosis and treatment: current western approaches may not adequately answer the needs of foreigners; and
- Insufficient time and money for service provision especially for foreigners.

1.5 The Dutch Midwifery System:

It is said that the system of midwifery and the importance of home delivery in the Dutch society are unique. The reasons why the Dutch system of obstetric care is unique in the Western world include the predominance of midwife-attended births, the high level of home delivery, and the low rate of intervention in the birthing process. The midwifery system in the Netherlands is characterised by a two-tier system of primary and secondary care. In addition to GP or family doctor, a separate independent professional group and independently practising midwives belong to the primary care tier. Gynaecologists/obstetricians or other specialists are included in the secondary care. As the midwifery care in the Netherlands is based on the principle that pregnancy and birth are essentially natural processes, Dutch midwives are trained to provide care during normal, uncomplicated pregnancies and deliveries.
The midwifery system in the Netherlands does not encourage ‘medicalization’ of pregnancy and birth. The midwives give full attention to the social and psychological aspects of delivery and employ only few medical technologies. Home births were a general phenomenon throughout Europe until the mid-1990s. By this time, obstetricians started to argue that home deliveries were hazardous and less safe than in hospitals. It was believed that in the hospitals, modern technology was available to protect the health of mother and infant during labour. There was a big debate in the Netherlands on this trend towards specialization and medicalization. It was because some reputed Professors of Gynaecology did not recognize the importance of home delivery. They influenced the idea that birthing is a physiological process and that home delivery would reduce or prevent unnecessary medical intervention, which in turn might increase the risk to mother and child. Moreover, they believed that home deliveries attended by a midwife or by a general practitioner would enhance psychological security of the mother.

Hospital deliveries were introduced in the 19th century. In the 1600s, the hospitals that were financed by the towns to serve the poor and destitute did not admit women about to give birth. Hospitalisation became significant only after World War II, and as late as 1960, 74 percent of babies were born at home. During prenatal care, midwives and general practitioners determine which women have pathological pregnancies. They find out the possible cases that are at risk for pathology. Those women must be referred to an obstetrician. In 1973, to limit the increasing hospitalisation, the national health insurance system introduced a list of ‘medical’ indications to distinguish between normal (physiological) and complicated (pathological) deliveries. Dr. Gerrit-Jan Kloosterman developed this list known as the Kloosterman list. The revision of 1987 recognizes three categories of pregnancies: low risk (eligible for home birth), high risk (hospital delivery) and medium risk.

In its response to the recommendations of the advisory committee, the government summarized its long-term maternity care as follows:

1. A midwife or a GP should care for a pregnant woman, unless there was a medical indication for obstetrician-led care.
2. Home birth is regarded as the natural and preferable way of birth. For this system, risk selection is considered essential, and for adequate risk selection, the caregivers (midwife, GP, and obstetrician) should cooperate.
3. Such cooperation has two aspects: cooperation in the care for an individual woman and an institutionalised form of cooperation.

When Kloosterman’s list of ‘medical’ indications for hospitalisation was introduced in 1973, a ‘social’ indicator was added. From 1948 to 1970 in Amsterdam, women in this category gave birth in the Zeeburg unit that was attached to the University of Amsterdam. Since the revision of the list in 1987, the former ‘social’ indication for hospitalisation includes women using hard drugs, those with psychiatric problems, and those who plan to give their babies for adoption.

Another important occupation within the midwifery system in the Netherlands is that of the maternity home-care assistant. Giving birth at home while spending lying-in period at the same place is possible because of the availability of maternity home-care assistant. The duties of maternity home care assistants include:

- Assisting a midwife or family doctor during home birth or a short-stay hospital delivery (maximum stay of twenty-four hours)
- Attending and caring for mother and baby, and looking after any older children in the family
- Recognising symptoms in mother and baby that make it necessary to contact the midwife or doctor
- Providing health education for parents, such as guidance on how to establish breastfeeding or on how to bottle-feed the baby, how to change diapers, and information concerning the general health-care of babies; and
- Housekeeping and other domestic tasks, such as cooking for the family.

While these are the basic features of the Dutch maternal health care, it would be interesting to find out how the Ghanaian migrant women experience this system. How do they perceive the ‘naturalization’ of birth? Do they also view home birth as safe as hospital birth? What is safe childbirth for them? The study tries to answer how the Ghanaian migrant women conceptualise and contextualize ‘safe childbirth’, being in a different country.
Chapter Two
Research Methodology

‘As a participant observer, you will need to increase your introspectiveness. In a real sense, you will learn to use yourself as a research instrument’ (Spradley 1980). It was during one of the first modules of Medical Anthropology course, when our professor Sjaak van der Geest first told us about ‘introspection’. While discussing about prospective research subjects, he suggested that we do something related to our experiences, something close to our hearts. Right at that moment, I thought I would do my research on a subject that I experienced and was exposed to as I mentioned earlier. Essentially, I was both a researcher and a research instrument myself of this study.

2.1 Gaining Access:

Gaining access to the group of Ghanaian women was the most difficult step in this study. I first wanted to gain contact through the midwives who have been working with Ghanaian women for many years. After two weeks of attempts, I finally had an opportunity to talk to one of them. Although she shared her own experiences, I found her quite reluctant to introduce me to other Ghanaian women. She kept saying that those women would not talk to me, because I am a stranger for them. They would only talk to her openly. The midwife was to some extent right. I also thought myself about why those Ghanaian women would talk to me and share their experiences of pregnancy and childbirth unless someone they trust introduces me to them! I discussed this with the midwife but she clearly stated that she could not help me because she was very busy and did not have any time to explain this to the women. Being disheartened, I came back. My time was running, but I still could not find anybody as my perfect ‘gatekeeper’. When I reached the point of absolute frustration, I thought about one of my classmates, Francis. He is from Ghana and he already knew about my research. So, I emailed him when he was in England. He promptly replied and promised that he would contact me as soon as he is back. He kept his promise.

I met Francis one morning and we tried to find a way together. We thought it would be best if we could contact the Pastor of a Ghanaian Church he attends and explain to him my
research. Francis called his Pastor that very moment and explained. He made an appointment for the next day. So, I went together with Francis to the Pastor's house. There, I met him, his wife, and his little children. I explained the reason for my visit, why I was particularly interested in Ghanaian women, and why I wanted to conduct research on their experiences of pregnancy and childbirth. After discussing these, he told me that I could start talking to his wife. Her four children were born in Ghana and two here. Therefore, we made appointment for doing her interview. In addition, the Pastor invited me to go to the Church where I would have the opportunity to meet many Ghanaian women and talk to them. 

I went to his church the next Sunday. After the service, the Pastor briefly introduced me to the Church members. Then I went to the front, introduced myself and explained why I came and what I wanted to do. I also told the women that it is not obligatory for them to participate in my study and it is completely a voluntary involvement. Those who were interested gave me their contact numbers and the weeks that followed were full of work and information. Once I gained their trust, it went quite smoothly. Later I realized that my pregnancy also helped me win their trust. They openly discussed about their feelings and emotions and their physical problems which at many times relate to my own experiences. I also shared with them about my own society, my own culture, and experiences concerning pregnancy and childbirth. I thought myself afterwards, if I were not pregnant, would they really talk so openly?

2.2 Objectives of the Study:

The broad objective of this research is to explore:
Ghanaian migrant women's perceptions of 'safe childbirth' in the Netherlands.

The specific objectives are to explain:
1. The socio-cultural factors which impact on the concept of 'safe childbirth'.
2. Service and other related factors that contribute to making the choices of childbirth specifically the place of birth
3. Decision-making process in choosing a safer birthplace.
4. What the women perceive as conditions necessary for a 'safe childbirth'.

11
2.3 Study Type:

This study is exploratory and descriptive in nature as it was carried out when little was known about the migrant Ghanaian women’s perceptions of safe childbirth (in the Netherlands). Due to time constraints, the research was conducted on a small-scale using a sample of only six women. It is also descriptive as it involved the systematic collection and presentation of data in order to give a clear picture of the particular situation being investigated.

2.4 Study Site:

The fieldwork for my research was carried out in Kraaiennest, a large apartment block in the Zuidoost (Southeast) Amsterdam. I chose to select this site for two reasons. Firstly, there is high concentration of Ghanaian residents who live in this part of Amsterdam. Secondly, I live in Amsterdam and for the short duration of time and limited resources, I think it would be convenient for me to conduct my fieldwork in this area.

2.5 Data Collection Technique:

2.5.1 Qualitative Approach:

I used published and unpublished data on the particular issue as background information of the study, but the main method of data collection for this study was in-depth interviews. The data were collected through semi-structured interviews with a high degree of flexibility. Questions were open-ended and no restrictions were imposed as to how the respondents would answer. These semi-structured interviews enabled me to probe deeply and ask several questions. This method also gave me an opportunity to learn more about research problem I was investigating. The key informants in this study included six Ghanaian women, four Ghanaian midwives, three Dutch midwives, one Dutch researcher and one Ghanaian Pastor.

Extended case histories were also used as a data collection tool. The issue of the perceptions of ‘safe childbirth’ came out of the Ghanaian women’s narratives. Perceptions of safety in childbirth might change during the course of time so I interviewed each of them twice.
during my fieldwork in order know what changes happened. Focus group discussions were held among four Ghanaian midwives and one medical-assistant (they came from Ghana for a ‘two-weeks’ visit in the Netherlands), and ten migrant Ghanaian male participants. Some of the male participants were husbands of my informants. Observation was made between interviews. I joined one of my participants during her visit to the midwife. This gave me an opportunity to gain first-hand experience of the consultation process. I also participated in Sunday church services of that particular group of Ghanaians.

2.6 Participants of the Study:

I identified some individuals suitable to the topic of my study. Then, I used their contacts to find people who could be my prospective participants. This particular method enabled my key informants to refer me to another and that provided a good introduction for the next interview. One disadvantage though of this method is that the variation in the ‘sample’ was limited because it consisted of informants who belonged to the same network of the index cases. The criteria for selecting my study participants were:

- Women, who were pregnant at present or recently had given birth in the Netherlands (two interviews);
- Or, women, who had at least one child born in Ghana (four interviews)

The following are brief profiles of the Ghanaian women I interviewed. Most of them came from Ashanti region and speak Twi. I will use their pseudonyms to protect their identity.

