Promotion of Fertility among Childless Couples: A Challenge to Contemporary African Society

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Abstract

Infertility or childlessness poses various challenges not only to the married but to society at large especially in Africa. Children are viewed as the foundation of society as it is through them that a society can exist and survive. Most African societies are patriarchal and procreation especially of male children is regarded as the primary purpose of marriage. Failure to get children therefore is viewed as a threat to the very survival of marriage and all means are employed to at least get a child. This paper begins by looking at the value of children in society. Possible causes of infertility are examined and some consequences of infertility, including divorce and use of violence are presented. Infertility in this paper is presented as a serious reproductive health problem that calls for both preventive and curative strategies to overcome it. Both the traditional and modern strategies for promotion of pregnancy which includes the use of reproductive technologies and their implications are examined. The paper therefore, explores the religious, moral, social, economic and legal implications of the reproductive technology especially in Africa. In conclusion, the paper proposes the way forward in handling the problem of infertility or promotion of pregnancy in Africa.

Introduction

Human societies all over the world view children as sources of happiness. Children are the buds of society and every birth is the arrival of a 'spring' when life shoots out, the community thrives. The birth of a child is, therefore, the concern not only of the parents but of the many relatives including the living and the departed. In most African societies, the main purpose for marriage is procreation. A marriage cannot survive if there is no procreation. Marriage is not fully recognized or consummated until the wife has given birth. The first pregnancy, therefore, becomes the final seal of marriage, the sign of complete integration of the woman into her husband's family and kinship circle (Mbiti J. S., 1976: 110).

Childlessness is undesirable in most African societies and is greatly scorned. Though procreation is a reproductive role for both men and women, more often than not, it is the woman who is blamed for infertility making it a woman's affair, that is, it is gendered. Motherhood is greatly idealized as it is seen as giving women status and place in society especially in patriarchal societies. Failure to get children in such societies, especially in Africa, is the worst thing that can befall a married woman; Unhappy is the woman who fails to get children, for, whatever other qualities she might possess, her failure to bear children is worse than committing genocide; she has become the dead end of human life, not only for the genealogical line but also for herself (Ibid).

Though infertility affects both men and women, women are affected more than men because of society's role expectations and socializations, based on the traditionalpractice that only women can be infertile, which is not true.

Definitions of Infertility

The inability to have children is described in various terms such as 'barrenness', 'sterility', 'infertility' or 'sub-fertility'. The term childlessness is a description of the state of a

married couple without any children. (Wilkinson J. 1988: 209). Infertility or sub-fertility may be defined as the failure of a woman to conceive following regular sexual intercourse for at least one year after marriage. Scientific evidence indicates that... for about half of the married couples who are initially infertile or sub-fertile will go on to produce at least one child. In the case of the other half who remain childless, the wife is responsible for sterility in about a third, the husband in another third, and both husband and wife in the remainder (Ibid). This shows that either wife or husband or both can be responsible for infertility and that it is possible to solve the problem of infertility.

Is Fertility a Right?

Marriage and procreation in African communities are a unity: without procreation, marriage is incomplete. As Mbithi (1976) pointed out, ...it is a religious obligation by means of which the individual contributes the seeds of life towards man's struggle against the loss of original immortality (p 133). Therefore, fertility in not a right in the strict sense of the word, but it is an "ought", an expectation and an obligation for all members of an African community irrespective of gender.

The idea that women have an absolute right to have or not to have children is a modern idea, which arises from the present-day emphasis on human rights. (Wilkinson J. 1988: 209) Single women who do not want to undergo the stress of pregnancy or do not want pregnancy to interfere with their career or for other inconveniences may claim to have a right to have children through non-coitus methods. The traditional or normal method of procreation is through coitus or sexual intercourse between husband and wife. In African culture, reproduction, of necessity must involve coitus. Today, reproduction technology has made procreation without coitus a reality. Hence an infertile couple can turn to reproductive technology as a way of resolving it. Any married couple who is infertile has the right to any help that modern medicine can provide and increase the possibility of conception, always subject to availability of the appropriate resources and to the consideration of the ethical issues involved ... whilst fertility is not a right, access to services which may restore or improve fertility is a right where such services are provided (Ibid).

