Practicing Support

Empowering and Counseling Members of
the Association of Childless Couples of Ghana

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Abstract

Worldwide, millions of women and men face involuntary childlessness and fertility problems. Especially in low/middle-income countries, infertility is a highly prevalent reproductive health condition. In these countries the infertility services available are often privatized and very expensive and as a result not accessible for most of the women and men with fertility problems. Recently, however, in several sub-Saharan African countries new initiatives have emerged, such as The Association of Childless Couples of Ghana (ACCOG), to improve the circumstances for women and men facing infertility. The aim of this study is to gain knowledge about the experiences of members of ACCOG with their biomedical and social condition and ACCOG's organized services and activities within the context of current day Ghanaian society. Therefore, I address the following research question in this thesis: How does ACCOG affect the way in which its members – women and men facing fertility problems – experience their childlessness?

In order to answer the research question, this thesis addresses two themes: empowerment and counseling. When analyzing the data, I treat the support group's activities - among those, counseling sessions – as social practices, that have emerged in a particular sociocultural context. Thereupon, these practices have the capability to influence the sociocultural context as well. My findings are based on fieldwork I conducted at the fertility clinic of the Pentecost Hospital in Ghana between February and April 2016.

I start my argument with exploring the various elements through which ACCOG has the capability to empower its members. In this first empirical chapter, I will show that not all the aims correlate with the consequences. I use anthropological literature on empowerment to link ACCOG's activities to broader ideas about empowerment. In addition, I join the debate about the capability of assisted reproductive technologies (ARTs), promoted by ACCOG, to empower childless women and men. The chapter ends with the argument that the social relations created between childless women and men through ACCOG might be defined in terms of 'biosocialities'.

I continue my argument by exploring how ACCOG's group counseling sessions might influence the ways in which childless women and men in Ghana cope with their situation. I use Foucault's notion of 'technologies of the self' to analyze the practices the clients of ACCOG develop. Using this anthropological lens to look at coping practices, I argue, helps to understand how ACCOG's members use advice given – taking into account the influences other social institutions, such as religion and family, may have on the experience of childlessness and fertility treatment. Therefore, the insights provided in this thesis may be used to improve the activities of the Association of Childless Couples of Ghana.

Content

Introduction

Infertility is a major issue all over the world: it is estimated that infertility affects approximately 10% of the reproductive-aged couples worldwide, though this percentage can be as high as 30% in some sub-Sahara African countries (Inhorn & Patrizio 2015: 412). This is the result of several factors, such as the high prevalence of sexually transmitted diseases (STDs), post-partum infections[1] and unsafe abortions in these low/middle-income countries (Ombelet 2008: 9). An additional problem is that childless women and men are stigmatized in many sub-Sahara African countries (Ombelet 2008; Inhorn & Patrizio 2015; Donkor & Sandall 2007; Hiadzi 2014). Within these societies, children are greatly desired for sociocultural and economic reasons, which is why lack of children is often (negatively) judged (Ombelet 2008: 8). For example, within traditional African religions it is believed that childlessness is a 'punishment for evil' (Hiadzi 2014: 30). Therefore, infertility may represent 'social death' in particular contexts (Inhorn & Patrizio 2015: 413).

Despite the severe impact of infertility and childlessness on the lives of women and men in Ghana and other sub-Sahara African countries, the importance and necessity of fertility care has often been neglected. Most of the biomedical fertility care in sub-Sahara African countries is provided by private clinics – and as the equipment for treatments is very expensive – costs for fertility treatments are high (Ombelet 2011: 258). On a global scale, fertility care in developing countries is not seen as a developmental priority. One of the reasons is that a major global concern is 'overpopulation'. Additionally, Africa is often associated with 'hyperfertility', which is why this major fertility problem in Africa has been described as 'barrenness among plenty' (Inhorn & Patrizio 2015; van Balen & Gerrits 2001). As a result hardly any initiatives have been undertaken to improve the lives of childless women and men in sub-Saharan African countries.

However, in the last decade, more attention has been paid to infertility in sub-Sahara Africa and other developing countries, such as through the emergence of the so-called low-cost IVF (LCIVF) movement (Inhorn & Patrizio 2015: 419). This is '….a reproductive justice movement, driven by the goal of helping the world's infertile, most of whom are located in resource-poor settings' (ibid.). One form of LCIVF is developed by the Walking Egg, a non-governmental organization based in Belgium, which is referred to as 'more affordable/ accessible IVF' in this thesis. In addition, on a national scale, support groups for childless

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[1] Post-partum infections are infections that emerge after delivery.

women and men have been founded throughout the African continent[2]. One of these is the Association of Childless Couples of Ghana (ACCOG).

Many researchers have emphasized the importance of support groups for patients with particular health issues, such as HIV/AIDS and infertility (Mupambireyi, Bernays, Bwkaura-Dangarembizi & Cowan 2014; Gerrits 2008; Igonya & Moyer 2013; van Uden-Kraan, Drossaert, Taal, Seydel, van de Laar: 2009; Gillett & Parr 2010). For instance, it is claimed that they empower their members and help them make well-informed decisions concerning treatment. So far, most of the anthropological literature on support groups and their activities in a sub-Sahara African context concerns support groups for people suffering from HIV/AIDS. The current study, however, focuses on (the influences of) a support group for childless women and men in Ghana.

The aim of this thesis is to explore how the activities of the Association of Childless Couples of Ghana affect the lives of childless women and men. My findings are based on fieldwork I conducted at the fertility clinic of the Pentecost Hospital in Ghana between February and April 2016. I will view the activities of ACCOG as a set of social practices, just like counseling – which is also part of ACCOG's repertoire – has been defined as a set of social practices in anthropological literature (Moyer, Burchardt & van Dijk 2013; Nguyen 2013). I will answer the following question: How does ACCOG influence the way in which its members – women and men facing fertility problems – experience their childlessness? In order to do so, I have chosen to explore two themes: empowerment and developing 'practices of self' through counseling. This ethnographic account will provide insight into the ways ACCOG attempts to empower its clients and help them develop practices to cope with their situation. Importantly, the aim of this thesis is not to evaluate or judge the activities of ACCOG. Rather, I wish to shed light on some of the aspects of ACCOG that might affect the lives of the childless women and men. In other words, I study how ACCOG practices support.

Firstly, I will discuss the anthropological literature on these two topics that come together in the activities of support groups within the context of sub-Sahara Africa. In this chapter, I show that empowerment has been defined differently in various contexts, for example, as patient autonomy or as increasing one's social capital (Van Uden-Kraan et al. 2009; Holmström & Röying 2010; Krabbendam, Kuijper, Wolffers & Drew 1998). In addition, I reflect on how Foucault's (1998) notion of 'technologies of the self', as a conceptual tool to analyze the coping practices ACCOG's members develop to deal with the

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[2] http://www.icsicommunity.org/regional-alliances/african-infertility-alliance (26-11-2015).

consequences of being childless, may produce valuable insights into the value of support groups for people facing infertility in a sub-Sahara African context. Then, I will devote a chapter to embed my research, elaborating on Ghanaian sociocultural values related to infertility, infertility policy, the Association of Childless Couples of Ghana, the Pentecost Hospital fertility clinic in Madina where I conducted my research and the more affordable/accessible IVF which is being introduced in Ghana with the help of ACCOG. Thirdly, I will discuss the methodology of the research, including the ethical considerations, positionality and limitations of the methods used.

The empirical part of the thesis starts with an ethnographic vignette of one of the group counseling sessions organized by ACCOG I attended during my fieldwork period. In the following two chapters, I will refer to this vignette to support my argument. The first empirical chapter discusses how ACCOG's activities affect the lives of childless women and men in terms of empowerment. I argue that the activities of ACCOG, including the group counseling described in the vignette, have both intended and unintended consequences for the members' experience of empowerment. In addition, I join the discussion on the capability of assisted reproductive technologies (ARTs) to empower women and men facing infertility (Franklin 2013; Jennings 2010; Bochow 2015). Finally, I suggest that empowerment, in the context of ACCOG, could be defined in terms of developing 'biosocialities' – social relations that emerge on basis of sharing a certain sociomedical condition and undergoing similar kinds of treatment (Lock & Nguyen 2010; Dimond, Bartlett & Lewis 2015; Hardon & Moyer 2014; Whyte 2009).

The second chapter focuses purely on counseling, which is a prominent activity of the Association of Childless Couples of Ghana. I explore how ACCOG's group counseling affects how members try to cope with their childlessness through developing certain practices, such as asking themselves certain questions to discover which treatments they want to undergo, or reconsidering their perception of parenthood to change their experience with stigma. By using these practices childless women and men attempt to become the 'best version of themselves', applying Foucault's notion of 'technologies of the self'. In this chapter, counseling is defined as a social practice, contradicting popular beliefs that counseling is a 'value-neutral' scientific discipline (Nguyen 2013: 441).

This study is part of the multidisciplinary research project 'Women and Men with Fertility Problems: A Quantitative and Qualitative Study on a New IVF Treatment and

Fertility Support Group in Ghana and Kenya' funded by Share-Net[3], aiming to increase awareness about infertility and involuntary childlessness amongst relevant stakeholders and to generate knowledge about the activities of support groups in low/middle-income countries, with research conducted in Kenya and Ghana. In addition, the results of the research are used to improve the current infertility care in low/middle-income countries. Although the research project involves both quantitative and qualitative research, I exclusively conducted qualitative research for this thesis. For this research project, researchers of the University of Amsterdam cooperate with the University of Ghana, ACCOG and the Pentecost Hospital in Madina, Accra.

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[3] Share-Net International is a 'knowledge platform for sexual and reproductive health and rights (SRHR)' that aims to contribute to policy and program development concerning SRHR in developing countries.

1. Theoretic Framework

To explore how ACCOG affects its members' experience of their childlessness, I have divided my thesis in two main subjects: the influences of support group's activities on the ways members may feel empowered and the impact of a specific activity, namely counseling, on (the development of) coping practices of support group members. Although they have often been presented as 'value-neutral' claims or practices (Nguyen 2013: 441), I, however, analyze empowerment as a social construct and counseling as a social practice. Moreover, in this thesis, I treat support group's activities in general as a set of social practices. The anthropologists I refer to in this overview all argue that it depends on the sociocultural context how empowerment is defined and counseling sessions are designed, put in practice and affect the group members. When I analyze and present the data I collected during my own fieldwork, I will support my argument with this body of literature. Importantly, within the African context, most anthropological literature about support groups and counseling practices is concerned with support groups and counseling practices for people with HIV/AIDS, which is why I will refer mostly to studies on support groups for people suffering from HIV/AIDS.

Empowerment

One of the aims and expectations of support groups worldwide is to empower its members (Rhine 2009; van Uden-Kraan et al. 2009). However, different definitions of empowerment are used in designing, carrying out and evaluating a support group activity. Instead of giving one fixed definition of empowerment, I discuss the claims of empowerment that have been made regarding support groups and discuss the character of these claims.

Patient Empowerment and Autonomy

The concept of empowerment arose during the European Enlightenment '….as a reaction to oppression and inequality within society at large' (Holmström & Röing 2010: 168), although it has derived from previous notions of freedom and liberation (Traynor 2003: 130-132). It was not until the 1970s that empowerment was introduced within healthcare as 'patient empowerment'. As Holmström and Röying (2010: 170) argue, 'in *patient empowerment*, the caregiver strives to promote and enhance the patients' abilities to feel in control of their health'. According to them, the concept of empowerment has been used in two different ways in the field of healthcare (ibid.: 168). On the one hand, it may be used '….to describe a

relationship between health and power, based on the assumption that individuals who are empowered are healthier than those who are not' and on the other hand, '….to describe a certain type of patient; one who may become empowered via health education programmes initiated by healthcare systems, or… via their interactions with healthcare providers' (ibid.). To illustrate this, in an article on unsafe abortions in Africa it is stated that one of the reasons many women are undergoing unsafe abortions is 'their lack of empowerment' (Hord & Wolf 2004: 31). In this example, 'lack of empowerment' is seen as a state that causes women to be unable to choose for a healthy abortion.

'Patient empowerment' is often associated with 'patient autonomy'; '[it] reflects the belief in patient autonomy and the right and responsibility of patients to access health information and to make their own health-related decisions' (Van Uden-Kraan et al. 2009: 61), where, within medical sciences, patient autonomy is defined as 'the right of patients to make decisions about their medical care without their health care provider trying to influence the decision'[4] – caregivers are allowed to educate the patient though.

However, linking patient autonomy to empowerment might lead to the faulty conclusion that acquiring information in itself can empower patients. Access to information can only be empowering once a client is able to do something with the information he or she perceives as beneficial for his or her position in society (Hicks, Sims-Gould, Byrne, Khan & Stolee 2012: 147). Thus, this medical definition very much individualizes health as a patient's own responsibility. In contrast, many anthropologists start from the assumption that health also depends on one's socioeconomic position in society and the sociocultural context, as the human body is 'embedded within wider systems of recognition and misrecognition' (Fisher 2008: 584). Especially in a sub-Sahara African context, where stigma and poor economic circumstances are part of daily reality for many, this definition of empowerment has superseded. As Traynor (2003: 135) argues, '"empowerment" is in danger of placing such emphasis on personal responsibility that it can perpetuate the status quo by failing to give attention to massive, but taken-for-granted, structural constraints on the life and consciousness of the individual'.

Closely linked to achieving patient autonomy is the notion of 'patient-centered health care', which is based on the idea that '….patients are known as persons in context of their own social worlds, listened to, informed, respected, and involved in their care – and their wishes are honored (but not mindlessly enacted) during their health care journey' (Epstein &

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[4] http://www.medicinenet.com/script/main/art.asp?articlekey=13551 (6-6-2016).

Street 2011: 100). According to Holmström and Röying (2010: 169), patient-centeredness and patient empowerment are both based on the idea that responsibility is shared between the caregiver and the patient, putting a stronger emphasis on the role of the patient. Therefore, the patient should be treated as 'a partner in healthcare with both rights and responsibilities' (ibid.: 167). In this approach patients are seen as 'experts on their own bodies', countering the argument that healthcare professionals should make the decision because they know what is best for the patient. Therefore, the aim of a patient-centered approach is to reduce the power of the medical specialist over the patient's decision-making and to increase a patient's autonomy (Gerrits 2014: 126). The idea is that by 'upgrading' the patient's position within healthcare – from a patient who does not know anything about health to a patient who has the ability to influence his or her own health, just like the caregiver – the patient becomes empowered.

Empowerment and Support Groups

Within the context of support groups, as McWhirter (1991: 222) notes, empowerment has been presented – both implicitly and explicitly – as a more or less self-evident goal of counseling interventions. An important aspect of counseling is the idea that the individual is in charge of his or her own health, enhancing one's patient autonomy (Nguyen 2013: 444). In this context, empowerment is defined as the capability to be responsible and reflexive: 'The idea is that once individuals have been freed from traditional structures, they have the capacity to act reflexively and create their own authentic identities free from the trammels of traditional oppressive rules and norms that organize people rigidly along the axes of gender, class and status' (Fisher 2008: 583).

Furthermore, empowerment in the context of support groups can also be described in terms of the extension of an individual's social network: '….those who share a biological connection can be empowered through their relationship with others, engendering a sense of kinship where protection and support are offered and differences normalised' (Dimond et al. 2015: 4). For example, in a study on members of support groups for women with HIV in Zimbabwe, it was concluded that the group members established a feeling of companionship with the other women, a friendship through which they could find the support they did not receive outside the context of the support group (Krabbendam et al. 1998: 36). In addition, through contacts made in support groups, members can gain knowledge on, and access to treatment. Group members may give advice about specific treatments, based on which they can, as Uden-Kraan et al. (2009: 61) state, '….make their own health-related decisions'.