Abena:

Abena came to the Netherlands seven years ago. She is from the Ashanti region of Ghana, is 39 years old, is a housewife, and has six children. The first twins are now 13 years old, the second are also twins and now 11 years, the third is a son 6 years of age and her daughter is 11 months old. Her younger two children were born here, the rest were born in Ghana and they live there with her sister.

Abena came to the Netherlands to join her husband who is a Pastor in a Ghanaian Pentecostal Church in Amsterdam. She never visited Ghana after she came here. She cannot
leave this country because her papers are still not ready. She thinks that as soon as they are ready she will go and visit her children. Her husband went to Ghana three times and visited them.

Adwoa:
Twenty seven year-old Adwoa came to the Netherlands almost three and half years ago. She is also from Ashanti region and a Catholic. She got married some months after she came here. Her parents and her husband’s parents completed all the rituals in Ghana. Although they were married in their own way, they still do not possess any legal document of their marriage according to the Dutch law. That’s why sometimes she refers to her husband as boyfriend. She has one child born in the Netherlands. Although her husband has legal papers, she does not have it yet.

Akua:
Akua is 31 years old. She has two sons; one is 3 years old and the other is 15 months old. She is presently 7 months pregnant. She works as an administration worker in a Dutch company. Akua was brought up in England. She has been in the Netherlands for almost ten years. Her father has been in the Netherlands for thirty years. Therefore, she already has her legal Dutch status. She is also a Pentecostal and from Ashanti region.

Afua:
Afua is 33 years old. She completed her ‘A’ level of education in Britain where she stayed for six years. Then she went back to Ghana and came to the Netherlands two years ago. In Britain, she had been working as a health care assistant. In the Netherlands, she helps her uncle in his shop and also volunteers in a private Ghanaian radio. Afua has two children. Her seven year-old son was born in Britain and 3 year-old daughter was born in Ghana. The children are living in Ghana with their father. Afua came to the Netherlands alone so that she can earn some money and help her husband’s business in Ghana. She is also from Ashanti region and is Pentecostal.

Akosua:
Akosua is 33 years old. She is a hairdresser. She had college education and has three sons. They are 13 years, 12 years and 15 months old. She has been in the Netherlands since 1997. Her
husband is working in a Japanese company. They are Pentecostal and originate from Ashanti region.

**Yaa:**

Yaa came to the Netherlands in 1992 with her elder sister. She comes from the Eastern Region in Ghana. She is 37 years old and mother of two children. Her 15-year-old daughter was born in Ghana and the 4-year-old son was born here. She completed her secondary school in Ghana and in the Netherlands she works as a housecleaner. She is Pentecostal.

The number of children of each participant and where they were born, are shown in the following table:

<table>
<thead>
<tr>
<th>Name of participant</th>
<th>No. of children born in Ghana</th>
<th>No. of children born in the Netherlands</th>
<th>No. of children born in other country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abena</td>
<td>4</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Adwoa</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Akua</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Afua</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Akosua</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Yaa</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

2.7 Ethical Considerations:

'Informants have a right to remain anonymous. This right should be respected both where it has been promised explicitly and where no clear understanding to the contrary has been reached...' *(Principles of Professional Responsibility, 1971, Para. 1,c)*. Although all of the participants agreed that I could use their original names, I decided to hide their real names in the final report for the sake of confidentiality. Verbal (and written) consents to conduct and tape-record the interviews were obtained from each participant. The respondents got assurance that participation in this study would be voluntary and that all information would be treated confidentially. The participants enjoyed every right to withdraw themselves from this study at any point of time.
2.8 Limitations of the Study:

As any human work, this study must have many limitations. I like to mention here the prominent ones. First of all, the duration for this study was really short. The study was conducted from May to August 2003, including fieldwork and writing of the thesis. The population I chose to conduct my research on was absolutely new to me, which means that I had to spend an enormous amount of time before I gained access to them. Consequently, this shortened my data gathering time. Secondly, being an enthusiast researcher of anthropology, I always thought ‘How much do I know about the lives of my participants?’ I found out that I was neither a complete participant nor a complete observer myself. This might have affected the process of obtaining more information about the study population. Thirdly, as the research was conducted only among six women, it is quite exploratory. Finally, the group of women I interviewed was quite homogenous. Most of them came from the same region of Ghana and speak the same language. Their social and economical status in the Netherlands is quite similar. Furthermore, most of them are Christians and they go to the same Church and maintain same social connections. This may limit any variation in my findings.
Childbearing is a term used to label human procreation from conception through birth, the puerperium and early parenthood, with all its physical, psychological and social ramifications (Sich 1988). Each pregnancy and each birth is unique, and thus every society conceptualises pregnancy and childbirth in its own way. When we talk about societies’ perceptions of ‘safe childbirth’, it eventually means that on the other side of the spectrum lies ‘risk’. The concept of risk puts birth as a life crisis event for the mother and the newborn child in terms of biological and socio-cultural context. The moment we talk about ‘life crisis’, ‘risk’ and ‘danger’ come along. But, what does “risk” mean to us? A risk is the harm that something may cause, but it necessarily does not mean that something bad will happen. It only means that something bad is more likely to happen. This concept of risk can be studied from two different dimensions: a technical, objective or scientific dimension and a socially experienced or lived dimension (Gifford 1986). In this chapter, I like to show how risk in childbearing has been studied from a biomedical point of view and how different dimensions of risk have been understood and experienced by lay women around the world.

The chapter mainly contains two sections. First, I like to discuss how risk has been defined and explained by epidemiologists and medical professionals. In the next section, I will show that risk can also be defined and experienced from a lay perspective. This lay perception combines acknowledged and unacknowledged risks, which consist of physical, social and spiritual aspects.

### 3.1 The Professionals’ Perceptions of Risk: A Biomedical Perspective

Birth is not only a life crisis, but also a transition from one phase to another for a mother and the newborn baby. This transition involves risk and danger. Most of the literature found on ‘risk’ and ‘safety’ during pregnancy and childbirth are epidemiological, which focuses mainly on technical,
medical and objective aspects of the transition. Here the concept of risk is mostly based on perinatal mortality and morbidity. It would be clearer to us if we look at the following statistics:

Throughout the world about 15% of pregnant women suffer life-threatening complications. An African woman has a one in 21 lifetime risk of dying from birth complications, a woman in Asia has one in 54 lifetime risk, and a woman in Northern Europe has an almost negligible one in 10,000-lifetime risk. Up to 75% of all deaths are obstetric emergencies, predominantly hemorrhage; septic abortion; eclampsia (convulsion and coma triggered by high blood pressure); infection; and obstructed labor (Nowak 1995).

The concept of risk thus has always embodied ideas of danger, but it has not always embodied ideas about chance. The concept of chance was introduced to the definition of risk more recently. The Concise Oxford Dictionary gives the contemporary meaning of risk as “the chance of injury, damage or loss. A dangerous chance, hazard”. Epidemiologists speak of risk as being a measured property of a group of people. For the epidemiologists, the concept of risk expresses a statistical measure of the degree of association between a characteristic and a disease within a defined population. For instance, when they talk about absolute risk, they mean, the incidence of a disease in a population. Clinicians on the contrary speak of risk as a specific property of an individual.

WHO (World Health Organization) categorises three kinds of risk factors in childbearing: reproductive, socio-economic and medical risk factors. Reproductive risk factors include age and previous pregnancies of a woman, unwanted pregnancy and unattended births. The broad category of risk addresses the educational and economic issues that have a bearing on women’s status in any given country. The direct causes of maternal death under medical risk factors are obstructed labour, haemorrhage, eclampsia, sepsis, and abortion. The indirect causes include nutrition, anaemia, malaria, tetanus, and reproductive tract infections and sexually transmitted diseases.

Although women speak about childbirth as a natural process, at the same time they accept the medical view of birth. Biomedicine has a great influence over women as it relies on technology and is a powerful and a forceful practice. The women may think that anything could
go wrong during childbearing and they ultimately rely on the medical professionals to ensure that they will do everything to have a healthy baby. As a result, nowadays, in most industrial and Western societies, childbirth is generally experienced in hospitals and is associated with increased and routine technological intervention. In his article “The Technological Model of Birth”, Robbie E. Davis Floyd (1987) investigates the paradigm that provides the underlying rationale for the obstetrical management of birth in the United States. The author shows that this paradigm, the technological model of birth, utilizes the assembly-line production of goods as its base metaphor for hospital birth. The basic tenets of this model, which include the Cartesian mind-body separation and the concept of the female body as a defective machine dependent on technology for successful reproduction, are both enacted and transmitted through routine obstetrical procedures. These serve as the rituals through which American society seeks to draw the individual belief systems of birthing women into the conformity with its dominant reality model.

3.2 Lay Perceptions of Risk: Acknowledged and Unacknowledged Risks

The professional and the lay perceptions of risk differ in many ways. According to Mary Douglas, one of the defining differences between expert and lay perception of risk can be found in their respective approaches to the individual subject (1992). The expert, she notes, has a commitment to methodological individualism: “To start with the individual and to stay with the individual to the bitter end, is their chosen escape route to objectivity”. The problem with the objective approach of the expert, Douglas suggests, is that it says nothing at all about subjectivity, nor about the influence of a person’s social support network. Nor does the expert acknowledge that “anger, hope and fear are part of most risky situations” and that a decision that involves cost also involves consultations with neighbors, family, and work friends.

3.2.1 Physical Risk

Obviously, the physical risk during pregnancy is not only examined and discussed by professional health workers. Lay people also think about their own and their children’s physical well being. In all cultures, there are beliefs and practices concerning physical safety at pregnancy.
and childbirth. These traditions may sometimes seem irrational or non-scientific; but, if one looks at them carefully, one will understand that they make sense within the people’s cultural context.

