

UNIVERSITY OF GHANA

**COUPLES IN SEARCH OF CHILDREN: A STUDY OF STRATEGIES AND
MANAGEMENT OF INFERTILITY IN CONTEMPORARY GHANA**



**THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN
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DECLARATION

I, Rosemond Akpene Hiadzi, hereby declare that, except for references to other people's work, which have been duly acknowledged, this thesis is the result of my own research work carried out and submitted to the Department of Sociology, University of Ghana, Legon under the supervision of Dr. Dan-Bright Dzorgbo, Dr. Akosua K. Darkwah and Dr. Daniel K. Arhinful.

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DEDICATION

This research work is dedicated to my dear mother, Mary Theresa Hiadzi, whose unflinching support and continuous encouragement have brought me thus far in my academic pursuits; and to my dearest Sel and our adorable children Selorm and Seyram for their understanding and sacrifice. They indeed challenged me with their presence to bring out the best in me.



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ABSTRACT

Marriages in Ghana are considered incomplete when there are no children. Changing social values have, however, placed more emphasis on biological parenthood while de-bunking the traditional ways of dealing with infertility. The pronatalist culture continues to persist in the light of these changes thereby making the burden of infertility even more pronounced and individualized. This creates an endless search for conception from various treatment options. This study describes the experiences of infertile married men and women and their responses to their infertile situation through the use of modern treatment options. It has the following objectives: to identify the categories of people utilizing low tech, medical herbalists and high tech fertility treatments, to understand the motivations behind their treatment seeking, to understand what determines their treatment choice as well as the contestations that exist between couples and other actors over treatment choices and how they are resolved. In addition, the study explored the processes that respondents follow in seeking treatment and reported on the social, religious and cultural context surrounding the use of ARTs as evidenced in respondents' ways of navigating around components of ART treatment.

The respondents for the study were purposively selected from three sites namely a private herbal clinic, a government hospital and a private orthodox fertility clinic which utilises Assisted Reproductive Technologies (i.e. IVF, ICSI etc). These clinics are located in the capital, Accra. Based on qualitative in-depth interview data obtained through convenience sampling of 45 respondents and nine key informants, the study noted the following: infertile men and women continue to desire to become biological parents based on both societal considerations and personal desires. Specifically, factors such as marital security,

children as social security and for purposes of inheritance and social status were at play. In addition, although the health seeking behaviour of respondents was influenced by both kin and non-kin actors, some respondents showed a degree of autonomy in the final decision taken regarding treatment. Explanations provided for the cause of infertility by both respondents and their friends and relatives led them to seek treatment from either the biomedical or spiritual healer. However, where such treatment options were unfavourable and/or did not achieve the desired results, some respondents moved from herbal treatment to orthodox treatment and vice versa. In addition, they intensified their efforts at obtaining healing by complementing biomedical healing with spiritual healing. Finally, respondents accessing ART treatment were found to select aspects of the treatment procedure that created the least forms of dissonance for them based on socio-cultural, religious and personal considerations. The use of these technologies were not seen as conflicting with religious beliefs as in most cases, respondents drew on religion to explain treatment successes and failures.

The study therefore recommends, amongst other things, that medical herbalism should be developed due to the continued reliance on herbal treatment. Some infertility treatments should also be considered for incorporation into the National Health Insurance scheme to improve access and reduce the burden of infertility. People also need to be well informed about treatment options while reducing the negative effects of media advertising. Future studies should also cover other major cities of the country and include an exploration of other modern treatment options such as surrogacy and the incidence of reproductive tourism as well as target those who may not be accessing any form of formal treatment.

TABLE OF CONTENTS

DECLARATION	i
DEDICATION	i
ACKNOWLEDGEMENT	iii
ABSTRACT	v
TABLE OF CONTENTS	vii
LIST OF TABLES	xiii
LIST OF ABBREVIATIONS	xiv
CHAPTER ONE.....	1
INTRODUCTION TO THE STUDY	1
1.0 BACKGROUND	1
1.1 THE PROBLEM.....	5
1.2 OBJECTIVES OF THE STUDY	10
1.3 SIGNIFICANCE OF THE STUDY	11
1.4 DEFINITION OF TERMS	15
1.4.1 Infertility	15
1.4.2 Marriage	15
1.4.3 Medical herbalism.....	16
1.4.4 Low-tech treatment	17
1.4.5 High-tech treatment/Assisted Reproductive Technologies (ARTs).....	17
1.4.6 In-vitro fertilization (IVF).....	17
1.4.7 Intra Cytoplasmic Sperm Injection (ICSI)	18
1.5 ORGANISATION OF THE THESIS.....	18

CHAPTER TWO	22
LITERATURE REVIEW	22
2.0 INTRODUCTION	22
2.1 INFERTILITY: PREVALENCE, TYPES AND CAUSES	22
2.2 THE GENDERED EXPERIENCES OF INFERTILITY	25
2.3. BELIEFS AND PRACTICES ASSOCIATED WITH INFERTILITY AND ITS TREATMENT IN GHANA	29
2.4 TRADITIONAL APPROACHES TO MANAGING AND TREATING INFERTILITY	33
2.5 MODERN APPROACHES TO TREATING INFERTILITY	37
2.5.1 Infertility treatment via Medical Herbalism.....	39
2.5.2 Infertility treatment via Low technology	41
2.5.3 Infertility treatment via Assisted Reproductive Technologies.....	44
2.5.3.1 The development and spread of ARTs in the West.....	44
2.5.3.2 Globalization of ARTs to the developing world	47
2.5.3.3 Access to ARTs	48
2.5.3.4 ARTs as gendered technologies	51
2.5.3.5 Effects of the emergence of ARTs in the West.....	53
2.5.3.6 Western technologies in non-Western worlds.....	54
2.6 CONCLUSION	58
CHAPTER THREE	60
RESEARCH METHODOLOGY	60
3.0 INTRODUCTION	60
3.1 RESEARCH METHODOLOGIES IN INFERTILITY STUDIES	60
3.2 PHILOSOPHICAL FOUNDATIONS OF THE STUDY	62

3.3 BRIEF PROFILE OF STUDY SITES.....	63
3.3.1 Lister Hospital and Fertility Centre - The High Tech Treatment facility	63
3.3.2 Champion Divine Herbal Clinic	66
3.3.3 Korle-bu Teaching Hospital.....	67
3.4 METHODOLOGICAL CHOICES.....	69
3.4.1 Selecting and negotiating access to research sites	69
3.4.2 Target population	72
3.4.3 Sampling size and procedure	72
3.4.4 Data collection instruments.....	73
3.4.5 Additional data sources	75
3.4.6 Negotiating access to potential respondents and initiating the data collection process.....	76
3.5 ETHICAL CONSIDERATIONS	79
3.6 ANALYSIS OF DATA	80
3.7 REFLEXIVITY	81
3.8 CHALLENGES ENCOUNTERED IN THE FIELD	83
3.9 LIMITATIONS OF THE STUDY	86
3.10 CONCLUSION	87
CHAPTER FOUR.....	88
THE RESPONDENTS AND THEIR REASONS FOR DESIRING BIOLOGICAL PARENTHOOD	88
4.0 INTRODUCTION	88
Ophelia’s story.....	88
Belinda’s story.....	89
4.1 THE CLIENTS’ PROFILES	92

4.1.2 The Age factor	97
4.1.3 Duration of marriage	99
4.1.4 Type of infertility	99
4.2 REASONS FOR WANTING CHILDREN	101
4.2.1 Marital security	101
4.2.2 Social Security and/or Inheritance	105
4.2.3 Other factors fuelling the desire for biological parenthood	111
4.3 DISCUSSION AND CONCLUSION	113
CHAPTER FIVE	121
QUEST FOR CONCEPTION: EXPLORING THE TREATMENT SEEKING BEHAVIOUR OF THE “INFERTILE”	121
5.0 INTRODUCTION	121
5.1. WHERE TO GO AND WHAT TO DO: EXPERIENCES OF “INFERTILE” MARRIED MEN AND WOMEN IN OBTAINING TREATMENT	121
5.1.1 Kin actors - Relatives: friends or foes	122
5.1.1.1 Mothers versus mothers-in-law	122
5.1.1.2 Spouses	127
The dilemma of having an absentee husband	131
5.1.1.3 Siblings and siblings-in-law	133
5.1.1.4 Extended family members	135
5.1.2 Non-kin actors	137
5.1.2.1 The church - a place for finding rest or restlessness?	137
5.1.2.2 Friends, colleagues and neighbours	140
5.1.2.3 Media advertisements	142
5.2. Patterns of treatment seeking	144

5.2.1 Simultaneous health seeking practice of respondents.....	145
Case study One - Herbal and spiritual treatment	146
Case study Two - Orthodox and spiritual treatment	146
5.2.2 Hierarchical health seeking practices.....	153
5.2.2.1 The preference for herbal treatment	155
5.2.2.2 The preference for orthodox treatment.....	158
5.2.2.3 The preference for spiritual treatment	159
5.3 Conclusion	161
CHAPTER SIX.....	166
ART USAGE IN GHANA: SOCIO-CULTURAL DIMENSIONS.....	166
6.0 INTRODUCTION.....	166
6.1 FEARS AND MISCONCEPTIONS ABOUT ARTs	167
6.2. CHOOSING THE LESSER EVIL	170
6.3 GENDERED DIMENSIONS TO ART USAGE	175
6.4 RELIGION AND ART TREATMENT	178
6.4.1 Explaining treatment successes - God is the ultimate healer	181
6.4.2 Explaining treatment failures	183
6.5 CONCLUSION	184
CHAPTER SEVEN.....	186
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS.....	186
7.0 INTRODUCTION.....	186
7.1 OBJECTIVES OF THE RESEARCH.....	186
7.2 RESEARCH METHODOLOGY	188

7.3 KEY FINDINGS FROM THE RESEARCH	189
7.4 POLICY IMPLICATIONS AND STUDY RECOMMENDATIONS	194
7.5 RECOMMENDATIONS FOR FUTURE RESEARCH	196
REFERENCES	199
APPENDICES	221

LIST OF TABLES

Table 1 – Monthly embryo transfers and success rates for the year 2013.....	65
Table 2 – Socio-demographic background data of study participants.....	93
Table 3 – Hierarchy of options.....	154

LIST OF ABBREVIATIONS

ARTs	Assisted Reproductive Technologies
CAM	Complementary and Alternative Medicine
GSS	Ghana Statistical Service
ICPD	International Conference on Population and Development
ICSI	Intra Cytoplasmic Sperm Injection
IVF	In Vitro Fertilization
TESE	Testicular Sperm Extraction
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION TO THE STUDY

There is no wealth where there are no children

Gyekye, 1996

1.0 BACKGROUND

Reproduction is the sure way of sustaining human life and societies have existed from generation to generation through this means. The ability to reproduce is often taken for granted due to the biological make-up of the human reproductive system which makes pregnancy a natural consequence of engaging in unprotected sexual activity. However, not everyone is able to reproduce during their lifetime. While some may voluntarily decide not to reproduce, others face circumstances that either prevent them or make it difficult for them to have their own children. Broadly speaking, the situation whereby a couple in their reproductive years are having sexual intercourse without the use of contraception but are unable to establish pregnancy within a year is medically referred to as infertility (Sciarra, 1994). It is a reproductive health problem that cuts across space and time.

However, socio-culturally, different societies define infertility in different ways based on the differing values attached to childbearing. Infertility may not necessarily denote the inability to bear children. Variations in these definitions are evident in terms of the time frame within which one is expected to get pregnant after marriage, sex preference of children, number of children one is expected to have and so on. In India, China and Korea for example, male children are preferred over their female counterparts mainly due to their economic benefits (Das Gupta et al. 2003). As such, women in these societies experience social pressure to produce male children

and their inability to do so results in them being regarded as infertile. This preference for male children, the absence of which results in being branded as infertile is also found in some African countries such as Ghana and Nigeria (Okonofua et al., 1997; Tabong & Adongo, 2013). Tabong and Adongo (2013) in their research on infertility in the Upper West region of Ghana found that, the inability to have many children was defined as infertility. In that study, they discovered that, although a couple could decide on the appropriate number of children to have, members of the society considered it ideal and appropriate for a married couple to have five children; any number less than that was therefore an occasion to be branded as infertile. Evidence from Egypt and Nigeria also shows that the acceptable time frame for married individuals to bring forth their own offspring is usually less than a year after the marriage (Inhorn, 1994; Okonofua et al., 1997). When this time elapses, societal members begin to define one as being infertile. All these examples provide evidence of the different socio-cultural meanings attached to infertility.

In order to gain a better understanding of the importance of infertility within the African social context, it is imperative to understand the importance of fertility in such contexts as well. The passion to conceive in Ghana as in many other African societies is anchored in the fact that children serve as social security for their parents in their old age (Caldwell, 1976; 1982). Children also bring prestige to parents, serve as free labour on their parents' farms, and help in perpetuating the lineage (Gaisie, 1972; Kamuzora, 1987; Nukunya, 2003). As a result of this, a lot of honour was attached to prolific childbearing in traditional Ghanaian societies. Amongst the Akans of Southern Ghana for instance, the birth of a tenth child heralded celebration. The woman who accomplished this feat was honoured with a public ceremony and she in turn offered her husband a ram (*badudwan*) as an appreciation to him for increasing the matriline by ten

(Agyei-Mensah, 2005). Women and men alike in such societies therefore aspired to receive such honour from their spouses and the community at large.

Beyond these expected familial and communal benefits, child bearing in African societies is culturally regimented to the extent that it is to be exercised only within wedlock and for a sizeable population, it remains the main purpose for marriage. As Mbiti (1990: 130) puts it “...marriage and procreation in African communities are a unity: without procreation, marriage is incomplete.” In addition, whereas in Western societies, reproduction is largely a personal choice made by the individual or couple and as such infertility does not always come along with societal implications (Pennings, 2008), the same cannot be said of pronatal African countries such as Ghana. Having children in Ghana is a social obligation due the family and community at large. Unlike Western societies, childbearing in the Ghanaian society is an important component of marriage.

The inability therefore to fulfil this obligation in marriage results in diverse social consequences in these societies targeted mostly at the women in such unions. Recent studies on infertility in the developing world have shown that it is mostly women in childless unions who suffer the shame and ridicule associated with childlessness. For instance, Nahar et al. (2000) report that infertile Bangladeshi women suffer marital insecurity, rejection and fear of abandonment from their spouses. In Cameroun, Feldman-Savelsburg (1994) reports that infertility is a ground for divorce and deprives the woman of access to land. In Ghana, Nukunya (2003) also points out how childless women face ridicule, humiliation and abuse from societal members. In Mozambique, Gerrits (2002) observes that infertility among the Macua ethnic group can result in the exclusion of infertile women from important social activities and ceremonies. In Nigeria, Okonofua et al.

(1997) report that women in childless unions suffer much more than their male counterparts. These women suffer abandonment, economic deprivation, physical and mental abuse, neglect as well as social ostracism.

In many traditional African societies which lacked sophisticated scientific knowledge and technology, there existed a number of practices which, intended or unintended, served as strategies to solving or coping with infertility. Anthropologists (e.g. Radcliffe-Brown, 1952) have documented various forms of polygamous or plural marriages which offered solutions to infertility. For example, polygyny, which was a common feature in traditional Ghana, allowed a man to marry more than one wife at the same time and this may solve an infertility problem in the first wife and consequently, childlessness in the home. This is because, social norms permit children born as a result of the sexual relationship between the man and his second wife to be regarded as children of the first (infertile) wife as well. This is by virtue of the fact that, these children are her husband's children. *Sororate* ("sister") marriages, common amongst such ethnic groups as the Dagaaba of Northern Ghana (Dery, 1987) also permit female siblings or cousins to marry their own sisters' husband and this could also serve the latent function of solving infertility problems in the first wife. There is also the practice of "female husbands" or woman-to-woman marriages which is typical among the Igbo of Nigeria - a situation whereby an infertile wife finds a young bride for her husband with whom he can have children. Children borne out of this arrangement are, however, adopted by the first wife as her own children, thus allowing such infertile women to "have" children (Amadiume, 1987). In parts of Kenya (Kershaw, 1973), Nigeria (Onah, 1992) and Sierra Leone (Harrel-Bond, 1975) amongst others, men gain *rights of genetricem*—that is, rights over the reproductive functions of wives. In this latter case, men have

exclusive rights over the offspring of their wives although they may have evolved out of extra-marital affairs. All these socially approved practices to a great extent provided respite for couples (both men and women) who were unable to have children of their own.

In addition to these marriage practices, many traditional African societies relied on indigenous knowledge to solve their infertility. For example, there existed traditional notions of fertility - enhancing foods specific to either men or women. Men were encouraged to eat tiger nuts whereas women were encouraged to eat a lot of yams. Anecdotal evidence from Nigeria for instance has suggested that, the high rates of twin births in some parts of the country can be attributed to their 'yam rich diet'. Myths about the potential of certain foods such as ripe plantain and okro in reducing men's fertility also existed. Spiritualists and diviners also provided charms and amulets to people who were seeking to conceive (Pobee, 1976) while the traditional herbalist (odunsini) who had profound knowledge in herbs (Twumasi, 1975) prescribed those herbs that enhanced fertility.

Fostering, a practice whereby people took care of the children of their relatives was also a common feature in the past (Caldwell & Caldwell, 1987). In such instances, a couple who was childless will take over the responsibility of raising a child (ren) of some other relative who had more children than they could adequately cater for. This helped reduce the burden of childlessness since they gained the experience of parenthood through this socially approved practice.

1.1 THE PROBLEM

Over the years, the burden of infertility has become more and more of a personal one rather than a shared burden. In the wake of modernity and social change induced mainly by Christian ideals,

formal education and medicalization amongst others, there has been increasing nucleation of the family and preference for monogamous marriages thus undermining some, if not most of these traditional strategies of solving infertility within the family structure. There is also an increasing emphasis on biological parenthood as opposed to social parenthood. Infertility is thus, to a greater extent, no longer being dealt with using the traditional methods outlined in previous paragraphs. This has led to a situation that Illich (1974) describes as cultural iatrogenesis, the destruction of traditional ways of dealing with life's situations brought on by the medicalization process. Cultural harm is therefore created because people lose the societal coping mechanisms to infertility. Nonetheless, the Ghanaian society remains largely pronatalist in orientation with childbearing considered as an obligation in every marital union. Given this situation, it could be expected that people would be willing to undertake all kinds of strategies on a more individualized level to ensure childbirth within their union.

Studies on the fertility seeking behaviour of people experiencing infertility problems in the developing world dating from the start of the twenty-first century have included such treatment - seeking options as biomedical treatments as well as traditional treatments employed by the infertile and rightly so. This is because, as some writers have observed, traditional healing methods fit into the traditional explanatory models about the causes of infertility (Gerrits, 2002; Mogobe, 2000; Nahar et al. 2000). This brings out the cultural relevance of these studies. However, few researchers have also studied the social and cultural aspects of biomedical infertility care as it applies to Sub-Saharan Africa. While only a few of these studies focus on low technology treatments (Hollos, 2003; Sundby & Larsen, 2006; Dhont et al., 2010 etc), even fewer focus on high technology treatments (Tangwa, 2002; Hadolt & Horbst, 2009; etc) despite

the increasing rates of provision of such services within the sub region (Giwa-Osagie,2002). Consistent with this literature, the existing studies in Ghana on the treatment seeking behaviour of the infertile focus mainly on the non-formalized modes of treatment employed by the infertile such as the use of traditional healers and spiritualists (Donkor, 2008; Tabong and Adongo, 2013). Other Ghanaian studies have also focused on biomedical treatments of infertility (Donkor and Sandall, 2007).

Missing from these recent studies, however, is research that examines the use of Westernized herbal medicine (medical herbalism) as a pathway for the treatment of infertility. To be sure, the practice of medical herbalism has infiltrated various parts of the Sub Region. In Ghana, this form of treatment is gradually being incorporated into the public health care sector albeit not for the purposes of treating infertility. People are beginning to subscribe to this form of treatment since it offers them a chance at receiving a systematic diagnosis and evaluation of their condition through laboratory examinations (something which traditional herbal medicine does not offer to them). At the same time, they derive the benefits that herbal medicine has over orthodox medicine which involves the use of extracts from the whole plant in preparing the medication and not just the use of only the most active constituents.

Anecdotal evidence shows that herbal clinics in Ghana that offer this Western style of herbal treatment and who have also incorporated infertility care as part of their services is gradually on the increase. Their role in infertility care can therefore not be overlooked since the demand for the service can be said to be what is contributing to its proliferation and subsequent gradual incorporation into the public healthcare sector. The omission of this form of infertility care in the

literature therefore does not do justice to the complete range of socio-cultural circumstances surrounding infertility and the responses to infertility within Sub-Saharan Africa in general and Ghana in particular. This study serves to fill this gap.

Furthermore, as previously stated, in spite of the globalization of assisted reproductive technologies that facilitate conception and the important role they play in seemingly solving infertility for many couples, few studies exist in sub-Saharan Africa and little is thus known about the ways in which these technologies are used and experienced by Africans. This research is therefore timely and will present a good sociological inquiry into this phenomenon.

The study also incorporates an analysis of the high level of religiosity exhibited by Ghanaians into their responses to infertility. The Global Index for Religiosity and Atheism (2012) placed Ghana first amongst the top ten most religious countries in the world with 96% of its population seeing themselves as religious people and only 2% stating otherwise. The Ghana Statistical Service (2013) also reveals that about 71.2% of Ghanaians are believers and practitioners of the Christian faith with 17.6% being Moslems and 5.2% being believers of traditional African religion. In tandem with these statistics, stories abound in both the print and electronic media in Ghana relating to spiritual healing of all types of ailments including infertility being offered by the charismatic and Pentecostal churches. ‘Men’ and sometimes ‘women’ of God as they are popularly called by their followers, often advertise prayer and healing sessions for people in search of the “fruit of the womb”. Moslem religious leaders popularly referred to as ‘mallams’¹ also feature in these stories. These are often spiritual healers who also utilize herbs in their treatment. The high level of religiosity in the country vis-à-vis the utilization of biomedical

¹ A traditional Moslem healer who utilizes herbs for the treatment of diseases.

treatments especially high tech treatments (where babies are created through the power of technology) presents a moot point- one worth exploring. Literature reviewed on treatment seeking for infertility in Sub-Saharan Africa showed that studies previously conducted had only focused on spiritual treatment relative to the African traditional religion to the neglect of the Western adopted religion of Christianity-another effect of Westernization.

In addition, most of the studies have focused solely on women (Donkor and Sandall, 2007; Donkor, 2008; Donkor and Sandall, 2009; Dyer et al. 2002; Hollos, 2003; Kielman, 1998; Mogobe, 2005; Yebei, 2000 etc). This study therefore seeks to bridge this gap by making the target group as all-encompassing as possible. Studies have shown that, both men and women experiencing infertility in a marital union also go through feelings of sorrow, guilt and isolation amongst others (Phipps, 1993) although these feelings may be expressed differently. Infertility concerns both men and women. It is therefore constructive to include both men and women who are experiencing infertility when conducting research on infertility.

Finally, a majority of the studies conducted in Sub-Saharan Africa (Bardon-O'Fallon, 2005; Denga, 1982; Gerrits, 2002; Leonard, 2002; Mammo & Morgan, 1986; Sekadde-Kigondu, 2004 etc) including Ghana (Ebin, 1982; Geelhoed et al. 2002; Tabong & Adongo, 2013) have been community based studies conducted in homogeneous peri-urban or rural settings. This study seeks to highlight infertility and its treatment within urban Ghana. The research is situated in Accra, a heterogeneous urban settlement where one is sure to find characteristics of all groups of people residing. This makes it more holistic. Accra is also characterized by a proliferation of social amenities and services of which infertility treatment services cannot be left out. One can count as many as nine high tech treatment centres located in the Accra-Tema metropolis alone not to mention the biomedical herbal clinics and low tech treatment facilities all over the city.

The surge in the provision of infertility treatment services (though mostly privately owned) within the nation's capital, Accra is perhaps a clear indication of the prevalence of infertility within the region and the country as a whole. However, the existence of these diverse treatment options for infertility brings to the fore the question of the extent to which these treatments are acceptable to the people it was meant for based on their socio-cultural circumstances.

To sum up, by highlighting the socio-cultural factors fuelling the fertility behaviour of Ghanaians, this study sought to provide an understanding of the social and cultural context within which infertile Ghanaian married men and women find themselves. This study explored the various strategies adopted by the infertile, the cultural nuances that played out and the consequences thereof. Few studies in Ghana exist that explore the treatment seeking strategies of infertile married men and women with particular reference to the use of Assisted Reproductive Technologies (ARTs) as well as scientific herbal medicines and low tech orthodox treatment. Each of these treatment options have differing clientele and the extent to which they are able to assist infertile men and women achieve desired conception. For example, one may ask, what determines one's choice of treatment? Are these various strategies being used exclusively or simultaneously or sequentially with other strategies and why? Does their usage come along with contestations and if so, how are these resolved? These types of questions provided the motivation to carry out this exploratory study into the health-seeking behaviour of infertile married men and women in contemporary Ghana and the factors that fuel such behaviour.

1.2 OBJECTIVES OF THE STUDY

The main objective of this study was to understand the present socio-cultural factors fuelling the desire for married men and women in contemporary Ghanaian society to address their infertility

as well as the experiences of these individuals as they seek treatment for their infertility. In addressing this objective, the following specific questions were developed for study:

1. What categories of people are utilizing fertility treatments such as low-tech treatments, medical herbalists and ARTs?
2. What are the motivations of the people who seek these treatments?
3. What determines their choice of treatment?
4. What processes do they follow in seeking treatment?
5. What contestations exist between couples and others over treatment choices and how are these resolved?
6. How does the social, religious and cultural context configure the meaning infertile couples make of ARTs?

1.3 SIGNIFICANCE OF THE STUDY

Although infertility has been a part of our human existence since time immemorial, social and cultural studies on infertility in Sub-Saharan Africa arguably began to take root only in the latter part of the twentieth century. Studies conducted by Ebin (1982), Mammo & Morgan (1986), Sangree (1987), amongst others, provide good illustrations of cultural responses to infertility in the various societies of South-West Ghana, rural Ethiopia, Kenya and Nigeria respectively. Since the beginning of the twenty-first century, the amount of studies conducted on the social and cultural aspects of infertility on the sub-continent continue to increase. Notable amongst them are studies conducted by Barden-O'Fallon (2005), Dhont, Luchters, Ombelet et al. (2010), Donkor & Sandall (2007), Feldman-Savelberg (2002), Gerrits (2002), Hollos & Larsen (2008), Horbst (2006), Leonard (2002), Mogobe (2000), Orji, Kuti & Fasubaa (2002), Sundby (2002) and

Sundby & Jacobus (2001). These studies were conducted within varying socio-cultural contexts in the respective countries of Malawi, Rwanda, Ghana, Cameroun, Mozambique, Tanzania, Mali, Chad, Botswana, Nigeria, Gambia and Zimbabwe. The authors shed light on the meanings and implications of infertility as experienced by the people in these various social settings. Some of these studies show that, the way in which the people in these various socio-cultural contexts have dealt with infertility has been largely shaped by their social and cultural circumstances as well as by the traditional health care systems available to them (Gerrits & Shaw, 2010).

The medicalization of infertility is one product of development which has trickled down from the developed world to the developing world. Infertility has thus gradually moved from being a socially defined condition to a medical one. In response to this effect of globalization and the increasing Westernization of these non-Western societies, research on present day responses to infertility is imperative. The effects of this medicalization of infertility in comparatively less developed societies need to be explored relative to the different social contexts. Some of the studies outlined in the previous paragraph have sought to do that. However, the extent to which the medicalization of infertility has penetrated the societies of Sub-Saharan Africa is not commensurate with research on the socio-cultural effects of this medicalization process.

This study sought to contribute to the literature on infertility and its medicalization by highlighting the 'modern' ways in which people experience, explain and deal with infertility in an urban Ghanaian setting. The cultural ideals existing in contemporary Ghana regarding reproduction continue to emphasize childbearing as an integral part of married life. Married couples experiencing difficulties with childbearing thus continue to be compelled into resolving their infertility. In Ghana today, avenues available for resolving such a societally undesirable circumstance include biomedical health care services in the form of low tech treatments, medical

herbalism and the highly modernized use of assisted reproductive technologies such as in-vitro fertilization and intra-cytoplasmic sperm injection. Being a highly religious country with about seventy one percent (71%) of its populace being Christian, faith-based healing is also an integral part of the repertoire of infertility treatments.

Knowledge gleaned from this research will contribute meaningfully to the medical anthropological and sociological discourse on infertility and infertility care. The research is all the more relevant as it targets an understanding of present day responses to infertility in this era of globalization and increasing Westernization of the Ghanaian society. On one hand, assisted reproductive technologies are a Western construct and may have implications when adapted in non-Western communities such as Ghana. Local considerations, be they cultural, religious, social etc may shape the ways in which these technologies are offered, used and experienced by these non-Western societies. An understanding of these local considerations therefore becomes significant in appreciating the acceptability and utilization patterns of Assisted Reproductive Technologies in Ghana.

On the other hand, an exploration of the relatively less expensive treatment options available in contemporary Ghana with particular reference to the use of herbal treatment and low tech orthodox treatments offered in public hospitals in Ghana makes it more encompassing. It brings to the fore the indigenous ways in which ordinary Ghanaians seek solutions to their infertility. It also unravels any differences that may exist in terms of local understandings of reproductive biology, gender dynamics within marriage, class-based barriers to access as well as local versions/understandings of infertility.

This knowledge is important in order to formulate a comprehensive reproductive health agenda in Ghana targeted at reducing the burden of infertility on those affected. Whatever knowledge and insights gained from the study may thus be useful to think-tanks both locally and internationally. Available literature also points to the fact that, it is the women in marital unions who often bear the brunt of infertility although they may not always be responsible for their condition. These women also become the objects of treatment and are often the ones who undergo the complex treatment procedures since their biological make-up makes them the carriers of the embryo- a product of the medicalization process. The research findings thus draw awareness to issues of the rights of women to safe and affordable reproductive health care with respect to prevention as well as treatment of infertility.

The 1994 United Nations International Conference on Population and Development held in Cairo defined reproductive health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so (United Nations, 1994). At the conference, a reproductive rights agenda was developed and had as one of its issues for future action, ‘the prevention and appropriate treatment of infertility where feasible’. However, almost two decades down the line, only a few developing countries (excluding Ghana), government agencies and clinics have made attempts at achieving this by starting to formulate policy and guidelines for the treatment of infertility, including regulations for institutionalizing and use of modern reproductive technology (Okonofua, 1996; Rowe, 1999). In addition, at a WHO meeting in Geneva in 2001, it was stated

that, infertility be recognized as a public health issue in all parts of the world including developing countries. Findings from the study may therefore contribute to policy in this regard.

1.4 DEFINITION OF TERMS

The thesis makes use of certain terms which are defined in this section. The definitions as provided were employed throughout the entire research process and have been provided here as a guide to the reader.

1.4.1 Infertility

Infertility is medically defined as the inability (for couples of reproductive age who are having sexual intercourse without contraception), to establish a pregnancy within a specified period of time usually one year (Sciarra, 1994). In addition to this medical definition, socio-cultural definitions of infertility also exist and differ from society to society. In this study, social definitions regarding the acceptable number of children to have as well as the sex of children that one desires to have are included in the study. Furthermore, infertility is of two types namely primary infertility and secondary infertility. Primary infertility denotes childlessness (or having no children) whereas secondary infertility refers to the inability to have an additional child after a successful live birth.

1.4.2 Marriage

Marriage is universal to all human societies but its form and nature differs from society to society. Reporting on his cross-cultural survey of various societies in North America, Africa, Oceania, Eurasia and South America, the renowned family sociologist, Murdock (1949), defined marriage as a union in which both the economic as well as the sexual components of the

relationship between a man and a woman are united into one relationship. According to Murdock (1949:1),

marriage defines the manner of establishing and terminating the relationship between a sexually associating pair of adults, the normative behaviour and reciprocal obligations within it, and the locally accepted restrictions upon its personnel.

Nukunya (2003: 42) also defines marriage as “any union in which the couple has gone through all the procedures recognized in the society for the purposes of sexual intercourse, raising a family or companionship”. This definition was adapted in selecting the participants for this study. To further clarify, the union must be a heterosexual one (between a man and a woman) since that is the legally and socially acceptable relationship in Ghana today. In addition, the procedures that are recognized in contemporary Ghanaian society today are customary marriage, marriage under the ordinance and Islamic marriage.

1.4.3 Medical herbalism

Medical herbalism is complementary or alternative medicine (CAM). It involves the combination of knowledge of traditional plant remedies with modern medical science. It is holistic medicine in the sense that it seeks to address the underlying causes of ill health in each patient as well as treating their symptoms. Medical herbalists use the healing power of plants to treat a wide range of medical conditions. They are health care providers trained in Western orthodox medical diagnosis who use plant based medicines to treat their patients. Whereas many conventional medicines are based on chemicals found in plants, herbalists use whole parts of the plant (such as leaves, berries or roots) as they believe this makes a more ‘balanced’ natural remedy. Medical

herbalists specialize in Western herbal medicine, Chinese herbal medicine or Indian herbal traditions.

1.4.4 Low-tech treatment

Low-tech treatment, according to Fidler and Berstein (1999), refers to infertility treatment that involves fertilization outside the body. They include such processes as the use of fertility drugs to stimulate superovulation (the development and release of more than one egg per ovulatory cycle) and intrauterine insemination (a process by which sperm are placed inside a woman's cervix to facilitate fertilization). In this study however, intrauterine inseminations are not included in the category of low tech treatment. This is because, these services rarely form a part of basic infertility treatment and are thus provided only by specialist (fertility) hospitals.

1.4.5 High-tech treatment/Assisted Reproductive Technologies (ARTs)

High tech treatment refers to treatments that involve the handling of human eggs and sperms for the purpose of helping establish pregnancy. The common ARTs include In-Vitro Fertilization (IVF) and Intra Cytoplasmic Sperm Injection (ICSI).

1.4.6 In-vitro fertilization (IVF)

In vitro fertilization is the most common type of assisted reproductive technology. When medical conditions prevent the sperm from reaching the egg, this procedure helps in the fertilization. It involves the fertilization of an egg by a sperm outside the human body. The term *in vitro* is Latin and means glass referring to glass containers such as test tubes, petri dishes or beakers. The procedure involves monitoring and stimulating a woman's ovulatory process, removing ova from her ovaries, inseminating them in the laboratory with a male's sperm and subsequently inserting back into the uterus as a fertilized embryo with the intention of establishing a successful

pregnancy. This is done after it has been cultured in a growth medium over a period of two to six days. In some cases, there is embryo cryopreservation. With embryo cryopreservation, excess embryos of good quality are frozen and stored for future transfer. A colloquial term used to refer to babies born through these means is the term *test tube babies*.

1.4.7 Intra Cytoplasmic Sperm Injection (ICSI)

Intra Cytoplasmic Sperm Injection is an assisted reproductive technology commonly used to treat sperm related infertility problems. As the name implies, it involves the direct injection of a single sperm into a mature egg and is used to enhance the fertilization phase of IVF. The fertilized egg is then placed in the woman's uterus. Additionally, ICSI may be used to aid in the fertilization process when eggs cannot be easily penetrated by sperm.

1.5 ORGANISATION OF THE THESIS

This thesis is organized in two parts. The first part provides the general introduction to the study, a review of literature underpinning the study as well as a report on how the fieldwork was undertaken. This constitutes the first three chapters of the thesis. The second part deals with the empirical findings of the research. It is also made up of three chapters and reports on the respondents and the social and cultural factors driving their desire for biological parenthood, their health seeking behaviour and the social and cultural dimensions of ART usage in Ghana. The overall summary and conclusions of the thesis are presented in chapter seven.

In chapter one, the writer sets the scene for the study by presenting a historical overview of infertility and how it was experienced and managed in the past. The chapter also highlights the importance of children in marriage and provides a review of the plural marriage forms that served the latent function of relieving one partner from bearing the entire burden of infertility.

Other traditional means of coping with infertility such as fostering, the role of the traditional herbalist and notions of fertility enhancing foods amongst others are also discussed. The chapter subsequently discusses the gap that this study seeks to fill by pointing out the changing nature of the Ghanaian society through the influences of urbanisation and Christianity and the need to explore present day experiences of, and responses to, infertility in the light of these changes. The objectives of the study are specified as well as the significance of such a study. The chapter concludes by defining certain key terms and concepts utilized in the thesis.

Chapter two provides an extensive literature review on ethnographic studies conducted on infertility in various parts of the world starting from the developed countries of Europe and America to the developing countries of Asia and Africa with particular emphasis on Sub-Saharan Africa. It highlights the experiences of infertility in these various cultural contexts as well as the different ways in which the infertile have dealt with their infertility within the various contexts. Traditional ways, biomedical ways and the new assisted reproductive technologies are the various treatment seeking strategies that are reviewed in the chapter.

Chapter three provides an extensive report on the fieldwork. This study was conducted in the urban heterogeneous capital city of Ghana, Accra. The rationale for this selection as well as the methodological choices employed in the study are discussed. The study was a multi-site study of three clinics/hospitals in Accra where infertility care services are provided. Two of the sites are privately owned and the third one is a government hospital. Clients and key informants in the form of health personnel were selected from these sites for the study. Additional data sources included key informant interviews with religious leaders, an interview with the chief executive officer of a non-governmental organisation targeted at childless couples, observation of a prayer session for people wanting to have babies of their own as well as media advertisements and

programs on infertility. The chapter concludes with a brief profile of the study sites and the core services being offered to clients of these facilities. Fieldwork and study limitations are also noted.

