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To cite this article: Trudie Gerrits (2018) Reproductive Travel to Ghana: Testimonies, Transnational Relationships, and Stratified Reproduction, Medical Anthropology, 37:2, 131-144, DOI: 10.1080/01459740.2017.1419223

To link to this article: https://doi.org/10.1080/01459740.2017.1419223
Reproductive Travel to Ghana: Testimonies, Transnational Relationships, and Stratified Reproduction

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**ABSTRACT**

In this article, I address reproductive travel to Ghana, based on research conducted in two private fertility clinics. Both clinics attract clients from West African countries as well as Ghanaians living in the US and Europe. Their motivations to visit these clinics include positive “testimonies” about treatment results, “bioavailability” of matching donor material and surrogates, lower treatment costs and the circumvention of restricting regulations in the country of residence. Communication technologies are central in facilitating reproductive travel. Finally, I argue that the “international choreographies” of reproductive travel are co-shaped by the unique biographies and transnational relationships of the people involved.

**KEYWORDS**

Ghana; assisted reproductive technologies; donor material; reproductive travel; surrogacy; testimonies

Cross-border reproductive travel – the transnational mobility of women and men in search of medically assisted conception – has become increasingly common over the past decade (Gürtin and Inhorn 2011; Hudson et al. 2011; Inhorn and Patrizio 2012; Whittaker and Speier 2010). However, scholarly attention on cross-border reproductive travel has been limited in geographical scope. Scholars from different disciplines, including ethicists, legal and medical scholars, and anthropologists, have mostly focused on reproductive travel within Europe (with Belgium, Spain, Cyprus, the Czech Republic, and Switzerland being the major destinations), and from and to Europe and/or North America (Hudson et al. 2011; Inhorn and Gürtin 2011). Only a few anthropological studies have been conducted beyond European and North American settings; these include studies on reproductive travel to India (Pande 2009, 2011; Rudrappa 2010), Thailand (Whittaker 2009; Whittaker and Speier 2010), and to and within the Middle East (e.g., Inhorn 2011, 2015; Inhorn and Shrivastav 2010). Little is known about reproductive travel from, to or within the African continent (Inhorn and Gürtin 2011). A few anthropologists have referred to cross-border reproductive travel undertaken by people from Africa to the USA (Bochow 2015), Europe (Hörbst 2015), the Middle East (Inhorn 2011), and India (Deomampo 2013). On the continent, South Africa in particular is a destination for reproductive travel from European countries (Bergmann 2011a, 2011b), as well as from Mozambique (De Faria 2016) and Botswana (Bochow 2015). However, a comprehensive analysis of people’s motivations for and experiences of reproductive travel to and from African countries does not yet exist. This article, based on fieldwork that I conducted in two private Ghanaian fertility clinics, is the first to explicitly explore reproductive travel to Ghana. In my study, I found reproductive travel to be common. While both clinics provide ARTs to Ghanaians and ex-pats living in Ghana, they also attract clients from neighboring West African countries such as Gabon, Nigeria, the Ivory Coast and Burkina Faso, and Ghanaians living in the diaspora in the US and Europe who return home to use ARTs. During my fieldwork, the clinics did not (yet) attract European or American clients without any connection to the country.
Hudson and colleagues (2011) and Gärtin and Inhorn (2011) have reviewed what motivates women and men worldwide to cross borders to achieve their reproductive goals, describing push and pull factors. Push factors are related to the situation in the person’s or couple’s country of residence, such as legal or ethical prohibitions, the high cost of ARTs, shortage of services or perceived low quality services. Pull factors pertain to the setting or clinic where treatment is performed, such as the clinic’s reputation, availability of matching donor material and surrogates, absence of limiting regulations and guidelines, and treatment affordability. In addition, Inhorn (2011) noted that diasporic Middle Eastern couples return to their home countries for ARTs because of “patriotic pride in one’s country and its medical system” (587), linguistic familiarity, comparable religious and moral positions, being surrounded by the comforts of home, and the absence of cultural discrimination.

While the motivations for reproductive travel show similarities across various sites, context specific features of country of residence or treatment destinations may also shape people’s motivations. Whittaker and Speier (2010), for example, observed that popular destinations for reproductive travel such as Thailand “usually have evolved through a combination of sophisticated medical infrastructure and expertise; particular regulatory frameworks (or the lack of them), which enable certain procedures; and lower wage structures, which allow ARTs to be performed at competitive lower costs than in other European countries” (365). Bergmann (2011b) noted that people do not move “unidirectionally from point A to point B,” but employ “multilayered strategies” with reproductive travel being “intertwined with biographical reasons, gender and identity, social networks and imagination” (602). This results in highly diverse trajectories, forming “multiple international choreographies” (Gürtin and Inhorn 2011:536; Thompson 2005) with considerable variation in detail and form. Here, I add to the project of understanding the diversity of these international choreographies by focusing on the experiences of women and men travelling to Ghana to access ART.

