FERTILITY SEEKING BEHAVIOUR AMONG INFERTILE MIGRANT GHANAIAN WOMEN IN AMSTERDAM

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With all my heart, I thank my husband Philemon for his faith in me. I am grateful to him for encouraging me to further my career and being bold enough to ‘let me go’. Thank you for accepting single parenthood for almost two years that I may undertake this study.

Signed: Violet

Violet Naanyu Yebei
Amsterdam, August 1999.
DEDICATION

To
my dear husband, Philemon Kiprono Yebei,
for his love and long suffering as I studied abroad,
And my little treasure, Ann Soila Chepkemboi,
for coping with a non-resident mother for almost two years.

AND

To my loving parents,
Joshua and Margaret Mankuleyio,
for bearing and sacrificially raising me.
DECLARATION

I, VIOLET NAANYU YEBEI hereby declare that this work, with the exception of acknowledged quotations and ideas, was written by me and contains a true record of my fieldwork in Amsterdam; and that as far as I know this work has never been previously published, nor has it been presented anywhere before.

________________________

VIOLET NAANYU YEBEI

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DR. ANITA HARDON
(SUPERVISOR)
ABSTRACT

This study was undertaken to describe fertility seeking behaviour among infertile migrant Ghanaian women. It was carried out in the period April 1999 to August 1999. Infertility among Ghanaians is seen as a state of “ill-health” physically and socially. This implies that, the women’s search for fertility is not just to overcome childlessness, but also to gain general ‘wholeness’ or well-being in the Ghanaian culture.

Infertility is considered a great misfortune in many cultures. This misfortune can be due to primary infertility, pregnancy loss or child loss. Infertile women desperately seek treatment or other solutions like adoption. Little is known about infertility among Ghanaian migrants in the Netherlands. Studies on infertility among Ghanaians are scarce.

Ghanaians are the third largest immigrant group in Amsterdam. This implies that although they are fewer than other cultural groups, if the undocumented/illegal are acknowledged, their numbers may be worthy of attention from further fertility and infertility research. Indeed, presently, there is no significant documentation on Ghanaian women's infertility experiences.

Infertility in Ghanaian women, draws contempt, resentment, scorn and perpetual unhappiness. On migrating to the Netherlands, Ghanaian women have to adapt to a new socio-economic, political and cultural environment. They have to adjust to the new host population, diet, language and prevailing lifestyle. In cases where these migrant women are illegal, they lack access to biomedical infertility treatments that are available in Amsterdam for they lack health insurance. They are allowed to benefit from the treatments on condition that they meet costs of the treatments.

Since illegal people are in low paying jobs, most of them opt for more accessible cheaper alternative treatments that do not require insurance. Some of these alternatives include consulting herbalists or spiritual healers. However, prior to getting legal status, most illegal Ghanaian women are more interested in economic gain and attainment of legal stay in Holland than in childbearing.

In this thesis, infertile migrant Ghanaian women’s fertility seeking behaviour, (FSB), in Amsterdam as well as in Ghana is described. The influence of a new and
modern environment in Holland on their fertility seeking efforts is explored. Other aspects that affect health seeking behaviour, such as education, legal barriers, relations with health personnel, stigmatisation of infertility, Ghanaian explanatory models for infertility and attitudes to the health care system are explored too.

Qualitative data collection techniques were employed. The criteria for finding the sample was threefold; women who were primarily infertile, women who were expectant but had a ‘culturally’ lengthy waiting period for conception and women who had begotten child(ren) but had waited for more than a year. Therefore, any Ghanaian woman who fitted into any of these three categories was suitable. Convenience sampling especially through snowball method was used to find these infertile women.

Available published and unpublished information was used in data collection. Observation of traditional medicines, key informant interviews and infertile Ghanaian women’s narratives on their experiences were used to collect data. Informal group discussions with Ghanaian women occurred but they were not pre-planned. Information from hospitals, clinics and Ghanaian-produced videos was used too.

In total, twelve infertile Ghanaian women and twenty other informants were interviewed. Two women had primary infertility while the remaining ten had secondary infertility. Most of the women were emotional as they retrospectively recalled their experiences. Biomedical treatment was found to be the most popular choice among them. They also used herbal medicine from Ghana and consulted spiritual healers. These options were used sequentially and sometimes concurrently. They spent a lot of time and money seeking treatment in Amsterdam and abroad. Other strategies such as extramarital sex, adoption and fostering, though known to alleviate childlessness problems, were not popular among them.

The fertility seeking behaviour of infertile Ghanaian women is influenced by their cultural and personal beliefs, marital status, age, education qualification, language barriers, legal status, social stigmatisation of infertility and biomedical doctor’s attitude towards their misfortune.
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<tr>
<td>AFAPAC</td>
<td>African Foundation for AIDS Prevention and Counselling</td>
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<td>AID</td>
<td>Artificial insemination by donor</td>
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<td>AI</td>
<td>Artificial Insemination</td>
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<td>AMC</td>
<td>Academic Medical Center</td>
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<td>ENVO</td>
<td>Endocrinologie en vruchtbaarheids onderzoek</td>
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<td>FGD</td>
<td>Focus group discussion</td>
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<td>FSB</td>
<td>Fertility seeking behaviour</td>
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<td>FSB</td>
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<td>FREYA</td>
<td>Patientenvereniging Voor Vruchtbaarheidsproblematiek</td>
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<td>ICSI</td>
<td>Intracytoplasmic sperm injection</td>
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<td>IVF</td>
<td>In vitro fertilization</td>
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<td>OLGV</td>
<td>Onze Lieve Vrouwe Gasthuis</td>
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<td>RT</td>
<td>Reproductive technology</td>
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<td>STD</td>
<td>Sexually transmitted diseases</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Chapter 1. INTRODUCTION

Infertility can be defined as the absent or diminished capacity to produce offspring. This can be due to inability to conceive, impregnate or carry a pregnancy to term. Infertility can be considered in terms of primary infertility, when the woman has never conceived, and secondary infertility, when she has conceived at least once but not subsequently despite efforts to become pregnant (Sherris and Fox 1983). The World Health Organisation, (WHO) sees a need to distinguish between the different conditions that are loosely grouped under the general term of infertility. In many societies, the term infertility is used synonymously to describe three categories; inability to conceive, the inability to carry a foetus to a live birth and the failure of a live birth to survive. WHO (1975 : 20), classifies the three categories as infertility, pregnancy wastage and child loss respectively. In addition, there is another category of infertility termed as “unproven fertility”. It refers to problems perceived as infertility in demographic surveys, for example, cases of lactating mothers and couples using contraceptives.

Infertility is considered a misfortune that can be explained in cultural ways. These lay explanations blame the individual’s behaviour, or the natural world, or the malevolence of other people or supernatural forces as causes of infertility (Helman 1994: 172-173). Though, medically infertility is considered after pregnancy has not occurred for 1-2 years of unprotected intercourse, criteria for defining infertility vary among disciplines, cultures, couples and even healers. This variation is mainly on grounds of the period considered necessary before one is considered infertile and the number of pregnancies or children lost. In accordance to Ghanaians, primary infertility is understood differently from secondary infertility. Although perceived causes for the two problems overlap, they differ in the way the cause is explained.

A woman, for example, with primary infertility may be excused as innocently suffering due to a curse in the family while the secondarily infertile one may be accused of having behaved in undesirable manner, like for instance, having abortions. In this study, infertile migrant Ghanaian women’s fertility seeking behaviour is described and factors affecting their efforts to find ‘wholeness’ are also explored.

Ghanaian women’s migrant status and fertility seeking behaviour are key subjects of this research considering the adjustment they have to make in the host
country. Migration to the Netherlands for the Ghanaians is profound psychosocial transition that can cause stress. Stress can result from unsuccessful attempts on the part of the individual to cope with and adapt to changed life circumstances. These adaptations include changes in the basic assumptions that people have made about their worlds.

Additionally, immigrants have to deal with isolation, helplessness, and a feeling of insecurity in their new surroundings coupled with a flood of incomprehensible stimuli (Eitinger in Helman 1994: 309). They are faced with language difficulties, hostility, indifference from the host population, and new cultural practices that may be at variance with their religious beliefs, behaviour, diet, language and dress (Helman 1994: 309).

Helman emphasises that the culture of the host community and its attitudes to immigrant populations will always influence the immigrant’s total lifestyle, which indeed, includes their health seeking behaviour (HSB). He explains that stress arises when the immigrants are subject to discrimination, racism, or persecution by the host community. In 1998, a new Dutch law, koppelingswet, permitted the linking of databases in order to ensure that immigrants without legal documents would not benefit from basic social services such as health care. It therefore follows that, a sick illegal worker lacks access to national health services while private health services are costly and carry the danger of exposing one’s identity which can result in deportation. There are many illegal Ghanaian migrants and this status limits their fertility seeking behaviour as study findings will show.

Migrant Ghanaians fertility seeking behaviour is also different from the prevailing Dutch one due to cultural differences in understanding infertility. Unlike the Dutch population, Ghanaians seek for personalistic causes of infertility. This makes them visit both spiritual and medical healers for help. Health in this study is defined as the condition of physical, mental, spiritual and social well being. This definition therefore incorporates fertility seeking behaviour (FSB) and any other strategies that are used to overcome infertility; a condition of ‘ill-health’.

Infertile Ghanaian women in Amsterdam seek treatment in Ghana, The Netherlands and other European countries. Studies carried out in the Netherlands on infertility treatment have nothing on this minority group. In their review of studies on fertility regulation in the Netherlands, Sciortino and Hardon (1994) reported that,
migrant groups that had been studied were mainly; Surinamese, Antillians, Aruba, Turkish, Moroccan and Caribbean. This may imply that there is no fertility nor infertility study before 1994 that has been undertaken on Ghanaians in the Netherlands. However, in studying experiences of infertile couples in their search for treatment, Van Balen et. al (1994, 1995, 1996, 1997) have been mainly concentrating on Dutch population.

This study generates information on unmet needs, attitudes, and beliefs of Ghanaian migrant women in Amsterdam concerning treatments available for infertility. It gives a description of their present socio-economic and political ‘environment’ as it influences their search for fertility. Studies on infertility in the Netherlands have little, if any, information on Ghanaians.

This can be explained as due to researcher’s personal interests or relying on patient records from specific dominant health institutions when sampling their study population. It can also be due to lack of funds to support fertility and infertility research among minority groups. Moreover, infertility among Ghanaians may have been ignored by being viewed as a ‘minor’ problem of a minority group. It could therefore be suffering from being demographically demeaned though obviously of great importance socially and personally to the sufferers.

Earlier infertility studies in Holland have also not explored personal experiences of the infertile. Indeed, studies mainly on the Dutch population, have described the attitude couples have to their childless situation and treatments given. Individual unique experiences have not been explored in depth. Ghanaian migrant women’s individual experiences as they search for fertility has been explored through this study. The question as to what extend their fertility seeking behaviour has been influenced by living in a foreign country where high reproductive technologies are ‘easily’ available and their feelings about the efficiency of the dominant reproductive health care facilities/personnel has been known through this study.

This study is therefore timely and necessary. In chapter one, an introduction and background to the study is given. Chapter two describes study methodology followed by chapter three, where three case narratives of infertile Ghanaian women are presented. In chapter four, causes of infertility are described as well as Ghanaian definition of infertility. Chapter five examines problems faced by infertile women. Chapters six and seven present treatment options available in Ghana and Amsterdam,
their efficacy and accessibility. Finally this thesis is concluded and recommendations are made at the end.

**Key Terms in the Study**

There are four key terms in this study; infertility, health seeking behaviour, treatment and migrant Ghanaian woman.

**Infertility**: Three ‘definitions’ of infertility that shall also be indicators for sampling respondents will be used. These are; involuntary childlessness for years, inability to produce children after earlier successful live births, consistent child loss and delayed conception for more than a year of unprotected sexual intercourse.

**Fertility Seeking Behaviour (FSB)**: The total activities undertaken by infertile women in order to reproduce live births and improve their social well being. Activities may range from cultural solutions to biomedical consultations. It also includes extramarital sexual affairs, fostering and adoption as strategies to overcome childlessness.

**Treatment**: The substances or methods used in order to make the women reproduce, increase their chances of reproducing and curbing child loss.

**Migrant Ghanaian Woman**: Any woman, of Ghanaian cultural origin, who was born in Ghana and is currently living in the Netherlands, legally or illegally.

**Theoretical Orientation**

Reproduction is a societal requirement for Ghanaians. Procreation is dictated by society’s norms. Ghanaians, like many other cultural groups in the world, value offspring. Reasons given though similar in many ways, vary from culture to culture. In this section, I wish to explain why childbearing is important to Ghanaians and at the same time, show how infertility is a great misfortune to these women. It is the value attached by the Ghanaian society to reproduction that makes infertile women seek treatment desperately.

Motherhood is often synonymous with being a ‘proper’ and fulfilled woman. During the study, when Ghanaian women were asked why children are important to them, they looked at the researcher with a bored expression suggesting that an

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1 These are the conditions held as indicators of infertility among Ghanaians.
‘obvious’ question was being asked! It is no wonder in Bleek’s Ghanaian study (1976:226), when a similar question was posed, he was asked, ‘If you don’t want to become pregnant, then why did you marry?’ Literally, here are some of the answers given to that effect by Ghanaians in Amsterdam;

“When you marry, then you get children”

“It is normal to have a child, it’s God’s way in this life”

“In my family, they all have children. My mother had 9 children, why not me?”

“It is the normal way, once you are married you have children”.

“It is a social expectation. One becomes a full woman after getting a child”

A Ghanaian Catholic Priest notes that, “In Africa, once you enter into marriage, children are expected and women are desperate not to loose their men through infertility problems.” From the foregoing therefore, to Ghanaians, infertility devalues a woman’s femininity, makes her ‘abnormal’ and endangers her place in marriage and in society at large.

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 generational2 or individual curses. An infertile woman in Amsterdam said she made this prayer to God;

“I said, ‘God, no I can’t go through it anymore, you know, I can’t go through it anymore, you know, I’m just living a life but I think I’m dead. You give children and children are your blessing for marriage and I’m married, I’m not just fornicating, so why don’t you bless me with a child? Then I’m worshipping you for nothing, I mean what kind of God are you? Or if I have done something wrong, please forgive me and do it for me, give me what I want, give me my heart’s desire, I’m not asking you for money, I’m not asking you for riches, I only want to have food to eat and something to wear, that’s enough, it’s enough, I’m not asking for more just give me the baby’. You know, that’s what I asked Him. I was walking, I’m talking, I am sitting in the tram, I’m talking. I’m talking to you God, I’m going to bother you, I’m going to bother you until you give me what I want.”

Childbearing is 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. “Childbirth is a pride for the woman, it’s a pride for the woman. In their prayers, they always ask God to help them multiply and this is very important. In the traditional society, if a woman gets more than ten children, then there is a special rite for that. The husband and in-laws are supposed to slaughter a sheep for her for having given birth to more than ten children. So, such women pride themselves by saying ‘I have eaten bejuae, it means, I have eaten the sheep for the tenth born and its a very important symbol.”

Ghanaian proverbs shows how much reproduction is desired. For example;

‘Procreation is a virtue’

‘He who has no offspring deserves commiseration’

‘Even the dead want their number to increase, how much more the living?’

There are other reasons why Ghanaian women value children. In a matrilineal society in Ghana, an only daughter is expected to give birth, in fact, to many children. A prospective Ghanaian husband gives an example; “My wife-to-be would like to have many children because she is the only daughter of her mother and she doesn’t know her mother. She lost her at birth, so such women value children, so I’m lucky I’ll produce!” It is probably due to matrilineal upbringing that infertile women in Amsterdam who are more than forty years old still crave for a female offspring.

Among the Kwahu, an infertile woman always becomes sad because she does not have any child to play with or to send (Bleek 1976 :170). Children not only bring happiness to their parents, but to the entire family. One of the women was smiling as she said, “If you don’t have (children), you won’t be happy. When you have something (ceremony), you call your children. Without children, the whole family won’t be happy.”

Social security and inheritance within the Ghanaian family depends on reproduction. This allows for perpetuation of generations and ensures a couple’s security in old age. As one Ghanaian said, “The family security is the child, so without children, then there is a problem and marriage can break with all the pressures from the family. In our culture we don’t have social (social welfare support), we don’t have any benefits.” When you bring forth children and train them well, in old age they take care of you as one woman said, “Our parents take care of us so that we can take care

2 In using the term ‘generational,’ it is curses that are upon a family or clan or lineage and are passed
of them when they get old.” Infertility implies that one has no helpers when old, sick and when carrying out daily chores.

In Ghana, it is better to have one's own children. In old age, many people reject the aged except their own children. One gets assured that close people will meet their needs. Children are the closest comforters compared to sisters or brothers especially in old age. “Children are our future,” women said.

It is good to have many children for some are expected to be successful as others turn out to be failures. When many are born, the chance of total failure is reduced. Moreover, without children, one lacks a network of relatives who support each other in life as a Ghanaian proverb suggests; ‘He lacks assured human support whose maternal blood relations lacked abundant births.’

To the Mozambican women, infertility implies that one has nobody to mourn over them and bury their remains when they die (Gerrits, 1993). Among Ghanaians, one needs children so that when they die, their children can organise a decent funeral celebration. The infertile are given tragic burials. This is because there is a strong belief in ancestors and their reincarnation. It follows then, dying without descendants means that the person faces oblivion (Bleek 1976, Ebin 1986, Kirby 1986, Leis 1972).

As one infertile woman said, “When you die, they (your children) bury you because in our culture when you die they say the children have to bury their parents.” For this reason, one of the infertile women cried as she explained her infertility. She fears that when she eventually dies, there may be no one to give her a ‘proper’ burial. Therefore, she currently begs her family to take care of her burial when the time comes; “Children help in burials, so whenever I go to Ghana, I always ask people to take care of me when I die, I’m always saying to them ‘you know very well that I have no children.’

In this study, fertility seeking behaviour is influenced by consequences of having the infertile woman labelled ‘abnormal’, ‘incomplete,’ ‘different’ or ‘deficient’ in regard to norms and values of the Ghanaian culture. Moreover, the treatment seeking behaviour embraced, as argued by many anthropologists, is a socially organised reaction to the problem (Kleiman 1980: 24). Culture is therefore the central feature determining infertile Ghanaian women’s response to this misfortune. It is Ghanaian...
cultural, in which these migrant Ghanaian women were socialised, that shapes their way of dealing with infertility.

The critical medical anthropology approach, which integrates historical, political and economical aspects that influence health-seeking behaviour also, informs this study. As migrants, they are faced with foreign health structures dominated by biomedicine while in Ghana, alternative medicine had a great role in treatment of infertility. Political and socio-economic factors have placed migrants at the bottom of the employment ladder making it difficult for them to afford treatments. Many of the infertile women have a tendency of unstable relationships or their husbands spent most of the year in Ghana for economic reasons. Therefore, as explained later in this thesis, for the migrant Ghanaian women, political and socio-economic factors influence their fertility seeking behaviour as they settle in the Netherlands.

Ghanaians in Amsterdam

There are several factors encouraging migration of Ghanaians. Firstly, Ghanaians have a high level of education, which has enabled many of them to speak good English. This has equipped them with an international language enabling them to communicate easily abroad. Secondly, their cultural socialisation also encourages pursuit of economic success allowing for separation from their initial environment and adaptation of a new one. Moreover, their culture values accumulation of material possessions and the personal prestige this earns. Through migration, the young therefore demonstrate prized virtues of courage, initiative and self-sacrifice. Other macro factors like unfavourable political and economic factors have caused this migration too (Ter Haar 1998: 134,136).

To a people living in a diaspora, identity is an important issue. Identity then, is a concept concerning groups of people who think of themselves, or are thought of by others as similar in some way. It indicates a distinguishing character of a group, like the Ghanaians in Amsterdam, which differentiates them from the society in which they live. To support arguments on the need for Africans in Europe to preserve their identity, is in effect a continuation of discourse on the perceived ‘otherness’ of Africans (Ter Haar 1998: 82, 85).

To find a home away from home and to find identity, Ghanaians in Amsterdam have thus developed strategies of ‘survival’ as a cultural group. For example, there are
Ghanaian foundations for health and social issues. They have Ghanaian churches, videos, clothing, radio broadcasts, foods and languages. Furthermore, they are becoming more defined as a "closed community" and this 'cultural closure' is increasing nowadays.

The legal or illegal status of an infertile woman in Holland affects her accessibility to health care in general. Amsterdam, in the Netherlands, is the most preferred place of residence for African immigrants of whom Ghanaians form a large majority. Illegal Ghanaians feel insecure and the Bijlmermeer area is a place of refuge for many of them (See appendix 5). Undocumented migrants can hide their illegal status there more easily than in any other place in the Netherlands for illegal migrants are today under permanent threat of expulsion. All the same, it is worth noting that most of the illegal infertile Ghanaian women are more interested in getting 'papers' (legal status) and having children later.