Possible Sources of Infertility

Various causes of infertility have been identified which may be both natural and man-made. There are personalistic, natural and man-made explanations of infertility. In most African communities, possible causes of infertility include: acts by people, spirits or witches, which are personalistic explanations for the causes of infertility.

The naturalistic explanations include: the physical, psychological or psychosexual ones. The physical causes of infertility may be general or local. General debilitating diseases and hormone deficiency may produce infertility which may be overcome by the treatment of these conditions. Local abnormalities of the reproductive organs of either husband of wife, which may prevent conception, may be correctable by medical treatment or surgical operation (ibid: 211). The causes may also be psychological or psychosexual which result in impotence in the husband or vaginismus or frigidity in the wife.

Consequences of Infertility

The problem of involuntary childlessness is negatively handled in most African societies. More often than not it carries a hidden stigma and discrimination borne of shame and secrecy. (Linda M. Whiteford and Lois Gonzalez, 1995: 27) In case it is the wife who is infertile, the husband remedies it by taking another wife or mistress to bear children; thus

becoming polygamous. In most African communities, the infertile wife would "marry" another woman to bear children for her, for example among the Gikuyu, Luhyia, Kalenjin among other communities in Kenya. In the attempt to get children, extramarital affairs often occurred uncondemned by the rest of the society (among the Gikuyu, Luo, and Luhyia).

Sometimes, infertility leads to serious consequences such as separation, divorce and marital violence in form of wife battery leading to death. A high premium is attached to children especially male children for other reasons other than continuing the family line. They were also valued for economic reasons. Traditionally the more children a couple had, the wealthier and prestigious they became. The children were used as a means to enrich their families. They contributed the labour force in tilling the family land and looking after livestock. Male children also inherited the family property. Female children were especially valued as they were expected to bring in dowry when they got married in future, "... female children always brought dowry"(Mbiti J.S., 1976: 110).

This perception of attaching high premium on children has, however, changed due to socio-economic reasons. These include poverty where family land has diminished, and parents feel the burden of feeding and educating their children leading to decreasing population rates in some families (Sunday Nation, "Lifestyle", 14th May, 2006: 7). The prevalence of HIV-Aids pandemic has discouraged polygamy to some extent among childless couples. This, however, is not universal as polygamy continues to be practiced amidst poverty and HIV-Aids.

Strategies of Overcoming Infertility

Apart from the strategies mentioned under the consequences of infertility, such as polygamy and extra-marital affairs as attempts to get children, other strategies are employed as well. In most African societies, traditional healers or medicine-men are consulted in order to advice and often treat cases infertility. The medicine-men supply them with counter-measures in form of charms, performing rituals or applying medicines that are swallowed or rubbed into the body (Mbiti, 1976: 170).

Apart from these preventive measures, medicine-men also advise and aided people on how to increase productivity, for example, they treate impotent men and barren women in their search for children.

Apart from these traditional healers/medicine-men, modern medical practitioners are also involved in addressing and solving the problems associated with infertility. Their strategies of overcoming infertility include the removal of any identified cause for infertility. Advice on the optimum conditions for conception is another way of overcoming infertility. Use of drugs to induce ovulation is another way of overcoming infertility. A combination of both oral and intramuscular drugs may be used to increase the possibility of conception. However, these drugs may have adverse negative consequences such as: multiple pregnancies, babies born with missing organs and thus the survival rates of such pregnancies and/or babies are minimal (Wilkinson J. 1988: 211).

Another way of overcoming infertility is artificial insemination (AI). This is mainly used where the husband is impotent or in case where sexual intercourse takes place but the seminal fluid is not effective in producing pregnancy. Artificial Insemination or AI usually takes the form of the introduction of semen into female vagina or uterus by means of a syringe, a procedure that is carried out by a medical practitioner in appropriate clinical surroundings. In the first type, ...the semen comes from the husband of the woman inseminated and so it is called artificial insemination by husband or AIH. In the second type, thesemen comes from a third party and not from the husband, and so this type is called artificial insemination by donor or AID (Ibid, 212).