In chapter four, the characteristics of clients utilizing infertility care services provided by a medical herbalist, government orthodox hospital as well as an IVF clinic are introduced to the reader. An analysis is made of such socio-demographic characteristics as the sex of respondents, ages of respondents, their duration of marriage as well as the type of infertility being experienced. The chapter further analyses the various motivations behind respondents' search for treatment highlighting any changes in motivations in comparison with the past. It concludes with a discussion of the sociological concepts of structure and agency which were seen as informing respondents' desire to become biological parents.

Chapter five reports on the health seeking behaviour of the respondents. This is presented in two parts. The first part delved into the various contestations that exist between couples and significant others over treatment options and the role of the various actors in the decision making process towards treatment. It also includes in the discussions the effects of the contributions of these various actors especially the various ways in which these contributions serve either as an increased burden for the infertile or as a relief. This is based on the backdrop that, health seeking behaviours of the 'sick' are influenced by various actors who form a part of their lives. The second part of the chapter reports on the patterns of health seeking behaviour employed by respondents. This is based on the plural medical systems in Ghana and highlights both the simultaneous and hierarchical treatment seeking patterns of respondents and the various reasons informing such treatment seeking behaviour.

Chapter six discusses the ways in which the Ghanaian's social, cultural and religious context influence the acceptability and usage of Western biomedical treatment options with particular reference to Assisted Reproductive Technologies. It discusses the various ways in which respondents rationalize and navigate their use of Western technologies in areas where its usage conflicts with socio-cultural, religious and personal values.

Chapter seven concludes the thesis by providing a summary of the findings of the research as well as recommendations for future research and policy.

CHAPTER TWO

LITERATURE REVIEW

2.0 INTRODUCTION

This study explored the experiences of infertile couples who utilize herbal and orthodox treatments (including Assisted Reproductive Technologies) in their search for conception. To gain a better understanding of this study, the chapter examines the literature on the subject of infertility. Literature is reviewed on the worldwide prevalence of infertility, the types and the various causes highlighting its severity and preventable nature in the developing world, specifically, Sub-Saharan Africa. In addition, the different meanings attached to infertility in various contexts are captured with evidence from both the developed and the developing world. An overview of some anthropological research on the search for conception by infertile couples across space and time with reference to traditional as well as Western approaches including the adoption of Western technologies in non-Western societies concludes the segment on literature review.

2.1 INFERTILITY: PREVALENCE, TYPES AND CAUSES

Infertility is a condition of our human existence. Current global estimates of infertility range between 8%-12% of couples in their reproductive years (Reproductive Health Outlook, 2002). This proportion translates into between 50-80 million of the world's population (Sciarra, 1994). There are, however, regional variations in the prevalence of infertility. Whereas the developed countries record infertility rates of between 5% and 10%, the problem is more severe in the developing world. Asia and Latin America record rates similar to the global rate of between 8 and 12%. In East Africa, infertility ranges between 8 and 13%, figures which are much lower than those recorded in Southern Africa (15-22%). Infertility rates among married couples range

from 15%-30% in Sub-Saharan Africa with some countries recording some of the highest rates of infertility in the world (Okonofua, 2003). Ghana is no exception when it comes to this. A study by Donkor and Sandall (2009) pegs the infertility rate of women in Ghana of childbearing age at 15%. Some community studies have also revealed high rates of infertility. For instance, a study conducted in the Berekum District in rural Ghana revealed an infertility rate of 11.8% among women and 15.8% among men (Geelhoed et al. 2002). These prevalence rates confirm the fact that Africa records the highest rates of infertility (WHO, 1991).

Related to the rates of infertility across regions are the factors that cause infertility as well as the type of infertility being experienced. Generally speaking, according to Vayena et al. (2002), infertility occurs in every 15% of couples worldwide. Out of this number, 30% are attributable to male factors such as azoospermia (no sperm cells produced), oligospermia (few sperm cells being produced), malformation of sperm cells, genetic and / or chromosomal abnormalities amongst others. Another 30% is attributed to female factors such as ovulation disorders and blocked fallopian tubes as well as some congenital / birth defects involving uterine fibroids and/or the structure of uterus. In some situations, infertility is caused by a combination of male and female factors and this is said to account for another 30% of cases. The remaining 10%, however, falls into a category of unexplained factors. All these factors point to the complex nature of conception that depends on a variety of factors to be successful. Starting from the production of healthy sperm by the male and healthy eggs by the female, unblocked fallopian tubes that will allow the sperms to move towards the egg, the ability of the sperm to fertilize the egg when they meet, the ability of the fertilized egg (embryo) to be implanted in the woman's uterus and finally sufficient embryo quality all add up to making conception possible. Thereafter, the embryo must continue to remain healthy and the woman's hormonal environment must

remain adequate throughout the development of the embryo for the pregnancy to be able to continue to full term. When even one of these numerous factors is impaired, the resulting effect is infertility.

In addition, infertility resulting from such natural causes as anatomical, genetic, hormonal and/or immunological problems affects about 5% of couples worldwide and is accountable for primary infertility. This figure does not vary much across regions and countries (Reproductive Health Outlook, 2002). Variations in prevalence rates of infertility across regions and countries, however, become more pronounced when preventable causes are examined which also accounts largely for secondary infertility (*ibid*). Most of the infertility that occurs in sub-Saharan Africa is as a result of untreated reproductive tract infections (namely postpartum infections, post abortion infections and sexually transmitted infections) and are thus preventable. Evidence from a WHO multi-national study attests to this. Eighty-five percent (85%) of infertility cases diagnosed were as a result of these infections (Cates et al., 1985). Anthropologists who study infertility in Africa have also documented the extent to which a large number of infertility cases on the continent are preventable. Their findings show that reproductive tract infections are the leading preventable causes of infertility in Africa (Bentley and Mascie-Taylor 2000; Brady 2003; Inhorn 1994, 2003a,b; Nachtigall 2006; van Balen & Gerrits, 2001). The “infertility belt of Africa” which refers to the stretch across Central Africa from Tanzania in the East to Gabon in the West earned its name as a result of these high rates of infertility in the region attributed largely to these infections (Leonard, 2001). Furthermore, some studies both in the developed and in the developing world have shown that, men are the main causes of infertility or were a contributing cause to it (Cates et al. 1985; Vayena, Rowe & Griffin, 2002)

2.2 THE GENDERED EXPERIENCES OF INFERTILITY

Although infertility can be biologically or medically determined, its meanings and effects vary from society to society. The experience of infertility is a shared reality of couples and/or individuals shaped by the specific social context within which they find themselves. It is associated with varying psychological and socio-cultural consequences for the one that is affected. In Western societies, studies on the effects of infertility on both men and women do not show any remarkable differences experienced by both sexes as a consequence of their infertility. Abbey, Andrews and Halman, (1991) for example in their survey in the United States of 185 infertile couples and 90 presumed fertile couples reported that the American society places emphasis on women's role as mothers. However, the consequences of infertility are experienced on a personal level rather than on a societal level with both infertile married men and women experiencing feelings of depression and helplessness. Similarly, in the Netherlands, Van Balen and Trimbos-Kemper (1993), in a study of 108 childless couples who were experiencing long – term infertility found out that these group of women experienced lower self-esteem and lower well-being than other women in general with no similar difference found between infertile men and men in general. The focus in the Western world on the psychological consequences of infertility could be attributed to the fact that, the prevailing cultural and economic circumstances of these countries make infertility a personal rather than a societal problem. As suggested by Pennings (2008), reproduction in Western societies is more of a self-chosen goal. This therefore makes studies on the psychological effects of infertility more relevant within these contexts.

Beside the individual level, the effects of infertility on marriage have also been explored. These studies report that infertility has positive effects on marriages in the West (Baram et al., 1988; Schmidt et al., 2005; Van Keep, 1973). This is especially evident in couples who undergo

treatment together since the process brings them closer together. This effect of bringing couples closer together is also attributed to their shared experience of having to adapt to infertility.

Greil (1997) in his review of the literature on the social and psychological effects of infertility with particular reference to the relationship between gender and infertility has, however, pointed out that writers who have conducted their studies on infertility in countries such as the United States, the United Kingdom and parts of Europe place little emphasis on the social construction of infertility. He is of the view that, although the various authors have portrayed these experiences as individual traits of the infertile, they are conditioned to a great extent by their social realities.

This seems to be more obvious in the studies on the effects of infertility in the developing world where scholars working with a social constructionist perspective point out clearly the differences in gender experiences of infertility based on the meanings and interpretations that society gives to infertility. The societal value placed on prolific childbearing in many of these societies stems from the fact that, children are highly valued for their economic, religious and personal benefits. Reproduction is therefore largely a social obligation due the family and the community at large (Pennings, 2008). As such, the inability to fulfil this societal obligation comes along with varying societal consequences. In such societies, women in particular bear the brunt of infertility and undergo high levels of stigmatization from other societal members. The experience of an infertile woman in such a context is further buttressed by Mbiti (1990: 110) when he says:

unhappy is the woman who fails to have children for, whatever other qualities she might possess, her failure to bear children is worse than committing genocide: she has become the dead end of human life, not only for the genealogical line but also for herself.

Evidence from anthropological studies conducted in some developing countries have revealed the nature and extent to which women in childless and/or infertile unions are stigmatized by the society in which they find themselves. This stigmatization comes in various forms ranging from divorce, abuse, loss of social status, gossip, lack of participation in community activities amongst others.

In Bangladesh for instance, Nahar et al. (2000) report that infertile women experience a lot of verbal abuse from family and community members. They also experience marital insecurity, rejection and a fear of abandonment by their husbands. In Cameroun, Feldman- Savelberg (1999), reports that infertility leads to stigmatization of women and can contribute to their impoverishment. Rural Bangate women, the subjects of her study, stand to lose their pride and full adult status if they are infertile. Among the Sara of Chad, Leonard (2002) reports that women who are unable to conceive are regarded as destined by nature to be sterile and are considered inferior in status to other women. In Egypt, Inhorn (1991) reports that infertile women otherwise referred to as '*umm il-ghayyib*' or 'mother of the missing one' face such societal consequences as outright divorce or polygynous marriage from their husbands, stigmatization from extended family members and outright ostracism from the community of fertile women. Sundby (1997) also provides evidence from Gambia to the effect that many infertile women experience marital instability and psychological suffering as a result of scorn and gossip from family and community members. An example of such gossip is given as ".....there are no women in that house, only two men-since she has no child" (Sundby, 1997: 34).

Donkor (2008) in her study in Ghana also refers to the stigmatization of Ghanaian infertile women as a common social consequence of infertility within the country. This stigmatization is evidenced in the form of verbal abuse, gossip and quarrels coming from family and societal

members. Furthermore, according to Liamputtong-Rice (2000), amongst the Hmong of Laos, women who are unable to bear children for their husbands end up in polygynous marriages. They face a similar fate when they are unable to bear sons and/ or bear as many children as their mother or their mother-in-law. Gerrits (1997) also reports that in Mozambique, infertile women are excluded from societal events and ceremonies. In Nigeria, Okonofua et al. (1997) report that infertile women risk expulsion from their husband's house. They also stand the risk of being excluded from inheriting their husband's property, may not be included in decision making within the family and risk having any financial or social security amongst others.

In South Africa, Dyer et al (2002) in their study of 30 women seeking treatment for infertility reported that these women experienced psychological suffering, marital instability, stigmatization and abuse from members of their family and the community as a whole. In Tanzania, Kielman (1998), reports that among the Pemba, infertile women risk losing their marriages. These various accounts of stigmatization suffered by women in African countries provide a worrying picture of the situation of infertile women in such societies and suggest the experience of even dire psychological effects as a consequence of the intensity of the societal effects being experienced.

Despite all these reported effects of infertility on women, some studies conducted in the developing world, specifically in some parts of Sub Saharan Africa and the Indian subcontinent have also revealed the negative effects that infertility has on the lives of men. Among the matrilineal Macau of Mozambique for example, men are often blamed for infertility with their wives (and their family members) calling for a divorce in such childless unions (Gerrits, 1997). Male infertility is also sometimes conflated with impotence and as such is amongst the most stigmatized of male health conditions in Egypt (Inhorn, 2004). Infertile men in India also suffer

social disgrace and are regarded as ‘*namard*’ or ‘lacking in masculinity’ (Gujjarappa et al., 2002). Furthermore, research conducted by Nene et al. (2002) of middle-class families in India revealed that, some of the men in these infertile unions experienced arguments, humiliating comments and the use of sarcastic language amongst others from their wives. Bharadwaj (2000) in his study of infertile couples visiting fertility clinics in India also found out that infertile men and women equally suffered from the stigma associated with their condition.

In sum, evidence provided by the various studies portrays a gendered dimension to the experiences of infertility in marriage in the developing world. Women in such societies suffer the most from the social consequences of infertility as compared to their male counterparts. Evidence from the developed world however points to the shared experience of psychological consequences of infertility by both men and women in such societies.

2.3. BELIEFS AND PRACTICES ASSOCIATED WITH INFERTILITY AND ITS TREATMENT IN GHANA

In Ghanaian traditional religion, the hierarchy of authority which formed the basis of the religion consisted of different supernatural beings namely the Supreme Being, the ancestors and the other gods. Each of them had a role to play in the fertility of the individual. Although the Supreme Being was regarded as the omnipotent, he was believed to work through the other deities since he was too powerful to be approached directly. The ancestors are believed to give children to the living for the continuance of the lineage. Believers therefore pray to the ancestors for fertility. Among the Akans, this is referred to as ‘*abawotum*’ (Pobee, 1976). In addition, there are fertility gods that are believed to endow people with fertility. Anyone desirous of children therefore prays to such gods and offers the necessary sacrifices for obtaining such blessings from the gods. Children born through these means could then be named after these gods. Some trees are also

believed to be inhabited by spirits which make people fertile (Eshun, 2011). Cutting down such trees therefore meant invoking the wrath of the spirit that was dwelling in the tree and punishment for this act came in the form of infertility (ibid).

Furthermore, the ancestors and the gods are believed to bless those who are good with many offspring. However, one form of punishment for evil was seen in the inability to conceive. As Caldwell and Caldwell (1987) put it, traditional African religion affects fertility behaviour in the sense that, fertility is equated with virtue and spiritual approval whereas reproductive failure or cessation is regarded as a consequence of sin.

Apart from the role of these deities in the fertility of the individual, witches also form an integral part of the traditional religious belief system and consequently, one's fertility potential. Witches are regarded as instruments of darkness that cause evil and misfortune to others. One of such misfortunes could be infertility. Sackey (2002), reports that the common belief in traditional Ghanaian society was that witchcraft was responsible for infertility. Meyer (1994) in her research in Ghana and Okonofua et al. (1997) in their research in Nigeria, also reported that witchcraft was often blamed for one's infertility. One way of combatting the effects of witches and to secure one's fertility was through the use of charms or amulets also referred to as *suman* (Pobee, 1976). These may be objects worn on or around different parts of the body and believed to be the repository of power derived from the gods or spirits.

The traditional rites of passage form another aspect of Ghanaian traditional religion that has influence on fertility behaviour and connotes the importance of fertility. One of such rites of passage is the puberty rites, a ceremony that is performed to signify the transition from childhood

into adulthood. In some communities, the ceremony involves, among other things, the swallowing of an egg in its whole state by the girl who has reached the stage of puberty. This act is believed to bestow upon her the ability to be fertile when she gets married. The rites in itself are performed to usher the girl into marriage. As previously mentioned, the main purpose of marriage is procreation. As such, barrenness and sterility in marriage are not uncommon grounds for divorce (Pobee, 1976).

With the advent of Christianity and Islam into the country, other beliefs associated with infertility and its treatment have emerged in Ghana in line with Christian and Islamic beliefs. According to Christian beliefs, man was admonished by his creator to “be fruitful and multiply....” (Genesis 1:28). The primary value of a woman in biblical times lay in her chastity and after marriage, her reproductive ability. These may explain the desire to reproduce on one hand and the negative reactions that one suffers from members of the society if this God given obligation is not fulfilled. Evidence from the Bible, the guiding principle of Christians, suggests that God blesses his people with the capacity to reproduce when they do according to his will. “Your wife will be like a fruitful vine within your house...” (Psalm 128:3) and “.....none of your men or women will be childless....” (Deuteronomy 7: 14) are a few examples to that effect.

However, there is evidence from the Bible pointing to the fact that childbirth was not necessarily an automatic consequence of the union between a man and a woman, nor was it always a consequence of doing God’s will. Biblical accounts attest to the fact that, as far back as the period before Christ, women have had challenges with conceiving and have sought help from their God. Names of such women include Sarah (Genesis 21: 1-2), Rebekah (Genesis 25:21), Rachel (Genesis 30: 22-23), Hannah (1 Samuel 1), and Elizabeth (Luke 1) amongst others. Some

of these women suffered mockery and ridicule at the hands of their relatives and other members of society due to their childlessness. However, many of them were able to be healed of their infertility through their fervent prayers to God and subsequently gave names to their children that depicted the role of God in the making of the child. However, not all women in biblical literature were able to overcome their infertility. An example of a woman who remained childless in the Bible is Michal, King David's first wife (1 Samuel 19). Others are Anna (Luke 2:36-38), Esther (the book of Esther), Moses' Egyptian mother (Exodus 2: 1-10) etc. This brings out the important question as to whether biological parenthood is essentially an obligation as quoted in Christian literature. In Luke 23:28-29, it is recorded that during the crucifixion of Jesus, he addressed the women of Jerusalem saying: "a time will come when you will say, Blessed are the barren women, the wombs that never bore and the breasts that never nursed!" This is a strong statement that could serve as a consolation to those who are having challenges in becoming biological parents. However, the extent to which this statement uttered by the person on whom Christianity is built is known and acceptable by its followers presents a moot point.

Furthermore, Islamic beliefs and practices associated with infertility and its treatment are similar to that of traditional religious beliefs as well as Christian beliefs. In the holy book of the Moslems, the Quran, it is written "...we cause whom we will to rest in the womb for an appointed term, then do we bring you out as babes....." (Quran 22:5). We, here refers to Allah or the Moslem God. This also brings to the fore the issue of conception being controlled by a supernatural being namely Allah. Likewise, barrenness is seen as a decree from Allah, "...He leaves barren whom He wills... (Quran 42:50). However, this situation of infertility may not necessarily be a consequence of one's disobedience. Rather, Allah is seen as all knowing and competent and His actions can therefore not be questioned. Such occurrences may therefore be

seen as a test of faith. Accounts are given of couples who found it difficult to conceive. Ibrahim and his wife Sara (Quran 11: 71-73), and Zakariya and his wife Ishba (Quran 3: 38-40) provide typical illustrations. These accounts however depict the barrenness of the women in these relationships and the role of Allah in curing them of their barrenness (Quran 51: 28-30; 21: 89-90). One woman who remained childless in Quranic accounts was Asya, Pharaoh's wife (Quran 66:11). According to Islamic beliefs, Pharaoh was stricken with impotence by Allah thus accounting for their childlessness. Barrenness does not, however, make you less of a woman as Allah blessed Asya abundantly in other ways.

In sum, the major beliefs associated with infertility and its treatment in Ghana point to the belief in fertility being orchestrated by a supernatural entity. For that matter, believers rely on these deities and their representatives in ensuring their fertility. In times when the potential for fertility is challenged, they again draw on religious beliefs and practices in the hope of obtaining a cure for their infertility.

2.4 TRADITIONAL APPROACHES TO MANAGING AND TREATING INFERTILITY

Aside the existence of religious beliefs and practices in solving infertility, cultural practices also exist in Africa that serves as a means to managing infertility in a marital relationship. Bohanan (1949), in her article on the revaluation of marriage in Dahomey (present day Benin) analyses the rights and duties between husbands and wives with regard to their children. She introduces the concepts of rights in uxorem and rights in genetricem during her analysis. She refers to the rights in a woman as 'wife' (uxor) and rights in a woman as 'mother' (genetrix) to denote these two concepts respectively. Rights in uxorem therefore refer to the sexual, domestic and economic rights that a male partner has over a woman by virtue of her position as his wife. Rights in

genetricem, on the other hand, refers to a husband's rights to filiate his wife's child (ren) once they are born. This conceptualisation is further used to explain the way that some societies handle infertility. For example, according to Kershaw (1973), among the Kikuyu of central Kenya, if a woman in an infertile marital relationship subsequently conceives as a result of having extra marital relations, her husband assumes rights of genetricem over this child. Similarly, in Nigeria, cleansing rituals are performed to legalize any child born out of wedlock and thereby conferring rights of genetricem to the man (Onah, 1992). A study by Harrel-Bond (1975) in Sierra Leone also reported that although adultery committed by a woman is considered a very serious offense, it is often overlooked in a situation where it results in conception, thereby proving the infertility of the husband. A similar situation exists in Northern Ghana among the Lo Dagaa whereby a man had custody of children born to the woman based on the fact that he had paid the bride wealth (Goody, 1956).

There are also other avenues that exist in some cultures that allow infertile couples to bring up children as their own though they may not be biologically related to them. Astuti (1988), reports that in Swaziland, a young and usually sexually immature girl is brought into the family of an infertile couple for the purposes of bearing children for the infertile woman. This girl is usually the infertile woman's sister or a member of the larger extended family. She is brought in by the family members of the woman and any child (ren) that she bears is considered as the infertile woman's child (ren). The Akamba of central Kenya also have a practice that allows an infertile couple to adopt a young girl for the purposes of assuming parenthood over any child she will bear through sexual relations with a third party male. This male therefore does not assume any role as either husband to the adopted girl or father to her child (ren). Children born out of such an arrangement belong solely to the infertile couple (Ueda, 1973). In Botswana also, Shapera (1955)

reports that, as part of traditional Tswana custom, another woman could be arranged for the husband of an infertile woman. Children born out of such a union were, however, considered to be the children of the infertile wife.

Furthermore, in some parts of Sub-Saharan Africa, an infertile woman may marry another woman and subsequently lay claim to her children (Caldwell and Caldwell, 1990). This works in different forms in the various societies. Among the Abagusii of Western Kenya for instance, a woman with only female children marries another woman with the hope that she will bear a son for her (Oboler, 1980). The Lovedu of South Africa also had a practice whereby a married wealthy woman may marry one or more women in order that they may bear children for her (Sacks, 1982). Similarly, among the Igbo of Nigeria (Amaduime, 1987) and Benin (Esqueridge, 1993), this practice of female husbands exists.

Other traditional approaches to solving infertility in the developing world include re-marriage (Nahar et al., 2000) and/or divorce (Okonofua et al., 1997; Kielman, 1998; Nahar et al., 2000; Leonard, 2002; etc). Macua women in Mozambique also engaged in extramarital relationships in an attempt to have children (Gerrits, 1997). They did this in order to check if the blood of these other men were more compatible with theirs than their husband's.

Adoption is another way of coping with infertility although it is less accepted in the developing world. Research by Bharadwaj (2003); Mogobe (2005); Inhorn (2006); Oladokun et al. (2009) amongst others have shown the low acceptability of adoption amongst infertile couples. Comparatively, fostering is more common and acceptable within the developing world (Gerrits, 1997; etc).

In addition to these cultural practices, many of which may no longer be acceptable today within the various societies due to the influence of modernisation, Christianisation and Westernization, there exists groups of local people who are specialized in the provision of treatment for infertility. These people are believed to have the ability to diagnose and offer treatment for problems that cause infertility in both men and women. Inhorn (1994) refers to these local practitioners as ethno-gynecologists. Such traditional healers include diviners and priests, herbal and spiritual healers and/or traditional reproductive health specialists amongst others. However, some studies on the health-care seeking behaviour of infertile couples show that, they do not rely on only one of the practitioners outlined above at a time. Macua women often visited *akulukanos* (herbal healers) and *majini* (spiritual healers) in search of treatment. The most common antidotes were in the form of herbal teas, balms, baths and exorcism rituals (Gerrits, 1997). Similarly, Liamputtong (2009) reports that infertile Hmong mountain women relied on *kws tshuaj* (a local medicine woman) and *txiv neeb* (shaman/ anyone in contact with the spirits eg. Medicine men, sorcerers, magicians, witch doctors etc) for treatment. Ethnographic fieldwork carried out among married adolescent girls in the Dhaka slum of Bangladesh also revealed that these girls heavily relied on traditional healers (*kabiraj*) and older women for the treatment of their reproductive failures (Rashid, 2007). The use of a spiritual healer (*hujur*), amulets, and herbalists is also common in Bangladesh (Nahar et al., 2000).

The reasons for the popularity of these ethno-gynaecologists are myriad. Generally speaking, their popularity may be attributed to the fact that, they are a cheaper alternative in terms of financial costs involved with treatments when compared to that of Western style biomedical practitioners. In addition, they utilize long established remedies in their healing processes. For some, these practitioners are often preferred as they promise an immediate cure. Yebei (2000)

confirms this in her study of infertile migrant Ghanaian women living in the Netherlands. For others too, it was a matter of familiarity, trust and confidence in traditional healers (as opposed to a foreign remedy) which made traditional healers the preferred choice (van Balen and Gerrits, 2001).

2.5 MODERN APPROACHES TO TREATING INFERTILITY

Whereas traditional beliefs and approaches to managing and treating infertility do not rely on systematic diagnosis and treatment of specific physiological disorders that impair reproductive ability, modern approaches do. These modern approaches were borne out of the process of medicalization. The medicalization of life, according to Illich (1975), refers to the process whereby more and more aspects of daily life have been brought into the biomedical sphere of influence such that those experiences that were once seen as a normal part of the human condition are now being given medical interpretations. The term has also been used by White (2002) in medical sociological terms to denote a situation whereby one fails to conform to the wider social expectations of appropriate social behaviour and as a consequence, becomes labelled as diseased or sick. It also refers to the process whereby otherwise ordinary human events and common human problems are no longer seen as such and are rather now being viewed as medical conditions (Conrad, 2007). This therefore means that such conditions are regarded as treatable by physicians.

In explaining how this medicalization process came about, some scholars have argued that, medicalization occurs when a particular social behaviour or condition is considered ambiguous and/or deviant compared to the laid down rules and regulations of that society (Becker and Arnold, 1986). An attempt is therefore made to correct or manage such an act by resorting to the health care system for a solution (Conrad and Schneider, 1980). Infertility is one such social

condition which is now been regarded as a medical condition or a disease. This was a consequence of the increasing attention being drawn in the United States of America, to the situation whereby more and more people were experiencing “involuntary childlessness” - the undesired absence of biological children - mainly as a result of delayed childbearing (Office of Technology Assessment, 1988). There was therefore the desire to seek a medical solution to this social phenomenon.

In addition, during the 1960's and 1970's, there was significant development in synthetic drugs that gave physicians the ability to control women's ovulatory cycles as well as the development of technologies such as laparoscopy which was useful in examining the internal reproductive system of a woman (Greil, 1991). This was coupled with an increase in the number of physicians who specialized in reproductive endocrinology. Other socio-economic factors occurring within the same time period such as the decrease in the availability of healthy babies for adoption, the sexual revolution as well as the increasing incidence of sexually transmitted diseases all worked in tandem to fuel the medicalization of infertility (Whiteford and Poland, 1990). This ultimately leads to the intensification in research on infertility and ultimately to the development of reproductive technologies.

The medicalization process has subsequently helped in the identification of one or more physical defects which may account for infertility. For instance, male factor infertility may be diagnosed when sperm count is below the acceptable level of 20 million sperms per millilitre- a condition medically referred to as oligospermia. It is therefore advantageous in the sense that, medicalization tends to shift the responsibility for the condition away from the individual, (as opposed to previous societal explanations), to more complex biological and physiological disorders over which the sufferer has no control (McLean, 1990).

However, such diagnosis, borne out of the identification of one or more physiological defects in the individual's biological make-up, may be only one step towards achieving the desired goal of biological parenthood as it does not provide legitimacy for the 'illness' of infertility. This is due to the secrecy that infertile couples attach to their search for diagnosis and treatment. This is so because, more often than not, infertility is seen as the absence of a desired social condition rather than the presence of a pathological symptom (Greil et al., 2010).

Furthermore, the manner and extent to which those seeking remedies to their conditions are subjected to diverse interventions which are physically, emotionally, and financially draining presents another disadvantage of the medicalization of infertility for those affected. Whereas in the past (about 60 years ago), an infertile couple will either succumb to their fate and make do with adoption, fostering or other societal means of reducing the burden of infertility, medicalization has created a situation whereby these couples now subject themselves to months and years of painstaking treatment with the hope of becoming biological parents one day; treatments that may not suffice in the long run and which may only exacerbate their psychological feelings of inadequacy.

In conclusion, the medicalization of infertility has led to the emergence of different types of modern treatments available for solving infertility. Three of such modern treatments namely medical herbalism, low technology treatment and high technology treatment will be discussed in the subsequent sections.

2.5.1 Infertility treatment via Medical Herbalism

Medical herbalism involves the combination of knowledge of traditional plant remedies with modern medical science. According to the World Health Organization (2002), about three

quarters of the world's population, mainly in the developing world, rely on herbal medicine as a means of improving and/or restoring their health. This could be attributed to the fact that they are locally available, are a cheaper alternative, and the belief that their use is not associated with side effects (Gupta & Raina, 1998). Herbal medicine is employed in different ways in different cultures. The Chinese, Indians, other Middle-Eastern and South-Asian and African countries of the developing world all have herbal traditions unique to their contexts.

In the African context for example, the traditional herbal medicine practitioner relies on knowledge gained from past experience and observations handed down either verbally or in writing from generation to generation in either diagnosing and/ or curing diseases (Sofowora, 1993; WHO, 2002). Medical herbalism, however, takes a more scientific approach to diagnosis and treatment of illnesses. A medical herbalist is a health care provider trained in Western orthodox medical diagnosis who uses plant - based medicines to treat their patients. Literature on medical herbalism is not readily available but can be found under the broader literature on herbalism. It is a Western concept that denotes the more modern use of herbal medicine thus distinguishing it from traditional herbal medicine.

Medical herbalism is also a holistic form of medical practise in the sense that it seeks to address the underlying causes of ill health in each patient as well as treating their symptoms. Medical herbalists use the healing power of plants to treat a wide range of medical conditions. Whereas many conventional medicines are based on chemicals found in plants, herbalists use whole parts of the plant (such as leaves, berries or roots) as they believe this makes a more 'balanced' natural remedy. The medicines are then produced in the form of tablets/capsules and ointments.

Medical herbalists specialize in Western herbal medicine, Chinese herbal medicine or Indian herbal traditions. This probably justifies why some literature place medical herbalism in the broader category of complementary and alternative medicines (CAM) distinct from traditional herbal medicine. The term complementary and alternative medicine is used by the World Health Organization to refer to the broad set of health care practices that are not part of a country's own tradition or are not integrated into the dominant health care system of the country (WHO 2002). This category of medicines is used together with (complementary) and/or in place of (alternative) the standard medical care in a country.

With regards to its usage, the sole use of medical herbalism to either enhance the treatment of infertility or to treat infertility is rare. A study by Rayner et al. (2009) found that Australian women reported using different forms of CAM (e.g. acupuncture, herbal medicines, naturopathy, dietary supplements etc.) to enhance their fertility potential while undergoing ART procedures. Smith et al. (2010) who conducted their study in the United States also found the use of CAM such as acupuncture, herbal therapy and meditation among couples seeking fertility care. However, there is no literature on the use of medical herbalism for the treatment of infertility in the African context.

2.5.2 Infertility treatment via Low technology

As previously stated, another modern treatment of infertility is in the form of low technology treatment. Low technology treatment refers to 'technologies that do not involve the retrieval of oocytes (female egg cell) or fertilization outside the body (Fidler and Berstein, 1999: 501)'. It involves the use of fertility drugs and surgical procedures to repair reproductive organs. For example, there is medication that stimulates superovulation (the development and release of more than one egg per ovulatory cycle) which helps correct female factor infertility. Intrauterine

insemination (a process by which sperm are placed inside a woman's cervix to facilitate fertilization) is also a low tech treatment which is used in some cases of male factor infertility (van Waart et al., 2001). In the United States, by the latter part of the 1980's, it was reported that 'low tech' procedures for infertility treatment constituted more than 95% of the treatments provided for infertility (Wilcox and Mosher 1993).

In the developing world as well, with particularly reference to Africa, low tech treatment is available in various public hospitals although the component of intra uterine insemination is rather rare in these hospitals. In addition, there are problems associated with the way in which low tech treatment is offered and used in these contexts. One such problem is related to the non-availability of skilled personnel in infertility care. Literature reviewed showed that, in some instances, the personnel working at the lower levels in these facilities did not have the requisite training in the specialized field of infertility care (Okonofua, 1999). This therefore would imply a negative effect on their service delivery. However, with respect to the higher level personnel, namely the doctors, it was possible to find some of them who were knowledgeable and dedicated to their jobs causing them to become well-known for their expertise in service delivery (Sundby, 2002). Some expatriate doctors were, however, found to have a negative attitude towards infertility care and treatment (Kielman, 1998).

Another problematic area in the field of infertility care and treatment via low technology in the developing world is in relation to the diagnosis of infertility. Comprehensive infertility care services are rare. The few countries that had these services available were able to render their services to a small number of the population due to the high cost of accessing the service. For example, comprehensive infertility health care services in Moshi, an urban setting in Tanzania was only available at the specialist tertiary level of health care and was very costly to access.

Fertility examinations such as sperm tests and ovulation assessments were not available at the primary level (Sundby & Larsen, 2006). Patients visiting primary health care facilities in search of infertility care often reported going through a gynaecological exam and screening for genital tract infections and this was not consistent for all patients. Similarly, Dhont et al. (2010) in a study conducted in Rwanda and Sundby and Jacobus (2001), in their study of health care services for infertility in Gambia and Zimbabwe, report the low emphasis placed on infertility care in the public sector and the high cost associated with such care. The non-availability of basic tests for semen and ovulation were also mentioned. These conditions prevalent in the health care sector of developing countries in addition to going contrary to the WHO guidelines (WHO 2004) for infertility investigation have the potential of preventing the early detection and treatment of infertility. When this occurs, basic and comparably low cost treatments for infertility may no longer be efficacious resulting in couples resorting to more costly treatment options where feasible.

Additionally, in the developing world, basic treatments available for treating infertility include antibiotics for sexually transmitted diseases, surgical operations to remove fibroids and /or clear blocked tubes, the administering of fertility drugs to boost ovulation etc. However, in some contexts, drugs are not always readily available (Gerrits, 1997), or they may be rudimentary (Leonard, 2002) and thus not beneficial in some situations. This means that, low tech treatment is not easily available to some people.

Even where these drugs and services are available, there are other problems related to its prescription which in turn pose risks to the health of the individual. Dhont et al. (2010) report that patients coming in for infertility treatment at a public hospital in Rwanda receive a ‘cocktail’

of drugs made up of antibiotics, female hormones, anti-inflammatory drugs, and steroids. The combination of these various medications may result in what Illich (1974) refers to as clinical iatrogenesis - the inadvertent and preventable harm or complications induced by medical treatment. Such iatrogenic effect in some countries is evident in health care practices as well. For instance in Nigeria, Koster-Oyekan (1999) reports that, it is common practice for Yoruba women to undergo a dilation and curettage (D&C) procedure as a way of preventing infertility. This is referred to as *fo inu* and means to 'wash the inside'. As such these women often undergo a D&C after a delivery, miscarriage, abortion or just when they are ready to get pregnant - a practise which sometimes leads to infections due to insalubrious conditions. A similar practice was found in Gambia's public health sector (Sundby, 2002).

The efficacy of low tech treatments in solving infertility does not rest on the service providers alone. A lot depends on the clients accessing the health care as well. Sometimes, clients in their desperation to have a child end up visiting different hospitals and trying out various medications simultaneously (Dyer et al., 2002; Sekadde-Kigindu et al. 2004), while others give up along the way due to the time consuming and cumbersome nature of the treatment process, costs and/ or the seeming lack of success of treatment (Dyer et al. 2002; Horbst, 2006).

2.5.3 Infertility treatment via Assisted Reproductive Technologies

2.5.3.1 The development and spread of ARTs in the West

The twentieth century brought along profound changes in human history ranging from the growth in science and technology to changes in politics and industry amongst others. As the end of the century drew nearer and as millions of couples continued to try to conceive naturally year after year without any success, gynaecologists and physiologists in the West (specifically Britain) also sought to assist such couples have children on their own through various researches

and trials. This led to the development of high tech treatments which promised to solve complex infertility problems. High tech treatments refer to treatments that utilize the power of technology to fertilize human eggs and sperms outside the human body for the purpose of helping establish pregnancy. The first of such technologies to emerge was in-vitro fertilization (IVF). Prior to the development of this technology, women with blocked fallopian tubes, had no chance of becoming pregnant since their condition meant the inability of their eggs to travel through the fallopian tubes to be fertilized by their partner's sperms. Since 1966, all attempts that had been made to solve this infertility problem in women resulted in the successful fertilization of the egg outside the woman's body. However, after replacing the fertilized egg in the woman's uterus, the pregnancies that resulted could not last for more than a few short weeks. Lesley Brown was to make history when she successfully passed the first few weeks of pregnancy (Rosenberg, J. accessed online at www.about.com).