Reproductive travel is enabled by processes of globalization that facilitate the transnational travel and flow of people, (medical) technologies, information and ideas (e.g. Franklin 2011; Martin 2009; Deomampo 2013). Whilst “new” forms of information and communication also shape the global ART industry, Sarah Franklin (2011) reminded us that reproductive travel also implies a continuation of existing practices. First, motivations underpinning reproductive travel are not novel, but reflect established practices and values, including “kinship obligations, conjugal aspirations, religion, national identity and so on” (815). Second, transnational travel and migration have – throughout history – always been ways for people to escape “restrictive conditions and limitations at home” and find new opportunities elsewhere (815). What is new, Franklin asserts, is the particular form that the globalization and pursuit of ARTs takes, as the convergence of the global IVF and tourism industries lead to particular choices, dilemmas and challenges (cf. Gürtin and Inhorn 2011). Further, Franklin (2011:815) contends, the expansion of the ART industry is neither predictable nor consistent, and contradicts homogenized views of the processes of globalization and technologization. Thus, “it will be necessary to attend to the wide variation in motivations and experiences that lead people down certain paths rather than others, precisely in response to the ways in which global ‘levelling’ is not occurring” (815).

Other scholars have pointed to the “very unevenness of globalization” (Martin 2009:261) that is reflected in, reproduced by and even increased through global reproductive travel, leading to “stratified reproduction” (e.g., Colen 1995; Deomampo 2013; Hudson et al. 2011; Martin 2009; Pande 2009, 2011). First, infertile couples who have access to information and can afford to travel can “circumvent the material and regulatory conditions of their home countries” (Martin 2009:254), enabling them to profit from globalization in ways that poor infertile people cannot. Secondly, wealthier infertile women and men can make use of the “bioavailable” wombs and gametes of less well-off women (and men) (Cohen 2005; Whittaker and Speier 2010). Surrogacy and egg donation – and the same could be said for sperm donation – have been alternatively framed by (feminist) researchers as forms of exploitation and victimization, or as reflecting reproductive freedom and
agency (Kroløkke and Pant 2012). Based on my conversations with surrogates during fieldwork, I am not inclined to consider them as (merely) victims of the ART industry (Gerrits and Hörbst 2016; Gerrits 2016a). These reproductive jobs provide them with financial opportunities that they would not otherwise have had. Without denying the potential for exploitation, I frame surrogacy as a survival strategy and as reproductive labor (see also Nahman 2011; Pande 2011; Rudrappa 2012).

In this article, I first sketch the context of ART provision in Ghana and subsequently delve into women’s and men’s motivations to travel to Ghana to make use of ARTs. Through the presentation of five case studies – chosen to reflect the variation in motivations I found – I explore what makes people facing fertility problems travel across borders to access Ghanaian clinics. I discuss both structural features in the countries of residence and in Ghana, and the particularities of personal biographies and (transnational) relationships that shape patterns of reproductive travel.

**Setting and methods**

This article is based on ethnographic research conducted over two periods in 2012 and 2013 (three months in total) in two private ART clinics in Ghana (which I identify with pseudonyms as LeleNa and Goornor clinics). The fieldwork was integral to a comparative research project focusing on the mobility of people, technologies, artifacts and knowledge associated with ARTs in Sub-Saharan Africa (SSA). The larger project tracked the transfer and appropriation of ARTs to Ghana and Uganda, as well as the search for fertility treatments and ARTs by Mozambican women in Mozambique and South Africa (Hörbst and Gerrits 2016; De Faria 2016).

I obtained permission to conduct the research from the clinic directors (both gynecologists who specialized in ARTs in Europe) and ethical clearance from the Noguchi Memorial Institute for Medical Research-IRB in Accra, Ghana. LeleNa clinic was the first private clinic to offer ARTs in Ghana in 1995. Goornor clinic opened in 2004 and performed its first successful IVF cycle that year.

Data were collected through interviews and casual conversations with staff, women and men with fertility problems visiting the clinics, and surrogates. I also conducted observations in clinic spaces, including consultation and treatment rooms (when staff and patients gave permission), the IVF laboratory in Goornor clinic and the “baby room” in LeleNa clinic. In Goornor clinic, I occasionally joined the doctor’s ward round. Hanging around gave me insight into clinic routines, interactions and conversations among staff and patients, and the concerns expressed by women and men. It also allowed me to select and approach 30 women and six men for interviews.

Most interviews were held in English (one in French). Selection of informants was purposive and aimed to include a broad range of people, in terms of their use of ARTs and place of origin. Out of 36 informants, 16 had travelled across borders, with five living in neighboring countries, eight in Europe and three in the USA. These men (4) and women (12) are the focus of this article. The average age for the women was 41 (from 25–53 years) and 45 for the men (33–53 years). Most informants had finished high school, some also had a university degree, and most had relatively good jobs or ran their own companies. One of the women profiled herself as “housewife;” one woman was jobless, and her husband worked in lowly paid road construction.