In AIH, the semen is obtained from the husband by masturbation or *coitus interruptus* or the use of a condom or by aspiration from the vagina after intercourse. The best time to carry out AI is about the time of ovulation. Once the day of ovulation is known, insemination may be carried out several times. In the AID, the semen in obtained from a third party, a male donor other than the husband. he procedure used is the same as in AIH. The identity of the donor is kept secret from the couple concerned. This method is advocated in cases of infertility due to the inability of the husband to produce potent semen, or where the husband is the carrier of some hereditary disease which could be passed onto a child he may father. It is recognized that AID is more successful in promoting pregnancy than AIH because the semen is obtained from a healthy fertile donor. Though this method has been used successfully in developed countries, it is a rare practice in Africa because of its social-cultural and economic implications. The social-cultural implications arise because a third party, "strange blood", is involved. This exercise is also financially prohibitive for most African families. In addition, most religions (e.g. the Roman Catholic Church) term this method as immoral because of the procedure of obtaining the semen.

Another strategy of overcoming infertility is through the In-Vitro-Fertilization (IVF) with Embryo Transfer (ET). The first human pregnancy following IVF and ET was reported by Steptoe and Edwards in 1976, but it was an ectopic pregnancy without a live outcome. Since then, numerous healthy babies have been born following this method of treatment of infertility including twins, triplets, and quadruplets mainly in developed countries. In-Vitro-Fertilization is so called to distinguish it from fertilization that occurs within a living organism or 'in vivo'. It occurs in a glass dish or test tube and is popularly described as resulting in 'a test-tube baby'. In-vitro-fertilization is successful in a high proportion of cases, even up to 85%, but the less than quarter will achieve a clinical pregnancy. Some of these pregnancies will result in spontaneous abortion. The best-established use for IVF is for those couples whose childlessness is due to tubal problems in the wife. However, this is a complex method of overcoming fertility with very high failure rates other simpler strategies that are available should be encouraged for the affected couples.

Embryo transfer of ET is the term used for the procedure by which the embryo produced by in-vitro-fertilization is taken from the glass receptacle or test tube and placed in the environment in which it is hoped that it will become implanted and develop. There are three possible destinations for the embryo in this procedure. The first is the uterus of the wife of the couple being treated for infertility. The embryo in this case may be the product of the fertilization of the wife's ovum by the husband's sperm.

When the child is born, it is handed over to the couple whom the IVF and ET were arranged. This is 'surrogate pregnancy'. It could also be used for less justifiable reasons where the wife wishes to avoid pregnancy for career or other reasons of social convenience and yet have a child. The third possible destination for an embryo transfer is an artificial environment created in a laboratory to create the conditions normally required for intra-uterine growth and development or octogenesis. The first two test-tube babies through IVF were born in Kenya on 8th May, 2006 through caesarian section and were supervised by Dr. Joshua Noreh and a team of four specialized doctors and support staff. This science success story was received with joy by the majority of Kenyans, especially the parents of those babies as well as those who were awaiting to get children using the same method. It was reported that at least one hundred more couples had contacted doctor Noreh to help them have children. This shows that childless couples are desperate to have children as society views their marriages as second rate. There is therefore social pressure that drives such couples to get children of their own despite the social-cultural, legal, and economic implications of the procedure.

Religious groups, civil society, legal experts and the government of Kenya reacted differently to this development. (Daily Nation, 9th May 2006: 5) The author, however, concedes that, though technology has made it possible for couples incapable of getting children naturally, to do so artificially, caution should be taken to ensure that the procedure does not compromise human dignity and moral standards of the society. Civil Society Groups such as the International Commission of Jurists' executive director, Cradle, a child rights organization and a Law Society of Kenya Council member supported the practice of test-tube babies technology. They urged for the need for adoption of a legal framework to resolve conflicts caused by the new technology. Such a law should state clearly

The legal status of the embryos; who 'owns; the embryo after divorce and when a genetic parent dies who should inherit the embryo. There is also the question of who 'owns' the baby especially where the donors request a third party to carry the embryo in her womb (surrogacy) or request for a donor of either sperm or egg. (Daily Nation 10.05.2006: 5)