Lesley and John Brown were a young couple from Bristol who had been unable to conceive on their own for nine years. Lesley had blocked fallopian tubes. Having tried various medications over the period, she finally went through in vitro fertilization in November of 1977. What was different about her procedure (as compared to many others that had been performed around that time) was that instead of waiting until the fertilized egg had divided into 64 cells (about four or five days later) before being transferred into the woman's uterus, the team of doctors decided to place the fertilized egg back into Lesley's uterus after two and a half days. After the successful implantation of the fertilized egg into the walls of her uterus (signifying pregnancy), weeks and months passed by successfully until full gestational period was reached. Thus Louise Joy Brown,

the world's first test tube baby was born on 25th July, 1978 bringing hope to many women who found themselves in situations similar to that of Lesley Brown.

Four years later, Louise's younger sister Natalie was also born as a result of IVF becoming the world's fortieth IVF baby. She is the first in-vitro baby to conceive and give birth in May of 1999. Her baby was conceived naturally thereby de-bunking earlier notions of IVF babies not possessing the full capabilities of naturally conceived babies. Louise herself also conceived naturally and gave birth to a son in December 2006 [BBC News. 14 January 2007].

The second major high tech treatment to emerge was Intra Cytoplasmic Sperm Injection (ICSI) which was first successful in Belgium in the year 1992. It is a procedure that is designed to overcome severe male infertility. It serves the purpose of enhancing the fertilization phase of IVF and involves the micromanipulation and injection of weak spermatozoa (a single sperm) directly into oocytes (a mature egg) under a high powered microscope (Inhorn & Birenbaum-Carmeli, 2008). In addition to IVF and ICSI, other variants of high tech treatments (ARTs) have been developed based on the peculiar needs to be addressed.

Data from thirty-two countries covering the whole of Western Europe for the period ranging between 1st January, 2006 and 31st December, 2006 shows a high prevalence of ART usage within the region corresponding to 850 cycles per one million inhabitants (ESHRE, 2010). The largest number of ART cycles was conducted in France, Germany, Spain, the United Kingdom and Italy (ibid). Success rates for procedures also ranged between 29% and 33% (ibid). In the United States, ART usage is also high. By the year 2002, there were 428 clinics in the U. S. performing an average of 115,000 ART cycles per year (Spar, 2006). By the year 2006, the number of reported ART cycles in the U. S. A. had risen to 138, 198 with pregnancy rates

resulting from ART usage pegged at 35% (CDC, 2008). Australia and New Zealand also recorded 53, 543 ART cycles and pregnancy rates from ART usage at 30.6% for the same year (AIHW, 2008).

In July 2012, the world's attention was drawn to the celebration of the five millionth baby to have been born using ARTs. This was announced during the European Society for Human Reproduction and Embryology (ESHRE) conference held in Istanbul and was the calculated figure derived from the total number of ART births recorded worldwide between 1978 and 2008 and also included estimations added for the subsequent three years (ESHRE 2012 press release).

2.5.3.2 Globalization of ARTs to the developing world

Since the birth of the world's first test-tube baby in England via in vitro fertilization almost three and a half decades ago, assisted reproductive technologies have spread rapidly across the world reaching the developing world as well. A multinational study from Latin America conducted in 1994 revealed the high prevalence of IVF centres throughout the region with Argentina recording sixteen (16) centres and Brazil, seven (7) out of the total number of forty-five centres studied (Nicholson & Nicholson, 1994).

The development of ARTs in Asia arguably begun in India with the country producing its first IVF baby on the 6th of August 1986 (Bharadwaj, 2000). The first ICSI procedure took place almost ten years later in December of 1994 (Bharadwaj, 2000). Anthropologists have documented the spread of these technologies to other Asian countries such as China (Handwerker, 2002), Iran (Tremayne, 2006), Lebanon (Clarke, 2007) and Vietnam (Pashigian, 2009) amongst others over the years. In the Middle East, Egypt was the first country to open an IVF centre in the year 1986 and had more than thirty-five (35) IVF centres in operation as at

1999 (Inhorn, 2003). By 2009, this number had grown to approximately fifty (50) IVF centres within the country (Inhorn, 2009). According to Inhorn (2003), IVF centres have spread to almost all, if not all of the eighteen nations that make up the Middle East including the smallest countries such as Bahrain and Qatar.

The first IVF baby to be born in the whole of East, West and Central Africa is believed to have been born at the Lagos University Teaching Hospital (LUTH) in Nigeria in March 1989. It was a bouncing baby boy named Olushina Eghosa Oluwaremilekum. Prior to this feat, his mother had lost both of her fallopian tubes in 1981 due to bilateral ectopic pregnancies and had attempted IVF twice in the past without success (Giwa-Osagie, 2002). Subsequently, ARTs have spread to other countries within the sub region such as Cameroun (Ngwafor, 1994), Gambia (Sundby, 2002), Ghana (Donkor & Sandall, 2007), Mali (Hö rbst, 2006), Nigeria (Gisa Owagie, 2002), Tanzania (Sundby & Larsen, 2006), and Zimbabwe (Sundby & Jacobus, 2001). By the year 2000, the number of IVF procedures being performed in Nigeria alone was estimated to be around 600 procedures per year (Giwa-Osagie, 2002).

IVF first came to Ghana in 1995, and was introduced by a German trained Ghanaian doctor who runs a fertility clinic in Tema. Since then, its popularity and usage is gradually on the increase. Today, Ghana can boast of about nine fertility clinics that utilize assisted reproductive technologies in the Greater Accra Region alone. However, all these centres are privately owned thus making access and affordability difficult for the majority of Ghanaians.

2.5.3.3 Access to ARTs

The development of assisted reproductive technologies in the West and its spread to other parts of the world is supposed to signify a breath of fresh air to those suffering from intractable

infertility and who desire to have their own biological children nonetheless. However, issues of stratified reproduction have emerged in different parts of the world as a consequence of the provision of infertility care via ARTs.

The term stratified reproduction was originally coined by Colen (1995) to refer to the inequalities of race, class, gender, culture and legal status experienced by women in their physical/biological and social reproduction. Many feminists have also adopted the term to examine issues relevant to the intersections of reproduction and stratification (Agigian, 2007). The cost of accessing reproductive technologies has proven to be a bane for many people the world over. In the United States, for instance, Spar (2006) reports that, insurance coverage for ARTs exists in only fourteen of the fifty states that make up the country. For that matter, many American couples who wish to utilize the service have to spend an average of \$12,400 per IVF cycle as at 2003. This is prohibitive and has resulted in very few numbers (1%) resorting to infertility treatment via this means. In addition to the elements of cost in the United States, issues of race also affect access to fertility treatment via ARTs. Groups of marginalized populations become disadvantaged both in terms of the fact that they are low income earners and also belong to a different race. This is evident in studies on African Americans (Ceballo, 1999), the Latino (Becker et al., 2006), Native Americans (Quirogo, 2007), and the Arab American population of the United States (Inhorn & Fakih, 2006).

In Britain as well, Culley et al. (2006) report a similar disadvantage experienced by low income earning British South Asians hoping to receive infertility care via ARTs. Some evidence also exists in studies carried out in Europe on the experiences of other races with respect to infertility care. In Sweden, Eggert et al. (2008) did not notice any significant difference between access to ARTs by foreign born women in Sweden as opposed to Swedish-born women as all women were

covered by the national health insurance system for their first three cycles of IVF. However, Yebei (2000), studying Ghanaian women in the Netherlands found that these women had a lower access to infertility treatment via ARTs as compared to the indigenes mainly because of poor insurance coverage, low socio-economic status and language barriers. Vanderlinden (2009) also reports of the situation whereby German Turks felt disrespected and discriminated against when it came to infertility care.

The situation in non-Western countries is even more severe in discussions of stratified reproduction with reference to cost of infertility care via ARTs. This is because, as alluded to in previous paragraphs, national health insurance rarely covers infertility treatment (Inhorn, 2001; Nachtigall, 2006). With the exception of South Africa, assisted reproductive technologies are rarely provided in the public health sector in Africa (Gisa Owagie, 2002). ARTs are offered in most instances, only in private clinics and are thus very costly. In an international survey of twenty-five (25) countries, it was discovered that, the mean cost of a single IVF procedure ranged from \$1300 in Iran to \$6400 in Hong Kong. This cost was found to be more than half of an average individual's annual income in each of these countries (Collins, 2002). Similarly, Inhorn (2001) reports that, in Egypt, as at 1997 when the annual per capita GNP was about \$790, a single trial of IVF could cost more than \$3000, an amount which is more than twice the annual income of the average Egyptian. In Nigeria as well, Giwa-Osagie (2002) reports that the average cost of one cycle of IVF is between \$2000 and \$2700- a figure which is much more than the minimum wage of \$52-\$60 a month. Donkor and Sandall (2007) also estimate the cost of one IVF procedure in Ghana to be the equivalent of a nurse's salary over a period of one and a half years.

Although figures presented here may seem outdated as they date back to about a decade ago, what is important is the comparison between the costs of accessing ARTs with the various national income levels of average citizens within the countries in question. The issue of high costs of treatment via ARTs is exacerbated by the low success rates of procedures across regions. Success rates of ARTs are estimated at 27% in the United States (Spar, 2006) and around 20% in Latin America (Nicholson & Nicholson, 1994). According to Gisa-Owagie (2002) the success rates of IVF procedures within the Sub-Saharan Africa region is estimated at between 5% and 15%. This therefore leads to a situation of repeated IVF procedures making it all the more difficult for the average citizen to be able to afford it. Repeated IVF procedures also bring mixed feelings of hope followed by despair when success is not achieved after every trial. Becker (2000) refers to this scenario as the pursuit of ‘the elusive embryo’.

2.5.3.4 ARTs as gendered technologies

With respect to the inequalities in the area of gender that have been heralded by the development of ARTs, Konrad (1998) notes that, ARTs are by their very nature gendered technologies. This is because the application of these technologies is specific to either the male or the female and each of these sexes undergoes procedures distinct from one another during its application. However, the woman’s body is the one that undergoes a greater chunk of the procedures involved and in some extreme cases even becomes objectified. This has been strongly opposed by feminists as it only goes to strengthen existing cultural norms that make biological motherhood a necessity (Thompson, 2002). It also tends to pre-suppose that women are the ones to bear the responsibility when difficulties with achieving and/or sustaining conception emerge (Inhorn and van Balen, 2002). However, worldwide prevalence rates of infertility show that more than half of infertility cases are male –factor related (Vayena et al. 2002).

Some writers also argue that, infertile men also experience their fair share of undesirable circumstances during infertility treatment via ARTs. Notable amongst them is the inability to produce their sperms at the right time and under induced conditions which may lead to increase in anxiety and sometimes impotence (Inhorn, 2002, 2007). In addition, until the development of ICSI in the early 1990s, donor insemination was the only way of resolving severe male factor infertility. However, the use of donor insemination in many Western countries is shrouded in a lot of secrecy for fear that these men relying on donors may become objects of stigmatization (Becker, 2002; Grace et al., 2007; Hanson, 2001; Nachtigall et al., 1997). In addition, in some countries such as Israel (Birenbaum-Carmeli et al., 2000), Botswana (Upton, 2002) and Denmark (Tjørnhøj-Thomsen, 2009) amongst many others, male infertility is conflated with impotence and thus provides another avenue for stigmatization.

The development of ICSI has, however, proven to have a double barreled effect. On one hand, it has been very advantageous to men. Infertile men who previously could never have become biological fathers now have the chance to do so. This has helped to repair their masculinity to a great extent (Inhorn, 2004). However, older women who have stayed in infertile unions for the most part of their lives have tended to become disadvantaged with the development of this technology. This is because, it re-enforces the power of men in marital relationships. According to Inhorn (2005), older infertile men with the development of ICSI can now have another opportunity at biological fatherhood whereas their female partners, who have now become infertile due to old age stand the risk of divorce and feelings of stigmatization. This is because a woman's fertility is highly age sensitive. There would often be the need to use donor eggs during the latter years of a woman's reproductive lifespan (Friese et al. 2006, 2008).

2.5.3.5 Effects of the emergence of ARTs in the West

One interesting development as far as ARTs are concerned is how different cultures perceive and accept these technologies. Some of the studies conducted in Europe and America on the impact of these assisted reproductive technologies on their societies reveal that they threaten the cultural ideals of some of these societies. For example, ethnographic studies on the effects of these reproductive technologies on kinship and notions of the family have revealed that some infertile couples do not subscribe to the use of donor material in ART procedures (Franklin, 1997; Ragone, 1996). For such couples, having complete biological relations with their offspring is paramount and as such will strive to have children of their own using their own sperms and/or eggs during ART procedures.

In other contexts, ARTs have come to redefine and expand notions of relatedness. It has been argued by some researchers that, ARTs that employ the use of donor material including donor ‘wombs’ (surrogates) have created ambiguity in social relations particularly when it comes to motherhood and fatherhood (Collard & Parseval, 2007 cited in Inhorn & Birembaun-Carmeli, 2008). This has led to the creation of a wide range of kinship/parenting forms (Franklin & Ragone, 1998). Weston (1991), however, argues that, biology is a cultural construct and families can therefore be created out of people actively selecting other people whom they choose to have intimate connections with and not necessarily only out of any biological connection that they may have with them.

ARTs are also creating varying forms of parenthood by giving other less traditional unions of people such as those in homosexual and lesbian relationships, unmarried couples as well as single men and women the opportunity to become parents as well (Spar, 2006). This, as noted by Mamo (2007), is a deviation from the American norm regarding reproduction. In response to

this, countries such as Denmark (Bryld, 2001) have enacted laws to prevent gay couples from accessing ARTs.

Furthermore, ARTs have created a whole new industry of labour and reproductive tourism in the developed world. This is because, egg and sperm donations have become lucrative money making activities (Spar, 2006); while emerging laws that restrict people from using donor material for insemination has only contributed to reproductive tourism-the situation whereby people travel out of their countries to other countries to access ARTs where existing laws on the use of donor material for insemination are less stringent (Deech, 2003).

The situation in the non-Western world is different, albeit more intense, owing to the fact that kinship is an integral part of their societal organization.

2.5.3.6 Western technologies in non-Western worlds

As previously noted, the Non-Western world, is modernizing and increasingly adopting assisted reproductive technologies as a treatment option for the infertile. Studies on the use of assisted reproductive technologies as a fertility seeking behaviour in non- Western countries are fewer in comparison with those from Europe and America despite the growing number of public and privately run fertility clinics that utilize these technologies. The spread of these technologies into non-Western societies may have different effects on potential users based on the different social and cultural contexts, distinct from those of the Western world. Existing social relations as well as cultural norms and values related to marriage, children and the entire family and religious institution may affect the acceptability and utilization of these technologies.

Factors such as religion, political ideology and morality amongst others, affect the acceptability of ARTs in non-Western societies. Among the Christian population of Israel for instance, the

biblical commandment to “be fruitful and multiply” has been the driving force behind the acceptability of ARTs both legally and socially (Shalev & Gooldin, 2006). This, coupled with the pronatalist culture of Israel stemming from the political desire to populate in order to occupy the vast lands seized from their Arab neighbours, has encouraged more births especially for the infertile through the use of ARTs (Kanaaneh, 2002). ART services are thus highly subsidized to encourage more people to utilize them (Birembaum-Carmeli, 2004).

Issues of morality associated with the use of donor material for ART procedures also come to play among the Sunni Moslem population in Egypt. Using donor semen especially was deemed inappropriate and equated with adultery which was against existing religious and moral principles (Inhorn, 2003). In other non-Moslem but traditional African societies, a similar belief was found to exist (Hornb, 2008; Onah et al., 2008). However, Shia Moslem laws in Iran and Lebanon have permitted third party donations to facilitate conception using ARTs (Clarke, 2006; Inhorn 2006b).

Although ART usage in Sub-Saharan Africa is relatively low compared to other parts of the developing world, its cultural dimensions have been explored. Anthropological studies conducted on the impact of assisted reproductive technologies in Africa are few and not commensurate with the extent to which these technologies have penetrated the continent. However, some evidence from Cameroun, Egypt and Mali exist to that effect. In Cameroun for instance, Ngwafor (1994); Feldman-Savelsburg (2002); and Tangwa (2002) report that the general attitude of Cameroonians towards ARTs is one of dislike and rejection of the technology since it is against their value systems. According to Ngwafor (1994), the average Cameroonian finds it more culturally acceptable for a man to marry another wife if his first wife is infertile. A woman whose husband is infertile is also permitted to have secret sexual relations with another

man in order that she might be able to conceive. Fostering is another option more socially acceptable in Cameroun as compared to the use of ARTs. These traditional solutions are preferred since they do not require a huge investment of money. Thus, the high cost of accessing ARTs makes the average Cameroonian view it as not necessary and not worthy of monetary investment especially when cheaper and less complex alternatives are available.

In Mali, ART procedures are generally acceptable whereas the practitioners who offer the service were criticized for their style of communication (Hö rbst, 2006). Its acceptability in Mali is attributed to the similarity in the way ARTs work and the cultural notions of the Malian regarding fertility. Fertility is believed to be a process to be shaped and influenced in order to be fully effective. Cultural practices such as female circumcision therefore exist to facilitate one's fertility potential in future. ARTs are thus seen as performing a similar role to subsequently serve a similar purpose and as such are no different from their cultural practices that are performed to influence fertility. Another cultural belief in tandem with the way ARTs work is the belief in the involvement of third parties when seeking treatment for infertility. While in the traditional context, these third parties could be herbalists, spiritualists, and the like, with the use of ARTs, these third parties become the technologies themselves. Hadolt and Hö rbst (2009) cited in Gerrits & Shaw (2010) also provide a gendered explanation for the acceptability of ARTs in Mali. When male-factor infertility is at play, resorting to ARTs was considered appropriate but in situations where it was female-factor infertility, the men in such unions preferred to marry another wife than bear the cost of ARTs. This is illustrative of the existing power relations between men and women in Malian society.

In Egypt, the differing ways in which ARTs conflict with Egyptian understandings of conception, religion and gender relations have also been reported. Poor, less educated Egyptians believed that a man's sperms contained pre-formed fetuses whereas a woman's only role in the reproductive process was to "carry, cushion and/or nourish" the growing foetus (Inhorn, 2003: 1845). Women could not have eggs as they were not chickens. However, infertility treatment via ARTs connotes a meaning distinct from earlier held notions of conception. It gives equal power to the woman as an active participant in the fertilization process since it requires the man to ejaculate his 'foetus-carrying sperm' whereas the woman takes medications to boost egg production. The highly educated elite also have moral reservations against the fertilization of sperms and eggs taking place in a laboratory. These beliefs create anxiety among Egyptians and result in the low acceptability rates of ARTs.

Similar to the Malian social context, gender power relations exist in Egyptian marriages with reference to the acceptability of the utilization of ARTs. ARTs become more acceptable in cases of male infertility as opposed to female infertility since the option of divorce and/or re-marriage for men presents a cheaper, less burdensome alternative for solving infertility in their partners (Inhorn, 2003).

Reservations towards and subsequent resistance to the use of ARTs in non-Western societies becomes more pronounced when the use of donor material (donor eggs, donor sperms) becomes necessary. According to Nijkam-Savage (1992), the infertile respondents in her study on the socio-cultural considerations regarding artificial donor insemination in Yaounde were less likely to accept donor insemination as compared to the fertile respondents. There were also fears that the donor may in future try to lay claim to the child thus revealing their 'secret' (Inhorn, 2003).

In cases where donor material was not needed, there were still fears (fuelled by media reports from the West) that unintended mix-ups of samples may occur in the ART laboratory thus putting the paternity of the child in doubt-an unpleasant situation to deal with (Inhorn, 2003).

Studies have also shown that, women in general are more likely to accept the use of donor material than men (Nijkam-Savage, 1992; Horbst, 2006; Onah et al., 2008; Hadolt & Horbst, 2009 cited in Gerrits & Shaw, 2010). This is attributed to the fact that, these women who find themselves in patriarchal and patrilineal societies suffer the most from negative effects as a result of being in infertile unions and are thus more eager to resolve infertility problems whilst keeping their marriages intact. Hadolt & Horbst (2009) cited in Gerrits & Shaw (2010) report that the more important thing for these women was that their pregnancies would become publicly visible and thus eliminate any further social stigmatization whilst they could get away with donor insemination which is not readily visible to the public.

2.6 CONCLUSION

In this chapter, literature was reviewed on the following areas of infertility: its prevalence, types and causes, the experiences of infertility highlighting both psychological and social effects, treatment seeking for infertility with regard to traditional and biomedical treatments including the more advanced use of ARTs, as well as the effects of these treatment options in both the developed and the developing world. In sum, infertility rates are higher in the developing world as compared to the developed world mainly due to the existence of preventable causes of infertility brought on by untreated reproductive tract infections. Similarly, women in developing countries suffer stigmatisation in the form of abuse, insults, exclusion from societal ceremonies and divorce amongst others as compared to their male counterparts. In an attempt to escape this stigmatisation therefore, women resort to the services of traditional and religious healers to

overcome their infertility. Some cultural practices also existed that helped manage infertility within the marital relationship. With the medicalization of infertility came more modern approaches to the treatment of infertility. However, apart from the high cost involved with accessing these treatments, other religious, moral and political considerations have affected its acceptability and usage within various cultural contexts.

It is therefore imperative to know how the urban Ghanaian society will react to these various elements of infertility care and its treatment, and these findings will be discussed in the empirical chapters of the thesis.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 INTRODUCTION

This chapter gives an overview of the various methodological choices employed by sociologists and anthropologists conducting research in the field of infertility. This serves as a basis for situating the research methods employed in this particular study. The chapter then follows with the philosophical and theoretical underpinnings guiding the selection of the methods for the study. This is merged with the methodological choices and strategies that were employed in this research. It also reports on the challenges that were encountered on the field and how attempts were made to resolve them. The chapter also gives a description of how data was analysed and concludes with a brief profile of the various sites where respondents were selected for the study.

3.1 RESEARCH METHODOLOGIES IN INFERTILITY STUDIES

As in all other areas of social scientific enquiry, researchers in the field of infertility also utilize quantitative and/ or qualitative research paradigms when obtaining information from their subjects. These quantitative studies have involved data gathered through large scale surveys while the qualitative data were collected through observations, in-depth interviews, and/or focus group discussions. Whereas the quantitative studies have been useful in providing information on large samples, the qualitative ones have served to enrich the data by providing details and insights into the population group.

With regard to research settings, there has been a general preference for clinic based studies especially in the West (Pasch & Christensen, 2000). This, however, has been criticized for its lack of generalizability to the other group of infertile people who do not access any form of

formal treatment or who do not access treatment at all (Greil, 1997). In response to this criticism, more and more studies are now being conducted on non-clinic based samples through the use of national samples (King, 2003) and internet surveys (Bunting & Boivin, 2007) amongst others.

This shift is more evident in the developing world where studies conducted on infertility have largely been community-based and ethnographic in nature (Greil, Slauson-Blevins & McQuillan, 2010). This has shed more light on the subjective meanings of infertility in varying socio-cultural contexts and has also shifted the reportage on Western style health care for infertility to other local options (ibid). However, questions about the representativeness of the samples in these small scale studies have been raised by critics as is generally characteristic of research that employs qualitative methods. The very delicate nature of research on a sensitive topic such as infertility, however, makes this approach more relevant especially when seeking to understand issues concerning meanings, experiences and responses to infertility and its treatment in different socio-cultural contexts.

One other contention in the literature regarding the selection of samples has to do with the conceptualization of the term infertility. Western biomedical definitions of infertility have the tendency to include or exclude from samples those categories of people who define their infertility using different personal or socio-cultural indicators. For instance, how would we classify a person who has had unprotected intercourse for a period of twelve (12) months without conception but who also did not have intentions of achieving conception and therefore does not define him/herself as infertile? In addition, literature from the developing world suggests different circumstances outside the biomedical definition within which people, especially

women, come to be defined as infertile by their societal members. Therefore, the ability to operationalize the definition as accurately as possible has implications for the representativeness of the sample selected.

In summary, whichever methods chosen by a researcher in conducting a study has its advantages and disadvantages in addressing the varying issues related to infertility. The best methods for any particular research depends to a large extent on the questions one seeks to answer and the researcher's evaluation of the best ways to achieve these objectives while maintaining rigor in the research process. In the next section, I discuss the philosophical underpinnings of my chosen methodology.

3.2 PHILOSOPHICAL FOUNDATIONS OF THE STUDY

A key item in the construction and process of any research is the philosophical basis upon which the methods selected for the study are built. The elements of ontology and epistemology are therefore crucial for social scientific research. Ontology refers to the form and nature of reality that researchers investigate whereas epistemology refers to the nature of the relationship between that reality and the researcher (Guba & Lincoln, 1994). These two elements are what lead to the methodological question of how the researcher will go about finding out what he/she believes can be known.

My ontological point of view regarding (in) fertility as a part of human existence is one consisting of individuals possessing different values regarding procreation that are continually being shaped/influenced by their experiences of the social world in which they live. Epistemologically, as the researcher, I am contributing to the construction of knowledge about

the experiences of infertile married men and women and about the responses that infertility generates in a particular social context. Qualitative methods are thus most suited for obtaining this kind of knowledge. This is because, it allows for an in-depth understanding of the infertility experience through the lens of the ‘sufferers’.

3.3 BRIEF PROFILE OF STUDY SITES

3.3.1 Lister Hospital and Fertility Centre - The High Tech Treatment facility

This hospital and fertility centre is reputed to be the most technologically advanced private hospital in West Africa. It began full operations in July, 2004 and has full accreditation from the Ministry of Health and is also regulated by the Ghana Medical and Dental Council. It is also a member of the Private Clinics and Maternity Hospitals in Ghana. The fertility centre at the hospital offers modern and advanced medical facilities for both in and outpatients, extensive general and specialist healthcare and diagnostic services. It is headed by a British trained Ghanaian who is a consultant Obstetrician Gynaecologist and fertility specialist with several years’ experience in the field. His team members are made up of 3 embryologists, including one consultant embryologist from Britain who comes into the country once every month during their fertility week. There are also other doctors, nurses and scientists all of whom specialise in various forms of assisted reproduction techniques.

The Assisted Conception Unit at the Hospital and Fertility Centre is a one stop fertility diagnostic centre which provides a detailed ultrasound scan as well as a detailed semen and hormone analysis to enable specialist doctors provide a couple with diagnosis of any fertility problem. The services they provide include donor sperm, sperm freezing, embryo freezing, embryo donation (donor eggs), surgical sperm collection, intra-uterine insemination, in-vitro

fertilization (IVF), intra-cytoplasmic sperm injection (ICSI) and natural cycle IVF. Once every month, there is a fertility week during which clients seeking IVF/ICSI treatment have their samples collected. After successful fertilization, they return to the hospital for the transfer of embryos and are subsequently advised to be on bed rest in the hospital for a period of five days after which they are discharged. An average of between nine (9) and fourteen (14) embryo transfers is done every month.

Clients of the fertility centre come from all parts of the sub region notably Nigeria, Sierra Leone, Liberia, and the world at large. A good number of the Ghanaians who patronise the centre live outside the country mostly in the United Kingdom and the United States of America. Not all cases are infertility related. Couples desiring to have multiple births or who have sex preferences also utilise the services of this fertility centre.

With regard to financial costs, at the time of the study, the cost of an IUI procedure was GHC 700 (about \$450). As part of the hospital's passion to provide couples with their much desired family, IUI procedures are repeated in an attempt to increase chances of conception. This is done the following day after the first procedure. It costs about GHC 10,000 (\$6,450) to undergo an IVF including medications, laboratory tests and admission at the hospital. However, when IVF is done with frozen embryos, the cost reduces significantly by about 75%. The cost of ICSI is higher at about GHC 11,500 (\$7,420). Patients undergoing either IVF or ICSI are required to be on bed rest at the hospital for about 5 days after the embryo transfer after which they are discharged to go about their normal duties. Table 1 below is a tabular representation of monthly embryo transfers conducted at the hospital for the year 2013. The table is provided to give the reader an idea of the frequency with which embryo transfers are conducted at the fertility centre

as well as the success rates of these transfers. As an illustration, in January 2013, a total of thirteen embryo transfers were conducted between the 9th and 22nd of January. Out of this number, four were successful (resulted in pregnancies). Likewise in February 2013, a total of seventeen embryo transfers were conducted at the hospital between the 22nd and 26th of February. Out of this number, five were successful. The success rates, however, do not necessary mean that all pregnancies resulted in a life birth as some of them are lost during the gestation period.

Table 1 Monthly embryo transfers and success rates for the year 2013

Month	Fertility week	Total number of Embryo Transfers (ETs)	Successful Embryo Transfers (pregnancy)
January 2013	09/01-22/01	13	4/13
February 2013	22/02-26/02	17	5/17
March 2013	23/03-26/03	17	11/17
April 2013	04/04	1	0
May 2013	02/05-05/05	17	2/17
June 2013	08/06-12/06	16	5/16
July 2013	27/07-31/07	12	6/12
August 2013	06/08-27/08	11	2/11
September 2013	06/09/-24/09	12	3/12
October 2013	01/10-15/10	6	0/6
November 2013	---	0	0
December 2013	04/12-24/12	22	06/22

Source: author's own

3.3.2 Champion Divine Herbal Clinic

Champion Divine Herbal clinic was established in 2002 to provide quality health services to Ghanaians and foreigners alike. It offers herbal medication to its clients for the treatment of all kinds of health conditions ranging from ulcer, stroke, fibroid, hepatitis, Sexually Transmitted Infections, low sperm count, sexual weakness, ovarian cysts and blocked fallopian tubes amongst others. Perhaps the multiple ailments for which they have medication to cure is what is reflected in their slogan, “ayaresa mu champion” meaning “the leader in curing illnesses”. The medications provided by this hospital are fully herbal based. The drugs are produced in Pakistan exclusively for the clinic and come in the form of capsules and tablets. One cannot find their drugs on the open market.

It is a well-equipped clinic with modern health facilities such as multipurpose diagnostic machines, laboratory equipment, ultrasound scan machines etc. Among the different health services, the clinic provides infertility treatment as well. In particular, infertility resulting from preventable causes can be remedied by using herbal medication available at the clinic. Interviews with the medical herbalist revealed that conditions such as ovarian tube block, ovarian cyst and fibroids can be treated with their herbal medicine without the need for a surgical procedure. There are also herbal medications for curing some Sexual Transmitted Infections (STIs) such as gonorrhoea.

The clinic has received a number of awards in the past. Notable among them is an award received from the New Ghanaian magazine and Nobles West Africa as the leading herbal based fertility clinic in 2009. It was also adjudged the most patronized herbal clinic and best alternative herbal clinic in West Africa in 2007 and 2008 respectively by the Intra-West Africa Communications Limited (Publishers of the West Africa International Magazine).

Consultants at the clinic have undergone training in herbal medicine at the Kwame Nkrumah University of Science and Technology, Kumasi. They have also gone through the necessary requirements for qualification as a medical herbalist².

3.3.3 Korle-bu Teaching Hospital

This hospital was established in 1923 primarily to address the health needs of the indigenous people of Accra and generally aims to continuously improve the quality of health care and enhance the satisfaction of its clients/patients in a most cost-effective manner. It is the third largest hospital in Africa and is Ghana's premier health facility. It is also the leading referral health centre in Ghana and is one of the tertiary hospitals located in the southern part of Ghana. It is located close to a lagoon, and derived its name from its location in the valley of this lagoon.

The hospital gained its status as a teaching hospital in 1962, when the University of Ghana Medical School (UGMS) was established for the training of medical doctors. The clinical and diagnostic departments of the hospital include the Accident Centre, Anaesthesia, Child Health, Laboratories, Medicine, Obstetrics and Gynaecology, Pathology, Polyclinic, Radiology, Surgery,

² The Kwame Nkrumah University of Science and Technology (KNUST) began offering a Bachelor of Science degree in Herbal Medicine (BSc Herbal Medicine) at the university in the year 2000. The successful completion of the four year program however is not equivalent to the license to practice. In order to qualify as a medical herbalist, one is required to undergo two additional years of internship training. These two years are spent at the Centre for Scientific Research into Plant Medicine (Mampong Akuapim) and/or the Tetteh Quarshie Memorial Hospital. This is an in-house training program. After the two years, a Professional Qualifying Examination for Medical Herbalists under the Traditional Medicine Council is written. This is a general requirement. A successful student thereafter possesses the title "Medical Herbalist" and is then licensed to operate as such. These licensed herbal practitioners thus provide their expertise to the growing number of Government hospitals in the country that provide herbal medicines to their clients as part of the treatment procedure (e.g. Police Hospital, Accra; Lekma, Teshie; St. Dominics, Akwatia). The majority, however, go into private practice.

and the Surgical/Medical Emergency. Other departments of the hospital include Pharmacy, Finance, Engineering and General Administration.

The Obstetrics and Gynaecology department of the hospital is divided into five units with a senior consultant heading each unit and other consultants and doctors equally distributed among the units. Each unit has its specific clinic, theatre and ward round days. The unit on call attends to all patients in the Obstetrics and Gynaecology wards as well as those coming in as emergencies and those admitted to the labour wards. The hospital does not have a separate unit for infertility care. Such clients are catered for at the obstetrics and gynaecology unit. This is indicative of procedures such as myomectomy (surgical removal of fibroids), diagnostic and therapeutic laparoscopic surgeries, excision of endometriotic lesions, tubal surgery etc. being offered by the department.

Although the hospital provides sophisticated and scientific investigative procedures and specialization in various fields such as neurosurgery, reconstructive plastic surgery and burns, renal, orthopaedics, cardiothoracic, paediatric surgery, it is yet to introduce assisted reproductive technologies as a treatment option to its clients. Most of the clients I identified at the out-patient department of the hospital with diagnosis of infertility have problems related to fibroids and amenorrhoea which fall within the group of preventable causes of infertility. The out-patient department of the gynaecology unit attends to about thirty cases on a daily basis about ten percent of which are infertility related.

3.4 METHODOLOGICAL CHOICES

3.4.1 Selecting and negotiating access to research sites

The overly sensitive nature of infertility makes it a difficult subject to discuss and one shrouded in secrecy. As a result, identifying the appropriate respondents for the study was a daunting task especially due to the heterogeneous nature of Accra, the study location. The initial sampling technique chosen was snowballing in the selection of respondents. This was chosen based on the inherent difficulty in identifying the target group of the study. However, taking into consideration the proposed sample size as well as the closed nature of the target group, this sampling method could not suffice. Thus, since the study is an exploration of the responses to infertility, including its treatment, the more appropriate alternative (in the researcher's estimation) for identifying respondents was to target hospitals and clinics where infertility care services are provided. Anecdotal evidence from media reports and advertisements suggest that Ghanaian men and women access various healing centres ranging from spiritual centres and traditional centres to formal health care providers in their search for biological parenthood. For the purposes of this study, primary focus was on formal health care institutions that provide services targeted at solving infertility in both men and women.

The research is a multi-site hospital study of three health-care providers. These three were selected based on the differences in their approach to solving infertility and consequently, the differences in clients patronizing these centres. In Ghana today, with the influx of Western technologies, the use of assisted reproductive technologies is gradually increasing. In addition, there has been a proliferation of herbal clinics in recent times especially in the capital city of Accra offering Western style herbal treatment for infertility. However, most of the facilities

identified within these two categories of health care providers are privately owned and thus not subsidized. The bulk of health care in the country is provided by the government. It was therefore expedient to include a public run health care facility. In order to reflect the health seeking behaviour of the contemporary Ghanaian in accessing health care, this study focused on these three different sites where different approaches to infertility treatment were offered. The sites comprised, a modern fertility clinic equipped with assisted reproductive technologies, a Western style herbal clinic and the obstetrics and gynaecology unit of a government hospital. These choices were also made in order to capture the diverse socio-demographic characteristics of the target group for the study to reveal any similarities or differences that may exist between them regarding their experiences of infertility and their responses to it.

At the time of the study, there were nine registered fertility clinics identified by the researcher located within the Accra-Tema metropolis which offer infertility treatment in the form of assisted reproductive technologies. They include: Del International Hospital, Family Health Hospital, Finney Hospital and Fertility Centre, Jubail Specialist Hospital, Lister Hospital and Fertility Centre, Medifem Hospital and Fertility Centre, Pro-vita Specialist Hospital, Tema Women's Hospital and Upscale Angels Fertility. Almost all of these centres were contacted and informed about the intention of the researcher to conduct fieldwork in their facility. Some disagreed outright whereas with others, it was the difficulty of meeting the one in charge who would give the final approval which posed the challenge. In one of these clinics, one of the workers confided to the researcher that, there were some ethical issues with the way the place was being run and that was why it would be impossible to get approval to use the facility as a research site. However, one of them namely Lister Hospital and Fertility Centre subsequently

agreed to the use of the facility as a research site and as such, follow up visits were no longer made to the other facilities.

Selecting a herbal clinic for the study followed a similar process. Major Western style herbal clinics located in Accra that provided services related to infertility care/treatment at the time of the study included Agbeve Herbal Hospital, Amen (Amin) Scientific Herbal Centre (named after its founder – Sheik Amin Bonsu), Blessed Herbal Clinic, Champion Divine Herbal Clinic, Prestige Herbal clinic, Sharp Sharp Herbal Clinic and Top Herbal Clinic amongst others. Findings from a pilot study revealed the popularity of two of these centres when it came to infertility care. One was, however, owned and run by Moslems with most of their clients being Moslems as well. This created a language and religious barrier between the researcher and the management and clients of the facility. Attempts at obtaining approval for the study were therefore met with disapproval. The other herbal clinic namely Champion Divine Herbal Clinic was, however, open to my request and was thus selected as the site for identifying and selecting respondents utilizing the services of medical herbalists for the treatment of infertility.