I interviewed some women and men while they attended the clinic for consultations or examinations, while others were interviewed during hospitalization following a fibroid operation or embryo transfer, and I was able to speak with some informants more than once. Interview questions concerned informants’ personal fertility history and fertility seeking behavior; reasons for coming to Ghana and the specific clinic; treatment experiences; views on ARTs (including the use of donor material); and the impact of the treatment on their personal lives, including financial issues. Additionally, I interviewed six surrogates during their pregnancy and/or after delivery and 12 staff members, including gynecologists, embryologists, nurses and nurse-counselors.

A subset of these data is used for this article. All informants, including the women and men coming for treatment and the surrogates, were asked to sign informed consent forms before participating in the study. Most interviews were recorded and transcribed. When the interviewees
preferred not to be recorded, handwritten notes were made. All names used in this article for clinics and respondents are pseudonyms.

**Assisted reproductive technologies in Ghana**

Ghanaian mainstream culture expects a married couple to have children; the total fertility rate for women aged 15–49 is currently four children per woman (Ghana Statistical Service, Ghana Health Service, and ICF Macro 2009). Couples need to have children to give meaning and worth to marriage and in order to be socially accepted and respected as complete human beings. With infertility prevalence of around 15 percent for Ghanaian women (Ghana Statistical Service et al. 2009), infertility rates are quite high. About 40 percent of men are estimated to be the primary cause of couple infertility. Childless people – in particular women – may suffer tremendous social and conjugal consequences (see e.g., Donkor and Sandall 2007; Dyer 2007). Women (and men) with fertility problems seek treatments from spiritual sources, traditional healers and biomedicine, in particular in the private health sector (Hiadzi 2014). The cultural importance of childbearing in Ghana, in combination with a national policy encouraging private health care and the existence of a growing economic middle class, has enabled the establishment of private fertility clinics (Hörbst and Gerrits 2016).

Privatization of the health sector in Ghana started at the late 1980s and early 1990s in response to a failing public health system, resulting from economic and political crises in the country (Blanchet, Fink, and Osei-Akoto 2012:76). In this period the World Bank with the International Monetary Fund enforced structural adjustment programs in Ghana (as in many other sub-Saharan countries), supporting privatization and liberalization in order to enhance economic development. In addition, the World Health Organization and the World Bank introduced a policy favoring private health care for Africa (Vasconi 2011). In the long term, these reforms encouraged and enhanced the privatization and commercialization of African health care systems, including in Ghana. In the last decades, curative care has increasingly been provided by the private sector; by 2010 private practitioners produced more than half of all health services used in Ghana (World Bank 2011:1–2). Ghana has also introduced a policy of public-private partnerships supporting the private health sector.

Unwanted childlessness is a lucrative field for private health care. Even more so AS, unlike FOR many other reproductive health issues and HIV/AIDS, no transnational NGOs are active in this field. This has enabled local private practitioners to cater to the needs of infertile Ghanaians (Hörbst and Gerrits 2016; Gerrits 2016b). Currently, 14 private clinics, most in or near the capital city, Accra, offer ARTs.6 Ghana is one of the few SSA countries – with Nigeria (16–20 clinics) and South Africa (12–15 clinics) – hosting a substantial number of IVF clinics (Giwa-Osagie 2002; Inhorn and Patrizio 2015).

The two clinics in which I conducted research received neither a government subsidy nor international financial support. The pioneering and entrepreneurial clinic directors invested their own (and others’) money in the clinics, thus taking on considerable personal financial risk. While IVF has been provided in Ghana since 1995, there are no legislation or professional regulations on the use of ARTs. Thus, the clinic directors are in the position to decide on clinical and laboratory procedures and practices (Hörbst and Gerrits 2016). Furthermore, clinic success rates are neither centrally registered nor made available to the public. Ghana may thus be described as neoliberal in its ART policy as it largely relies “on self-regulation and market forces,” similar to the US which lacks a central ART policy or ART registry (Martin 2009:256). In 2016, however, professional organizations for embryologists and IVF specialists have been established in Ghana, and this may lead to the creation of national regulations.

Both Ghanaian clinics I studied provided intra-uterine insemination (IUI), in-vitro fertilization (IVF) and intracytoplasmic sperm injection (ICSI), including the use of donor gametes and surrogacy. In both clinics, more treatments involved ova than sperm donation. The clinics recruited and screened their gamete donors themselves. LeleNa clinic also performed all related non-medical tasks associated with surrogacy, including recruiting, screening, informing, contracting and organizing...
legal procedures. Goornor clinic used the services of an intermediary agency for surrogates. In both clinics, recruited gamete donors were generally university students; the surrogates were lower educated and single mothers.