It has been found in many countries that there are restrictions on certain foods and activities which may affect the mother and the baby (Lefeber 1994). For instance, in Kenya (Digo people), Somalia and Zambia (Tonga people) food restriction, especially of staple-food during the last three months of pregnancy, is advised to prevent the child from becoming too big. There are other reasons why people believe that certain kinds of food have to be restricted in the antenatal period. In Kenya, for instance, Akamba people believe that herbs may damage the child’s eye and alcohol may cause severe haemorrhage during delivery. They also believe that too warm food may cause burning of the child and the forming of Mongolian spots on the child’s buttocks. Mende people in Sierra Leone restrict coconut milk because they think that the milk may cause postpartum haemorrhage. Food recommendations for the pregnant women are as important as food taboos. Pregnant Hausa women in Nigeria are recommended to eat liver, palm oil and green leafy vegetables in order to get more blood. Pregnant women in Zimbabwe are encouraged to eat green leafy vegetables especially pumpkin leaves. In addition, vegetables 'high in mucin content' such as okra are encouraged, as it is believed that they 'increase laxity of the vaginal mucus thus facilitating easy delivery'.

Some activities of pregnant women are also commonly restricted by the TBAs in Africa and Asia. They believe, for instance, that standing in the doorway may cause obstructed labor. They also believe that going for a walk and returning halfway may cause prolonged labor, bathing late in the morning or at night, or walking at night may draw evil spirits. Sleeping during daytime or being lazy may cause a long delivery as the child may behave in the same way on its delivery day. These beliefs on foods and activities are very important as they are highly related to uncomplicated pregnancy and safe delivery. It tells us how much these women are concerned about their unborn children’s and their own physical well being. By practicing these rules, the women want to prevent ‘physical risk’ during childbirth.

An example of how lay women make rational choices can be found in Sargent’s (1982) study. The author examined women’s choices of obstetrical care in a Bariba community in the People’s Republic of Benin, West Africa. A detailed examination of the utilization patterns of home and maternity clinic services demonstrated that village women prefer traditional birth attendants for delivery, but attend the clinic for prenatal consultations. Sargent argues that women
who do not give birth in a clinic are making rational choice as maternal morbidity and mortality rates are parallel in the two settings.

### 3.2.2 Social Risk

Besides the above-mentioned physical risk, women in many societies also experience social risk concerning childbearing. They are concerned with the fact that there is relationship between women’s status and motherhood. In a vast majority of the world’s societies, a woman’s status is valued by the number of children she bears. Her status may be further enhanced if she produces abundant male offspring. Browner and Sargent (1990) mention that a woman’s desire to bear a healthy child for her husband stems in part from her recognition of the relationship between female adult status and successful childbearing. It also derives from the fact that a respected position as a wife in a polygynous household is dependent on that woman’s ability to bear healthy children.

In Ghana, infertile marriages are a serious problem according to Amonoo-Acquah (1978). The infertile woman is scorned, mocked and shunned. Usually male infertility is not acknowledged but when it is, it is considered synonymous with impotency. Amonoo-Acquah describes various beliefs, attitudes and practices in relation to infertility in the Ghanaian society. This author also reveals the humiliating condition that the infertile couple is bound to encounter in the society, such as ridicule, resentment, worry and unhappiness. These attitudes, plus the strong desire to produce children lead many women in this situation to seek herbal medicine, consultation of ‘juju’ men and modern medical treatment to rectify the condition.

Patricia A. Kaufert and John O’ Neil explored the three languages of risk (clinical, epidemiological, and lay), developed through the analysis of a debate over risk between a physician and a woman from one of the Inuit communities of the Canadian Arctic (1993). The authors showed that the Inuit women’s assumptions about the general ‘riskness’ of human existence (including assumptions about risk in childbirth) were linked with the physical environment in which they lived and with their recent history and cultural traditions. The Inuit were living in the Keewatin, an area along the western coast of the Hudson Bay. They presented a view of birth as naturally safe, in contrast to clinicians who saw birth as inherently dangerous. Their language of risk was rooted in a view of a traditional way of life in which people had
survived in a harsh and dangerous world by their own competence and self-reliance. Older women described managing birth totally alone, or talked about helping other women give birth. Competence was linked with the possession of knowledge. Risk is not denied, but accepted as part of the reality of northern life. The meaning of risk thus varies depending on who uses the term; the society constructs the meaning of the term.

In her article “Asking women why: a study in Tanzania”, Denise Roth Allen (1998) suggested that listening to how people define risks to their own or their family members’ health is an important first step in understanding their health care decisions. Fortney (1995) and Lupton (1993) mention the same. Although it is rarely done, an important part of assessing a patient’s risk is to evaluate how her community’s characteristics contribute to her pattern of risk. Denise Roth talked about acknowledged and unacknowledged risks. Acknowledged factors, which are known to affect maternal health outcomes include for instance, underlying health problems, age at the time of pregnancy, spacing between two pregnancies and the number of previous pregnancies. While talking with women and their family members (in Tanzania) about some of the dangers they associate with pregnancy and delivery, Roth learned that an alternative set of risk factors existed- a corresponding set of unacknowledged risks. She showed that there were delays not only in getting treatment, but also delays in seeking health care. She thinks that these are sometimes an unacknowledged side effect of illiteracy and poverty. For example, some health care workers treated poor and illiterate women with less respect than they accorded pregnant women of higher socio-economic standing. Poverty and women’s low status in society posed risks to maternal health in other ways as well. The day-to-day frustrations of working in conditions where the health workers are unable to respond appropriately to obstetric emergencies undoubtedly affect health workers’ ability to remain motivated at work and ultimately, the quality of provider.

3.2.3 Spiritual Risk

Women also acknowledge spiritual risks of childbearing, although they are bio-medically unacknowledged and pushed aside as ‘irrational’ beliefs. Blanchet’s study (1984) shows that avoidance of some activities, together with the avoidance of ‘bhut’ (low spirit), is the most important antenatal care in Bangladesh. “Menstruating, pregnant and parturient women are
believed to be especially vulnerable to the mischievous action of 'bhut'. These ghost-like spirits play a conspicuous role in the life of rural women, far more than that of men. ...Pregnant women fear 'bhut' very much as it is believed that spontaneous abortions and stillborn children are caused by the action of ‘bhut’. ..."

Niehof (1988) reports that in Madura of Indonesia, the mother “should confine herself to the house and compound, and should not come near the kitchen or participate in cooking and cleaning activities.” The mother has to follow this rule because she and the child are believed to be in a transition and therefore very vulnerable to supernatural evil forces. In addition, they are not only contaminated, but also contaminating their environment.

For the Bariba (Sargent 1982), humans are considered as evil and they attempt to manipulate the powers of nature to their own advantage and against others. Thus, men as well as witches, sorcerers, ancestors or spirits can cause sickness. Witches are primary agents of misfortune in Bariba cosmology, because they are believed to present themselves at birth, any problematic birth, including an eight-month pregnancy, can be a potential witch baby. Since witches are thought to kill their patrilineal kin, any witch birth is of concern to a baby’s patrilineage. Although in principle witch births are viewed as acts of God, in actuality, the women who produce them are likely to be blamed by their husband’s kin.

**Conclusion**

The distinction between expert and lay perceptions of risk is similar in many ways to how biomedical and non-biomedical approaches to health and healing have been characterized in the medical anthropological literature. Within the biomedical context, sickness and ill health are seen in terms of how disease affects the individual person, and as a result, the focus of treatment is on the individual. This approach reflects the values of Western, industrialized countries, wherein individualism and an emphasis on high-tech treatment figure significantly. Non-biomedical approaches to ill health, in contrast, often include a focus on the social and symbolic aspects of sickness and ill health and in doing so, call into play a wider set of relationships external to the individual.

Following the above discussion on risk assessment in pregnancy and childbirth, I like to conclude that the concept of risk in childbearing depends to a large extent on the society’s
construction of childbirth. On the one hand, where the society looks at it as a normal physiological process, ‘risk’ is looked upon as intrinsic part of childbearing, something that a woman normally goes through. On the other hand, in a society where childbirth is considered as a medical, social, or spiritual problem requiring specific intervention, risk becomes a reality that forebodes danger.
Chapter Four
Analysis and Presentation of Data

4.1 Significance of Children among the Ghanaians:

The attitude in Ghana towards having children appears to be universally positive. Children are wanted by every married couple and are regarded as ‘gifts from God’. Children are greatly valued, since they help in the house and on the farm, they serve visitors, they support their parents and are their heirs. As one of the male participants in the study mentioned,

“We are proud to have children. You can go out holding the finger of your child and feel very proud. Proud because, when you will be old, your child will take care of you. In Europe, if you are old, you have no problem. But in Ghana, when you are old, you depend on your children. So we are proud to be fathers. Also, in Ghana, if a woman does not have any child, the mother-in-law will come and ask her, when will you give me a grandchild? If you are married for a long time, and you do not have any child, the family people will create trouble by asking you to have another wife. The family wants a child because the child will succeed you after your death. So, when you have a child, you are proud because the family member will not come and disturb you with such things”.

When I asked about abortion in Ghana, one Ghanaian man said,

“It’s not good, because everybody is created by God for a purpose. The child is a creature of God. When you abort the child, you kill a human being. It’s like a human slaughter! Secondly, you do not know may be your child is going to make a difference for the nation, or for the family or for home. When you abort, you destroy this...it is as simple as that. If you abort, it means you have destroyed what God has created. As a Christian, you must not do it”. All other men present said they agreed.

In a study conducted by Bleek (1976), the most frequently expressed idea about having children is that children enhance a woman’s happiness and her fulfilment of life. Children bring
companionship, and a woman without children can never become happy, she always remains lonely and sad and becomes envious of others. Closely connected with this is the idea that the child helps in the house. It would not be merely of economic utility. The help that children do in the house has as much personal as economic value; it is a kind of active companionship. Children do innumerable small errands each day. A third category of associations has been grouped under the title ‘social pressure’. It is felt that children are the sign of a woman’s normality, femininity, and healthiness. A woman who has no children is open to various suspicions. The two most common suspicions are that she is witch and has killed her own children, or that she leads a morally despicable life. The connection between infertility and moral behaviour is laid in various ways. Some see barrenness as a supernatural sanction by God, others think of a venereal disease. Most Ghanaians believe that children come from God; they stress the religious value of children that they are a blessing of God and human beings must pray to God for children.