Nonetheless, according to Stephens (2008: 1175), these social relations should not merely be seen as 'empowering' or increasing one's 'social capital' – resources accessed through social contacts – and she warns for the risk of simplification. A social contact is not a 'good' one can obtain. Rather, social connections should be understood as 'varying aspects of complex social processes' as they are embedded in sociocultural practices which influence the character of the contact in various ways (ibid.: 1182).

Support groups can also be important for addressing neglected topics, as is for example the case with a support group for men with HIV in Kenyatta: 'The support group, which was the first of its kind in Kenya, served as a site of discovery for all participants, including the group facilitators and us [anthropologists Emmy Kageha Igonya and Eileen Moyer] as researchers, providing a space to explore sex, sexuality and gender norms as they related to contemporary HIV treatment regimes at Kenyatta' (Igonya & Moyer 2013: 569). Here, support groups offer a platform to address topics, such as male sexuality, that are routinely overlooked. The acknowledgement of these issues can give the members a sense of recognition, a status that is often perceived as empowering (Fisher 2008: 584).

Finally, support groups can empower people indirectly in a way that was not intended. According to a study carried out in Nigeria, members of an HIV support group for women and men living in the northern city of Kano turned out to use the activities in support groups differently than what were the initial intentions of the support group: 'Women join support groups and reluctantly take part in their activities to access the economic resources occasionally channeled through these groups' (Rhine 2009: 395). In this example, Rhine describes these members as active agents who use the activities of support groups to empower themselves – economically – while maneuvering through the cultural constraints of society.

In line with the above, in this thesis, I will explore the various aspects of empowerment by which the Association of Childless Couples of Ghana affects its members' experiences with childlessness. The various aspects of empowerment I discuss are based on this anthropological literature on empowerment and my fieldwork findings. I also use this literature overview to support my argument that ACCOG's activities that have the capacity to empower its members, are dependent on sociocultural values.

Counseling

One major activity ACCOG offers is counseling, which will be the focus of the second empirical chapter. The focus on counseling as a social practice (Nguyen 2013: 441) requires other anthropological literature than I have used to embed the elements through which a

support group may empower its members. Below, I will reflect on anthropological literature on counseling practices and their influence on the ways people deal with health issues in sub-Sahara Africa. I will use Foucault's notion of 'technologies of the self' to analyze the practices members develop with the help of support groups. To my knowledge, counseling practices in infertility care in Africa have so far not been analyzed through this anthropological lens, with the exception of HIV/AIDS counseling practices.

Counseling in 'Africa'

Counseling, '….understood most broadly as a set of practices employed by counselors to bring their clients to self-awareness in their decision making….' (Nguyen 2013: 440), emerged in Europe and North America in the twentieth century. According to Nguyen (ibid.: 441), basing his argument on Foucauldian theories, counseling derives from the belief that sexuality is something that has to be explored, an idea that emerged in the Victorian era (ibid.). As a result, counseling came into existence '….as a practice aimed at revealing these fundamental secrets of the self' (ibid.).

This does not mean that there were no forms of advice-giving in other continents before the professionalization of the practice in western countries. According to Clement Chela, the director of the Zambia National AIDS Council interviewed by Simbaya and Moyer (2013: 456), '"in terms of origins, counselling has always existed in African societies. It has always been part of life. Elders provided guidance based on their experience in life"'. The European and North American form of counseling has been introduced in Africa in the last two decades of the previous century, mostly with the aim to combat HIV/AIDS through 'reinforcing change in sexual behavior' – after it was discovered that informative mass campaigns turned out to be inefficient (Nguyen 2013: 440-1).

Because of the western origin of the professionalization of counseling, counseling practices in Africa can be understood as 'traveling technologies', which are technologies or practices that are applied in other sociocultural contexts than they were developed (Simbaya & Moyer 2013: 453; Nguyen 2013: 441). By defining counseling practices as traveling technologies, counseling practices are defined to be connected to 'globally circulating and politically accepted constructions of need' (Moyer et al. 2013: 432) and not merely, as Nguyen (2013: 441) has argued, understood as 'value-neutral machines'. In addition, how a traveling technology is being adapted depends on the local context as well. Meanwhile, it also has the capacity to influence the sociocultural context. Therefore, newly introduced counseling practices can challenge local ideas '….about the relationship between healthcare

providers and patients and about patient rights and responsibilities….' (Simbaya & Moyer 2013: 454). Thus, to understand a practice as a 'travelling technology' one should explore where the practice comes from – how it emerged – in what context it is adapted and how it influences this particular context. The influence of these counseling practices on the members of a support group can be explained through their coping practices, as I will explore below, using Foucault's notion of 'technologies of the self'.

Developing 'Practices of the Self'

Counseling, as a form of advice-giving, has the capacity to influence the manner in which people deal with a specific issue. Women and men who suffer from a (stigmatized) medical condition such as infertility may cope with their situation in various ways. For instance, they may deny their condition and its consequences; talk about it to others; take control, for instance by seeking treatment; act as normal as possible or 'let fate decide' (Donkor & Sandall 2009: 87; Bell & Hetterly 2014). Counseling practices can affect these coping practices of an individual, which I will show below. In order to do so, I view these coping practices as 'technologies of the self', or rather 'practices of the self'.

Michel Foucault introduced the term technologies of the self to refer to '.…technologies or practices which make up the care of self, and which are carried out on the self by the self' (Mitcheson 2012: 59). Foucault (1998: 18) defined his concept as follows: 'Technologies of the self, which permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection or immortality'. It is thought that through these practices one can transform the self into its 'better version' and achieve the 'good life' (Lock & Nguyen 2010: 27; Nguyen 2010: 39). Although Foucault acknowledges that how individuals shape these technologies is dependent on their socio-economic position in society and the socio-cultural context they live in, he wants to direct attention to the active position of individuals. To use his own words, 'the way people act is linked to a way of thinking, and of course thinking is related to tradition' (Foucault 1998: 14). Foucault's focus is on how an individual '.…participates in the policing process by monitoring his own behavior' (Hutton 1998: 132). Thus, Foucault is interested in how individuals, despite the fact that they are subordinate to a moral rule, establish practices in a certain way by themselves.

An example of practices of the self clients might develop during counseling is what Vinh-Kim Nguyen calls 'confessional technologies' (Nguyen 2013; Nguyen 2010). During

counseling activities, members of a support group are encouraged to talk about their condition, as Nguyen shows happens during counseling sessions of HIV/AIDS support groups in Burkina Faso and Côte d'Ivoire. He refers to 'confessional technologies' – based on Foucault's theory – when he describes counseling practices and this 'talking' aspect. Through this term Nguyen wants to not just analyze the practices the group members develop, but he also aims to draw attention to the Christian character of counseling and the fact that it is often introduced by foreign or international NGOs in sub-Saharan African countries: the idea that talking openly about a certain medical condition, sharing it with people who may only have the certain condition in common, has a western cultural background (Nguyen 2013: 447).

Counseling is also believed to encourage patients to disclosure their condition, as is the case in Kenya where support groups for people living with HIV help their members develop enough confidence to 'come out' and share their HIV-positive status with others (Gillett & Parr 2010: 337). Disclosure is (globally) perceived as an important step in preventing HIV transmission (ibid.). However, in many sub-Saharan African countries, HIV/AIDS patients are strongly being stigmatized and as a result the consequences of disclosure can be devastating for the HIV/AIDS patient (ibid.). In those cases, the idea that an individual can take control of their own health is being undermined by strongly rooted cultural perceptions of the certain disease.

Furthermore, issues that are the most urgent or disrupting about the sociomedical condition the group members suffer from can be dealt with in counseling sessions. For example, the support group for HIV-positive people in Nigeria – investigated by Kathryn Rhine (2009) – has not only offered an opportunity to discuss sexual, social and health well-being or to '....cultivate self-responsible and economically autonomous patients' (Rhine 2009: 370), but it also enables members to negotiate and facilitate their marriage arrangements. In a context where marriage is of great sociocultural value and economic importance, members of the support group cope with one of the side-effects of being HIV-positive – namely not being a suitable candidate for marriage – by searching for a husband or wife, using the contacts in the support group. This coping behavior can be understood in terms of technologies of the self too: the group members try to achieve the 'good life', which is in their eyes – although influenced by sociocultural values concerning marriage – a married life.

In the second empirical chapter, I will use Foucault's notion of 'technologies of the self' as discussed above as a conceptual tool to analyze the coping practices ACCOG's members may develop with the help of the support group. I will use examples based on what happens during ACCOG's group counseling session presented in the *ethnographic vignette.*

Although I do not explore the foreign origins of ACCOG's group counseling in detail, I argue it reflects some aspects of Ghanaian society and has the capacity to influence the sociocultural context, which is why I suggest that this group counseling can be understood as a 'traveling technology'.

2. Childlessness and Fertility Care in Ghana

The aim of this chapter is to contextualize my research by discussing Ghanaian sociocultural values related to infertility, infertility policy, the Association of Childless Couples of Ghana, the Pentecost Hospital fertility clinic in Madina where I conducted my research, and the more affordable/accessible IVF which is being introduced in Ghana. The information in this chapter is based on both literature and the observations and interviews I conducted during my fieldwork.

Demographics of Ghana and (In)Fertility

Ghana (officially the 'Republic of Ghana') is a West-African country with a population of over 26 million people, which was founded on the 6th of March 1957 when the British colonial areas Gold Coast and British Togoland were declared independent and merged together. The current president of Ghana is John Dramani Mahami. Ghana is considered a low/middle-income country (in 2014 Ghana ranked 169 out of 213 on the world list of GNI per income)[5]. Ghana is a very religious country; approximately 96% of the Ghanaians consider themselves to be religious (Hiadzi 2014: 8). About 70% of the total population practices Christianity (Pentecostal, protestant, catholic or other forms of Christianity), 18% practices Islam and over 5% of Ghanaians practice traditional African religions (ibid.). Although English is the official language of Ghana, many other languages are spoken, such as Dagbani and Frafra in the northern part of the country, and Twi, Akan, Ewe and Ga in the southern and eastern parts of the country.

In 2014, the fertility rate in Ghana was 4,2 births per woman; in urban areas 3,4 and rural areas 5,2[6]. This number has decreased slightly over the past few decennia: at the beginning of the century Ghana's fertility rate was 4,7; in urban areas 3,0 and in rural areas 5,5. However, there are also a lot of women and men in Ghana who are not able to conceive. Although infertility is a health issue worldwide, in sub-Sahara Africa the infertility rates are among the highest: in some countries, there is an estimate infertility rate of 30%, due to the high prevalence of sexually transmitted diseases (STDs), post-partum infections and unsafe abortions. It is computed that about 30% of the cases of infertility worldwide is due to female infertility, of which blocked fallopian tubes, ovulation disorders and uterine fibroids are common causes; 30% due to male infertility, of which azoospermia (no sperm-count) and oligospermia (low-sperm count) are the most common causes; another 30% is caused by a

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[5] http://databank.worldbank.org/data/download/GNIPC.pdf (22-6-2016).
[6] http://data.worldbank.org/indicator/SP.DYN.TFRT.IN?page=3 (2-6-2016).

combination of male and female infertility and in 10% of the infertility cases, the causes are unknown (Hiadzi 2014: 23). In Ghana, it was estimated in 2000 that 2% of the women suffered from primary infertility, while 14% of the women was suffering from secondary infertility (Osei 2014: 99)[7]. A study based on reported infertility in rural areas in 2002 showed a higher prevalence of male infertility (15,8%) than female infertility (11,8%) (Geelhoed, Nayembil, Asare, Schagen van Leeuwen & van Roosmalen 2002: 137)[8].

(Not) Having Children in Ghana

Having children is very important for Ghanaians (Osei 2014; Donkor & Sandall 2007). Besides the fact that children are loved, Ghanaians want to have children for (financial) security at old age, for inheritance, or because (they feel) it is expected from them by their family to conceive and raise children (Donkor & Sandall 2007: 1683). In the traditional Ghanaian society, procreation is the ultimate purpose of marriage as it will guarantee the immortalization of the family lineage (ibid.). Besides the (extended) family, religion also promotes childbearing (Heaton & Darkwah 2011: 1577). Not wanting children is unthinkable for many Ghanaians: '….."voluntary childlessness" cannot be found in the dictionary of people in Ghana' (Osei 2014: 99). The fertility rates described above – and the relatively small decline in them over the years – indeed suggest that having children is highly valued within Ghanaian society

Since in Ghana, religion is strongly connected to morality and sexuality, religious leaders have the capability of influencing ideas about infertility and fertility care (Anarfi & Owusu 2011: 5). First of all, traditional African religions explain the inability to conceive as a 'punishment for evil', as a consequence of committing a 'sin' (Hiadzi 2014: 29-30). It is also believed that 'witches' cause infertility, since they are viewed '….as instruments of darkness that cause evil and misfortune for others' (ibid.: 30). When Christianity and Islam were introduced in Ghana, another belief about the cause of infertility emerged: that it is the will of God/Allah – as stated in the Bible/Koran – to have both fertile and infertile people (ibid.: 31-33).

Despite the fact that both Christianity and Islam suggest that it is God/Allah's will to also have infertile women and men, in Ghana, and many other African countries, childless

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[7] From a biomedical perspective, infertility is described as the inability to achieve a pregnancy after at least one year of having sex (about three times a week) without protection. One refers to primary infertility if the woman or man has never achieved a pregnancy, while secondary infertility is used when the woman or man is not able to achieve a pregnancy after a previous pregnancy.

[8] There are no figures to be found that are more accurate and complete.

women and men are strongly stigmatized and infertility as a topic of conversation is taboo (Van Balen & Gerrits 2001: 216). As Hiadzi (2014: 115) notes, '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'. Childless women are believed to suffer the most from stigmatization (Hiadzi 2014: 97; Osei 201: 99; Ombelet 2013: 162). This was confirmed in my own fieldwork by the members and employees of ACCOG: they said that in some cases childless women are accused of being a witch, that they 'ate all the children in the womb' or that they committed a sin by aborting the child. Men, in turn, are sometimes accused of 'living with another man', by which they mean that the wife of the man is not truly a female since she cannot conceive.

Limited Attention for Infertility

In Ghana, fertility treatment is offered by several institutions, including public hospitals – funded by the government –, private fertility clinics, herbal centers and traditional or spiritual healers (Hiadzi 2014: 36-41). As the public healthcare system is limited – though most of the healthcare in Ghana is provided by the government (Mawuli Adinkrah 2014) – it only offers low-technology fertility treatments for women and men with fertility problems (Hiadzi 2014: 41). These low-technology treatments include the prescription of fertility medicines and the execution of surgical procedures to repair reproductive organs, such as the removal of fibroids. Additionally, all these costs need to be paid by the clients themselves, for they have no access to insurances that cover those costs. This is one of the reasons that many women and men with fertility problems seek treatment through traditional healers, such as priests, herbal and spiritual healers and traditional reproductive health specialists (ibid.: 36), which is often more affordable and accessible than the treatments offered by expensive private clinics (Tabong, Adongo & Wainberg 2013: 6-7). Furthermore, the treatments the traditional healers, or 'ethno-gynaecologists', offer are often more embedded in sociocultural beliefs, which makes it more plausible for Ghanaians to undergo such treatments (Hiadzi 2014: 36). There are also medical herbal centers childless women and men go to, where treatments are offered that involve both knowledge on traditional plant remedies and modern medical sciences (ibid.: 39). Noteworthy is that most people undergo different kinds of treatments (ibid.).

A number of specialized private fertility clinics in Ghana offer high-tech fertility treatments, assisted reproductive technologies such as IVF and ICSI[9] (ibid.: 64). However, the costs for these treatments are very high: for example, according to the employees of the fertility clinic I conducted research, one cycle of IVF can cost about 4500 dollars, which does not include the costs for examinations and drugs. For many childless Ghanaians, this means that they cannot afford high-tech fertility treatments at all; for others undergoing ARTs is – as Inhorn and Patrizio (2015: 420) call it – a 'catastrophic expenditure', meaning that it is a financial sacrifice that threatens household survival.