Since Ghanaian national health insurance does not cover ARTs, most women and men paid themselves for these expensive treatments. IVF procedures in both clinics cost around US $2500–3000 (excluding examinations, medication, ultrasounds, stays in the clinic, and so on). ICSI and treatments with the use of donor material or surrogacy were much more costly. A few could rely on private (international) health insurance. Most study participants belonged to the middle or upper classes, although not all were wealthy. Some of them saved for a long period of time, took out bank loans, or gained support from relatives to cover the treatment costs.

Clinic reputation and perceived quality of care

In Nigeria, the quality of the treatment is low. There is little human concern. It is only about money making. There are no feelings of caring. The caring here [in LeleNa clinic] is much better. In Nigeria, they release the women to go home. But what do you do when something is happening in the night? You don’t know! Here they want the women to stay in the clinic [after the embryo transfer] and that is good. In Nigeria, they don’t have lodging in the clinic; here they have it. (Rebecca, 45, originally from Nigeria, residing in the Ivory Coast)

When I asked my informants why they came to the particular clinic where I met them, most – from within and beyond Ghana – mentioned in the first instance the clinic’s good reputation. Most couples found their way to the clinics through “word of mouth.” The senior doctor of the LeleNa clinic especially seemed to have built a strong reputation in the West African region as a successful IVF pioneer.

Reputation was also what attracted Rebecca, quoted above, and her husband John to LeleNa clinic. When I met them, Rebecca was four months pregnant with triplets and hospitalized in this clinic. Rebecca and John were originally from Nigeria – which has the highest number of IVF clinics in Africa (Giwa-Osagie 2002). They had been living for many years on the Ivory Coast, where she was a successful trader and he worked as a car mechanic. They had been together for 25 years and had visited many traditional healers and doctors in their search for fertility, but – to their great sadness – always in vain. Some years ago, John’s family had arranged for another woman for him in the hope that she would conceive a child. When Rebecca learned of this, she was very upset. She then involved her own family and a church leader, hoping to solve their conjugal problems. The couple then decided to attempt IVF. While Rebecca initially planned to attend a Nigerian IVF clinic, a fellow trader from Kumasi advised her to go to LeleNa clinic in Ghana, suggesting that “treatments would be better and cheaper over there.” She told her: “Many people go there. Also they come from London for treatment there. In Nigeria they do not stay in the clinic [after the embryo transfer]; here [in LeleNa clinic] they stay.” Following this recommendation, Rebecca and John travelled to LeleNa clinic, where Rebecca was diagnosed with fibroids, for which she was immediately operated. John in turn had a low sperm count, for which he was treated. They agreed to return for IVF after Rebecca had healed from the fibroid operation, and the doctor advised that given Rebecca’s advanced age, they had no choice but to attempt IVF using donor eggs. While John initially did not like the idea, the doctor reassured him that “it would not make a big difference.” Upon their return to the clinic, they used IVF with ova donation and conceived on their first attempt.

While Rebecca stayed in LeleNa following the embryo transfer until delivery – which was advised given her advanced age (45 years) and the fact that she was pregnant with triplets – John traveled on a monthly basis from the Ivory Coast to visit her. In the various conversations I had with them, they were very grateful to the clinic doctor who had successfully treated them and they felt well taken care of by the clinic staff. Both emphasized the importance of Rebecca being able to stay in the clinic after the embryo transfer, even when this increased the treatment cost enormously, which Rebecca covered by using her savings and selling her car. They felt that as long as they could return home with their children, it would be worth the expense. Other women attending LeleNa clinic also
mentioned this extended hospitalization following the embryo transfer as an important reason for coming to this clinic. However, some women disliked the fact that they were strongly advised to stay so long in the clinic. They were upset about having to spend a large amount of money on top of their expenses for fertility examinations, medicines, the IVF, and – for some – the use of donor gametes. While Rebecca and John saw the possibility of prolonged hospitalization as a marker of the quality of the care – adding to their overall satisfaction – for others this was not a reason for coming to the clinic. As Mol (2008) has also observed, what people consider to be good care is highly variable and very much depends on particular circumstances, experiences and contexts.

**Testimonies and matching donor material**

The women and men I spoke to were unanimously attracted by “testimonies” – or success stories – they had heard or read on the Internet about the clinic they visited. The importance of testimonies is well illustrated by the case of Grace, a Ghanaian woman who had lived in the Netherlands since childhood, but had returned to Ghana for fertility treatment. Grace had undergone fertility examinations in the Netherlands and was diagnosed, at 35 years old, with early menopause. As she put it, she had “no eggs left.” The only remaining option was to attempt IVF with egg donation, but the Amsterdam clinic could not arrange a “matching” egg donor for her. Her Ghanaian friends recommended that she return to Ghana for IVF where egg donation would be more accessible. This was convenient for her because her partner lived in Ghana and traveled to and from the Netherlands as a trader in secondhand goods.