As we see in Yebei’s (1999) study, the birth of children among Ghanaians is held as a sign of marital blessings from God. Children are a blessing to the family and so most marriages that are unfruitful, are believed to be influenced by the ‘generational’ or individual curses. Childbearing is sometimes valued more than marriage. Childlessness affects the stability of marriage because children are seen as indispensable for happiness in life. Therefore, a mother of many children is showered with gifts and gains social prestige.

There are other reasons why Ghanaian women value children. In a matrilineal society like Ghana, a daughter is expected to give birth, in fact, to many children. Without children, one lacks a network of relatives who support each other. As a Ghanaian proverb suggests, *He lacks assured human support whose maternal blood relations lacked abundant births.*

4.2 Experiences of Pregnancy and Childbirth: Let’s hear from the Women

This was Adwoa’s first pregnancy. She had to wait six months before she became pregnant. On one hand, this pregnancy brought lots of happiness in Adwoa’s life, on the other hand, it caused her many physical problems. During the first months of pregnancy, she was not able to eat anything. The midwife then suggested her to drink anything she liked. So she ate only fruits and drinks containing sugar. Later when the midwives checked her blood, they found that the level of sugar in her blood went high. She had to stop eating all kind of sweet things, which she was used to. She started to eat other foods. Four weeks later Adwoa’s blood sugar came down.
The case of Adwoa is not unique. Almost every woman faces physical problems like nausea, sickness, swollen legs etc during pregnancy. Sometimes they also encounter diabetes, hypertension, anaemia etc. The women in this study reported a variety of reactions to pregnancy. Vomiting was a common physical problem that most of the participants complained about. They could not eat anything during their pregnancies. When they complained about this to their midwives or gynaecologists, they all told them that it was normal during pregnancy and did not suggest any medication. Getting swollen legs in later stage of pregnancy was another problem faced by some of the women. The only suggestion they received from their midwives or doctors was that they should not to eat too much salt and should elevate their legs while sitting.

The women I interviewed told me about other changes and problems they experienced when they were pregnant. For instance, Yaa experienced bleeding from the sixth month in both of her pregnancies. For the first one, when she went to the hospital, the midwife told her to have an echo (ultrasonography). When the midwife checked it, she found that the baby was in good position but she could not tell her why she was bleeding. The midwife gave her iron tablet. After experiencing this twice, Yaa thought it might be part of her.

Afua experienced bleeding too, but in a different manner. When she was pregnant, her husband cracked jokes and she laughed a lot. All of sudden, she saw her nose bleeding. Then she called her GP who told her that it was normal and that some women experience that during pregnancy. When she was about ten weeks pregnant, she had chicken pox. The doctor said that it would not affect the baby. Akua shared her experience in this way:

"My experience with this pregnancy is much different from the previous one. This time I experienced the abdominal pain earlier than the previous one. In the previous one, I started to feel the abdominal pain and the weakness at the stage of seven months. Even with my first child, I never experienced such pain. I was very strong all throughout my pregnancy to the end, but during this one, it started at about four months. It was very surprising for me to have this pain at around four months. Every time while I was sleeping, I felt like I was in a labor. I already have two children. My age is also not like I used to be. I am grown now. I would expect it's normal. I should take it easy, I should rest more, but then in this country you cannot rest more, especially with children...you know. As a working mother, you cannot rest more, but once in while, the pain subsides when I
take rest. Although it goes down, I cannot sleep in the night. The pain is less than it was
during five months, but I still have pain. It’s the workload! I am sure. Because every time,
I take more rest, I do not experience such pain.
In addition, my work is mostly a sitting down job. While sitting down, my legs are
hanging for a long time, it can be painful, you know. Sometimes I need to put my feet up,
but in the office, people are always coming, it’s not proper to put my feet up, in the chair.
I was thinking to bring something to put my legs, but it is now time for my maternity
leave. Sometimes, I just put my feet on the chair. I was also working during my first
pregnancy but at that time I was very strong. I had same kind of job, but in a different
place. During that time, I was resting more. Sometimes I did not even go out. I stayed at
home. I had more rest until my maternity leaves started. During the second child, I was
staying at home”.

Only one participant experienced almost no physical problem. She could eat properly. Everything
went normal throughout the time. It was only going to the toilet that was difficult when she was
about six months pregnant. She went to her midwife and the midwife suggested that she takes
more yoghurt. After that, everything was again normal. She said, “Me, myself, I don’t have
problem if I am pregnant. I do not vomit. I have no problem, not even morning sickness. No”.

4.2.1 Antenatal Care:

Most of the participants went to the midwives in Kraaiennest for their antenatal check-ups.
Those who gave birth in Ghana also went to the hospitals for their regular antenatal checkups.
Most of the women consulted midwives; some of them were taken care of by gynecologists or
general doctors. One of the participants did not have any childbirth experience in the Netherlands.
She had her first child in Britain. All of them had to take the regular tests like, echo, blood tests
for HIV, diabetes, iron, sugar etc. Among the routine check ups were blood pressure, weigh, and
fetal heart sound. Four of my participants had health insurance while they were pregnant in the
Netherlands. Only two of them did not have any health insurance, which means they had to pay
almost double than the other women did.
Concerning medication, every participant had a different experience. In Adwoa’s case, her iron level was low, so she had to take certain medicine. Akua took medicine for the same reason during her first pregnancy. During her second pregnancy, she had urine infection and she had to take medications. Afua continued taking a multivitamin during her first pregnancy. For her second, she had anemia for which the doctor gave her a kind of injection to boost her blood up. Akosua took Gravitamon, a multivitamin specially made for pregnant women. As Yaa was bleeding from the sixth month during her two pregnancies, she had to take iron tablet regularly. It was interesting to find out that every woman opted for medication while experiencing physical problems. Although, some problems were normal during pregnancy, they expected that their midwives or doctors would give them medicines. They termed multivitamins or iron tablets as medicines instead of supplements.

4.2.2 Experiences of Childbirth: Pain and Pain Management

Like childbearing, childbirth experiences also differ from one woman to the other. As Abena told me about her second childbirth in the Netherlands,

“Oh! During the delivery, it was very easy. I think it was five minutes, I think even less than five minutes. When I had contraction at home in the night, my husband called a friend to bring us to the hospital. So the friend came and drove us to the hospital. When we were on the way to the hospital, I felt severe pain. Before we entered the hospital, the baby was almost coming. Then I cried out, the baby is coming! The baby is coming! So, my husband and his friend had to rush me from the car and we were just close at the door at the emergency of the hospital. My husband started to shout that the baby was coming! So, when they heard us, they rushed with the bed and met us at the gate. As soon as they put me on the bed, the baby was there. It was just like one minute! My pain started on Tuesday at 5.30 in the morning. I delivered on Wednesday at 3 o’clock in the morning. After delivery I stayed in the hospital for almost three hours and then came home”.

Giving birth normally is indeed different from giving birth with medical intervention. In Afua’s case, she had caesarean sections in both of her deliveries. During her first childbirth, she laboured
for almost two days but she dilated only three centimetres. The water bag was broken too. Her
pain was so severe that even the doctors were surprised. Initially she thought she would stay at
home. Her pain started at 5 in the morning and then she called the clinic. Afua saw the water a
week back. It was dripping a little bit. She did not know what it was. She remembered that the
doctors had told her that if she saw any blood, it would be the time to deliver. As soon as she saw
there was blood, she called her husband and showed him and then they called the hospital.

When they called, the doctors said, as it was her first baby, she would not dilate quickly.
They also suggested her that she should try to stay in the house until the pain would become
unbearable. Afua called them again and they said they would send an ambulance. She waited
until the evening. It was almost 5 o’clock and ‘the pain was really painful’. It kept coming; the
interval was becoming shorter. She again called them and when she went to the hospital they
checked her and informed her that she had dilated only one centimetre. Afua could see it on the
monitor. When the pain came, the pointer climbed up the line and then came down. She could not
bear the pain and opted for an epidural. It was quite a long time, but the baby was not coming.
She thinks the epidural worked well. It numbed the lower part of her body. When they checked
her again, her dilation was still below, only few centimetres. What was really painful for Afua
was when the doctors put their fingers inside her vagina. She remembers that when they took her
to the theatre they gave her catheter. That was painful too. Even after one year of the delivery, she
still had that pain.

Afua’s experience reminded me of my first delivery. If I look back, I still feel the pain in
my body. My pain started in the afternoon. The whole night and the next day passed with this
severe pain. I could not sit nor stand, and I could not even lie down. Another night came and
passed too. I went to the hospital in the early morning. The doctors checked me and told that the
progress of dilation was slow and I should wait as it was my first delivery but I was in so much
pain that it was impossible for me to bear that state any more. I was eagerly waiting for the time
to deliver. In the evening, at around 6 o’clock, the doctor injected some medicine and told me, it
would help them to know if the pain was true or false. After experiencing pain for almost 48
hours, when the doctor told me about false and real pain, I was not only surprised but also was
shocked. How could this pain be false? Has she gone mad?

After getting that medicine, the interval of pain became shorter and stronger. It became so
unbearable that I decided to go through caesarean. I only wanted to get rid of the pain in any way
or at any cost. As the baby was in normal position and everything was normal, the doctor was reluctant to do the operation. At that time, I could not think of the baby, I could not think of the consequences of caesarean. I only thought about my sufferings and the pain, which I wanted to go out of my body. After struggling for two days, I finally surrendered! If my friends want to know about the labour, I can only tell them, “If no body was around during that time, I would have killed myself. It would be better to die than to suffer from that pain”.

Every woman in the study talked about severe pain during childbirth. Except for Afua, none of the participants opted for epidural or any other kind of pain medication. It was clear from the interviews that experiencing pain was natural and normal during childbirth.