As explained in the introduction, until recently, not much has been done about the infertility problem in Ghana and other African countries. Within development aid, the emphasis is on fertility control and not on treatment of infertility, especially in regions that are associated with 'hyperfertility' and rapid population growth (Pigg and Adams 2005: 24; Ombelet 2011: 258). As a consequence, as Hörbst and Wolf (2014: 190) argue, a focus on solutions for involuntary childlessness within development programs has been absent so far.

A first step to draw attention to fertility care on a global scale has been the International Conference on Population and Development, held in Cairo in 1994, during which reproductive rights were added to the list of universal human rights: 'At the most basic level, the right to reproduce protects an individual's freedom of choice relating to whether or not to have children, with whom and when to have them' (Chan 2006: 370). The past decennium has seen some changes throughout the sub-Sahara African continent as well: in 2003, the African Infertility Alliance (AIA) was founded and in several countries infertility associations have been established. The objectives of these associations are to create more awareness about infertility issues among African populations; to promote ARTs; to erase stigma on infertility; and to promote infertility counseling and support groups[10]. In Ghana, the Association of Childless Couples of Ghana (ACCOG) was founded in 2012 by Nana Yaw Osei, which will be the focus of this study.

ACCOG and the Fertility Clinic of the Pentecost Hospital
The Association of Childless Couples of Ghana is an independent, non-religion based NGO. Nana Yaw Osei is the chief executive officer (CEO) and as of yet the only fertility counselor in Ghana. He obtained a diploma in counseling at the Akona School of Counselling (ASOC)

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[9] ICSI (intracytoplasmic sperm injection) is an assisted reproductive technology (ART) applied when the sperm count of the man is very low. A sperm cell is directly injected into the egg cell (in a laboratory).
[10] http://www.icsicommunity.org/regional-alliances/african-infertility-alliance (26-11-2015).

located in Accra, which offers professional counseling training in psychosocial, Christian and marriage/family counseling. In the Annual Report of 2013, ACCOG outlines the following objectives: 'to eliminate the stigma associated with childlessness; to build mutual understanding between couples for life free of violence; to provide members interested in assisted reproductive technologies (ARTs - IVF, ICSI, IUI) with counseling and/or other assistance for the treatment; to empower members, especially women, economically and provide them with training and education; to encourage members to consider adoption as an alternative; and to help members meet their material needs especially during retirement'. In order to fulfill these objectives ACCOG organizes activities such as seminars, couples counseling appointments and group counseling sessions. In addition, ACCOG plays an important role in making available fertility treatments as affordable as possible for its members by arranging discounts and collaborating with the Walking Egg project, which I will elaborate on below. The association helped the Pentecost Hospital in Madina (Accra) to build the fertility clinic where I conducted research. Both ACCOG and the clinic receive funding from the hospital – which receives funding from the Ghanaian government.

Nana Yaw Osei is the central person within the organization and during our stay in Accra, he was the only employee of the association. Since the fertility clinic in Madina was established only one year ago and the clinic is not yet equipped to do all the treatments, ACCOG refers its clients to the TrustCare Specialist Hospital in Kumasi for most ART treatments. Although this hospital is a five hour drive from Accra and there are more hospitals and clinics in Accra that perform ART treatments, the hospital in Kumasi and ACCOG have an arrangement through which members of ACCOG can get discounts on treatments.

Interestingly, the fact that there are as of yet hardly any national or international policies on infertility in developing countries affects ACCOG in two ways. On the one hand, it is worrying that infertility is not on the global and national agenda, which makes it – for example – difficult to get funding. On the other hand, though, ACCOG has not been influenced by international and national infertility policies and guidelines, as is the case with HIV/AIDS programs (Angotti 2010: 986). As a result, ACCOG does not have to integrate certain top-down methods with regard to counseling suggested by policy-makers. The fertility counselor is not in a 'critical position' like many HIV counselors who '….are intermediaries between the rule-making of international and national policymakers and the norms of the communities in which they live and work' (ibid.). Unlike these HIV/AIDS programs, how Nana Yaw Osei organizes his association and designs his counseling sessions does not have to meet the regulations set by the Ghanaian government or any international NGO. Nevertheless,

ACCOG depends on some rules set by the religion-based hospital. For instance, certain treatments, such as IVF, are only allowed to be offered for couples – not for single people – and treatments involving third parties – such as IVF with donor eggs and sperm and surrogate mothers – is not allowed (yet). Above all, ACCOG needs to achieve certain targets (for instance a number of members that attends group counseling sessions) to receive funding from the Pentecost Hospital.

The Walking Egg Project

Recently, ACCOG started collaborating with the Walking Egg (tWE), a Belgian based non-profit organization, to explore the possibilities of introducing more affordable/accessible IVF in Ghana (Ombelet 2011: 263), which is called 'low-cost IVF' (LCIVF) by some authors (Inhorn & Patrizio 2015)[11]. This form of IVF, unlike regular IVF, '….does not require specialized equipment common in high-resource IVF programmes such as microprocessor-controlled tissue culture incubators, large area air filtration systems and an infrastructure dependent upon medical-grade gases (N_2, O_2, CO_2), costly cultureware or the near immediate availability of replacement (e.g. electronic) components and the technical expertise to effect repairs' (Van Blerkom et al. 2014: 311). In order to cut down the costs of the IVF procedure, the experts of the Walking Egg have developed the 'tWE lab method' (Ombelet 2013: 165). By simplifying diagnostic procedures, by 'modifying the ovarian stimulation protocols' and by reducing the amount of drugs, the Walking Egg tries to reduce the costs as well (ibid.: 170), although these methods have been used in other low-cost programs as well (Van Blerkom et al. 2014: 311). The tWE method has already produced forty Belgian babies[12]. Developing low-cost fertility treatments is one of the strategies through which the Walking Egg Project tries to achieve their main goal: '….to raise global awareness surrounding childlessness, and to make infertility care in all its aspects universally available and accessible' (Ombelet 2013: 162). It is thought that Ghana, as a pro-natal and low/middle-income country, could greatly benefit from more affordable/accessible IVF, although it appears that rich countries might also profit from this invention[13].

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[11] In my study I will refer to 'more affordable/accessible IVF' rather than 'LCIVF', because the developers of the Walking Egg technology do not want to claim that their technology is cheap, because it is still quite expensive. Additionally, they do not want people to think that the treatment is 'low quality' as well.

[12] http://www.pickabrain.fr/2016/06/how-a-team-of-belgian-doctors-is-bringing-cheap-ivf-to-the-world/ (22-6-2016).

[13] http://www.pickabrain.fr/2016/06/how-a-team-of-belgian-doctors-is-bringing-cheap-ivf-to-the-world/ (22-6-2016).

Unfortunately, the first batch of treatments in Ghana, which was carried out in November 2015, did not result into any pregnancies and at the moment I am writing my thesis, it is still not fully clear what went wrong. The fertilization rate was in fact very high; above 90 percent and therefore higher than with the regular IVF. After analyzing the reasons of this failure, the experts of the Walking Egg and the fertility clinic speculated that the fertilized embryos did not develop into pregnancies, because of the low dose of the ovarian stimulation drug Tamoxiphene: 'Despite very good results in London and Copenhagen with the same stimulation protocol there was a very poor response to this medication for a (so far) unknown reason'[14]. The twenty women that underwent this first batch without any positive result are now participating in the second batch of treatments, which is being carried out in the third week of June 2016. None of the women are charged the costs for this second cycle.

The failure of the first batch of more affordable/accessible IVF in Ghana is one of the many challenges the Walking Egg faced when developing and introducing tWE. So far, there has been no support from international agencies. Meanwhile, critics are very skeptical about the 'simplification' of the IVF treatment and the developers of the conventional IVF: 'After two years of testing mice, Van Blerkom [professor in the department of molecular, cellular and developmental biology at the University of Colorado and IVF Laboratory Director at Colorado Reproductive Endocrinology in Denver] spent a year convincing the Belgian medical ethics authority that it was worth trying in humans. "It's so simple that some people don't believe it," he says'[15]. Promotors of the more affordable/accessible IVF have also received skepticism from fertility specialists working in the lucrative private sector. As one of them said, while staying positive: '"….people will first laugh at you, then they obstruct you, and eventually they'll join you…."'[16].

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[14] The Walking Egg: 'News' on the 3rd of January 2016:
http://www.thewalkingegg.com/news?field_thema_target_id=6 (20-6-2016).
[15] http://www.theverge.com/2014/6/10/5793872/a-low-tech-breakthrough-could-put-in-vitro-fertilization-in-reach-for (22-6-2016).
[16] http://www.pickabrain.fr/2016/06/how-a-team-of-belgian-doctors-is-bringing-cheap-ivf-to-the-world/ (22-6-2016).

3. Methodology

The research I carried out is a qualitative explanatory study – as very little is known yet about support groups for childless women and men in this context – and has an ethnographic research design, including in-depth interviews, observations, informal conversations and a focus group discussion (FGD). For eight weeks I have been doing fieldwork in Madina Accra, Ghana, with a fellow MAS student, Mara van Stiphout and a master student at the University of Amsterdam Graduate School of Child Development and Education, Margot Visser, who carried out the quantitative part of the research project. I conducted my research in English, which is the official language of Ghana and the standard language used for education, and it is also used predominantly within government and business affairs. Since some of the study participants were not fluent in English, the research assistants, Esther Abedu, Deborah Baiden and Charles Yajalin, graduate students from the University of Ghana, functioned as translators – to Twi or Ewe[17] - during some of the interviews. The recruited participants were clients at the Fertility Clinic of the Pentecost Hospital and staff members of the clinic. Most of the clients were also members (or clients) of ACCOG, which is why I use 'client' and 'member' interchangeably when I refer to the respondents. Only once I will refer to a client who is not a member of ACCOG, which will be evident from the text. In this chapter, I will describe the methods I used during my fieldwork and for my data analysis, including the ethical considerations, positionality and limitations.

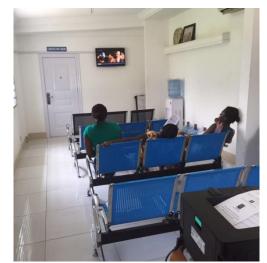**Research Site: The Fertility Clinic of the Pentecost Hospital**

The fertility clinic of the Pentecost Hospital was built about a year ago, just behind the Pentecost Hospital in a building that used to be a residence. The office of ACCOG is in the fertility clinic. The reception functions as a waiting room as well, where clients wait for their appointments with the doctors, Gordon Attoh and Paul Lartey, or ACCOG's counselor, Nana Yaw Osei, whom I refer to as Nana in this thesis. Behind the offices is the 'arena' – as the employees of the clinic call this area – where treatments are carried out. They can be entered through a door near the reception through passing a fingerprint-screening. Inside the treatment area there is a room for sperm collection, the office of the embryologists, the laboratory, two changing rooms, some sanitary facilities and the resting room where patients come after they have undergone treatment. Almost every day two doctors, the administrator, an embryologist, a medical scientist/embryologist, two nurses and one cleaner are present at the clinic. Mara,

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[17] Twi is the most spoken language in Accra and surroundings after English; Ewe is spoken mostly in the Eastern Region (and many participants come from the Eastern Region).

Margot and I were allowed to be in the reception/waiting room at any time and to visit the 'arena' occasionally.

Fertility Clinic of the Pentecost Hospital

Reception/Waiting Room

Data Collection

The collected data exists of observations, informal conversations, in-depth interviews and a focus group discussion.

Observations and Informal Conversations

The data I collected through observations, such as through attending three group counselling sessions and being present in the waiting room during the opening hours of the clinic, gave me insight into ACCOG's daily activities and staff-client interactions. I was not able to participate in clinic activities because I am neither a medical professional, nor a member who is seeking fertility care. Nonetheless, I participated as much as possible in non-medical activities to get a better understanding of the lives and daily activities of the Ghanaians I met during my stay. For instance, we lived in a neighborhood with only Ghanaians lived (no expats, tourists, etcetera). We had informal conversations with the people selling food on the streets, we used the tro-tro as transport, we bought a bicycle and biked to work almost every day like many other Ghanaians. We also went to a church ceremony three times and we attended the 'one week celebration of the death of auntie Scarlett', a ceremony one week after the death of the mother of an acquaintance of ours, during which the dates of the funeral and

burial were being announced[18]. In addition to these observations, we had many informal conversations with Nana, the employees of the clinic, taxi-drivers, neighbors and others.

Recruitment of Study Participants for Interviews

We used a couple of methods to recruit participants for interviews, all based on convenience sampling (depending on the willingness of women and men to participate). Firstly, we attended one of the group counseling sessions where Nana introduced us to the couples present. We also briefly introduced ourselves and asked them for their phone numbers – if they were interested in participating in the research. Together with the research assistants, we called the clients who left their phone numbers to make appointments for questionnaires and interviews. Secondly, we were present at the clinic on the three days when the clients who were going to do the more affordable/accessible IVF treatment (the second batch) were at the clinic for some necessary checkups and minor surgeries. Nana introduced us and suggested that the clients could fill in questionnaires and participate in the interview while they were waiting. During those three days, we conducted questionnaires (for the quantitative part of the study) and interviews between 8am and 4pm. We also contacted women and men, who filled in the questionnaire and indicated their willingness to be involved in the qualitative study, by phone and made appointments at the clinic, preferably when they had to be there for an appointment with one of the doctors or Nana. The last few weeks we recruited clients at the clinic, who were having appointments.

In-Depth Interviews

In total, Mara and I conducted thirty-one interviews of approximately an hour each with thirty-seven clients (six couple interviews). We conducted twenty-three of those together, Mara did four interviews by herself and I did three interviews by myself. We recorded all the interviews and transcribed almost all of them. We also conducted and recorded four interviews with seven staff members.

The topics we addressed during these interviews with clients are their reproductive history; experiences with ACCOG's activities (couples counseling, group counseling and seminars); perceived impact of ACCOG's activities on their experience of infertility, self-image, personal life, conjugal relationship and perceived stigma; views about ARTs; and financial issues (See *Annex 2* for the topic list and interview questions). I attempted to let the

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[18] We learned from our acquaintances in Ghana that this ceremony is carried out by members of the Pentecost church (not by Muslims for instance).

participants describe their experiences and views in their own words, avoiding too suggestive questions. However, the participants did not always understand the open questions, so I sometimes ended up asking suggestive questions.

All interviews, except for one, were conducted at the clinic, most of them at ACCOG's office. One week, we did interviews with female clients who were present at the clinic to undergo final check-ups and minor operations before they were allowed to do the more affordable/accessible IVF. Most husbands were not present, which is why we interviewed only women during those days. Women often came alone to the clinic, which went against the advice of the staff, the doctors, and ACCOG to always come together with their husband. As a result, our sample includes twenty-eight women and nine men (two of the interviews with men were without their wives) with ages ranging between 24 and 53 (the oldest woman was 45). In our sample of clients of the fertility clinic (most of them were members of ACCOG as well) we had people who travelled all the way from the Northern part of Ghana, the Volta Region, Cape Coast, Kumasi, Kwahu and other places, as well as clients living in and around Accra. None of the clients we interviewed had children with their current partner that were genetically related with the mother *and* the father (See *Annex 3* for more details of the informants).

Focus Group Discussion (FGD)

On Second Easter Day, we organized a focus group discussion. In order to recruit men and women Nana asked the administrator to call approximately ten couples to invite them for the focus group discussion. Eight clients – four couples – attended the focus group discussion (See *Annex 4* for the topics addressed during the FGD). I led the first part of the meeting, explaining our research to the four couples and leading the first round of discussion; Mara led the second part. During this focus group discussion, we collected date about different perspectives on infertility and childlessness.