The third site for the study was selected based on its position as the major public hospital in the country as well as the country's major hospital for referrals. It was therefore justified to choose the Obstetrics and Gynaecology unit of this hospital as a study site. This hospital is the Korle-bu Teaching Hospital. Based on the aim of the research to be as inclusive as possible in terms of the categories of people seeking healthcare for their fertility problems, this site was ideal as it captured those categories of people who could not afford private healthcare.

3.4.2 Target population

This study targeted only those who were married and wanting to conceive. This is because, they are the ones who will feel the societal disapproval that comes with being infertile the most. This is based on the premise that childbearing is somewhat culturally restricted to those that the society has approved and accepted as being married. The target population for the study therefore included married infertile men and/or women (experiencing either primary or secondary infertility) who are seeking to have children of their own through either artificial (orthodox) or natural (herbal) means. It therefore excluded anyone found at the fertility clinic who is not married. Key informants comprising the owners and operators of the fertility clinics, other hospital staff and Christian religious leaders (since Ghana is predominantly Christian in religious orientation) were also interviewed in this study.

3.4.3 Sampling size and procedure

There is no existing sample frame for the target population. Based on the exploratory nature of the research, a total sample of forty-five (45) respondents was selected for the study. As a qualitative researcher employing the phenomenological approach in research, my aim was not to have a sample that is representative of the larger population. Rather, my sampling was influenced by an understanding of the experiences of Ghanaian infertile married men and women from their own perspectives. The number of respondents sampled was therefore determined by the overly sensitive nature of the research and the difficulty in getting respondents to open up and reveal the secret aspects of their life regarding their experiences of infertility. As noted by Patton (2002), in qualitative research, there are no rules for sample size; rather, the sample size depends on, amongst other things, what is being investigated and the purpose of the research. This number of

respondents was therefore enough to provide the in-depth, rich data that was required in the study.

Purposive sampling was first used to select respondents based on the type of healthcare being accessed. Accidental sampling was then used to select clients seeking fertility care from the three research sites already identified. With respect to the key informants for the study, the religious leaders were purposively selected based on their religious orientation. Specifically, one of them is a Catholic priest, and the other a Protestant. Some members of staff at the hospitals/clinics who were in constant interaction with clients of the hospitals also served as key informants. These were selected based on the fact that, they had additional information that the researcher is not privy to which would enrich data for the study.

3.4.4 Data collection instruments

Semi-structured in-depth interviews were the main data collection instruments for this study. The semi-structured interviews consisted of several key questions that defined the areas the research explored (see appendix A). One advantage of this instrument is that it allowed the researcher to diverge to pursue ideas or responses that emerged during the interview period (Britten, 1999). Furthermore, the semi-structured in-depth interview was appropriate because the research sought to elicit information from respondents (through their descriptions) about their meanings and interpretations of infertility as they experience it (Kvale, 1983). It also allowed flexibility for the emergence of themes related to their experiences which were not previously anticipated by the researcher. With this instrument, the respondents became active participants in the communication process and were able to reveal their subjective meanings through their verbal and non-verbal cues (Kreuger and Neuman, 2006).

Data from the semi-structured interviews were supplemented with observations of non-verbal cues. This approach provided me with what Lincoln & Guba (1985:273) refer to as an “in depth here-and-now experience” of my respondents experiences of and responses to infertility.

In addition, field notes on observations, thoughts and ideas concerning the entire research process were made during or at the end of a day spent on the field. Since the research process is a continuous one, I continued to take notes (even on days when I did not visit research sites) on any random encounters I had on the subject of infertility which were in line with my research objectives.

In summary, this is a breakdown of how data for the research was gathered:

- Observation of activities taking place in each of my research sites which are directly related to the diagnosis and treatment procedure for patients desiring to have children
- In-depth interviews with patients visiting the research sites with the particular aim of having children of their own. This entailed fifteen respondents selected from each of the sites for interviews.
- In-depth interviews with key informants comprising the owner of one hospital, the medical herbalist of another clinic, two embryologists, two gynaecologists and two religious leaders.
- Follow up interviews and conversations with some key informants and clients of fertility clinics
- Study of some hospital documents and records, newspaper articles, bill boards and radio advertisements

3.4.5 Additional data sources

At the tail end of my data collection, there emerged a lot of media hype in Accra on the issue of infertility in Ghana. It began with the advertisement of a conference being organised by the owner/Chief Executive Officer of a Non-Governmental Organisation with the name “The Association of Childless Couples of Ghana” (ACCOG). Having been established in 2012 by the owner who himself had been in a childless marriage for the past ten years, the conference sought to, amongst other things, reduce the burden of childlessness on infertile couples by facilitating their access to other alternatives of having children such as adoption and low cost IVF. This advertisement coupled with the presence of the CEO of ACCOG on various media platforms, led to a number of documentaries and news items being run on the radio and television stations about the issue of infertility in the country. For that matter, additional data for this study was gathered from the news items and documentaries that were being aired at the time on the issue of infertility in Ghana. Joy FM, Ghana’s leading English speaking private radio station located in the capital Accra with affiliates in other regions in the country as well as internet presence was another source of this information. I also interviewed the CEO of ACCOG (who is also an ‘elder’ in a Pentecostal church) in order to gain more insight into the experiences of the infertile since he served as a contact point for them.

Furthermore, I found it useful to observe and take part in a religious program that was organised by the International Prophetic Centre (a charismatic church located at Ashaley Botwe) dubbed “Operation 1000 Babies”. This event was held on the 1st of March and was an annual event that was organised by that particular church. This was its fourth year running. This exercise was very beneficial as part of the research process in giving me a deeper understanding of the religious context surrounding infertility and its treatment.

3.4.6 Negotiating access to potential respondents and initiating the data collection process

At Lister Hospital and Fertility Centre, it was difficult identifying the right respondents to talk to as is characteristic of the initial stages of every research. This was because the hospital offered general gynaecology and medical services in addition to the infertility care they provided. In addition, clients of the hospital were what could be described as high class society members who had reservations speaking to anybody who was not a member of staff at the hospital. The protocol of the hospital also did not permit me to go directly to these clients. I therefore relied on the staff to assist me. Initially, I requested to sit in consultation sessions with the doctor but this was not favourable to the doctor and I was allowed to sit in on only one consulting session. Subsequently, I tried identifying the target group while they sat in the waiting area prior to the doctor's consultation by handing out flyers regarding my study. I had no positive response from this as well. Finally, upon consultation with the doctor's assistant, she suggested that the most effective means of identifying and speaking to prospective respondents was to target them during the monthly fertility week when they would be on admission at the wards after the successful embryo transfer procedure. This proved very useful and as such, over a period of 10 months, respondents (who had undergone either IVF or ICSI) were selected for interviewing during the fertility week while the clients were on admission at the hospital. A few others whose procedures did not require hospital admission (that is, those coming for intra uterine insemination/IUI procedures) were identified with the help of the embryology staff of the hospital. Clients were more receptive whenever either one of the embryologists first spoke to them and informed them of my research intentions before subsequently being introduced to them.

At Champion Divine Herbal Clinic, I was given permission by the medical herbalist to sit in the consultation room with him to enable me identify those who were seeking infertility care and treatment. I usually arrived at the hospital at about 8am and stayed on till about 3pm when the number of clients coming in for consultations had reduced to the barest minimum. In the consulting room, I was given a lab coat to wear at all times and this helped clients to feel at ease with my presence although they did not know me. The herbalist introduced me as a student conducting research but I dare say my apparel also gave me an added advantage as some regarded me as an assistant to the “doctor” (as the medical herbalist was popularly referred to). Some of them therefore sometimes engaged me in the conversations they were having with the doctor by asking my opinion about certain issues being discussed. These questions were, however, not related to the scientific field of medicine. During such moments, I tried my best to voice my opinions based on my knowledge of the situation or previous experience. My presence in the consulting room prior to the interviews not only helped in identifying potential respondents but also gave me a glimpse into their situation even before the start of the interview. This was beneficial in making the interviews more fluid. My presence in the consulting room prior to the interview also helped respondents to be more open as they regarded me as part of the health personnel and therefore trustworthy to share their personal stories with. This may also be because they felt by being open, I could be better placed to assist them medically on their path towards achieving desired conception.

Whenever I came across a potential respondent, I would walk out of the consulting room with him/ her and sit in the waiting area until he/she finished running all the required tests. I would then speak to the client as they waited for their test results. This waiting period usually lasted for

between an hour and two hours and was thus an opportune time to conduct my interviews. After the interview, I usually walked back into the consulting room with the client and sat in while the medical herbalist explained the results to the client and offered prescriptions. This experience helped me capture some of the dialogue that took place between the medical herbalist and the client related to their diagnosis and negotiations regarding treatment and its costs. Following that, I stayed on in the consulting room until I identified another potential respondent. The usual routine previously outlined was then followed with each potential respondent that was identified. With time, there was the need to conduct follow up interviews with respondents in order to enrich the data collected. I was able to do this by requesting the telephone numbers of the respondents and contacting them at later dates for any additional information. These subsequent interviews were, however, conducted at a location of their convenience such as their work place, over the telephone, or the clinic. In most cases, respondents were comfortable conducting the interview during their next visit to the clinic since it served as a neutral ground for them where anonymity could be assured.

Finally, at Korle-bu Teaching Hospital, gynaecology and obstetrics consultations were held every week day. There are usually about five different gynaecologists consulting at the same time every day. I received an introductory letter from the owner of Lister Hospital and Fertility Centre addressed to the head of the Gynaecology and Obstetrics unit of Korle-bu Teaching Hospital who was his classmate in school and a good friend of his. This letter facilitated the approval to conduct the study in the hospital. After being introduced to the Deputy Director of Nursing Services (DDNS) and her assistant, I was set to start with data collection. On a typical day, I arrived at the out-patients department (OPD) of the gynaecology unit of the hospital

around 8:30am. This is usually the same time that the nurses begin sorting out the patients' folders according to the gynaecologist they were going to see. I identified a nurse who could assist me in identifying the kinds of people I needed for my study as she sorted out the folders for the day. I was, however, not allowed to be part of this process and so she often drew my attention whenever she identified a patient who was a potential respondent through her health records. She revealed to me that she was able to identify them through the medications that were being prescribed for them or through their laboratory requests. She then advised me to call out the name of the patient just as the nurses do when they are preparing the patients in a queue for consultation. I then walked with the patient to a part of the waiting area where no one else was sitting and we were assured of privacy. Almost all the potential respondents selected in this way consented to the interview. However, on a typical day, I could identify only one or two potential respondents as most of the cases coming in were for general gynaecological care, ante-natal or post natal consultations.

Almost all the interviews I conducted with respondents from Champion Divine Herbal Clinic and Korle-bu Teaching Hospital were done in the local languages (Twi and/or Ewe). A few interviews at Lister Hospital and Fertility Centre were also done in the local languages (Twi and/or Ewe). Additionally, the informed consent of respondents who willingly took part in the research and who did not withdraw from the research at any point in time was secured.

3.5 ETHICAL CONSIDERATIONS

As much as infertility cannot remain hidden for long, it is a subject that is shrouded in secrecy. This is because of the stigma that comes along with the inability to fulfil this marital obligation. Utmost care was therefore taken to protect the interests of all the informants in this study. Ethical

clearance was first received for this study from the Institutional Review Board of the Noguchi Memorial Institute for Medical Research, University of Ghana. In order to ensure that no physical or psychological harm was suffered by any of the respondents, the following steps were taken:

- Request the voluntary participation of potential respondents: this means that informant participation was free from coercion or excessive inducement and they were given the freedom to withdraw from the research at any time without any penalty,
- Secure potential respondents' written informed consent to participate in the research: this means that respondents were informed about the aims and objectives, risks and benefits, of the research in the language they understand to enable them do self-evaluation before assenting to participate; and
- Ensure the privacy and confidentiality of data collected: this means that steps were taken to safeguard participants' right to privacy since the information they provided could embarrass them when revealed. Data gathered was kept strictly confidential and publications that will result from the research will be presented in a form that ensures complete anonymity of all participants.

3.6 ANALYSIS OF DATA

Qualitative data gathered through semi-structured in - depth interviews and conversations were recorded and transcribed. In some instances, interviews could not be recorded and as such notes were taken. These formed part of the field notes and were all used in analysing the data from the research. Data were analysed manually and content analysis was the main tool employed in the analysis of data from this study. Robert Philip Weber (1990:9) defines content analysis as “a

research method that uses a set of procedures to make valid inferences from text. These inferences are about the sender(s) of the message, the message itself, or the audience of the message”.

The transcripts including the field notes were first organized into manageable units guided by the objectives of the study. I then compared transcripts of a particular unit and grouped those with similar meanings or connotations by assigning codes to them. Some of the codes were also derived from terms used by the respondents. Similar codes were synthesized to form a category. This process was followed for all the various units that the transcripts had been organized into. Subsequently, the constant comparison of these categories and the search for patterns helped me to group those categories that share some commonality into clusters which subsequently formed the themes discussed in the empirical chapters. They also formed the basis for the organization of the chapters of this thesis.

The process of discovering what was important and what was to be learned as well as deciding what to report was guided by the objectives of the study coupled with my prolonged engagement with the respondents and the long hours I spent at the research sites. This culminated in transcripts and field notes that as much as possible reflected the voices of the respondents. Other mediating factors based on the characteristics I possess and my role in the research that could have influenced the research process are discussed in the next segment.

3.7 REFLEXIVITY

Reflexivity according to Ruby (1980) refers to an assessment of the influence of the researcher’s background, perceptions and interests on the qualitative research process. As the researcher, I cannot deny my involvement in the construction of knowledge influenced by my own social

experiences. Being a married woman I was mindful of the fact that, by sharing my own experiences in marriage with my respondents, I would become a co-producer of the data derived and analysed from the study. I was therefore torn between revealing this status to my respondents or not. This is because, often times, the next question one asks when they find out someone is married is the number of children they have. Thus, in an attempt to avoid that question, I did not go out of my way to reveal my marital status to respondents. However, I also did not hesitate to let them know of it whenever the question came up during interviews and subsequent conversations.

For some of those who did not know that I was married because of the absence of a ring on my finger and my non-disclosure of my marital status to them, my identity as a student conducting research is what stood out and may have affected their responses negatively or positively. This is because, my outsider position of not fully understanding their experiences since I was still 'single' and therefore had not gotten to that stage in my life yet, coupled with the misinterpretation of the fact that I was doing the research solely in fulfilment of an academic requirement, could have contributed to some of the respondents not revealing their 'full' story to me. On the other hand, the sharing of this insider status helped some respondents to identify better with me provided my outsider position of not being infertile remained undisclosed. Due to the flexibility allowed in qualitative research, I shifted between disclosing and not disclosing my marital status to my respondents whenever I deemed it fit.

Furthermore, my outsider status of having two children of my own created some discomfort for me especially when interviewing some of the respondents who were childless. This happened when interviews got emotional and during such moments, I felt their pain and frustration. Having experienced some challenges myself when I was trying to conceive (marked with miscarriages

and being put on bed rest so I do not lose the subsequent pregnancy), their stories reminded me of my own experiences during that phase in my life. However, I do not purport to fully know how it feels to be trying to have a child with no success. This is because the subsequent birth of two children has caused those experiences to somewhat lose their hold on me. Bearing all of this in mind, I took extra care whenever I was conducting interviews in order not to undermine the position of the respondents.

For my male respondents as well, my outsider status of being a woman could have contributed to the way they responded to me. They often summarized their experiences and though I tried to probe further, they were still economical with information. I tried to lessen this effect by employing the services of the medical herbalist to sit in with me and ask some of the questions during my interviews with the males. This proved to be quite useful although I believe I did not obtain the same depth of information as I did with some of my female respondents.

3.8 CHALLENGES ENCOUNTERED IN THE FIELD

Although the fieldwork proceeded fairly well, it was not without some difficulties and limitations. Each site presented a unique challenge to me in terms of accessing the potential respondents. Despite months of conducting research at Lister Hospital and Fertility Centre, prior to each interview, one of the embryologists always had to speak to each potential respondent and receive their consent first before I had the chance of presenting myself to them. Although beneficial in allowing more people to agree to taking part in the study, there were instances where the respondents withdrew from the study because they thought that for a student conducting research, I was prying too much into their private lives. The majority of clients visiting this hospital were highly educated and could be described as an elite group of the

Ghanaian society who were uncomfortable opening up to me. There is the popular notion that, the rich do not have any problems in this world and I dare say their very attitudes sought to confirm that notion. This also resulted in my inability to establish friendships (which would have allowed me to make follow up interviews) with a greater number of them as they were always very busy with their work schedules. About half of them were also living outside the country and only visited occasionally.

On the other hand, access to respondents at the herbal clinic was relatively easier. This could be attributed to the characteristics of the majority of clients visiting the health facility. Being of middle class and low class status, with relatively less education, they were less critical of my presence. I received the typical unquestioning attitude and respect that the ordinary Ghanaian gave to a medical doctor (one who has spent many years in school). However, within that context, respondents often felt I could assist them in one way or the other. Redefining my role as a researcher to them led to a situation in which in most cases, they still preferred to see me as a medical practitioner who could solve their fertility problem for them.

It was a different challenge at the government hospital. This is because, there is an outpatient department for the obstetrics and gynaecology unit of the hospital and identifying fertility cases required more effort. Since I had to rely on one of the nurses in identifying potential respondents for the study, it was completely up to her to decide who was a potential respondent or not. This meant some potential respondents could easily be overlooked.

Furthermore, my request to use a recorder for the interviews was sometimes met with suspicion, fear and even disapproval. These respondents expressed fears about having their voices played back on the radio or on the television since they could easily be identified by their friends and

relatives should that happen. This was especially so because as indicated earlier, during the time of the research, there was media hype about infertility on radio and television stations. This resulted in some interviews not being recorded. Coincidentally, these respondents were the ones who in my opinion opened up the most and had a web of issues surrounding their experiences. As such, during the interview, I made note of some of the expressions they used and jotted points that would help me remember the details. In order to capture all that they said, I re-wrote their stories soon after the interview. However, some parts of the data were inevitably lost. Similarly, the need to sign a consent form further questioned their anonymity. As such, I did not make it an obligatory part of the research since I made sure they consented to the interview before starting and also gave them the opportunity to withdraw whenever they felt like doing so.

There was also the issue of “reluctant informants”. Although these respondents had agreed wholeheartedly to the interview, they sometimes withheld some information or gave false information about themselves. For instance, in order to fully understand their experiences, I sought to find out whether it was male factor or female factor infertility. However, some respondents did not disclose this to me. This can be attributed to the sensitive nature of the problem and the respondent’s desire to cover up his/her circumstances. However, there were also situations whereby the respondents genuinely did not understand whatever diagnosis and/ or treatment they were being given and relied solely on the trust they had in the medical practitioner.

In addition, the researcher sought to have as many male respondents as female respondents in the study. Identifying these respondents from the health care centres was meant to serve the latent function of assisting me to create a balance between the sexes when it came to sampling respondents for the study. This is because, at two of these sites, it was mandatory for both

couples to attend the hospital for proper diagnosis before the commencement of treatment. However, due to the various ways in which I identified the clients, it became difficult to achieve that balance. Since it was women whose bodies went through the treatment process at Lister Hospital and Fertility Centre, I had access to more females than males there. Also, at Champion Divine Herbal Clinic, although I met couples, conducting couple interviews revealed to me some disadvantages since one party often remained quiet while the other did most of the talking. Whenever I tried to get the other person's comments, the response was always in affirmation of what the other partner had said. For that matter, I decided to do follow up interviews and in most cases, the women were the ones I was able to get a hold of. For that matter, their voices became more pronounced in the interviews. Male interviews were more plausible when it was only the man who visited the hospital or in cases where the partner was less literate and thus fell under the shadow of the man.

3.9 LIMITATIONS OF THE STUDY

It was the aim of this study to explore the experiences of infertile married men and women in marital unions and how they respond to their infertility in modern times with particular reference to their attempts at solving their infertility. Respondents were selected from hospitals and clinics that provide such services. For that matter, the research findings cannot be generalized to those who do not seek treatment.

Furthermore, there are several strategies that childless/infertile couples in Ghana employ in their search for biological parenthood. Some of these are not institutionalized and therefore cannot be found within the formal health care system. Billboards and other print and electronic media operating in the city reveals the existence of other health seeking avenues for infertility such as churches (especially charismatic), local medicine men/herbalists who sometimes double up as

spiritualists, itinerant herbal and orthodox medicine vendors as well as the influx of Chinese medicine on the market. Although I tried to interrogate respondents' use of the church and these other local sources of treatment, the data gleaned from their responses may not be comparable to those for whom that was the only option or who solely relied on those sources of treatment. Nonetheless, their experiences of these other sources of treatment provide useful insights that require further interrogation in subsequent studies in order to enrich the data.

3.10 CONCLUSION

In this chapter, a review of the methodological choices employed by researchers conducting infertility studies was made. This formed a basis for discussing the methodological choices made in this particular study. The chapter also provides a brief insight into the activities of the three study sites selected for this research. The methodological choices and the rationale behind the choices were also discussed extensively. The chapter also includes reflections on the research process as well as some dilemmas encountered during the research process. In the subsequent chapters, I present an analysis of the data gathered from the research based on the broad themes that emerged from the data and informed by the objectives of the research.

CHAPTER FOUR

THE RESPONDENTS AND THEIR REASONS FOR DESIRING BIOLOGICAL PARENTHOOD

4.0 INTRODUCTION

In this chapter, readers are first presented with two case studies illustrating the experiences of infertile respondents and their attempts at obtaining treatment. Subsequently, the study participants are introduced by discussing some socio-demographic characteristics of the respondents and how this has influenced their choice of treatment. The question regarding the various motivations behind infertile married men and women's search for treatment drawing from the attitudes of family members (including spouses), friends, colleagues and other societal members towards these respondents is also answered.

Ophelia's story

Ophelia is a 45 year old petty trader who could not continue her formal education after class four. She is a Christian who attends a Charismatic Church. She has been married for about twenty years now and has no child. Soon after moving in with her husband, they began actively trying to conceive. Year after year passed with no success. She, however, prayed and hoped that she would be able to conceive soon. She began to face problems in her marriage as a result of her inability to have a child. In her desperation, she tried anything and almost everything that anyone recommended to her. She visited several prayer camps and drank different types of herbal preparations. She also visited a government hospital every now and then. However, she was constrained by the little money she earned in her trading activity. For that matter, there were times when she

could not afford the medication that was prescribed to her. She was not too sure about what accounted for her inability to conceive. Her menstrual cycle has always been irregular. Sometimes, in a whole year, she has her menses only three times. Her husband does not accompany her on any of her visits to the hospital. He has refused to do so. Neither does he support her financially when it comes to buying the necessary medication. It has been a lonely journey for her. Her marital relationship changed for the worse when her husband had a child out of wedlock five years ago. He does not try in any way to conceal this child from her. He even brings the child home to spend weekends sometimes and other times too, her husband leaves home for about one week at a time to stay with his child's mother. Her sisters-in-law are accusing her of being barren and keep picking quarrels with her in an attempt to get her to leave her marital home. Sometimes, her husband also passes comments to that effect. She is therefore on the verge of losing her marriage especially if she is unable to give birth to a child anytime in the near future. This situation has made her more desperate now than ever before to have a child because she has toiled with her husband all these years and now that things are better financially, she feels she is losing out since she does not have any children with him. Even if she is able to sustain the marriage, she believes her husband will leave her with very little or nothing at all when he dies because of her childlessness.

Belinda's story

Belinda is a 42 year old woman who holds a managerial position at one of the Telecommunication Companies in Ghana. She has a Bachelor's degree from one of the Universities in the country and has also completed several professional courses related to her field of work. She is a Christian who attends one of the orthodox churches in Ghana

and is also an orphan. She has been married for the past twelve years now with no child. She recounts how after one year of marriage, her mother-in-law (who was a medical practitioner prior to retirement), spoke to both her husband and herself and encouraged them to go and have tests done to determine if everything was okay. According to Belinda, her mother-in-law advised that, her husband goes for the tests first since it was easier and less cumbersome testing a male as compared to a female. All the tests conducted at that time showed there was nothing wrong with both of them with respect to their reproductive abilities. After 6 years of marriage when she had still not conceived, her mother-in-law's sister advised them to go and try IVF but they hesitated. This was mainly because of the financial cost involved with the procedure. Fortunately, in her 8th year of marriage, she conceived and carried the pregnancy for 6 months until one night when her water broke. All attempts to access healthcare that night failed (since it was a holiday) leading to the loss of her baby - a very painful experience which she has still not gotten over.

After persistently trying to conceive naturally for another two years with no success, the couple decided to go for an IVF procedure. Upon the doctor's advice, she went through both an IUI and an IVF procedure during that same time but did not get pregnant from both procedures. The disappointment that came with such bad news did not make them consider the procedure anymore until this year (two years later) when they decided to try again since she had still not been able to conceive naturally. However, the doctor advised that she used donor eggs this time round. She recounts how a friend had told her about her success story after receiving care from another fertility clinic. What was more important to her was that her friend had her own eggs used for the procedure although she

was 45 years old at the time (that is, three years older than she currently is). For that matter, she decided to come to this fertility clinic (which her friend used) for treatment. This is her preferred choice of treatment because over here, she can get to use her own eggs through ICSI.

Her mother-in-law and her husband have been very supportive. Her step mum has also never given her any worries concerning her childlessness. However, she feels incomplete without a child. She always feels uncomfortable around colleagues at work, in church and amongst friends because she feels everyone is talking about her childlessness. Whenever people are having a conversation without her, she feels she is a subject of their conversation because she sometimes notices their glances at her and overhears their comments. She is very affected by her childlessness and prays for God's intervention. She believes God's time is the best and only He knows why it is taking so long for her to conceive and subsequently have a child of her own.

These two case studies present two different scenarios that one is likely to encounter upon a visit to a fertility clinic in Ghana. Although the first case is more common than the second, some experiences run through all cases notably societal reactions to the infertile. These two women are both experiencing primary infertility but come from different socio-economic backgrounds which had an influence on the way they perceived and dealt with their situations. However, irrespective of these differing circumstances, they both find themselves in a cultural context where childbearing is mandatory in marriage and therefore become subjects of either subtle or intense ridicule and stigmatization from family members, friends, colleagues, acquaintances and generally anybody who gets to know of their situation. This situation creates a lot of discomfort for them and results in an endless search for biological motherhood.

4.1 THE CLIENTS' PROFILES

All the men and women who participated in this study were Ghanaians. They lived and worked in all parts of the country as well as abroad and when necessary, they travelled to the nation's capital, Accra to access fertility treatment from their preferred hospital or clinic.

Table 2 Socio- demographic background data of study participants

Characteristics of respondents	Korle-Bu Teaching Hospital (n=15)		Champion Divine Herbal Clinic(n=15)		Lister Hospital (n=15)		Total		
	Frequency	Percentage (%)	Frequency	Percentage (%)	Frequency	Percentage (%)	Frequency	Percentage (%)	
Sex of respondents									
Male	0	0.00	5	33.33	0	0	5	11.11	
Female	15	100	7	46.67	13	86.67	35	77.78	
Couple	0	0.00	3	20.00	2	13.33	5	11.11	
Age of respondents									
20-29	3	20.00	5	33.33	1	6.67	9	20.00	
30-39	9	60.00	7	46.67	7	46.67	23	51.11	
40-49	3	20.00	3	20.00	5	33.33	11	24.44	
50-59	0	0.00	0	0.00	2	13.33	2	4.44	
Years of marriage									
0-4	6	40.00	6	40.00	3	20.00	15	33.33	
5-9	6	40.00	3	20.00	5	33.33	14	31.11	
10-14	2	13.33	5	33.33	4	26.67	11	24.44	
15-19	1	6.67	0	0.00	1	6.67	2	4.44	
20-24	0	0.00	1	6.67	1	6.67	2	4.44	
25-29	0	0.00	0	0.00	0	0.00	0	0.00	
30-34	0	0.00	0	0.00	1	6.67	1	2.22	
Number of children									
None (primary infertility)	10	66.67	10	66.67	10	66.67	30	66.67	
Child in current relationship	1	6.67	2	13.33	2	13.33	5	11.11	
Child from previous relationship	Man	1	6.67	2	13.33	1	6.67	4	8.89
	Woman	0	0.00	0	0.00	1	6.67	1	2.22
	Both man and woman	2	13.33	0	0.00	0	0.00	2	4.44
Deceased	1	6.67	1	6.67	1	6.67	3	6.67	

4.1.1 Sex distribution of respondents

In all the centres, I spoke to more women than men and couples based on their availability. A total of 35 respondents constituting 77.78% of respondents were female, with five (11.11%) being male respondents and another five (11.11%) constituting couple interviews. As previously noted, the structural arrangement of the centres could have accounted for the presence of more women than men. At Korle-bu Teaching Hospital, since the site for the study was the out-patients department of the gynaecology unit, this may have had an influence on the non-availability of males. However, what is of interest is that, none of the women I spoke to at the government hospital were accompanied by their partners. At Lister Hospital and Fertility Centre also, probably the mode of selection of my respondents could have had an influence on the gender imbalance. Respondents were sampled and interviewed while on admission after undergoing treatment in the form of an intra-uterine insemination or an embryo transfer procedure. Since men do not undergo such treatment, it therefore stands to reason that, sampling men will be an impossibility. However, on few occasions, I chanced upon husbands who had come to visit their wives in the hospital which gave me the opportunity to interview both partners. At the herbal clinic also, I selected the respondents as I sat in the consultation room. This could have accounted for the reason why I was able to sample men as well. In sum, two of the research sites have been designed in such a way that, either male or female can walk in for diagnosis and treatment. The third one being the public hospital is, however, more female biased. All these methodological limitations notwithstanding, studies from Africa and other parts of the developing world have shown that, infertility blame and its treatment have been skewed towards women more than men (Inhorn 1994; Nahar 2010).

The women gave several reasons as to why they often initiated treatment. Although all three research sites request that both partners come in for diagnosis, conversations with respondents revealed that, for most of them, their partners only come to the hospital upon the request of the doctor. As such, they only come in when their semen is needed for analysis or for artificial insemination. One reason the women gave for their role in initiating treatment is the fact that, they feel the societal pressure to conceive the most as compared to their male counterparts. This finding is also evidenced in studies contained in Inhorn and van Balen (2002).

Another reason why the women felt they had to initiate treatment was because they feel they are the carriers of the embryo and so whatever the case may be, it will be imperative to make sure that they have the ability to get pregnant and carry the pregnancy to full term before getting to know if their partners were also capable of impregnating them. This goes to show that, sometimes, the women are the first ones to blame themselves for their situation. In other situations, however, these women were blamed by their spouses for infertility in the marriage. For example, Nyamekye's husband refuses to accompany her to the hospital for a diagnosis because he does not think he has any reproductive disorder. This is because, according to him, two of his past girlfriends had gotten pregnant for him while he was dating them. This, in his view rules out any incapability on his part of getting a fertile woman pregnant. As such, though Nyamekye's diagnosis does not reveal any reproductive disorder (which she has informed her husband about), he continues to desist from going to the hospital to have any tests run on him. Studies on the utilization of health care services suggest that in all parts of the world, infertility is seen more as a woman's problem than as a man's problem (Abbey et al., 1991; Inhorn, 1996; Greil, 1997) and this reinforces women's urge to find out their fertility status where there is a difficulty in childbearing in the union.

Furthermore, some of the women interviewed also said they did not want to “bother” their husbands with such visits to the hospital since their husbands had relatively busier work schedules. For example, according to thirty-two year old Silvia,

It is almost impossible to get my husband to come with me to the hospital. He is always very busy with work and cannot find the time to do so. Besides, he is not very bothered about our childlessness because he keeps saying I am still young.

Women in such circumstances therefore said they preferred to undergo all the necessary tests and thereafter inform their husbands of the doctor’s diagnosis. Following that, and if need be, they can then request that their husbands accompany them to the hospital on their next visit. Contrary to this view that wives held, personal conversations with the doctors revealed that, it is simpler to test the male partner, since, comparatively, the female reproductive system was more complex and required more clinical examinations in order to determine the cause of infertility.

However, a few men seek treatment first and they do so secretly. This is because they want to know first-hand if it is a male factor infertility problem or not. Twenty nine year old Mustapha has been married for about eight years now without a child. He and his wife have been taking herbal preparations for boosting fertility bought from itinerant herbal vendors for many years now without any positive results. I met him on his first visit to the herbal centre. It was the first time he was going to receive a diagnosis concerning his inability to conceive. I was in the medical herbalist’s consulting room with him and after reading through his test results, the practitioner informed him that he had very low sperm count. Subsequently, he was advised to bring his wife for the necessary tests to be conducted on her as well which he declined. According to him,

I do not want my wife to know of my condition. Everyone in the family blames her for our childlessness. Should she get to know of my condition, her attitude towards me may change to my detriment and she may even be forced to reveal my condition to anyone who blames her for our childlessness. I cannot deal with that. I would rather keep this diagnosis from her than risk letting my condition become public knowledge.

As such, for men like Mustapha who took the initiative to seek diagnosis and treatment for infertility because they were worried about their wives' inability to conceive, receiving a negative diagnosis prevented them from attending the hospital with their spouses on subsequent visits. This is because, they did not want to bear the blame for infertility and thus risk losing the respect of their wives and other family members.

4.1.2 The Age factor

The ages of participants at the time of their inclusion in the study (November 2012- November 2013) ranged from twenty-one to fifty-eight years. Given that only 2 respondents, (representing 4.44%) were between the ages of 20 and 24 at the time of their inclusion in the study, it shows that most respondents were older than the age considered to be the most fertile period in one's life (Utting and Bewley, 2011). The largest age group was the 30-39 age group which represented more than half of the total number of respondents (i.e. 51%). A further breakdown of this shows that in all, 20 respondents (representing 44.44%) were below the age of 34 at the time of their inclusion in the study. This means that, the likelihood for the remaining 25 respondents (55.56%) to have children naturally without any medical intervention is reduced since, biologically, their fertility has also reduced.

According to the American Society for Reproductive Medicine (2012), it has been medically proven that the single most important factor influencing a woman's ability to conceive is age.

Studies have also shown that, women are most fertile between the ages of 20 and 24 (Utting and Bewley, 2011). Fertility starts to decline from the age of 30 and drops very steeply from age 35 (NCCWCH 2013). Although the decline in fertility for men is more gradual, the proportion of men with sperm disorders also increases with age (RCOG 2011). Gynaecologists also attest to the fact that it is best to start a family before age 35 (Utting and Bewley, 2011).

However, the influence of one's age on their reproductive abilities is related to their age at marriage. An analysis of the data from the study regarding the relationship between respondents' education and their age at marriage is consistent with the 2010 census data. Respondents with lower levels of education generally got married at earlier ages than respondents with higher levels of education. This was also linked to their employment status with a greater proportion being unemployed or employed in the informal sector. As such, the desire to have children at that earlier age stemmed from the fact that, they were already married and needed to fulfil their marital obligation of procreating. In addition, their colleagues were already having children and this further compelled them into seeking a solution to the challenges they were having with childbearing.

The reverse holds for the older starters (age 30 and beyond). These invariably got married late due to their quest for higher education and therefore postponed childbearing till after marriage. However, other factors such as the absence of a partner, previous history of a reproductive failure (e.g. miscarriage) etc, also accounted for such late starts. These will be discussed in subsequent chapters.

According to the GSS 2010 Population and Housing Census data, more people are currently pursuing education today as compared to four decades ago (40.7% in 2010 as against 14.2% in

1960). In addition, more females are pursuing higher education than in the past. At the University of Ghana for instance, the proportion of female enrolment increased from 9.1% in 1961/62 to 42.4% in 2008 (ibid). Education is generally a necessary prelude for entering into paid formal sector work which subsequently equips one to becoming independent of the family and thereafter establishing one's own family. Therefore, the higher the level of education, the higher the age at marriage and this is consistent with data from the GSS 2010 Population and Housing Census.

4.1.3 Duration of marriage

The number of years that respondents had been married ranged between 0 and 30 years with the highest frequency falling within the 0-4 years duration of marriage closely followed by the 5-9 years range. This only goes to buttress the point that married couples in Ghana would want to conceive soon after marriage. Another indicator which I explored is the number of years that the respondents had been actively trying to conceive measured by both individual effort and seeking assistance from a professional. According to the findings, there is not much difference between the number of years that one has been married and the number of years that one has been trying to conceive. Most respondents tried to conceive during their first year of marriage. This is in tandem with findings from other studies conducted in Egypt (Inhorn, 1994) and Nigeria (Okonofua et al., 1997) where the expected time frame for having a child fell within a year after marriage. For those who did not start so early, it was for reasons such as the absence of their spouse and desire to complete one's education.

4.1.4 Type of infertility

Most of the respondents in the study (66.67%) were childless (experiencing primary infertility) at the time of their inclusion in the study, while 26.67% of them already had a child (ren) or were

experiencing secondary infertility and wanted more. The remaining 6.67% had lost their surviving child. To fully understand the importance of primary infertility over secondary infertility and/or vice versa, it is useful to consider the social definitions of infertility within a particular social context rather than relying solely on biological definitions of infertility. For instance a study by Tabong & Adongo (2013) revealed that, in the Upper West Region of Ghana, the ideal number of children for a married couple to have was five. Couples who had less than five children therefore risked the chance of being regarded as infertile. Also in patriarchal and patrilineal societies where there is preference for male children (Das Gupta et al., 2003), having a child (ren) who was female, therefore required the birth of more children in order to ensure the birth of a male child.