Illegal immigrants are vulnerable to unemployment, deprivation, poverty and associated poor housing, diet, sanitation, clothing and exposure to crime (Helman 1994: 302). It is indeed true that Ghanaians in Amsterdam are often in poorly paid jobs doing dirty or monotonous work. Most of the women interviewed were cleaners or social workers. Many migrated for economic reasons. They therefore work hard and send money to the family at home for support because of strong moral obligations to help those left back in Ghana (Ter Haar 1998: 126, 134-135).

European migration policies that have been known to change as politicians and officials constantly review them, making immigrants insecure as their status is questioned. Neutral terms for defining migrants have been replaced by new official value-laden categories that are constantly being invented and that create ideas of 'good' and 'bad' migrants. Unfortunately, this encourages the tendency to criminalise illegal migrants. It is very difficult for Ghanaians to legalise their presence in the Netherlands for they are considered to be economically oriented and cannot claim political refuge.

To get legal stay, Dutch law requires them to have stayed in the country for at least six years and have earned an income from legal employment. During that period, many of them work and pay social charges related to employment but are unable to

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3 Building a strong sense of Ghanaian identity and social network to help them survive in Holland
enjoy the protection offered by social welfare systems as they do not fit the requirements to legalise their status (Ter Haar 1998: 113,117).

In 1992, it was estimated that 10,000 Ghanaians were living in Amsterdam. They are the third largest immigrant group in Amsterdam Zuidoost after Surinamers and Antillians. Once in the Netherlands, research shows that plans of returning to Ghana diminish with time as efforts to achieve economic success gain priority. The idea of returning to Ghana simply serves to strengthen the belief among host members that one day these immigrants will go to Africa; ‘a mere politically convenient thought for European policy makers’ Ter Haar (1998: 39,87,126,135).

**Infertile Ghanaian Women in Amsterdam**

As observed by some Dutch doctors, considering the total number of Ghanaian migrants in the country, the ratio of infertile Ghanaian women in Amsterdam is relatively high when compared to other ethnic groups in Amsterdam. Infertility is a sensitive issue and therefore personal to Ghanaians. As an informant put it, “In Amsterdam, infertile women disguise their suffering. So, sometimes their pain is not noticed by others because they live individually. In Ghana, life is more communal. Relatives recognise the problem and try to help.”

Some have not informed their husbands about it nor dared to go to their native homes in Ghana on holidays. They fear being questioned on their childlessness and resulting ridicule. As a Ghanaian man puts it;

“They (infertile women) don’t have the social environment in Ghana that you can freely go to friends, visit family members or go to church. There are so many ways of dealing with your problems unlike here. You go sit down in your room, thinking of your problem and it will eat you up, so they prefer to work, get tired, come home and sleep. Here, it is very difficult to come out and voice infertility problems because life here is so enclosed. In Ghana, women go and dance off their fears and anxiety in church and in prayer, you know. But here, the churches are not very vibrant for the society has tamed the church. You can’t make noise like in Ghana where you can worship the whole night. Here, you don’t have time for anything, not even to make that noise. One infertile woman told me that life is very boring. There are no people to confide in so you work hard. If you don’t have a child to play with, then you just stay in the room, life is so boring”.
Most of the infertile Ghanaian women interviewed have secondary infertility. Many had a child or children in Ghana before migrating to Europe. On settling down in Amsterdam, they got married and wished to have more children. Paradoxically, according to existing records, Ghanaian women's demand for abortion at the abortion clinics in Amsterdam is high. For example, at the sexuality and abortion clinic MR70, there are Ghanaian abortion clients and the numbers are increasing (Appendix 5).

Although far away from Ghana, infertile Ghanaian women suffer from the social pressure felt by infertile women back home and are desperate to have children.

The Problem

Many infertile Ghanaian women in Amsterdam are endlessly looking for treatment due to socio-cultural pressure bestowed upon them. All forms of health care should ideally be available for all in the Netherlands. As migrants in a foreign country, various factors influence their fertility seeking behaviour making accessibility of treatments difficult. These are: explanations (biomedical or cultural) given for causes of infertility, what is considered to be an appropriate treatment for the problem, literacy levels of infertile women, costs of treatments, language barrier, legal barriers and stigmatisation of the problem.

Given that success of reproductive technologies may only be realised by a few couples and often after several attempts, insurance that limits the number of times a couple can use treatments disables efforts of low income earners to make further attempts. Since most of the treatment information is in Dutch, accessibility of sufficient information on causes of infertility and utilisation of treatments among Ghanaians was a problem worthy of investigation. Many illegal Ghanaian women often lack health insurance and their fertility seeking behaviour in Amsterdam was of interest to this study.

View points of different actors were to be analysed. Therefore, health worker's and partner's attitude to the infertile women was important. Infertile women's attitude to the health systems available in Ghana and in Amsterdam, as well as Ghanaian emphasis of the female's role in childlessness, all had their effects on fertility seeking behaviour worthy of investigation.
Chapter 2. STUDY METHODOLOGY

Objectives of the Study

The general objective of this study is to describe the fertility seeking behaviour of infertile migrant Ghanaian women living in Amsterdam. Specific objectives include:

1. To describe infertility treatment options existing in Ghana and in Amsterdam for the infertile Ghanaian women.
2. To examine strategies employed and procedures undertaken in treating/ solving infertility among Ghanaian women in Amsterdam.
3. To investigate emic ideas on causes of infertility and resulting consequences that may influence the fertility seeking behaviour of Ghanaian women in Ghana and in Amsterdam.
4. To explore Ghanaian women’s personal experiences that they have undergone in search for fertility.
5. To explain unmet needs in provision of health services among the infertile Ghanaian women in Amsterdam.

Study Type and Design

The study was exploratory and descriptive in nature. This is because it was aimed at exploring a group of people that has received little attention on infertility in the Netherlands. This implies that little is known about Ghanaian migrants perception of infertility and treatment seeking behaviour. Moreover, like other exploratory studies, due to time constraints, the study was small scaled and done in a few weeks. Ghanaian women’s situation/ experiences so as to give a clear picture of their predicament were explored. This raised information on their fertility seeking behaviour and related ideas and beliefs.

A comprehensive approach was used for the study included cultural and socio-economic status of the ‘respondents’ that influenced their treatment seeking behaviour. This is because some of them have unstable partners, are employed in low paying jobs and have a hard time adjusting to a foreign cultural environment. Exploration and description of their Amsterdam ‘context’ in totality was elucidated.

The study was aimed at collecting qualitative data, through literature review of available information, personal narratives and key informant’s interviews. The
existence of women's groups in the Bijlmer raised the possibility of having focus group discussions (FGDS). These discussions could raise information on general treatment seeking behaviour of infertile Ghanaians and the labels attached to such people. It was to allow for exploration of this sensitive issue by both fertile and infertile participants. The reality was that, FGDs were not ideal for this study. Many of the infertile women did not want others to know about their problem because it would predispose them to being labelled as 'not normal.' This element of secrecy and high sensitivity of infertility among them made individual interviews more appropriate. Informally, general discussions with more than one woman happened but they were not pre-planned.

**Study Variables**

The following variables raised background information in the study:

**Legal status, Occupation, Income**: These variables were used in order to explore if the infertile women's working experience or job and insurance packages attached to it affect fertility seeking behaviour.

**Education and language skills**: Exposure to schooling influences work opportunities and understanding of infertility treatment. The number of years of education attained or the last grade attained was therefore an indicator. Degree to which the women spoke and read Dutch and its influence on their treatment seeking behaviour in Amsterdam was also considered.

**Age**: The infertile woman's and partner's age influence reproductivity. In sampling, the age of a sexually active but infertile willing respondent did not matter. It was only relevant in its role as a possible cause of infertility.

**Religious Affiliation**: The role of religion in treatment seeking behaviour was important as many infertile Ghanaian women were members of churches in Amsterdam. Seeking conception and avoiding pregnancy loss through prayer or other religious rituals was a possible strategy.

**Marital Status**: Legal/Official marriages versus unstable unions affect fertility seeking behaviour. It was crucial to know whether an infertile Ghanaian woman was single, divorced or having casual relationships.

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1 For example I CARE women's group in the South East of Amsterdam
Reproductive History: Information on previous pregnancy or child losses and the total number of children delivered prior to secondary infertility was solicited. Considering varying periods of infertility, this variable raised information leading to understanding as to why there was a desire for (more) children and any differences in treatment choices made by the respondents.

In addition to these variables, there was the theme on attitudes to infertility treatments. In this case, the women’s utilisation of various treatment options and their experience thereof helps one deduce satisfaction/efficacy perceived and how it affected further fertility seeking motivations. Reasons for choosing particular treatment options were sought. Availability of treatments, costs, how often a treatment was used and whether in Ghana or Amsterdam was questioned.

Data Collection Tools

The following data collection techniques were employed.

Available information: Published and unpublished data, Ghanaian videos and oral literature were used as sources of data. On visiting several Ghanaian organisations in Amsterdam, general information of importance in fertility seeking behaviour of infertile Ghanaian women emerged. A list of possible treatment options that had been found in existing literature was applied during interviews.

Observation: The only observation made was of fertility enhancing medicines/potions and body language of infertile women as they passionately narrated their experiences. Photographs of the herbs and major health institutions where these women go for help were taken.

Key Informant Interviews: Using guiding topics, open ended questions were informally and formally administered to key informants. They were either chosen because of their interest in infertility in the Netherlands; Ghanaian culture; or their encounter with infertile Ghanaian women in Amsterdam and in Ghana. They included among others; Ghanaian researchers, gynaecologists, Ghanaian traditional healers, infertility researcher, Ghanaian medicines/potions sellers, Ghanaian organisation’s leaders, Ghanaian Priests and an official of FREYA. Absence or presence of Ghanaians in FREYA helped shed light on their ability to get information on infertility treatments.
Interview topics specific to each of these key informants were prepared and implemented. For a full list of the questions asked to each key informant category (Appendix 3).

**Narratives by infertile women:** To find out how cause and consequences of infertility affect their fertility seeking behaviour, in-depth retrospective interviews with infertile women were conducted. In-depth interviews were handy in exploring their experiences with existing health systems during their search for cure. Informal conversations with friends or relatives of infertile women helped with generation of tertiary information, which complimented information given by infertile women.

A monetary token was given to the ‘I CARE’ women’s group to boost one of their social projects considering their help during fieldwork and prevailing complaints that Ghanaians are facing “research fatigue” due to much attention that has been focused on them lately.

**Sampling**

Being a sensitive topic among Ghanaians, it was a difficult task to find women who were willing and comfortable to discuss a ‘personal stigmatising’ problem to a stranger. Nevertheless, a rapport was created as contacts were established through church gatherings in Amsterdam. Since the research period was short, convenience sampling was used implying that a truly representative sample of these infertile women was not used. Snow ball method, starting with the few women with whom rapport had been developed earlier helped a lot. Once the confidence of Ghanaian organisation and church leaders had been won, more infertile women were reached. The aim was to get at least a minimum of eight women. In total, twelve infertile women were interviewed and twenty other informants.

Besides currently primarily infertile women, the following groups were sources of respondents:

1. Women who had begotten children but had waited for more than a year

2. Primarily infertile women that had children who were not biologically theirs, for example, adopted children

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2 There is a publication that has all Ghanaian organisations in Amsterdam. It is by Berger et.al 1998. See references.
3. Women who were expectant but had a 'culturally' lengthy waiting period for conception

In sampling, age, educational status and social character of respondents did not have to be specific but as earlier mentioned, these served as research variables. Key informants were randomly and conveniently selected too.

Ethical Considerations

Efforts were made to ensure that respondents remained anonymous during and after the study for I was living with a Ghanaian family and some of the respondents were known to this family. Objectives of the study were explained to them before interviewing and they were assured of confidentiality. With each interview, informed consent was sought. Indeed, no unwilling person was coaxed to yield information.

Respondents were also protected from any possible harm that could develop during the study period and thereafter. Contacts of counsellors who were willing to help the infertile women were given to the women after the interviews. As the need arose, I re-visited infertile women who needed more information on their problem or who simply wanted "to chat with somebody they could trust to give advice about it."

Implications of the Study

This study has raised information on the fertility seeking behaviour of infertile Ghanaian women in Amsterdam. Results will be helpful in any intervention to ease problems faced by infertile Ghanaian women as they seek treatment. Findings are useful to health workers who want to understand differences in the fertility seeking behaviour between Ghanaian migrants and other cultures represented in Amsterdam. Findings can also trigger further research in other aspects of reproductive health of Ghanaians and other minority groups in Amsterdam.

On the other hand, carrying out a study on a group that has lately received a lot of attention from researchers in other fields can be disturbing. As a male Ghanaian said to me, "Why does every researcher pick on Ghanaians? must you document our way of doing things? why can't you interview other groups and leave us alone!" In

3 Among Ghanaians, a couple is fully suspected of infertility after one year of sexual contact and persisting childlessness.
the wake of increasing insecurity among the illegal, they may feel more vulnerable when studied.

**Data Processing and Analysis**

All data was analyzed manually. Background variables became important during the interpretation phase of the study for, as will be discussed in the final chapter, they influence fertility seeking behaviour.

Qualitative analysis was done through a search for patterns and groupings in the data in an attempt to understand the experiences of these infertile couples as they seek for treatment. Descriptive analysis presents particular trends in their fertility seeking behavior. These patterns are then analyzed in later chapters within the framework of specific study objectives.

Production of displays through laying out of tables and matrixes was used to compile and communicate findings.
Chapter 3. THREE NARRATIVES

In order to give a general idea of the problem, three examples are given to illustrate the kind of narratives these women gave. The first woman had primary infertility for six years but is now having children, the second is currently suffering from secondary infertility while the last one has primary infertility. These cases, in a general way, represent the categories of infertile women interviewed in this study. The original emic use of language is maintained as much as possible throughout the text. Names used here are fictitious.

Marietta's Story

Marietta is thirty-two years old. She finished elementary studies and undertook a professional course in Ghana. She is a pentecostal Christian, married and has legal stay in the Netherlands. She has health insurance. She has experienced six years of primary infertility and one miscarriage. Currently, she is not working because her children need a lot of attention. She has two sons. The first is one year and ten months old and the second is four months old.

In 1990, she got married in Ghana to a man who had been living in Holland for twenty years or so. She joined him in Amsterdam in 1992. She is his second wife; the first one divorced him and they had two female children together before they separated. These children are twenty and sixteen years respectively and live in Amsterdam with their mother.

While in Ghana, for two years, Marietta had no children. She never wanted to talk about her problem. When she joined her husband in Amsterdam, she went to the house doctor who performed tests on her and saw nothing wrong with her. Her menstruation periods were not regular and two weeks after each menstruation episode, she got a lot of pain for three to four days. In 1994, she was transferred to a specialist at Vrije University medical hospital. She was to wait for six months before her appointment date with him for they had long waiting lists at the hospital. "They made echoes and just asked me to mark my menses. By 1995, I gave up on Vrije University, they did no treatments on me but continued checking menstruation and saying you are normal excetera."

So in 1995, she decided to go to a hospital in the Northern part of Amsterdam. They did lots of tests there. "They did not have many equipments so they sent me to OLGV where I got more treatment". In 1996, she conceived but miscarried after three months. She went for further check up and started artificial insemination treatment. She tried this treatment twice. After the miscarriage, she went to a clinic in Gent, Belgium. She was given medicine to take but on returning, she never used it and explains why; "I was angry at myself for running
about in search of treatment as advised by people and yet I was praying about it and was still young. *If a doctor in Gent can help her, so can one in Holland. God can work through either of them, I decided to shut my ears from further advice*.

In early 1997, she got pregnant without any medical treatments. She told the doctor about it when she was two and a half months pregnant. She prayed a lot when she got this pregnancy. Then, when she was about two months pregnant, she started bleeding while at her place of work. She rushed home and even decided to stop working from then onwards. She went to hospital and the doctor confirmed that she was pregnant. She got a son in September 1997. *My children are Gods gift,* she says.

Apart from the hospital in the North where they took a ‘short time’ to decide what was wrong, the other doctors took long. *At OLVG, I had to wait for a very long time before the tests and treatments could start. They have many women going there.* She emphasises. She used herbs for a short time after the miscarriage. Her mother sent them to her from Ghana. In Ghana, herbs are believed to help treat problems like menstruation pain and fibroids.

She felt that the Netherlands health and information dissemination system was inadequate; *When I was in Ghana, I believed the best treatments are in Europe, not anymore. When they give you information at the hospital, they always say, 'if your husband reads Dutch, he can read it or go find somebody to read it for you'. Sometimes I just ignored it, sometimes my husband who reads a little Dutch tried to see what it means. Sometimes, when it looked very important, we got somebody to read it for us*.

Her husband is much older than her. He is very supportive and she openly tells how much he loves her. This is what she said about him; *I was much worried but he always advised me not to worry too much. He had two daughters before so I always said he has children and that's why no worry!* When his mother asked him about our problem, he asked her, *Is that your problem, go your way and I stay my way*. In 1994, he went home (Ghana) alone. Family members asked him why we had no children. I had told him, *I will not want to go home before I have babies.* Every two to three years he went home and I refused to go.

When she got her two sons, her husband was so excited and said, *Because you have given me two boys, you can have my car and I shall be riding a bicycle to work*. And thus it is to this day.

Friends asked, *What's the problem?*, Others said to her, *You work too much. You want money more than children*. The first four years, that is in 1992 to 1996, she worked for ten and a half hours daily, *In Europe here, you have to work too hard to pay bills*, she said.
When she got the baby, after only two and a half months, her employers, a flower firm, called her asking her to go back to work unless she was sick. She complains; "When I reported back, they would take me to a different section every other day because I stayed home for one year because of the baby."

One close friend of hers, living in her neighbourhood upset her very much during her infertile period. She gave testimonies in their church on how God had blessed her with two fine children although she had no 'papers' (legal status) and that children are more important than 'papers'. She even said this to Marietta who became furious but kept her peace. On telling her husband about it, he called her friend and told her to keep off and stop disturbing his wife. He even criticised her 'housewifery' nature leaving her husband to do all the work and support the family; for she had been spitefully commenting that Marietta had bruised hands because of the roses she dealt with at her place of work.

Thus she concludes; "Friends can be difficult. When you have no child, they ask questions and say you should now have children and when you get them too quickly, like I did, they say something else." She hopes to have a third and final child someday, hopefully a girl child. She had hoped her second baby would be a girl. Now that she has children, she plans to go home in December 1999.

She had ideas on infertility in Ghana; "In Ghana behaviour of in-laws, like mother or sister can be implicated as a cause but as a believer in God, You don't think much of what witches, the devil excetera do". She has heard that many infertile Ghanaian women go back home for treatments and get pregnant. Some go purposely on holiday to seek treatment there. There are many gynaecologists there and this is what she thinks of their work; "they just want the money and in a short time you have a baby." Infertile women in Amsterdam go to Ghana for herbs. "Herbs help many people. I know, my brother waited for ten years and his wife finally got a baby through herbs. People advised me to go back and get treatment. I just laughed it off when people asked about it."

On adoption she said, 'You can't really adopt a child because of infertility. It's not like yours, you have to fight for it yourself.'"
Felicity’s Story

Felicity is forty years old. She is married and is a social worker. In Ghana, she went to school up to high school level. She is a Pentecostal Christian. She has legal stay in the Netherlands and has health insurance. Prior to 1990, she had several abortions. She has also experienced one ectopic pregnancy and one miscarriage. She has been secondarily infertile for seventeen years. She is the proud mother of a twentytwo year old girl. She had few abortions when she first came to Holland, “you know paper problems make people do such things,” she said. She got married in 1990. In 1993 she got a miscarriage. Since 1995 to date, she has been going for check ups at the hospital. The doctors said she had womb problems but never gave her any medicine.

In 1998, plans to try in vitro fertilisation began. The doctors removed her eggs and took her husband’s sperms and then claimed that she did not have sufficient eggs. They wanted seven eggs and had found only two, they said to her. Blocked tubes were concluded to be her problem by some doctors. She said, “They say it’s costly but I think it’s because of my age that they are reluctant to help me.” Now she is forty years and her wishes for in vitro fertilisation have been turned down. They say after forty her baby will be handicapped, she will have much suffering for nine months and she can also die.

She knows a woman who had a child at the age of forty-four years. She knows a clinic in Gent, after Antwerp, where private clinics help people even after they turn forty but it is costly. In November 1998, she left for Ghana and in January 1999, while there, she used herbs in soups and also boiled them in water and drunk. “I’m trying everything, I just want a quick solution” she said. She has been to Kodie too, the Ghanaian herbalist in Amsterdam. He gave her a herb that hurt her so much. She stopped using it; “I felt like it was cutting up my inside. I want a solution immediately so I try everything. I’m desperate. My sister-in-law used Kodie’s herbs and three months later she got a baby. Kodie said the herb cleans the womb and that is why the cutting feeling is there.”