Data Analysis

My aim was to do a grounded theory analysis, '....a cyclical process of collecting data, analysing it, developing a provisional coding scheme, using this to suggest further sampling, more analysis, checking out emerging theory and so on, until a point of "saturation" is reached, when no new constructs are emerging' (Green & Thorogood 2009[2004]: 203). In order to do so, I transcribed my data during my stay in Accra and worked out my field notes and memos of the observations and informal conversations on a daily basis, on which I

reflected in the two interim fieldwork reports I wrote during my stay. These reports helped me to think about linking theory to the data I was collecting and to reconsider the interview questions I formulated. Nevertheless, the period of my research was too short to reach a point of 'saturation', because I was not able to do any follow-up interviews. Moreover, the aim of this thesis is not really to develop any theory. Therefore, my analysis is partly a thematic content analysis, '....a comparative process, by which the various accounts gathered are compared with each other to classify those "themes" that recur or are common in the data set' (ibid.: 199). I used various anthropological theories to analyze these themes, aiming to contribute to existing theories.

After considering Atlas-TI for data analysis, I decided to do my analysis solely in word and excel – due to practical and time considerations. Based on the four steps suggested by Green et al. (2007) for analysis, Mara and I analyzed our data as follows: first, we 'immersed' in the data, which we did mainly during the process of transcribing the interviews and by reading back our field notes. Then, we coded all the interviews in word and divided these codes into categories. We used a colour scheme to highlight the overarching themes.

Ethical Considerations

This research project has been approved by the Amsterdam Institute for Social Science Research (AISSR) and has received a Ghanaian research permit by the Noguchi Memorial Institute for Medical Research (NMIMR).

Before the start of every interview, we provided the participant with written information about the qualitative part of the study. We checked whether the participant was still willing to participate after reading. When this was the case, we asked the participant to sign the informed consent letter. Finally, we asked the participant if she or he would give permission to be recorded. In some cases, the participants initially did not want us to record the interview. However, they all agreed to it after more detailed explanation of the procedure.

I had to take into consideration that the childless women and men I interviewed might become emotional as 'childlessness' is a sensitive topic and they may perceive stigma in their personal lives. Sharing details about these topics may affect them negatively – although it could affect them positively as well. For instance, they might feel relieved when offered the chance to talk about these issues. Thus, I had to consider the participant's feelings and to try to protect their anonymity to make sure that there are no negative social consequences for the study participants, such as increased stigma. For this reason, I use pseudonyms for all the clients I interviewed and leave out identifying details of them. Nevertheless, I did not render

the Association of Childless Couples of Ghana anonymous, because, after all, this is the only initiative that works together with the Walking Egg to introduce more affordable/accessible IVF in Ghana. The same holds for Nana Yaw Osei, the Fertility Clinic of the Pentecost Hospital, doctor Gordon Attoh and doctor Paul Lartey.

All interviewed participants were asked to fill in an informed consent form, as described earlier. Because of the sensitive character of the topics of infertility and involuntary childlessness, we wanted to make sure that everyone was informed well about the research. Of course, it could be possible that participants did not exactly know what they started when they agreed to be a study participant, which is why the participants were offered to end the interview if and when they wished to. No one outside the research team will get access to the recordings of the interviews. They will be kept for a period of a maximum of five years, after which they will be destroyed. For the observations I did not necessarily ask the women and men present at the group counseling session or at other moments at the clinic to fill in an informed consent form, but I will not mention or refer to observations that are too suggestive of their identities in this thesis to secure their anonymity.

Limitations

All the recruiting methods had their disadvantages. For instance, making appointments, or rather establishing times, with clients did not always work as we had hoped for. Sometimes the clients arrived one or more hours later than the agreed time, often due to traffic. Going to the clinic on good faith also did not work out as well as planned: in many cases there were almost no fertility clients during the whole day. Conducting interviews during the three busy checkup days was a challenge, because the clinic was quite chaotic during those days: the interviews were constantly interrupted and some of the clients we interviewed were quite nervous due to the prospect of the procedure. Some of the present clients did not want to be interviewed for this reason.

Another limitation of the study is inherent to convenience sampling: it is possible that my sample will not be representative for all the clients at the clinic. For instance, we recruited significantly more women than men for the interviews, as described earlier. As a result, the sample represents more childless women than childless men. Furthermore, the sample is not representative for the whole childless population in Ghana, because it only includes childless women and men who are seeking treatment and who have the means to get access to several fertility treatments. The sample is also biased in the sense that we almost exclusively talked to

clients who decided to stay together despite their childlessness. After all, literature suggests that childlessness may be grounds for divorce for many (Hiadzi 2014: 3 and 27-31).

Furthermore, the observations were limited because we were not allowed to attend private appointments with doctors or the counselor. In addition, we were not able to observe the study participants – except for one client and one employee – during their daily lives or moments the clients were confronted with their childlessness, such as during family visits. As a result, this study does not pretend to give a complete picture of the influences of ACCOG's activities on the daily lives of childless women and men.

The language barrier turned out to be an issue, which is why we were very pleased that we could work with research assistants who translated our English into Twi or Ewe and vice versa if the study participant preferred to speak in one of these languages. If the study participant agreed to do the interview in English, different accents caused another language barrier: sometimes the respondents could not understand us due to our Dutch accents and we could not understand them due to their Ghanaian accents. One of the consequences was that the process of transcribing the interviews took a long time. The research assistants helped us to fill in the gaps of the incomplete transcripts.

Lastly, interviewing as a method has additional limitations and pitfalls. For instance, during the interview the respondent is separated from the time, place or process the interaction the researcher is interested in actually takes place (Briggs 1986: 3). In order to capture the essence of the subject discussed during the interview more precisely, within its context, I compared the data collected during the interviews with my other data, which includes observations and informal conversations. In addition, as the research developed, I started to ask participants (most of them staff) about the differences between talking about infertility and childlessness within this kind of setting and talking about infertility and childlessness in daily Ghanaian life.

Positionality

While I introduced myself as a (medical) anthropologist or researcher, in many cases the study participants did not really understand my position. They often thought I was a medical expert, which became evident once they started asking me questions about the medical part of infertility and fertility treatments at the end of an interview. In those cases, I tried to explain my role as a non-medical student and advised them to ask these same questions to one of the doctors or Nana.

Beforehand I thought that, since infertility is such a sensitive topic, and I am not Ghanaian and a newcomer to the field, eight weeks might not be enough to gain someone's trust. This could affect the quality of the data in the way that topics that are deemed 'personal' or 'shameful' are not being addressed. However, I found that a lot of clients were willing to participate in the interview and that most clients we interviewed were quite open about these topics to us – probably *because* we were strangers – which they said they were not towards their family members and friends.

Finally, our relationship with our gatekeeper often challenged us to think about our positionality: Nana Yaw Osei was not only our gatekeeper – opening the doors to the clinic and ACCOG for us – but also our key informant and our landlord. We depended a lot on him in terms of the research. Every time we asked him for some advice about recruiting participants or organizing the focus group discussion, he took full responsibility, for which we are very grateful. Still, we – as (stubborn) Dutch students trained to be autonomous – might have come across as ungrateful whenever we tried to take matters in our own hands, such as when we recruited participants by ourselves.

4. Ethnographic Vignette: ACCOG's Group Counseling

Group Counseling Session on Saturday the 13th of March 2016, 1.50pm - l 5.5 pm

The morning of the first group counseling session, we witnessed on 13 February, Nana, his cousin, Mara, Margot and I attended Nana's graduation – he did a training at the Akona School of Counselling to enhance his insight and skills in counseling – at the other side of Accra. Because of the traffic and the protraction of the graduation ceremony, we were about an hour later than planned for the start of group counseling. The reception/waiting room of the fertility clinic was already filled with clients; five men and five women. In a split second, Nana turned from a student who just graduated and was running late into a professional counselor. That is how focused and smart he appeared in the next few hours. He took a flipboard out of his office and started to write the following sentence down on the board with a marker he just bought on his way to the clinic: 'Why Association of Childless Couples of Ghana?'. He waited with explaining this question, because the couples first needed to fill in a sort of informed consent form for attending the group counseling.

Nana stands in front of the group, all eyes are on him. He starts with making a distinction between 'childless' and 'infertile'. While explaining, he constantly switches between English and Twi. According to Nana, the couples present are not 'infertile', 'barren', or 'fruitless', but they are rather 'facing infertility'. Infertility should be viewed as a kind of disease and not as a punishment from God or something like that. Moreover, Nana says, a couple faces infertility if there is 'no pregnancy after consistent love-making' – every week, three times a week – without the use of contraceptives for at least one year.

Nana goes on to argue that there are people, like doctors and employees at pharmaceutical companies, who do not think counseling is important and who even like to keep clients 'in the dark'. In other words, clients are not informed about 'what is going on'. At the same time, however, it is often the clients who do not ask questions. Then Nana asks the following question to the group: 'What do you ask your doctor after egg selection or collection?'. Nobody answers. After a minute, Nana says passionately: 'How many eggs did you get?'. After all, if you, as a patient, do not know how many eggs have been selected, then you will never know if some of the eggs might have been

sold. 'It is your body', so the client has to critically ask what medical specialists are doing with it.

Nana continues with saying that, besides the objective of clarification (described above), ACCOG aims to be independent and attempts to arrange the best and most affordable treatments for its clients. Furthermore, ACCOG aims to ensure that a couple will not suffer 'psychological trauma' after a failed treatment. For instance, only thirty-three percent of the IVF treatments succeed into a pregnancy internationally, which is the case for all IVF treatments. Triggered by hearing a percentage, one of the women present asks how many cycles are necessary to succeed. Nana answers that for every cycle a chance of thirty-three percent applies and 'if the woman's uterus is not destroyed' it depends on three things: the money the couple can make available, the time a couple wants to spend and the strength of the couple to carry the psychological burden.

Subsequently, Nana makes a distinction between two types of counseling: 'implication counseling' is concerned with the biomedical process of the treatments, while the basis for 'therapeutic counseling' are the 'true key questions'. The answer to these true key questions needs to come 'from within; not from what you have heard'. 'You must have a reason for everything you're going to do, every decision you make', he says. Nana asks the clients the first true key question 'Why do you want or need a child?'. Many clients raise their hands. A woman in the front answers first. She says she has several reasons for wanting a child. First, she wants a sibling for her 8 year old child; secondly, she misses having baby. The man next to the woman, probably her husband, adds that he had to grow up without a sibling and he does not want that for his own child. Another reason one of the clients gives is the need for a child to inherit the family name. Furthermore, various attendants say having children is seen as 'fulfilling the holy scriptures' (both the Bible and the Koran); children are supposed to support them financially at old age; it is believed that once the couples get a child, the societal pressure and pressure from family will be gone; and some clients fear that without children 'nobody will remember' them after they have passed on.

Then Nana asks the following rhetoric question: 'If you do not have a child to fulfill this reason, should you be miserable with yourself?'. According to him, there might be 'alternatives to fulfill these reasons', without having this child. For instance, with regard to financial security at old age, it is not only (biological) children who can deliver such security. He gives a personal example: Nana does not only care for his

biological mother, he also takes care of his foster parents with whom he grew up himself. Thus, children sometimes take care of their foster parents if they are old or sick. Furthermore, if you are forty-two when you get a child, even when you turn sixty, the child is probably still too young to look after you financially. Furthermore, Nana says that, according to the holy scriptures, nobody has the life of a child in their own hands. The Bible even says 'some wombs that never bear, some breasts that never nurse'. So, in fact, by remaining childless, a couple fulfills the holy scriptures as well. According to Nana, there is even a person in the Bible, Michal the daughter of Saul, who never conceives herself. Similarly, the Koran states that Allah made some persons infertile and some others fertile.

Then, he turns to another issue: 'Is there really societal pressure to conceive children in Africa?', Nana asks. A family member asking 'why have you not given birth to a second child?' does not necessarily have to be considered as a form of social pressure. Your family members might ask this out of love or because they are worried. It is thus not an odd question. According to Nana, violence towards a woman facing fertility problems is an exception and should be treated just as it is: as violence or marital abuse. He continues by saying that a lot of women report all kinds of things as social pressure. To illustrate this, he gives another example: if a childless woman offers food to a child and she or he refuses it, then that is not because the parents of the child learned her or him to refuse food offered by childless men and women, but because the parents of the child taught her or him not to accept food from anyone. Thus, it all depends on 'how you process the information that comes to you'. Nana ends this section with the idea that the society as we know it, is 'only in our head'.

Nana continues by saying that 'a child is a gift from God'. Like with all gifts, you would never 'demand for a gift', so you should not demand for a child. Then, to illustrate the next argument, Nana draws a family tree. The idea that a child ensures that you will be remembered when you pass on is not very realistic: many people have never known their grandparents, let alone their great- or great-great-grandparents. The idea that you will be remembered by your great-grandchildren, even by your grandchildren, is a myth. After all, he adds, most people will be remembered because of what they 'achieved personally', not because of how many children they have produced.

After a short break, Nana starts the second part of the group counseling with the following question: 'What do you want or need?'. All the clients say 'a child' in unison. This is exactly what Nana was expecting, because he asks: 'Aha, apparently none of you

needs a pregnancy!' Everyone laughs and some say, 'oh no, we do need a pregnancy'. Then Nana suggests that some of them might want to have a 'biological child' as well, since a pregnancy does not necessarily mean that the child is a biological child when one uses donor sperm and/or eggs. Again, all the persons present laugh; 'okay, we need a biological child'. According to Nana, if they do not know what they truly want – a child, a pregnancy or a biological child – they might end up with psychological issues. For example, he says, 'if you get a biological child through surrogacy, but your desire was to become pregnant yourself, then you will not become happy of having the child'. Some of the clients nodded, but none of them said anything.

During the last part of the counseling session, Nana gives an explanation of the different kinds of assisted reproductive technologies ACCOG offers access to: ICSI, IUI and IVF. These technologies are at the moment not performed at the fertility clinic, but in Kumasi. Chronologically, clients have to go through many steps: examination, protocols, egg selection, fertilization, transfer, and the pregnancy test, all of which he explains in more detail. The group counseling ends with a big applause for Nana.

5. Empowerment: (Cl)Aims and Consequences

Every second Saturday, ACCOG organizes a group counseling session as described in the ethnographic vignette. Clients of the fertility clinic of the Pentecost Hospital in Madina are all encouraged to go to this session. During this particular session ten clients were present (presumably five couples). In this and the following empirical chapter I will refer to the ethnographic vignette to support my argument.

The aim of this chapter is to analyze what ACCOG does in terms of empowerment for its members: how do ACCOG's activities and vision affect the personal lives of its members in terms of empowerment? To answer this question, I will describe and analyze practices through which empowerment of ACCOG's members may be achieved. In addition, I will explore how these activities reflect aspects of Ghanaian society. In order to do all this, I will treat empowerment as a 'social construct' and the activities organized by ACCOG as social practices that have the capability to empower members in several ways. I refer to anthropological literature on notions of empowerment (see *theoretical framework*), when I argue that whether a member feels empowered depends on the sociocultural context. Additionally, I link other notions related to empowerment, such as patient autonomy and the 'ambiguities' of patient-doctor relations (Gerrits 2014; Holmström & Röing 2010), to my findings within the walls of the fertility clinic.

The aim of this chapter is not to evaluate whether ACCOG actually does empower its clients. Rather, it reflects on how ACCOG's members might become to *feel* empowered as a result of ACCOG's activities: which elements of empowerment can we distinguish? In addition, I argue that some of ACCOG's practices that may achieve empowerment have also other effects. In order to support my arguments, I refer in this chapter to the *ethnographic vignette* and the interviews and other observations I conducted during my fieldwork.

Access to Information and Treatment: Making One's Own Decision?