Grace was born in Kumasi, where an IVF clinic had recently opened. She had informed herself about this clinic and found that the costs for IVF were much lower there than in the clinics in the Accra region. However, she opted for LeleNa clinic in Accra, because she had not heard any testimonies about the Kumasi clinic:

> So there [in Kumasi] it was also much cheaper, but I didn’t get anybody telling me ‘Yeah, here is good’ or ‘I did my own there.’ I didn’t get any testimonies from there. Only here [LeleNa] did I get testimonies … I said ‘Let me come to [LeleNa clinic]. It doesn’t matter the cost.’ (Grace, 35, originally from Ghana, residing in the Netherlands)

Seeing and hearing about the clinic’s treatment success was a paramount criterion for women’s and couples’ choice of clinic. Virtually all couples were guided by success stories, sometimes reported in the local newspaper (in particular regarding LeleNa’s status as a pioneer clinic) or on the Internet. Most women did not know their chosen clinic’s actual success rate – only a few had asked. For example, when I asked Caroline, a Ghanaian woman who had lived for 14 years in the US, why she had chosen for LeleNa clinic, she immediately responded: “They have a good track record. Many successes. More results, more than in other hospitals.” When I asked how she knew about these results, she underlined once more the importance of word of mouth:

> You know, through conversations, the Internet. It was the first clinic in Africa [sic]. They talk about him [the clinic doctor] a lot. People from many other countries come here. From Togo, Nigeria, etc. Every time I come here I see a lot of people. People believe in him. (Caroline, 41, originally from Ghana, residing in the US)

Although only a few women had asked about the clinic’s success rates, many had communicated via the Internet with clinic staff about various other aspects of ART treatments, long before actually visiting the clinic. Overall, there seemed to be limited interest in clinic statistics, as observed elsewhere (Paxson 2006:493). Clients’ trust in their chosen clinic’s performance was thus not based on transparency about clinic’s actual success rates, but on the verbal evidence of babies being born in the clinic. In addition, photographs of babies pinned up in some of the doctors’ consultation rooms, including several of twins and triplets, contributed to the image of the clinic as successful.
The provision of trustworthy statistics, upon which women and men facing fertility problems could make well considered decisions and choices about their use of IVF, has become a core feature of patient-centered infertility care in the global north (Gerrits 2016c). However, the reliability and relevance of often highly generalized success rates have been criticized: women and men with fertility problems question what these percentages actually tell them about their own situation and chances, as many different factors determine the success of ARTs (Gerrits 2016c:159–162). Annemarie Mol (2008) has argued that good medical practice has little to do with “patient choice,” but rather with “patient care.” As discussed above, there was considerable diversity in people’s views of what good care entails, but for many of my respondents, good care was reflected in the concrete evidence of babies born. The testimonies were thus of paramount importance for their choice of clinic.

**Patriotic pride and matching donor material**

Elizabeth (46), an African-American woman (with a Ghanaian mother) and a nurse, also commented on the importance of word of mouth when referring to the fame of Goornor clinic: “You just ask – it is all word of mouth. They do not even have to advertise here.” Elizabeth, who had lived most of her life in the US, and her husband Richard, a wealthy Ghanaian businessman, emphasized that trust in the clinic’s capacities was an important reason for undergoing treatments “at home.” While this couple would have had no problem paying for more expensive IVF treatments elsewhere, they chose to go to the Goornor clinic.

Elizabeth’s quest for a child started in 1991, when she married her first husband and conceived – naturally – for the first time. Unfortunately, it was an ectopic pregnancy that had to be interrupted, and because of this she lost her first fallopian tube. Not long after the same occurred again, and despite efforts to save it, the second tube was also seriously damaged. “So then both tubes were blocked. And the marriage did not work as well!” Elizabeth divorced and remained single until she remarried in 2006. With her new partner, at the age of 40, she underwent her first IVF attempt in the US, which she combined with preimplantation genetic diagnosis (PGD), a procedure recommended “to diagnose the embryos.” While the IVF resulted in a “perfect embryo” for transfer, fibroids complicated the transfer, and the first IVF attempt failed. After her fibroids were surgically removed, she had to wait a year before attempting another round of IVF, which again failed. Elizabeth felt devastated, her second marriage “went downhill,” and once again she divorced.

In 2009, when visiting her family in Ghana, she met her third and current husband, Richard. Richard had two older children with his former wife, who had recently passed away. After a while they decided to try to have a child together. Financially, they could afford to travel elsewhere, but they decided to try IVF in Ghana. Richard had said, “I feel that we have good fertility doctors here in Ghana. So let us do it here.” Elizabeth had fully agreed. This expression may reflect what Marcia Inhorn (2011) has called “patriotic pride,” and is a factor which emerged in some other stories as well.