She seems to have given up on Dutch doctors; “Doctors here give no medicine at all, they just checked my womb and always said I was okay. When I was thirty nine going forty, I went to see them more because I feared I was getting old since my first visit when I was thirty six years. The doctors help but they don’t give medicine. Some say, ‘Holland is full of people, you have five children, why worry yourself?’” She feels that Dutch doctors should look into her need to have children and not on ideals on numbers of children. In comparing Dutch
doctors with those in Belgium, she said; "Belgium doctors are very encouraging, it does not matter how old you are."

She has been spending £150 for each consultation in Belgium. Transport costs about £600 per month and she has to buy the medicine prescribed by Belgium doctors. Reflectively she said, "Here, insurance pays for me, maybe that is why they are less helpful."

She has been looking for healing in the church too. "In 1998, a Pastor from Ghana came here and called me by my name and said I have one child and that my people (in Ghana) sealed my womb because of my success in Holland. He prayed for me and so I'm waiting. God says He'll give me a child, what else can I do?" She asked miserably. She is now waiting for God's help.

She also said that infertility can be caused by a spiritual 'figure sleeping' with the woman, and that such cases are hard to cure. She also had a wound on her breast as she was looking for a baby. When she showed it to the doctors here, they said it was not something they could do much about. She went to Ghana and used herbs and she is happy to say that she got full cure.

She extensively talked about her husband's attitude to her infertility. Normally, failure to reproduce leads to polygamy as parents force the man to marry another. In her opinion, polygamy 'is out', she loves her husband and they have invested a lot together. Divorce is a risk always. He bought a big house in Ghana saying it is for his children. "He acts like it's no problem but inside, I know he complains. His friends encourage him to take another wife. If he should get another woman pregnant, then I'm in trouble." In her husband's family, they are only two therefore she feels a need to reproduce although he does not pressurise her. She does not want to loose her husband because 'she has suffered so much to build a home with him.'

"He is calm, polite, he would not even raise his voice to complain if he has complaints about my problem, he never hurt me, I was married before, I know how they can be, I never want to lose him." She said. She is afraid to tell him that the doctors have given up on her because she is afraid he will leave her, "He keeps saying, 'It's alright' but I know deep inside he feels broken because it's African to have children and he doesn't have even one. If it wasn't for him, I wouldn't bother getting a child, at least I have one already, a beautiful girl, in fact she is a model." She adds with motherly pride.

Friends and relatives have been very supportive. Her daughter wishes for a sister or brother to play and make friends with. When she accompanies her mother shopping, she says to her, 'Mom, Aaaa! get a baby and I will buy you this and that.' "She feels alone and so
She ‘adopted’ children ‘on paper’ in the past at a time when it was favourable to do so. She ‘adopted’ four of them in Ghana and so the system here sees her as a biological mother of five but they are not hers at all. The doctors therefore think that she should not be so desperate to have more children.

There are reasons why she values children; “It is good to have many children for some will be successful and others not. When many, the risk is reduced. Children help you in old age, they take care of you as you do not have a job or money. If you had no earlier investments in business, when you age you suffer and are poor. Children help in burials too, whenever I go to Ghana, I always ask people to take care of me when I shall die, I’m always saying to them you know very well that I have no children.”

Hope’s Story

She is forty years old and is a social worker. She only went to elementary school in Ghana. She is customarily married. She is legal in the Netherlands and has health insurance. She is a Pentecostal Christian. Hope suffers from primary infertility. For nineteen years, she has been trying to get a baby. She realised that she had the problem after arriving here and getting involved in a relationship in the 80s.

‘Obonini’ is the Ghanaian term for her problem. Doctors say her problem is caused by fibroids. She feels like there is no solution “as doctors will not help her make a child because she is forty.” She had tried in vitro fertilisation five years ago, but she got tired of the injections procedures after one try. She got information on treatments from Academic Medical Centre (AMC).

She believes that doctors here discourage childbearing. For example, her friend, a young lady was asked to abort her baby but she refused to do it and carried the baby to term. “She prayed and got a beautiful girl. The doctor had said she would have an abnormal child, they said they expected it to be headless.” She is not willing nor her present husband to try in vitro fertilisation again. She is waiting for God’s intervention.

Her first husband left her because of this problem. Her family is supportive and pray for her. She feels no stigma, in fact, she feels that people sympathise with her. She has used herbs often to cure the problem; “I have used them many times, almost always,” She said.
In May 1999, she went to Belgium and the doctor told her that she had fibroids five centimetres long. He gave her medicine 'which is not found here.' On returning, she showed it to the AMC doctor 'who searched in vain for it in books'. It is called vibratab (100mg, Doxycyclin, monohydrat). Consultations in Belgium cost f150 and an operation to get rid of the fibroids is f5,000. She is not even considering it. It is too costly for her.

There is also medicine (tablets) from South Africa which is 'very powerful' and would be brought for her use via Ghana. She said she wants children because "It is normal to have a child, it's God's way in this life. In my family, they all have children. My mother had 9 children, why not me?"
Chapter 4. CAUSES OF INFERTILITY

In this chapter, nature and causes of infertility among Ghanaian women in Amsterdam and in Ghana are discussed. Ghanaian understanding of primary and secondary infertility is also investigated. Controversial blaming of women by Ghanaian society for childlessness is also analysed.

Nature of Infertility among Ghanaians

In many societies, the term infertility is used synonymously to describe inability to conceive, the inability to carry a foetus to a live birth and the failure of a live birth to survive WHO (1975: 20). These three categories mentioned amount to Ghanaian’s definitions of infertility. In Ghana, immediately after one marries, a child is expected that year. Conception is expected within the first week. If no baby is born, people start defining the couple as suffering from infertility. Within the year they must see signs unless the couple is able to prove that it is due to separation. For instance, as one partner travels.

Among Akans, a cultural group that is highly represented in Amsterdam, there are terms used to define and describe male and female infertility. A female who cannot have children is called bonini, literally meaning, ‘barren person’ while a male is called okrawa or kukuba. Most of the time, infertile men are referred to using euphemisms are such as:

- 'Aban agye ne tuo’ (‘The government has confiscated his gun’)
- 'Ido benada’ (‘He farms on Tuesday’) There are certain days that are taboo for one to work. In the past, such days were set apart for some traditional rites to be carried out. Having sex on such a day amounted to doing something that was forbidden, thus leading to infertility.

- ‘He is dead in the night’. If one is blind, he is seen as ‘blind in the day’ and if one is impotent, he is said to be blind or dead in the night.

Biomedical Causes

Sexually transmitted diseases (STDs) are said to cause infertility. Gonorrhoea has been highly implicated in both male and female infertility. Tuberculosis, filariasis, leprosy, schistosomiasis and mumps have also been implicated although further research is needed to establish this suggestions (Sherris and Fox, 1983). Endeavour
Health Care Research\(^1\) gives a comprehensive list of possible causes of infertility in both sexes which I shall briefly mention.

Appertaining to women, ectopic pregnancies, abdominal surgery, fibroids and previous trauma to the genital tract can cause late or early spontaneous abortion. Obstetrical difficulties also cause late foetal deaths and influence early neonatal deaths. Other causes in females include previous use of contraceptives, intra-uterine devices (IUDs) complications, excessive physical activity, extreme weight gain or loss, severe mental or physical stress, malnutrition, hormonal imbalances, drugs and having an allergy to spouse's sperm.

There are male factors too in infertility. These include; inadequate sperm production, anti-sperm antibodies, poor sperm motility and use of tight underwear has also been noted. Other causes include undescended testicles, glandular diseases, nutritional deficits and obstruction in the seminal tract caused by genital abnormalities and infections. Advanced age, genes, erectile dysfunction, environmental and psychological factors can also influence fertility.

Ghanaian women interviewed mentioned the following as causes of infertility: Fibroids, irregular menstruation, excess weight, excessive physical activity, high blood pressure, ectopic pregnancy, physical stress, ovulation problems, production of unviable eggs, 'old' age, sexual dysfunction and various tubal problems. Endocrinial related complications especially in women suffering from secondary infertility were also noted.

Ignorance on the fertile period in the woman's cycle can reduce chances of conceiving. Some of the infertile women in Amsterdam were not sure of when they would be able to get pregnant during their cycle. It was even more difficult for those whose husband’s reside mostly in Ghana. Ghanaians migrate a lot in search of work. Seasonal or temporary migration of a partner reduces the number of times a couple can have coitus. This may also create room for extramarital sex leading to exposure to STDs that may lead to infertility.

It is highly probable that a man who works away from home may develop unstable conjugal unions or visit prostitutes. For example in Africa, many males migrate in search of jobs and are required to undergo periods of postpartum

\(^1\) Endeavour Health Care Research Internet site(1999)
abstinence. Extramarital relations for such men are generally acceptable (Odile 1983). Marital instability, immorality and polygamy increase the number of sexual partners one is involved with, thereby, increasing chances of getting an STD infection that can lead to infertility (Neizer 1983, Sherris and Fox 1983).

Local birth and postpartum practices, use of indigenous contraceptives or abortifacients and ritual operations on the genitals have also be implicated in ability to cause infertility. Among Ghanaian women in Amsterdam, traditional ways of cleaning the vagina can be implicated in causing infections that lead to fertility problems too. The vaginal canal is believed to harbour 'bad smelling substances' and the use of herbal substances in cleaning it reduces this 'stench'.

Most of the infertile Ghanaian women interviewed had abortions in their youth. Abortions done without professional assistance, are likely to lead to infections that affect the reproductive system. Some Ghanaian women think that it was their own fault that led to infertility since they had abortions in their youth when they were in Ghana. Some of these abortions were done crudely which could have lead to infections. For instance, here is an example of a traditional way of performing an abortion; 'In Ghana it is a common practice in most rural areas and in some urban communities to tie a piece of string to a twig of jatropha which is placed in the womb and then pulled out by means of the string as soon as the woman starts bleeding' (Cutrufelli 1983: 142).

According to informants, no legal married Ghanaian woman in Amsterdam would want an abortion. "In fact, it is beneficial to have a child while in Holland". Women postponed births for any of the following reasons. For some, childbirth at a particular time would have interfered with their career opportunities or personal ambitions. For those who had been aborting in Amsterdam, the reason is that, since they had come for economic reasons, 'accidental' pregnancies were best terminated. Moreover, some of these women were initially working as prostitutes and childbearing would have interfered with their source of livelihood. Absence of children may probably have enabled these women to find marriage partners too. This explains abortions that these women opt for in their teenage and early adulthood.

There was further suggestion that until recently, abortions had not been thought to cause infertility among Ghanaian women. It is therefore, according to them,

http://urology-health.com/med-malinfert_main.htm
a recent trend in Ghanaian society. To quote an informant; "When they are young, they abort all their children and now they go around crying for children. It's one of the modern concepts because in the olden days, they had many puberty rites so one could not just become pregnant for they were under strict rules. Society regulated itself. It was really a big disgrace for a girl to get pregnant because she had to wait for performance of puberty rites and parents were very strict with their children. There was no sex after puberty rites, until you got married. That's in the traditional concept but it's broken down now, everything is mixed up." The high abortion rates are seen as an undesirable product of modernisation.

Non Biomedical Causes
Witchcraft
Possession by spirits and witchcraft are held as causes of infertility. Infertile women are often suspected of being witches. Witches are believed to remove the womb and throw it in a latrine pit so as to cause barreness (Debrunner 1959).

Many women in Amsterdam blamed their family or other wizards for bewitching them. As one Ghanaian woman leader said; "Some women complain saying, 'my in-law is a witch, they have some motive behind it'. They say witches are making them childless. That's psychology or something like that. Some say, 'tis my sister who is doing this to me." A Ghanaian woman who had several abortions, after some time met a man in Holland and married him. After a while, she got pregnant. When her pregnancy was five to six months old, one night she dreamt that her aunt came and touched her stomach saying; 'I'm going to take your baby'. A few days later, she got a miscarriage which she believed was due to witchcraft practised by her aunt.

When a woman has no children, sometimes people suggest that she has 'eaten' her children. Therefore when she gets infant mortality, people will say to her, "no no no, you're doing yourself this harm, eating your children. You are a witch."

There is also a mysterious spiritual cause of infertility among Ghanaian women. There is a belief that, in the night, a 'spiritual figure' can come to sleep with the woman and cause infertility in her. It was confirmed by an informant who had a miscarriage due to the same 'spiritual figure'; "I had that experience myself. When I was having my first pregnancy, when my husband was away, I dreamt that I was
having sex with him. The spiritual figure always wears the face of your husband. Immediately after, I got a miscarriage. It happens to many women. I never told my in-laws when I got pregnant again. They can cause evil.”

Sanctions by Deities

Infertility is seen as a ‘natural’ requirement of a deity or a possession by spirits. To the Ijaw, infertility can be due to a request by a deity to be barren forever or after having one child (Leis 1972). To the Asante, sometimes childlessness is explained as from God and is one’s “nkrabeda”, destiny or it can be due to neglect to propitiate family ghosts and family gods (Field 1960).

Infertility is also explained as a curse from the gods. It can be a sign of displeasure by an offended ancestor. For example, undesirable marriage arrangements which may be implicated in incest taboos are cursed by deities leading to barreness. Women in Diaspora tend to think that their infertility is a manifestation of links to their family situation and the powers they distrust in Ghana. Not only gods are believed to curse, women blame parents and ancestors too. This is especially so when several women in one family are infertile. An informant’s example explains how cursing is understood by some couples;

“My friends (in Amsterdam) had eighteen years of marriage with no children. Both were tested at ENVO and the problem was with the woman. She started blaming parents of the man because she was having differences with them. She believed they cursed her. She went to Ghana seeking a solution; a spiritual challenge of in-laws. Another lady had only one child and no more. She was blaming her mother for it. So she stopped sending money to her mother and other family members involved.”

Misconduct and Interpersonal Conflicts

Disrupted social relationships, for example through marital disharmony and negative emotional feelings such as anger, hatred, envy and jealousy endanger the well being of the community which can result in cases of infertility (Ebin 1982). At a shrine in Ghana, one quarrelsome Asante couple was asked; ‘Which do you prefer, quarrels or children?’ Kinship strife and marital disharmony is therefore blamed for childlessness. To Ghanaians, infidelity and quarrelling cause infertility (Field 1960: 120).
Failure to honour clan obligations and to observe taboos are also prominent explanations for infertility. Failure to treat umbilical cords in culturally appropriate ways after delivery is believed to cause infertility in Mozambique (Gerrits 1993). In Ghana, as earlier mentioned, ‘Ido benada’ (‘He farms on Tuesday’) is a euphemism that implies that some marriages are childless because certain taboo days are not observed. Having sex on these particular days therefore, leads to infertility. As a Ghanaian man elaborates; “It’s a very big disgrace for the man to be said to be infertile, so you’ll see the impotent chasing women, running after women even when he is not able to have sex. When he is actually weeding on Tuesday, he’ll still be pretending he can work on Saturday!”

Among the Anufu of Ghana, adultery is considered a violent malicious act aimed at destroying a husband’s fertility. After a woman’s menstruation, if her husband does not have intercourse with her first, both her fertility and his spirit will be endangered by any possible intruding adulterer. It is believed that the essence of the lover enters and resides within the woman after intercourse. This essence is believed to be antipathetic to that of her husband and affects the possibility of conception. This ‘spoiling’ of the womb is believed to also lead to miscarriages (Kirby 1986: 197-199).

**Incompatibility**

The problem of whether the woman or the man is the cause of childlessness can sometimes be a complicated one. For example, both may have had children from previous unions. In such cases, it is believed some men and women simply do not mix well. Infertility due to lack of compatibility of a couple’s blood has been noted elsewhere in Africa (Gerrits 1993, Kane and Snow 1995).

Incompatibility is a common explanation among Ghanaians too. The infertile women are believed to be married to the ‘wrong’ man and this causes childlessness. They are thus advised to try another man lest they should die childless. A Ghanaian man explains it; “You have not met your man, that’s one of their arguments. A woman may not have children with one man and on getting another, may have a child or children. So you see, there is a special man who can sort of make things right.”
Who is to Blame for Childlessness?

Although the woman is usually blamed when a couple cannot have children, male factors explain about one-third of all infertility in Africa (Sherris and Fox 1983). Generally, men's role in procreation is not ambiguous in Africa but most responsibility for childlessness is attributed to the female. Even where male infertility is acceptable, it is the women that feel more depressed. For instance, in Egypt, Inhorn notes that despite the fact that males are believed to have foetus carrying sperms, women bear the major burden of infertility in terms of blame, social ostracism and relentless search for therapies which are often tortuous and even harmful. To the Egyptian infertile males therefore, a woman suffering from kabsa, a reproductive binding problem, is to blame for their childlessness and their sorry state in society (Inhorn 1994).

Another example is from Cameroon where for infertile women to do ‘nothing to redress pregnancy loss or childlessness is tantamount to a personal admission of failure and of responsibility. It is also perceived as an overt admission of guilt’ (Savage 1996: 103). The social consequences of infertility are therefore particularly profound for women as compared to men.

Similarly, in Kane and Snow’s research (1995), there was no mention of male factors spontaneously in focus group discussions as a cause of infertility until prompted by the moderator. Despite mentioning several causes of male infertility, namely; natural, supernatural, infections, drugs, circumcision and having sex with older women, these Nigerians felt that society deemed men incapable of being infertile. Most of the men thought that having an erection and coitus meant that a man was fertile.

Men's reproductive organs are external and produce seminal fluid regardless of sperm count or motility, thereby projecting a semblance of normality. Women's organs, on the other hand for the most part are internal and hidden. Since they are perceived as prime actors in childbearing, women also bear the brunt of any reproductive failure. As a result, they feel a strong sense of responsibility to become pregnant and produce a live birth (Savage 1996). A Ghanaian herbalist in Amsterdam explained why women are blamed for infertility,

"Women are very fragile. They are two bodies in one. What I mean by two bodies is that apart from the main body itself, the woman has another body inside which is the uterus. Since this womb is very volatile, it can be easily affected by infections. So in childlessness, it's always the woman to be tackled first. We only get a
handful of men becoming the problem, women causes in childlessness are more that’s why we always pounce on the woman as responsible”.

It is no wonder the main petition in Akan prayers is; ‘Life! Life to the town, life to the chief, life to the crops, life and fertility to the woman! (Debrunner (1959: 42) In this common prayer, the man’s fertility is not prayed for. Probably because he is assumed to be unquestionably fertile.

Ghanaian cultures understand the role of both sexes in procreation. For example, among the Anufo (Kirby 1986), spirits of fertility are thought to control the productivity of the land, the fertility of men and animals. Conception depends on the “spirit” element in the male manifest in ‘penis water’ (body water or semen) and the “blood” element in the female. A similar belief is also found among the Aowin (Ebin, 1986) and Akan (Ventevogel 1996 : 13) of Ghana. Furthermore, to the Anufo, the enlivening elements in both sexes are greater or lesser depending upon the potential presence of certain sicknesses that are believed to lie dormant in people and influence virility (Kirby 1986 : 194-195).

Infertility is seen as a feminine concept. For example, among the Nanumba of Ghana, it is believed that a man can never be infertile (Fogelberg 1981 : 46). Leis (1972) also, writing on the Ijaw woman of Ghana found terms used to describe a woman that are linked to her physical development and marital status which shows the importance of reproduction in a woman’s life. For instance, there is a descriptive name for a newly wed woman, one who is married but as yet without child and for one who has just given birth. Further, there is also one for barrenness or for one past menopause. By contrast, there is scarcity of Ijaw terms for male statuses at any period of the life cycle although a man can be insulted by being reminded that he has had no children.

This further illustrates the association of the female in Ghana with fertility as her concern and not the males and thereby, with blame for childlessness. On the other hand, in the same Ijaw culture contradictory behaviour would suggest that male infertility is indirectly appreciated. A woman who, ‘fails to conceive within a reasonable time after marriage has sufficient grounds to divorce her husband and will be encouraged to do so by her kinsmen’(Leis 1972 : 29). In this case, there is clear indication that the blame can also be on male factors in some Ghanaian cultures.
Amonoo-Acquah (1978) notes that, in Ghana, male infertility is ‘usually not acknowledged but it is recognised’. People consider it to be synonymous with impotency. This “recognition” of male infertility is insufficient for the mere ability to have and maintain an erection does not mean that the man is fertile and that he should not be blamed for a childless union. There is evidently a grave error in Africa of associating production of semen with outright male fertility. For instance, in Southeast Tanzania, midwives and experts in female initiation rites and even their male counterparts do not differentiate between semen and sperm; one term is used in referring to both (Wemba-Rashid 1996).