ACCOG offers its members access to information and treatments. In order to inform its members as accurate as possible about the biomedical workings of the treatments and their limited success rates, ACCOG devotes the last part of the group counseling session to explaining the treatments and the treatment procedures, during which attendants are allowed to ask questions (see *ethnographic vignette)*. In order to be able to grant its members access to treatments, ACCOG works together with the Pentecost Hospital, the Trustcare Hospital in Kumasi and the Walking Egg project. The access to information and treatments ACCOG

offers may affect its members' decision-making, as I will explore below. However, as I will show, the information and access to treatments ACCOG offers is not the only aspect that influences clients' decision-making.

One way of ensuring that members make their 'own decision' is encouraging them to form a critical attitude towards caregivers, so as to make sure they receive all the relevant information: they are encouraged to ask questions to the doctors who are examining or treating their body, such as 'How many eggs did you select?' after an egg selection procedure (see *ethnographic vignette*). By doing this, the counselor '….strives to promote and enhance the patients' abilities to feel in control of their health,' which, as Holmström and Röing (2010: 170) have argued, is 'patient empowerment'. The fact that ACCOG emphasizes the importance of having a critical attitude towards medical specialists, suggests that this is not a given in this particular context. This is illustrated by the fact that most of the clients I spoke to say or appear to trust medical doctors unconditionally – among them both the clients who attended ACCOG's counseling as the ones who did not. One of the study participants, Edward, said that 'God created everything and he gave the wisdom, the knowledge to the doctors and the researchers'. Similarly, one of the medical scientists at the clinic said: 'God has called you to do this job. He directs you'. Thus, both the client and the scientist demonstrate the high status of the medical professional within religious Ghanaian society. By encouraging to ask critical questions to these highly esteemed doctors, ACCOG tries to change its members into critical consumers or patients.

ACCOG is not the only institution clients receive information from. The fertility clinic, their church and their family also provide them with insights on infertility care that might influence their decision-making and, with this in mind, one might wonder if the client is able to truly make their 'own' decision. In addition, every institution has its own beliefs concerning reproduction and fertility treatment. For example, as mentioned in *chapter 2*, the Pentecost Hospital does not support – for moral reasons – the use of third parties (donor sperm and eggs and surrogate mothers) while ACCOG does not exclude these treatments from their repertoire. Consequently, clients might receive different, sometimes even contradicting, messages and information about how to reach their goal in the best and most moral way (Jennings 2010: 234-5). As a result, these different perceptions might make it difficult for clients to make a – moral – decision and they might not feel empowered at all, but burdened instead.

The consequences of this division in opinions are illustrated further by a story Nana told us about one of his male clients calling him one day. He was desperate for Nana's help:

he and his wife had undergone an IVF treatment, which turned out to be successful. She conceived three healthy children (a triplet). However, after a couple of years, the mother's pastor had said to her that every child that comes from artificial reproductive technologies is a 'child of the devil'. She has been neglecting and mistreating her three children ever since. Thus, also after a decision has been made and the client has undergone treatment, the decision can still be judged and influence an individual's opinion about the decision that was taken.

Another way of helping its members to make their 'own decision', is by giving them access to several fertility treatments, in particular assisted reproductive technologies, of which it is claimed to empower childless women and men globally. Mostly within medical discourse, the development of ARTs has been promoted as empowering, in which infertility is described as a 'maternal loss' that can be solved through ARTs (Jennings 2010: 217). 'Accordingly, ART is marketed as enhancing reproductive choice. Many feminists[, however,] counter that ART actually narrows choice by discouraging alternatives like child-free living and adoption' (ibid.). The feminists' argument in a way applies for ACCOG as well: although 'encouraging members to consider adoption as an alternative' is one of the objectives of ACCOG, the association appears to devote more attention to ARTs. Especially the introduction of the more affordable/accessible IVF treatment attract a lot of attention, perhaps away from the 'adoption alternative'. The prioritization of ARTs is evident from many clients who would not consider adoption at all or merely as a last resort, something that is also found in other studies in different sociocultural contexts (ibid.: 234). Thus, the existence of ARTs also influences the decision-making of childless couples.

Thereupon, studies – although carried out outside of the African context and with a focus on women only – have shown that people who struggle with fertility issues '….feel compelled to at least "try" [ARTs]' (Jennings 2010: 218 and also see: Franklin 2013: 748). This might also be the case within the Ghanaian context, where families try to convince their childless family member to undergo treatment, as I learned from my informants. Deciding not to undergo treatment is equalized with 'not wanting children', which is unimaginable for many Ghanaians: 'I can't even say out loud that if I don't have kids it is not a big deal, because everyone will be like "aaah, how can you say this?"', as one of the study participants said. Therefore, as Bochow (2015: 150) argues, 'from a critical perspective, one might argue that these technologies subject women to painstaking and cost intensive procedures with only moderate success rates, especially if they have passed their prime fertile years'. However, when Bochow judges purely on what her informants – educated professionals in Botswana who underwent ARTs – told, ARTs rather represent 'tools of empowerment' (ibid.). That is

why Franklin (2013: 748) describes the impact of ARTs as 'paradoxical'. According to her, ARTs, on the one hand, has relieved many from distress and involuntarily childlessness. On the other hand, simultaneously, ARTs have '....blurred the boundary between fertility and infertility, creating new forms of confusion about the very conditions they are designed to mitigate' (ibid.). Thus, the information and access to treatment ACCOG provides, on the one hand, enables clients to undergo the treatments they want to undergo. However, on the other hand, they might feel compelled to try all the available treatments, including ARTs. As a result, it is questionable whether clients are truly able to make their 'own decision'.

By cooperating with the Walking Egg Project to bring the more affordable/accessible IVF to its members, ACCOG offers childless Ghanaians another opportunity to have a child. The introduction of more affordable/accessible IVF enlarges the number of people who have access to ARTs. The fact that this treatment is three times cheaper than the conventional IVF means that some of those who first could not afford IVF can now undergo this more affordable/accessible IVF. In addition, some childless women and men now 'have a chance to do several tries comfortably' (according to Meredith, one of the female informants). As a result, members of ACCOG have the capability to increase the chance of escaping from the consequences of being childless, like stigma.

Eliminating Stigma

Another objective of ACCOG is 'to eliminate stigma on childlessness'. If successful, this would – obviously – empower the childless women and men as their sociocultural position in society becomes better. ACCOG attempts to eliminate stigma in several ways.

First of all, ACCOG draws attention to the problem on a national scale. ACCOG has organized seminars, participated in research projects, done interviews on television and radio and informed about childlessness and fertility care in most churches the association has visited. This can function as a form of sensibilization, which is – as I learned in my fieldwork – believed by both employees of the clinic and some clients to slowly reduce stigma. Additionally, two of the childless study participants who happened to be pastors said they wanted to publicize ACCOG's goals and beliefs themselves. Although some clients and employees have the feeling that it is impossible to change the dominant view on childlessness, some study participants said they noted some changes recently within Ghanaian society concerning family formation and infertility. They claimed that there is less stigma, more acceptance of adoption and people are having less children in the cities. Thus, sociocultural

values appear to be changing (slowly), as a result of which ACCOG's message may be easier to accept for Ghanaians.

Secondly, during group counseling, clients are encouraged to look differently at stigma. This is illustrated by the example the counselor gives of a childless women offering food to other people's children, who refuse the offer (see *ethnographic vignette*). Here, the focus of ACCOG concerning stigma is questioning the perceived stigma. If they are able to look at perceived stigma differently, the clients might indeed feel empowered. However, it does not free the childless couples from the oppressive rule Fisher (2008: 584) refers to when he speaks of empowerment, because it does not question the sociocultural context that is perceived to be stigmatizing.

ACCOG also faces some challenges on its journey to eliminate stigma. For instance, Nana deliberately named his organization the Association of *Childless Couples* of Ghana, to indicate that one of ACCOG's goals is to reduce the stigma around childlessness. This choice, however, has had its consequences: according to some staff members of the clinic, some of the clients did not want to apply for the clinic through ACCOG's form, since they do not feel childless or they already have one or more children. Eileen, one of the female clients I interviewed, said the following:

> I don't want to be part of this association, because I've already had two miscarriages. And yet one or some [children] will come. So if I joined, it will be like I'm limiting myself if I say I don't have a child.

As a result, the controversial name of the association has achieved the opposite reaction in some cases, excluding clients who do not associate themselves with childlessness.

Although not necessarily used by ACCOG as one of the methods to eliminate stigma, the introduction of the more affordable/accessible IVF has also been perceived by clients as helping them in finding a 'way out', freeing them from their stigmatized condition. The clients believe the treatments that are offered by ACCOG help to eliminate stigma, since conceiving helps to overcome their own stigmatized position in society. In this sense, by helping its clients to conceive through ARTs, ACCOG eliminates stigma. Nevertheless, this does not change the dominant body of thought on childlessness directly. As Jennings (2010: 217) puts it, 'while infertility can invite a reevaluation of dominant reproductive practices, it can also invoke a desire to restore order by utilizing ART'. In this quote, she defines ARTs as a method to 'restore the order'. In contrast, Inhorn and Patrizio (2015: 418) argue that

'….access to ART appears to be changing gender relations….' because it decreases 'stigma, blame and social suffering' – among other reasons. From their perspective, the order is not being 'restored' through ARTs, as Jennings argues. Rather, 'the very existence of IVF and other assisted conception technologies has transformed how fertility, infertility and fecundity are understood, both privately and professionally' (Franklin 2013: 748) and as a result, the reasons for the stigmatization of childless women and men need to be reconsidered as well.

In relation to this, the fact that ARTs help many women and men with their fertility problems might influence ideas on childlessness over time. For instance, some of the clients said they felt relieved to hear that their childlessness was not a 'punishment from God', but the consequence of a physical problem that needed to be solved. Thus, the fact that there are methods, such as ARTs, that can 'fix' this physical problem, could influence other people's perception on the nature of infertility: that it is not something that cannot be somehow solved. Furthermore, two clients and an employee said that they believe that – even in case of lack of success – at least the pressure from family and neighbors might decrease once they see that the couple has tried every possible treatment, which is also evident in other studies: 'It is already well documented that people seek out IVF for many different reasons, including wanting to be sure they have tried everything, satisfying the demands of in-laws and not wanting to be seen to be complacent in the face of adversity' (Franklin 2013: 749). In this sense, by offering every possible treatment, ACCOG may help its members by decreasing stigma: because of their commitment, the childless women and men cannot be accused of not wanting any children.

Empowering Women

Another objective of ACCOG is to empower women (ACCOG Annual Report 2013). This focus underlines the notion that, within Ghanaian society, the woman is often held responsible if she and her husband cannot have a child together. For example, during a number of couple interviews the man emphasized how difficult their situation was for his wife, saying that he had to stay strong in order to be there for her. A certain discourse becomes evident: that the women are the main sufferers. Thus, by focusing on women empowerment, ACCOG in a way affirms that women are the ones who suffer the most from stigmatization.

ACCOG may empower women by explaining to its members from a biomedical point of view that women are often wrongly accused of causing infertility. A number of clients – both women and men – said that they learned from ACCOG that the fact that a couple cannot get a child does not mean that the woman has a physical issue per definition: 'The problem is

not always with the woman, sometimes the problem is with the man', said Charlotte. ACCOG attempts to emphasize that both women and men can cause infertility, which may lead to the revaluation of the position of the women in relation to the men. Nevertheless, in many cases, it turns out that it is the woman who has a physical issue. In those instances, it does not matter that men can have fertility problems as well, because the woman can still be held responsible. Consequently, the woman might still suffer from stigma and not feel empowered at all.

On the one hand, by explicitly mentioning women in their objectives, ACCOG recognizes the serious problems women face when they are not able to conceive. On the other hand, the impact childlessness has on men might be underestimated. One woman I interviewed had just received the test results for her husband from the doctor, who said that her husband also had problems with his fertility: he had a low sperm count. When she came back from the doctor's appointment and we wanted to continue the interview (we paused the interview once she was called into the doctor's office), she started to cry, because she felt so sorry for her husband and was afraid of telling him the news. This example suggests that the husband can suffer as well from the psychological consequences of having fertility problems. Other anthropological studies have suggested that childless men are treated differently than men with children and may suffer from stigmatization (Hörbst 2010: 22-3). As has been argued by Parrott (2014: 175), '….semen analysis has the capacity to confirm men's reproductive problems, complicating their marital and social lives in their communities with life shattering consequences', which is why men are not always willing to undergo semen analysis (Hörbst 2010: 23; interviews with employees of the fertility clinic).

'We Are One Umbrella'
Though not one of ACCOG's aims, its members may feel empowered by bringing together the individual clients who face fertility problems as well. The knowledge that they are not the only ones dealing with the kind of situation they are facing was experienced as a relief by many clients: they felt recognized, which may be perceived as empowering as Fisher (2008: 584) has argued. Prince, one of the male clients I interviewed, said 'we are one umbrella', expressing how he felt to be part of a bigger group. Some, however, also felt sorry for those others who are suffering from fertility issues, especially when they themselves already achieved a pregnancy or two – while those others never did[19].

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[19] Most clients said they preferred to have achieved a pregnancy (without conceiving) over never having achieved a pregnancy.

Some of the clients tried to stay in touch with other clients after they met each other during group counseling sessions or even after the Focus Group Discussion we organized. For instance, Edward said that he and his wife exchanged phone numbers with Olive and Daniel to talk about the IUI treatments they both wanted to undergo. Since Olive and Daniel already planned a date to undergo this treatment, Edward wanted to ask them after the treatment how things went to determine if he and his wife wanted to undergo the same treatment as well. Thus, via the social relations build during ACCOG's activities, these clients get access to resources, which is in this case an extra opinion on the treatment.

To give another example, Meredith said that she is a member of a whatsapp group with a number of women she met at a research project on infertility at the University of Ghana. Over the months, other women have been added to the group, among them also women who go to the fertility clinic in Madina and who are members of ACCOG. Right now, the group consists of approximately ten women. Via this app group, they let each other know when they go to the doctor, what kind of treatment they are undergoing, what they think of the treatment and they also give each other advice: 'So if someone is going to do something she can ask, "I'm going to do this test, is it painful?"'. They also support each other emotionally: if one of the women feels sad, she tells the other women and they may offer her words of encouragement. By openly talking to each other about childlessness and the fertility treatment the women are undergoing, they – in a way – normalize their condition (Dimond et al. 2015: 4). Although this group did not emerge within the context of ACCOG, this example suggests that when childless people are brought together, they might feel a connection with each other they wish to maintain and is perceived as empowering.

These examples of emerging social relations can be understood in terms of 'biosocialities', a notion introduced by Paul Rabinow, which are defined as social relations '….organized on the basis of biological conditions or common genetic make-up' (Lock & Nguyen 2010: 201). Some authors (Dimond et al. 2015: 7; Hardon & Moyer 2014: 109; Whyte 2009: 10) go a step further by emphasizing the importance of science and the development of medical technologies for the development of these social relations. '….it is not the genetic variation itself that binds members, but rather how individuals respond to that knowledge' (Dimond et al. 2015: 7). As is the case with the clients described above, they do not only share the same 'biological condition' but they also undergo biomedical treatments, such as IUI and IVF, which is the main reason why they got and stay in contact with each other. Thus, via ACCOG childless women and men appear to form a kind of 'biosociality' – an 'umbrella'.

Interim Summary

Summing up, in this chapter, I have showed the various ways in which ACCOG's members may feel empowered as a result of ACCOG's activities: they might gain patient autonomy; feel less stigmatized within Ghanaian society; and make social connections. In addition, a focus on childless women could decrease their suffering compared to men's suffering due to stigmatization. The way empowerment is addressed and experienced is dependent on the sociocultural context and, as I have discussed, it can reflect aspects of Ghanaian society as well − such as the focus on women empowerment, which reflects a sociocultural notion that women are responsible for infertility.