4.2.3 Why do Women Want to Deliver in Hospital?

Abena did not have any plan to deliver at home. When I asked why, she almost cried out, “No! No! At home, something can happen, which I do not know. So, hospital is safe for me”. She did not have any complications during her pregnancies, but still she preferred to deliver in the hospital. She thinks, “Yes, I had no complication. However, you know, in this world things do not give you information before it happens. All of a sudden, it happens. We prefer to go to the hospital, in case there is any complication. Then the doctors will be there to help me. Moreover, I did not have Ziekenfonds. Even if I wanted to deliver at home, the midwife might refuse to come”. Although her midwife gave her options for home or hospital, they preferred to go to the hospital. Her midwife also thought that was better. I wanted to know if they asked the midwife why it was better to deliver at hospital. Abena’s husband promptly answered, “No, we did not ask, because we think she was saying good thing to us. Normally, when you know somebody is saying good thing to you, you don’t ask any question”.

Adwoa also preferred to go to the hospital for delivery even if she was in Ghana. She fears that in delivery there are sometimes complications. In Africa, they do not have money; they do not have ambulance and other means for emergency. If any complications arise, these people cannot handle critical conditions. So, she would rather prefer to go to hospital. Adwoa told me about a mishap she experienced in Ghana,
“After completing my training college, I was sent to a village, a remote village, where I was supposed to teach. There, a lady was about to deliver. I think the baby was breech; it wasn’t in normal position. When it was time for her to deliver, they kept her in the village for two days. Later she had to be sent to the hospital, she had to be rushed from the village to the hospital. The lady was almost dying but she was lucky she did not die. Unfortunately, she lost her baby”.

I asked Afiu, if she would not have any physical problem, where would she deliver? Without any hesitation, she replied

“In the hospital. I cannot risk my life. If anything happens, there will be emergency in one minute. The doctor can come immediately. But, if you are at home, before the ambulance comes, it’s too late. So, personally, I have never dreamed of having baby at home, putting my baby’s life at risk. If you are in hospital and if anything is wrong with your baby, they will put your baby in the intensive care. I am not saying that it will happen, but you never know...Even in Britain, in Ghana, any part of the world, I would never dare to dream of having a baby at home, no. If anything happens and you have to go to the hospital, that five or ten minutes can make a difference. I think it’s better to go to the hospital, because they can help you in any moment. They have the facility”.

All of the participants thought that it was always better to deliver in the hospital. Hospital was the safest place for them to give birth. One of the reasons for which they preferred to be in hospital was that, if anything went wrong, there would be immediate medical support. They trusted the hospitals because of the facilities they could provide. They thought that if they were at home and something happens, they had to rush to the hospital. It would take some time before they get a taxi. In Ghana, as they mentioned, ambulance is not as common as in Europe. They had to hire a taxi or someone’s private car and they would rush to the hospital. One woman even told me, “So, why should you wait for this waste to come? Its always better if you are in the hospital”.

While being in the Netherlands, they still preferred to go to the hospital. The reasons they mentioned were the same. Only one participant told me that it was not possible for her to deliver
at home, because there was little space in her house and she was sharing the flat with another couple.

4.2.4 Family and Social Support:

Most of my respondents shared their experiences concerning family and social support. The support and help they had received in Ghana was much different than in the Netherlands. In most cases, they stayed alone with their husbands and children in the Netherlands. It was also not possible for them to bring their mothers from Ghana. But getting support was very important for them while they were pregnant. For instance, Abena got lots of help and support from her ‘Christian mother’ during her pregnancy. She came home almost every day and took care of everything. She calls the lady ‘Christian mother’, because she is an elderly woman, like her own mother and they go to the same church. That ‘Christian mother’ of Abena took care of her, cooked for her, and did everything for her, like her own mother. Abena felt, although her own mother was in Ghana, she received almost the same support from her ‘Christian mother’. Not only the mother, but also her husband helped her a lot. He always went for shopping, cleaned her vomit, cleaned the house and sometimes also cooked for them.

Adwoa on the other hand, got much support from her husband and sister-in-law. There is a big community of Ghanaians in that area but she hardly got any support from them. The reason she mentioned was that “You know, here everybody is busy and they always work. So, the support is not as much as you can get in Africa. We go to the Church and sometimes in weekends, we meet. That’s all”.

Although Akua’s mother is with her during her pregnancies, she does not get much help from her. She gets involved in certain things. When her mother goes out and her husband is busy with work she has to take care of the children, which she cannot avoid. But she gets much support from her colleagues. They always show their concerns, but unfortunately, her boss is somebody who never shows his concern. She told me, “I am surprised because they also have children. I think that at that time his wife was a housewife, so he did not feel that pain as much as we working mothers feel. I do not think he feels the same way as women feel”.

Akua’s other colleagues are all mothers. She believes only a mother can feel the problem of another mother, but the men do not feel that way. On one Thursday, she had terrible headache
and she could not go to work. She called her colleagues and they understood but not her boss. On another day, she was late and he asked, ‘so, where are you coming from?’ She thinks her boss should understand her situation. He didn’t even need to ask. Concerning help from the Ghanaian community, she replied to me, “No, because everybody knows I have my mother; I have my husband with me. They say, Oh! You are lucky you have your mother. But you know although I have my mother with me, I have to contribute in domestic work”.

Afua also got much support from her work place while she was in Britain. Her colleagues were very happy when they had heard that she was pregnant. They were even the first persons to send her flowers after delivery. She is still grateful to them, “Yes, it was really nice of them! Some of them visited me at home as well”. Her husband was also nice to her during her pregnancy. But the only problem was that he did not know any household work. So, in Britain, Afua had to do all domestic work. But in Ghana her sister was there and people were around. They helped her with the work.

Akosua got almost every support from her husband during her pregnancy and also after childbirth. He cooked, he did all the shopping, and he was the one who did everything. When she was nine months pregnant, he stopped working. He stayed at home with her until she delivered. Even in the night, if the baby was crying, he took the baby, fed him and let her sleep. He did everything he could do. Concerning others support, she thinks,

“Here, if you are a member of any association, they will come to visit you and bring you presents. They will come to greet you. If you are alone, I think it would be a problem, because here, if you join some church group they will come. If you have friends, they will come. Like in my case, I know many people from the Church, the women’s fellowship group, also those who come to make their hair. So, I have many people around me. I get much mental support from them”.

But in Yaa’s case, her sister supported her all the time, because her husband was always busy with his work. He works the whole week.

During my discussion with a group of Ghanaian men, I asked them if they joined their wives when they went to the midwives. For most of them it was not possible to join their wives regularly, because of their own workload. But they were all very interested to go to there with
their wives. One of the men shared his feelings and said “I was very curious to know the system, my wife’s physical situation and the baby’s situation”. Concerning supporting their wives, every participant told me that they helped their wives one way or the other. If the women need something from outside, they help bring it home. They sometimes helped their wives in the kitchen. One male participant told me, “We don’t usually cook in Ghana. That is the real job of a Ghanaian woman! Compared to Ghana, here we help our wives more”. Other men present at the discussion confirmed that too. When I wanted to know why, one of them explained,

“Why? Well, you have to understand that we try to blend our culture with European standard. In Ghana, even if your wife is pounding with work, you do not help her. Because if your friend or any body will see you, they will laugh at you. But here, it is a closed society. No body interferes in other’s life. But in Ghana ours is an open society. So, when your wife is cooking, people will see her. We can not go and help her”.

4.2.5 Financial Matters:

The Ghanaian women as well as men were very concerned about the financial matters concerning antenatal care and delivery. Those who did not have any health insurance had to pay almost double the normal amount. It was difficult for some women to arrange for that money. One of the participants mentioned how she avoided the money matters. In her last trimester of pregnancy, she always told the midwife that her husband left Amsterdam and went somewhere she did not know. So, it was not possible for her to pay the rest of the amount. Although her husband was staying with her, she had to make this trick to get a waiver on the consultation fee.

Abena, for instance received some support from a Dutch lady. Someone introduced Abenaand her husband to the lady. She wanted to know about her pregnancy and delivery, and asked how much they had to pay altogether. She told them that she would try to get any help from somewhere. That Dutch lady came after some days and told them that she would negotiate with AMC. She came to them again and told them that they would pay Euro 450 out of seven hundred and the rest would be condoned. Some men during the focus group discussion also mentioned about this kind of external support. As one mentioned, “Sometimes, if anybody can guarantee,
you pay in instalments, but you have to pay”. Although it was hard to afford, most of the men put importance on their wives health more than money.

As I mentioned before, I was in the Netherlands during my first and second pregnancies. The health insurance my funding agency provided did not cover any pregnancy costs. That means I had ‘own risk’ coverage. A certain amount had to be paid by myself and the rest would be paid by the insurance company. I remember, how hard it was for me to pay the midwife consultation fee and every cost related to my pregnancies. On one hand, I did not have enough money to easily pay and on the other, I was very concerned about my baby’s and my own health. I had to cut my budget from other things and then paid the midwives out of my savings. At that time, my health was more important than money.

4.2.6 Special Food and Activities during Pregnancy and after Childbirth:

Concerning special foods, some women told me that they should not eat ripe plantain while they are pregnant. The reason why other women advised them was that, if they consumed ripe plantain it would be difficult for them to push well during delivery. Adwoa, heard about this from her friend and then called her mother in Africa. Her mother told her that people used to say that. While she was pregnant she ate them and nothing happened. So, she told Adwoa that if she likes, she could eat them. Akua cannot eat sugar while she is pregnant, because she gets severe headache. She also experienced this during her second pregnancy. She always used diet sugar. During Akua’s first and second pregnancies, she ate lots of crab as they allegedly make the baby very strong. She cannot eat crabs during her present pregnancy because they are very expensive nowadays.

In Africa, they also make special soup for the mother after delivery. There are special leaves and bark of trees which they use to make concoctions (special soup). They give it to the mother to get more breast-milk for the baby. This soup also helps the mother to be healthy and helps to heal the wound. As they are made of fresh leaves and herbs, it is hard to make it in the Netherlands.

The women also told me that there are some restrictions that pregnant women have to follow. For instance, if a woman is pregnant she is not supposed to stay out during the night. She has to go to bed early. The pregnant woman also should take a bath early and she should not open
her belly for another person to see. She always has to cover it. The pregnant woman also should cover her feet. One participant told me that a pregnant woman should not eat outside or should not eat while walking. Afua knew if she were staying with her parents, they might correct her. As she and her husband were far from her parents, they used to go out late night and visit friends. There was nobody who could give her any suggestion now.