There are reasons why Ghanaians blame women for infertility. Moreover, they have culturally understood ways to prove male fertility. In traditional Ghanaian societies, they knew an impotent person as one who could not have sexual intercourse. So, for as long as a man was performing sexually, they did not suspect him for the childlessness in his marriage.

If he could not perform sex well, then it was said ‘Oh! this man is not a man, the government had confiscated his guns’. It is true that Ghanaian men, like their counterparts in many other cultures, get very uncomfortable when suspected of infertility. Their ego and reputation is at stake. For as long as a man could have sex, the entire fault was left to the woman. As a Ghanaian man said; “It is very difficult for a woman to convince a performing man that she is fertile and yet not get a child. So they are not out to blame the woman, it is lack of knowledge.”

They had a way to find out whether the man was ‘fertile.’ After the marriage, the following morning, the woman’s relatives talked to the man. Everybody in the community waited to hear the news the day after the wedding. It was assumed that the woman got married as a virgin. They spread a white bed sheet and it was expected that when he broke her virginity, there would be blood on the sheet. Once that was done, then they said, ‘Oh! the man has no problem’ and thus, his case was sealed; he was considered ‘fertile.’

It is clear that there are men in Ghana who are ridiculed because of their impotence. Bleek (1975 : 58) quotes Rattray’s finding from an old man who described how an impotent man was treated in the past; “...At the gate of your house, they would tell a small child to slap you twice on the face and that child would ask you whether you have ever produced a child and insult you. After this they would let you
march through the streets and make a mockery of you while singing “kote krawae” (wax penis).

In a study in Hwidiem, Ghana, the cause among 398 infertile marriages was investigated. In males, azoospermia and low spermatozoal density was noted. Low sperm count, often the result of infection was the most important male factor (Meuwissen 1966). Any man in Ghana suffering from the two conditions would probably be childless. Looking at traditional herbs sold ‘to make a male sexually strong’, indirectly, Ghanaians recognise that males should be implicated in infertility.

However, Ghanaian males continue to perpetuate the myth that they can never be infertile. It is a contradiction because men who believe that they can never be infertile are to be found utilising ‘medicines’ to help them in reproduction. Even though male factors are said to exist and are believed by many to be less than female factors in causing infertility, African men make deliberate efforts to deny the possibility of being infertile. There are extremely rare occasions when the woman is declared fertile and the man blamed for childlessness. This can happen if the woman had children from former sexual relations prior to getting married. One Ghanaian woman gave examples:

"In my city, only one man is known to be infertile. He had ‘the disease of infertility’ and on having sex with any woman, she got it too. Everyone knows him in my home town. My relative was married to him and it happened. I’m not sure what the disease is. He was so good looking. I also know two couples here in Amsterdam. The men have been confirmed as having weak sperms but they do not want to accept blame or act on it or to follow treatments. One of the women miscarries so often. Herbs and fetish priests are normally used by men to improve their fertility."

Indeed she was right. In the Ghanaian shops in Amsterdam, infertility treatment herbs are sold for both sexes. According to the shopkeepers, the herbs ‘clean the system’ of both males and females to increase chances of reproduction. Most of the time, it is women that seek for treatment for they are the ones blamed for infertility.

There is also more evidence that infertile males ‘exist’ and are therefore acknowledged as such by Ghanaian society. This is due to the fact that they get special burial rites. Some of the procedures were described as; "They put spear grass in your penis to show society’s abhorrence for what you were. You needed children to sustain you but you didn’t get them. With the notion that humans reincarnate, they treat you
that way so that when you are coming back, you come with something that society wants. They do it to warn you not to come back the same."

Spear grass is symbolic. A Ghanaian man explains it this way; "You see, the spear grass, you cut it today, in the evening it has come up again, it shoots fastest than all grasses in my village, so it’s a sign of fertility in a sense, ‘When you come back, come as a spear grass.” This is evidence that male factors in infertility are there. Strangely, not even one respondent knows how an infertile woman is buried.

Sometimes men’s faults are hidden through spiritual explanations. For example, some priests tell infertile Ghanaian couples that the only solution for their childlessness is for the woman to move in with the priest for a while. This way, God is said to correct ‘their infertility’ through sexual relations with the priest.

‘Fertile’ men have been known to lose their fertility too and suffer from secondary infertility just like the women. A Ghanaian man learnt a lesson the hard way. A respondent tells the story;

"I had a girlfriend who was infertile and married ten years. She was the one going for treatment because the man had children from earlier relations. But when they went to the hospital, the doctor said it was the man’s fault but he didn’t mind; he thought the doctor was just making it up or he did not want to know and didn’t want to marry her. He kicked her out of the house and she left. She re-married and now has two babies. He was left alone and was crying. She is a Christian and if the man never kicked her out, she would still be there in fifteen years of marriage and no baby!”

Primary Infertility versus Secondary Infertility

Primary infertility is assigned when after one year of marriage, a couple attempts to have offspring is in vain. A Ghanaian woman who has never had a child at all is a disgrace to the society. She does not command respect and it is very difficult for a woman to bear this shame. Secondary infertility is not a major problem when compared to primary infertility. "After the first child, if more ‘come’, it is seen as ‘good’, a blessing. ’ But if there are no others coming forth, the women start running from one fetish to another or one church to another asking God about it”.

Once a woman has delivered one child, society gives her due respect for having brought forth. It is therefore better to have a child that dies than to be totally barren. If a child dies a few days after birth, he is counted as a human being (but if he dies before
that, he is counted as a ‘thing’). As a man said; “It’s even better you have a child and then this child dies and you are then barren in the normal sense (secondary infertility), you’ll have some respect. They will say, it’s not you, it’s death that has made you so.”

Causes of primary and secondary infertility are often viewed as similar but primary infertility is considered more spiritual; a curse from the gods. On the other hand, if one has secondary infertility, the gods are believed to have sent blessings and whatever happens after that, causes of infertility are not seen as curses only, but as more of biological/physical factors that are added to the spiritual. In secondary infertility therefore, a woman’s past behaviour is often blamed for the problem.

As a herbal healer in Amsterdam said, “I have come across women who blame their people or families back home. But since she is already a mother, it’s not difficult for her to become pregnant. If there is a problem, then even if the family has done something (for example bewitched her), one way or the other she caused it (her secondary infertility) unless you can prove to me spiritual bodies can sent infections into our bodies. With the barren (primary infertility), I ask them to check with family members to see whether there is any curse and then we see what we can do.”
Chapter 5. CONSEQUENCES OF INFERTILITY

I am done for
Fori Gyaama, I am done for
O, Fori Gyaama, alas!
The trap has sprung up
When the trap springs up
I must go back home
When my marriage is over
I must go to the Boadwo\(^1\)

(A popular Ghanaian song, Cutrufelli, 1983: 51)

Infertility is a major problem and to the Ghanaian woman, a great misfortune. She is faced with difficulties in her relationship with her partner, extended family, friends and society at large.

Problems with partner

Most of the women interviewed feel extremely insecure and lonely in their marriages. Some have been divorced before because of their infertility and are afraid that it may happen again. A woman who had children in Ghana before migrating and getting married in Holland said, "He is upset. Maybe he feels because I have two children already I am not serious about it. He needs a baby very badly. I don't like to think about it, it doesn't benefit us, for sure I know God will do it one day." Another woman whose history of continuous miscarriages was broken by having a son called Jeremy, said emotionally;

"He was scared that I might loose Jeremy too because it always happened. With earlier miscarriages, he was disappointed, very disappointed. Before he said, 'Oh, don't worry, you'll have more, you'll have more', but later on, I felt lonely, because I didn't get anyone to comfort me anymore. When I cried, he said, 'No, don't worry, don't cry, you'll be okay.' But later, I think he also gave up. Yeah, I think he gave up, he is a man. After eight miscarriages, won't you give up? 'Maybe this woman cannot give birth anymore,' (he thought to himself) But he's a man, he has the mind of a man, he's a human being.'"

From the foregoing, it is evident that infertile Ghanaian women are resigned to their fate as possible losers of spouses. In a study in Krofofrom, Ghana, some male respondents recommended divorce should a woman be infertile. Moreover, 62% of the

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\(^1\) See Glossary, Appendix 2
women respondents favoured divorce too on grounds of barreness (Mensah 1980). A Ghanaian informant describes how a husband goes about creating problems in his home leading to separation; "When she is barren, suspicion comes in and the man will not start by going straight away for another woman, but, he will start by picking quarrels of course to disturb the atmosphere and then he will start being unhappy, and then, family members will put pressure on everything and the next time, yeah, he goes out late and doesn't come home early..."

On the other hand, there are infertile women who have a lot of support from their partner, children, relatives and friends. A secondarily infertile woman whose husband stays in Ghana most of the time enjoyed his visit when she miscarried. Her friends were very sympathetic too. Her daughter who is studying in America was even calling her often. Most of the women who have Christian husbands say that 'he waits for God's help with me.' In fact, some of the secondarily infertile women's treatment seeking effort is discouraged by their partners. They see it as stressful and unnecessary. Such husbands want their wives to concentrate on the children they already have and on other aspects of life. For instance, a woman who is forty three years old said, "My husband says I'm getting old and I should stop (looking for treatments) and that if it's God's will, I will get a child. I have two boys and now want a girl. I just need a girl, I love it..."

One of the primarily infertile women was partially interviewed in her husband’s presence. Although she has been ‘left’ twice in the past by men who could not stand her childlessness, her current husband is very supportive. He is willing to go through all six available artificial insemination attempts with her at OLGV hospital.

Problems with family members and friends
Most of the women feel encouraged by their family and friends as the seek for fertility. They get this encouragement in the form of advice, sympathy and prayers made for them. However, there are many occasions of sorrow. Two women suffering from secondary infertility describe encounters with their children as they were affected by their mother’s infertility experiences.

The first woman tells of her nine year old son’s memories; "It’s terrible. One day I was in the tram with my son and he said, 'This is where they took your baby,' I don’t like that. My son knows I was pregnant and that they took me there, St. Lucas
In fact, sometimes I don't like to go through that place." The second woman has a twenty-two-year-old daughter. She tells her mother that she wishes for a sister or brother to play and make friends with. When she accompanies her mother shopping, she says to her, 'Mom! Aaaa! get a baby and I will buy you this and that.' Her mother reflectively said, "She feels alone and so goes out too much and gives this (lack of sibling company) as an excuse. Friends cheat her because she depends on them too much. I feel so so terrible."

Some of the women find their own mothers more supportive than their mothers-in-laws. For example, a primarily infertile woman said her mother is very supportive and she never tells many people about her problem nor her current biomedical treatment because relatives can bewitch her. A few family members who are in Holland and friends know "for they are also having similar problems... but not just everyone." On the other hand, mothers-in-law are often accused of making life difficult for their infertile daughters-in-law. For example, a woman who has had eight miscarriages said:

"My mother-in-law called always (from Ghana) and asked, 'Are you pregnant, are you pregnant? and I said, Hey, don't worry about my pregnancy eh! My God will give me a baby, I'm not worried, don't worry about it, my God will do it for me, I have a God who never fails.' I don't know how she felt, she said 'what is happening to you is not good' and I said I believe in God and I know my God will do it at His own right time."

Key informant emphasised that the man's parents often pressure males when the marriage is childless. Talking of infertile women in Ghana and Amsterdam, one of them said, "The mother-in-law will come and say, I want my grand-children to sit on my lap before I die, even here in Amsterdam, some men have gone home to take another wife because they are not getting children. Sometimes, they just drop her and take a new wife."

Another infertile woman explains further how the family interferes with an infertile woman's marriage:

"If it happens that the women have no children, sometimes the family of the man is not happy and will say 'Ah! Leave this woman and have another to make a child,' that's what they used to say. Not even that you should marry another, but leave her completely. And then they will be making trouble with you, but the way I see that, I have not had anything like that. Maybe they will say it at my back!"
Some of the infertile women prefer to keep the problem totally private. They do not confide in any friend or relative. The issue is only known by the couple. For example, one of the women said:

"During the five years (of infertility), people questioned why I had one child and I told them that I was waiting. When they said 'Your son is big and needs another,' I never told of my problem (to them)." Concerning, her parents and his parents, they questioned this childlessness when her husband went for holidays to Ghana. "He never told anyone about the problem", she emphasised. It is worth noting that she refused to accompany her husband to Ghana for holidays, like many other infertile women because of her childlessness. She did not want to face the family without having had children. She feared to be ridiculed.

For some infertile women, friends are a nightmare. They make them more conscious of their infertility and treat them with scorn and contempt. This happened to one of the infertile women who tells her experience passionately:

"Once a friend of mine came to me saying, 'I'm pregnant! I'm pregnant!' So at first I looked, then I said, look at what this woman is saying to me, 'I'm pregnant! I'm pregnant! and rather strange, she also has my problem now. She doesn't want to talk about it now because she knows we'll cry together, because she knows how I felt. It's terrible when women try to tease you in a way, the way they behave even saying things to me. And when my husband was going to buy things, clothing and bed etc, for my baby, I said to my friend, 'Oh my husband is really excited, he is going to buy things for my baby and she said 'Why don't you wait until he's born before you buy things?' But I didn't say anything because always my baby died. Yeah, you know women can say things, that's how people are. I didn't say anything to her, you are ashamed, ashamed, God had made you ashamed."
Problems with Ghanaian society at large

Look, woman, at the barren woman
Alas, alas!
The childless woman
Look, oh, look
At the childless woman
He who knew you once
No longer knows you
You, a barren woman
Look, oh, look
At the childless woman

Ah, this womb of mine
Is the cause of my fall
And brought dishonour on me
Yes, this womb of mine
Is the cause of my fall

Two popular songs from Ghana (Cutrufelli 1983 : 133)

Infertile women are resented, constantly worried and unhappy. The Akan live in big compounds. After a couple has had several years of childlessness, they may share the problem with friends within the compound and word spreads quickly. Absence of a child in a home indicates also that you are barren. There is no way to hide the problem. In Amsterdam, because people live in apartments, it is easier to disguise one’s problems.

Infertility and Incompleteness of Women

The infertile are seen as both personally unfulfilled and socially incomplete (Helman 1994 :172). As a Ghanaian woman observed “Marriage is not a personal issue, it is a family affair so it is a social problem to be childless. Infertile women can be feeling incomplete in themselves even when others accept them”.

An infertile Ghanaian woman made a prayer that clearly shows this ‘incomplete’ feeling and accompanying frustrations, “I prayed to God, ‘Have mercy, please its enough, I cannot bear it any more, I’m so ashamed, like I’m not a complete woman. What’s happened to my life?’ I say I’m human, I’m human, because you are married and sometimes the African men when they get married and the wife is not having children, they start looking outside, they start to misbehave, you know and I’m a Christian, if my husband misbehaves, I can’t sit down and look, go outside to go and have a boyfriend like maybe other women do, so it’s very difficult, you know. It’s
very difficult, so I'll lose a lot, the bible says you don't have to leave your husband, just look at what he's doing and you know the reason why he is doing that, you'll understand."

One of the important roles of rituals performed at shrines is to ensure the fertility of newly married couples. Ability to reproduce is the ultimate criterion for maturity among many Ghanaians. For this reason, many infertile Ghanaian women feel incomplete.

**Infertility and Loss of Social Status**

In many societies, fertility not only ensures the continuation of society, but it also ensures future labour and inheritors. It ensures that a network of relatives who support each other persists. Children therefore signify self-fulfilment, companionship, enjoyment and social acceptability. An elderly person without descendants lacks prestige for honour and pride is attached to having children in Ghana.

Moreover, children are living proof of men's virility. As a result, an infertile woman is shunned for 'embarrassing' her husband. Lacking somebody to sent on errands seriously impairs his social esteem for he has to do all the petty jobs himself. Infertile Ghanaian women therefore sink into a humiliating social status with every passing year. In Africa, the infertile woman is never fully accepted for there may be cultural activities that she is exempted from. This can lead to psychological problems. For example in Mozambique, special ceremonies in pregnancy, after delivery and when death occurs are to be attended by women who are fertile making the infertile feel isolated (Gerrits, 1993).

To quote a Ghanaian man's observation of an infertile woman; "She's not respected by society. When people see someone without a child, even if you are rich, a very poor woman with children can ask you, 'Are you a woman? Have you got a child? With all your education, have you got a child?' And if you are involved in a fight with her, she will call children to make a show of you."

The infertile woman's social position is diminished further when she is suspected of being a witch and killing her own 'children' or that she leads a promiscuous life which has led to infertility. Secondarily infertile women, though scorned are not as stigmatised as the primarily infertile cases. At least, they have been pregnant once and either lost the baby or had a live birth.
Infertility is also seen as ground for abuse. It is a big problem, when an infertile woman gets in a fight for she is easily reminded of her predicament. The only infertile woman who cannot be easily abused is a rich one. In Ghana, they call infertile women *bonini* in a conflict situation saying, “you are just like a man, you couldn’t even make a baby”.

Mothers-in-law are said to be one source of this verbal abuse. As a respondent explained, “If you are infertile, Your mother-in-law can abuse you saying, ‘you bonini go so that I can get another wife for my son to bear children’ or ‘I want my son to name after me’...Even her age-mates, when there is a conflict, they’ll tell her in her face, they’ll explain to her, her bareness, so the woman, and you know women are not able to bear such things, they always run around to seek treatment.”

**Infertility and Death Rituals**

In Cameroon, descendants are essential for they organise appropriate and befitting burial ceremonies for the dead and subsequent funeral rites (Savage 1996). In Ghana, dying childless has implications on how the funeral rites are carried out. This is clearly confirmed by a Ghanaian key informant who said, “In our culture, they said if you are a woman and you don’t have a child, when you die they have to do some rituals for you but I don’t know if they are doing it now or not.” Informants could describe how an infertile man is buried but nobody seems to know how an infertile woman is buried. All they said is that ‘when the infertile woman dies, there are all kinds of ‘treatments’ done’.

Dying without descendants means that the person faces oblivion for an ancestor expects to be remembered and responded to by his children and their children. ‘Ancestors must be remembered and venerated through regular offerings of oil, salt, food, etc. Fertility is thus an essential factor in the process of ensuring a continuous link between the living and the dead through deities and ancestors’ (Savage 1996: 96).

**Infertility and Self Esteem**

Infertile Ghanaian women loose self esteem. A Ghanaian priest who has been counselling infertile Ghanaian women observed that, “On their part, infertile women feel that attending a ceremony on childbirth, will get them psychologically disturbed. So they feel they shouldn’t be there at all. This is a problem within them and not from
the society. In the past, if you do not give birth, you are nothing at all, this is not so anymore, things have changed. These women become very impatient on children matters. Any little thing said or done that reminds them of their infertility sparks them into annoyance. So people have to weigh their words when around them.”

Some infertile women expressed how disturbed they got when careless words or actions with bearings on their infertility directly or indirectly were uttered. One woman was so annoyed by her friend's bragging about her newly delivered baby. Her friend said to her, “You see my baby, she'll grow, very soon she'll start walking and I won't be tired anymore, very soon, see?” To this, the infertile woman commented, “She knew what she was doing to me.” She was convinced that her friend was not just sharing her joy with her but intentionally meant to hurt her feelings because she had miscarried. Her interpretation of her friend's comment could have been marred by her own suffering as an infertile woman.

Some of the infertile women develop envy and jealous attitudes. A woman who had several miscarriages said “I decided to ask God why, why, because it gets to a time when I see babies, I just can't stand watching them, I just don't look, you know, I remember a certain friend of mine, she had a child naming ceremony. I said I cannot go, I can't stand to see children. I felt disappointed you know, I mean how can a woman, you are married and you cannot have children, all the time you get miscarriage, all the time, all the time. “That time when I was pregnant, I saw people pregnant and they gave birth and I said, ‘Oh my baby would have been like this, for I can remember she was pregnant, now look at her, the baby is walking.”

From the efforts infertile Ghanaian women make in trying to get over their stigmatised problem, it is evident that there is a great need for a practical solution, whether they live in Ghana or in Amsterdam. They long for children and but with a stigma as heavy as this one, a caring compassionate social environment would go along way in easing their suffering.

As is usually the case globally, films and videos are often pregnant with themes arising from what has happened or is happening in society. One of the popular Ghanaian videos, Expectations, shows how society can influence an infertile woman’s destiny and also how problem-laden the venom of a mother-in-law can be to a childless daughter-in-law. The infertile woman is named Gifti. The story is about a couple who
are childless for five to six years. A clan elder pressures Gifti’s mother-in-law to find another wife for her son lest she disgraces her clan. They are worried that the chief’s stool, which was to be inherited through this particular marriage, would be passed on to another clan. So she swears to her son who loves his infertile wife saying, “If the stool is taken from us, never step on my ground again”. She adds, “When I die don’t come near my corpse, leave it to rot.”