I have argued that the elements that are perceived as empowering have certain implications and consequences. First of all, by encouraging patient autonomy, ACCOG challenges usual conventions regarding patient-doctor interaction. Secondly, by helping its members to get access to ARTs, ACCOG in a way challenges previous sociocultural notions of reproduction, while others might inadvertently be confirmed, as demonstrated by the unpopular status of adoption and the centrality of biological parenthood. Furthermore, ACCOG's aim of 'eliminating stigma' in the Ghanaian sociocultural context, where it is hard to imagine a society free of stigma, should be understood in terms of helping as many people as possible with conceiving, changing 'experienced stigma' and slowly changing cultural notions of childlessness. Fourth, ACCOG's focus on childless women should be understood within a sub-Sahara African context in which women are often blamed for infertility and the psychological consequences of diagnosed male infertility are not yet known − since biomedical semen analyses have been applied quite recently in African countries (Parrott 2014: 174). Finally, ACCOG – unintentionally – plays a role in the creation of social relations among childless women and men, which could be understood in terms of 'biosocialities', which also strengthens one's position in society.

6. Counseling and the Development of 'Practices of the Self'

In this chapter, I will examine how the group counseling session is experienced by and affects the personal lives of women and men who face infertility. The focus on counseling in this chapter derives from the prominence of group counseling sessions in ACCOG's repertoire. Furthermore, a focus on counseling '….allows researchers to study sites and interactions in which discourse on sexuality [reproduction in this case] is cast into specific moulds, binding people in situations that generate observable practices that have important, if often also unintended consequences' (Moyer et al.: 431).

In order to gain more insights into this specific discourse on reproduction, I will discuss how the Association of Childless Couples of Ghana attempts to help its member cope with their situation, through counseling sessions. The chapter is divided into four themes; each of them represents a practice, related to what happens in the group counseling, to cope with the consequences of being childless. In every subchapter, I will consider the aims of ACCOG, the way clients react to these aims, and what the specific advice or piece of information as described in the *ethnographic vignette* achieves (both intentionally and unintentionally). Thus, this chapter is mainly based on the observations I made during the three group counseling sessions I attended during my stay in Accra, which all differed slightly from each other. I will use Foucault's notion of 'technologies of the self' (Foucault 1998) as a conceptual tool to analyze the practices the clients develop. This tool may help us understand how clients use advice and information given 'to act upon themselves', with the aim of 'improving themselves' (ibid.: 19). It explains the developed technologies as arising both from the individual's agency as from the advice given during counseling.

I will follow anthropologists like Moyer, Burchardt and van Dijk (2013: 432) in defining counseling as a social phenomenon that is '….embedded in wider social institutions and contexts linked to specific repertoires of expertise, experience and knowledge' and which might also influence the lives of the clients beyond the counselor's intentions and imagination. The counselor is defined as an authorized person that has achieved his or her status through education and training – unlike many traditional healers who gain their status through descent or personal experiences (ibid.: 434).

Knowing Themselves: Making a Well-Informed Decision

A major goal of ACCOG is to help clients make an informed and well-considered decision about their treatment trajectory. The counselor does this by informing clients about the

different kinds of treatments, but the most crucial part of the fulfillment of this aim is – as described in the *ethnographic vignette* – encouraging clients to ask themselves the 'true key questions': 'Why do you want/need a child?' And, 'what do you want/need?' Only by answering these questions, the counselor contends, one can know what kind of treatment(s) the client needs to undergo to achieve happiness and avoid psychological trauma. Without counseling, clients could base their decision solely on biomedical advice given by doctors, at least within the walls of the fertility clinic.

From the perspective of the clients, the counseling sessions are very informative and thus very helpful for their decision-making. As one of the clients said, 'he [Nana] asks questions, and you're supposed to give answers and when you give the answers, [but according to Nana, the right one] is not there, he encourages you to explain to him what you mean and then he tries to explain it again'. The perceived role of Nana as an educator or mentor is evident in this example. As a result, the clients I spoke to felt that they could make a well informed decision concerning their treatment – which corresponds to ACCOG's aim. Another couple, Elizabeth and Prince, said that after being presented with all the different ways of getting a child, they were going to consider adoption in the group counseling session. They would not have considered this as an option prior to counseling. However, since many of ACCOG's clients already have a long history of fertility treatments, having been to a number of different hospitals to undergo IUI and IVF, some of them already decided which treatment they wanted to do and did not need ACCOG's help with making an informed decision. They just came to the fertility clinic in Madina because they heard of the more affordable/accessible IVF, which is supposed to accomplish essentially the same as the conventional IVF, but is cheaper.

One of the women who attended group counseling reacted on the counselor's suggestion that, when determining whether a couple wants to do another IVF cycle, they should consider how much money, time and strength they want to put into their mission. During the break, she said to another client that she would sell her house, as long as she could undergo treatment and have a child. This example shows that group counseling makes attendants think about what they are prepared to spend or sacrifice for (having a chance of) having a child.

The practices that the clients develop to assess whether they want to undergo treatment and, if so, which treatment they want to undergo, can be understood in terms of the Foucauldian notion of 'technologies of the self'. There are two moments in the counseling session which may encourage the development of practices to determine the treatment

trajectory. First of all, it happens when the client is encouraged to answer the 'true key questions' mentioned above. Here, the clients are encouraged to 'know themselves'. Nana argues that only when they know what they really want, they can take care of themselves by choosing for a certain fertility treatment. The idea ACCOG advocates is that clients should know something about their 'self' – by which ACCOG in a sense also problematizes their previous non self-reflective behaviors – in order to make the best of oneself by making the 'right' choice, Therefore, clients have to learn specific techniques that allows them to (get to) know themselves. These 'new regimes of self-knowledge' (Moyer et al. 2013: 435) should help the client to make decisions. In a way, ACCOG thus practices what Foucault (1998: 22) argues as follows: 'In the modern world, knowledge of oneself constitutes the fundamental principle'.

Secondly, the counselor's answer to the question 'how many IVF cycles am I able to undergo?', which was asked by one of the women attending the group counseling (see *ethnographic vignette*) encourages clients to asses themselves how they want to follow their treatment trajectory. His answer was twofold. He gave a 'biomedical' answer by saying that as long as the woman's uterus is fine, a couple can try IVF. Secondly, he added, that it also depends on the money, the time and the energy the couple wants to put into this mission. The answer, to this the client has to base, once again, on self knowledge.

However, one could argue that, even though the counselor aims to give the clients all the possible information to ensure they truly make their own decision, this decision is still influenced by the unequal relationship between the specialists and the clients. In an article that reports on a study at the Radboud fertility clinic in the Netherlands, Trudie Gerrits (2014: 127) discusses the ambiguities of patient-centered practices: '….although patient-centred medicine may liberate the medical encounter from paternalistic power, at the same time it introduces a new complex of power relations between doctors and patients'. It seems this phenomenon also occurs within the walls of the fertility clinic of the Pentecost Hospital: although the employees of ACCOG and the fertility clinic try to inform the clients as well as possible – even encouraging the clients to always be critical towards their doctors – the relationship between client and doctor is still not neutral: the specialists, which may be doctors or counselors, are the ones 'grant' partial responsibility to the client and as a result, he or she still enjoys a higher socioeconomic status. After all, '…. [the] key to patient autonomy and personhood also opens the door to a new web of power relations that produce the patient to become a confessing subject' (Mayes 2009: 492). Although they might feel less dependent on the specialist, in fact it is those same specialists who tell the clients when to be critical. As

a result, the decisions about the treatments the client undergoes not exclusively come 'from within' as Nana advocates.

Furthermore, what comes 'from within', as Nana puts it, is strongly influenced by society, although he presents it as something 'natural'. Most clients do not want donor eggs and/or sperm, because their opinion has been influenced by society in which a 'biological child' is highly valued, as discussed earlier. Only one woman I spoke to said that she would not care too much if the child was not biologically hers, but as she said herself 'I'm not like other women'. Therefore, asking clients whether they prefer a biological child or a child from donor egg and/or sperm is not really a 'neutral question'. Within Ghanaian society – and within many other societies – having a biological child is preferred in basically every situation. The decision-making also depends on whether a couples is able to have a biological child. If a couple cannot have a biological child, then this given might also influence one's feeling about children who are conceived by donor eggs and/or sperm. In practice, all clients I interviewed prefer a biological child, although most of them would consider other options, such as using donor eggs and/or sperm and adoption, but only as last resort. The unintended consequence of ACCOG's suggestion that a client can only achieve happiness when their decision comes from 'within' is that, for example, clients who answer 'a biological child' to the question 'what do you want/need?' (one of the true key questions) might think they 'will never be happy', to use Nana's own words, if they choose to undergo treatments that include a donor eggs and/or sperm.

Finally, while they claim that their clients have choices, counselors are 'intuitionally induced to think' they know what is in the best interest of their clients (Moyer et al.: 435). When pointing out the choices clients have, they might mask that their own beliefs play a role in their advice as well. Moyer, Burchardt and van Dijk (ibid.: 435) call these by the counselor suggested choices 'necessary fiction required for counselling as a social form to endure'. To give an example, in ACCOG's group counseling session, the counsellor argues that it is in the client's best interest to choose for a treatment trajectory based on whether they want 'a child, a biological child or a pregnancy', which ACCOG believes will prevent them from psychological trauma. By appointing the several choices to the clients, the counselor covers up the philosophy that a 'right' decision is an individual decision, free from the influences of society on one's decision-making.

Knowing Their Own Bodies: Becoming Critical Clients

Another aim of the group counseling is to encourage clients to take care of their own bodies by making clients more critical towards the medical specialists. Nana uses the egg selection-example to show that the clients should know what is – biomedically – going on inside their own body and during the treatment trajectory. They should carry this responsibility as individuals. With the help of this example, ACCOG shows how childless women and men can take care of their body, namely by asking specialists what they are doing with their bodies.

Knowing what is going on in their bodies from this biomedical perspective has been experienced as a relief by some clients: the childless women and men learn what is going on biomedically and they feel they only have to focus on physical dysfunctions, instead of challenging their whole infertility. Daisy, one of the clients I interviewed, said 'it's just the fibroids and the idea was to get the fibroids away and the rest would come'. She also did not consider herself as childless. Rather, she felt she 'just' had a relatively small issue with her body that had to be solved. However, some of the women and men who did not get any diagnosis after undergoing several tests – meaning that the specialists were not able to find the cause of their infertility – seemed quite unconcerned. They were happy that they did not have any physical dysfunction and realized they could still try IUI and IVF treatment. Knowing that they did not have any biomedically defined disability, they seemed to have peace with the idea that it was now 'in God's hands'.

Consequently, ACCOG, together with the clinic, exposes its clients to a certain view on the human body. First of all, their body is being described as a biomedical entity. The staff of ACCOG and the clinic explain childlessness mainly in terms of biomedical errors within the body, which are not the consequences of immoral behavior on the client's side. As a result, clients may develop a way of thinking about their own bodies in biomedical terms. In addition, when they cannot give a diagnosis, the medical specialists advice biomedical treatments such as IUI and IVF anyway, because it is proved they might work – despite the fact that the cause of infertility has not been (biomedically) established. Thus, although they cannot explain the cause of infertility in biomedical terms, the specialists assume that there is a biomedical explanation for it and might still advice a biomedical treatment.

By giving advice about the different ARTs, ACCOG and the clinic encourage clients to think of their bodies in biomedical terms as well. By asking what kind of child the client wants or needs, Nana makes a distinction between how a biological child can be produced: not only through the 'normal' or 'natural' way, but also with the help of a lab and some tubes.

He also shows that a pregnancy and a biological child are two separate things that do not necessarily have to come together.

Secondly, the body is defined as what Scheper-Hughes and Lock (1987: 7) call the *body politic*, which refers to '….the regulation, surveillance, and control of bodies (individual and collective) in reproduction and sexuality, in work and in leisure, in sickness and other forms of deviance and human difference'. On the one hand, ACCOG emphasizes that the individual can take control of his or her own body, encouraging its members to become 'responsible sexualities' (Moyer et al. 2013: 432-3). On the other hand, Nana suggests that the human body can also be misused by medical specialists and that one should not trust those specialists unconditionally with one's body. As a result, ACCOG encourages clients to develop practices that may help them to know *and* – as a consequence – protect their own bodies.

Reconsidering Perspectives on Parenthood and Sociocultural Pressure

Another aim of the group counseling is to help the childless women and men deal with sociocultural pressure. First of all, ACCOG questions whether the perceived stigma truly is 'stigma'. According to the counselor, family and friends who ask whether they are already pregnant, do not necessarily mean to pressure childless women and men (see *ethnographic vignette*). Another example the counselor gives, is about the holy scriptures. He counters the 'I should reproduce'-argument and argues that there is no sociocultural pressure coming from the religious corner. By altering these arguments with another religious explanation, ACCOG offers its members a different perspective on their childlessness than they were familiar with. Although ACCOG is in principal a non-religion based NGO, Nana chose to integrate religious perspectives on childlessness into the group counseling sessions because religion plays an important role in Ghanaian daily life, as discussed earlier. According to him, without addressing these issues, one risks not reaching all the clients. Clients can use this perspective on childlessness to look at their situation differently, without going against their religion.

Secondly, ACCOG also aims to give some practical advice. In the group counseling session, Nana explains that for every reason to have a child one can look for alternatives. He gives the example of needing a child for financial security at old age and suggests that there might be someone else to take care of the childless women and men when they are old – for instance, a cousin or nephew. Clients can realistically put this advice into practice by making arrangements with other family members, while reconsidering what parenthood actually means (to them).

'He [Nana] was able to clear our minds of certain negative perceptions', said Mike, one of the clients I interviewed, right after the group counseling sessions he attended. This example illustrates that ACCOG is capable of influencing clients' experience with stigma. Most clients I spoke to said that they ignore insults anyway – like they always used to do. Nonetheless, this new perspective could make it easier for them to deal with their situation. They may suffer less from the insults, because they do not perceive it anymore as such. As a result, clients develop specific techniques to deal with stigma, to become their 'best possible self': a person who does not feel stigmatized.

Furthermore, most of the respondents who attended the group counseling remembered one message in particular: that it is God who decides who will get a child and who will not. According to the counselor, not only having a child is a gift, *not* having a child is a gift from God as well. The fertility problems the clients are facing are neither the consequence of their own behavior, nor the consequence of a curse. It is God who gives as he pleases – 'in His own time' – and no one should 'demand gifts' from God. Clients seemed to find support in this message.

Thereupon, in first instance, I found it interesting – it even seemed paradoxical to me – that all the clients believe that God will give the child to them, *if* He pleases, in His own time, and simultaneously try as hard as possible to determine their own faith by undergoing several treatments, spending a lot of money. I learned, however, that it also depends on the individual how to interpret God's will and that they use information selectively in certain instances. For example, one of the employees of the fertility clinic who also faces infertility has not undergone any treatments so far, because she believes that if God would want her to have a child, He would give it to her 'naturally' – without the assistance of treatments. However, all the clients who were undergoing treatment believed that they had to show their dedication by undergoing treatments to see if God indeed wants to give them a child or not. It is worth noting that some clients also had phases during which they did not undergo treatment because they believed that God still might want to give the child to them 'naturally'. Another example is based on clients' treatment-seeking behavior: most of the clients were quite active in their search for treatments and were not scared to undergo any of them. Nonetheless, when they have to wait for results they say 'it's in God's hands', referring to the idea that having a child is, in the end, a gift from God. Thus, dependent on their sociocultural context and the phase of treatment they are in, clients switch between different beliefs about how they have to overcome their childlessness. This practice can be understood as another 'technology of the

self', as clients use information and perspectives advocated in the group counseling selectively in certain instances, not during their whole journey.