Elizabeth and her partner had to use both donor eggs (as she was 46 at this point) and donor sperm (as Richard had undergone radiation therapy to treat scrotum cancer). “Matching” donor material is readily available in Ghana on a commercial basis and its provision is neither prohibited nor regulated. The clinic doctor had promised that he would find a donor that would match her skin color (which was rather fair), and with a smile Elizabeth added, “of course we want the donor to be healthy and intelligent.” The latter criteria were also somewhat guaranteed by the clinic, which mainly seeks university students as gamete donors. Furthermore, Elizabeth knew that both donors were Ghanaian, something that she highly appreciated, and which – again – might be linked to patriotic pride.
Escaping restrictive regulations

In Europe, at a certain age you are too old. But as an African woman, you are out when you don’t have a child. (Gloria, 52, originally from Ghana, residing in the UK)

For most Ghanaian participants living in Europe or the US, reasons for returning to Ghana included restrictive regulations and conditions in their country of residence (cf. Gürtin and Inhorn 2011). These included: the maximum age of the woman in order to be eligible for IVF; legal prohibitions against the (commercial) use of donor material and surrogacy; the lack of surrogates or matching donor material; and the high cost of ARTs, donor gametes and surrogacy.

Gloria, quoted above, was considered too old for IVF in her country of residence, the UK, where she had lived for almost two decades. When I met her, she was 52 years old and three months pregnant with twins. She had migrated to the UK in her twenties and for many years she had – from a distance – taken care of her orphaned siblings back home. She had become a successful businesswoman in London. In 2001, she had become pregnant spontaneously for the first time, but miscarried. In 2005, at the age of 45, she had unsuccessfully attempted a round of IVF in London. Somewhat later, she had wanted to try IVF again in London, but was then told that she was too old. A friend who had undergone successful treatment in LeleNa clinic told her about it. Gloria subsequently visited the clinic and decided that she would try IVF with donor ova: “With my age they did not want it [treatment with her own eggs]. They did not want to attempt it – so forget about it!” Her friend who had done a successful IVF attempt in the clinic herself (at the age of 53–54) had used a surrogate. But Gloria told me decisively: “I want to carry it myself. In the UK, you can’t do it at this age. You don’t get that many chances as here in Africa.”

After the examinations, she returned to the UK to prepare financially. She had also arranged her own egg donor, but in the end “they did not use her eggs” because the intended donor’s blood group was genetically incompatible with her partner’s blood group. So another donor, arranged by the clinic, was used for three IVF cycles. In the first two cycles, only one embryo was transferred because of her “advanced age,” which she was clearly not pleased about. Each time her husband had to fly from the UK to hand over semen, as the clinic did not freeze sperm because of the high costs involved. Her husband had become a bit reluctant – “he was moaning,” Gloria put it – to travel a third time to Ghana to provide semen, but Gloria managed to convince him to do it once more. In the third IVF cycle, “more than one egg” was transmitted. “Only because my husband had explicitly consented to it, they [the doctor and embryologist] had been willing to do so,” Gloria stated. This third IVF led to her pregnancy with twins. Gloria was very content that the clinic had allowed her to have IVF at her age – in contrast to the UK – and had been able to arrange an egg donor for her.10

Several other Ghanaian informants residing abroad referred to similar constraining conditions in their country of residence and the expanded possibilities that were available in Ghanaian clinics.

Lower costs, but still costly

You see, with this program, if you have a problem – if a rich man is facing this problem, it is not too difficult for him, because he has some amount [of money] to do it. But people like us, if you have this problem, we don’t have money, and you have financial problems, you always think of financial [implications]. At times you come here [to Goornor clinic], you think you use 100 Cedis [at that time about US $26], 100 Ghanaian Cedis for medicine. When you come here, he [the doctor] prescribes medicines, and it passes 100 Ghanaian Cedis. Very difficult. (Daniel, 33, originally from Ghana, residing in Spain)

For Daniel and his wife Linda (25), the costs of the treatments needed to resolve their infertility were their main reason for returning to Ghana. They were the youngest couple I interviewed and had been married for seven years, five of which they had lived in Spain. In contrast to most other couples I met, this couple was not financially well off and had low levels of formal education. In Spain, Daniel worked in road construction and Linda was unemployed. Since puberty, Linda had experienced menstrual problems. Daniel and his family knew about this when they married, and it
was not an obstacle. Daniel stated that his family loved her very much. “They like me, but they love her,” he emphasized with a broad smile.

Whilst living in Spain they had begun to inquire about fertility treatments. However, for them – not being permanent Spanish residents – it was difficult to access a public hospital, and the private clinics were far too expensive. Friends had told them about the fertility clinics in Ghana, which encouraged them to return home and visit Goornor clinic. The gynecologist they consulted diagnosed Linda with “a small womb” and had been able to “enlarge it.” The next step proposed was IVF with egg donation. However, they were unable to pay for this. When I interviewed them, they had already spent 14,000 Ghanaian Cedis (at that time about US $3600). They were informed that IVF without an ova donor would cost US $2500; and ova donation would increase the costs substantially, though exactly how much they did not yet know. In desperation, they had informed Linda’s family that they were undergoing fertility treatment in the hope that they would be able to assist financially.