Experimentation on human life should be restricted especially where human embryos are concerned, because this reduces the human person to an object of experimentation, rather than one with dignity and uniqueness. Embryos are human life worthy of full legal and ethical protection and argue that technology subverts the family, the marital covenant and the creator's gift of sexual union and procreation. The government of Kenya also reacted for the new technology. On May 16th 2006, it moved to ensure IVF or any other reproductive technology would be controlled. The task force would look at the eligibility of women for IVF technology i.e. whether HIV positive women and those over 50 years should be allowed to benefit from the technology; the ownership of the embryo should couples separate before it is implanted into the uterus. It would also evaluate whether restrictions should be placed on the availability of IVF services, what should be done to an embryo found abnormal, risks of genetic manipulation, commercialization of embryo, the role and obligation of the state, the question of parentage if services of a surrogate mother are sought and the handling of embryos and their rights vis-à-vis those of parents. This is a positive move by the government since it aims ensuring that reproductive technology, however successful, is not abused for commercial and selfish purposes.

Another strategy of overcoming infertility is Gamete Intrafalloplain Transfer or GIFT. The technique of IVF and ET involved complex and expensive procedures thus necessitating continued research to find a simpler method of treating infertility, which would be more effective. In 1984, gamete intrafallopian transfer or GIFT was developed in the US. In Britain, this method was referred to as tube sperm egg transfer or T-SET. The first success of this method was a twin pregnancy in the university of Texas Hospital which resulted in the normal delivery of a boy and a girl in 1985. In 1986, the first GIFT baby was born in Britain (Wilkinson J. 1988: 216).

Surrogacy is another way of trying to deal with childlessness. This is a practice whereby one woman carries a child for another, with the intention that the child should be handed over after birth. The surrogate woman is known to the couple and usually signs an agreement to hand over the child after it is delivered and she is paid for it. Surrogacy may have psychological, personal, pathological and social implications. First, there is a risk of emotional involvement arising between the couple and the surrogate woman. Secondly, the surrogate mother's health may be endangered or damaged by the pregnancy if she suffers from one of the pathological complications of pregnancy such as *eclampsia*. Some complications may also arise during the delivery of the child which may endanger her life and/or that of the child. The method may also have problems in relation to the child. A surrogacy agreement may be regarded as degrading to the child since it represents a financial transaction in which the child is bought for money. The child may also be born with some abnormality or handicap or even HIV positive, or may be injured in the birth process with the result that the couple may refuse

to accept it from the surrogate mother, leaving it to face an uncertain future. The registration of the birth may be problematic about what should be recorded on the birth certificate as the identity of the mother and even that of the father, if the husband did not donate the sperm for the IVF. When the child grows up, the problem may arise of informing it about the nature of the conception and birth with all the potential difficulties this may involve.

Another way of overcoming infertility is adoption or fostering of children. However in recent years, there has been a dramatic fall in the number of children available for adoption. The legal process is quite long and complex. These limitations make couples to resort to reproductive technology methods other than adoption of a child.

The final way that can be used possibly in the future to overcome the problem of infertility is through genetic engineering evident in the phenomenon of human cloning. Human cloning means human propagation through asexual reproduction. Sexual reproduction, therefore, may probably not be necessary in order to produce human beings in future in developed. However, this may not be widely practiced in Africa in the near future.

Implications of Treating Infertility

The first basic religious or Christian principle is that the integrity of the marriage relationship must be preserved and no third party should be introduced into the relationship. There is no ethical objection from the Christian point of view, to any procedure aimed at the promotion of pregnancy which is skillfully and responsibly performed and which involves only the husband and wife. (Ibid, 218) Most Christians would be willing to accept the permissibility of AIH and of methods of artificial insemination where only the husband and wife were involved. Some Roman Catholic ethical authorities have objected to AIH on the grounds that it was a method contrary to nature and involved male masturbation in order to obtain semen (Ibid, 219).