Furthermore, during the group counseling a certain perspective on stigma, childlessness and family formation is being advocated which differs (partly) from dominant thoughts on these matters. Other studies have also suggested that during the counseling sessions of support groups a certain view on the certain condition and its possible coping practices is being advocated (Igonya & Moyer 2013). In sub-Saharan African countries, where medical conditions such as HIV/AIDS and infertility are being stigmatized, this view is often different than the dominant perspectives in society. Nevertheless, also this alternative and open-minded perspective can become fixed. As Igonya and Moyer (2013) argue, sociocultural values and the Christian character of counseling can influence the advice given during a counseling session as well: 'Shielding themselves with claims of biomedical neutrality, these experts sometimes instituted silences instead of the openness toward which they claimed to be working' (ibid.: 578). Counseling, in this sense, both encourages talk *and* enforces silences (Moyer et al. 2013: 436). Therefore, counseling should be viewed as an institution that encourages 'normative family formation', just like religion and family (Jennings 2010: 216). In addition, Jennings (2010) argues that 'yet at times, these institutions promote different visions of the 'appropriate' path to parenthood for infertile couples' (ibid.). As a result, what the family is supposed to look like is influenced by many different institutions and none of the perspectives on family formation are neutral. I argue that also ACCOG's perspective on parenthood and sociocultural pressure can become fixed, despite the fact that it is a considerably different view on infertility and childlessness than the dominant perspective in Ghana, which many clients and clinic staff perceived as static and unchangeable. As one of the respondents said during an interview, 'sometimes he [Nana] is so passionate that he doesn't– he misses the little details a bit… he oversees what your concern is… maybe he assumes your concern and works on it'. In this case, ACCOG's view on childlessness and fertility care became a little too 'fixed' for the respondent's taste.

Finally, trying to show its clients that the perceived stigma or societal pressure may not truly be meant as stigma or societal pressure, ACCOG risks neglecting the fact that many Ghanaians strongly experience stigma. Although marital abuse is mentioned, which according to Nana needs to be treated 'just like that and nothing else', the danger of such an approach is that the socioeconomic and sociocultural position of the individual is not taken into account, merely their own agency. It is assumed that an individual can only change their own attitude towards childlessness. However, changing one's own attitude towards childlessness can

become difficult in a pro-natal society like Ghana. Having children is integrated in many aspects of society. As a result, asking whether someone is pregnant a couple of months after marriage or getting worried about relatives who are after one year of marriage still not pregnant, is very culture-specific for Ghana. Even though it may not be meant harmful, this recurring situation highlights the importance of children and – as a consequence – reminds childless couples of the fact that they do not have children. To explore a more explicit example of perceived stigma, one of the respondents said that, when she said to a friend of hers that she was happy meeting other people who face fertility problems, her friend responded that she could not believe that she wanted to be associated with 'those kinds of people'. These kinds of situations are directly linked to childlessness and infertility, directly devaluing the minority. How is this no stigma? In the group counseling sessions I attended, these kinds of issues were not addressed.

Doing it Together

ACCOG encourages its clients to face fertility issues together as a couple, which highlights the association's vision: 'For childless couples to live together "till death do them part" through mutual understanding and love for each other'. Both the clinic and ACCOG give a pretty clear message: these fertility issues should be faced by the husband and wife together, as a couple. This vision is illustrated during an appointment with doctor Attoh and a client I was allowed to attend: doctor Attoh offered to call the husband of the female client to convince him to come to the next appointment, *together* with his wife. Highlighting the importance of coming to the clinic together appears to work: at all the three group counseling sessions I attended both the wife and husband were present, except for two women who came without their husband.

Many of the clients I interviewed said that they went to all the appointments together as a couple, so they were pleased with the vision of ACCOG to focus on the married couple. However, some of the clients did not want to 'do everything together', as ACCOG and the clinic wished of them. In most cases it was the husband who did not want to come to the clinic. For example, one woman told me that her husband once said 'I'm not the one who isn't menstruating' to explain why he did not feel the need to come to the clinic like his wife. Caroline, another client, said that her husband only understood that he had to come as well thanks to the resoluteness of ACCOG and the clinic.

Another message the clients took very seriously was the idea that having children is not 'the only issue in marriage'. As respondent Marian and Charles said, 'our happiness in

marriage is not based upon the child we can produce'. For many of the clients I interviewed, the idea that having children is not the ultimate purpose in marriage, as ACCOG supports, appeared to be not new. Many of our study participants were already for five, ten or even more than fifteen years married and were still together. They had already made their decision to face their childlessness together, as is the case with Peter and Maria: because he wanted to know if the infertility was caused by him, Peter went to another woman to see if he could make her pregnant. He got a child with her, but he chose to stay with his wife. In addition, his family members tried to convince him that he should divorce his wife and marry someone else. Still, regardless of his family's wishes he chose to stay with his wife. And now, after almost ten years of marriage, he and his wife, Maria, were undergoing treatment at the Pentecost Hospital fertility clinic in Accra. Peter and Maria's story was only one of the stories I heard from study participants about how they chose to stay with their partner.

Another consequence of ACCOG's focus on marriage and living together as a childless couple is that the association partly disconnects marriage from having children, which contrasts the popular believe in Ghana that '….the ultimate purpose of marriage is procreation….' (Donkor & Sandall 2007: 1683). The emphasis is not on living together without children, but on living together facing childlessness. By constantly reminding its members to come to appointments together with their partner, ACCOG encourages them to develop a certain perspective on marriage – that marriage is not only about children – and how to become the best possible wife or husband – by accompanying their partner to appointments.

Interim Summary

By way of conclusion, ACCOG's group counseling is a social practice that influences the personal lives of women and men who face infertility in several way. Some of the consequences are not (necessarily) intended. Via the group counseling, ACCOG offers its members tools to deal with childlessness, such as asking themselves 'true key questions' to gain 'self-knowledge' on basis of which they can determine whether, and if so, which treatment they will undergo. These can be understood in terms of Foucault's 'technologies of the self', since clients might develop practices with which they actively try to become the 'best version of themselves', taking into account the advice and information given.

Interestingly, some of ACCOG's messages seem progressive and 'western', especially the idea that an individual is responsible for his or her own body. Other messages are perhaps more characteristic for 'traditional' Ghanaian society, such as the idea that a child is a gift

from God. Therefore, this group counseling session might be a reflection of counseling as a 'traveling technology' (Simbaya & Moyer 2013: 453; Nguyen 2013: 441); once introduced, it is being adapted to the local context. The particular shape of ACCOG's group counseling – the discourse and the social relations that are produced during the session – derives from this particular religious, pro-natal and low/middle-income context. ACCOG's focus on religion and marriage underlines the idea that counseling is 'embedded in wider social institutions and contexts' (Moyer et al. 2013: 432). Meanwhile, ACCOG's group counseling has the capacity to affect local cultural notions and the way people relate with each other. This occurs when they affect the way in which childless women and men cope with childlessness, as I have argued in this chapter.

Conclusion

The aim of this thesis was to answer the following research question: how does ACCOG affect the way in which its members – women and men facing fertility problems – experience their childlessness? In order to answer this question, I have relied on anthropological literature of two different themes within the context of a Ghanaian support group: empowerment and counseling, treating empowerment as a social construct and the activities of support groups, among them counseling, as social practices. In two empirical chapters, I have showed the value of a support group named the Association of Childless Couples of Ghana and, in particular, the offered counseling practices for its members within a sub-Sahara African context. In both chapters, I described the aims of ACCOG, the methods the association uses to achieve these aims and the way clients, in their turn, react to these aims. Above all, I have illustrated that – besides the intended consequences – the methods ACCOG uses have wider implications and consequences beyond ACCOG's imagination.

Most of the literature on support groups and counseling practices in sub-Sahara Africa is on HIV/AIDS. Therefore, this study on a support group for childless women and men in Ghana contributes to anthropological insights into the activities of support groups and counseling practices in the African sociocultural context. What makes ACCOG interesting is that it is – unlike many support groups for people struggling with HIV/AIDS – an initiative founded by a Ghanaian person, without any support from (inter)national agencies. Thus, the support group is relatively independent compared to most HIV/AIDS support groups in sub-Sahara Africa studied by anthropologists.

In the first empirical chapter, I have argued that ACCOG helps to empower its members in various ways, both intentionally and unintentionally. ACCOG encourages them to make their 'own' decision; attempts to eliminate stigma; questions women's blame for infertility; and brings childless women and men together. To achieve the first objective, ACCOG emphasizes the important role of the client: he or she should be able to take responsibility and as such, an empowered client has a high degree of patient autonomy. Furthermore, support groups are also believed to empower its members through their mission to eliminate stigma, which is – as I showed – a major focus of ACCOG and can be understood in terms of helping as many people as possible with conceiving, changing 'experienced stigma' and slowly changing cultural notions on childlessness. By explaining male infertility and promoting semen analysis, ACCOG, together with the fertility clinic, goes against traditional beliefs about the cause of infertility, as a result of which women might be relieved from the burden of blame they may carry. Finally, through ACCOG, social relations are created – although indirectly – between childless women and men, which allow them to get access to information on fertility treatments. The emergence of social

relations between childless women and men through ACCOG is an interesting example of an unintended consequence.

In addition, I have argued that experiences of empowerment are also influenced by the sociocultural context. One of the examples I used to support this argument is based on how ACCOG's clients define ARTs. Most of my study participants thought of ARTs as opportunities to be 'freed' from stigma, while – in an North American context – people have felt that ARTs maintain stigma (Jennings 2010). When analyzing the importance of the role ACCOG or any support group plays, these sociocultural factors need to be taken into account. This is where anthropology can make an important contribution.

An important discussion I have joined in this thesis is whether and how assisted reproductive technologies – which are promoted by ACCOG – empower childless women and men (Franklin 2013; Jennings 2010; Bochow 2015). It has been argued that, on the one hand, ARTs have the capacity to empower childless women and men by giving them an(other) opportunity of having a child. On the other hand, however, many women and men might feel obliged to try ARTs, because of e.g. pressure from family and end up paying a lot of money to undergo treatment, of which the chances of success are quite low. I think that for most of ACCOG's members, ARTs, especially the more affordable/accessible IVF, offer hope and a new opportunity to conceive – which Bochow (2015: 150) has concluded as well after conducting interviews with educated professionals in Botswana. Nevertheless, it is important to keep in mind that ARTs also limit choice in several ways and, secondly, that sociocultural ideas about childlessness influence whether ARTs is perceived as a choice or not. More and longitudinal anthropological research on this topic may help to gain more insight into the ways childless women and men perceive ARTs. These insights can be used to improve fertility care, balancing ARTs and other options of overcoming childlessness.

Besides contributing to its members' empowerment, I have argued that ACCOG also helps childless members to develop practices to cope with childlessness. In the second empirical chapter, I have zoomed in on a prominent activity organized by ACCOG: the group counseling session. Based on the observations I made during one of the group counseling sessions I attended (see *ethnographic vignette*), I found four practices ACCOG encourages its members to develop: making a well-informed decision based on self-knowledge; becoming critical clients by gaining knowledge on their own bodies; reconsidering perspectives on parenthood and sociocultural pressure; and facing childlessness together as a couple. I have argued that these coping practices could be viewed as 'technologies of the self' (Foucault 1998).

I used Foucault's theory as an anthropological lens through which to look at ACCOG's group counseling sessions in order to understand how childless women and men in Ghana cope

with their health issue. To my knowledge, this has not been done as of yet – at least not for the topic of infertility in a sub-Sahara African context. Foucault's notion of 'technologies of the self' is useful to understand these coping practices as deriving from both an individual's agency and the sociocultural context he or she lives in. However, other approaches may also lead to interesting insights. For example, ACCOG's objectives and its members' response may be analyzed in terms of 'identity politics', which is '….about the revaluation of difference: the assertion of a difference that had been disvalued, the witnessing of discrimination, and the struggle for recognition, rights and social justice' (Whyte 2009: 7). Furthermore, a focus on the (re)construction of hope with the help of ACCOG may also produce interesting insights into the value of support groups in a sub-Sahara African context.

Another conceptual tool that could offer valuable insights into counseling practices is the notion of 'traveling technology' (Simbaya & Moyer 2013: 453; Nguyen 2013: 441). I have argued that ACCOG's group counseling session can be defined as such, because some aspects of the counseling appeared western, and others traditional to me. However, as this particular counseling session is designed by a Ghanaian person – not implemented by international agencies – how this counseling session is influenced by western ideas – if you can even speak of these – on advice-giving is difficult to say, purely based on my fieldwork. Therefore, I recommend further research into the origins of ACCOG's group counseling.

Although the aim of this research was not to evaluate or judge ACCOG, this study produced some insights that could be used to improve the association. For example, since my data has suggested that social relations between some childless women and men have emerged which allows them to share experiences, ACCOG could perhaps respond to this phenomenon by facilitating group exchanges for its members. During these meetings, issues could be discussed that are not addressed (yet) during counseling sessions and clients themselves could have the chance to share their experiences with childlessness and fertility treatments.

In conclusion, I have argued that the value of a support group named the Association of Childless Couples of Ghana exists of several aspects. Above all, I found that clients enormously appreciate ACCOG's services and have high expectations. A new service, giving its members access to more affordable/accessible IVF, is ACCOG's next step to improve the lives of childless women and men in Ghana. As of yet four embryos are successfully placed into the wombs of four Ghanaian women. And now we wait for the pregnancies to come.

Bibliography

Association of Childless Couples of Ghana (ACCOG)

    2014   ACCOG 2013 Annual Report.

Anarfi, J. & Owusu, A.

    2011   The Making of a Sexual Being in Ghana: The State, Religion and the Influence of Society as Agents of Sexual Socialization. *Sexuality & Culture* 15(1): 1-18.

Angotti, N.

    2010   Working Outside of the Box: How HIV Counselors in Sub-Saharan Africa Adapt Western HIV Testing Norms. *Social Science & Medicine* 71(5): 986-993.

Balen F. van & Gerrits, T.

    2001   Quality of Infertility Care in Poor-Resource Areas and the Introduction of New Reproductive Technologies. *Human Reproduction* 16(2): 215-219.

Bell, A. V. & Hetterly, E.

    2014   "There's a Higher Power, But He Gave Us a Free Will": Socioeconomic Status and the Intersection of Agency and Fatalism in Infertility. *Social Science & Medicine* 114: 66-72.

Blerkom, van, J.; Ombelet, W.; Klerkx, E.; Janssen, M.; Dhont, N.; Nargund, G.; Campo, R.

    2014   First Births With a Simplified Culture System for Clinical IVF and Embryo Transfer. *Reproductive BioMedicine Online* 28(3): 310-320.

Bochow, A.

    2015   Chapter 7: Ethics, Identities and Agency: ART, Elites and HIV/AIDS in Botswana. In: K. Hampshire & B. Simpson (ed.), *Assisted Reproductive Technologies in the Third Phase: Global Encounters and Emerging Moral Worlds*. New York: Berghahn Books, pp. 135-151.

Briggs, C. L.

    1986   *Learning How To Ask: A Sociolinguistic Appraisal of the Role of the Interview in Social Science Research.* New York, Cambridge: University Press.

Chan, C. C. W.

    2006   Infertility, Assisted Reproduction and Rights. *Best Practice & Research Clinical Obstetrics and Gynaecology* 20(3): 369-380.

Dimond, R.; Bartlett, A.; Lewis, J.

    2015   What Binds Biosociality? The Collective Effervescence of the Parent-Led Conference. *Social Science & Medicine* 126(C): 1-8.

Donkor E. S. & Sandall, J.

    2007   The Impact of Perceived Stigma and Mediating Social Factors on Infertility-Related Stress among Women Seeking Infertility Treatment in Southern Ghana. *Social Science & Medicine* 65(8): 1683-1694.

    2009   Coping Strategies of Women Seeking Infertility Treatment in Southern Ghana. *African Journal of Reproductive Health* 13(4): 81-94.