Gifti’s mother-in-law gets under pressure to find a second wife for son and even confronts Gifti about it. When her son goes away on business, she packs Gifti’s belongings and sends her out saying, “Go to your mother, Go and treat yourself.”

With Gifti out of the way, her mother-in-law brings in another woman who waits for her son’s return. On arrival, she is introduced to him by his mother as an extremely fertile woman who has given birth to three healthy sons. Gifti’s husband is very annoyed and prepares to go and pick her in the village. His mother lies infront of his car on the driveway and says, “You’ll have to kill me before you bring her back, kill me, kill me!” At some point later on, looking at Gifti’s photo in his bedroom he asks, “Gifti, does this mean you cannot give me a child?”

As the video continues, it shows how witches sent a woman to his office who bewitches him and he begins to like the second woman in his life.

In another brief story from Ghanaian video collections, the importance of having live-births is emphasised. Bitter Love, as it is titled, is about a husband who beats his wife, Alice, after delaying in the office and getting a lift from her boss who is suspected by her husband of dating her. She happens to be pregnant and when he beats her, she collapses. On getting to the hospital, Alice loses the baby and also the ability to ever have one.

Later, as a banker, she helps him procure a loan from her bank. After a short period, he starts dating other women. Their marriage gets strained and at one point on coming home late asks her in an argument, “Who should meet a man at the door when he comes home from work?” She answers, “His wife ofcourse!” The man yells back at her, “His children! I was born to reproduce. When we visit our friends we see their children. I cannot come home and see Alice, Alice only!” To this, Alice answers that children come from God.
After such conflicts, he moves out. He ends up living in a mansion he built with money from the loan Alice procured for him. A close girlfriend moves in with him and the story continues into other themes.
Chapter 6. INFERTILITY MANAGEMENT STRATEGIES

Infertility Treatments Available in Amsterdam and in Ghana

Driven by a strong desire to have children, infertile Ghanaian women in Amsterdam look for treatment in various ways. They are willing to try anything that works. In general, there are several interventions that might help the infertile. For a minority of infertile people, simple treatments exist. For cases of infertility due to infections, they can use antibiotics to get cure. Those taking drugs, alcohol and smoking can have a change of lifestyle. Others lacking identifiable causes simply increase timing of coitus in line with the woman’s menstrual cycle.

For many other infertile couples, the search for treatment is much more expensive, complex and time consuming. Verdumen (1997: 203) describes help seeking behaviour of the infertile in the Netherlands. Infertility is suspected after fourteen months of trying to conceive. In the beginning, these couples try to conceive by seeking information about the normal time to achieve pregnancy, changing sexual habits and ‘living healthier.’

Verdumen discusses four distinguished types of health seeking behaviour. These are: choosing one strategy, choosing different strategies sequentially, choosing different parallel strategies and doing nothing. Most of them choose to have medical treatment as the first step. It is only after about two years that their options diversify to include less utilised strategies to solve their problem. These other options are adoption, foster-care and alternative medicines including; visiting healers, taking potions, using magic objects and having other life goals (Van Balen and Visser 1997, Verdurmen 1997).

Biomedical Treatments

Available options in The Netherlands include artificial insemination by donor, (AID), which involves use of donated sperm so as to overcome male infertility; in vitro fertilisation, (IVF), that makes it possible for a couple to have a genetically related child; and surrogate motherhood which involves implantation of an embryo three days after it has been fertilised in a woman’s uterus (Sciortino and Hardon 1994). There are many variations of IVF. For example sperm aspiration allows for many procedures used to obtain viable sperm from the male reproductive tract. These sperms
are then used with intracytoplasmic sperm injection, (ICSI), a variation of IVF\(^1\).

Artificial insemination by donor, (AID), which has been available in the Netherlands since 1948, has also been successful with about 2,000 children being born every year. The infertile decide which treatments to go for but some couples leave the decision to specialist doctors who are seen as the experts (Verdurmen 1997: 205).

Although public health insurance funds cover reproductive technology use, treatment costs are generally high. This makes insurers cover mainly the first three treatment attempts per client while some do not include IVF in the package or give a refund for a limited number of treatment trials (Sciortino and Hardon 1994). Limits set by insurers can reduce attempts made by the infertile in using these treatments. None of these reproductive technologies offers 100% treatment for. Thus, infertile couples have to live with the fear of possible ‘treatment’ failures.

These modern technical treatment options that are available in Amsterdam have had their share of criticism. AID has been opposed by the Catholic church and there is a debate as to whether the sperm donor should be anonymous, whether AID should be available for single and lesbian women; and whether the child has rights to know his/her paternal roots (Kirejczyk 1996: 254, 266). IVF, a popular technology with the infertile, was introduced in the Netherlands in 1982 and since then, there are about 30 clinics giving IVF related services. Success rates vary and have a tendency of being discouragingly low. Generally, most women have to go through three to six attempts, as success rates per attempt are still between 15-20%. Critics emphasise that these treatment attempts create dependency on medical technology and raise the couple’s hopes, thus interfering with efforts to accept involuntary infertility (Gupta 1996: 253, 267).

Reproductive technologies (RTs) are seen by feminists as raising new gender constructs. They argue that it intervenes in procreation, consequently, in the relations between men and women. Concerns on the invasiveness, efficacy and safety of in vitro fertilisation have rendered the technology questionable by social groups and policy makers too (Kirejczyk 1996: 337-340). In vitro fertilisation has also been associated with diverse undesirable effects such hyperstimulation syndrome; spontaneous abortion or miscarriage; ectopic pregnancy, multiple births, difficult labour and caesareans;

\(^1\) Information from the Centre for Male Reproductive Medicine, Internet site, 1999
premature births, low birth weight; peri-natal and neo-natal mortality; and genetic
defects (Gupta 1996).

There are two support groups for the infertile in the Netherlands (Gupta 1996: 279-280). FREYA is the largest. It is a lobby group formed in 1985 to represent the
interests of those who would like to be considered for infertility treatments and
mediates between them and the reproductive technology specialists. It also lobbies for
extension of services to more centres, to widen the list of indications so that more
people can be eligible for treatment and to increase number of treatments allowed per
person.

Among its members are infertile men and women, gynaecologists and
researchers involved in development and application of reproductive technologies. The
second interest group for men and women who are involuntarily childless is called ‘De
Bakermat’. They aim to support unhappy childless couples find quality in life. They do
so through individual and group sessions.

Study findings show that, most of the infertile Ghanaian women interviewed
use or have used one or several of the foregoing biomedical treatments and a varying
list of drugs. None of them is a member of the available lobby groups. In fact, most of
them have never heard of them.

According to study findings, the following biomedical measures were
undertaken to treat infertile Ghanaian women. Cases of blocked fallopian tubes
underwent surgery to increase chances of conception. When this failed, further check
ups led to the commencing of artificial insemination. After considerable insemination
trials, these were followed by in vitro fertilisation procedures for the women until forty
years of age. After this age, further treatment was stopped. There were a few special
cases whose treatment extended by one or two years after forty. Women with ectopic
pregnancy underwent surgery. Infertile women who suffered from painful irregular
menstruation had records of their periods taken.

Drugs were given to ease painful menstruation and to stimulate ova in those
lacking ‘viable’ egg production. One of the women had extremely painful menstruation
that her husband had to go to an extent of suggesting hysterectomy to overcome the
problem. Moreover, drugs were given to reduce fibroids in the uterus. One woman
was advised to go on diet treatment to reduce her weight as a possible remedy.

Non-Biomedical Treatments

There are other types of health care among Ghanaians which are informal. For this reason, they are not included in mainstream health care in the country. For example, "a visit from a healing prophetess from Ghana is not something that's taken up, not only would Dutch institutions not know about her visit, but they also even wouldn't care because it's not something, from their perspective, to be taken seriously" said an informant.

This health care is termed 'alternative medicine'. It is built on the socio-religious system that is operating in the Ghanaian community. Hence, it is founded on their cultural perceptions of health, beliefs of well being and protection. So while the biomedical doctors are consulted for physical treatment, on the other hand traditional healers deal with the social and spiritual aspects of the illness. As an informant describes it, to many Ghanaians; "If you have a broken leg, you first go to the hospital, to have your leg attended to but in addition to that, you may also perceive certain spiritual problems that led to the breaking of the leg which also need to be attended to but which these Dutch western doctors of course cannot do anything about."

Herbal Treatment

There are infertile women having the notion that traditional herbs 'work' for some people but are reluctant to use them. This is due to the fact that most of them are already going to hospital and express fears of using herbs concurrently with biomedicine. As a primarily infertile woman put it, "I never wants to mix it with the doctor's treatment for it can go wrong". Some religious Ghanaian women who practice Christianity are very suspicious and critical of herbal healing. However, some of the secondarily infertile respondents got their healing after getting treatment from herbal priests but their attitude to these healers has totally changed.

For instance, one of the women said, "I don't like them (herbalists). Most of the herbs are with these 'native doctors things', are you not aware? They won't tell you that they are spiritual because most of them know that if you are spiritually involved, some of the women won't come and have treatments with you. Yeah, How
can you just sit there and someone tells you I'm going to help you, do you know who he is? Yes, that's why you have to be very careful how he is or where you go. So you don't have to get involved with them unless you like those things, Yeah, I'm a Christian, from the beginning I have told you. So I don't like them, most of them have spirits, most of them are witchdoctors”.

On the other hand, some women believe syncretism of several treatments will increase chances of success and even lead to quick healing. They have been using herbs ‘so often, almost always’. For example, women have testified to the efficacy of herbs in treating fibroids. One woman said; “I want a solution immediately so I try everything. I’m desperate. My sister-in-law used Kodie’s herbs and three months later she got a baby. Kodie said the herb cleans the womb.”

Spiritual Healing

When childless couples believe that their infertility is a result of curses or witchcraft, they value spiritual healing more than any other treatment. For example, as narrated by an informant, an infertile woman in Amsterdam “started blaming parents of the man because she was having differences with them. She believed they cursed her. Such understanding explains the craze they have for spiritual churches.”

Hundreds of Ghanaians attend healing meetings graced by prophets and prophetesses in Amsterdam and in Ghana. They seek to be touched and healed by them. There are prayer camps too in Ghana where women spent long periods of prayer in the hope that God will heal them. This is often the case when they explain their infertility as caused by God, ‘for His own good reasons’. They are resigned ‘He gives and He takes’ they sadly said. Having faith in God therefore, makes them strong enough to live each and expect miraculous healing at God’s appropriate time. Some priests tell infertile couples that the only solution is for the woman to move in with him for a while.

There are also visions and prophecies regarding the healing of infertile Ghanaian women. One woman explained her situation, “Pastors have told visions of me having a baby, I have been having dreams of me pregnant too. My church prophet (in a Bijlmeer Ghanaian church) prayed for me. She is also praying for completely

2 Ghanaian herbalist in Amsterdam
barren women”. Another one told of her experience, “In 1998, a Pastor from Ghana came here and called me by my name and said I have one child and that my people sealed my womb (through witchcraft) because of my success in Holland. He prayed for me and so I am waiting. Such women feel reassured that God is working out a solution for their problem.

Education and awareness of the benefits of biomedical treatments does not waver the spiritual perception in many of these women. As a woman who is already in her thirties and therefore having decreasing chances of in vitro fertilisation trials with advancing years said; “The doctors offered a test tube baby plan (in vitro fertilisation) but I said no because I am a Christian. I am waiting on God to fix it. The hospital staff are often writing letters to us (as a couple), We tell them we are thinking about it. They still write.” It is not therefore surprising to know her reaction to in vitro fertilisation technology; “I say to myself, if a human being can do this, how much more God?”. She knows many women who gave up after many in vitro fertilisation trials and finally decided to stop. Some conceived later without seeking treatments.

Such women believe that, it is only a matter of time and their infertility shall be no more as supernatural intervention will occur.

FERTILITY SEEKING BEHAVIOUR

There are various activities characteristic of infertile Ghanaian women’s efforts to overcome inability to conceive, miscarriages and child loss misfortunes.

Seeking Help from Healers

Seeking treatment is the most common initial reaction. Herbalists and biomedical practitioners are held as possible curers. In Ghana, women go to gynaecologists, homeopathics and herbalists.

Bareness is a typical problem brought to a traditional healer in Ghana. Many infertile women in Ghana prefer to seek help from the herbalists more than from biomedical doctors for several reasons. Biomedical treatments take long and these women prefer instant cure which herbalists promise. They tackle the problem holistically too for their aim is to heal the body as well as broken social networks. In most cases, they speak the same language as their patients. “But western medicine reduces patients into pieces”, says a Ghanaian man. “Investigations on one patient
are carried out by a host of different specialists. So they refer patients from specialist to specialist. This means no close contact develops like with the herbalist. In Ghana, many go to hospital but those who cannot afford go to herbalists. Doctor's services are costly. Only the rich can afford it in Ghana”.

With regard to costs, many herbalists in Ghana charge “affordable’ fees and live in the countryside where they are close to the people. In Amsterdam too, many infertile illegal women are not insured. They go to herbalists not just because they fear to be exposed in the hospital, but due to the cost factor. For example, the one and only registered Ghanaian herbalist in Amsterdam treats infertile women. He came in 1993 and considers himself lucky to be the only Ghanaian herbalist in the Netherlands. He has participated in workshops on herbal medicine in the Netherlands and featured in the mass media. He describes causes of infertility as; “the women’s exposure to Holland’s cold climate which affects body organs, use of ‘anti-baby tablets’ and consumption of sweet foods and beverages.”

At the time of this study, he had about two hundred and sixty infertile Ghanaian women seeking his help in Amsterdam. He charges f. 25 per consultation that has no time limit. Furthermore, payments can be made in instalments. When compared to the consultation schedules in biomedical institutions, the herbalists are much more accessible and affordable to them.

In Ghana, many infertile women visit the hospital for treatment after all other avenues have been exhausted. This is due to existing notions about infertility. If for example, infertility is believed to be caused by witchcraft, misconduct to parents and broken taboo, it is regarded as being more spiritual than physical (Bleek 1975 : 181). This spiritual dimension would be least understood in a hospital. Although many suffering from STDs know that the infections can be treated at the hospital with little trouble and expense, they are still convinced that without witchcraft or bad magic they would not have succumbed to it. Therefore, hospital treatment is seen as futile until the ultimate malevolent power has been broken.

Moreover, as Bosu (1986) found in his Ghanaian study on the concept of infertility, most infertile women preferred traditional treatment as compared to the hospital, for they felt that the hospital treatment ignored their specific socio-economic state and psychological fears of being infertile.
In the Ghanaian shops in Amsterdam, infertility-treating herbs for both sexes are sold.

**Ghanaian Herbs in Amsterdam**

<table>
<thead>
<tr>
<th>Name</th>
<th>Source</th>
<th>Dosage</th>
<th>Seller</th>
<th>Cost (guilders)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Alafia Bitter</td>
<td>Ghana</td>
<td>1 dessertspoon twice a day</td>
<td>Ghanaian shop</td>
<td>15</td>
</tr>
<tr>
<td>2. Living Bitters</td>
<td>Ghana</td>
<td>1 teaspoonful twice a day</td>
<td>Ghanaian shop</td>
<td>15</td>
</tr>
<tr>
<td>3. Action Herb Bitter</td>
<td>London</td>
<td>Initial 80ml at bed time followed by 1 tablespoon twice a day</td>
<td>Ghanaian shop</td>
<td>15</td>
</tr>
<tr>
<td>4. Laxative Bitters</td>
<td>London</td>
<td>Between half a tablespoon to half a wine glass before breakfast</td>
<td>Ghanaian shop</td>
<td>18</td>
</tr>
<tr>
<td>5. Blood Purifying Herb</td>
<td>Ghana</td>
<td>1 glass twice or thrice a day</td>
<td>Ghanaian herbalist</td>
<td>-</td>
</tr>
<tr>
<td>6. Enidanie</td>
<td>Ghana</td>
<td>1 glass three or four times daily</td>
<td>Ghanaian Herbalist</td>
<td>-</td>
</tr>
<tr>
<td>7. Urinary track infections</td>
<td>Ghana</td>
<td>1 glass four times daily</td>
<td>Ghanaian herbalist</td>
<td>-</td>
</tr>
<tr>
<td>8. Odaie</td>
<td>Ghana</td>
<td>1 glass four times daily</td>
<td>Ghanaian Herbalist</td>
<td>-</td>
</tr>
</tbody>
</table>

Herbs in this table are all used to treat infertility. The Ghanaian herbalist in Amsterdam had varying prices for his herbs. They ranged between f. 58 and f. 135.

According to the shopkeepers, herbs clean the reproductive system of both males and females. Those who return from holidays in Ghana also bring potency drugs for sale. Many infertile Ghanaian women got back to Ghana for treatments. Some of the study respondents left this summer for holidays in Ghana with the sole purpose of seeking treatment there. Apart from herbs, they can get hormonal drugs that are otherwise difficult to be prescribed by Dutch gynaecologists. As one infertile woman explained, "In Ghana, they give tablets if you need them for example folic acid and
hormonal tablets unlike here". Infertile women go to neighbouring countries for help too. Countries mentioned in the interviews are Belgium and Germany. To quote an informant, “they go to Belgium because probably these women have heard of others who succeeded at Gent (a clinic in Belgium) or they feel doctors here have given up on them. The issue is to have a baby, so you see, they’ll go anywhere, even if to USA or Britain or Germany”.

**Spiritual Help**

When infertility is seen as spiritually caused, treatment is sought in spiritual churches. These churches have been popular as healing centres for many years. For example, in one Church of the Twelve Apostles found in Western Ghana, a large proportion of “patients” who went to church for healing were pregnant and barren women wanting to have children. The prophetess in the church vigorously rubbed the barren woman’s stomach with the bible while exorcising the spirit of barrenness within her (Baeta 1962: 21). Many of them go for prayers as they believe God is the giver of children and once requested, He can make them fertile. In the coastal region of Ghana, some priests perform healing rituals for the infertile women by the sea.

In Amsterdam, there are many African churches fulfilling this demand for healing rituals. Priests and pastors help the infertile women cope with their problem. In one of the churches, approximately eleven infertile Ghanaian women have been confiding in their priests. Special individualised prayer programmes unique to their situation had been developed. One of the leaders said “they come to me thinking I, the priest, has a solution for the problem. I pray with them and instil confidence in them and present God as a merciful God to them. I tell them that they must not hide anything”. He sees withholding information as ‘hiding’ and as a sign of insincere repentance for past misconduct. He adds, “I encourage them to think positive. In fact one of them got pregnant and delivered. She is so happy at the moment.” As the prayer programmes go on, he advises them to see doctors and when going to Ghana, to also use herbs.

Prayer camps are popular in Ghana too. Leaders with the charismatic gifts of healing perform healing rituals for hundreds who flock there for help. One of the biggest is in Cape Coast led by a prophetess. She receives as many as 70,000 visitors at her camp in one year. Some of the infertile women in Amsterdam travel to these camps
for prayers healing. People stay there for weeks or months. Bareness and 'weak penis' are some of the problems noted (Van Dijk 1997: 143).

Shrines and prophets play a prominent role in the struggle against infertility in Ghana. According to Field (1960), 23% of requests at an Ashante shrine were directly linked to infertility. Fetish priests are consulted too and special foods eaten to improve fertility. For example, tiger nuts, milk and fresh coconuts were believed to increase a man's sperms (Bleek 1975: 57). There are special gods for childbirth too. For example, the river god called gbolo is specifically for childbirth. Anyone in Ghana named 'gbolo' was a result of this god's intervention in the life of an infertile woman. There are therefore people named after goddesses and gods.

There is also a belief that contact with some special children blesses infertile women with good luck. For example, a Ghanaian woman told a story about her sister. She works as a prostitute in Germany. She unexpectedly got pregnant and delivered. An infertile Caucasian woman decided to foster the baby boy. Within a short time, the Caucasian lady conceived and was later unwilling to part with the boy. They were all convinced that it was the boy who helped her find cure for her infertility by bringing good luck.

In her thesis on Ghanaian women in the Netherlands, Weiland (1998) found infertility a disturbing concern to the women. Pregnancy loss was associated with prostitution, jealousy by infertile people and "voodoo". Barrenness was seen as solved through opening of wombs by praying or drinking holy wine in the church. These Ghanaian women held religion as a means of solving their many problems among which, barrenness and problems associated with pregnancy are mentioned.

In Ghana and Amsterdam, these women "go for 'pray-for-me' healing and sometimes the pastors and priests they go to abuse them sexually. I even know a woman who ended up marrying the pastor! They also go for counselling to priests or pastors. In Ghana there are no professional counsellors and so the clergy help fill this role", said a Ghanaian narrator. Pray-for-me religious leaders are people popularly known as having the gift of healing through prayer. Whenever they visit Amsterdam from Ghana or other countries, infertile women go to them for healing.