In Bangladesh, for instance, many women believe that eating, cooking, cutting, trying or twisting anything as long as there is a lunar or solar eclipse may cause the birth of a child with a shortened, tied up or twisted limb or body. Although I knew, I did not follow them while I was in the Netherlands.

### 4.2.7 Prayer: God’s Protection

Prayer plays an important role in the women’s lives. Almost all of the participants prayed regularly while they were pregnant. As Christians, they always prayed. They believed that they had to pray for God’s protection for themselves and for their children. As Abena said, “During childbirth anything can happen. Some mothers go to deliver but they don’t come home. Some mothers will deliver the baby, but the baby will die and the mother will come home. We have to pray all the time, so that there will be a safe delivery for the mother and the child”.

Akua precisely mentioned that she does not believe in human beings. She only believes in God, so she prayed a lot especially for the first pregnancy. She had never prayed in her life, as much as she did during her first pregnancy. Sometimes she was fasting. She regularly went to the Church; even the day she delivered she went to the Church in the morning. Akua believes that God does everything. Human beings are just human beings! She also prayed for the second child but not as much as she did before. The reason, she thinks is that, it was the first time and many things could happen. She could have miscarriage... many things can happen in this world. So, she prayed all the time.

Women pray to become pregnant. As we see in Akosua’s case, she wanted to become pregnant for a long time, but the pregnancy did not come. She went to the specialists. After checking her, they found that everything was ok. They did not give her any treatment. So, she prayed a lot before she got pregnant. As a Christian, she kept on praying and “God did it one
day”. She continued to pray even after delivery so that God would protect her son, give him more wisdom and “put a Holy Spirit on him so that he can grow and can be a good person.”

Yaa saw a strange dream that she was sleeping with another man. She told this to her pastor. He said that the dream was bad and he prayed for her. He told her it might be evil spirit. When a pregnant woman sees in her dream that she is sleeping with another man, it’s not normal. He said that if people see this dream, sometimes it happens that they get abortion. She said that prayer helped her and she never had that dream again. The pastor expressed the same thing as the women did. He told me,

“ We only pray for them for God’s protection for the mother and the children. If the mother is not healthy, it affects the baby. If the mother’s life is not going well spiritually or physically, it affects the baby. So, we pray for the woman so that she can be spiritually good, emotionally good and physically good. When the mother is healthy emotionally, psychologically and physically, it affects the baby. As the woman is healthy herself, the baby is also healthy. That’s why we like to do that. Because we know in Amsterdam or in Europe as well, life is full of stress! If any bad thing happens to a pregnant woman’s life, it put more stress on her. In Europe, it does not happen often, but in Africa, it happens often. We know, some pregnant women go to deliver and they don’t come back. Sometimes the mother will come back but the child will not come back. Sometimes the child will come back but the mother will not come back. When both of them are blessed, they come back home together. When we know that the woman is going to deliver, we pray for her so that she will deliver at home or in hospital peacefully, successfully and joyfully”.

The pastor thinks it is the doctors’ or the nurses’ fault that they are not able to help. But he believes that evil spirits cause such mistakes. So, they pray against evil spirits so that they lose their power to harm the woman or the baby. The mother will then deliver safely with the protection of God. People in the Ghanaian community also believe in evil spirits, because they said that in Africa the evil spirit’s manifestation is real.
4.2.8 ‘Out-dooring’ and Baptism:

On the eighth day after birth, the child is given name and brought outside. This is called ‘out-dooring’, because before this day the newborn is kept inside the house. They also call it name-giving ceremony. Before eighth day, the newborn child is seen to be somebody from the spirit world and on the eighth day onwards, the baby is really seen as a human being. On this day, the parents invite their families, relatives, and friends and give a big party. According to one of the participants, “We invite them to come, eat, drink, dance and to enjoy.” After migrating to the Netherlands, the Ghanaian parents hardly can maintain this time frame. Some babies are given name after six weeks, some after three months. When the parents decide the date of the ceremony, they announce it in the church. They also make announcements in radio, distribute handbills to people that at such time the baby’s name will be given. So they gather in the Church and publicly announce the name of the baby. During the gathering, the father will be called by the pastor. Then the pastor will ask the father to pronounce the name of the baby in front of the congregation. They clap and they pronounce the name again so that it will be kept in people’s mind. Then the rest of the celebration goes on. Almost all the parents baptised their children; some were baptised when they were infants, some when they were grown up. Akosua thinks,

“One week after you give a name to the child, you are free. In Africa, it is our culture to give the name after seven days. If somebody comes, he will call your child by his own name. In Africa, when you give name to your baby, you are free. You can go outside, you can even start your job, if you feel strong. Without the name, you have to stay at home”.

By freedom, she means,

“If you have a child, you are supposed to be at home, because you are not ok. When you give the name, you are ok, that means you can start work now. In those days, our mothers gave name after one-week, because they had to go out for work. It continued to our time. If you want, you can stay at home, but you have to give the name in one week. If you have money, you can arrange a big party on the occasion of name-giving ceremony and after that you can go out. Otherwise, you are not allowed to go out”.

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Akosua invited her pastor and his wife at home. They came and prayed for the child. She liked it simple; she didn’t like many people. She believes, “It is God who is supposed to bless the name, not the people. So, I prefer to do it simple. After two months, I went to church to thank God. I made food at home and then brought it to the church for the congregation”.

One of my participants described how the name giving ceremony was celebrated 20 or 30 years ago. All of her children were born in Ghana. Her church members call her ‘Mama Tina’ as she is one of the senior members. She told me that on the name giving ceremony, the baby is bathed and clothed nicely. She is then brought outside and put under the sun. A scythe is laid beside the baby. There would be one glass of water and one glass of alcohol too. The father would pronounce the name to the elderly family member and he would then announce the name publicly. The elderly person would put his finger first in the alcohol and pours some drops into the baby’s mouth. He would then pour some drops of water. Then he utters, “Here lays the scythe. It symbolizes work. Now your parents are working for your subsistence. When you will be grown up, you have to take care of them. We also give you the taste of alcohol that is bitter. Remember, in this world, there will be many bitter things. You have to stand against it. We give you water too. When you drink water, you cannot talk. If somebody comes to you and wants to create trouble, think that your mouth is full of water so that you cannot talk to that person. It will save you from any kind of argumentation”. In many cultures, the first food given to a newborn baby is very important because it is full of symbolic meanings. There is a Swahili saying: “A newly born baby is given some honey and aloes in order to make it realize that it must meet with both sweet and bitter experiences in its life”. In Bangladesh, for instance, a newborn baby is given some honey so that the baby will be grown up with an amiable personality. Although nowadays this custom is fading away particularly in urban areas, people still practice this in many rural parts of Bangladesh.

Another interesting thing is that in Ghana the name of a child is usually based on the day he or she is born. There are 14 names for boys and girls separately, on the basis of seven days of a week. They are the following:

<table>
<thead>
<tr>
<th>Day</th>
<th>Girl</th>
<th>Boy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>Adwoa</td>
<td>Kwadwo</td>
</tr>
<tr>
<td>Tuesday</td>
<td>Abena</td>
<td>Kwabena</td>
</tr>
</tbody>
</table>
Wednesday Akua Kwaku
Thursday Yaa Yaw
Friday Afua Kofi
Saturday Amma Kwame
Sunday Akosua Akwasi

The baby’s surname is usually given after father’s name, which is rather a new development. Father’s name is used for some practical reasons like in schools, offices etc.

4.3 Being Pregnant in Ghana and the Netherlands: A Comparison made by the Women

In Ghana, the women usually visit midwives for their antenatal check ups. In Ghana, most of the women come to visit midwives when they are in their second trimester. Some women deliver at the midwifery, but most deliver at the main hospital. Some midwives have their own practice; they have opened their own private hospitals for delivery. These midwives help the pregnant women during delivery at their own private hospitals. The Ghanaian women mentioned that they also have government hospitals. The government hospital is cheaper than the midwifery. The government hospital is reasonable; it’s also public where everybody can go. But in the private midwives, not everybody can go. As it is their own, they will charge whatever they want. The midwives are well trained in Ghana. They are well checked by the government officials if they are qualified or before they open their own hospital. A lot of women deliver at home. Some women do not see any midwife or any doctor for their whole pregnancy and they deliver at home. There is some training for Traditional Birth Attendants, who assist women to deliver in the village. The hospitals and the clinics provide this training.

While Abena was in Ghana, she preferred going to the government hospital to private, because she thought the government hospital was easy to go and it was safer. They also help many people, so they must be experienced. Abena experienced many differences between Ghana and the Netherlands. In Ghana, they check urine, stool, and blood pressure; they also take blood tests and after that they give the pregnant woman some medicine, like iron tablets, vitamin B complex. etc. In the Netherlands, she said, “When you are pregnant, they will not give you any
Almost all women respondents believe that in Africa, the midwives do not have equipment, but they have experience; they work more than the midwives do in the Netherlands. In addition, the way they relate with the patient is different. As one of the Ghanaian midwives said, “The most important work for us is to give ‘emotional support’ to the women”. The workload situation became clear during the focus group discussion with the midwives. The work they do as a midwife includes antenatal care, labour and delivery, postnatal care, family planning, post abortion care, child welfare, training of the midwives and TBAs, management of STDs, management of minor illnesses, adolescent and school children’s health. This discussion was done among four women nurse-midwives and one male nurse-medical assistant. They were all state registered medical personnel. They worked in the district hospital of Berekum in Rural Ghana.

I wanted to know their opinion particularly about the ‘home birth’. They think it is good because the woman’s family will be around during delivery. For them, it is better but it is not possible that most women will deliver at home in Ghana. First of all, there is lack of privacy. If a woman wants to deliver at home, there will be many people around, especially when they live in a compound house in Ghana. Some have their private houses, but most of them live in a big house with many people. The midwife not only deals with one patient, but they also have to take care of other women who do not have private cars. So, it is also impossible even for a private midwife to go to a pregnant woman’s house and wait 24 hours for the woman to deliver. In Berekum district hospital, for instance, they have one gynaecologist, six doctors and thirty midwives. Although the number of the midwives seems quite a lot, they cannot even manage to work properly. They have to contribute to other departments within the hospital, including attending 150 deliveries on average every month.