Epstein, R. M.; Street, R. L.

    2011   The Values and Value of Patient-Centered Care. *Annals of Family Medicine* 9(2): 100-103.

Fisher, P.

    2008   Wellbeing and Empowerment: The Importance of Recognition. *Sociology of Health & Illness* 30(4): 583-598.

Foucault, M.

    1998   "Technologies of the Self" in *Technologies of the Self* by Luther Martin, Huck Gutman, and Patrick H. Hutton, eds., 16-49. Amherst: University of Massachusetts Press.

Franklin, S.

    2013   Conception Through a Looking Glass: The Paradox of IVF. *Reproductive BioMedicine Online* 27(6): 747-755.

Geelhoed, D. W.; Nayembil, D.; Asare, K.; Schagen van Leeuwen, J. H.; van Roosmalen, J.

    2002   Infertility in Rural Ghana. *International Journal of Gynecology and Obstetrics* 79(2): 137-142.

Gerrits, T.

    2008   *Clinical Encounters: Dynamics of Patient-Centred Practices in a Dutch Fertility Clinic*. University of Amsterdam.

    2014   The Ambiguity of Patient-Centred Practices: The Case of a Dutch Fertility Clinic. *Anthropology & Medicine* 21(2): 125-135.

Gillett, H. & Parr, J.

    2010   Disclosure Among HIV-Positive Women: The Role of HIV/AIDS Support Groups in Rural Kenya. *African Journal of AIDS Research* 9(4): 337-344.

Green, J. & Thorogood, N.

    2009[2004]   *Qualitative Methods for Health Research: Second Edition.* Los Angeles, London, New Delhi, Singapore, Washington DC: Sage Publications.

Green, J.; Willis, K.; Hughes, E.; Small, R.; Welch, N.; Gibbs, L.; Daly, J.

    2007   Generating Best Evidence from Qualitative Research: The Role of Data Analysis. *Australian and New Zealand Journal of Public Health* 31(6): 545-550.

Hardon, A. & Moyer, E.

    2014   Medical Technologies: Flows, Frictions and New Socialities. *Anthropology & Medicine* 21(2): 107-112.

Heaton, T. B. & Darkwah, A.

    2011   Religious Differences in Modernization of the Family: Family Demographics Trends in Ghana. *Journal of Family Issues* 31(12) 1576-1596.

Hiadzi, R. A.

    2014   Thesis 'Couples in Search of Children: A Study of Strategies and Management of Infertility in Contemporary Ghana'. *Submitted to the University of Ghana, Legon.*

Hicks, E.; Sims-Gould, J.; Byrne, K.; Khan, K. M.; Stolee, P.

    2012   "She Was a Little Bit Unrealistic": Choice in Healthcare Decision Making for Older People. *Journal of Aging Studies* 26(2): 140-148.

Holmström, I. & Röing, M.

    2010   The Relation Between Patient-Centeredness and patient Empowerment: A Discussion on Concepts. *Patient Education and Counseling* 79(2): 167-172.

Hörbst, V.

    2010   Male Perspectives on Infertility and Assisted Reproductive Technologies (ART) in Sub-Saharan Contexts. *Facts, Views & Vision in ObGyn* 2010: 22-27.

Hörbst, V. & Wolf, A.

2014   ARVs and ARTs: Medicoscapes and the Unequal Place-Making for Biomedical Treatments in Sub-Saharan Africa. *Medical Anthropology Quarterly* 28(2): 182-202.

Hord, C. & Wolf, M.

2004   Breaking the Cycle of Unsafe Abortion in Africa. *African Journal of Reproductive Health* 8(1): 29-36.

Hutton, P. H.

1998   "Foucault, Freud, and the Technologies of the Self" in *Technologies of the Self* by Luther Martin, Huck Gutman, and Patrick H. Hutton, eds., 16-49. Amherst: University of Massachusetts Press.

Igonya, E. K. & Moyer, E.

2013   Putting Sex on the Table: Sex, Sexuality and Masculinity Among HIV-Positive Men in Nairobi, Kenya. *Culture, Health & Sexuality* 15(4): 567-580.

Inhorn, M. C. & Patrizio, P.

2015   Infertility Around the Globe: New Thinking on Gender, Reproductive Technologies and Global Movements in the 21st Century. *Human Reproduction Update* 21(4): 411-426.

Jennings, P. K.

2010   "God Had Something Else in Mind": Family, Religion, and Infertility. *Journal of Contemporary Ethnography* 39(2): 215-237.

Krabbendam, A. A.; Kuijper, B.; Wolffers, I. N.; Drew, R.

1998   The Impact of Counselling on HIV-Infected Women in Zimbabwe. *AIDS Care* 10(1): 25-37.

Lock, M. & Nguyen, V.

2010   *Anthropology of Biomedicine*. Chichester: Wiley-Blackwell; a John Wiley & Sons, LTD., Publication.

Mawuli Adinkrah, J.

2014   #GlobalHealth: Discussions and Perspectives on Global Health > Healthcare Systems in Ghana- Problems & Ways Forward. http://globalhealthstudents.blogs.ku.dk/2014/02/12/healthcare-system-in-ghana-problems-ways-forward/ (19-1-2016).

Mayes, C.

    2009   Pastoral Power and the Confessing Subject in Patient-Centred Communication. *Journal of Bioethical Inquiry* 6(4): 483-493.

McWhirter, E. H.

    1991   Empowerment in Counseling. *Journal of Counseling and Development* 69(3): 222-227.

Mitcheson, K.

    2012   Foucault's Technologies of the Self: Between Control and Creativity. *Journal of the British Society for Phenomenology* 43(1): 59-75.

Moyer, E.; Burchardt, M; van Dijk, R.

    2013   Editorial Introduction: Sexuality, Intimacy and Counselling: Perspectives from Africa. *Culture, Health & Sexuality* 15(4): 431-439.

Mupambireyi, Z.; Bernays, S.; Bwkaura-Dangarembizi, M.; Cowan, F. M.

    2014   "I Don't Feel Shy Because I Will Be Among Others Who Are Just Like Me: The Role of Support Groups for Children Perinatally Infected with HIV in Zimbabwe. *Children and Youth Services Review* 45: 106-113.

Nguyen, V.

    2010   *The Republic of Therapy: Triage and Sovereignty in West Africa's Time of AIDS.* Durham and London: Duke University Press.

    2013   Counselling Against HIV in Africa: A Genealogy of Confessional Technologies. *Culture, Health & Sexuality* 15(4): 440-452.

Ombelet, W.

    2008   False Perceptions and Common Misunderstandings Surrounding the Subject of Infertility in Developing Countries. *Human Reproduction* 2008(1): 8-11.

    2011   Global Access to Infertility Care in Developing Countries: A Case of Human Rights, Equity and Social Justice. *Facts, Views & Vision in ObGyn* 3(4): 257-266.

    2013   The Walking Egg Project: Universal Access to Infertility Care – From Dream to Reality. *Facts, Views & Vision in ObGyn* 5(2): 161-175.

Osei, N. Y.

    2014   Association of Childless Couples of Ghana (ACCOG). *FVV in ObGyn* 6(2): 99-102.

Parrott, F. R.

    2014   'At the Hospital I Learnt the Truth': Diagnosing Male Infertility in Rural Malawi. *Anthropology & Medicine* 21(2): 174-188.

Pigg, S. L. & Adams, V.

    2005   *Sex in Development; Science, Sexuality and Morality in Global Perspective.* Durham: Duke University Press.

Rhine, K. A.

    2009   Support Groups, Marriage, and the Management of Ambiguity among HIV-Positive Women in Northern Nigeria. *Anthropological Quarterly* 82(2): 369-400.

Scheper-Hughes, N. & Lock, M. M.

    1987   The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology. *Medical Anthropology Quarterly* 1(1): 6-41.

Simbaya, J. & Moyer, E.

    2013   The Emergence and Evolution of HIV Counselling in Zambia: A 25-year History. *Culture, Health & Sexuality* 15(4): 453-466.

Stephens, C.

    2008   Social Capital in Its Place: Using Social Theory to Understand Social Capital and Inequalities in Health. *Social Science & Medicine* 66(5): 1174-1184.

Tabong, P. T.; Adongo, P. B.; Wainberg, M.

    2013   Understanding the Social Meaning of Infertility and Childbearing: A Qualitative Study of the Perception of Childbearing and Childlessness in Northern Ghana. *PLoS ONE* 8(1): 1-9.

Traynor, M.

    2003   A Brief History of Empowerment: Response to Discussion with Julianne Cheek. *Primary Health and Care Research Development* 4(2): 129-136.

Uden-Kraan, van, C. F.; Drossaert, C. H. C.; Taal, E.; Seydel, E. R.; Laar, van de, M. A. F. J.

    2009   Participation in Online Patient Support Groups Endorses Patients' Empowerment. *Patient Education and Counseling* 74(1): 61-69.

Whyte, S. R.

    2009   Health Identities and Subjectivities: The Ethnographic Challenge. *Medical Anthropology Quarterly* 23(1): 6-15.

Acknowledgements

Annex 1: List of Abbreviations

ACCOG	Association of Childless Couples of Ghana
AIA	African Infertility Alliance
AISSR	Amsterdam Institute for Social Science Research
ART	assisted reproductive technology
CEO	chief executive officer
FGD	focus group discussion
ICSI	intracytoplasmic sperm injection
IUI	intrauterine insemination
IVF	in vitro fertilization
LCIVF	low cost in vitro fertilization
NGO	non-governmental organization
NMIMR	Noguchi Memorial Institute for Medical Research
tWE	the Walking Egg

Annex 2: Topic List and Interview Questions

1. Personal data of woman, man or couple

(date of birth/age, religion, country of origin, ethnic group, date of marriage(s) or co-habitation; children, foster children, family background, school/education, profession)

2. Personal history of involuntary childlessness

3. First acquaintance with ACCOG

Can you tell us when you came acquainted with ACCOG for the first time? Which activities did you attend?

4. Experiences with the activities of ACCOG: couples counseling, group counseling sessions and seminars

What is your experience with the activities you attended?

5. Experiences with the employees of ACCOG

What is your experience with the employees of ACCOG (Nana)?

6. The topics being addressed during ACCOG's activities

What do you think of the topics that are being addressed during ACCOG's activities?

Do you agree with the manner in which the topics are being discussed?

7. Thoughts about the manner in which certain topics were being addressed during ACCOG's activities

Examples of topics: living with involuntary childlessness/infertility/ARTs/adoption/gender-based violence

8. The given advice

9. Influence of ACCOG's activities on personal life

Do ACCOG's activities influence your personal life? If so, how does it influence your personal life?

10. Change in self-image as a result of ACCOG's activities

Did your self-image change as a result of ACCOG's activities? How did it change?

11. Change in opinions about topics such as living with involuntary childlessness/ infertility/ARTs/adoption /gender-based violence as a result of ACCOG's activities

Did your opinion about topics (such as living with involuntary childlessness/infertility /ARTs/adoption/gender-based violence) change as a result of ACCOG's activities? If so, how did it change?

12. Trust in ACCOG('s employees)

Do you feel you can trust ACCOG? Why do you trust the organization?

13. Contact/bonds with other members of ACCOG

Do you come in contact with other people who are struggling with the same issues? How is that contact? Do you perceive a form of bond or connection with them?

14. Financial issues

Do you have to pay to be a member of ACCOG? What kind of costs do you have as a member of ACCOG?

15. Course of treatment and influence on personal life

Annex 3: Details of Study Participants

Study Participants					Years of	Illegitimate/Foster Children
# Pseudonym	F/M	Age	Religion	Ethnic Group	Marriage	Taking Care of Other Children
1 Oumaima	F	24	Muslim	Gao	3	0
2 Maria couple	F	44	Christian	Ewe	10	taking care of 1 child from R3
3 Peter	M	49	Christian	Ewe		
4 Elizabeth couple	F	42	Christian	Adangbe Krumpu	17	taking care of 1 child
5 Prince	M	44	Christian	Ashanti		
6 Meredith	F	36	Christian	*Unknown*	8	0
7 Simone	F	43	Christian	Akan	5	helping take care of the 4 children of her husband
8 Marian couple	F	34	Christian	Akan	15	3 foster children
9 Charles	M	39	Christian	Akan		
10 Catherine	F	40	Christian	Akan	6	Looking after 2 children (not living at her place) and husband has 2 children
11 Anna	F	44	Christian	Ewe	7	Has 1 child
12 Eve	F	38	Christian	Akan	8	Husband has 2 children
13 Debby	F	29	Christian	Akan	3	0
14 Caroline	F	43	Christian	Ewe	8	Taking care of 2 children
15 Nora	F	44	Christian	Akan	17	2 foster children
16 Kate	F	37	Christian	*Ewe*	Divorced	Husband has 1 child, current partner has 2 children
17 Mike couple	M	38	Christian	*Ewe*	2	R17 has 2 children
19 Rose	F	38	Christian	*Ewe*		
18 Miranda	F	38	Christian	Ewe	6	Taking care of 1 child
20 Agnes	F		Christian	Ashanti	9	Husband has 5 children
21 Eileen	F	33	Christian	Akan	5	Used to take care of 1 child, not anymore
22 Denise	F	45	Christian	*Unknown*	Divorced	Has 1 child with ex-husband
23 Amy	F	44	Christian	*Unknown*	15	Used to take care of 2 children, not anymore
24 Charlotte	F	28	Muslim	*Unknown*	10	Husband has 3 children
25 Daisy	F	31	Christian	Akan	3	0
26 Adam	M	37	Christian	Akan	7	0
27 Eleanor	F	40	Christian	Akan	11	Taking care of 1 child
28 Isabel	F	42	Christian	Bono (Akan)	*unclear*	Taking care of 2 children (staying with her)
29 Edward	M	44	Christian	Ashanti	15	3 foster children
30 Olive couple	F	33	Christian	Akan	8	0
31 Daniel	M	36	Christian	Akan		
32 Patricia	F	28	Christian	Amacan Acchi	1	0
33 Sabrina	F	39	Christian	Ewe	18	Taking care of 2 children
34 Violet	F	38	Christian	*Unknown*	4	Husband has 2 children
35 Jane couple	F	33	Christian	Akan	7	3 foster children
36 William	M	36	Christian	Akan		
37 Aaron	M	53	Christian	Ewe	10	Has 2 children

Annex 4: Focus Group Discussion: Program and Topics

On Monday the 28th of March Mara, Margot and I organized a focus group discussion with help from Nana. Nana suggested to invite the clients who were interested in doing IUI and that he could tell some information about IUI during the focus group discussion as well. Four couples came to the group counseling.

The meeting took place in the reception/waiting room of the fertility clinic. Nana started at 11am with his explanation of IUI. After half an hour, we started with the focus group discussion. I explained a little about the research and about the two rounds that were going to take place. First we started with discussing the following statements:

- I share my thoughts and/or struggles about my childlessness with friends and family;
- Once I have a child, all the stigma will be gone/all my problems will be solved;
- In Ghana, a man/woman without children is being seen as... [complete the sentence];
- This treatment is my last hope;
- The more I pray, the sooner I will get a child;
- The government should finance fertility treatment.

After a short break, we started the second round. In this round, we split the group in two: a group of four women and one of four men. They were asked to discuss three cases within the smaller groups. After that, we compared the results with the whole group together. We discussed the following cases:

1. You're at the market and a stranger walks up to you and asks 'Hello, how are you? How are the children?' How do you react?
2. During a conflict an acquaintance says that you should not interfere, because he/she thinks only 'useful people' (people *with* children) are allowed to do so. According to him/her, childless people do not have any valuable things to say. How do you respond?
3. An aunt recommends a herbalist to you. What do you say?

After this discussion we thanked everyone and Nana ended the focus group discussion with a prayer.