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3 Weiland, M. Jesus Never Fails, an exploration of the role of religion in the migrant Ghanaian women’s lives
In Amsterdam, advertisements by African mediums are not uncommon and there is a possibility that infertile people turn to them for help. Apart from using radio broadcasts, they also sent adverts to people's letterboxes. For example, in 1999, the following note was occasionally dropped in my mailbox:

Leaflet in the mailbox; advertising medium in Dutch and English.

The English portion reads; Mr. Manma

Payment after result. May I introduce myself. I am a real African, international, very quick medium. I can help you with: Return of your beloved people or your lover, your career, exams, chance of happiness, sexual impotence, infertility or bad spirits, even when your problem is hopeless. I guarantee you a quick result and I can receive you from 7 o'clock in the morning till 9 o'clock in the evening. Tel 020/6838514

Extramarital sex

In Africa, extra marital sexual relations have been known to ‘solve’ infertility. Some infertile men arrange for a kin to impregnate their wives for them, which is a ‘clever’ way of hiding male infertility. When incompatibility is suspected as causing infertility, extra marital sex or even divorce is encouraged. In Mozambique, some infertile women are involved in extra marital relations. Such a woman claims that traditional healer’s advice her to do so at the time when her husband is away or when he marries a second wife. This is in an effort to find out whether ‘the blood of another man is more compatible’ and can lead to conception (Gerrits, 1993).

Transfer of sexual rights to another member of the family or a healer is indeed held to be a practical remedy. In Nigeria, one of the traditional ways of treating infertility is through the woman having intercourse with the healer. Herbalists can use their penis to push herbs into women’s vagina. Furthermore, it is common for the infertile man to seek to have a child with someone else as is often encouraged by his family. To impregnate a woman outside one’s marriage is to prove one’s fertility. (Kane and Snow 1995). Polygyny also allows such a woman to stay married and probably raise children born of co-wives as her own.

In this study, one informant said, “Because we blame the woman all the time, the men even hide it, you know, when I’m married and I’m infertile, what I do is maybe contract other people to have children with my wife. It’s a very big disgrace
for the man to be said to be infertile, so you see the impotent chasing women, even when he is not able to have sex.”

Some couples are told by priests/pastors that God will only make the woman pregnant through sexual intercourse with the priest. As an informant explained, “what usually happens, even if it's assumed to be the males fault, they will not think of it in that light, instead, they will be saying that it's something spiritual and that it's only the priest who can solve it. So they will not look at it from that side; that it's the man who was infertile.” Informants knew cases of infertile women who ended up living with priests as their wives.

Appeasing Ancestors

When misbehaviour or failure to meet given obligations is considered to be the cause of infertility, spirits are propitiated in the hope that they will reverse the man's fate by making him reproductive.

In the past, infertile women carried fertility dolls (akuaba) on their back. They believed that if an infertile woman carried it, the gods would bless her and she would be able to reproduce. Actually, the carrying of akuaba was a psychotherapeutic treatment for infertility. The doll was made by the husband of the infertile woman. She had to carry it on her back, play with it during the day and at night, take it to bed until she bore a child (Cutrufelli 1983:134). These dolls are still sold in the markets but it is not common to see people carrying them nowadays.

Adoption and Fostering

Adoption and fostering also occurs across the African continent but its details differ with cultures. This strategy helps women cope with infertility for it decreases the extent to which childlessness is experienced. For example, it ensures that the woman has descendants and can take up the parental role. Orphans and relative's children are fostered in Mozambique (Gerrits, 1993). Among the Maasai of Kenya, after weaning, a child can be adopted by an infertile woman in exchange for a heifer. She then becomes the child’s mother and acquires a more secure position in society. The original mother who already has other children, in sharing the affliction of the infertile, avoids losing her other children through sorcery (Spencer 1988:45).
In Ghana, family size constantly changes after birth through continual child distribution among members of the kin group as children are delegated to other relatives. There are two kinds of fostering in West Africa. Firstly, there is crisis fostering which happens when a family is scattered through divorce or death of parents. Secondly, purposive fostering which is entered into with the intentions of securing some benefits to the child, his parents, the foster parents, or perhaps to all (Goody, 1975). An infertile woman in Ghana falls under the second type of fostering.

Perceived Efficacy of Various Treatments/Solutions

The last treatment infertile Ghanaian women have before getting a child is considered the best. They do not have a standard way of evaluating for they have these treatments for long. If one fails to work immediately, they try another one. So, even when one treatment works, they are never sure which one is more efficient for they try several treatments simultaneously. In the olden days, when people consulted priests or gods, they were told, 'in a year's time you'll give birth and you'll come and sacrifice something'. So they were given a time frame within which the infertility treatment was expected to work.

Several infertile women interviewed said that only prayer was effective in helping them overcome infertility. One of these women had been suffering from repeated miscarriages. She said, "The prayer helped. The doctors said they can't do anything for me, they said there was nothing wrong with me so they can't give me any treatment. They'd given up on me, even my specialist was telling me, to give up because it's dangerous for my health and he asked why I was trying many times. He said I should just give up. I don't think even the diet helped because I got pregnant all the time and I always lost it. So the diet did not help, only the prayer". So she confidently narrates the prayer she made over and over again until she got her baby:

"I started calling unto Him for He said I should call unto Him and He would answer. Also, since I was born I have never heard that the bible has been changed or it's a new bible, so I started praying. I have prayed before but I prayed like I never prayed before. Fasting and praying I said, God, I'll never start eating if you do not give me this baby because I know you'll give me, I'll never start eating. I continued praying. I am going to the toilet, I'm praying. I'm walking, I'm praying. I was talking even when seated on the bus. This baby is not going to die, this baby is
going to live and it's going to be a prophet of God because He'll give it to me. Yeah, because I was saying, God give me this baby because I'll give it back to you”.

Infertility treatments have been implicated as having side effects. Women complained of bodily changes that were unpleasant. There was also emotional 'cost' as expectations were always raised with each new treatment attempt. Unfortunately, many of them never succeeded. One of the unlucky women said, “At the hospital, there are a lot of pictures. Black...white, everything is there. As for me, from the look of things, you could find that a lot of pictures there were the white peoples. I don’t know why. Maybe a lot of black people don’t have the problem. I don’t know. But then you can find a black one but it’s not too often. I gave up on all reproductive technologies after several attempts. I believe only the prayers worked”. After three IVF's and several artificial insemination failures, she said;

“No, I think enough is enough. The rest we have to leave to the Lord. If it is His will, then we'll have it, not because of that IVF. He will provide so we should live it (give up on treatment). I was tired of treatment you know. During the treatment I was growing fat and my breasts hurt because of the hormones. I was experiencing headaches and I think everything has advantages and disadvantages. So after some time I had to put an end to it because it was too much...

Herbal sellers in Amsterdam consider herbal treatments efficient for some women. They know clients who delivered babies after using their products. A herbalist said “Most of them (infertile women) take a month or two or three and everything goes fine, so I have a lot of them who just take a short time and a few who take longer. Women who have wasted over f 5,000 to about f 10,000 for fertility treatments only waste f 100 with me and their heart’s desire is fulfilled”.

On the other hand, many infertile women said that they have been using herbs for years with no positive effects. One of the desperate women used more than ten bottles of herbal medicine but unfortunately, she is still waiting to overcome secondary infertility.

Fostering and adoption has been known to alleviate the problem of childlessness. Unfortunately, its efficacy as a solution is questionable among Ghanaians. It is a complicated system and there is hardly any information on it. In some Ghanaian cultures, children are an important economic asset on farms as well as in the household. For example, paternal relatives of a Nanumba child have rights to it
and can claim it. It is also common use to ‘lend’ children to relatives who need temporary labour force (Fogelberg 1981: 29).

This fostering of children as a source labour has been known to raise tension. It is not uncommon to have parents complain that a fostered child is overworked. There is a Ghanaian proverb, ‘it is unpleasant to be a child, which is a reality to many children. When children are sent to live with relatives or others to whom the parent is under obligation, they are made to work virtually as little slaves. This trend can make fostering as a solution for the infertile less preferable especially when one adds legal barriers that have been known to hinder adoption efforts.

The experience of an infertile woman who fostered a baby sheds some light on how problematic fostering can be in Ghana. “I had friends, a couple who were working in the police force in Ghana. This woman was barren for a long long time. The man was from my village. He had seven children with six different women before marrying the policewoman. The youngest of these children was left with him at seven months and his infertile wife raised her. They tried everything to get children. They consulted witches, spiritual churches, and medical doctors. The doctor prescribed a special diet and how to do a lot of things and at last it succeeded; they got a child.” when she (policewoman) finally got a child, the little girl she had fostered was taken by force from her by her husband as he moved to another city. The woman wept bitterly and said, ‘If God had not heard my prayer, If I had not had this child (her biological one), I would have died today because of what this man has done to me”.

In Africa, observes a Ghanaian man, adopted children can never be called your own. For example, Ghanaians had this to say, “The family allows informally, for one to take and raise a child. But true identity of the child is told to them by others and the mother ends up regretting as the child is taken back by the biological mother. You can’t really adopt a child because of infertility. It’s not like yours; you have to fight for it yourself. We say, you can’t take someone’s intestines and exchange for yours”. In Ghanaian culture therefore, when adoption or fostering occurs, the infertile woman lives with the knowledge that one day the child will be repatriated back to its biological mother. It is not a convenient solution to infertile women at all. It is only a temporary solution.
Chapter 7. FACTORS AFFECTING FERTILITY SEEKING BEHAVIOUR

Infertile Ghanaian women invest financially and emotionally as they spent a lot of money and time seeking treatment. Their treatment seeking efforts are influenced by several factors.

Partner’s Role

An infertile woman’s husband influences her efforts to find treatment. When the man is supportive, the woman is encouraged to try all possible strategies to overcome the problem. He helps her financially to meet any costs that may arise and gives her moral support. He also defends her when relatives and friends try to abuse or discourage her.

When a husband is indifferent, the woman does not confide in him totally. In such cases, the woman fears losing the man and would never tell him when the doctor finally tells her that she cannot find medical help. Most of the infertile women interviewed have had sympathetic husbands. They have been willing to accompany them to the hospital and have their sperm quality checked among other procedures.

This has not always been the case. One infertile woman said; “Unlike in the past, nowadays men go to the hospital and find fault. But in most cases, they blame the woman, yet the fault can also come from the man. There is nothing we can do about it. Sometimes even if the fault is from the man, he’ll tell you ‘Yeah! I can have a child and there’s nothing the woman can do about it’.

Some infertile women change partners often. One condition in the Amsterdam hospitals for treatments to be carried out is for the woman to be in a steady relationship for at least one year. This is important for the obvious reason that pregnancy takes both the man’s and woman’s involvement. As one doctor said, “If the man changes every three months, it’s very difficult to give a final diagnosis and to decide on the best treatment.”

Unfortunately, many of these infertile women do not choose ‘to change their partner’, they are simply ‘left’ by the men when they realise the women’s infertility. Some of the men married to infertile women have extramarital affairs that can lead to sexually transmitted diseases. Others live half the year in Ghana and it causes a lot of problems because their short visits may not coincide with their wives’ fertile period.
Moreover, when the man is in Ghana, for half a year, some tests cannot be
done. Some treatments require not only the woman but also the husband’s
participation. If then any tests to be done on the man are not possible for several
months, some treatments are postponed. When such a partner returns from Ghana,
some tests done before his departure have to be repeated. If the infertile woman is in
her thirties, she loses valuable treatment time before she gets to be forty when
treatments are stopped in the Netherlands.

One of the primarily infertile women is concerned about these separations. Her
husband plans to migrate to Canada soon because his Dutch citizenship is being
scrutinised. The Dutch government has confiscated his ‘papers’. This will be a problem
as far as more infertility treatments go. As a couple, they asked the doctor whether it
was possible to have his sperms stored for artificial insemination trials and he said that
it was feasible but added that fresh sperms are preferable. Her fertility seeking
behaviour is thus going to be disrupted when he migrates.

**Legality, Work and Costs**

There are legal barriers influencing fertility seeking behaviour. For example,
illegality determines choice of treatment, doctor, type of health care and health
insurance. Job opportunities are limited for the illegal and this has implications on
affordability of infertility treatments. It is worth noting that to be an illegal Ghanaian
and infertile is to experience a double disadvantage; not only do prevailing political and
economic circumstances cause stress, but the cultural stigma attached to being infertile
pressures its victims deeply.

An informant explains how these women try to find treatment for their
infertility; “They see priests. The system does not take care of illegals”. Herbal sellers
allow illegal infertile women to pay for treatment and herbs in instalments. In Ghana,
some medical doctors practising privately treat infertile women on credit too. “You go
there, even if you do not have money, he can do it and say sign and pay when you
can. You can pay even for years,” said an informant.

Legal status is important when discussing Ghanaians because it is approximated
that one in four or so Ghanaians is ‘illegal’. Given the low paying illegal jobs they get
to do and the Netherlands legal system, they have difficulties accessing health care ‘not
because hospitals and doctors are not there, but because they are in problems when it comes to covering costs'. Many illegal Ghanaians cannot afford health insurance.

This has implications on accessibility to treatments and encourages either postponing of childbearing or a general fixed choice for alternative medicine. They cannot afford the use of reproductive technology. In Amsterdam, there are insurance packages that are available for illegal migrants, which however have cost implications. There is also the possibility of paying directly for infertility treatments. In the hospitals, they are allowed to pay a certain amount of money as deposit and then the treatment starts. Doctors do not investigate whether they are legal or not.

Some illegal Ghanaian couples fear that the use of government run health institutions will endanger their stay in Holland. Illegal people are insecure and suspicious of all government institutions. Due to the ‘koppelings wet’, once they register at a health care institution, they have fears of being followed up. To quote an informant; “If you are an illegal, you are never sure what will happen with those bits of information that you give at the hospital. It has become more and more difficult for the illegal migrants to make use of health facilities.”

In Amsterdam, there are two clinics where un-insured or illegal people go for medical help. They only have to pay what they can afford during each visit. They are; De Witte Jas¹ and Stichting Kruispost² in the central zone of Amsterdam. There are doctors willing to treat infertile illegal women. For example, an infertile woman who had been living illegally in Holland said; “I was introduced to a doctor who was seeing illegals and charging only five guilders. He used to operate people even without papers. Finally, I got papers and had my first operation in 1996”.

A doctor gives an example, “Sometimes people are afraid. The woman may be legal and having legal status in Holland while the man doesn’t. They get afraid to do sperm tests because they think that they will be brought before the law, which is not the case of course. Sometimes I ask for it over and over again and he (her husband) does not help us and I ask, ‘Tell me what’s the problem?’ Finally, I see it’s because he’s (illegal and) not insured and I assure them we just want to give the bills and tests, period. They do worry, but they shouldn’t”.

¹ De Witte Jas, De Wittenstraat 43-45, 1052 AK Amsterdam
² Stichting Kruispost, O.Z. Voorburgwal 129, 1012 EP Amsterdam
In contrast, study findings show that some illegal Ghanaian women can shoulder the stigma of being childless until they get legal status in the Netherlands. In fact, they are not interested in childbearing because their priority is to get economic stability and legal stay. Some of them had children in Ghana before they migrated to Holland and their ‘new’ marriages in Amsterdam require a strong foundation through childbearing. Although they experience the stigma of childlessness, the need is not as important as getting the ‘papers’. Some simply want to acquire material wealth and then return to Ghana wealthy. Not many of them will therefore be looking for fertility treatments. At the hospitals and other health centres therefore, the numbers of illegal Ghanaian women seeking treatment for infertility is negligible.

Some Ghanaian women interviewed are well trained. They had college education before they migrated to The Netherlands but because of the labour market here, they do not find easy access to ‘good’ jobs leaving them at the lower levels of the labour market. Some women have to choose between working and seeking for infertility treatment. This is a very difficult choice because they have bills to pay and their income as couples is very low because of the kind of jobs they take. Most women do physically involving work for long hours that can cause miscarriages.

For instance, one of the women suffering from primary infertility is undergoing artificial insemination. She is not working because she fears jeopardising conception possibilities in any way. She said, “things will drop out (from her womb)” if she works. Another infertile women who worked for ten hours and a half daily was accused of valuing work more than bearing children. A friend said to her; “You work too much. You want money more than children”, she said. Employers were also accused of being indifferent to the women’s suffering. They wanted them to work just like any other employee in the firm.

For the legal and insured working Ghanaian women, their income also limits their desire to find treatment. Given that success of reproductive technologies may only be realised by a few couples and often after several attempts, insurances that limit the number of times a couple can use reproductive technologies cripple efforts of low income earners to make further attempts. To illustrate this financial inaccessibility, in vitro fertilisation, one of the popular technologies costs about f3,500 to f5,000 (Gupta 1996 : 268). Funds are urgently needed to meet other basic needs like; housing food and sending support home (to Ghana).
For those who pursue treatments in Belgium and Germany after they turn forty, they complain that it drains their meagre resources because their jobs are low paying and their insurance packages do not include treatment abroad. As one infertile woman complained; “I have been spending f150 for each consultation there (Belgium). Transport costs about f600 per month and I have to buy the medicine prescribed myself. Here, insurance pays for me, maybe that is why they are less helpful”.

Understanding Causes of Infertility

Many Ghanaians believe their infertility is a result of witchcraft. For this reason, many do not trust western medicine to solve their problem so they turn to herbalists and spiritual healers. As an informant gives an example;

“Two to three years ago, a pray-for-me fetish priest, came to Amsterdam and many went to him. People had to pay. Sometimes they ask people to bathe (healing-ritual acts) as part of their treatment. There is a degree of laziness and ignorance among our people. Lazy because they leave the problem to others to deal with instead of self and ignorant because their trust in local medicines hampers our development. Even some sent for herbs from home (Ghana)”

Education makes an insignificant difference in how the problem is perceived. Educated lecturers can be found in charismatic churches looking for fertility solutions. “Education or not, the mentality of witchcraft follows us. Even failure in exams after one has been drinking heavily, witchcraft is blamed for the thirst! But it’s better to believe in both, so they should deal with the spiritual and ENVO hand in hand” notes a Ghanaian man. The only problem is that most of the infertile Ghanaian women rely on spiritual healing and underutilise biomedical treatments.

Due to limited education in some of the women, they believe that they are simply unlucky to have been incompatible with the men they have married thus far. They therefore move from one relationship to another. This is detrimental to their goal for they can get sexually transmitted diseases that may further jeopardise their fertility. Moreover, even when information is orally given in English, some of these women do not fully comprehend the medical details due to their limitations in education. This can lead to a misunderstanding of fertility promotion methods.

Due to limitations in education, several of them are believed to be unable to read and write. As some doctors explained, “they don’t say it, but they cannot read
and write. For that reason, we rely mainly on oral communication. These Ghanese women speak English very well, so you can talk to them and then find out whether the information is understood. If you give them a piece of paper, it’s not everything”.

Other doctors think that most Ghanaian women do not have enough education to understand everything on treatments completely, scientifically and biologically. One of them gives a solution, “you can explain it to them and say, ‘I think you have or you don’t have any chance. Your body is too old or your tubes are not good’; that’s simple information they can understand. But you shouldn’t give all the technical information and that kind of thing”.

Infertility is a stigmatised illness due to beliefs that it may have been due to misconduct on the part of the woman. Preoccupation with treatment efforts is usually seen as a sign that one is accepting the ‘infertile label’ and the stigma attached to it. It can therefore limit the health care facilities the women may visit. As a Ghanaian organisations leader noted, “People hide from others at ENVO because they don’t want others to know that they are infertile. There is fear to expose weakness, it’s an African thing. Infertility is purely a social problem. It is associated with witchcraft and sins unlike other illnesses.”

Language Barrier

Inaccessibility of sufficient information on biomedical causes of infertility can affect utilisation of reproductive technology among Ghanaians. Since most of the information is given in Dutch, many Ghanaian women, learned or not, do not understand most of it. When doctors give information at the hospital, they say to the women, ‘if your husband reads Dutch, he can read it or go find somebody to read it for you.’ It is only when the information looks very important, that infertile couples get somebody to read it for them.

Irrespective of non-dutch patients, group sessions are done in Dutch and no efforts are made to translate to other languages. For example, oral information is given in Dutch before some treatments commence. An infertile woman gives her experience; “When you went to start insemination, they have something like a conference for all those who will be starting but then everything is in Dutch. They didn’t care about it. I went alone and I saw other Ghanaians maybe with their husbands who can speak a little Dutch. So everything was in Dutch, you know these top tests, sometimes they use
their terms, eh? Even in Ghana, I worked in a hospital before, doctors use terms in English when discussing something, you know. So, even if you can speak English, if you don’t know anything about medicine, when they use those terms, you can’t hear it, you know. So when we went, there was a Dutch lady beside me, so sometimes when they used something and I didn’t understand or they used typical Dutch and I didn’t understand them, then I asked the lady about it. But everything is in Dutch, everything.”