In this study, respondents who were experiencing secondary infertility often desired to have more children either for personal reasons or to secure their current marriages. Five of these respondents (representing 11.11%) already had a child in their current relationship and wanted to have more based on a mix of personal desires and societal expectations. Another seven (representing 15.55%) had children from their previous relationships. Out of the seven, four (representing 8.89%) of them were men who had children from their previous relationships, two (representing 4.44%) were both the men and the women, each having had children from their previous relationship. In one case, the woman had two (2) children while her husband had one child. In the other case, the woman had two (2) children while her husband had four (4). Only one woman had a child from a previous relationship but this woman also had a child in her current relationship and wanted to have another child with her current partner. This data goes to show that, irrespective of whom the biological parent is, respondents felt the desire to have another child with their current partners. This may be attributed to the fact that, having children

with current partners serves as a form of marital security for them (Dyer, 2007). Further analysis also reveals a tendency for more men than women to enter into unions with a child from a previous relationship. This may have implications for their attitudes towards the need for treatment and will be discussed in subsequent sections. Furthermore, it shows that, secondary infertility is as bad as primary infertility in Ghana. That is to say, as one of my respondents aptly put it, 'In Ghana, it is not normal for someone to have only one child'.

4.2 REASONS FOR WANTING CHILDREN

The findings from the study revealed that, not much has changed over the years when it comes to the main driving forces fuelling the search for conception and consequently biological parenthood on the part of respondents. People continue to desire to have their own offspring based on such factors as marital security, the acquisition of social status and children being a form of social security in one's old age amongst others (see Caldwell and Caldwell, 1987). However, the continuities and discontinuities with regard to these factors is what is discussed in the sections below.

4.2.1 Marital security

The importance of having children in order to ensure marital security played out as equally important amongst clients accessing herbal treatment as well as those accessing low technology treatments. Respondents often alluded to the fact that, having children helped to consolidate their marriages. The urge to secure their marriage was, however, stronger amongst those respondents accessing herbal treatment and low technology biomedical care and this can be explained by their lower levels of education and lower income levels. For example 24 year old unemployed wife of Desmond reveals that,

He has been giving me a lot of pressure. Every month, he asks me if my menses has come or not. Sometimes, I try to avoid answering the question because of the way he has been reacting when he finds out I am not pregnant. The way he is behaving, I am afraid someone will take him away from me. He might try having a child with someone else if I don't get pregnant soon.

Some women seeking healthcare from the herbal clinic and the public hospital have comparatively lower levels of education mostly ending at the basic level or senior secondary school level. These women due to their position as being low skilled or semi-skilled often engage in such income generating activities as small scale trading, hairdressing, sewing and some are also unemployed. As stated by Takyi (2001), research has shown that women's autonomy in marriage is linked to their higher educational attainment which invariably places them in a job where they can adequately cater for their needs. The absence of these achievements therefore leaves them in a situation of greater dependence on their male partners for the fulfilment of economic needs which they cannot cater for by themselves. This subsequently has implications for the marital union since for such women, the incentive to stay in non-fulfilling marriages may be stronger (Spitze, 1988). With this at play, such women feel the need to have children since that is one way they can be guaranteed their spouses' continued financial support.

Conversely, for economically successful women like Amanda (who holds a managerial position in her job), who do not rely mainly on their husbands for financial support, the need to secure their marriage is not strongly exhibited especially in the face of challenges. It is in the face of such challenges that Amanda expressed less zeal in maintaining her marriage. According to her,

It was a headache for me to get him to come with me to the hospital so that they can prepare him for the procedure (IVF). I even told him that, if it is about money, I have got the money to do it. It was with a lot of prayers that he finally came....then he started relaxing about the whole thing again. It was around that time that he told me another boy had been added to the family (referring to his child conceived out of wedlock). At that point I said to myself, why don't I just find another person to do this (referring to a donor for IVF). I don't think this marriage is going anywhere so what difference does it make? Infact, I was ready to get a donor to do it for me. But I thought about the implications of it - looking for a donor will delay the process, and he had already produced his sample for the procedure so it will be difficult for me to tell the doctor that I no longer wanted to use his sample... So I decided to go ahead with his sample. What is more important is for me to have this baby.

As such, the increasing opportunity for women to find work outside the home, and more importantly within the formal sector, as a result of increasing urbanisation and educational attainment, and their ability to do so has arguably increased the economic independence of women and reduced their need to stay in non-fulfilling marriages.

Although existing literature suggests that divorce is acceptable amongst the matrilineal Akan (Bleek, 1976), evidence from this cross-ethnic marriage group of respondents suggests that divorce is feared by some women (the economically dependent ones) as it denotes a loss of their source of economic livelihood as well as failure on their part to sustain the marital relationship. For that matter, these women try to avoid such circumstances to the best of their ability. However, the economic independence of women in non-fulfilling marriages, although depicting less concern for the stability of their marriages, does not necessarily imply societal acceptance/approval of their marital dissolution. This is because of the existence of Christian doctrines which frown upon divorce.

What is more, the mothers of these women who are having difficulty in either conceiving or sustaining a pregnancy also express this need to secure their children's marriages. Clients of

these health facilities often reported that their mothers were the ones who showed the most concern about their situation. As one respondent put it, 'according to my mother, my marriage root is bare, there is no soil to cover it and hold it firm'. These mothers therefore continually recommended various doctors they could visit or various medications they could try. According to 32 year old Grace who has been married for 3 years without a child,

My mother keeps asking me every now and then if I am pregnant or not. When I tell her that I am not, she gets agitated and is not happy with the way I am handling it. She says I am not making enough effort to remedy the situation. She is the one who convinced me to come here (Korle-bu Teaching Hospital). In the past, she would send me gallons of herbal medicines to take. After finishing two gallons, I got tired of taking them and asked her to stop sending them to me since I was not seeing any positive results.

For others too, it is the negative reactions of their in-laws that compel them to seek treatment at the health centre. Given that a number of ethnic groups in Ghana are patrilineal in their inheritance system thus giving men the advantage when it comes to marriage and childbearing, many women in childless unions risk losing their husbands to other women. This is because, children inherit from their father's line and the absence of children therefore means that, the lineage cannot be perpetuated. As such, some men in such unions are pressurized by their family members to marry other women so that they could have children with the presumption that, it is the current wife who is infertile. According to 48 year old Angela who has been married for the past 16 years without a child, her husband has been very supportive throughout their marriage and has never showed any indication of wanting to marry another woman as a result of their childlessness. In her words,

...The main problem is with my husband's family. Apart from his mum of blessed memory, the rest are not so helpful with their attitude towards the problem. There was actually an uncle of his that said that if I had not had a child by 2010, he'd have to marry someone else.

This threat to the security of one's marriage is felt more strongly by the women in these unions as compared to their male partners. This is attributable to the fact that, the Ghanaian society is patriarchal in nature. According to Manuh (1984), under customary law in Ghana, men can divorce their wives on the basis of childlessness. The threat to marital security intensifies as the years go by. This is evident in the experience of some of my respondents. Forty-five year old Ophelia whose story was outlined at the introduction of the chapter provides a perfect example of this threat.

In sum, reproductive experiences regarding childbearing in marriage reveal the potential of marriages without children being less stable as compared to marriages with children (Takyi, 2001). In addition, the number of children borne out of the marriage also has the potential of influencing the stability of the marriage (ibid). As such, the consequences of not having children or the desired number of children in marriage namely marital instability, divorce, extra marital affairs and/or polygamous marriage is what serves as a driving force fuelling the desire to have children. This effect on the marital relationship has been reported in various parts of the developing world (Dyer et. al, 2002; Inhorn, 1991; Kielman, 1998; Liamputtong-Rice, 2000; Nahar et. al, 2000; Okonofua et. al, 1997; and Sundby, 1997 etc.).

4.2.2 Social Security and/or Inheritance

The intergenerational flow of wealth as espoused by Caldwell (1976, 1982) which served as an explanation for why fertility rates are high in African countries about four decades ago continues

to be relevant when explaining the reasons why people desire to have children in present day Ghana. This is because the situation whereby children add positively to their parents' wealth in their old age by serving as a form of social security for them persists. The decision therefore to have children continues to be an economically rational response to the prevailing social conditions of inadequate social security systems especially for informal sector workers. Data from the study reveals that of the economically active respondents, 37.78% are self-employed while 17.78% are employed in the informal sector. Together, they make up 55.56% of the economically active respondents whereas only 26.67% are employed in the formal sector. Nationwide statistics from the Ghana Population and Housing Census 2010 (GSS, 2013) also reveals a similar situation whereby 65.2% of the economically active female population are self-employed while that of the male population who are self-employed is 54.4%. These national statistics, however, do not account for the other categories of informal workers such as casual workers (domestic helps, labourers, etc.), apprentices and the like which further add to the numbers. This scenario helps to situate the economically active Ghanaian in a proper context when it comes to social security benefits in a better light. For that matter, children continue to be seen and are indeed obliged to take care of their parents in their old age. As an Akan proverb states, "if someone looks after you to grow your teeth, you must also look after him to lose his" (Gyekye, 1996). The difference in this type of care, however, is evidenced in the fact that, in the increasingly modernising Ghanaian society, only biological parents get to benefit from it. Fostering does not yield such an advantage anymore. This is what is accounting for the increasing preference for biological parenthood. This form of marginalisation, characteristic of urban societies may be attributable to the higher costs of living in the urban centres.

In this study, respondents who were heavily dependent on their spouses economically expressed their worry over their infertile unions based on this function of social security that children provide. This is because, having the desired number (and/or sex) of children in their marriage will in turn serve as a form of social security for them in their old age in the absence of their husbands. Traditional patrilineal and matrilineal inheritance norms in Ghana do not favour women and these widows are often left with no assets. This is based on the traditional presumption that assets acquired during marriage belong to the husband (Kutsoati & Morck, 2012). The 1985 Intestate Succession (PNDC) Law 111 was enacted to change this adverse effect. However, studies have shown that, the law is seldom used and traditional inheritance norms persist (FIDA, 2007; Fenrich and Higgins, 2005; Kutsoati & Morck, 2012; Scholz and Gomez, 2004). Reasons for the persistence of these norms are attributed to the dearth of information about the law, the cost and cumbersome nature of the legal procedure, the lack of access to the formal judicial system amongst others (Kutsoati & Morck, 2012). This may explain the need of the woman who is financially dependent on her male partner to ensure she brings forth children in her marriage so as to ensure her financial security during her old age. This benefit of social security is therefore linked to the issue of inheritance and/or marital dissolution rights. This is because, in the event of the death of the man or the dissolution of the marriage, the children borne out of that relationship are the ones who benefit the most in terms of gaining access to their father's economic assets.

Furthermore, the 1998 Children's Act 560 mandates that 60% of the benefits accrued from Social security payments are passed on to the deceased's children who are under eighteen years of age (Kutsoati & Morck, 2012). These children will therefore be economically well placed (in

the absence of their fathers) to take care of their mothers in their old age especially in the case of older parents.

Forty-eight year old Agyeiwaa who is currently unemployed and who had two children before her current marriage feels compelled to have children with her current husband because of problems of property sharing she is currently experiencing with her husband. According to her, she has sacrificed a lot of her time, energy and resources in the past thirteen years of their marriage. However, her husband does not want to disclose all his properties to her. According to her, her husband has about four or five houses in Accra yet they live in an old family house together. Her husband also has four children of his own and she believes neither she nor her children will benefit from any of her husband's properties. Anytime she tries to get her husband to take her along whenever he is visiting any of his properties, he refuses. He has told her on several occasions that she can go away if she thinks she cannot stay with him anymore. However, to Agyeiwaa

...I cannot stay with you for 13 years and then you tell me one day that I should go and you expect me to go just like that. All those years of having invested my time and energy in taking care of you cannot be in vain like that. I will not accept it. I believe that, if I am able to have just one child for him, things will be a whole lot different. That way, I can also stand to benefit from some of the properties he will give to the child I will have with him.

Forty-five year old Ophelia who is a petty trader and who has been married for 20 years without a child expresses a similar sentiment.

...I will not leave that marriage even though I am going through hell at the hands of my husband and his relatives....not after struggling to take care of him all these years and the sacrifices I have made for him.

It is worthy to note that, this situation is more common amongst older women who have been in the marital relationship for a longer period. Consequently, these women have almost run out of their reproductive life span and are thus in a disadvantageous position regarding childbearing should they have to start new relationships with new partners.

Furthermore, the situation whereby children in marriage are important because they serve as a form of social security does not pertain to women alone. Men also sometimes depend on women for financial support although this is not as common as the reverse. The few men in this study who depended on women for their sustenance also saw their ability to procreate as a way of ensuring that they continue to enjoy not only the financial benefits but also the social benefits that their wives provided them. For example, thirty-eight year old Sani stands to lose his wife if he is unable to get her pregnant in the near future. What troubles him the most is that, losing his wife also means losing his source of income since he has been employed by his wife's family members. He therefore feels pressurized to solving his infertility problem lest he loses his livelihood. According to him,

In fact, I must admit that I am very hot. If I don't get my wife pregnant soon, I'll be in trouble. Already, her people have started talking. It is as if they suspect that the problem is from me. I don't even know how that happened. But once I lose her, I will lose my job too. In these difficult times, where will I start looking for a job from? As a man, I need to work and get some money to take care of the home. Otherwise, my wife will not respect me. So I have to solve this problem quickly before it brings about more problems for me.

Another male respondent spoke of the financial and other forms of physical as well as emotional support he derived from his wife on the basis of which he would do all it takes to keep her and make her the mother of his children. According to him, this will ensure a better future for his kids, one which is an improvement of what he had to go through during his formative years. In

sum, it is evident that children as social security in marital unions is more characteristic in unions whereby one partner is heavily dependent on the other for the fulfilment of their economic needs.

However, another dimension to the reason why children were desired for inheritance purposes was identified. This was based on the need to pass on one's property in the form of land, houses and/or businesses to one's own children rather than to siblings or members of the extended family. Respondents felt the ultimate reason for their hard work and success in life was for the sake of creating a sound future for their children. The absence of biological children therefore made their toils futile. This is because, extended family members were not regarded as good custodians of one's property. They are seen as less deserving of inheriting property especially because they tend to mismanage and misuse such properties. A typical case in point is the situation that 58 year old Dela finds herself in. She is in dire need of a child because her only child died four years ago at the age of 36. Having spent all her working life in the United Kingdom, she had entrusted all her properties and building projects back home to her son who was living and working in Ghana. According to her,

I believe some of my family members may have killed my son out of envy since I had entrusted all my finances and properties to him, who to them, was a child. I remember my sister told me she was disappointed in me for overlooking her (the sister) and rather entrusting the responsibility of creating and managing my estate back at home to my son. They were always talking about that decision I had made. So now that he is dead under strange circumstances, I cannot help but blame them for it. After all this, how can I leave my properties to them? I have toiled very hard for what I own now and none of them deserve to inherit my hard earned properties since they have not done anything to help me throughout my struggles in life. I am even more annoyed with my son..., if only he had had a grandchild for me, I would not be in this situation now.

She is therefore currently seeking to have a child through IVF with a partner whom she has been in a relationship with for the past eight months. This helps to understand the importance of

biological parenthood over extended family ties/relationships for the purpose of passing on one's property in the event of death.

4.2.3 Other factors fuelling the desire for biological parenthood

Other factors provided by respondents as motivating their desire to reproduce include the role that children play in serving as a form of social status as well as the importance of children in ensuring the continuity of the lineage. In modern times, social status and recognition can be attained through one's educational attainment and employment status. However, children continue to serve as a form of prestige and consequently, social status. Statuses regarding motherhood and fatherhood have to be achieved. The practice of teknonymy³ continues to enforce this. As one respondent puts it "(exclaims) eiii...I also want to be referred to as someone's mother". This form of social identification therefore serves as a form of prestige/honour. Failure to achieve such status is met with shame and ridicule as was discussed in previous sections. Other ethnographic studies have also confirmed the lack of social status suffered by infertile women (Dyer, 2002, Leonard, 2002; Horbst, 2008).

The negative consequence of status loss is not felt by women alone. Men also stand to lose respect from their wives should their wives get to know of their infertility. For that matter, men do not disclose their infertility to their partners. As reported by some of the health workers in this study who served as key informants, men often come to the hospitals in search of a diagnosis alone in order to establish the cause of the childlessness in the marriage. It was only when they received a clean bill of health that they bring their wives along on the next visit. Conversely, they refused to accompany their wives on visits to the hospital to avoid the situation whereby their

³Teknonymy is the practice of referring to parents by the names of their children. In the Ghanaian context, parents are called by the name of their first born child

wives will get to know of their negative diagnosis. Some respondents expressed their willingness to bring their wives to the hospital for a diagnosis only if the doctor promised he would not disclose their condition to their partners. I also encountered two situations at the herbal clinic whereby although both partners were present for the consultation, the female partners unknown to their husbands, later secretly came into the doctor's consulting room to enquire about the husband's diagnosis since that was their only way of finding out. The secrecy with which men handle their diagnosis especially in instances of a negative diagnosis is borne out of the fear of losing the respect of their wives.

The potential of losing respect/status for men is not restricted to the marital relationship. Male respondents also expressed the sentiment that having children is part of what makes you "a man". As such, they risk losing this status if they are unable to father children. Adomako Ampofo, Okyerefo and Perverah (2009) report a similar finding whereby men expressed the importance of having children because it allows them to be regarded as real men. Outside the Ghanaian context, Gujjarappa et al. (2002) and Inhorn (2004), also report on the effects of male infertility in Indian and Egyptian social contexts respectively.

A few respondents also expressed the importance of children in ensuring the continuity of the lineage. These respondents expressed the desire to have their names carried on by their descendants so as not to risk extinction. This finding is similar to that of Inhorn (2003) and Nahar (2007). The importance of children in the continuity of the lineage was especially common amongst male respondents and could be explained by the practice in Ghana whereby children bore the name of their fathers. It could also explain why some respondents experiencing secondary infertility were desirous of having male children.

4.3 DISCUSSION AND CONCLUSION

The dynamics in the data reflects the structure/agency debate in sociological theory where some sociologists argue that an individual's actions are shaped by the structures of society. Others who focus on agency argue the primacy of the individual's judgments and decisions in determining his actions. The branches of sociology which assert that social life is largely determined by the social structure that one finds him/herself in include structuralism, functionalism and Marxism. Social structure is believed to exert a constraining effect on human activity. An example, par excellence, of contributions to this school of thought is the work of Durkheim which emphasizes the importance of social facts. According to Durkheim social facts "...consist of ways of acting, thinking, and feeling, external to the individual, and endowed with a power of coercion, by reason of which they control him" (1982: 60). These social facts may further be disaggregated into material or nonmaterial social facts. Whereas material social facts refer to the physical structures, for example technology, housing arrangements, population distribution; nonmaterial social facts refer to the non-tangible aspects of society such as the norms, values, roles and systems (Durkheim, 1982). The individual's actions can therefore be explained mostly as an outcome of the social structure or in more simple terms can be said to be a product of the effects of socialization on an individual's behaviour.

The influence of the social structure exerting a constraining effect on the individual can be observed among those who took part in the study. All the respondents were of the view that parenthood was an obligation they had to fulfil especially in their marriage which explained their search for treatment. Voluntary childlessness within marriage is something that was unheard and unthought-of. Both male and female respondents shared the same view on this, thus explaining why both women and men were found seeking treatment for their conditions. For these

respondents, the social expectation of parenthood drives them to go and seek treatment for their infertility. This also confirms the statement that childbearing in marriage is an obligation in the Ghanaian society (Pennings 2008) and that marriages in many parts of Africa seem meaningless without children (Kayongo-Male and Onyango, 1984). As one respondent put it, “I think as a Ghanaian woman, you need to have a child”. Furthermore, both primary and secondary infertility are unacceptable in Ghanaian society as evidenced in this research.

From the medical sociological perspective, it is essential to place health, illness and medicine in the context of a sociological analysis of power and social structure. This is in response to a call during the latter half of the 1980’s, for medical sociology to be linked to general sociological themes (Williams, 2003). On this basis, the arguments on the primacy of the structure in determining an individual’s actions become useful in analysing the responses of the study participants to infertility. When the ability to have biological children in marriage is defined as a norm or value by the members of any given society, it assumes the position of a non-material social fact in the lives of the individual members in that society. The individual therefore, in an attempt to conform to this ideal, tends to respond to this external pressure by seeking treatment for their infertility. An understanding of the responses that infertility generates in a society where children form the basis of marriage therefore brings out the importance of structure and social facts and makes it a useful paradigm for reference.

Linked to the importance of structure in determining an individual’s actions is the added role of labelling and stigmatisation. The concepts of labelling and stigmatisation assert that the social identities we possess are influenced by the reactions of others. These concepts are derived from the interactionist perspective in sociology. Labelling as a sociological construct has been used to inform medical practice since the 1960s. These concepts when applied to medical sociology also

focus on the importance of the symbolic meanings of health and illness. It seeks to draw attention to the interpretation of the experience of 'being sick' as resulting in not only physical, but social consequences as well (Crinson, 2007). Howard Becker's book on 'outsiders' served as the basis of labelling theory. In this book, Becker writes:

...social groups create deviance by making rules whose infraction creates deviance, and by applying those rules to particular people and labelling them as outsiders. From this point of view, deviance is not a quality of the act the person commits, but rather a consequence of the application by others of rules and sanctions to an 'offender.' The deviant is one to whom that label has been successfully applied; deviant behaviour is behaviour that people so label (Becker, 1963: 9).

The findings of the study reveal that some respondents experience labelling and stigmatization. Being a pronatalist society that attaches a lot of importance to not merely childbearing, but prolific childbearing, it is not surprising that people who have been unable to conceive or who have only one child become the subject of ridicule. Respondents spoke of negative reactions coming from their spouses, their in-laws, their own family members, their friends, colleagues, neighbours, church members and even mere acquaintances. Laureen (36, married for 11 years without a child) together with a few others like her, recounted incidents of ridicule she had encountered at her workplace and with friends during a social gathering. She states:

You have no idea....,you have no idea (with more emphasis). Someone can look you in the face and tell you that even when a man urinates here and I jump over it, I will get pregnant; those of you who have been wearing shorts to lie beside your husbands in bed, take them off ooo, take them off...and these are people who are not even connected to you in anyway.

It is obvious that Laureen and other respondents in like situations do experience some form of labelling and stigmatization as a result of their infertility. In relating this to infertility therefore, being unable to bear biological offspring becomes socially created as a deviant act when

members of the society make rules which oblige every married couple to have children. Applying this rule to people who are unable to have their own biological children means labelling them as ‘outsiders’. However, this quality of being infertile does not lie in the condition itself but in the interactions between the person who has committed the act and those around him/her who respond to it. That is to say, for infertility to be successfully labelled as deviating from the norm, it is necessarily dependent on the value judgments of one’s in-laws, other family members, friends, colleagues and other significant others who are in a position to impose such labels based on their position in the individual’s life. Labelling theory therefore focuses less on the deviant act of being unable to bear biological offspring and more upon the societal reaction to that particular situation. This results in the creation of such social labels as “barrenness” for infertile women and “not being a man” for the infertile man.

Owing to the fact that labelling is a negative social reaction to a deviant act, it can subsequently lead to stigmatization. According to Goffman (1968), when a label is attached to a person, the very label itself has the power to spoil the sufferer's personal and social identity. Whereas the ‘imagined’ social reaction can drastically change a person’s self-identity and is distinguished as felt stigma, the actual discriminatory experiences – a product of the negative societal reaction to the labelling process – results in social stigma and is referred to as enacted stigma. Infertility therefore becomes felt stigma when the sufferer begins to imagine/harbour fears that their condition will attract a negative social reaction. When such a person begins to experience actual discrimination from the society, then the stigma is enacted. In this study, the infertile women experienced both felt and enacted stigma.

Stigma can also be discreditable or discrediting. It is discreditable when it is hidden (except to close ones) and it is discrediting when it cannot be hidden. Thus according to Goffman (1968), although the stigmatized individual may be able to hide the discrediting attribute from others, he/she cannot do so from him/herself. As such, infertile people in addition to experiencing discredited stigma from societal members, may also experience psychological distress from their inability to have children as evident in studies on the psychological and social impact of infertility on the infertile (see Greil, 1997; Greil, Slauson-Blevins & McQuillan, 2010).

In contrast to the argument of the individual being coerced by the society or social facts external to him/her and its associated influence of labelling and stigmatisation, phenomenological sociology, ethnomethodology and symbolic interactionism provide explanations to social phenomena which reflect the opinions of the individuals being studied. They highlight the ability of the individual to construct and reconstruct, and give meaning to their world. In other words, the importance of human agency in an individual's actions is what is emphasized. Agency therefore refers to the capacity of individuals to act independently and to make their own free choices (Barker, 2005). The individual is believed to be in control of his social world. A person will therefore choose to have children in marriage at all costs based on his/her own free will. In this way, his/her desire to have children is seen as innate and not dependent on the structures of the society.

In this study, respondents going for high technology treatment show themselves as more autonomous and less affected by the unfavourable reactions they receive from friends and family as compared to those opting for herbal treatment as well as low technology. For example, Lauren, an employee in corporate Ghana, exhibits this autonomy in reaching a decision to have

a child of her own out of her own free will and without the coercion of society. She showed her ability to withstand social pressures especially since they were not coming from her kinsmen and women. According to her,

People make it seem as if you are the one that makes the baby, as if you are God. I don't allow what they say to affect me. I just want to have children of my own and so I encourage myself because I know my time will come. The bible makes us understand that somebody's own comes in the morning, others in the afternoon and some others in the evening.

Martha also expresses her autonomy in these words,

I love children very much and I love to play with them as well. If you come to my house, you will always find children around me, children from the neighbourhood. They enjoy my company just as I enjoy theirs. That is why I also want to have my own children. It will be nice to have children around me all the time. Why should I let what others say influence my decision? Are they the ones who feed me or who will take care of my children for me? No.

This autonomy is further exhibited in cases of secondary infertility whereby some respondents chose to have another child to serve as a companion to the only child they had. This is expressed by thirty seven (37) year old Jennifer in the following words,

Well, when I look at my son he's alone in the house. He's got no one to play with so I thought it was necessary so we (referring to her husband and herself) discussed it and that is why I am here now. I wish I could have someone my son could play with, that is the most important thing.

However, as alluded to by one of my respondents, with time, the motivation to have children of their own becomes a mix of societal mandate and one's personal desire. This may be because, having been socialized within a cultural context whereby childbearing within marriage is mandatory, such women (and men) begin to accept this societal ideal and therefore see themselves as deviants in Ghanaian society. As one woman, Maame who has secondary

infertility puts it: "...In Ghana, it is not normal for a person to say I want only one child so I am not okay".

Tina (married for 8 years, no child, been living in the UK with her husband for the past ten years) also has this to say concerning the issue:

Well, to me, I think as a woman, you need to have a child. So Yes! The 'white' woman will not care because most of them, even before they get married, they say they won't have babies but with me, I want to have a child, I want someone to be around, someone that you can laugh with, so I guess I'm still a Ghanaian

From the various responses provided by respondents, one realizes that, there is a thin line between societal mandate and one's personal choice. In a bid to resolve the structure/agency debate, scholars like Giddens (1979) have sought to answer the question, do social structures determine an individual's behaviour or is an individual's behaviour determined by human agency? They stress the complementarity of the two and see the importance of both structure and agency in explaining social life and organization. Giddens' work on structuration theory provides us with a good example of this synthesis. According to Giddens (1979), as much as there exists a structural reproduction of social practices, opportunities also exist for individual innovation in social conduct. When we assess the meanings and experiences of infertility, for example, we recognize that these essentially individual experiences cannot be understood devoid of social structure. Infertility is something that one first and foremost, has to face individually, and this may subsequently develop into structures (social facts) that tend to shape people's lives. Conversely, one's self-identity as 'lacking biological parenthood' is not only provided by the social system we live in but by one's own volition as well.

It is therefore difficult to accurately decipher between the strength of structure over agency and/or vice versa when it comes to the reasons why people desire to have children of their own. This is because, on one hand, people may want to present themselves as autonomous decision makers who are not under the influence of an external agent. On the other hand, a proper assessment of this influence also requires the conscious awareness of the actor of the influence of such social pressures in his/her life. In order to ascertain the distinction therefore, an attempt was made at analysing how the respondents manage the social expectations of biological parenthood. This analysis was made using the sociological concepts of labelling and stigmatisation as an explanatory model for respondents' actions.

In summary, by situating this study within the structure - agency debate, the study has sought to find answers to questions such as: does the individual have the power to determine whether he or she wants to have children or not? Does the individual have the choice to determine the number of children he/she will like to have? Is society the driving force in an individual's quest for conception and childbirth? As indicated in the data, for some, there is a thin line between the structure and agency elements in an individual's decision for which it is impossible to distinguish between the two. In such instances, the individual's decision is a blend of his/her own free will and that of the influence society exerts on him/her. For a few others too, their decision to have children is as a result of their own free will. These therefore exhibit their agency in the decision towards biological parenthood.

CHAPTER FIVE

QUEST FOR CONCEPTION: EXPLORING THE TREATMENT SEEKING BEHAVIOUR OF THE “INFERTILE”

5.0 INTRODUCTION

This chapter reports on the health seeking behaviour of respondents in reference to their search for treatment. It is divided into two sections. The first section reports on the role of various actors (both kin and non-kin actors) in the decision making process towards treatment. It brings out the contestations that exist between the various actors during the decision making process and how they are resolved. In the second section, the various patterns of health seeking employed by respondents are discussed. The patterns employed by respondents that were identified were simultaneous treatment involving the use of spiritual healing with biomedical healing and hierarchical treatment seeking based on factors such as belief and trust in the health care provider and cost amongst others. However, the lack of success with treatments led to a never ending search for conception through the use of various treatment options.

5.1. WHERE TO GO AND WHAT TO DO: EXPERIENCES OF “INFERTILE”

MARRIED MEN AND WOMEN IN OBTAINING TREATMENT

Studies have shown that women in Africa do not have full autonomy when it comes to decision making concerning their reproduction. Their decisions regarding their reproductive lives are often influenced by family and community members (Adamchak and Mbizvo 1994; Caldwell and Caldwell 1987; DeRose and Ezeh 2005). In this section, the reader is introduced to the therapeutic management actors of the study participants. The various actors that are involved in the negotiations that take place regarding the treatment for infertility namely mothers and mothers-in-law, siblings and siblings-in-law, extended family members, friends and colleagues

are outlined. The various considerations informing the arguments they raise for or against a treatment option are included in the discussions. Their respective roles regarding the final decision taken by either one or both couples over where to go for treatment and what to do have been found to depend on kinship ties. The power of extended family ties was found to be dwindling whereas nuclear family ties are strengthened when it comes to decisions regarding the treatment of infertility. In other words, the study revealed that, suggestions from in-laws and other extended family members especially with regard to re-marriage, were not often heeded. This denotes a decreasing influence of these actors on the reproductive decisions of the infertile. Furthermore, an analysis is made of the effects of the contributions that the various actors make distinguishing it as either leading to an increased burden or a relief for the infertile. The chapter also includes discussions on the role of other social and religious actors in the decision making process.

5.1.1 Kin actors - Relatives: friends or foes

5.1.1.1 Mothers versus mothers-in-law

In analysing the data on the kinds of contestations that exist between wives and their mothers and mothers-in-law over treatment options, it was discovered that, such contestations occur more over the need to constantly seek treatment and who to seek treatment respectively. Dialogue between the two actors namely wives and mothers as well as mothers-in-law is centred around suggestions as to where one can go for treatment or what one can do to remedy the situation. The final decision as to where to go for treatment and/or what to do however rests ultimately with either one or both partners.

Female respondents reported that, their mothers were the most concerned about their infertility/inability to have children. These mothers expressed this concern by constantly

enquiring from their daughters if a pregnancy has been established yet. Any little symptom of illness is immediately questioned as to whether it is a pregnancy or not. This anxiety by mothers is mostly fuelled, not by the desire to have grandchildren, but rather by the desire to ensure marital security for their daughters as discussed in the previous chapter. This is because, for most of these respondents, their siblings already had children thus their parents were already grandparents. These mothers were in constant search of a solution to the problem. They therefore kept suggesting new remedies and providing new medication to their daughters based on whatever information they gain from their research all in a bid to increase their daughters' chances of conception. One of my respondents aptly summed up this attitude this way,

...as for my mother, even if you put paracetamol in a different package and you tell her it is a drug for infertility, no matter the cost, she will buy it and come and give it to me to take.

This overzealous attitude by mothers, however well-intended, had a negative effect with time. This sometimes led to arguments between mothers and their daughters because, whereas mothers felt their daughters were not putting in enough effort to remedy the situation, daughters felt burdened by the numerous medications and suggestions of treatment coming from their mothers. Respondents alluded to feeling pressurized and 'fed up' with some of their mothers' suggestions. This reaction is, however, not often exhibited to their mothers in order not to offend them. Rather, they receive such medication without consuming them or they convince their mothers that they have booked an appointment with that particular doctor and would let them know once they have something concrete to say.

Mothers-in-law in comparison, more often than not, had a more negative approach towards wives when it came to infertility and its treatment. One area of contestation between mothers-in-law and wives was related to the blame for infertility. This is explained by the fact that they seek the interest of their sons, in this case, ensuring that they become fathers and consequently do not lose their respect as men. As such, some of them were reported to be quick to blame infertility on their daughters-in-law and were not interested in getting to know about the medical diagnosis. This blame is usually in the form of comments they pass which allude to the fact that, the wives are the cause of the infertility in the marriage. Before leaving her mother-in-law's house following a visit to her during one Christmas season, one respondent reveals, 'my mother-in-law told me that, next year when you are coming to visit and you do not have a child, don't come.' She believes her mother-in-law could not have been joking when she passed such a comment. As such, she has not been able to visit her mother-in-law following that incident since she still does not have a baby to take along with her on her visit.

This blame therefore led to treatment suggestions targeted at the woman. While some of these suggestions involve the taking of medication and/or consultations with gynaecologists, others involve more drastic suggestions like re-marriage for their sons. My female respondents who were experiencing this kind of behaviour from their mothers-in-law were saddened by it because, their mothers-in-law were not open to the fact that their sons could be contributing to the situation. They were more eager to put the burden of treatment on their daughters-in-law. Twenty-nine year old Ethel has received a positive diagnosis regarding her fertility potential from the various gynaecologists she has consulted after running all the necessary tests. Hers is a situation of male factor infertility. Yet her mother-in-law gives her no peace regarding their five year childless marriage. She is constantly pestering her with treatment suggestions which have

created a tense relationship between the two since Ethel's mother-in-law feels she is not heeding her advice. Some of the explanations that respondents found for this behaviour of their mothers-in-law included the following narratives, "she thinks I am just spending her son's money and have nothing to show for it"; "she just doesn't like me and I don't know why"; "she has never liked me, she actually wanted her son to marry someone from their hometown but her son defied her wishes".

Such situations invariably led to arguments between husband and wife, mother and son, wife and mother-in-law. To reduce such tensions and arguments, respondents revealed that, they, together with their partners often choose not to disclose their steps to treatment to mothers-in-law in order to avoid their 'long talk'. They also simply ignored some of their suggestions which included re-marriage. A few husbands, however, sided with their mothers either because they already had a child from another union, believed they were incapable of being infertile since they had impregnated someone in the past, or simply acted based on the situation of male pride. The role of husbands in the decision making process towards infertility treatment will be discussed extensively in the next section.

It is also worthy to note that, these interferences from mothers-in-law leading to disagreements are not occasioned by the fact that, these mothers-in-law live in the same house with the couple. None of these respondents reported living with their mother-in-law. This presents a different dimension to that of Abane (2003) who in her study of the social dimensions of marital conflict in Ghana found that unhealthy relationships between couples and in-laws are mostly fuelled by the fact that they live together.

Furthermore, anecdotal evidence exists to support the fact that, in marriages everywhere, there is the tendency for wives and mothers-in-law not to get along very well. This poor relationship has been explained as resulting from the fact that, mothers-in-law sometimes find it difficult to cut off the umbilical cord with their children. As such whereas the mother-in-law wishes to continue with the role of mother to her son, the daughter-in-law also sees her husband as a 'man' to whom she is married. This situation intensifies in traditional African marriages based on such factors as the payment of bride price by the man's family. Some writers have suggested that this bride wealth payment gives more authority to the man and his family members over the bride especially when it comes to reproductive decision making (Horne et al. 2013). The wife- mother-in-law relationship is also more problematic in gerontocratic societies (e.g. Africa and Ghana for that matter) due to the cultural norm of respect for the elderly. This implies that, wives are supposed to show respect to their mother-in-law based on the latter being the more elderly one. Any sign of disrespect shown by the wife towards the mother-in-law therefore creates an atmosphere of tension between the two since cultural norms of respect for the elderly have been defied.

However, this is not to suggest that good relationships never exist between wives in infertile relationships and their mothers-in-law. Mothers-in-law who were found to be very supportive, in terms of not putting all the blame and consequently the treatment solely on the wives, were health workers mostly nurses. Their profession in the medical field made them more open to both partners going for diagnosis and subsequently treatment. According to 42 year old Belinda,

I remember that, after about one year of marriage, my mother-in-law (who was a medical practitioner at the time) spoke to my husband and I and advised us to go and have all the necessary tests done to check for any reproductive disorders. She even suggested that my husband (her son) goes for the tests first since according to her, it is easier to test men as compared to women.

However, some couples in such circumstances still chose not to reveal to their mothers-in-law, their actual steps to treatment. According to 27 year old Abena who was attending the herbal clinic in the company of her husband “my mother-in-law (who is a nurse) is the one who recommended that we come here but she is not aware of the step we have taken.”

A few mothers-in-law offer not only suggestions, but are also actively involved in the treatment process. According to one respondent, “my mother in-law is the only one who calls to encourage me all the time and prays for me too”.