In February 1987, the Sacred Congregation for the Doctrine of the Faith issued an official Instruction on Respect for Human Life, in its origin and on the Dignity of procreation for the guidance of Roman Catholic Christians. The second part of the Instruction discussed the permissibility of the various methods of artificial fertilization. The principle was laid down that the act of sexual intercourse was the only permissible setting for human procreation meaning that non-coitus reproduction was not allowed; "IVF with ET even though this involved only the husband and wife was not permissible". (Ibid, 220) Also AIH was only permissible if it followed normal sexual intercourse after which the husband's semen was to be aspired from his wife's vagina for use in the insemination procedure. Only in this way could the unitive and procreative meaning of sexual intercourse be preserved." (Ibid) The main purpose of marriage in the Bible is love and companionship. Procreation is a secondary purpose. Furthermore, in infertile couples, the procreative element is altogether absent for this absence is the very reason why artificial insemination is being performed. "It is therefore difficult to understand an argument against the techniques of AIH based on the need to preserve the procreative element of sexual intercourse when by definition, that element is lacking in cases of infertility" (Ibid).

AID or gamete donation" introduces a new factor into the marriage relationship because it involves a third party, and in case of embryo donation, even a fourth party. For this reason, gamete donation has sometimes been regarded as adultery though it is difficult to justify this new". (Ibid, 122) Adultery is basically the unfaithfulness of one partner in a marriage to the other, but in gamete donation both partners know what is happening and approve of it.

According to Matthew 5:27–28, adultery springs from lust, but gamete donation is an expression not of lust or the desire for sexual pleasure as an end in itself. It is based on the desire of both partners to have a child. There is no sexual intercourse in gamete donation as it is in adultery; "Adultery destroys marriage, the object of gamete donation is to preserve the

marriage and to strengthen it" (Ibid, 123). Therefore, the view that gamete donation is really a form of adultery is wrong.

Gamete donation has also been viewed as immoral because of its emphasis on procreation as the primary purpose of marriage. The purpose of marriage is not procreation but for uniting two individuals of different sex in a loving personal relationship out of this union may arise the conception of another life in procreation thus procreation becomes a secondary purpose of marriage. Emphasizing procreation at the expense of personal union in marriage means "that childlessness in marriage is an unacceptable state and even implying that a childless marriage is a second-rate marriage." (Ibid, 122) This is true also with regard to IVF with ET or test-tube babies phenomenon. This view is unjustifiable and undesirable and may lead to the imprudent desperate endorsement of any procedure, which may lead to the conception of a child irrespective of its ethical and other implications. Though AIH and IVF with ET preserve the marriage relationship, AID does not. However, "the desire for conception irrespective of its source or cost cannot be regarded as a responsible or Christian attitude." (Ibid) It is God who is the giver of life.

Gamete donation or AID is objected to, because it introduces into the marriage relationship a third party. Marriage is essentially a covenant between husband and wife, and gamete donation cannot but disturb that relationship by introducing a third party that is not bound by that covenant. The third party cannot be the subject of a fully free and informed choice by the couple concerned because the identity of the donor remains anonymous. The identity of the donor will remain unknown to them and to any child born as a result of gamete donation. Complications can also arise such as legal ones with respect to birth registration and inheritance. There is likely to be a problem with regard to the identity of the child and also with who his or her parents are whether biological or social.

Another objection to gamete donation is that it lays the foundation for future unhappiness in marriage; the child conceived by gamete donation is a constant reminder of the infertility of one or both partners to the marriage. The donor child incarnates the existential fact that their one-flesh unity is now divided. This child does not yet exist and its interests cannot yet be safeguarded. This is also true with regard to IVF with ET or test tube babies; "This too may lead to future domestic and legal difficulties especially on the premature death of the husband and wife" (Ibid).

Transmission of disease from the donor is another reason for objecting gamete donation. "Infectious diseases such as the acquired immune deficiency syndrome or AIDS may be transmitted by the sex cells of either parent to the embryo which results from their union. If this occurs, then the child may be born already infected with the AIDS virus and may go on to develop AIDS that is invariably fatal".(Ibid) This is also true of IVF with ET or test tube babies. Another type of diseases that can be transmitted by gamete donation is that which results from genetic abnormality in the donated sex cell. These include cystic fibrosis, which appears in infancy and Huntington's chorea which presents in adult life. Disease may also be transmitted from the donor to the recipient of the donated sex cells as well as to the embryo especially with regard to HIV-AIDS.