To Ghanaian women, some Dutch doctors have problems communicating in English. This implies that, doctor’s assumption that Ghanaian women are not learned enough to understand technical aspects of the treatment may be exaggerated. Indeed, there are many infertile Ghanaian women with enough education and who can understand a biological and technical explanation if it is comprehensibly translated into English. Dutch doctors consider it the responsibility of patients to understand what is expected in treatments and yet some of them cannot explain treatments comprehensibly or well enough in English. One doctor observes this breakdown of communication, “Sometimes, they (Ghanaian) don’t really understand what we mean and that’s why some treatments go wrong. Particularly when they say ‘yes’ and nod their heads when they actually don’t understand anything. This makes it very difficult to communicate with them. I tell them ‘If you don’t understand, no problem just let us know because we are willing to tell it again and again and again. We can draw pictures or something like that. But when they say ‘yes’ and nod and I get to think that they understand.’”

Translation can help bridge the doctor and the patient communication hitches. Sometimes doctors use translators in explaining treatments that cannot be performed if the patient does not understand adequately. However, for a sensitive health problem such as infertility, it is difficult to find couples willing to work with translators. Moreover, translation work has cost implications because information on treatments changes often due to development of newer procedures and there would be a need to make updates often.
Age

Many infertile Ghanaian women in Amsterdam seek conception as they approach forty years of age. This can be attributed to time taken migrating, finding a 'job' and finding a steady partner with whom such a woman wishes to settle and raise children. By the time she decides to conceive, she would be already in her thirties. The need to be acceptable to her 'new' husband in Amsterdam and his family in Ghana makes her seek for treatment desperately. This makes it difficult for her to accept a doctor's decision that she has to stop further biomedical treatments. She is not willing to give up at all.

A Ghanaian man criticised infertile women's behaviour saying, "They expect magic from the doctor who is not a magician. They do not want to wait and treatment Success takes time." He explains the 'magician-doctor image' as due to the fact that many had given up conceiving but "suddenly when they hear of treatments, they want to try them out. When they succeed, all others want to try and succeed too. The doctor cannot do everything," he says.

Their desire to have children even makes them misunderstand the health personnel. For example, one woman complained saying; "Doctors gave no medicine at all, they just checked my womb and always said I was okay. When I was thirty nine going forty, I went to see them more often because I feared I was getting old since my first visit when I was thirty six years. The doctors try to help but they don't give medicine".

Some of the women felt that house doctors tend to delay before sending them to the gynaecologists. The urgency with which they want to have a child can blind their interpretation of the house doctors treatments. Indeed, general practitioners act as a good filter because they select cases to sent to specialists but sometimes mistakes can be made and delaying of an infertile woman can occur. Should this happen, an infertile woman's chance of finding treatment is reduced, but this is rare.

Chances of having a baby at forty are low. It is lessened by the fact that these women may be having other problems like irregular menstruation or fibroids. To decision-makers therefore, it is not economical to spent time, drugs, and money on these women. After all, undergoing treatment raises their hopes while chances of pregnancy are already known to be low.
The consensus among infertile Ghanaian women is to decline to give up at forty years of age. They reflect on women back in Ghana and in Amsterdam who give birth after forty with or without medical help. They have a strong belief that Dutch doctors do not want to assist them. They believe that as long as they are still in an egg producing stage, with the aid of biomedicine, they should be able to have children easily. One angry woman commented; "I know a woman who had a child at forty four years. I know a clinic in Gent, after Antwerp, where private clinics help people even after they turn forty!"

Doctors interviewed had reasons as to why they ceased treatment at forty. Women over forty get more miscarriages and it is very difficult to help them with reproductive technologies. As a doctor explained; "It’s not impossible for them to get pregnant, but it’s impossible to improve their chances with any drugs or any other treatment. If their chances of getting pregnant are 1% or 2% and when the chances with all the treatments we have are the same, I think it’s very good reason not to treat them. It’s a question of investment and expectations. If the results are as low as in a spontaneous conception, we don’t do it. The only thing I can do is help them accept the situation”.

When these women insist on continuing treatment and are willing to put in the efforts themselves, doctors give advice and addresses of hospitals where they can find help. This is because doctors do not have 100% certainty that the women cannot get children. Many of them end up in the Belgium clinics. Infertile women who have been there like the services given; "doctors are very encouraging, it does not matter how old you are", they say.

A Ghanaian herbalist has been treating these women after forty too. Some women that were classified as too old to have children in the university hospitals have been to his clinic and many of them have children. He said; "I have many ways of taking care of these women. I would only advice a woman who is fifty years and above not to continue giving birth. A woman of forty-eight is not to be termed old. An African woman over fifty can give birth to a strong child like one giving birth at twenty five."
Communication Problems with Health Personnel

Unknown to each other
We stay sealed in cocoons of silence
Neat nurses pass smartly back and forth
...Pleasant but with faces lacking the light of recognition
...In clear tones...our names are called
Doctors greet us
And look out from kind but no contact eyes
Do what they can to heal the body
But have little time to ease the troubled mind
Its not their fault
They have their schedules to keep
Their numbers to get through
Oh how much rather would I be where I am known
Back in the warm waiting room of the village doctor
Where I can feel that I am me
And know that I exist

From a poem by Margaret Gillies (Sergeant ed. 1980)

Many infertile Ghanaian women generally express experiencing indifference demonstrated by Dutch doctors. Some feel that the doctors are too casual and do not take their problem with the intensity it calls for. Doctors are viewed as too technical. Disease is too biological and laboratory oriented. However, there are hospitals identified as being more patient-friendly and with encouraging doctors than others. Doctors comments, serious or not, have an effect on these women. For example, a doctor’s joke on the number of children a secondarily infertile woman has can have psychological consequences. As women said, "He (doctor) can be discouraging, insisting two children are enough. He had a negative attitude; I didn’t want him to treat me anymore. Many doctors say ‘Holland is full’.

Another woman said she never consults the doctors 'because they always put fear in people'. They feel that Ghanaian gynaecologists back home tend to be sensitive when dealing with an infertile woman; "Here they try but you can’t push them as in Ghana”. The women feel that doctors do not bother about their culture. For example, Ghanaians complain about how Dutch doctors ask questions, the kind of questions they ask and their attitude to the patients. To many Ghanaians, health personnel are covertly discriminative and lacking sympathy for them.

Some infertile Ghanaian women are not given sufficient feedback on the prognosis and diagnosis. They are informed ‘only when there is fault’. Some of the women have come to believe that doctors do not inform them because doctors have
"some secrecy". For instance, one woman said after doing some tests, the doctors promised to call her and give test findings but they never did. Infertile Ghanaian women want to be informed of their prognosis and management strategies foreseen. They get frustrated when they are continually told 'all is okay and pregnancy possible'. "They cannot explain to you too much because your are not a Nederlands, they don't care" said an infertile woman in annoyance.

Failure of Dutch doctors to give infertile Ghanaian women infertility drugs to help them overcome their problem is a concern among them. The women do not seem to understand why doctors do not prescribe the drugs which otherwise would be done without questioning in other countries. This could be a reflection of health beliefs from Ghana because in Africa, many people believe in the use of drugs as the best way to deal with any illness despite the prognosis.

Some doctors complained that infertile Ghanaian women do not indicate to them when information given is not clear. They simply say 'yes' and nod positively leaving the doctors satisfied that everything is understood. Ghanaians are aware of this hitch in doctor-patient communication too. One of them commented; "Ghanaians don't ask questions. I don't know why." There is therefore a communication problem between some infertile Ghanaian women and some biomedical doctors that may lead to misunderstanding before and during treatments.
CONCLUSION

In Amsterdam, there are Ghanaian women suffering from primary and secondary infertility. The major cause of their infertility is fallopian tubes infection. Infertility is sensitive and therefore personal to Ghanaians. They are desperate to bear children because in Ghanaian cultures, child bearing is a source of womanhood, happiness, labour, descendants and security in old age.

They value hospital treatment which is often sought concurrently with herbal and spiritual help to increase quick chances of treatment. They expect quick healing. Given that some attribute infertility to supernatural causes, they value ‘spiritual cure’. This spiritual dimension would be least understood in a hospital. Although many women know that they can be treated at the hospital with little trouble before the age of forty, they are still convinced that without bad magic they would not have succumbed to infertility. This is why they have syncretism of treatment options.

Illegal infertile Ghanaian women can have biomedical treatments in Amsterdam. They simply have to meet the costs of their treatment. Their legal status is irrelevant to the medical personnel.

Infertile Ghanaian women in Amsterdam have unmet needs in their search for fertility. They belief in utilization of medicines as a sign of good treatment and vice versa. Because Dutch doctors are hesitant to prescribe drugs for them, they feel dissatisfied with the treatment which is characterized, for the most part, by endless tests. They feel discouraged by doctors who can barely communicate in fluent English. Moreover, the written information they are given on treatments is in Dutch, a language they are still hoping to learn.

When they turn forty years old, they have to seek further biomedical help abroad because Dutch doctors stop administering infertility treatment at that age. Given that most of them find suitable partners in Amsterdam after many years of ‘settling’ down as migrants, they are unwilling to give up at forty years. Their marriages are at stake because they are infertile.

Some infertile Ghanaian women in Amsterdam have husbands/partners living in Ghana or elsewhere who visit them occasionally while others lack stable relationships.
This problem makes application of reproductive technologies available difficult to administer. It also reduces chances of conceiving by ‘natural’ means.

Although living away from their native home (Ghana), they feel stigmatised. Their partner, friends and relatives are supportive but there are periods of intense loneliness when they suffer in solitude. When all treatment options have been exhausted and the problem persists, other measures that are not directly linked to reproductive health improvement can be applied in Ghana as well as in Amsterdam. These include divorce and remarriage, polygamy, fostering and adoption of children in order to avoid dying childless.

In Ghana, children worked on the farm for their parents in the past. The more children one had, the more the income that was realised. Today, everybody wants their child to go to school, to be well fed and clothed. Indeed, Ghanaian couple’s attitude to childbearing is changing. People want to have fewer children. As a Twi proverb goes, *many children means poverty*. All the same, the trend is towards smaller family units, not childlessness.

Continued denial of male infertility makes the women suffer ridicule and marginalisation. An infertile woman loses respect as motherhood is synonymous with womanhood. Medical and social cultural factors causing it have to be assessed for the problem to be strategically dealt with. In Ghana, there are matrilineal and patrilineal cultures. There is little difference in the way the two societies understand infertility although matriliny bestows on the woman a distinctly better status than patrilinily. There are extremely rare occasions when women divorce their infertile husbands. In both societies, the woman is blamed for infertility.

Given the desperation infertile women go through and their never ending efforts to conceive, infertility ought to be considered a major reproductive health issue in Ghana as well as in other countries. Gender issues should not be ignored for the blame is often heavily placed on the women in Ghana. Indeed, women are not only there for childbearing, they can also be in other spheres of political and socio-economic life.
RECOMMENDATIONS

The Netherlands is a multicultural society. Health personnel ought to appreciate this fact and make more efforts to understand cultures represented in this country. Ethnocentrism has a key place in doctor patient interactions in Amsterdam. When doctors discuss childbearing issues with infertile Ghanaian women, they should try to understand what infertility means to the patient and to her (patient’s) culture.

Some doctors see infertility as a minor problem ‘because infertility is not a life threatening situation even if the patient’s culture dictates it’. This depends on people’s definition of ‘a crisis’ or emergency. Fertility or sex problems can be an emergency for some people. For Ghanaian women, it is an intense problem for it is ‘like a chronic isolating illness having consequences in all areas of life’. As one doctor commented, “if the infertile Ghanaian woman sees childbearing as an essential part of her life, who am I to say that this isn’t true?”

Doctors need to exercise more patience and understanding. They can spent more time with these patients explaining the problem, the treatments and giving counsel. Any words, comments or jokes made at an infertile Ghanaian woman may build or destroy her morale. Dutch doctors can try understanding why infertile Ghanaian women are desperate for children even after the age of forty. They can avoid making remarks on ‘ideal’ numbers of children any family should have. For a doctor to say to an infertile woman that ‘Holland is full, why worry yourself?’, this is to pre-empt distrust in her as to whether he is willing to assist her conceive at all.

Little is written in English to inform infertile women on infertility treatments. Although many of them lack high education, most of them can read and write in English. Efforts to provide this information can be made because it does exist in other countries, for example, in America and basics for treatment are the same globally. Translation of the existing Dutch information can also be a good solution. FREYA people have extensive experience in dissemination of information. Although their information is in Dutch, they are willing to have it translated to English or other languages but they need volunteers to do this work.

For infertile Ghanaian women who are forty, there is a need to assess whether treatments can be extended by a few more years. They can also have insurance cover extended to cover further infertility treatment abroad after the age of forty.
The Ghanaian ministry of health can make deliberate efforts to prevent further secondary infertility in Ghana. Sexually transmitted diseases (STD) control programmes, provision of condoms and inclusion of infertility services in the family planning and STD programmes would help in prevention efforts. For example, STD education programmes can lead to reduction in incidence of venereal diseases which are highly implicated in causing secondary infertility.

In Africa, so much attention has gone into family planning and child health issues which are all linked to fertility. Given the high fertility in Africa, distribution of contraceptives gains priority while infertility is marginalized. Governments have their bit to play. The Ghanaian government can consider having intensive studies on causes of infertility and the best way to cope with the problem.

All the same, provision of drugs for those already infected with STDs would alleviate the problem. When educating ‘infertile’ couples, medical and cultural factors associated with infertility such as understanding of the menstrual cycle, sexual activities, possible harmful use of indigenous medicines, long term effects of abortion and use of contraceptives should be investigated. Moreover, counselling of the primarily sterile should be encouraged.

Infertile Ghanaian women in diaspora should be encouraged to undertake Dutch courses so that they can find better paying jobs in Amsterdam. This way, they do not have to desperately hold onto their partners who eventually leave them because of their problem. Education for both sexes should be emphasized. Education will lead to better understanding of biomedical causes and men will be more cooperative and willing to have their sperm quality checked.

Although traditional fostering has been implicated as leading to child labour, it is a useful way of making the infertile ‘whole’ in a Ghana where reproductive technologies are difficult to access. In a period when reproductive technologies are still unsure of complete success in conquering infertility, laws governing adoption and fostering should be reviewed in order to make it easier for infertile women to ‘have’ children. It will be a long while, before African women can have a ‘strong voice’ in their relationships on reproduction issues. Infertile women ought to emancipate themselves by for example, making efforts to be economically self sufficient and achieving higher education which can enable them find lucrative jobs. This way, they can establish other life goals besides motherhood.
REFERENCES

Baeta, C.G. (1962)
*Prophetism in Ghana A Study of some Spiritual Churches*
London : SCM Press Ltd

Barfield, T. Ed (1997)
*The Dictionary of Anthropology*
Oxford : Blackwell

Berger, M. Et al (1998)
*Ghanese Organisaties in Amsterdam een netwerkanalyse*
Amsterdam : Het Spinhuis

Bleck, W. (1975)
*Sexual Relationships and Birth Control in Ghana A Case Study of a Rural Town*
Amsterdam : University of Amsterdam

“Concept of Infertility in Kitampo District” A Project work in partial fulfilment of M.B Ch. B. Degree, University of Science and Tecnology, Kumasi.
In : Ardayfio-ShadorfE. And Kwafo-Akoto (1990) *Women in Ghana*
An Annotated bibliography, No. 182, Accra : Woeli

Cutrufelli M.R (1983)
*Women of Africa Roots of Oppression*
London : Zed

Debrunner, H. (1959)
*Witchcraft in Ghana* Kumasi : Presbyterian Book Depot

Ebin, V. Interpretations of Infertility : The Aowin People of South-west Ghana
In : MacCormack, C. P. Ed. (1982) *Ethnography of Fertility and Birth*
London : Academic Press

Field, M.J. (1960)
*Search For Security An Ethno-psychiatric Study of Rural Ghana*
London : Faber and Faber

*Nanumba Women : Working Bees or Idle Bums*
Sexual Division of Labour, Ideology of Work and Power Relations Between Women and Men
Leiden University : ICA Publications, No. 53.

Social and Cultural Aspects of Infertility in Mozambique
Goody, E. (1975)
Delegation of Parental Roles in West Africa and the West Indies
In: Goody, J. Ed. (1975) Changing Social Structure in Ghana : Essays in the
Comparative Sociology of a New State and an Old Tradition
London : International African Institute

New Freedoms New Dependencies New Reproductive Technologies, Women's
Health and Autonomy Ph.D dissertation, Leiden : Leiden University

Helman, C.G (1994)
Culture Health and Illness Oxford : Butterworth

Kabsa (A.K.A Mushahara) and Threatened Fertility in Egypt

Kane T. and Snow R.C. (1995)
The Social Meaning of Infertility In Southwest Nigeria

Patients and Healers in the Context of Culture.
Berkeley : University of California Press

Kirby, J.P (1986)
God, Shrines and Problem-solving among the Anufo of Northern Ghana
Berlin : Dietrich Reimer Verlag

Met Technologie Gezegend ? Gender en de Omsreden invoering van in vitro
fertilisatie in de Nederlanse gezondheidszorg
Uitgeverij Jan Van Arkel

Leis, P.E. (1972)
Enculturation and Socialization in an Ijaw Village

"The Relationship Between Childlessness and Marital Instability : A case study of
Krofofrom, a suburb of Nkawkaw". A project work in partial fulfillment of a B.A
Degree in Sociology In : Ardayfio-Shadorf E. And Kwafo-Akoto (1990)
Women in Ghana, An Annotated bibliography, No.201, Accra :Woeli

Meuwissen
Neizer, A.A. (1983)
"Study of the Social- Cultural Aspects of 33 Cases of Infertility, Kpando Catholic
Hospital". A project work in partial fulfilment of MB.ChB Degree, 38pgs.
In: Ardayfio-Shadof E. And Kwafo-Akoto (1990) Women in Ghana
An Annotated bibliography, No. 201, Accra: Woelfi

Odile, F. Infertility in Sub-Saharan Africa

Savage, 'Children of the Rope' and other Aspects of Pregnancy Loss in Cameroon
Oxford : Berg

Poems From the Medical World
Lancaster : MTP Press Ltd.