5.1.1.2 Spouses

As is characteristic of all human relationships, arguments sometimes come up between spouses when decisions need to be taken regarding situations that affect the couple and their union. In the infertile relationship, such arguments are found to be dependent on who is to blame for the infertility and consequently, whether the treatment is for the husband or for the wife. Discussions will therefore be centred on these elements amongst others.

In marital unions where infertility is defined as woman’s problem either by the spouse, relatives or based on a diagnosis, the woman concerned tends to be at the receiving end and therefore has the extra task of convincing the partner to go for a diagnosis and if necessary, treatment. Generally speaking, men were more reluctant to receive a diagnosis from a health professional especially in the company of their wives. The arguments they raised included the fact that, they had impregnated someone in the past which absolved them from having any reproductive problem. Some of these men also had a child (ren) with another partner other than their wives and thus blamed their wives for the infertility. As a result, women were more likely to seek health care.

Respondents revealed some of the contestations they had with their spouses regarding treatment. Some of these were related to the costs involved with treatment. In many instances, husbands had to bear the greater financial cost (if not the full cost) associated with the treatment. This financial burden on husbands therefore led to contestations between spouses regarding whether or not to access the services of a particular clinic. Whereas husbands preferred cheaper options, wives were more concerned with obtaining quicker results which inadvertently led to higher costs.

After his wife had undergone an unsuccessful IVF procedure in 2011 that cost him an estimated amount of GHC 10,000, Gameli had this to say,

...I gave up, I gave up, (referring to the possibility of becoming a father). It was not easy to come by that kind of money and I was not sure whether I was ready or even able to make such an investment again but she kept pressing that we should try again. She will just not let it go.

Another male respondent had this to say regarding the cost of treatment, “(exclaims) aah!, there is so much money involved when me myself I can do ‘gbu gbu gbu’ (referring to the act of sexual intercourse) and then I can get my thing”. Yet another respondent who was scheduled to undergo an IVF treatment in the past had it postponed because her husband had called her saying, “...do you know what? I am not going to send the money right now. It will not be long, I’ll be back by 6 months’ time and we can try it again naturally”. Such contestations confirm the nature of assisted reproductive technologies as a form of stratified reproduction.

Nonetheless, this financial burden is not restricted to those accessing high tech treatment alone. Grace, whom I had met at the government hospital, had tried accessing health care at a private herbal clinic in Kasoa in the past. She, however, could not go back there for treatment because

the total cost of treatment was GHC 2,500. At that point in our conversation, she laughs, saying, "...that amount of money can even be used to buy a plot of land". According to her, there is no way she and her husband could have afforded it and so her brother-in-law, who is a doctor and was working at that particular government hospital, recommended the particular gynaecologist whom she is currently consulting for diagnosis and subsequent treatment. This option was thus more favourable to both partners in terms of the cost involved. In sum, this study affirms the fact that the costs involved in accessing infertility treatment can serve as a hindrance to accessing treatment in both the developed and the developing worlds (Collins, 2002; Culley et al., 2006; Inhorn, 2003b; Spar, 2006) as well as a major source of contestation.

Another area of contestation between spouses was in relation to what the treatment involved or the specific requirements of the treatment. At age 58, Mrs. Gameli could not produce any viable eggs for an IVF procedure. The doctor therefore advised that they used donor eggs. For Mrs. Gameli, all she wanted was to have a child of her own. Carrying that child in her womb made that child her own therefore, she had no reservations towards the doctor's advice. However, her husband summed up his feelings regarding the use of donor material in the following words, "I am doing this so that she can be happy". For forty-two year old Belinda and her husband, however, the doctor's suggestion to use donor eggs due to her advanced age did not sit well with both partners. As such, they relied on the services of another doctor who had been recommended by a friend based on the friend's success with the infertility services provided by that particular doctor/hospital. Ethnographic studies on the acceptability of donor material in ART procedures have revealed similar disagreements based on notions of relatedness within the family (Franklin, 1997; Nijkam-Savage, 1992; Ragone, 1996).

Other contestations between spouses can be categorised as attributable to the situation whereby men generally are less concerned and less likely to attend health centres for health care as compared to women. Female respondents in this study were more eager to access treatment than their spouses. This situation may explain why forty-three year old Cynthia's husband did not see the rush in his wife undergoing an intra-uterine insemination when he had been put on medication to boost his sperms barely a month earlier. He therefore suggested to his wife that they wait a few more months for him to finish his medication while they keep trying to conceive naturally especially since they have been able to have a child in the past. The couple have a five year old son while Cynthia has a fifteen year old son from a previous marriage. However, for Cynthia, she felt her biological clock was ticking and she was eager to undergo the IUI as soon as possible in order to conceive and have another baby, hopefully, a girl.

Forty year old Amanda also revealed that her husband was less enthusiastic about treatment. He had even suggested to her that she take a vacation or start a master's program so as to help take her mind off the desire for conception for some time. She, however, felt she did not have the peace of mind for any of that. Her situation is peculiar because her husband already has two sons from different relationships. He had, however, expressed that he did not mind having a girl in addition to his two children and so he had been supportive towards the treatment; nonetheless she bore the financial costs single-handedly. Across the developed world, studies have shown that, men are less likely than women to seek help from health professionals especially in the absence of physical symptoms (Hunt et al., 1999; Murray-Law, 2011). In addition, writers conducting similar studies in Africa (e.g Nanda, 2002) suggest that, despite the interference of social and physical barriers to women's access to health care services, especially due to their

unequal need for reproductive health care, women continue to seek health care more often than men do.

Furthermore, some spouses reported that, their partners were generally uncomfortable with the production of semen in the hospital. This led them to postpone visits to the hospital as often as possible. Some wives in a desperate attempt to solve the problem, tried to convince health workers to allow their husbands to produce the sample at home and promised to personally ensure that, the samples are kept warm and safe and subsequently delivered to the hospital within an hour of its production. This option was, however, not available at the herbal clinic. As such, for respondents like Wisdom (married for ten years, childless) who could not produce his sperms on his own (through masturbation), and had to rely on the presence of his wife at all times, arguments always arose between them when they had to go for follow up visits at the clinic. This is because Wisdom's wife also feels uncomfortable with having sexual intercourse in the hospital environment. The contestation between the couple could also be explained by the fact that, since treatment was for the man, Wisdom's wife had gotten fed up with the process which was not yielding any positive results. This shows that, men are also sometimes at the receiving end when it comes to contestations over treatment. In such situations, clients fell on the medical herbalist/doctor to intervene in the situation since their advice carried more weight.

The dilemma of having an absentee husband

Migration researchers have documented the more common feature of men migrating in search of labour as compared to their female counterparts over the years (e.g. Amin, 1974; Adepaju, 1995 etc.). The phenomenon of absentee husbands continues to be a feature in modern marriages as is reflected in the situation of some respondents. These husbands are away from home as a result of work demands and some also due to the existence and acquisition of better paying jobs outside

their region of abode. While some of them find themselves in different countries, others are in different regions. This situation does not auger well for childbearing as it reduces the frequency of sexual intercourse between partners. Thirty seven year old Aseye has been married for the past nine years. However, her husband comes home only once in the year and did not start visiting Ghana due to the lack of proper travel and visa documents until 2010 (five years into the marriage) when he came to visit for the first time. The situation has therefore reduced her chances of natural conception drastically. She is sometimes advised by family members and friends to 'walk away from the marriage, you're growing old. All of us are waiting to see your baby'. However, according to her,

It is not easy to walk away, especially when your husband is not a bad person. My husband..., he is the cool going type, he doesn't worry you. He doesn't want to sit on your happiness. These days, these crazy men out there... you'll be living with him and you don't know what you are getting yourself into.

She is therefore torn between staying in a relationship in which her chances of natural conception are greatly reduced due to the absence of her husband and the desire to become a mother. Her situation is further exacerbated by the fact that, she is advancing in age which further reduces her chances at natural conception.

Other respondents in like positions also face similar situations of inner conflict. However, these absentee husbands (by virtue of their workplaces being located away from home) were in relatively better economic positions to be able to afford treatment. These men are either working in oil and mining companies, are businessmen dealing with imports and exports or work in developed countries such as the United Kingdom or the United States of America where remitting home improves the financial situation of wives. This point was clearly stated by the

women. Based on that, these women prefer to stay in the marriage for the time being and try conception through artificial means, especially if the husband is “a good man” and is “supportive”.

5.1.1.3 Siblings and siblings-in-law

More often than not, siblings as well as siblings-in-law are the most supportive in the search for treatment as well as the on the path to obtaining treatment. They are the ones least likely to focus on who to blame for the infertility. Often times, these siblings and siblings-in-law have children of their own which makes them even more concerned about the difficulty in childbearing that their sibling is experiencing. They therefore have strong desires for their siblings to also experience motherhood and fatherhood based on their shared beliefs regarding procreation. This feeling is more obvious if good relations exist between these siblings and their brothers/sisters-in-law (that is, the spouses of their siblings). They provide any kind of support (when practical) that is required to endure the challenge of childbearing. Some of the support offered is in the form of advice regarding where to go for treatment. Such advice is based on their own experiences or experiences of their friends or even just general hearsay and advertisements. Some couples welcome such advice and subsequently adhered to the suggestions. A number of my respondents spoke about the advice their siblings gave regarding treatment from the particular health centre in which I had found them.

Siblings (and siblings-in-law) also offer financial support as well as emotional support where possible. For Laureen, all six of her siblings came together to contribute financially towards her IVF procedure. Similar stories of financial support exist where siblings sometimes lent some money (no matter how little) to offset some of the consultation and treatment charges. Many others also revealed that, their siblings were as concerned as they were if not more. During my

fieldwork visits to respondents who were on admission at the high tech treatment facility, I was often introduced to siblings of my respondents who had come to visit them. Siblings were more likely to be visitors than mothers. This is because respondents explained they did not want to get their mothers 'worked up' over the treatment since it was likely their reaction would have an effect on them as well which might affect the success of the procedure. In order to ensure they were as relaxed as possible, they found it expedient not to involve them. This could also be explained by the closeness in age to siblings as compared to mothers. Siblings accompanying one for treatment was, however, only restricted to this facility. In the other facilities, respondents mentioned the contributions of their siblings through advice, encouragement, prayers and the like. Such support served as a relief to the infertile couple and is often welcome.

However, in cases where siblings (and/or siblings-in law) focus on the cause of infertility in relation to the type of treatment to access, their advice is unwelcome especially in cases where their perceived cause conflicts with respondents' perceived or actual cause of their infertility. Such situations lead to an increased burden on the infertile which results in tensions within the sibling relationship. For instance, thirty-seven year old Linda who has been in a childless marriage for the past seven years does not have a good relationship with her siblings-in-law because they blame her for the situation and keep pestering her to find a solution to her 'barrenness' or alternatively, leave their brother's home. She explains their attitude as one of self-centredness since they are only concerned about their brother's welfare and interests.

Some siblings also offer treatment suggestions which lead to disagreements between siblings.

According to one respondent:

I remember once when I was in the office and my brother called me that he needed my help urgently. I went there only to see my brother and a pastor with

two apples. He told me the pastor wants me to eat the apples and get my babies. I've never been mad at him like that before. I was like, how on earth should I eat an apple coming from a pastor I don't even know. I got really angry and his wife knelt down and held my legs and pleaded that I take the apples because the pastor was good.

5.1.1.4 Extended family members

Aunties, uncles and other extended family members are often not directly involved in the decision making process due to the secrecy surrounding infertility treatment. However, since infertility cannot remain hidden for long, they begin to contribute to the situation by suggesting such drastic alternatives as re-marriage. According to one respondent,

...His uncles told him that, if I had not had a child by the year 2010, he would have to marry someone else. They were ready to go with him and perform the necessary rites

(Angela, aged 48, married for 16 years, childless)

Thirty year old Jamila who has been married for the past nine years and is currently childless is experiencing a similar situation. Although she gave birth to a son five years ago, the baby died three weeks after birth. According to her, "they (referring to her husband's extended family members) behave as if I have never been pregnant or even given birth before". This brings another definition of infertility to light in that, irrespective of whether one has ever been seen pregnant, or has had a baby before, one is still considered infertile and suffers marital insecurity if there is no visible sign of a subsequent pregnancy or another child after a few years especially in the event of the death of the born child.

Marriages in Africa are a family affair and bride wealth payments as well as the dissolution of marriages are transacted between family members (Bleek, 1987; Caldwell & Caldwell, 1987; Fortes, 1978). This explains the stance regarding the dissolution of marriage or suggestions of re-

marriage that such family members take when children are not forthcoming in marriage. This is because, children are needed to perpetuate the lineage. In addition, in some African communities, a man's family may not pay the full bride wealth until after the woman gives birth to a child, thus assuring family members of her fertility (Lesthaeghe, 1989) and consequently, her ability to perpetuate the lineage.

To summarize, the relative lack of importance attached to advice given by in-laws and the exclusion of such actors and more importantly other extended family members (such as uncles, aunties, grandparents etc.) in the decisions that couples take towards treatment reinforces the increasing nucleation of the family that is characteristic of urbanisation. In most cases, it was obvious that, only close family members notably, parents and/or siblings were aware of the actual steps that one or both couples took towards diagnosis and/or treatment of their conditions. This may be due to the fact that, the reliance on family members for support is not borne out of an economic dependence on these actors, but rather out of other factors such as respect for their concern and the willingness to try new options especially when existing remedies did not seem to be yielding any positive results.

The economic reliance of women on their partners (and/or vice versa) in part or in full, brought on by urbanisation and increasing nucleation of the family could also explain this. As established by Oppong (1974), when there is pooling of resources and sharing of tasks amongst spouses, the women (and men) in such situations will become more dependent on their partners since these processes of urbanisation, higher education and salaried employment results in less of a reliance on extended family members. Although this was said for the matrilineal elite based on their inheritance system which makes women affiliated more to their own lineages rather than to their husbands, evidence from this multi-ethnic sample supports the claim and is thus applicable to

both matrilineal and patrilineal groups. This may be as a result of the overarching influence of urbanisation and modernisation leading to nucleation of the family.

5.1.2 Non-kin actors

The role of the various kin actors in the decision making process towards infertility treatment as well as the contestations that have emerged between them and the infertile en route towards achieving desired biological parenthood have been discussed in the previous section. Other non-kin actors also have an influence on the decision making process towards treatment. These include friends, colleagues and/or neighbours as well as the church and the media. For these actors as well, some treatment suggestions from them lead to disagreements which cause these married men and women in infertile relationships to develop ways of coping with the increased burden they bring to their situations. These will be discussed in this section.

5.1.2.1 The church - a place for finding rest or restlessness?

Christianity teaches the importance of adhering to religious virtues in order to find favour in the sight of God. One such virtue is that of chastity especially before marriage. The Bible, which is the guiding principle of Christians, contains evidence that suggests the value placed on chastity before marriage for the woman. Adherence to such principles places one in a favourable position to receive the blessings of God, in this situation, regarding childbearing. Religious leaders often stress this in their sermons to the youth especially the adolescents and young tertiary students. One therefore grows up with the belief that, being chaste is an added advantage to ensuring one's fertility after marriage. Respondents who were virgins before marriage, begin to make a self-appraisal when faced with difficulties in childbearing. The crucial question of 'why me?' thus becomes a mantra. Twenty-seven year old Abena who has been married for a year and a half now with no sign of a pregnancy in a frustrated voice says: "I was a virgin when I got married

and so I do not understand why I am not getting pregnant”. A midwife whom I spoke to during one of my visits to the public hospital also shared her experience, “I was not sexually active until I got married at the age of 30 and yet I have had 14 miscarriages”. However, being a midwife has equipped her with knowledge about the medical condition accounting for her situation. Her earlier comment, however, shows the belief that chastity before marriage should not be synonymous with difficulty in childbearing.

Self-appraisal is also done following the adherence to other religious obligations such as the payment of monthly tithes, praying and regular attendance at church or even belonging to a church group. The incongruence between religious virtues and infertility becomes apparent to these respondents who, after having passed their self-appraisal tests, are left with the inexplicable situation of facing difficulties with childbearing.

A second source of restlessness for childless couples are some church celebrations. The church is increasingly performing a different socialisation role when it comes to marriages and childbearing. The creation of moral standards such as the performance of wedding ceremonies, baptism/dedication of babies/children in church, mothers’ day celebrations, membership of church groups and organisations (e.g. Christian mothers association) etc. have all served to make the situation of infertility more conspicuous and more unbearable for the ‘sufferers’. One respondent revealed,

I am a regular church goer. I never miss church on Sundays if I can help it. But these days, I hate going to church on mothers’ day because all mothers will be called to the front of the church for special prayers followed by an elaborate ceremony in honour of mothers. When this happens, I am reminded of my childlessness and it is very painful. Last year’s mother’s day, I remember crying the whole day.

Maame also reveals how after moving into a new neighbourhood and joining a society in the neighbourhood church, she was faced with the unpleasant situation of having to deal with the woman who was assigned to her as her mother in the group. According to Maame, when she revealed to her 'church mother' that she had one child, she looked at her strangely and exclaimed, "what are you waiting for, hurry up and give birth to some more!"

The church serving as a place for socialisation has thus contributed to the creation of a restless environment for the infertile through the creation of these standards. Those who deviate from the church norms have become easily identifiable despite the heterogeneity of the society. This is because, the church seeks to create a family of belongingness through its activities which have inadvertently led to the conspicuousness of the infertile who then suffer latent forms of stigmatisation.

Additionally, the church sometimes provides contrary views to that of orthodox scientific treatment of infertility. In his sermon on infertility and its treatment, a pastor of a charismatic church quoted from Ruth 4:13 which states, "So Boaz took Ruth and she was his wife and when he went in unto her, the Lord gave her conception". Emphasis here is on who gives conception. Based on this bible passage, the pastor explained that conception was the work of God (and not the sperms of a man). For that matter, he believed that scientific treatment cannot handle it since no biological reason is strong enough to prevent one from having children. In his words, "barrenness is (therefore) satanic and not scientific".

The Catholic Church is also strongly against artificial insemination as treatment for infertility. At the Catholic Bishops conference, the commercialisation of sperms (and eggs) donation was strongly condemned based on the fact that, it makes mockery of the marriage institution

(www.myjoyonline.com published on 8th September, 2013). According to one of my key respondents who is a Catholic priest, some aspects of the process of artificial insemination was against Catholic principles. Notable amongst some of the unapproved practices is the discarding of sperms (and/or embryos) that are considered not viable enough for the transfer. He equated this practise to murder which is against God's commandments. Research conducted in Italy on IVF legislation (Benagiano and Gianaroli, 2004) corroborates this view. Being the home of the Catholic Church, the Italian law obliges the re-implantation of all produced embryos. This law is borne out of the desire of the Catholic Church to protect every newly produced embryo. Not all practising Catholics, however, adhere to this rule. This is because, their desire to have a healthy child outweighs these religious doctrines. The gynaecologist at the high tech treatment facility is a Catholic but also a health professional whose passion to solve infertility invariably overrides his religious doctrines.

5.1.2.2 Friends, colleagues and neighbours

One very common contestation regarding treatment which respondents spoke about was the criticism they received from some colleagues at work, 'so-called friends', and neighbours amongst others, regarding their seeming lack of concern about their infertile situations. They interpreted this lack of concern as evident in their expensive mode of dressing reflected in their new clothes, nice shoes with matching bags as well as nice jewellery. These friends and colleagues whom they encountered during social gatherings or even on any ordinary day, did not hesitate to point out that, "this is not what is necessary (referring to the nice clothes and other accessories)". Rather, they were to invest such monies into finding a cure for their infertility. To this, one of my respondents retaliated,

...babies are not like shoes or hand bags that one can just enter into a shop and buy. As for this one, it is not in any store in Ghana or anywhere in the world. If they were, and even if they were expensive, I would have gone for a loan from the bank a long time ago in order to be able to secure one for myself. Should I look miserable because I do not have children? No way!

(Kafui, aged 39, married for seven years, childless)

The lack of prioritization with expenditure deduced from such societal reactions to infertility presents a scenario whereby the infertile woman is not only chastised for her wrong prioritisation regarding her expenditure, but also regarded as a deviant to the societal expectations of their outward appearance by virtue of the fact that, she appears trendy and therefore unconcerned about her situation.

Such economic analysis on the part of societal members may lead to the commodification of babies, treating them as objects that are subject to exchange or trade within the market economy. These responses from friends, colleagues and/or neighbours regarding infertility treatment are thus seen as a subtle form of commodification, which may later develop into more vibrant forms as the search for treatment intensifies especially in the era of Assisted Reproductive Technologies. For example, in Ghana, anecdotal evidence and media reports (www.myjoyonline.com published on 2nd October, 2012) attest to the growing incidence of the sale of sperms. In addition, Assisted Reproductive Technologies in the West have created a vibrant economy in areas such as egg and sperm donations, pre-implantation sex selection and surrogacy amongst others which have subsequently resulted in reproductive tourism (Spar, 2006).

5.1.2.3 Media advertisements

Catchy advertisements have become the order of the day in modern day Ghana. Radio and television stations as well as the print and electronic media are all competing for the attention of the listening, viewing and reading public. Advertisements on infertility drugs and the services of infertility clinics, herbal as well as spiritual healers (Christian and Moslem alike) also compete for the public's attention. Their advertisements are catchy and present a 'one size fits all' scenario whereas infertility treatment does not necessarily work in such manner. These advertisements are sometimes advantageous by creating an awareness of available infertility products and services as well as influencing a buying and/or patronising decision. Some of this information is so catchy that respondents decide there is no harm in trying it out. This attitude is related to the willingness of the infertile to try new options in their relentless search for biological parenthood.

Many respondents attested to the fact that, they had gotten to know of the services of a particular health provider based on their advertisements either on the radio, television or via the internet (which they or other actors had heard, seen or read about). A respondent I met at a religious function regretted she had not taken seriously, the advertisement that said one should bring the appropriate baby clothes, in addition to the baby's name to the prayer session. It was the content of the advertisement namely, "Operation 1000 babies next year, come and receive your baby" that convinced her to attend the program since she wanted to benefit from the blessings that were being announced. However, since she still had her seven year old daughter's baby clothes, she decided to carry those along to the function instead of buying new 'blue' clothes (since she wanted a boy). She therefore blames this lack of strict adherence on her part to the pastor's

admonishing as accounting for the birth of another baby girl. For that matter, she was no longer taking chances and had thus come well prepared this time round.

These advertisements also have the potential of causing a shift in the thinking of consumers. In this way, they have the potential of turning into stumbling blocks when they are unable to deliver according to what the advertisements say. One respondent I met at the herbal clinic was very shattered by the recommendation she received from the medical herbalist. She had earlier received a diagnosis from an orthodox clinic that required she undergo a surgical operation to remove a fibroid. Having heard on the radio that, this herbal clinic had medication for dissolving fibroids and thus one need not have to undergo surgery, her hopes and desire for a non-surgical treatment had been rekindled. However, these hopes were dashed when the medical herbalist advised her to go for surgery at a government hospital because their medication could not dissolve her fibroids since they were too big and too many. The gradual process the herbs took to work did not make their efficacy practical in her situation. This brings in another dimension to treatment namely the acceptability of less invasive treatment options as compared to the more invasive ones. Drugs/medication were considered the least invasive option and the most acceptable by husbands and wives alike. Both male and female respondents especially at the herbal clinic were often seen requesting for drugs even when they were not prescribed any. Surgical operations were considered invasive since they involved the introduction of instruments into the body. In addition, respondents expressed the pain and discomfort associated with them and more importantly, the fear of losing one's life or one's partner during a surgical operation.

In sum, media advertisements, when they do not serve the purpose for which they were intended in the lives of the infertile create situations of inner conflict and despair leading to an increased burden for the one in search of biological parenthood. This is because, they initially boost

confidence in obtaining a remedy only to disappoint later. Some respondents regard this situation as worse than coping with a negative diagnosis since it means re-living a negative diagnosis all over again.

In conclusion, findings from this study regarding decision making towards infertility treatment reveals another dimension to the influence of in-laws and extended family members on infertile marriages with particular reference to their suggested decisions of re-marriage. The study shows the weakening of the influence of in-laws' decision making regarding infertility in the lives of some couples. These couples freely choose who to inform and who not to inform about their treatment decisions and did not succumb to decisions of re-marriage. This signifies a form of liberation from external family influences and implies the existence of some positive marriage effects associated with support and sharing between spouses during the experience of infertility and its treatment. This is contrary to the reports in some studies conducted in Sub-Saharan Africa on the effects that infertility has on the decision making process regarding the marital relationship. In those studies, women in infertile unions were not only harassed but were exploited, abused and rejected by their in-laws (Koster-Oyekan, 1999, Leonard, 2002). This often led to negative relationships existing between spouses and consequently to the dissolution of some of such marriages. In addition, other non-familial actors namely, friends, colleagues, the church and the media have been noted to play a significant role in the decision making process towards infertility treatment. The increasing influences of urbanisation and modernisation as well as globalisation and Christianisation may be accountable for these shifts.

5.2. Patterns of treatment seeking

Studies on infertility conducted in the 1970's and the 1980's revealed a preference for traditional treatment options utilised by infertile men and women in marital relationships in an attempt to

engender conception and childbirth (Bleek, 1976; Amonoo-Acquah, 1978; Mensah, 1980; Neizer, 1983; Bosu, 1986). These traditional treatments included the use of the services of herbalists, juju men, fetish priests, re-marriage and fostering. Orthodox treatment was often resorted to only when all these treatment options had been exhausted (Bleek, 1976). However, about three decades later, the use of orthodox treatment has been found as a common option amongst the infertile (Donkor & Sandall, 2009).

This section explores the various patterns of health seeking behaviour that respondents employ en route to achieving desired conception and subsequent childbirth. Although in this study, respondents were purposively selected from the specific professional healing sectors namely, herbal and orthodox treatment facilities, their histories regarding the various places they had sought health care in the past for their infertility were explored. Two patterns of health seeking behaviour were identified namely simultaneous health seeking practices and hierarchical health seeking practices.

5.2.1 Simultaneous health seeking practice of respondents

Respondents in this study who spoke of seeking parallel treatment for their infertility acknowledged that they resorted to both biomedical and spiritual healing. One reason for resorting to biomedical treatment was as a result of their belief in the mode of treatment. Additionally, physical symptoms being experienced led them to resort to biomedical care. Common physical symptoms that respondents reported experiencing included irregular menstrual cycles, premature ejaculation and severe abdominal and/or waist pains. These respondents irrespective of their level of education and perceived cause of their infertility also relied heavily on the Supreme God to solve their infertility problem. Below are two case studies illustrative of this pattern of treatment seeking.

Case study One - Herbal and spiritual treatment

Thirty-seven year old Adobea is a trader and has been married to her current partner for the past ten years without a child. Although she had a son from her previous relationship, that child died about eight years ago. She has been able to conceive twice in her current marriage, but those pregnancies resulted in miscarriages. She is currently accessing herbal treatment in search of a solution to her childlessness/miscarriages. She is also regular at prayer sessions in search of deliverance from her condition. Two of the pastors have told her during prayer sessions that, her ex-husband is responsible for her current situation. She also believes this to be true because she remembers her ex-husband telling her that she will never have children with another man if she leaves him. She, however, did not take it seriously at the time because her desire to end that relationship was strongly fuelled by his abusive nature which she could no longer tolerate. She therefore associates the symptom of all her husband's ejaculate being expelled from her vagina after sexual intercourse as evidence of her ex-husbands spiritual attempts at preventing her from having a child with another man other than himself.

Case study Two - Orthodox and spiritual treatment

Amanda, aged forty, is a successful employee in corporate Ghana. She has been married for the past two years to her current partner who has two children of his own. Her previous marriage lasted for five years and although during that time she conceived once, she subsequently lost the pregnancy. She has not been able to conceive again. She is currently trying to conceive through in-vitro fertilization. She is also heavily reliant on God to give her a child. Ever since she realized conceiving was a difficulty for her, she has been visiting several spiritual healers and orthodox clinics/hospitals in search of a

treatment. She believes strongly that divine intervention is a necessary complement to scientific/orthodox treatment. As such, she never misses an opportunity to consult with pastors and spiritual healers (sometimes recommended by her siblings) who are noted for such purposes. She also attends prayer sessions and has a personal pastor who prays with and for her regarding this particular intention/desire to have a child.

The above case studies are illustrative of some respondents' simultaneous pattern of treatment seeking. This particular configuration in treatment seeking is of interest since it clearly excludes the combination of herbal treatment with orthodox treatment. It implies that it is acceptable to combine spiritual treatment with either herbal treatment or orthodox treatment but this kind of mixture is unacceptable when it comes to herbal and orthodox treatment. Both clients and service providers hold this view which will be discussed in more depth in subsequent paragraphs. It is, however, worthy to note here that, my reflections on the data reveal that, responses obtained may have been influenced by the fact that respondents were selected from the various clinics and as such, they may have either been afraid to reveal other configurations to me or trusted that particular form of treatment (herbal or orthodox) enough so as not to jeopardize their chances of success by engaging in other configurations. However, as an active participant in the research process, my experiences on the field confirm these particular configurations.

For some, the reliance on spiritual treatment as well as biomedical treatment was borne out of the fact that, to them, their infertility was attributable to both biomedical and spiritual causes. As such although there was a general preference for biomedical sources of treatment owing to the more systematic and scientific approach to diagnosis and treatment which it offered, the spiritual component was essential in providing further explanations where science fell short. This explains why despite having received a biomedical diagnosis to explain their conditions, a spiritual

intervention was sometimes sought in addition. Some respondents thus assigned spiritual causal theories as an added explanation to their difficulty in childbearing.

The findings from the study revealed two groups of respondents based on the type or manner in which spiritual intervention was sought. There was one group of respondents who actively sought intervention in the form of spiritual healing by continually visiting noted spiritual healers, attending church services targeted at praying for the ability to have children and engaging the services of spiritual leaders who constantly prayed for them. Some of these would make time and travel to other regions in the country such as the Northern, Ashanti and Eastern regions in order to access the services of a known spiritual healer. Others travel to neighbouring Nigeria in search of the services of the notable Prophet T. B. Joshua, who is believed to have the gift of curing all kinds of ailments including infertility.

The other group of respondents were more passive in their search for divine intervention. Their use of spiritual treatment is categorised as passive because it did not involve conscious spiritual acts such as travelling away from home to engage the services of a spiritual healer, attending special prayer services for the infertile etc. Rather, they mentioned acts of praying to God on their own and trusting in him for a solution.

Respondents provided a number of reasons for their search for spiritual treatment in addition to biomedical treatment. One such reason provided for accessing spiritual treatment was for deliverance purposes from anyone who could be preventing them from achieving conception or maintaining a pregnancy. In such situations, spiritual explanations for infertility included the interference of external agents such as witches and the devil in the desire to achieve biological parenthood. This is because, for some, evil forces were the cause of their physiological disorder

which then accounted for their inability to bear children. These evil forces most of the time operated out of envy or jealousy and resided in their ex-spouses, in-laws, siblings and other relatives. A medical herbalist has diagnosed Michael, a 33 year old successful businessman who has been married for less than a year, with a low sperm count. However, Michael seeks help from a spiritual healer as well because, he believes his sisters caused this physiological disorder. According to him,

My sisters do not want me to have children of my own. I believe they are the cause of this problem. They want me to use all my hard earned money to take care of their illegitimate children for them. During my last two relationships, I was able to make the women I was dating pregnant so I do not believe this is natural. It's just that, I was not ready at that time that is why I asked them to abort the pregnancies. Now that I am married and ready to have children, look at what is happening? It is my sisters' fault. I know it.

Michael's sentiments stem from the fact that he had on several occasions in the past had arguments with his sisters concerning their promiscuous lifestyle which had resulted in the bringing forth of children with irresponsible fathers whose financial upkeep had become his responsibility. On one such occasion, one of his sisters told him that "you will also give birth for us to see" (literally translated) implying that he will not be able to have children of his own and interpreted by the respondent as a curse. According to Michael, having his own children will mean that, his sisters' illegitimate children will have to compete with his own children for money for their upkeep putting his sisters at the losing end. He has been on medication for the past three months but there has been no significant improvement in his condition which only goes on to strengthen his belief. This is why Michael seeks spiritual intervention in addition to biomedical herbal treatment. During these prayer sessions, he actively prays for a restoration of his reproductive ability.

Studies conducted on the work of charismatic/pentecostal churches in Ghana over the years have revealed the role played by these churches in delivering the afflicted from supernatural entities (e.g. witchcraft, demons etc.) that afflict them and are a cause of their misfortune (Gifford, 1994; Meyer, 1992). Furthermore, in her study of religion and modernity among the Ewe in Ghana, Meyer (1999) revealed that Christianity in Ghana is a localised process whereby the witches and gods from the traditional religious beliefs have become diabolised by Christians into demons from which one has to obtain deliverance. Some of these respondents exhibit a similar belief and is evident in their treatment seeking behaviour in the spiritual realm. These local understandings of Christianity thus have an effect on perceived spiritual causal explanations for infertility and subsequently treatment seeking behaviour for infertility.

Another reason that respondents provided for accessing spiritual treatment in addition to biomedical treatment was simply to seek the blessings of God when it comes to conception. This was because, according to them, children were gifts from God. However, God chooses the right time to bless his children with this gift. As such, it was necessary to continually pray for this gift until the time when it becomes manifest. A common saying to buttress this point which a number of my respondents alluded to is the fact that: “God’s time is the best”. Again, as an explanation for the reason why this gift from God was delaying/not readily forthcoming, some respondents fell on such explanations as “all the fingers are not equal” and “God’s ways are not our ways”.

Furthermore, religious explanations are sought in cases of unexplained infertility or biomedical conditions which by themselves are not strong enough to account for one’s infertility. The belief is that evil forces could be working in tandem with such physiological factors to aggravate the

situation. A respondent selected from the public hospital who had been married for the past three years without any conception had this to say:

I do not understand why I am not getting pregnant. The doctor says I have a fibroid but he again said the fibroid is not very big so I can still get pregnant. Sometimes, I think my mother-in-law is to blame for all this. She has never liked me. She actually wanted her son to marry someone from their hometown but her son defied her wishes. If she had good intentions for me, I wouldn't be having any problem with conceiving.

For that matter, she actively seeks divine intervention in order to re-solve whatever may be preventing her from achieving conception.

Similarly, according to 42 year old Martha, who has been married for the past ten years without a child,

I do not understand why I am not getting pregnant. I have done a lot of tests and Doctor says he has not seen anything wrong with me or my husband... God's ways are not our ways. Deep down in my heart, I know I have children. I strongly believe that, sometimes, God does these things so that He can glorify his servant at the right time and thus show us all His greatness. I do not doubt it at all; just look at the story of Sarah in the Bible....for me, that is enough proof. Because of that, I do not joke with my prayer life at all.

These reasons explain why some respondents rely on spiritual healing as a complementary form of healing to biomedical healing. For that matter, some of these clients request for the scan and laboratory results from the doctors since they want to carry them along to church to pray over them in order to obtain healing. By so doing, these objects become a medium through which healing from these physiological disorders can be obtained. Respondents also revealed that, some pastors request that their clients bring along their test results when attending prayer sessions. This is done in order to serve as substantive evidence for the existence of the disorder in the first

place. It also serves as proof in instances of treatment successes that the spiritual has power over the biological.

In the same vein, anecdotal evidence from healing sessions being telecast on the radio and television stations reveal the emphasis spiritual healers place on prayers for the disappearance of fibroids, regulation of menstrual cycles, clearing of blocked fallopian tubes and improved sperm production amongst others. The acknowledgement of reproductive disorders causing infertility is thus not restricted to the medical realm and for that matter, the physical realm but has been incorporated into the spiritual realm of healing as well. By acknowledging the existence of physiological disorders and using specific biological terms in the spiritual healing process, Christianity is being culturally re-defined by the respondents and forms part of the localising process of Christianity.

Thus infertility is no longer being summed up simply as a situation of barrenness amongst women or *k)te krawa* (impotence) amongst men. Rather, specific biological terms related to reproductive disorders such as fibroids, blocked fallopian tubes, irregular menses, low sperm counts etc. are now being actively used in the spiritual world of treatment seeking. This is because external spiritual agents are seen as capable of causing such specific biological disorders which therefore require the intervention of the more powerful spiritual agent in remedying the situation.

The service providers as well, namely the doctors, embryologists and the like exhibited the belief in complementing biological healing with spiritual healing. These did not fail to mention the role of the Supreme Being in addressing the challenges that their clients who were trying to conceive faced. According to one of the embryologists at one of the fertility clinics speaking after an

embryo transfer: “we are going to leave everything in God’s hands, we are merely instruments”. My observations during embryo transfers also revealed that at the time when the transfer was being made, the doctor often said to his patients, “say a prayer for them”. A similar situation occurs at the herbal clinic where the medical herbalist often tells his patients not to worry and to make sure they take their medications and “God will do it”. These type of responses to treatment seeking reveals the reliance of the Ghanaian on the supernatural being especially in circumstances that are beyond their control/inexplicable.

Additionally, out of the four Christian religious leaders who served as key informants in the study, three of them did not have any reservation towards complementing prayer with biomedical treatment. According to them, it was not enough to passively wait for God’s intervention in the form of the blessings of a child without going through a biomedical diagnosis and treatment. It is only when these forms of orthodox treatment do not work that one can “leave it to God” since he knows best. In such circumstances, they offered other options as fostering and adoption for infertile couples. The exceptional case amongst the religious leaders expressed the belief that ‘barrenness is satanic’ and that ‘conception is the work of God which no scientific treatment could handle’. One, however, had to overcome the obstacles of unbelief, hopelessness, falsehood of science, etc in order to attain this blessing.