In the quote above, Daniel expresses his concern about the high costs involved in IVF and the subsequent inequality in access to treatment, referring – in his own terms – to the notion of stratified reproduction, implying that some people, for structural or cultural factors, are more empowered to reproduce than others (Colen 1995). When Daniel and Linda returned to Ghana in the hope of accessing more affordable fertility treatments, they were confronted with the high treatment costs charged in the Ghanaian private sector.

The high costs of ARTs were a recurrent theme in many interviews, for women and men living in Ghana, as well as for those traveling from abroad. While a few mentioned that they could (easily) afford these expensive treatments, many others described how they struggled to pay. Their strategies included selling their cars, borrowing money, asking for support from relatives and saving money (sometimes postponing the treatment trajectory significantly). Nevertheless, some of the Ghanaians residing in Europe or the US mentioned the “relatively lower costs” as one of their reasons for returning to Ghana.

The high cost of surrogacy in the US was, for example, the reason for one Ghanaian woman who had lived for many years in the US to return to Ghana. When I met her, she had recently become the mother of twins born through surrogacy. While she was taking care of her twins in the baby room, she confided that in the US she would never have been able to make use of a surrogate; this option would have been far too expensive. She was therefore extremely happy that more affordable surrogacy was offered in Ghana, the country where she had been born. This points to another form of stratified reproduction: the only reason that she could afford surrogacy in Ghana was that surrogates in this clinic earn much less than surrogates in the US, as a result of the competitive “lower wage structures” (Whittaker and Speier 2010:365) that prevail in Ghana (see also Gerrits and Hörbst 2016; Gerrits 2016a).

Transnational relationships

Finally I want to draw attention to the ways in which transnational relationships, where one partner lived in Ghana and the other abroad, shaped patterns of reproductive travel in this study. In the stories of my informants, I noted different forms of and reasons for transnational relationships. One example is the relationship between Grace and her partner, introduced above. Grace was living permanently in the Netherlands, while her partner commuted as a trader between Ghana and the Netherlands. Other transnational relationships involved one partner temporarily studying or working abroad. In some cases, this gave temporary access to subsidized health care, including IVF, for the partner residing in that country (e.g., the Netherlands, Sweden and the UK). For the other partner, residing apart complicated IVF access, as treatment typically involves both partners.

Another situation was that of Sheryl, who I met in Goornor clinic. Sheryl (41) had been living in the US for 14 years, after initially going there to study. She had married in the US, but divorced in 2007. Her current fiancée was a Ghanaian man who had been a longtime acquaintance. They “met again” in 2008 over the Internet, and started a relationship, maintaining intensive contact over
Skype. The period they started the treatment was also the very first time that she and her partner had met “face to face” since starting their relationship. Over Skype, they had decided to have a child together. As they knew that she had blocked tubes and would need IVF to conceive, she had arranged an appointment at the clinic and planned to undergo IVF before traveling to Ghana. Sheryl mentioned that the main reason for them to attempt the treatment in Ghana, instead of her fiancé coming to the US (which would have been more convenient for her), was the difficulty of her partner obtaining a visa for the US. Besides, she added, she found it more relaxed "here in Ghana, as my family is around." Furthermore, the treatment was somewhat cheaper in Ghana than in the US, although according to Sheryl this was not the primary reason for pursuing IVF in Ghana. Thus, transnational relationships – which seem quite common for Ghanaian citizens, partly because traveling abroad for study or work is common – may also shape the motivations for, pattern of and the direction of reproductive travel.

**Conclusion**

I have explored motivations for cross-border reproductive travel to Ghana among infertile couples living in Ghana’s neighboring countries and of Ghanaian people living in Europe and the US. Overall, their motivations show similar patterns to those discussed in the literature, including: the perceived high quality of treatment and good treatment results in the Ghanaian clinics (based on testimonies, not statistics); the circumvention of restricting regulations in the country of residence; lower treatment costs; and the availability and affordability of matching donor material (in particular donated eggs, which many of my interlocutors needed) and surrogates in Ghana. Further, for some Ghanaians living in the diaspora, it was comforting to undergo treatment “at home.”

While the reproductive travel of my interlocutors was influenced by structural and legal features and their perceptions of good care, the case studies also highlight the “multi-layered strategies” (Bergman 2011b:602) that infertile couples employ. The situations of each of the couples discussed above were unique. The choices they made very much depended on their specific (reproductive) life story, including their physiological issues and their current and/or past relationships. Moreover, reproductive travel – in contrast to travel for other medical purposes – typically involves two people whose lives and decisions about the use of ARTs abroad have to be finely attuned. This was particularly so in the case of transnational relationships (engendered by the Internet). When partners were (temporarily) residing in different nations, bureaucratic or regulatory issues beyond the specific area of ARTs, such as visa arrangements and access to subsidized health care, also affected their choice of location for assisted reproduction.