Almost all of my participants were unhappy with the midwife consultation in the Netherlands. Most of them find that the Dutch midwives spend less time with them. During her second pregnancy, Akua was visiting her midwives at Kraaiennest. She was not happy, because they always told her the same old story, ‘Oh! There is too much water, we cannot feel the baby… etc.’ She shared her experience with me,
“They didn’t even feel the baby. They were busy chatting about their salaries, about their payment. You know, at that time, Euro was coming...so, I just lied down on the bed, and they were busy talking with other colleagues. As soon as the midwife removed her hand, I felt the baby moved inside me. She came again, but she did not feel the baby. I felt the baby was kicking. Actually, her attention was to the other colleagues. So, when she came, she couldn’t feel the baby. I was not happy with their consultation. Every time I go there, they listen to baby’s heartbeat, check my weigh, check my blood pressure and say everything is ok. Then I come home. It’s just like that”.

She expects more time from them. For instance, when she complains about her problems, they say it’s normal. Akua expects them at least to say, ‘Ok, let’s check the baby as you are complaining’; but they don’t say anything. Her first childbirth experience with the midwife also disappointed her. As she mentioned to me,

“When I told the midwife that I was in labour, they said ‘Oh! This is your first time; you have to wait so many hours...’ I said no, and I felt that the baby was on its way. They said, ‘no, you have to wait, you have to wait...’ They asked me ‘Is there any water?’ I said no. They said ‘you have to see water first’. I said, no, it’s not for everybody that you have to see water first. I learned that already from my mother. She told me that she did not see any water during her labour. Then the midwife again told me, ‘Oh! You have to see water’.

That was Sunday evening, around 12 midnight. I slept one hour, from 1 to 2 in the morning. I felt I was in labour and I called the midwife. They were telling me the same things again. I waited until 10 o’ clock in the morning. I could not sleep throughout that night and they said, ‘oh, it’s not the time yet. Go to sleep, take a bath...so, when I slept I felt the baby was on it’s way-coming. You know I even had ‘goose bump’ around nine o’ clock. I was shivering, but the midwife was telling me the same old story. At that time my boss was a Ghanaian, so I called him. Actually, he was somebody who was concerned about my pregnancy. After my call he called the midwife and explained what was happening. Then the midwife rushed in to my house. They checked me. I didn’t know what they said, but they knew that the baby was coming. You know I even felt the head of
the baby. The midwife told my boss to quickly get a car. At that moment, I could not walk all the way to garage. So, they brought the car nearby. We were lucky; thank God that we did not stick in traffic. If we were, I would have the baby in the car. When we reached the hospital, I quickly walked without any help and lied down on the bed; they were putting their gloves on and the baby was just coming. They had to quickly run to catch the baby, you know. We arrived at the hospital at 12:45 and the baby came out around 12:47. You see the baby was on its way. They put it on the record that I had a good delivery”.

It was 2 February, when Akosua was due, but the womb was not opening. That day, the midwives told her to see a midwife after three days. When she came back, the midwife checked her and found that it was not time to deliver. Her pain started on 6 February and she waited one day. On 7 February, when she called the midwife, she told her to wait further. Akosua waited and around 7 in the evening, she called the midwife again. The midwife assured her that she was coming. She came after two hours. Akosua went on,

“I said it’s painful, I can’t stay any more but the midwife said I should try. The midwife wanted to deliver for me at home. I refused because I had wanted to go to the hospital. We had a lot of discussions before she allowed me to go to the hospital, in AMC.

In AMC, I had severe pain and the midwife tried a lot. But I knew it was God who delivered for me. So, the next morning the midwife decided that I should have a caesarian, but my husband did not agree. He told them that it was not my first time; it was my third delivery and I did not need any caesarean. The midwife did not want to accept and then I told her that my God is alive. I would deliver safely. I don’t want any operation. The midwife continued arguing that she never saw any woman whose womb was already open but yet did not deliver. She said it was too much for her to wait and she had to leave. So, I said ok. You can leave. If the time is ready, my God will deliver for me. At 6.50 something, I delivered safely”.

All the women I interviewed preferred to deliver in Africa. One of the reasons they mentioned is that during delivery, it is not only one midwife who will attend, there will be two or three. They will help the woman in pushing. One midwife will stand in the front; the other will stand beside
her. They will help the woman a lot before the baby comes out. But in the Netherlands, it is only one midwife and the midwife does not help. As one participant mentioned to me, “She will only stand and say ‘ok now you can push. Stop, now you can push. The midwife will not even hold her leg or her hand. In Africa, they will hold her hand or her leg and they will say ‘now you have to push. It’s coming. It’s coming. Push! Push!’

Family support is another reason for which women wanted to deliver in Ghana. There is happiness around when a woman delivers in Africa. One of the women felt like a ‘new wife’. Everybody will come to greet the new mother. They will talk to her or give her advice; bring many presents for the mother and the baby. The woman’s mother has a great role after the baby is born because she cooks for the new mother, takes care of the child, washes clothes and does almost every household work until the woman is fully recovered. For instance, Afua felt much stronger in Ghana, because there she had less work and less stress compared to Britain. In Britain, she had to force herself to go to work. In Ghana, there was a lot of help. She knew she could ask anybody around if she needs help. “In Ghana, although you do not know anything, you know one thing for sure. You are in your own place. You can call anybody and ask for help”.

Interestingly enough the Ghanaian men held a different opinion than the women. Concerning their wives’ prenatal and postnatal care, they think it is better in the Netherlands than in Africa. They said that hospitals in Ghana do not have sufficient equipment or expertise but in the Netherlands, they keep all the records and require the pregnant women to submit themselves on time for prenatal and postnatal care. All of the men told me that it was a great experience for them to be with their wives during delivery, which they cannot do in Ghana. They found it rather hard to see their wives in pain. One of them said, “If your wife delivers laughingly, you would have laughed. That is not the case. We share the pain with her, we hold the hand of our wife, we pray at that time, because she is bringing a child in this world”.

4.4 Ghanaian Women’s Perceptions of Safe Childbirth:

Once the diagnosis of pregnancy has been made and the mother has decided to carry the pregnancy to term, her attention turns to maintaining her own and the baby’s health. In some cases, the concern for safe delivery may center on the mother or the baby; in these cases the specific focus will be decided on the basis of family medical history, personal medical history
and personal experience (Melender & Lauri 2001). The effort invested in seeking safe passage also depends on various situations. For instance, the meaning of safe childbirth among the Ghanaian migrant women in the Netherlands is associated with family and social support, income and living arrangements, traditional beliefs and practices, as well as knowledge and education on reproductive health. Ghanaian women's perceptions of safe childbirth are also related to health and health care services provided to them. Gender relations and role of men and women in decision-making play an important role in choosing safe birthplace. The following are the factors that contribute to the perceptions of Ghanaian migrant women on safe childbirth in a wider Dutch context.

The antenatal care is always important for the Ghanaian women. They expect the antenatal caregivers to provide sufficient time, information, medication and early detection and treatment of problems. The women feel safer when they have ultrasounds and particularly listen to their babies' heartbeat.

The Dutch conceptions of pregnancy and delivery do not coincide with the views of Ghanaians on safe delivery. There are differences of opinion between Ghanaian women's views on safe delivery and the Dutch obstetric system which emphasizes 'demedicalization' or 'naturalization' of birth. Most of the women I interviewed however, wanted to deliver in the hospital, even if, they did not fall in the category of 'high' or 'medium' risk. For them, giving birth in the hospital was the safest place both in Ghana and in the Netherlands. They considered the hospital staff to be trained professionals and believed, if necessary, they could offer immediate medical aid during delivery.

At the same time, the Dutch health insurance system has a great influence over making a decision at where the woman will give birth. In normal home deliveries, the national health insurance pays for the services of a midwife, which include all pre- and postnatal care. On the other hand, the health insurance covers hospitalisation only where there are some suspicions or evidence of a problem. Since the 1980s, however, women covered by the national health insurance who prefer the twenty-four-hour or short stay hospital delivery are reimbursed (Abraham: 1996). Women who are privately insured can freely choose between home or hospital delivery. They are also free to choose between the services of a midwife or a general practitioner. This health service factor affects women's ability to choose between delivery options. This delivery care arrangement in the Netherlands is very different from what Ghanaians have at
home. There, they have choice, as long as they pay for the services. In the Netherlands, choice is limited by institutional guidelines and health insurance system. The immigration status of Ghanaians in the Netherlands is a major factor in choosing a safer birthplace. Any illegal migrant lacks access to the national health services. Given this circumstance where they also cannot afford costly private services, their choice of place of birth becomes limited.

Sufficient income and good living arrangement are important for Ghanaian women to feel safe and secure throughout pregnancy and childbirth. This support means having a steady job, the opportunity to continue with one’s own studies, financial stability etc. Having enough money usually creates a sense of security; parents need not worry when it is needed.

Social support from women’s own networks and support from their families help them to cope with the stress of pregnancy and childbirth. This support can be of many forms like emotional and moral support, financial aid, advice and information about pregnancy and childbirth etc. We saw that one’s own mother is often an important person in this group. For them, their mothers are people they can trust, who knew a lot, who would tell about her own pregnancy and childbirth, and who also give good advice.

Having a good relationship with one’s own spouse and getting emotional and material support from him are important too. Some women also referred to their colleagues’ attitude to their pregnancies. If their colleagues are concerned about them and take a positive attitude to requests for sick leave, it helps the women feel a sense of safety.