5.2.2 Hierarchical health seeking practices

This section reports on the previous treatments sought by respondents and will be categorised based on the present form of treatment they were seeking. The reasons they provide for their choices are also discussed. Table 3 below is a tabular representation of the frequency of resort to the various sectors of treatment arranged based on the first treatment option sought by respondents.

Table 3 Hierarchy of Options

Treatment facility	Primary resort (number of respondents)			
	Herbal	Orthodox	Spiritual	Total
Herbal	7	5	3	15
Low tech	8	4	3	15
High tech	3	10	2	15
Total	18	19	8	45

Source: author's own

The study found that respondents resorted to different treatment options prior to their current treatment method. The above table (table 3) depicts the different treatment options that respondents first resorted to categorised according to the treatment facility where respondents were sampled. From the data, orthodox treatment is the primary treatment option for most respondents making up 19 out of 45 respondents representing 42.22% respondents. This was closely followed by herbal treatment which was the first option for 18 out of 45 respondents or 40% of respondents. The least common treatment option that respondents resorted to first as a means of solving their infertility was spiritual treatment. Only 8 out of 45 respondents or 17.78% of respondents chose this as their first option. The various reasons that respondents provided as influencing and determining their first choice of treatment will be discussed in the following sections.

5.2.2.1 The preference for herbal treatment

Out of the 15 respondents (see above – Table 3 Hierarchy of Options) selected from the herbal centre, seven of them revealed that, they had earlier on tried other forms of herbal treatment. Similarly, eight out of the 15 respondents selected from the government hospital revealed that the first type of treatment they had accessed was herbal treatment. Such herbal treatments were in the form of local herbs from a known herbal medicine man, herbs from an itinerant herbal vendor or from a ‘mallam’. Resorting to the use of local herbs from a known traditional healer was as a result of a mix of factors. Such respondents mentioned the belief in the ability of that healer to cure their infertility. This belief was borne out of the proven track record of the healer which they had heard about from either their mothers, siblings or their friends. According to them, what they had heard about and from that healer were convincing enough and therefore they decided there was no harm in trying the herbs they had to offer. This choice was also influenced by the relatively cheaper cost of treatment associated with such healers.

These findings are similar to that of other ethnographic research on the reasons for the popularity of ethno-gynaecologists in the treatment of infertility. Trust and confidence in traditional healers and the relatively cheaper costs were some of the determinants for the use of traditional healers who offered herbal treatment (van Balen & Gerrits, 2001). However, Mogobe (2000) suggests that the popularity of traditional healers is occasioned by the fact that these healers know the people of the area and use traditional long-established medicines. This study situated in an urban heterogeneous setting does not support this finding. This is because respondents often accessed the services of those healers who were living in other parts of the country other than the capital, Accra. They did so in order to avoid being recognised or discovered by known faces. The

situation whereby some also bought herbal medicines from itinerant medicine vendors questions the influence of trust and fame being a determinant of the popularity of such healers.

Despite the belief in these healers and the cheaper cost of their services, respondents sometimes terminate this particular mode of treatment, usually within a period of one year. Some of the reasons for termination of treatment that the respondents indicated included experiences of side effects such as frequent loose bowels and blood stains in bowels, lack of ready access to the medication (evident in the distance to be travelled in order to access the treatment) and the lack of a positive result after a few months. Others also indicated that their decision to terminate treatment was due to the packaging of the drug, which requires that they drink several litres of bitter concoctions at a time. According to Vic,

My mother, who lives around Tarkwa, was sending me herbal medicine through my sister. After some time, I got tired of taking all that medicine so I asked her to stop sending it. Besides, my sister was not able to go there regularly and when that happens, my mother has to find someone else to send the medicine through. I felt I was worrying her so I decided to look for a herbal clinic that was not very far away.

The use of “mallams” as a treatment seeking option is also common as a hierarchical strategy amongst the Moslems in this study. Some of these mallams perform the dual role of offering a spiritual diagnosis for their clients coupled with traditional herbal preparations as treatment for the various conditions thus explaining their importance. However, clients did not always believe the spiritual diagnosis that these healers offered. Most respondents indicated failure of the treatment to yield the desired result prompted them to do a further reflection on the whole process. Most of them said upon further reflection their faith in the spiritual diagnosis was dampened and thus they discontinued the treatment. For example, one respondent remarked:

Hmm..., he told me that I had too much heat in my womb which was being caused by an evil eye. So he gave me some herbal medicine to take which he said will regularise the temperature in my womb. It was in three vial bottles- the big ones. I drank it all but I am still not pregnant. Now, I don't even believe that I had too much heat in my womb. Otherwise, the medicine he gave me should have worked. Besides, I don't feel any heat inside me so what else can I say? At least I should have been experiencing some symptoms, or?

Thus, although she finished taking the bottles of herbal preparation that the healer gave her, she did not go back there for more medication. This means that, spiritual diagnosis of their situation was not the focus of some of these respondents, but the ability to provide cure for their situation. A respondent contended that herbs provide a holistic cure to bodily dysfunctions. This is the premise upon which she sought the treatment in the first place and why she was willing to take the herbs she received.

As far as respondents selected from the high tech treatment facility were concerned, only three had resorted to herbal medicine before accessing high tech treatment. This goes to show that, not all people accessing herbal treatments first are doing so because they cannot afford high tech treatments. One of these respondents explained that she had received such medication from her mother who believed in the efficacy of these herbs. The remaining two reported having resorted to herbal medicine from a medical herbalist because of their belief in the efficacy of herbs and the hope that a more natural form of treatment would remedy their situation. For these respondents, their initial inadequate knowledge on the availability of such treatment and misconceptions about the way it works led to their choice of high tech treatment as a secondary resort. The embryologist at the high tech treatment facility confirmed this. In addition he mentioned that some clients think that seeking treatment via ART is expensive hence they resort to a cheaper alternative in the form of herbal treatment. He expresses this in the following words,

“I will say ignorance. People do not know we exist. Others too think IVF is expensive and they can't afford it so let's try something less expensive”.

5.2.2.2 The preference for orthodox treatment

Orthodox treatment was the next common form of initial treatment that respondents selected from the herbal centre (five out of fifteen respondents) and from the low tech treatment facility (four out of fifteen respondents) had chosen. It was also the most common first form of treatment for those selected from the high tech treatment facility (ten out of fifteen respondents). These respondents indicated that the reason for accessing orthodox treatment first was in search of a scientific diagnosis for their condition and the general belief and orientation towards orthodox treatment. They believed in the efficacy of Western orthodox medicine and hoped to get a sound explanation as well as the necessary medication that will remedy their conditions. According to one respondent,

Well, I have always gone to the hospital when I am sick. That is what I believe in and it is what I grew up with. It works well for me. I have never thought of trying anything different. So it's only natural that I continue to tow this line in this situation. The only other thing that I must admit I tried sometime in the past was acupuncture. But obviously, that didn't work that is why I am back here.

However, in some situations, the diagnosis received and suggested treatment option given at the orthodox clinic as well as the lack of positive results after a period of taking orthodox medication led some respondents to opt for herbal treatment as an alternative. One very common diagnosis that led patients to resort to herbal treatment was the diagnosis of a fibroid which required a surgical operation in order to increase chances of conception. However, the fear of death associated with surgical operations and the promise of a cure which did not require a surgical

operation being offered at the herbal centre served as a strong reason to access herbal treatment.

Thirty five year old Rachel expresses her sentiments regarding this,

I was first diagnosed with having fibroids when I was in the U. K. about eight years ago. I was hoping that I could still have children but as the years went by, nothing was happening. Then, sometime last year, I went to Ridge hospital and the doctor told me it has gotten worse so he has to operate to take out the fibroids. When he said that, my heart skipped a beat. I am very scared of operations. I will never wish it for even my enemy. I just don't like the whole idea. After some time, I gathered the courage to go and book for the operation and make all the necessary preparations but on the day I was supposed to have the operation, I did not go. I could not bring myself to go. Then I heard that herbal medicine too can remove the fibroids. As for me, any amount of medicine you give me, I will take it without a problem. Even if it is injection, I will prefer it. But as for operation, hmm....I've told God that, I beg him, I don't want that one.

Additionally, male respondents who had been diagnosed with a low sperm count at the orthodox clinic and had been on medication without any positive results had been informed through conversations with their peers that, herbal medicine from this particular health centre (Champion Divine Herbal Clinic) was very effective in remedying such conditions. This explained their choice of herbal treatment as a second option. According to Francis,

I was given some medicine at the hospital to take but I am not seeing any improvement.....it's getting to 6 months now. Every time I go for tests, it's the same thing. If anything, only a little improvement (referring to sperm count). So me and my boys boys were talking about it and one of them said that the herbal medicine being provided here is very good so I decided to try it.

5.2.2.3 The preference for spiritual treatment

Spiritual treatment as a first option was reported as the least common form of treatment at all the centres. Three respondents out of 15 who were selected from the herbal clinic had initially sought spiritual treatment; another three out of 15 respondents selected from the low tech treatment facility had also sought spiritual treatment initially; and two out of 15 respondents selected from the high tech treatment facility had sought spiritual treatment initially. The

phenomenon of 'hoping and praying' and/or vice versa was the main reason for resorting to spiritual treatment first and is most common during the early stages when one is trying to conceive. It is also common among those experiencing secondary infertility since the belief is that, the ability to have a child is an assurance of the ability to have subsequent children. The reliance on God for children is borne out of the belief that children are gifts from God and as such the reliance on God for children. This form of treatment seeking starts off as a passive one and intensifies with time to include more strategic spiritual exercises such as fasting, weekly prayer sessions (e.g. Jericho hour at the Christian Action Faith Ministries), all-night prayer sessions, seed-sowing and the like. However, due to the eagerness to establish a pregnancy/bear a child, this phase does not last long and is soon complemented with other treatment seeking options.

For 30 year old Akua, however, her sole reliance on spiritual treatment for four years was borne out of her deep faith in God to give her a child of her own and by the fact that, she was experiencing spiritual symptoms which suggested the existence of a spiritual problem. Additionally, neither she nor her husband was experiencing any physical symptoms which could suggest the existence of a physiological disorder. On that basis, she did not see the need to go to the hospital initially.

At first, there was no problem so I was just waiting for it to happen. Then there was a time when I started having strange dreams. When I sleep at night, I will see myself having sex with someone other than my husband. So I started praying seriously about it. My pastor said it was a sign that I was in a spiritual marriage with someone so we needed to break that yoke. We fasted and prayed a lot and eventually, by the grace of God, I stopped having those dreams. It has been some time now and still no pregnancy so we decided to come to the hospital and check.

Active spiritual consultations as a first option for infertility treatment were not restricted to the church but extended to the services of traditional spiritualists as well. However only respondents with lower educational background usually below the junior secondary level reported this. For example, twenty-six year old Rashida spoke of having consulted a spiritualist first who diagnosed her inability to conceive as due to some members of her family who did not want her to have children. To revert this, she needed to pay an amount of eighty Ghana cedis (which she referred to as eight hundred thousand-signifying a lot of money). According to the spiritualist, a reduction in the charges will render the treatment ineffective since the spiritual entity's wrath will be evoked with a lesser payment thus resulting in non-performance. However, she could not afford to pay for the services. With time, she sought cheaper alternative treatment in the form of local herbs based on the fact that she no longer believed her family was against her desire to conceive.

In summary, much as some respondents seek spiritual treatment as a first option, others seek it as a secondary or last resort. When other sources of treatment do not yield the desired results as discussed, some respondents then intensify their search for a spiritual remedy. It is at this stage that other explanations such as the interference from witches and other supernatural entities also come up.

5.3 Conclusion

The data has revealed that some respondents accessed spiritual treatment based on their perceived cause of infertility as resulting from the interference of an external spiritual agent. Others also attribute the cause of their infertility to the poor relations they have with their in-laws. Apart from pointing out the causes, some respondents noted the following as the signs and symptoms of their infertility: dreams of having sexual intercourse with unknown persons; sperms

being expelled from the vagina after sexual intercourse; irregular menstrual cycles, premature or delayed ejaculation; abdominal and/or waist pains and reduced quantity of sperm.

The causes and signs and symptoms that the respondents outline resonate with the explanatory model for explaining the causes of diseases. As Foster & Anderson (1980) argue, the explanatory model is informed by amongst other things, the signs and symptoms of a disease as well as the perceived causes of the disease. In addition, based on explanatory models, illnesses can be classified as being either personalistic, naturalistic or biomedical (Foster, 1976). Personalistic illnesses refer to those illnesses that are believed to be caused by an external supernatural agent while naturalistic illnesses are believed to be caused by nature. The biomedical model explains illness based on impairment in the body functioning. Culley et al. (2009) also use these models in explaining infertility.

Furthermore, studies have shown that, health seeking behaviours are borne out of the explanatory models that the individual has regarding the particular ailment/disease (Foster & Anderson, 1980). The data has also revealed that the health seeking behaviours of the respondents are hinged on the perceived causes of their infertility. Evidence emanating from the data shows that some respondents consider infertility as a personalistic illness in that they attribute external supernatural agents such as witches as the cause. These agents were believed to operate out of envy and jealousy. Engaging in religious rituals and activities is the remedy in such situations. Likewise those who attributed the cause of their infertility to reproductive disorders were found accessing biomedical treatment. Similarly, other studies (Ebin, 1982; Gerrits, 1997; Inhorn, 1994; Kielman, 1998 etc.) have revealed that the treatment seeking behaviour of the infertile depends largely on their perceived causes of the infertility, the availability of the service as well as the affordability of the service.

Moreover, it is not only the infertile who believe in such explanatory models. Family members and other social networks are also found to believe such explanatory models. Such actors also utilise this model to determine the best choice of treatment for the sufferer of the disease (Foster & Anderson, 1980; Kleinman, 1980). As some respondents indicated, their choice of either seeking help from a herbalist, an orthodox healer, a spiritual healer or from a particular hospital or clinic was based on the recommendation of some family members and friends.

The treatment seeking behaviour of respondents in the study also showed a never ending search for biological parenthood. This never ending search intensifies with age and is occasioned by a lack of success with treatment. This form of health seeking behaviour has also been noted in other socio-cultural contexts (e.g. Dyer et al., 2002; Inhorn, 1994; Nahar, 2010 etc.). The scenario is what Inhorn (1994) aptly refers to as the quest for conception. The various attitudes also depict a situation whereby results are expected sooner than later. As such, when results do not seem to be forthcoming, respondents are eager to try out new remedies. Additionally, in this study, respondents at a point during their journey towards the goal of biological parenthood, become frustrated and fed up with the lack of success with biomedical treatments and thus intensify spiritual efforts based on the belief that God is the ultimate giver of children. This is one factor that also accounts for the waiting period associated with accessing biomedical treatments. However, before long, they are again tempted to try out new and different remedies as and when they hear about them since the problem has become a nagging one which needs to be solved to obtain some peace of mind.

The findings from the study also revealed that the patterns of health seeking that respondents employed were influenced mainly by trust in the health care provider and knowledge about the service. Other variables such as economic status, social networks, geographical factors (distance

of service provider), cultural determinants (status of women) also served as influencing variables in determining the pattern of treatment seeking and which service was utilized first.

It was also observed in the findings that some respondents combine some sources of treatment. This behaviour ties in with the phenomenon of healer shopping and medical pluralism. Healer shopping is used to refer to the situation whereby a patient requests care from multiple healers without a referral from the initial caregiver (Kroeger, 1983). Medical pluralism, on the other hand, refers to the use of both biomedical and ethno-medical health care systems. In this study, respondents reported accessing herbal treatment from different herbalists. Likewise, orthodox treatment as well as spiritual treatment was accessed from various orthodox clinics and hospitals and spiritual healing centres respectively. This is similar to the findings of De-Graft Aikins (2005) whereby healer shopping amongst her Ghanaian rural and urban diabetics was not restricted to the ethno-medical system as Green (1992) and Nkwi (1994) initially observed but cut across biomedical, ethno-medical and faith healing systems.

In addition, the observed pattern of simultaneous treatment seeking from spiritual healing centres as well as biomedical healing centres reflects the situation of medical pluralism. Medical pluralism has been shown to exist in Ghana as well as some other African contexts (Ernst, 2002; Slikkerveer, 1992; Twumasi, 1975). This is largely due to the existence of both ethno-medical and biomedical health care systems on the African continent. Respondents' utilisation of these plural medical systems can be explained by the fact that each system provides a unique and different treatment for different purposes. They thus complement one another. As Senah (2013: 302) states,

...the African may visit the hospital, the healer, and the prophetwithout feeling any sense of contradiction....because to him, all these health facilities are along the same continuum; their explanatory models may differ but together they constitute one cosmology.

CHAPTER SIX

ART USAGE IN GHANA: SOCIO-CULTURAL DIMENSIONS

6.0 INTRODUCTION

Socio-cultural values and religious beliefs have been found to play a role in the acceptability of infertility treatments that are artificial in nature (Horbst, 2006; Inhorn, 2003; Ngwafor, 1994; Nijkam-Savage, 1992 etc.). In the desire to achieve pregnancies, these beliefs sometimes are in contention with the use of technology. At the same time, beliefs also function as a means through which both patients and practitioners navigate their way around treatments and the successes and failures of these treatments. These various nuances will be discussed in this section. Economic considerations that deal with cost of treatment are excluded from the discussions since issues related to affordability and accessibility is not the focus of this section.

In all, data for this section was gleaned from study participants (those accessing and those not accessing high tech treatment). Out of the fifteen respondents accessing high tech treatment, three of them had undergone Intra-Uterine Inseminations (IUI) and the remaining twelve had undergone either In-Vitro Fertilisation (IVF) or Intra Cytoplasmic Sperm Injection (ICSI). Three key informants at the clinics also contributed immensely to the data. There were many more with whom I had casual conversations who are not included in this sample but whose input I have included in this section. Field notes from ethnographic fieldwork observations at the treatment facility revealed some more information about the use of these technologies in a Ghanaian fertility clinic.

6.1 FEARS AND MISCONCEPTIONS ABOUT ARTs

The declining role of fostering in serving the needs of the infertile and the increasing emphasis on biological parenthood has left couples experiencing irretractable infertility with no other option but to rely on assisted reproductive technologies in order to achieve their much desired goals of childbearing in marriage. However, this does not make the procedure automatically acceptable to the Ghanaian. Generally speaking, when one hears of artificial insemination, the first thing that comes to mind is the production of a baby that does not have the biological make-up of either one or both parents. The clients who were accessing high tech treatments were not immune to such views. The most common concern they expressed is the fear that such children may have a different genetic make-up (DNA) which will eventually prove to others that such children are not biologically their own. The artificialness of the procedure is what creates such fears. These fears are also borne out of the lack of knowledge about the exact ways in which the procedure works.

Thirty-four year old Francis has been married for the past five years without a child. I met him at the herbal clinic and I discussed the option of artificial insemination with him during the interview. According to Francis,

“I do not know if I can truly love that child as my own knowing that he/she is not made out of my sperms. Artificial insemination puts the woman at an advantage because she has her blood in that process whereas the man does not. Apart from that, she carries the baby and also gets to breast feed the baby so she feels more connected to the baby”.

Forty-two year old Martha who is a pastor’s wife shared a similar view when I discussed the option of IUI with her, “Really? Is that true? Will they use my own eggs and my husband’s sperms”?

Intra-uterine inseminations are helpful in solving male factor infertility, unexplained infertility, anti-sperm antibodies or hostile cervical mucus (van Waart et al. 2001). It is a simpler procedure and less invasive while at the same time improving chances of conception and helping to reduce the occurrence of miscarriages (ibid). Other more complex forms of artificial insemination such as ICSI and TESE⁴ also help solve male factor infertility and are good substitutes for donor insemination. Such essential information is, however, not in the popular domain except for those who seek treatment at high tech treatment facilities.

In addition to these misconceptions are fears that sperm, egg and/or embryo samples will get mixed up in the laboratory leading to the creation of babies that did not have the same genetic configuration as the parents. When this happens, the purpose of achieving biological parenthood could be defeated. This will be exacerbated and made more obvious when the physical characteristics of the baby come in sharp contrast to that of the parents. This fear of “accidental donation” was also prevalent amongst Inhorn’s (2003) Egyptian sample of respondents contemplating and/or undergoing IVF or ICSI in local Egyptian IVF centres. However, whereas the Egyptian harboured these fears based on Islamic restrictions to third party donations, that were regarded as synonymous with committing adultery, the Ghanaian is concerned with ensuring that, having invested so much money in the procedure, no doubt is created about the parenthood of the child for his own sake and for the sake of onlookers.

The prevalence of myths surrounding babies born through artificial conception is another area of concern for clients accessing high tech treatment. Forty six year old Abena who is a baker

⁴ Testicular sperm extraction (TESE) refers to the extraction of sperms from the testicles through a surgical procedure when no viable sperms are produced in the ejaculate

revealed to me some of the myths she had heard surrounding babies who were conceived through artificial means.

I heard that such children do not grow up as normal children...; you have to keep taking them to the hospital for regular check-ups since they require special medical attention. Some people even say that some of them have mental problems; they sometimes behave like mad people or something like that. Others also say such children will be drooling all through childhood and even up till adulthood. As if that is not enough, I also heard that, they will not be able to have any children of their own in future.

For that reason, she was sceptical about accessing care at a high tech treatment facility. However, a friend informed her that, such stories were not true. At the health care facility, the doctor and embryologists further allayed her fears by explaining to her the manner in which the technology works. This helped put her mind at ease and enabled her make the decision of going ahead with the procedure.

A look at beliefs regarding conception helps to understand the prevalence of such myths. The Ghanaian has a lot of traditional beliefs surrounding pregnancy and childbirth as evident in various studies (Darko, 1992; Senah, 1993; Arhin, 2001). These myths are found to regulate pregnancy in such a way that would prevent contamination of the 'naturalness/normalness' of the unborn foetus during the entire gestation period. The fear of giving birth to spirit children (Senah, 1993) and children with disabilities (Darko, 1992) is what informs the existence of such myths regarding pregnancy. Bearing this important component in mind, one can understand why babies derived through artificial conception will have myths surrounding their birth due to the unnatural way in which they are produced.

Moreover, the process of artificial insemination is improbable to some people. It provides the opportunity to question the parenthood of the offspring. The importance of having children who have the same genetic make-up as the parents therefore influences the acceptability of ARTs. Since biological parenthood is the desired option, ARTs thus threaten the achievement of this desire especially for those who rely solely on hearsay and are unable to access additional information which negates all preconceived ideas about ART babies.

Beliefs about ARTs are not restricted to the naturalness of the procedure. It also includes understandings of the procedure. During field work, there was a case where a client accused the doctor of not transferring any embryos into her uterus. This followed a negative pregnancy test result that the client obtained. The doctor had informed her he was transferring two embryos and so she was expecting to have twins. In other words, embryo transfers meant automatic conception. It therefore meant the doctor had lied to her about transferring embryos into her uterus. The case reflects yet another misconception surrounding IVF procedures.

6.2. CHOOSING THE LESSER EVIL

As the earlier discussions have shown, child bearing/childbirth is an important component of marriage and couples are expected to have biological children who bear the traits of both parents. Those who have no option but to seek treatment through ART in order to have biological children are faced with a host of options to choose from. In dealing with the fact that some components of the procedures though helpful to their situation are unacceptable to society, they make choices which do not conflict with their own beliefs and values and at the same time conforms to society's expectations. For example, the following excerpts from a 44 year old woman whom I interviewed at the high tech treatment facility summarises one way in which

clients of high tech treatment facilities rationalise their use of assisted reproductive technologies in engendering childbirth:

“Have you ever seen anything that the white man has invented which is completely bad? No, I am yet to hear of anything like that. So as for me, I just look at it critically, I take the one that is good for me and what is not good, I leave it out”.

The above situation arises when both partners have to make decisions regarding the type and the components of the treatment to go for, such as whether to go for an IUI or an IVF, the number of embryos to be transferred at a time, the use of their own genetic material or that of a donor, whether or not to freeze ‘excess’ embryos for future transfers and what characteristics to look for in anonymous donors.

What goes into the decisions that respondents take with respect to the type of treatment needed was usually found to be dependent on the extent to which the procedure remains as natural as possible. In this regard, IUI was preferred to IVF because the former does not involve any manipulation of eggs and sperms *ex-vivo* to attain fertilisation. Some clients therefore negotiate for that treatment option especially if they have chances of conception via that medium. This is because IUI’s were seen as more natural as compared to IVF and ICSI. In addition, some respondents expressed concern about the possible mix up of the fertilised embryos in the IVF procedure. In order to guarantee that such accidental mix-ups do not occur, respondents preferred the option of IUI. In an attempt to increase chances of conception via IUI procedures therefore, the hospital offers a free IUI repeat session for its clients.

To freeze or not to freeze “excess” genetic material was found to be another area of concern to respondents. The idea of freezing “excess” genetic material created discomfort for some clients.

According to one respondent,

Freezing can never be the same as having it fresh. Just look at all the things that we buy and store in the freezer..., tomatoes for instance, or even bread, once you defrost it, the quality is diminished and it can never be compared to the one that is fresh. It loses some of its quality through the process of freezing and de-frosting. And so, I will rather produce a fresh sample if there is a need for it. Once they managed to get some good ones now, I believe they can get it again.

As such, some clients prefer fresh samples to those frozen over a period. This preference is based on considerations such as ensuring that the process remains devoid of as many facets of ‘artificialness’ as possible. This is because of fears that, any further manipulations of the procedure through freezing will result in the production of baby(ies) who will not possess similar qualities of any other baby conceived naturally; thus, depriving the client of having a child who would not have the same biological traits as the client. For others too, it was the optimism with which they approached treatment procedures which they did not wish to be tainted by possibilities of requiring another procedure. These concerns of the clients prompt them to choose the use of fresh genetic material, which is deemed the lesser evil of the two.

Furthermore, respondents showed a preference for ICSI as compared to donor IVF. ICSI procedures involve the injection of sperm directly into the ova. This helps with fertilization and is usually the case when sperms are unable to move and fertilize the female egg or when eggs cannot easily be penetrated by sperm. It is therefore ideal in solving both male and female factor infertility. As such, when faced with the option of going for a donor sperm or egg, clients opted for ICSI procedures in order to ensure the utilisation of their own genetic material. For example, 42 year old Belinda and her husband terminated treatment at a previous fertility clinic because

the doctor did not provide them the option of using their own genetic material. However, at this current fertility clinic, they were informed they could use their own genetic material through the ICSI process. According to Belinda,

I asked the doctor of my chances and he suggested I used a donor's egg since as you grow old, your eggs become weak....So I came back home and discussed it with my husband but we both did not like the idea. I mean, we don't know who that person is or what kind of person she is. You can never tell with these things. I don't want to have a child who will be very different from me. It's always better to be on the safer side. Then we remembered one of my husband's friends whose wife was above 45 but has a child now so we called him and asked him about it and he told us that this is what they did (referring to ICSI) and that we should come here (Lister). So we came, and the doctor explained to us that, when you grow older, the egg shells become a little harder so it becomes very difficult for the sperms to penetrate. So he recommended this method (ICSI) and we decided to go ahead with it because we can use my egg and his sperm and that is what is important.

Additionally, although clients prefer the use of their own genetic material, where it is impossible to use one's own sperms or eggs due to its non-availability or its poor quality, such couples are forced to rely on donors. In most circumstances, anonymous donors are the preferred choice. However, in the selection of these donors, couples have specific characteristics which they desire their donors to possess. Obvious similarities to the couple such as skin colour and height are the most common requests. This brings to light the importance of physical characteristics to clients. In that sense therefore, stark differences in height and skin colour between the parents and their donor IVF baby (ies) will not become an issue to contend with observers. Furthermore, as the embryologist noted, the preference for ethnic similarities is becoming an emerging feature with the use of donor material. This can be explained by the desire to have children who can be considered as belonging to their in-group as opposed to their out-group. Indeed, as noted by Nukunya (2003), the existence of tribalism in Ghana has led to the creation and assigning of stereotypes to ethnic groups. These stereotypes invariably lead to prejudice or the development

of negative feelings and beliefs about the traits associated with the members of particular ethnic groups simply based on one's membership in that ethnic group (ibid). Examples of such ethnic stereotypes are Ashantis are hardworking, ambitious and possess a superiority complex and Ewes are good scholars. Such stereotypes therefore have a potential of influencing donor choices especially when parents desire their children to possess certain specific characteristics. Therefore, the growing preference for donors who belong to similar ethnic groups as couples can be explained by the fact that, these couples may be acting out any prejudices they may have about certain ethnic groups as though such perceived traits are indeed transferrable through genetic material. The social and cultural context surrounding childbearing which stress biological parenthood can be seen as accounting for this preference.

Finally, negotiations over the number of embryos to be transferred are made especially when many embryos are able to reach the blastocyst stage successfully. The advice from the doctor is usually based on the age of the woman. The older you are, the lesser your chances of conception as such, the advice is to have more embryos transferred, usually three or four. In this sense therefore, the decision to transfer more embryos is based on the cost benefit analysis between age of the woman and chances of conception at that age. Some respondents therefore choose to go with the doctor's advice rather than their husband's choices based on the trust in the advice of the doctor due to his expertise in the field. According to one respondent,

My husband wanted them to transfer two embryos because he said two children at a time was okay. I am sure he was thinking in terms of the cost of taking care of them and the amount of work it involves or something, I'm not sure. But the doctor explained to me that, not all the embryos are likely to survive and so advised that due to my age and the difficulty in getting the eggs initially, it was better to transfer three to improve my chances. So I felt, well, he knows best and there was no harm in doing so.

In the above case as in similar ones, it was better to ensure the survival of at least one embryo by transferring more embryos as compared to transferring the exact number of embryos that one desired to stem the risk of losing one or all. This is even more important considering the age of the woman and the time involved in preparing one for another procedure. This is based on the fact that, information obtained from respondents who had undergone IVF procedures in the past revealed that, it took them an average of at least two years to undergo another IVF procedure although this was based on an interplay of factors.

6.3 GENDERED DIMENSIONS TO ART USAGE

Anthropological evidence from Cameroon points to the fact that, the average Cameroonian finds it more culturally acceptable for a man to marry another wife if his first wife is infertile (Ngwafor, 1994). Likewise, a Cameroonian wife whose husband is infertile is permitted to have secret sexual relations with another man in order that she might be able to conceive (ibid). In the light of these therefore, the general attitude of Cameroonians towards ARTs is one of dislike and rejection of the procedure since it is against their value systems.

The decision of Ghanaian respondents and clients to use ART was, however, found to have a gendered dimension. Both men and women had different notions and perceptions about the use of ART. This has a bearing on the notion of what constitutes biological parenthood among the respondents. For male respondents, biological parenthood has to do with the use of one's own genetic material in the fertilisation process; while for female respondents it had to do with the ability to carry a child to term and the visibility of pregnancy. Despite this, respondents preferred the use of their own genetic material as long as there was the slightest possibility of fertilisation

taking place. The social and cultural context surrounding childbearing whereby biological parenthood is stressed throws light on these preferences.

In the light of these preferences, female respondents were more open to donor insemination irrespective of whether it was male factor infertility or female factor infertility. This is because they feel the negative societal reactions associated with infertility more than their male counterparts. In addition, the visibility of pregnancy as well as the similarity in physical features between parents and offspring and the secrecy associated with the use of donor material all work together in making donor IVF acceptable to female clients. According to 38 year old Tina,

Sometimes, I think we worry ourselves unnecessarily. The doctor says our chance at conception without the use of a donor is next to impossible. What other choice do we have? So we go ahead with an anonymous donor, finished. It stays between the three of us (both spouses and the doctor) and none of us is going to tell. If I had gone and had an extra marital affair, yes, I may get pregnant. But imagine the consequences of that. First of all, I love my husband and will never think of doing that (laughing....at least not anytime in the near future). This is less complicated, no emotions, no guilty feelings of having cheated, no sin of adultery, nobody is going to come and fight with me later that he wants his child back. So sometimes, I just think we make life too complex for ourselves. I don't think God will have any problem with this one, in fact, I have not even thought about it in that sense.

Some women's acceptance of anonymous donor sperm in cases of male factor infertility can be explained by the fact that, women want to avoid any contestations regarding the fatherhood of their child. This is linked to the fact that, it is culturally unacceptable for a Ghanaian married woman to engage in extra-marital affairs. Such an act is frowned upon and is considered as grounds for divorce (Nukunya, 2003). Thus, the secrecy associated with anonymous donors becomes the overarching advantage that comes along with the use of donor IVF. What is more, the ability to give birth to children bearing similar physical characteristics as the parents does not create any questioning attitude regarding the biological parentage of the child.

The male respondents in the study, however, expressed concern about the possibility of their children bearing the same characteristics as them. On that basis, in cases of male factor infertility, ICSI was the preferred choice since it allowed the use of one's own genetic material as compared to donor sperm IVF. In instances where donor sperm was the only option, one respondent mentioned that he would prefer the use of a close relative as a donor. This was because, this would make the child more of a part of the family as compared to an outsider. According to another respondent whose wife had undergone donor sperm IVF,

Left to me alone, I would probably have considered adopting. This is because...God forbid, but if my wife should disclose this to anyone, it will be more humiliating for me as compared to adoption. As for adoption, even if people get to know, it involves both of us, and so, right from the onset, you find a way of dealing with it then and there. But this one, imagine after so many years of taking care of the child, then, one day, your wife decides to rub it in your face all because she is annoyed. What can you do at that time? This is what we call delayed humiliation (laughs). So, under the circumstances, I just pray that day never comes.

Thus the reservations that males had towards donor sperm IVF were based on futuristic considerations. They expressed fears of their wives blurting out their 'little secret' in moments of anger to the hearing of others. This would mean a loss of respect first and more importantly, from their wives and also from other family members and friends when it becomes public knowledge especially in the event of the dissolution of the marriage. As a result of this some respondents mentioned that they preferred the use of a close relative as a donor or adoption to donor sperm IVF. This shows that, for men, issues of legitimacy of their parentage and the need to enjoy the continued respect as men and fathers was what was paramount.

In cases of female factor infertility however, male clients did not have any reservation towards donor IVF. Donor egg IVF was seen as an acceptable replacement of the old system of polygamy especially due to the all important consideration of Christian values (which preaches monogamy and denounces polygamy). For these male respondents, other advantages that it has over the old system of polygyny include less financial burden of running multiple households and less emotional distress associated with having multiple partners. This position of the male clients is in contrast to the preference of male partners in Mali (Hadolt and Horbst, 2009 cited in Gerrits & Shaw, 2010) where anthropological studies conducted revealed that male partners do not easily subscribe to the use of donor material for their wives. This is because, for these male partners, the high cost involved with IVF procedures was regarded as a waste of money. The cheaper alternative for them therefore lay in marrying another wife. In contrast, the willingness of Malian men to accept donor sperm stems from the fact that it is used as a cover up for their infertility in order to avoid the shame that comes with being infertile.

Despite the gendered prejudice, it is important to note that, in some cases, although females were found to have physiological disorders which made it difficult for them to conceive naturally, it was often discovered after tests run on their husbands that, these men were equally contributing to the problem. In such instances, male partners became more accommodative of the treatment procedure since there was a shared burden of infertility. Such situations usually led to closer relationships between partners.

6.4 RELIGION AND ART TREATMENT

In this section, an analysis is made of how respondents utilising high tech treatments understand and negotiate treatment with particular reference to any existing tensions and/or apparent equanimities that exist between religion and biomedicine. By so doing, I aim to contribute to the

literature on the intertwinings between religion and modernity (with particular reference to ART treatment) as practiced, experienced, and understood by my Ghanaian respondents.

The findings from the study revealed that, in very rare cases, some Catholic clients have expressed their reservations towards the procedure based on the ‘unnaturalness’ of it and the fear of going against religious doctrines. The Catholic Church is known to be against anything artificial that aims at interfering with the process of reproduction. Catholics do not subscribe to the use of contraceptives to prevent conception and are also against abortion equating it to the sin of murder (www.catholic.com/tracts/abortion-birth-control). In addition, the manipulation of human embryos ex-vivo and the discarding of excess embryos are against Catholic doctrines (Benagiano & Gianaroli, 2004). The Catholic Church’s position on this explains why some (albeit very few) Catholics accessing ART treatment expressed some discomfort with the idea of artificial insemination but later go ahead with it after receiving assurance from the doctor that, embryos that are discarded are the ones not viable. Their change in acceptability of the procedure could also be explained by the need to have children which is a more pressing and felt need. In connection with these, one respondent revealed that she had approached her parish priest for special blessings before coming in for the procedure to which he had obliged. This was done to ensure the success of the procedure.

In her study of the intersections between religion and modernity, Roberts (2006), discovered that, in the strong Catholic state of Ecuador, there was a stable separation between the church and the state in the area of IVF treatments. As such, despite the existence of strong Catholic sentiments for both patients and practitioners, these did not influence the acceptance of IVF in a negative way. In addition, the services of religious leaders were employed to aid in fertilisation and implantation. Despite the fact that Ghana does not possess the identity of being a Catholic state,

such similarities in the separation of church doctrines and actual practice in the field of IVF treatments is useful in providing an understanding of the synergies between religion and science in varying contexts.

Respondents belonging to other Christian religious denominations did not express any reservations towards the procedure based on their religious beliefs. This may be because, other Christian denominations are not as dogmatic in orientation in the area of reproduction and the non-interference of human agents in the process. Perhaps, for all groups of believers, their high levels of education could also explain their openness to new scientific information.