Gamete donation is also objected to since it is argued that it is not the only option open to the infertile couple. There are other options open to them such as AIH, IVF/ET or GIFT within marriage. Gamete donation may also involve deception at the registration of birth of the donor child if the name of the social father is put on the birth certificate instead of the name of the genetic or biological father. Gamete donation may have a remote risk of consanguity if the donor is related to the husband or wife and this is unknown to the doctor arranging the procedure. There is also the risk of blackmail by the donor or other persons if information

about the identity of the couple or the procedure is leaked to them and they are unscrupulous enough to use it for this purpose.

Another problem is that the procedure makes difficult the keeping of accurate genetic records where it becomes necessary to compile these for clinical purposes in the future. This is because the donor is unknown so is his or her genetic history. The provision of facilities for the practice of gamete donation also raises the question of service priorities in the allocation of resources. This is because of the specialized nature of the facilities that may require a number of nurses, gynecologists, geneticists, medical social workers and doctors.

Another issue is that the infertile couples are in good health for infertility is not a disease and is never fatal. Gamete donation is expensive and time-consuming and it may be questioned whether it is justifiable to use finite resources to fund it when these resources could otherwise be used for the prevention and treatment of diseases which are more disabling and serious than the symptom infertility could ever be. In Kenya, this may be true because there is the HIV/AIDS pandemic and malaria, which may be more serious than infertility. IVF with ET or test tube babies possibility in Kenya costs about 300,000 Kenya shillings which is far beyond the reach of majority of Kenyans who live on less than a dollar a day. However, gamete donation can be justified because it meets a real human desire. Every married couple has the desire to have a child in order to be happy. The moral character of gamete donation or IVF with ET is however, questionable in as far as meeting this human desire is concerned. Another justification of gamete donation by a third party to the marriage is that it is equivalent to the donation of tissues and organs in skin grafting, blood transfusion and organ transplantation, therefore it should be permitted. However, there is a significant distinction between these two types of donation. The nature of the procedure must be taken into account and also the consequences of the introducing a third party into the marriage relationship for that relationship, and for the child conceived by the procedure.

Another argument is that it will often save a marriage, which is in danger of breaking up because of the inability of the couple to have children. However, the use of gamete donation in order to save a marriage is not a responsible use of the procedure because of the additional stress within the marriage, which it may produce, particularly if it fails to promote pregnancy. This is also true with IVF with ET. Use of reproductive technology is not therefore a remedy for it. Gamete donation is sometimes justified on the basis that it is really a form of adoption or even semi-adoption when one of the parents is the father or mother of the child. However, "the anonymity of the donor means that there is no real parallel with adoption for the stringent requirement of the adoption process cannot be applied and the future of the child safeguarded as they can be in adoption". (Ibid, 223)

It appears then that the only argument for gamete donation is that derived from compassion for an infertile couple and whose desire for a child might be satisfied by this procedure. There are certain guidelines that would be generally accepted and found to be relevant in any consideration of the problem of the infertile couples. These are that: i) the investigation and treatment of infertility should only be carried out for a legally married couple; ii) the investigation and treatment of infertility should only be carried out if marriage is 'happy' and 'stable'; iii)the written consent of both husband and wife should be obtained after a fuller explanation of what is involved has been given and accepted by the couple including details of all the stages and procedures which may be necessary in the management of the situation; iv) the need for the investigation and treatment of their infertility should be assessed in the light of the other needs of their situation and the priorities for the use of the facilities and resources which will be required; v) the option to withdraw from the investigation and treatment at any stage should be provided for the couple if the stress and strain of the procedures become intolerable for them; vi) the investigation and treatment of the couple should not be

conducted on a purely biological basis but should give due consideration to their personal dignity and emotional reactions; vii) full counseling services should be provided for both husband and wife and should cover all the relevant personal, social and spiritual factors of the situation of the couple; viii) nothing should be done which will involve deception on the part of any party in the present or in the future and ix) finally no procedure should be regarded as acceptable which may produce an abnormal embryo or child.

Conclusion

Childlessness can be a source of grief and unhappiness to a married couple but it needs not be. There are many infertility married couples who have found happiness and fulfillment in the services of their fellows. However, there are many ways of trying to overcome infertility that are available to a married couple. The fact that certain procedures can be done to promote fertility does not mean that they ought to be done. Whether they should be done will depend on considerations other than the availability of technical knowledge or medical technology to do them. These are religious, moral, social, legal and economic considerations as discussed in the paper.

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