“Another important factor is the nature of decision-making process during labour and delivery, with particular focus on the degree of self-management allowed to the women in each system. It is apparent that together with birth territory and specialization of personnel, decision-making is particularly intimately tied with who ‘owns’ the birth. Who is entitled to determine what happens when, and who determines what is to be seen and treated as normal or abnormal, indicate who holds the running responsibility and final achievement for the birth produced in a particular setting” (Jordan: 1993). In the Netherlands, even in hospitals, most normal births are managed not by physicians but by midwives. Thus the decision-making of normal birth is separated from medical decision-making. Although many decisions, such as the location of the birth, who will be present, the question of medication and pain relief, and so on, are institutionally managed, we saw that the Ghanaian women decided themselves where they would deliver and how.
One of the most important factors to explain safe childbirth is the parity of women. If they were first-time mothers-to-be, they preferred to give birth in hospital for safety reason; these women felt safe enough in knowing that, in case of complications, they would always be able to get available medical services. Also, prior experience with the Dutch maternal health care system affects their perceptions of safety. A Dutch midwife I spoke to expressed the same thing. She had been working among Moroccan and Turkish women for almost 8 years and during first pregnancies, most of these women gave birth in the hospital. The reasons she mentioned were that they usually gave birth in the hospital in their own countries, they liked to show their wealth and richness and they found it fancy to deliver in the hospital. They did not trust young midwives, and were not familiar with the Dutch midwifery system. Once those Turkish and Moroccan women become experienced with the system or become familiar with the same midwives, they would give more authority to their midwives during their second pregnancy. Also prior good birth experience influences them to deliver at home.

Her experience with the Moroccan and Turkish women contrasts with Cinibulak’s (2002) study. Leyla Cinibulak studied 16 Turkish women of diverse socio-cultural and economic background. Her study focused on similarities and differences between women concerning their views, needs, experiences and behaviour during pregnancy and childbirth. The Turkish women of her study give a big value on antenatal check ups, especially routine ultrasounds (echo). They also prefer to deliver in the hospital. This need for antenatal check ups and preference for hospital delivery stem from increasing process of medicalization. Although these Turkish women make use of this regular health care, they also seek help outside biomedicine. Being active in health seeking, they integrate their own knowledge together with biomedicine. Social network is very important to transfer this knowledge, which they term as ‘common people’s knowledge’. Cinibulak’s study also shows medical pluralism among the Turkish women. They visit midwives or doctors for regular check ups, but at the same time they go to religious specialists for Islamic healing. The will of Allah and the influence of hot-cold theories are very important when they are concerned about their health.
Pregnancy is universally regarded throughout Ghana as a joyous event, though any joyous feeling on the part of the pregnant woman conceiving her first baby may be tempered with anxiety about the approaching delivery. Childbirth is thought of as so beset with dangers, both physical and supernatural, that during the process the women is often said to lie ‘between life and death’ (Kaye 1962: p.40). This danger can also be found in the social realm.

Like every other woman, Ghanaian women are very concerned about their unborn children’s physical well-being. When they talk about safe childbirth, they always mean that they want their children to be born healthy and without any complication. They attach much importance to antenatal care and prefer to deliver in hospital in order to ensure a safe delivery. Some women also follow certain taboos so that their children will be born without any physical disability. For the spiritual safety of the child, the Ghanaian women pray a lot during their pregnancies and after the children are born. They believe that, through regular prayer they can assure God’s protection over their children. It is very important for them to have children because they are the essence of life for them. The status of a woman depends on her motherhood. Children are also considered important as proof of masculinity.

In a matrilineal society of the Akan, high value is placed on children as they consider having children essential for the continuation of the matrilineal family through time. Female members of the matrilineage are expected to be instrumental in the increase of its numbers and to give important ancestors the opportunity of reincarnation, thus perpetuating the cycle of life. Female children are as welcome as male children are. After all, daughters will continue the line of matrilineage in the future. While prolific child bearing is honoured, barrenness is regarded with contempt. Besides religious and social values attached to children, they are regarded as economic assets and social security that give added incentives to prolific reproduction.

Physiological reproduction faces two competing paradigms. In the first, pregnancy and childbirth are regarded as potentially hazardous that need to be dealt with through medical assistance and intervention. Therefore, deliveries should always take place in a hospital setting. In the second, pregnancy and childbirth are regarded as natural processes among
fecund women for whom medical assistance is usually not required. Following this paradigm, most women's deliveries can safely be performed at home.

If we look at the Ghanaian women's perceptions of safe childbirth, it is clear that they think labour may suddenly become complicated and if they are in a hospital setting, they can call for specialist services. In the Netherlands, however, many people still regard childbirth as a normal physiological phenomenon, and there is no need for medical intervention unless necessary. It is still believed that given good prenatal care for the mothers and ready access to hospital facilities for emergencies, most deliveries can safely be performed by a midwife at home.

When we compare the Ghanaian women's perceptions and the Dutch ideology on safe childbirth, we find the contrast ironical. Although in Ghana midwives and traditional birth attendants are most trusted advisors and caretakers during pregnancy and birth, the women I interviewed could hardly accept the idea of giving birth at home. They all talked about medical, social and spiritual dangers related to childbirth, but they still prefer to deliver in the hospital. Home can be seen as the safest place because of the support and familiar surroundings, but for the women, hospital seems to be the safest. The reason may be that the women can still perform certain things that may ensure safety during and after childbirth. For instance, when I talked to the Ghanaian pastor, I asked that if a woman had gone through a caesarean section and could not come back home soon, how did they pray for the child? He replied that in such cases the parents call the pastor and he goes to the hospital and prays for the mother and child. When these Ghanaian people are in the Netherlands, is it possible for them to call a pastor to pray for them in a hospital? It is not.

The women in this study view childbirth as a normal and natural physiological state of womanhood. They also believe that it is normal for a woman to go through pain during delivery and they accept that they do not need any unnecessary medical intervention. Although the situation is the same in the Netherlands, the women think it is very risky to have a baby at home. They mentioned several reasons that from their perspective are practical. If they need any emergency medical care, it would take some time before they reach the hospital. They cannot take any risk in these few minutes. We also found in the narratives of women that it takes some time before the midwife and a woman come to an agreement that
she would deliver in the hospital. The Ghanaian women do not want to waste this time and put their children’s lives at risk.

It is believed that the Dutch system gives the pregnant woman more choice of where, how, and with whom she will give birth, and gives the midwife a higher level of professional autonomy. Dutch obstetric services are seen as efficient and economic, with low rates of perinatal mortality. Thus, it is argued that the Dutch system is highly successful, confirming that “midwives, practicing their skills in human relations and without sophisticated technological aids, are the most effective guardians of childbirth and that the emotional security of a familiar setting, the home, makes a greater contribution to safety than does the equipment in hospital to facilitate obstetric interventions in cases of emergency” (Tew 1990). But how true is that for the migrant women? Many Dutch women can see the choice of a home birth as advantageous, but it is not necessarily true for the migrant women. While talking about social and psychological aspects of pregnancy, most of the participants in the study found it very difficult to be pregnant in the Netherlands. Most of them expected more time from the midwives.

The midwives’ task is linked to the prevention of unnecessary medical intervention and the prevention of pathology where it is not needed. The clients also expect midwives to function as their psychological and social counsellors. The method that is used by midwives is known as physiological approach. The main element of it is that, in human beings, pregnancy and birth are essentially normal physiological processes. These require good prenatal care and counselling so that the mother would be more confident. She will feel that she is in control of her body to give birth effectively and without fear.

During a discussion, one Dutch researcher was critical about the concept of ‘normal’ or ‘physiological’ birth. She thought, the concept of ‘natural birth’ in the Dutch sense was not opposite to a medical approach but actually embedded in it. It is the basic element in a preventive strategy to keep healthy women out of the hospital. So, when Dutch midwives emphasize natural birth, they always do so within a medical context, and according to a task-division along with the system of primary and secondary care, together with risk-assessment.

The high percentage of home births is directly related to the decision made in 1941 by the Ziekenfondsen. The system is made by the Dutch national health insurance which covers 65 percent of the population to give midwives a monopoly over normal obstetrics. The
training midwives receive and their experiences make them more experts at normal deliveries than the average medical practitioner. A general practitioner can be called if there is no midwife available in the municipality. The Ghanaian women, who do not have Ziekenfondsen or national health insurance paid almost double. According to the midwifery practice in Kraaiennest, full assistance by the midwife during pregnancy, childbirth and maternity bed is almost Euro 763.00 with an extra Euro 71 for ultrasound and laboratory costs.

Communication is a key ingredient in the development of the social and support networks that are so crucial in helping refugee women adapt to their new surroundings and navigate their way through health care system (Ascoli 2001). This is not only true for a refugee woman but also for a migrant. Many women in the study reported that they did not know that pregnancy classes existed. Those who knew chose not to enrol because they did not know Dutch. Migrants complain about language problems, lack of information and claim that professionals do not take their complaints seriously (Van Dijk & Van Dongen 2000; Cinibulak 2002). Professionals say that they have the following problems: expressive complaining behaviour, simulation, presenting of vague complaints, a taboo on psychosocial problems, difficult consultation with women etc. Medical professionals generally think that the problems are due to language difficulties and cultural differences.

Some of the Dutch midwives are now trying to improve the health situation of migrant women. Anne Annegam, who is working at KNOV (Koninklijke Nederlandse Organisatie van Verloskundigen), is developing a project together with other researchers and midwives. In that project they will train some information-givers from the same socio-cultural and language background of those migrant women. The information-givers will work as mediators between the midwives and the migrant women, and will transfer information on maternal and child health. In Amsterdam, there is a multicultural centre called ‘Mimoza’ for Moroccan and Turkish women. It is the only centre in the Netherlands, where healthcare information is provided for migrant women only. The employees are Moroccan and Turkish.

It must be considered that the high rate of home delivery is possible in the context of the Dutch situation. The Dutch obstetric system has highly qualified midwives, good prenatal and postnatal care, maternity home care assistants, and an efficient system for high and low risk pregnancies. If complications suddenly occur during a delivery at home, rapid transport to a nearby hospital is easy because of the high density of hospitals and the absence of isolated
rural areas. The view that ‘birth is a natural process and it is therefore natural for a woman to do the labour, and delivery’ should not be taken for granted. On this ground, unnecessary medical intervention by obstetricians diminishes a woman’s control over her own body. Women may have different ideas regarding pregnancy and childbirth, based on their age, education, geographical location, family support etc. Women might have their own preferences in choosing a birthplace but it is the system they are in that often dictates the choices they make.
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Annex- 1
Photographic Observation

Kraaiennest, a large apartment block in Zuidoost Amsterdam

One of the participants and her son
Researcher with the Ghanaian nurse-midwives (females) and nurse-medical assistant (male)

Ghanaian women singing in the Sunday Church service