Fertility Regulation in the Netherlands From a North-South Perspective
Medical Anthropology Unit : Amsterdam

Sherris, J.D and Fox, G.
Infertility and Sexually Transmitted Disease : A Public Health Challenge In :
Population Reports, Series I, No. 4 July 1983
Johns Hopkins University : Baltimore

Spencer, P. (1988)
The Maasai of Matapato A Study of Rituals of Rebellion
Bloomington : Indiana University Press

Ter Haar, G. (1998)
Halfway To Paradise African Christians in Europe
Cardiff : Cardiff Academic Press

Van Balen, F. And Trimbos-Kemper, T.C.M. (1994)
Factors Influencing the Well-being of Long Term Infertile Couples

Involuntary Childless Couples : Their Desire to have Children and their Motives
In : J. Psychosom. Obstet. Gynecol., 16, 137-144

In-vitro Fertilisation : The Experience of Treatment, Pregnancy and Delivery
In : Human Reproduction Vol. 11 No. 1 pp. 95-98

Van Balen, F. Et.al (1997)
Choices and Motivations of Infertile Couples

Perspectives of Reproductive Health In: Elsevier. Patient Education and Counselling, 31, 1-5

From Camp to Encompassment: Discourses of Transsubjectivity in the Ghanaian Pentecostal Diaspora
In: Journal of Religion in Africa, XXVII, 2, pp. 135-159

Amsterdam: Spinhuis

Verdurmen, J. (1997)
Keuzesbij Onvruchtbaarheid Besluitvormingsprocessen bij Onvruchtbare Paren
Academic Proefschrift, University of Amsterdam

Wemba-Rashid, J.A.R Explaining Pregnancy Loss in the Matrilineal Southeast Tanzania
Oxford: Berg

WHO (1975) The Epidemiology of Infertility
APPENDICES
Appendix 1. Study Diagram
Fertility Seeking Behavior Among Infertile Migrant Ghanaian Women

**Infertility Problem**

- **Perceived Causes**
  - Biomedical and Cultural Explanations of infertility

- **Experiences on being labelled infertile**
  - Individual women's narratives

- **Seeking Treatment**
  - *Traditional Healers, Prayers, Folk Medicine, Hospital Care, other...
    - Syncretism of several/ all options
  - *Perceived Efficacy of Treatments

- **Consequences of being Infertile**
  - Issues of Blame, Stigmatisation etc

- **Factors Influencing their HSB**
  - *Awareness of infertility treatments:
    - How it is given, Where this is done and the language used, Probability of conflicting sources of information e.g. doctors vs. traditional/ church healers
  - *Accessibility of RT:
    - Legal barriers for illegal migrants, High costs of treatment, Limited knowledge of causes and possible treatment of infertility
  - *Stigmatisation of the problem
  - *Others...
Appendix 2. Glossary of Ghanaian Terms and Expressions

<table>
<thead>
<tr>
<th>Term/Idiom</th>
<th>English Translation/Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bonini</td>
<td>Barren</td>
</tr>
<tr>
<td>Gbolo</td>
<td>A river god specializing in childbearing</td>
</tr>
<tr>
<td>Nkrabea</td>
<td>One's destiny set by God</td>
</tr>
<tr>
<td>Akuaba</td>
<td>Akan fertility doll</td>
</tr>
<tr>
<td>Okrawa/Kukuba</td>
<td>Barren man</td>
</tr>
<tr>
<td>Papers</td>
<td>Having legal documents as a Nederlands resident</td>
</tr>
<tr>
<td>Aban agye ne tuo</td>
<td>‘The government has confiscated his gun’. His manhood has been dysfunctioned making him infertile</td>
</tr>
<tr>
<td>Ido benada</td>
<td>‘He farms on Tuesday’. He has sexual intercourse on a culturally inappropriate day. This makes him infertile</td>
</tr>
<tr>
<td>Eating bejujae</td>
<td>Refers to the slaughtering of a sheep to celebrate the birth of a tenth child</td>
</tr>
<tr>
<td>He is dead in the night</td>
<td>He is impotent</td>
</tr>
<tr>
<td>When the trap springs up</td>
<td>An idiom referring to divorce</td>
</tr>
<tr>
<td>I must go to the Boadwo</td>
<td>Bo-adwo literally means a place where there is peace of mind</td>
</tr>
<tr>
<td>She eats her children</td>
<td>She has recurring infant mortality and is culturally suspected of having consulted witches for favours which are payed back with the life of her children</td>
</tr>
<tr>
<td>She has not met her man</td>
<td>Her infertility is due to incompatibility. Her present husband is not able to get her pregnant but there is the possibility of finding a perfect match for her</td>
</tr>
<tr>
<td>When he weeds on Tuesday,</td>
<td>This is a description of an infertile man who flirts a lot and has extra marital affairs</td>
</tr>
<tr>
<td>he still pretends he can</td>
<td></td>
</tr>
<tr>
<td>work on Saturday</td>
<td></td>
</tr>
<tr>
<td>Phrase</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Pray-for-me Priests/ Pastors</td>
<td>Religious leaders affiliated to a christian church who specialise in spiritual healing</td>
</tr>
<tr>
<td>When you come back, come as the spear grass</td>
<td>A request made to the corpse of an infertile man. Due to beliefs in reincarnation, he is asked to reincarnate as a fertile man just like spear grass sprouts quickly</td>
</tr>
<tr>
<td>You are just like a man</td>
<td>An abuse directed at an infertile woman. Although she has a womb, she is not feminine due to childlessness</td>
</tr>
<tr>
<td>I want my son to name after me</td>
<td>This is a common comment made by parents of a man in a childless marriage. It is based on the naming system in cultural groups where children are named after relatives.</td>
</tr>
<tr>
<td>Infertile women expect magic from the doctor</td>
<td>Infertile women look for quick remedies. They want immediate healing. They are not ready to wait patiently</td>
</tr>
<tr>
<td>Picking quarrels to disturb the atmosphere</td>
<td>An infertile womans husband who wants to divorce her causes conflicts and tension in his marriage so as to find an excuse to sent her away</td>
</tr>
</tbody>
</table>
Appendix 3. Guiding Questions

Guiding questions or statements/topics were used to interview key informants and infertile women. Free flow of interviews in a friendly conversation-like style was encouraged. In interviewing infertile Ghanaian women, the term 'childlessness' was used more than 'infertility' for the former is more 'friendly' while the latter has more negative connotations.¹

Due to the topic’s sensitivity, during interviews with the infertile women, questions on personal details were asked last.

1. Key Informants
   a) Interview with Ghanaian researcher
      1. Socio-economic characteristics of Ghanaians in Amsterdam;
         Probes: What is their context;
         Social status,
         Lifestyle,
         Job opportunities,
         Literacy levels,
         Religious background,

      2. Which ‘term’ is more appropriate, use of Ghanaian or Ghanese in describing them?

   3. General HSB of Ghanaians in Amsterdam
      Probes: When in need of medical help, what do Ghanaians do?
      What are the different options sought?
      Can the illegal use private medical clinics?
      Which are preferred (e.g prayers, herbalist, doctor etc)?
      Does the complaint/ illness influence preference?
      Why do some Ghanaians complain about the dominant health system? What about for infertility problems in particular?

   4. Nature of the infertility problem;
      Probes: Is it a sensitive topic?
      How are infertile Ghanaian women perceived?
      How can I approach the study population?
      Are incentives like money useful?

   5. Why is Ghanaian’s FSB in Amsterdam undocumented?
      Probe: Is their minority status responsible?
      Is illegality for some to blame?
      Is the group discriminated against in research on fertility?

   b) Interview with infertility researcher
      1. Why is infertility among Ghanaians in Amsterdam ‘underresearched’?
         Probe: Is their minority status responsible?

      2. Why is this problem a major concern to the women?

¹ I noticed this from experiences I had when discussing infertility with Ghanaians
3. Does illegality influence the Ghanaian's FSB?
Probes: How do the illegal get medical/RTs help?
How do they meet the costs of such treatments?

4. How sensitive/difficult is it to research on this topic in Amsterdam?
Probes: Which method(s) would be appropriate in doing the study?

c) Interview with Ghanaian herbalist
1. Do you have Ghanaian women who complain of childlessness?
Probes: General number of patients, How often does a 'case'/patient come again with the same problem?, Any who come as a couple for treatment? Any men?

2. What causes the problem of childlessness among these women?
Probes: The question of male factors in infertility, supernatural/cultural explanations, effects of perceived causes on treatment seeking behaviour.

3. What treatments (would you give to the childless?)
Probes: Possibility of several treatment options, their sequence, perceived efficacy, possibility of him dispensing medicines to the patient, treatments/solutions given in Ghana.

4. Is there a payment made by the women?
Probes: Is there a fixed consultation fee? Is there a possibility of paying after perceived efficacy? What about those who may not be having money?

5. Are you treating childlessness together with any other healers in Amsterdam?
Probes: Any collaboration (e.g. referral) with medical doctors? Any collaboration with prayer healers? Others?

d) Interview with FREYA member
1. What are the objectives of FREYA?
Probes: Set-up of the organisation, Activities, Funding, Number of members.

2. How do you recruit members?
Probes: Which ethnic groups are represented in FREYA?
Do infertile Ghanaians join FREYA?
How many?
What efforts/activities are used to reach them?
Do illegal Ghanaians get membership?

3. What are the benefits of being a FREYA member?
Probes: Can this be helpful to infertile Ghanaian women?

4. What are your perceived reasons for the numbers of Ghanaians in FREYA?
Probes: In your opinion, do you think of any hindrances to their participation in FREYA?
Is there a need to have the hindrances destroyed?
How can these barriers be overcome? By who (government, health workers, interest groups, other)?
Would it help them access infertility treatment more easily?

e) Interview with traditional medicine seller
1. Do you have any medicines for treating childlessness?
Probes: Different types available in his shop
How they are utilised by the infertile,
Whether they are used in Ghana too

2. Where do you get these medicines?
Probes: Any from Ghana?
If yes, who/where is the source in Ghana?
Are the medicines in demand in Amsterdam?

3. Who are your clients?
Probes: Any men?
Any Ghanaian women?
His perceived number of these female customers?

4. How is the prescription done?
Probes: Prescription of single potions vs. Multiple,
Any addition of rituals/behaviours to be observed?

5. What is the general range of costs for medicines used for a full treatment of childlessness?
Probes: Possibility of different prices for different potions,
Do costs of medicine affect women’s choice of treatment?

6. What is your perceived efficacy of these drugs?
Probes: Do the women conceive/get live births?
Do the women seek after any other treatments?

f) Interview with a gynaecologist
1. Do you get infertile Ghanaian women as patients?
Probes: A general number/figure of attendance,
Any illegal women on the list?
How are the illegal dealt with?
Any special problems in trying to provide them with treatment?

2. What are the most common causes of infertility among Ghanaian women who come to the clinic?

3. What treatment is given?
Probes: Kinds of treatment,
Any defaulters of treatment programmes?
Any suspected reasons for the default?
Costs of different treatments offered to Ghanaian women,
Perceived efficacy

4. What is your opinion on Ghanaian women’s FSB?
Probes; Do the women utilise RTs?
Are there barriers to their utilisation of RTs?
Do they get information on RTs?
What kind of information and in which language?
Is this information given adequate in your opinion?

1g) Interview with the Head of AMC sexuality Department
1. Have you encountered infertile Ghanaian women in your work in Amsterdam
Probes; How many
Any illegals
Any special problems characteristic to these women

2. What are the most common issues concerning them that are brought to your
attention/department

3. How do you deal with their problems

4. What is our opinion on Ghanaian womens FSB
Probes; Do they utilise Rts
Do they get information on Rts
What kind of information, Is it adequate

1H) Interview with Sikaman/Ghanaian radio official
1. What kind of programmes do you broadcast
Probes; Any on reproductive health?
What kind of information is given?
Any programmes on infertility or infertility treatments?
When do you broadcast?
Who do you target as your listeners?

2. What kind of music is aired?
Probes; Any with the theme of infertility or childbearing?

3. Where can I find Ghanaian films/videos?
Probes; Do they have the theme of childbearing and infertility?

4. How do hearers react to radio programmes and music on infertility?

5. In your opinion, which treatments are sought by infertile Ghanaian women?
Probes; In Amsterdam
In Ghana
Preferences and reasons why
6. Can you help me contact infertile Ghanaian women in Amsterdam?

11) Interview with I CARE Womens Foundation Leader
1. What does your organisation do?
   Probes: When it began
   Objectives
   Activities

2. Do infertile Ghanaian women come to I CARE for assistance?
   Probes: Why do they come to I CARE?
   How do you help them?

3. How/Where do infertile Ghanaian women in Amsterdam look for treatment?

4. What treatments are available for infertile Ghanaian women?
   Probe: In Ghana?
   In Amsterdam
   What do the illegal do?

4. Who is blamed for childlessness among Ghanaians?
   Probe: Why is that person/thing blamed?

5. What is the attitude of infertile Ghanaian women to prevailing health care in Amsterdam?

1j) Interview with AFAPAC Director
1. What is AFAPAC in full?
   Probe: When did you start this foundation?
   What are AFAPAC's objectives?

2. What kind of programmes do you broadcast?
   Probe: Any on reproductive health?
   Any on infertility?
   Any on infertility treatments?
   Who are targeted as hearers?
   When is the radio broadcast?
   What information is given?

3. Do you have any interviews on air with reproductive health personnel?

4. Can you help me contact infertile Ghanaian women in Amsterdam?

5. What is your personal opinion on the health seeking behaviour of these women?
   Probe: In Amsterdam
   In Ghana
1k) Interview with AFAPAC Womens Affairs Head
1. Can you tell me what your department does?
2. Do you know any infertile women in Amsterdam?
3. What is the importance of having children among Ghanaians?
4. What problems are faced by infertile Ghanaian women?
5. Can you compare the situation in Ghana and Amsterdam for the infertile Ghanaian woman?
6. What infertility treatments are found in Ghana?
7. What influences these women's health-seeking behavior in Amsterdam?

11) Interview with a Catholic Priest, Afrika Huis
1. What is the general lifestyle of Ghanaian women in Amsterdam?
2. Do you know any infertile Ghanaian women?
   Probe: How many?
   Why do they come to you?
   How do they present their problem to you?
   How do you assist them?
3. What explanations do they give for infertility in their lives?
   Probe: In Amsterdam
   In Ghana
4. What are the consequences of being labelled infertile among Ghanaian women?
5. Who is to blame for the problem?
   Probe: What are Ghanaian beliefs on males factors in infertility problems?
6. What is the value of having children among Ghanaians?
7. Where do infertile Ghanaian women look for treatment?
   Probe: In Amsterdam
   In Ghana

1m) Interview with 2 UVA Postgraduate Ghanaian students
1. Which ethnic Ghanaian groups do you come from?
2. How is infertility defined among Ghanaians?
   Probe: What is the local term for barreness/infertility?
   What names are given to the infertile?
3. What is the importance of childbearing among Ghanaians?
4. What is considered to be the cause of infertility?
   **Probe:** Is there a difference between the cause of primary and secondary infertility?

5. Who is blamed for the problem?
   **Probe:** How do Ghanaians understand male factors in infertility?

6. What are the problems faced by infertile Ghanaian women?

7. How do these women look for treatment/solutions?
   **Probe:** Which treatment options are preferred? Why?
   Adoption/Fostering option?

8. How is efficacy of treatments assessed?

2. **Guiding topics for retrospective narratives by childless women:**
   **a) Her Experience**
   I know that you have/had a problem related to childlessness. Could you please tell me your story?
   **Probes:** What is/are the Ghanaian term/s for this condition?
   When is one considered childless among Ghanaians?
   When were you considered childless by self/others?

1. What is your understanding of perceived causes of childlessness?
   **Probes:** What are the Ghanaian beliefs on the causes?
   How do you explain childlessness in your life?

2. What experiences did you have on being labelled childless?
   **Probes:** social consequences at the house, kinship and community levels,
   Level of blame on the woman,
   Any rituals/activities she may be exempted from, any abuse or marginalisation?
   Any differences/similarities in consequences encountered in Ghana and in Amsterdam?

3. Did you seek treatment/a solution?
   **Probes:** Any treatment preferences?
   Sequence in choice of treatment/solution,
   Any treatments sought back in Ghana?
   Any utilisation of different medical systems concurrently (syncretism)?
   Perceived efficacy of different treatments used

4. What factors (are) influencing(ing) your child seeking efforts?
   **Probes:** Her knowledge of possible treatments e.g RTs,
   Attitudes to RTs/dominant health system,
   Her legal/illegal status,
   Stigma attached to the problem,
   Costs as possible barriers to treatment,
   The influence of her cultural explanatory model/husband/partner/family
b) General Information on the infertile woman

Topic list No. :
Location :
Date :
Respondent’s No./ Nickname :
Name of Interviewer :

c) Personal Data
1. Age :
2. Education attained :
3. Occupation :
4. Income :
5. Religious affiliation :
6. Marital status :
7. Reproductive history/ Period of childlessness :
   Probe ; Any past abortions, stillbirths, miscarriages
8. Legal/ Illegal status :
APPENDIX 2

AANTAL ABORTUS TEVOREN NAAR ETNISCHE HERKOMST 1996 t/m 1998
(percentage van de cliënten)

Zoals in eerdere jaaroverzichten blijkt ook in de periode 1996 t/m 1998 weer dat het bij Nederlandse, Turkse en Marokkaanse cliënten in een grote meerderheid om de eerste abortus gaat, terwijl dat voor de cliënten met een andere etnische herkomst anders ligt.

<table>
<thead>
<tr>
<th></th>
<th>géén</th>
<th>één</th>
<th>twee</th>
<th>meer dan twee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nederland</td>
<td>72.2%</td>
<td>21.1%</td>
<td>4.7%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Suriname</td>
<td>44.4%</td>
<td>34.6%</td>
<td>12.6%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Antillen</td>
<td>44.5%</td>
<td>39.1%</td>
<td>9.9%</td>
<td>6.6%</td>
</tr>
<tr>
<td>Turkije</td>
<td>62.5%</td>
<td>23.8%</td>
<td>8.0%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Marokko</td>
<td>63.0%</td>
<td>25.2%</td>
<td>6.8%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Ghana</td>
<td>30.6%</td>
<td>38.5%</td>
<td>18.5%</td>
<td>12.4%</td>
</tr>
<tr>
<td>anders</td>
<td>56.9%</td>
<td>30.1%</td>
<td>8.4%</td>
<td>4.7%</td>
</tr>
<tr>
<td>totaal</td>
<td>60.4%</td>
<td>27.1%</td>
<td>7.9%</td>
<td>4.6%</td>
</tr>
</tbody>
</table>

PERCENTAGE VAN CLIËNTEN NAAR HERKOMST MET 2 OF MEER ABORTUS

Wanneer het aantal eerdere zwangerschapsonderbrekingen bij cliënten vergeleken met de voorgaande jaren, dan valt op dat cliënten van Ghanese, Surinaamse en Antilliaanse herkomst het vaakste twee of meer eerdere ingrepen hebben doorgemaakt. In het verloop van de tijd lijkt het aantal eerdere ingrepen niet zeer te veranderen.

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Source:
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Appendix 6. Ghanaian Films and the theme of infertility

There are many Ghanaian videos in Amsterdam. Most of the themes center on love, murder, betrayal, greed for money/success and issues concerning children. Some of the videos with themes on infertility and children are:

1. The Victim of Love,
   By Princess Films Productions
   In this video, a mother expresses her wish to see her son’s children and asks him to marry. She nags him about it. Eventually he marries a hardworking accountant who he asks to leave her job and join him in family business. When she does, her in-laws start complaining that she is rude to them, denying them money and using business money to support her own parents and sister. Her husband, without confronting her with the accusations chases her away and a girlfriend moves in with him. His wife was pregnant when she left and struggled until she finally got a good job once more. Many years later, her husband goes bankrupt as his family members misuse business money. With the help of her favourite Pastor, he and his mother come to meet their son-grandchild and beg to have her back with them. They are so excited at seeing her son. She seems to forgive them as the drama continues...

2. Expectations,
   By Miracle Films, a D’joh mediacraft production
   The story is on plans to sabotage a Christian couple’s efforts to have a son who is to be the next chief. The Christian lady is named Gifti. Gifti’s food is mysteriously poisoned by witches during a visit to her parent’s village. She gets a miscarriage and the doctor doubts whether she will ever conceive again. The witches rejoice and make further plans to separate the couple as a sure way to stop reproduction between the two for Gifti’s husband had been told concerning her, “She is the key to your future glory”.

   5-6 years pass by and no pregnancy is forthcoming. An elder pressures Gifti’s mother-in-law. They are worried that the chief’s stool will be passed on to another clan. She is advised to find another wife for her son lest she disgraces her clan. So she turns on her son who loves his infertile wife very much and swears, “If the stool is taken from us, never step on my ground again”. She adds, “When I die don’t come near my corpse, leave it to rot.”

   Gifti’s sister in the village argues with her mother concerning this problem. She insists that her mother should go and advise Gifti on how to look for cure. Her mother affirms that only God can help Gifti through prayers. Meanwhile, Gifti’s mother-in-law is still under pressure to find a second wife for her son and even confronts Gifti about it. When her son goes away on business, she packs Gifti’s belongings and sends her out saying, “Go to your mother, Go and treat yourself.”

   As her driver takes her to her parent’s village, he advises her to go see a fetish priest. She answered him that she would not do such a thing for she had Jesus. He said to her, “Then use your Jesus well”. In the village, her drunkard uncle brings her herbs saying, “Go use this when you get back to your house.”

   With Gifti out of the way, her mother-in-law brings in another woman who waits for her son’s return. On arrival, she is introduced to him by his mother as an extremely
fertile woman who has given birth to three healthy sons. Gifti’s husband is very annoyed and prepares to go and pick her in the village. His mother lies infront of his car on the driveway and says, “You’ll have to kill me before you bring her back, kill me, kill me!” At some point later, looking at her photo in his bedroom he asks, “Gifti does this mean you cannot give me a child?”

The witches sent a woman to his office who bewitches him and he begins to like the second woman in his life. This is part one of the drama.

3. Bitter Love,
By Great Idikoko ventures, 1997

A husband beats his wife after delaying in the office and getting a lift from her boss who is suspected by her husband of dating her. She happens to be pregnant and when he beats her, she collapses. On going to hospital she loses the baby and also the ability to ever have one.

Later, once rich through a loan she helped him get, he leaves her for other women and at one point on coming late asks her in an argument, “Who should meet a man at the door when he comes home from work?” She answers, “His wife of course!” The man retorts, “His children! I was born to reproduce. When we visit our friends we see their children. I cannot come home and see Alice, Alice only!” To this, Alice answers that children come from God. As the argument goes on, she recalls how the abortion occurred.

He then moves for good into a mansion he built with money from the loan his wife procured for him. A close girlfriend moves in with him as the story continues into other themes.

4. Mother’s Revenge,
By Adanse productions limited

A woman in love with a married man poisons the man’s wife without his knowledge. Her death brings bad luck to the entire village. She lives behind a son and daughter. The killer finally gets married to the man and has a problem conceiving. She consults a juju man who helps her get a baby girl but she has a scar/mark on her as a juju-child. She is also evil and tries to poison her step-sister. Eventually, she and her mother’s ways are unearthed as the dead woman uses her daughter as a link with the living. When this happens, peace in the family and entire village is restored.