Furthermore, religious explanations that clients accessing IVF and ICSI give are often evident at all three stages of treatment namely before treatment, after a successful procedure and also after an unsuccessful procedure. Before treatment, clients often explained their decision to undergo the procedure with the common Christian phrase that says “God helps those who help themselves”. This means that, they did not see the scientific procedure as in opposition to God’s will. Religion is therefore not a conflicting system but a complementing one. Religious faith is also important in providing a source of strength to cope with the emotional and physical pains associated with treatment. Religious explanations that clients provide after successful and unsuccessful procedures will be discussed in subsequent sections.

Moslem clients are not ruled out of IVF and ICSI procedures. They were found accessing IVF and ICSI treatments in cases of both male and female factor infertility. In Moslem marriages whereby polygyny is practised, female factor infertility can be resolved simply by marrying another wife. However, this is not always the case. One Moslem man whom I encountered on one of my fieldwork days at the high tech treatment facility was in a polygynous marriage.

Although he had borne seven children with his first wife, his second wife of ten years was childless. He therefore wanted her to undergo an IVF procedure so that she could also have a child of her own which will bring honour to her. This means that, religious rules permitting polygyny do not always prevent Moslems from accessing IVF treatment. In other words, this female factor infertility posed no threat to the marriage for the woman.

Furthermore, key informant interviews revealed that Moslem clients expressed more discomfort with the idea of masturbation which led to some withdrawing from treatment without considering the possibility of the production of semen via sexual intercourse with their partners within the hospital. This is because masturbation is regarded as sin in Islam since it is tantamount to having an extra marital affair.

In addition, the data revealed that, Moslems accessing IVF treatment did not subscribe to the use of donor material. This is because it was against religious doctrines to involve a third party in the fertilization process. This was seen as adultery and is in tandem with findings amongst the Sunni Moslems where it was considered illegal to use donor material (Inhorn, 2006). However, the extent to which such religious doctrines are strictly adhered to is also of interest. Key informants revealed that, in very rare cases, Moslem clients accessed donor IVF procedures. This attitude could again be attributed to the greater need to have a child.

6.4.1 Explaining treatment successes - God is the ultimate healer

As previously discussed, the religious beliefs of clients showed a general acceptance of the procedure. It is often regarded as ‘the work of God through man’. The IVF doctor was seen as one who was “utilizing the knowledge that God had endowed man with to cater for their needs”. For that matter, treatment successes were understood not only in terms of the capabilities of

science and technology but more importantly in religious terms as the ultimate hand of God being at work.

The part that both God and science play in the success of IVF/ICSI treatments is also evident in the names that respondents revealed they would give to such children. Two respondents revealed they would name their children Nukunu which is an Ewe name meaning ‘a wonderful thing/creation’. When used as a noun, the word wonder signifies ‘a feeling of amazement and admiration, caused by something beautiful, remarkable, or unfamiliar. It can also be used in reference to ‘a person or thing regarded as very good, remarkable, or effective’. Thus, aptly expressing the sentiments of the ‘to be’ and actual parents regarding the means of conception. Others also had selected Ghanaian names with religious undertones to express their sentiments towards God’s role in the process of achieving desired conception. Ghanaian names such as Seyram (God has blessed me), Aseye (Praise Him), Nyamekye (God’s gift) and Nhyira (God’s blessings) were some of the names that respondents had chosen for their children.

God’s hand is also seen to be at play throughout every step of the process beginning from the medications taken in preparation for the procedure, through conception to successful gestation and delivery. Aside having undergone a successful IVF procedure and having carried the baby in her womb for 29 weeks, Akuvi’s experience at labour and successful vaginal delivery was the icing on the cake for her desire to experience motherhood. At 57, the doctor had advised her to have a caesarean birth but she had convinced him she would try and give birth naturally. She narrated her experience with such joy and in such detail. During her week-long stay at the hospital following the birth, she was easily noticeable as she was often found walking up and down the corridors waving her white handkerchief amidst songs of praises to God for his

goodness. According to her, "...it is God ooo, my sister, it is God. At long last, my dream has come to pass, my dream has come to pass, it is all in the past now".

Likewise, multiple pregnancies and births were interpreted as additional blessings from God. Despite the fact that transfers of more than one embryo at a time is the norm (except in few cases where only one embryo is available for transfer), the ability for more than one embryo to be implanted is regarded as divinely coordinated. For Adzo, after ten years of a childless marriage, God had finally blessed her not with one, but two babies. By so doing, he has brought happiness to her and shamed all those who were thinking and speaking ill of her based on her childlessness. This proves the omnipotence of God and the wonderful way in which he works. These sentiments are what have been summed up in the popular Twi gospel song written by Brother Philip titled 'Menk) da me nyame ase' interpreted to mean 'Let me go and thank my Lord' with the following lyrics (translated),

Brothers and sisters, come along with me, while I go and thank the Lord for his many blessings (repeat). It is he who has made the barren give birth to twins,...Almighty God, we thank you (repeat).

I have something to say, I have a testimony to give. Sometime in the past, the devil used me for many of his deeds, In the long run, God has preserved me. Today, He has changed my name. Let me go and thank my God. Oh yes, he is the one who has made the barren one give birth to twins...Almighty God, we thank you.

6.4.2 Explaining treatment failures

When procedures are not successful, clients again fall on religion as an explanatory model. However, the supernatural entity (God) is never seen as opposed to their desire to have children. Rather, it is blamed on circumstances such as timing. Although they could not explain why they were unsuccessful at that particular point in time, as one of the respondents put it, "God's time is

the best, His ways are not our ways”. This meant one had to keep trying until the right time when God chooses to ‘endorse’ the conception and birth. Laureen, who miscarried each one of her triplets after almost eight weeks of pregnancy expressed a similar sentiment. Although it was a very painful experience, since she lost them, one after the other, she expresses joy at the opportunity to also feel what it is like to be pregnant even if for a short time. According to her,

“Only God knows why I lost all three of them and in such a manner. Especially Lisa/ Seyram, the last one. I was so sure that she would survive because each time the doctor did a scan, we could hear her heartbeat. I kept saying, God, as for this one, do not take her away. But in the long run, the doctor discovered she was growing outside my uterus and I could have died if the baby had survived. That is why I was bleeding so much. So I believe that, despite the fact that they all didn’t survive, at the end of the day, God knows best that is why I am still alive today”.

Service providers were never blamed for treatment failures. This may probably be because, the doctor had told the clients over and over again that, he, together with his team, had done everything that was humanly and scientifically possible and could only do so much. The rest was up to God. Clients and service providers thus interpreted and understood treatment successes and failures in scientific and more importantly in religious terms as well. Kahn (2006) in her study of Orthodox Jews in New York who were undergoing infertility treatment presents a similar scenario. According to her, a common Jewish principle was found to influence the way both doctors and patients interpret treatment successes and failures. This Jewish religious principle enjoined believers to exert the most effort at whatever task they were performing in order to achieve a desired outcome. However, God determined the ultimate success of that effort.

6.5 CONCLUSION

In analysing the effects of Western biomedical treatment options for the infertile and their acceptability and utilisation in the Ghanaian context, varying considerations emerged. These

were influenced by existing social, cultural and religious beliefs. Socio-culturally, based on the overarching desire to be biological parents, clients navigated their way around treatment options in such a way as to reduce dissonance to the barest minimum. The different worlds of science and religion were also found to be necessary synergies that supplement one another rather than being in opposition. This explains the use of biological terms such as the existence of fibroids and low sperm counts relating to infertility and its treatment in both biomedical and spiritual worlds of treatment.

CHAPTER SEVEN

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

7.0 INTRODUCTION

This study sought to contribute to the literature on infertility and its treatment by providing an understanding of the present social and cultural factors at play in the lives of the infertile during their search for treatment and biological parenthood. It helps to throw more light on the subject of the health seeking behaviour of the infertile based on the influences of urbanisation, globalisation and Christianisation. The most important gap that this research fills therefore is its focus on modern biomedical treatments in the form of medical herbalism and Assisted Reproductive Technologies. An analysis of the roles of all three actors, namely, health professionals, the infertile, as well as the other members of the society provide an all-encompassing overview of the socio-cultural context of infertility. What is more, it adds on to findings reported in medical/clinical studies on infertility by providing a more holistic picture of infertility.

7.1 OBJECTIVES OF THE RESEARCH

Following the ICPD conference in 1994, many more published studies have focused on the experiences of infertility within differing social and cultural contexts while utilizing social scientific methods of enquiry. These studies have been focused on Africa and Asia and rightly so due to the relatively higher infertility rates within the region. A section of that literature has also reported on the utilization of the global assisted reproductive technologies in engendering childbirth. However, there is a dearth of literature on the experiences of infertility and its treatment in the Ghanaian context. In contemporary Ghana where polygamy is socially disapproved to a large extent and fostering is no longer seen a good substitute for parenthood due

to the focus on not only social parenthood but biological parenthood as well, it is imperative to explore the socially constructed realities of modern day infertile marriages. The focus on infertility within marriages is borne out of the obligation to bear children in marriage and the societal disapproval of divorce (attributable in part to the Christianisation of the society) with the latter being contrary to what studies conducted in the past revealed concerning divorce in marriage (Bleek, 1976). Thus, the various negotiations that take place between health care providers, clients and the society at large in the journey towards desired conception is of major sociological interest. This study therefore sought to contribute to the literature on infertility studies by focusing on the current experiences of the infertile Ghanaian in marital relationships with regard to treatment in the light of the effects of urbanisation, modernisation, Christianisation and globalisation. The study is situated within the orthodox health care system namely medical herbalism, low technology treatment as well as high technology treatment. Clients of selected health care facilities offering these services shared their experiences regarding their infertile unions and their desires to have children evident in their relentless search for a solution. More specifically, the study sought to answer the following questions:

1. What categories of people are utilizing fertility treatments such as low-tech treatments, medical herbalists and ARTs?
2. What are the motivations of the people who seek these treatments?
3. What processes do they follow in seeking treatment with reference to their patterns of treatment seeking?
4. What determines their choice of treatment?
5. What contestations exist between couples and others over treatment choices and how are these resolved?

6. How does the social, religious and cultural context configure the meaning infertile couples make of ARTs?

7.2 RESEARCH METHODOLOGY

This study utilised a qualitative research approach to help answer the research questions stated above. It is based on the social constructionist paradigm characteristic of qualitative researches. Respondents were selected from three different fertility care and treatment facilities namely a private Western style herbal clinic, a government hospital utilising low tech orthodox treatment as well as a privately run IVF clinic. These treatment centres are all located in Accra, the nation's capital. Although the clinics/hospitals were selected to help identify the experiences of clients using the various treatment options, the long periods of observations and interactions at the clinics brought an ethnographic discernment to the clinical setting and the experiences of these clients.

In all, forty-five respondents were selected for the study, fifteen from each treatment facility. In addition, nine key informant interviews were held with doctors, medical herbalists, and embryologists working in these facilities. The views of religious leaders on the subject of infertility and its treatment were also obtained.

Semi-structured in-depth interviews were the main instruments for data collection. After conveniently sampling respondents from the clinics/hospitals, interviews were conducted at their preferred location most often the clinic/hospital premises. Interview sessions usually lasted for an average of one to two hours depending on the rapport that was created between the researcher and the respondent. Follow up interviews were also made for respondents who were willing to

share more information. The researcher was also able to track the progress of some respondents undergoing treatment to the point of treatment successes and/or failures.

The use of a recorder for interviews was not possible in all cases. Field notes were thus generated to make up for those interviews which could not be recorded. The interviews were then transcribed and analysed manually maintaining the rigour in qualitative data analysis. Interviews were conducted in English and in the local languages of Twi and Ewe where convenient and depending upon the preference of the respondent. The themes that emerged from the data were then used for discussions as evidenced in the three empirical chapters of the thesis. These discourses were made based on existing literature and bearing in mind the questions that the research sought to answer.

7.3 KEY FINDINGS FROM THE RESEARCH

This study makes some major contributions to the study of infertility in the developing world. First of all, the desire for children has not changed, indeed it has intensified due to the decreased popularity of previous practices such as polygyny and fostering. Children within marriages continue to be desired for purposes of securing the marriage, social security, inheritance, and less commonly as a form of prestige and social status based on differing circumstances. Their absence has therefore led to experiences of labelling and stigmatisation especially targeted at the women in infertile marriages. It is, however, noted from this study that, female autonomy from extended family influences brought on by urbanisation, nucleation, higher education and professionalization has reduced these effects on the female somewhat. This is because, women experiencing these forms of autonomy revealed that they were able to cope better with the negative societal consequences of stigma and labelling associated with infertility. This pattern is consistent with the findings of other studies in Ghana (Donkor and Sandall, 2009). Despite that,

the personal desire to be mothers was so strong that, it led to a relentless search for treatment which brings to bear the influences of both society and agency in respondents search for biological parenthood.

The study incorporated the new options of infertility treatment available to the infertile. Although respondents were selected from modern health care facilities that utilise Western style diagnosis and treatment for their clients, an analysis of previous treatment strategies and an examination of treatment preferences points to the fact that, people are now more inclined towards receiving systematic analysis and treatment of their conditions. This is so because, these offer a more scientific diagnosis while promising a cure as well. Further analysis also shows that, the urban Ghanaian dweller tends to resort to ethno-medical healers mainly because they promise a more immediate cure and provide cheaper alternatives. The health seeking behaviour of the infertile can thus be summed as best as one of a relentless search. New options are constantly being sought all the time especially as the reproductive years run out. Such situations are also marked by phases of rest and inaction whereby sufferers get fed up with treatments not yielding desired results. These are soon followed by an even more relentless search when they are reminded of their situation. On that basis therefore, the fertility specialist at the high tech treatment facility revealed that, the busiest times of the year when clients come in for fertility consultations are usually the months of November, December, January and February. This is because, during those times of the year, infertile couples experience the unpleasant reminder that their desired aim of biological parentage had not yet been achieved as the year draws to a close. This renews their strength in seeking a solution and achieving biological parenthood in the New Year. Likewise, at the herbal clinic, the beginning of the month was often the busiest time due to

the fact that, salaried workers were in a better financial position during that time to afford treatment.

With respect to their patterns of treatment seeking, the study found that, unlike in the past when herbal and orthodox medicine was used simultaneously as treatment strategies, respondents seeking infertility treatment did not engage in simultaneous health care seeking with regard to Western style medical herbalism and orthodox treatment. However, respondents opted for either herbal treatment or orthodox treatment based on their belief and trust in that system. In the event that the desired result (conception) was not obtained, respondents then resorted to healer shopping from one herbalist to the other or from one orthodox healer to the other. At this point, some respondents selected healers based on their ability to afford their services. The study also found that some respondents switched from herbal treatment to orthodox treatment when they were not obtaining any positive results. For others too, inadequate knowledge with regard to treatments in the form of Assisted Reproductive Technologies led them to opt for herbal treatment first. Conversely, respondents previously accessing orthodox treatment also switched to herbal treatment when they received the treatment option of surgical operation from the doctor. They did this due to the fear of surgical operations which may result in the loss of their lives. Others also switched from orthodox treatment to herbal treatment when they were not obtaining any positive results from orthodox treatment and when they learnt through advice from friends that, herbal medicines were more potent in solving reproductive disorders such as low sperm count. As such, whereas in the past, people resorted to orthodox treatment only when all other existing treatment options in the form of traditional treatment (e.g. herbalists, fetish priests etc) had been exhausted (Bleek, 1976), the use of orthodox treatment has become a common first option for some respondents especially the wealthier and better educated ones.

In addition, spiritual causal theories for infertility continue to exist leading to a resort to spiritual treatment. This is usually evident when cure is not being obtained from either the doctor or the medical herbalist. Some respondents also turned to spiritual cures in cases of unexplained infertility. However, both spiritual and biomedical treatments are not in contention with one another but have been found to complement one another. This is seen in the respondents' simultaneous use of spiritual treatment with either orthodox treatment or herbal treatment. Explanatory models that respondents held related to the cause of infertility whereby respondents relate their infertility to the existence of reproductive disorders on one hand, and the interference of external agents on the other hand, thus explaining the interplay between biomedical and spiritual treatment. However, for some, resorting to spiritual treatment was based on the belief in the Christian God being the ultimate healer and the belief that God is the one who gives children.

Furthermore, en route to achieving desired conception, infertile men and women are bombarded with various considerations regarding where to go for treatment and what to do about the situation. Spouses, family members (including in-laws), friends and associates and recently the media, all play a part in shaping the choices made. This sometimes creates an atmosphere of contestations over the best treatment option that will guarantee the much desired results. Whereas other studies (Koster-Oyekan, 1999; Leonard, 2002) revealed the strong influence of in-laws in the decision making process regarding infertility treatment, this study while confirming the applicability of this to some respondents, revealed another dimension. The advice from in-laws (with particular reference to mothers-in-law and other extended family members) was not always heeded. Some male partners were found to have ignored their suggestions at re-marriage that had been borne out of the perception by in-laws that, wives were solely to be blamed for infertility. Thus, in such dicey areas as infertility, spouses were found to be supportive of one

another with regard to treatment while excluding any unfavourable interference from in-laws. This support is even more evident when clinical diagnosis reveals that, the men in these unions are also contributing to the infertility. This attitude of male partners especially and spouses in general could also be explained by the effects of urbanisation which have led to the increasing nucleation of the family and has been manifest in the final decision taken by some respondents regarding infertility treatment.

Thus, the shift in the effects of infertility become two-fold, namely, a reduction in external influence of in-laws on decision making regarding infertility and secondly, an increasing awareness of the contribution of men to infertile unions leading to a shared burden of infertility amongst spouses. However, owing to the fact that infertility is a secret affair between couples, this effect is restricted to the marital relationship and is never revealed to the outside world. For that matter, women continue to experience the societal consequences of infertility namely stigmatisation and ridicule.

Furthermore, assisted reproductive technologies of IVF and ICSI have come to improve chances of conception especially for those suffering from irretractable infertility. However, owing to the Western nature of these technologies, respondents accessing treatments via these technologies have found ways of rationalising their use of the technologies to fit into the socio-cultural and religious ideals of the Ghanaian. In that vein, clients often select the options that will create the least form of dissonance for them such as IUI's instead of IVF, ICSI instead of the use of donor material, anonymous donors with similar physical characteristics, and the non-freezing of excess eggs, sperms and/or embryos. Religious beliefs are also drawn on in explaining the successes and failures associated with treatment. Religion is thus a complementing system that is not in contention with the use of these scientific technologies.

7.4 POLICY IMPLICATIONS AND STUDY RECOMMENDATIONS

Given that one effective and societally acceptable solution to infertility lies in treatment to correct physiological disorders which prevent one from achieving biological parenthood, the following recommendations are useful for policy considerations. First and foremost, men in infertile unions need to be encouraged to go for diagnosis as well. This can be achieved by creating more awareness amongst men about their role in infertility treatment and sensitizing men to go for diagnosis. This is because, fertility is a shared responsibility and thus the reverse is also applicable. When a diagnosis is sought early, retractable conditions resulting from untreated sexually transmitted infections and other lifestyle effects have higher chances of being treated and hence corrected. This helps to prevent prolonged periods of infertility and thus reduce the personal and social burden of infertility on the women in these relationships.

Secondly, the study recommends that, given our pronatalist tendencies as Ghanaians, a dialogue is initiated between all relevant parties such as service providers and clients with the future aim of possibly expanding the National Health Insurance scheme to cover some infertility treatments. For example, treatments involving medications for the infertile (e.g. clomid) as well as relatively less complex surgical procedures such as removal of fibroids and the clearing of blocked fallopian tubes. These procedures should also include intra-uterine inseminations for the infertile. In that way, the financial burden related to the costs of treatment is reduced for those who can afford premium health insurance payments. In developed countries such as the United Kingdom and parts of Europe such as the Netherlands, infertility treatment via IVF is covered under their health insurance such that the insured are eligible to undergo three free IVF cycles.

Furthermore, it is recommended that, the scientifically approved herbal drugs⁵ for boosting fertility, curing sexually transmitted infections and other reproductive tract infections, regulating menstrual cycles and managing uterine myomas (fibroids) amongst others be made publicly available in state run health care facilities and registered pharmacies and licensed chemical shops. The establishment of the Centre for Scientific Research into plant Medicine (CSRPM) is a laudable effort taken up by the government in developing such scientific herbal medicine. The Centre should thus increase and improve its coverage to include the research and development of all medications required by the infertile in improving their chances of fertility. As a further step, research institutions should take interest in the area of developing cost effective ways of packaging these medications so as to improve its look in line with Western style medications that come in the form of tablets, capsules and infusions (such as herbal teas). This will make the medications more consumer friendly and thus make such Western style herbal medication more available and accessible to those for whom herbal treatments are a preferred option as compared to orthodox treatments.

Additionally, I cannot help but borrow the African proverb which states that, “the freedom that comes from ignorance enslaves the one who entertains it” (Gyekye, 1996) to express the abstract idea that knowledge creates freedom. In stressing the importance of being well informed about scientific causes of infertility, lifestyles that promote infertility (e.g. poor dietary habits, excessive alcohol intake etc.) as well as the existence of a variety of treatment options, fears and misconceptions regarding infertility and its treatment will be greatly diminished. The resultant advantages of the prevention of infertility, especially irretractable infertility and the ability to make informed choices regarding infertility treatment will go a long way to free married men

⁵ Those herbal drugs that have been approved by the Food and Drugs Authority

and women in infertile relationships from the enslavement that their difficulty/inability to conceive and give birth brings them. Such reproductive health education is therefore recommended to be carried out by the Ministry of Health in partnership with the Ministry of Information and Media relations to disseminate such information both in the local languages as well as in English to the listening, viewing and reading public. Religious leaders should also be incorporated in the dissemination process through church and mosque activities such as counselling sessions that serve as learning grounds for infertile married couples in particular and the entire body of followers in general.

In relation to that, more efforts must be made at regulating the activities of private media houses as well as churches in the content of information regarding infertility care that is made available to the public. This is because, they have the potential of delaying access to more effective treatment options. In matters of infertility, time is of paramount importance as one only has a fixed period during their reproductive life span during which fertility potential is at its optimum. Delays with accessing scientifically proven remedies thus reduce chances of conception and child birth drastically.

7.5 RECOMMENDATIONS FOR FUTURE RESEARCH

The breadth of possible studies on the experiences of infertility and its treatment is not only extensive but multifaceted as well. In order to generate policy strategies and development goals that are targeted at reducing the incidence of infertility, there is the need for more exploratory research into the subject in Ghana in order to allow for a further assessment of the socio-cultural influences on infertility and infertility care.

While this study is significant in its focus on people receiving treatment in Western style biomedical treatment facilities (both herbal and orthodox), it makes it difficult to fully grasp the stories of traditional treatment seekers. The study sought to do this by enquiring about previous treatment seeking strategies of respondents. The information obtained from this showed the persistent though less common use of traditional herbal and spiritual treatment. In that regard therefore, conducting longitudinal studies on the reproductive life histories on infertile men and women in marital relationships will be useful in providing more details and insight into the health seeking behaviour of the infertile. The emergent patterns of health care seeking studied over a longer time frame will help establish more grounded cause and effect relationships regarding the experiences of infertility and its treatment.

In addition, the study was confined to the Greater Accra Region of Ghana, specifically in Accra. Although it was noted that some respondents travelled from different regions to access the services of these hospitals and clinics located in Accra, there are a lot more people's experiences which could not be captured due to the location of the study which provided the context as it pertains to Accra. To be sure, fertility clinics providing ART services as well as medical herbalists are springing up in other major cities in the country such as Kumasi and Takoradi amongst others. It is therefore recommended that, to get a more comprehensive understanding of the experiences of respondents and their health seeking behaviour through the use of modern biomedical treatment options, future studies must expand to include other urban cities in Ghana.

Furthermore, assisted reproductive technologies being practised in Ghana today have as an added feature namely the component of gestational surrogacy⁶. This study did not include surrogates

⁶ In gestational surrogacy, the pregnancy results from the transfer of an embryo created by IVF in such a manner that, the resulting child is genetically unrelated to the surrogate

nor the intended parents of gestational surrogates. Their experiences are, however, useful in adding to the literature on the use and experiences with modern assisted reproductive technologies in Ghana.

The issue of reproductive tourism in Africa is also one of medical sociological interest. The globalisation of assisted reproductive technologies is not restricted to the movement of the technologies alone. Specialists (personnel) offering these services as well as the clients in search of treatment also move across borders to access the service. Personnel move from the West to provide services for clients in Ghana just as practitioners in Ghana often travel to the west to engage with other like personnel in an attempt to improve service delivery and be at par with developments in the West regarding the use of these technologies. Having concentrated my study in only one high tech treatment facility, I could only report on what pertains in that facility which is not substantial enough to make useful deductions based on comparisons. In addition, although I encountered clients from different countries accessing high tech treatment, I did not include their stories in this thesis because the focus of this thesis is on the Ghanaian experience. Further research in these areas is therefore recommended to add to the literature on reproductive tourism in Ghana.

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APPENDICES

Appendix A

THESIS TITLE: COUPLES IN SEARCH OF CHILDREN: A STUDY OF THE STRATEGIES AND MANAGEMENT OF INFERTILITY IN CONTEMPORARY GHANA

INTERVIEW GUIDE FOR CLIENTS OF FERTILITY CLINICS

Socio-demographic background of respondents

1. How old are you? How old is your spouse?
2. How long have you two been married?
3. Do you and your spouse live together?
4. What is your level of education?
5. What is your religion?
6. What work do you do? How about your spouse?
7. Do you have any children? If yes, how many?
8. What is your main reason for coming here?
9. How did you get to know of this place?
10. How long has it been since you found out you were infertile?

To understand the nature of the decision making process that leads infertile couples to resort to herbal medicines, orthodox treatments and/ or ARTs in Ghana

1. How did you come to know that you are infertile?
2. Do you (and your partner) know what is causing the infertility?
3. Do you (and your partner) know which one of you is infertile?
4. Which one of you decided where to go for treatment?
5. What did it take for the other party to agree to the source of treatment? (e.g. pastor, parents etc)
6. How long did it take to convince your partner to do this?
7. What is the reaction of your family members regarding your situation?
8. What role do family members play on the way to obtaining treatment?
9. Do some of your family members know that you come here for treatment?
10. Who knows and why them?
11. What is their reaction to this?
12. What kind of reaction do you get from the following groups of people regarding your inability to conceive and your subsequent quest for conception: i) in-laws ii) other married members of your family iii) other unmarried members of your family
13. Are you comfortable at work/ church etc where others know about your situation?

14. What is their reaction and how do you deal with it?

To explore the pattern of utilization of infertility treatment seeking options

1. Why are you using this particular remedy?
2. How long have you been using this method?
3. How confident are you that this method will work for you and why?
4. Are there some other things that you are doing at the same time to help you get a child?
5. Why do you use different methods at a time?
6. Have you tried to have a child using different remedies in the past apart from this one?
7. What are these remedies?
8. Why did you choose these remedies?
9. Are there some other options you would have liked to pursue but are constrained? If yes, name them

To identify the contestations that arise concerning treatment choices and how the contestations are resolved

1. How long did it take for you to come here for treatment after you had decided you would visit a fertility clinic?
2. What are the things that prevented you from coming here earlier?
3. How did your spouse and other family members react to this?
4. What is the reaction of friends, colleagues and others about your situation?
5. Are you satisfied with the kind of treatment you are receiving here?
6. What are the things that are preventing you from accessing the service to its fullest?
7. What are the things you would like to change about the way the service is being provided here?

To explore the ways that respondents navigate their use of ARTs

1. What type of treatment are you undergoing?
2. Whose choice was it?
3. What are the reasons for your choice of treatment?
4. How do you understand the process?

INTERVIEW GUIDE FOR KEY INFORMANTS

MEDICAL PRACTITIONERS/HERBALISTS (HOSPITAL STAFF)

1. What are the various services you offer to infertile couples seeking to have children of their own?
2. What is the level of patronage of infertility treatment services at your facility?
3. Do you receive clients from all over the country (and beyond)?
4. Who are those who normally patronize your services- age? age specific causes? sex?
5. From your observations, what can you say about the husband-wife relationship when it comes to solving infertility?
6. What types of services do you offer your clients?
7. What kinds of complaints do you receive from clients who access your services for the first time?
8. Are you able to satisfy your clients' needs?
9. What are your views concerning religion and infertility treatment?

RELIGIOUS LEADERS

1. What is your stance on infertility?
2. What help/options would you offer a church member who informs you of his/her infertility?
3. Would you encourage infertile church members to seek artificial means of conception? Explain your answer.
4. What would be your reaction towards members who engage in assisted reproductive technologies in order to have children?
5. Would you accept a child into your church (i.e. baptism, confirmation etc) if you knew that such a child was conceived through artificial means?
6. What does your religion say about infertility and the use of herbal medicines and assisted reproductive technologies to achieve conception?
7. If you were to give a sermon on the use of assisted reproductive technologies, what will be your message to the faith community?
8. Have you ever mediated in cases whereby one partner refuses to subscribe to the use of these technologies? Please explain further.
9. How often are you called upon to intervene in such cases and how successful are these interventions?

Appendix B: Education and Employment status of Respondents

Characteristics of respondents	Korle-Bu Teaching Hospital (n=15)		Champion Divine Herbal clinic (n=15)		Lister Hospital (n=15)		Total (n=45)	
	Frequency	Percentage (%)	Frequency	Percentage (%)	Frequency	Percentage (%)	Frequency	Percentage (%)
Level of education								
None	0	0.00	0	0.00	0	0	0	0.00
Primary	7	46.67	6	40.00	3	20.00	16	35.56
Secondary	7	46.67	8	53.33	4	26.67	19	42.22
Tertiary/University	1	6.67	1	6.67	8	53.33	10	22.22
Socio-economic status								
Unemployed	4	26.67	2	13.33	1	6.67	7	15.56
Employed (formal sector)	2	13.33	1	6.67	9	60.00	12	26.67
Employed (informal sector)	4	26.67	4	26.67	0	0.00	8	17.78
Self employed	5	33.33	8	53.33	4	26.67	17	37.78
Retired	0	0.00	0	0.00	1	6.67	1	2.22

011-302-916438 (Direct)
011-302-289-522574
011-302-502182-513202
info@noguchi.mimcom.org
Acc: 2556 UGL GH

INSTITUTIONAL REVIEW BOARD



Post Office Box 661
Legon, Accra
Ghana

ETHICAL CLEARANCE

14th November, 2012

GENERALWIDE ASSURANCE FWA 00001824

NMIMR-IRB CPN 037/12-13

IRB 00001276

IORG 0000908

On 14th November, 2012, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting reviewed and approved your protocol titled:

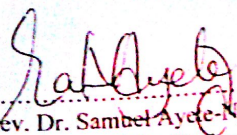
- TITLE OF PROTOCOL** : **Couples in Search of children: A Study of the Strategies and Management of Infertility in Contemporary Ghana**
- PRINCIPAL INVESTIGATOR** : **Rosemond Akpene Hiadzi (PhD Candidate)**

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 13th November, 2013. You are to submit annual reports for continuing review.

Signature of Chairman: 
Rev. Dr. Sambel Ayete-Nyampong
(NMIMR – IRB, Chairman)

Professor Kwadwo Koram
Director, Noguchi Memorial Institute
for Medical Research, University of Ghana, Legon

NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH
Established 1979 *A Constituent of the College of Health Sciences*
 University of Ghana

INSTITUTIONAL REVIEW BOARD

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 Telex No: 2556 UGL GH



Post Office Box LG 581
 Legon, Accra
 Ghana

My Ref. No: DC.22
 Your Ref. No:

8th January, 2014

ETHICAL CLEARANCE

FEDERALWIDE ASSURANCE FWA 00001824

IRB 00001276

NMIMR-IRB CPN 037/12-13 amend. 2014

IORG 0000908

On 8th January 2014, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting conducted continuing review and approved the amendments to your protocol titled:

TITLE OF PROTOCOL : **Couples in search of children: A study of the strategies and Management of infertility in contemporary Ghana**

PRINCIPAL INVESTIGATOR : **Rosemond Akpene Hladzi PhD Cand.**

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and within seven days in writing.

Your certificate is valid till 7th January, 2015. You are to submit annual reports for continuing review.

Signature of Chair:

Mrs. Chris Dadzie
 (NMIMR – IRB, Chair)

Professor Kwadwo Koram
 Director, Noguchi Memorial Institute
 for Medical Research, University of Ghana, Legon

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title "Couples in search of children: A study of the Strategies and Management of Infertility in Contemporary Ghana" has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

Date

Name and signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

_____ was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

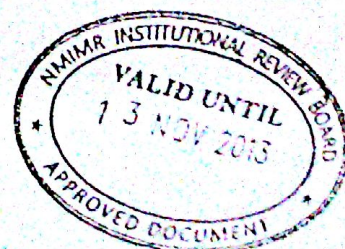
Date

Name and signature of witness

_____ certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

Date

Name Signature of Person Who Obtained Consent



DEPARTMENT OF SOCIOLOGY
UNIVERSITY OF GHANA

P. O. Box LG 65, LEGON-GHANA Tel: 0302-21-500312/500300 Ext: 6154/6084 Tel/Fax: 0302-21-500312
E-mail: sociolog@ug.edu.gh

A.24

4th May, 2012

TO WHOM IT MAY CONCERN

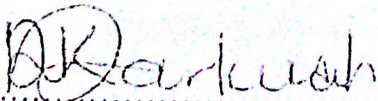
As part of her PH.D Degree course in Sociology, Ms. Rosemond Akpene Hiadzi, a first year student at the Sociology Department, University of Ghana is conducting a study on:

“COUPLES IN SEARCH OF CHILDREN: A STUDY OF THE STRATEGIES AND MANAGEMENT OF INFERTILITY IN CONTEMPORARY GHANA”.

The findings of her research will be presented to the Department of Sociology in a form of “Thesis”. The data will be confidential and used for statistical purposes only. Identity of source of information will not be disclosed.

I should therefore be grateful for every assistance that you give to Ms. Hiadzi.

Yours faithfully



DR. AKOSUA DARKWAH
(THESIS SUPERVISOR)

/roa



LISTER HOSPITAL AND FERTILITY CENTRE

1 Finali Drive, Airport Hills (Off Spintex Road)
P. O. Box CT 966, Cantonments, Accra-Ghana
Tel.: [233-302] 812325/6, [233-303] 409030, Fax: [233-302] 812397

February, 2013

THE HEAD OF OBS/GYNAE
KORLE-BU TEACHING HOSPITAL
KORLE-BU
ACCRA

ATTN: PROF. S. OBED

Dear Prof Obed,

SHORT RESEARCH IN FERTILITY
RE: ROSEMOND HIADZI

The above-named lady who is doing research for PhD in Sociology has gotten clearance from Noguchi Memorial Institute for Medical Research.

She is currently interviewing some clients at Lister Hospital and is keen to extend it to the Public Sector as well.

Kindly give her the necessary help as always.

Counting on your usual cooperation.

Yours sincerely,

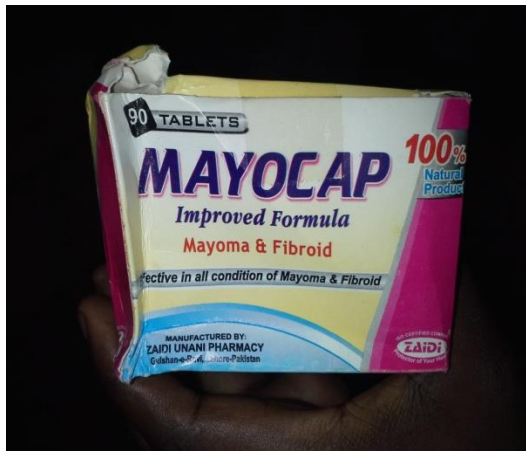
R. E. K. HIADZI

CONSULTANT OBSTETRICIAN/GYNAECOLOGIST/
FERTILITY SPECIALIST

Dr. Edem K. Hiadzi, FRCOG FWACS
Consultant Obstetrician Gynaecologist /
Fertility Specialist
Lister Hospital and Fertility Centre
Airport Hills, Off Spintex Road
Accra, Ghana

DANS 1/c
W. assure the
applicant
J.S.
2013

SOME HERBAL MEDICATIONS FOR INFERTILITY TREATMENT



Fibroid treatment



Clearing of blocked fallopian tubes



Treatment of no sperm count



Treatment of STIs



Regulation of menstrual cycles

FIELD WORK AT FERTILITY CENTRE



Containers for storing/ freezing sperms, eggs and embryos



Researcher viewing sperms on a slide



Sperms being prepared for insemination



Incubator for storing embryos



Researcher with a 58 year old proud new mother



Observing egg extraction

ADVERTISEMENTS ABOUT SOME AVAILABLE INFERTILITY TREATMENT OPTIONS

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without any complications?

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INTERNATIONAL PROPHETIC CENTRE
AKA
AMBASSADORS CHAPEL

OPERATION 1000 BABIES

DATE: **1st MAR. 2014**
TIME: **9AM TO 11AM.**

Bring your baby dress, baby name, anointing oil. If possible husband and wife attend together.

ADONAI JOSE

LOCATION: **ASHALLEY BOTWE, NMAI - DZORN** SC
OPPOSITE FOOTBALL PARK

MALLAM MUSAH
Herbal Last Stop
SPIRITUAL & DISEASES AND PROBLEMS SOLVED LAST STOP

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SPIRITUAL WORKS	SEXUAL WEAKNESS
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WADNESS	LOST OF CONTACT
TRAVELING ISSUES	DIABETES

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Location: **Sankana Area - Nkwanta**