I observed two key differences in the Ghanaian situation compared to accounts of reproductive travel to popular ART destinations in Asia. First, all study participants coming from Europe or the US already had a connection with the country: they were black Africans born in Ghana. While Caucasian women and men from Europe and the US frequently travel to Asian countries (e.g., India and Thailand) for ARTs, they did not (yet) travel to Ghana (at the time of the fieldwork). One can only speculate why this would be the case. Has Ghana – or probably even the entire continent with the exception of South Africa (Bergmann 2011a, 2011b) – not yet been identified as a destination for reproductive travel? Or are people just not eager to travel for reproductive assistance to Africa, as the continent is generally depicted as poor, lacking functional health care systems, and suffering an AIDS pandemic? Several Asian nations (Thailand, India, Singapore, Nepal and Cambodia) recently banned commercial surrogacy, raising the question whether Caucasian reproductive travelers from Europe and the US now will turn to SSA countries with minimal regulations (excepting South Africa).

Second, none of the reproductive travelers I spoke to referred to any form of tourism connected to their visit to Ghana. While the term “reproductive tourism” has been criticized by both reproductive travelers and social scientists (Inhorn 2015), the convergence of the commercial IVF industry and the tourism industry does exist in many places (Franklin 2011). While some Ghanaians living
abroad spoke about the combination of treatment and family visits, they never depicted their stay in Ghana in terms of tourism.

Most striking, all reproductive travelers in this study were attracted to the clinics by the testimonies of others who had had good experiences. Some respondents were also attracted by the extended period of hospitalization following embryo transfer (as practiced in LeleNa clinic), despite the fact that this substantially increased treatment costs. As discussed above, the criteria which inform perceptions of the quality of care and patient satisfaction may differ greatly in specific contexts, and providing statistics and enabling informed choice is not necessarily perceived as equivalent to good quality of care (cf. Mol 2008).

The case studies presented here involve patterns of “stratified reproduction” discussed by several authors in this field. While primarily well-off and privileged couples (living abroad) access ARTs using donor material and surrogacy in Ghana, they can only do so because the bodies of other Ghanaian woman and men – in need of money – are “bioavailable” (Cohen 2005); they sell their wombs (as surrogates), eggs or sperm in order to fulfill the reproductive desires of others.

The case studies point to the centrality of communication technologies, facilitating reproductive travel in various ways. The “word of mouth” advertisements “travelled” also through the Internet, and transnational clients communicated with clinic staff through email and phone calls to discuss their situation and treatment options long before entering the clinics. Without these means of information and communication, the Ghanaian IVF industry would not be able to function as it does (cf. Hudson et al. 2011:8). Communication technologies greatly facilitate the circumvention of regulatory and material conditions for people with fertility problems within their countries of residence (Martin 2009:254). Yet as I illustrate, not all infertile people profit equally from the advantages of globalization; reproductive travel does not resolve but rather confirms and enlarges the inequalities that exist between rich and poor people suffering from infertility.

A unique combination of push and pull factors, together with biographical and relational features of the women and men involved, including their social networks and financial possibilities, have fashioned individuals’ and couples’ cross-border reproductive travel choreographies to Ghana. However, further research is needed to scrutinize the ways in which “global ’levelling’ is not occurring” (Franklin 2011:815) and to examine in more detail the various components constituting Ghanaian or African reproductive travel choreographies.

Notes

1. Other terms referring to the same phenomenon include reproductive or fertility tourism or mobility and cross-border reproductive care (for discussion, see Gürtin and Inhorn 2011; Hudson et al. 2011; Inhorn and Patrizio 2012). I have chosen the term cross-border reproductive travel, as it covers the content in what I consider an appropriate way, without referring to either “tourism” or “care.”
2. This collaborative project was designed by Viola Hörbst (2015).
3. The “baby room” is the place where the recently born babies stayed and were taken care of by their parents and nurses.
4. Big fibroids are known to impede fertilization and have to be removed before IVF can be successfully performed.
5. Reasons the doctors mentioned for (extended) hospitalization after the embryo transfer included the bad road conditions, the fact that the pregnancies created were ‘precious’ (both culturally and financially), because most of the couples had to pay for the IVF themselves; the fact that part of the women had to travel long distances and thus could not easily return for follow-up visits; and the fear that possible complications resulting from the IVF might not be recognized by doctors not involved in IVF treatments (Gerrits 2016b).
7. Since fieldwork was conducted the clinic’s practices have changed.
8. In 2013 the average per capita gross income in Ghana was US $2713 (Ghana Statistical Service 2014:153).
9. While those I spoke with did follow the doctor’s instructions, as they did not want to put their pregnancy at risk, I also heard stories about women who had left the clinic earlier against the doctor’s advice, as they could not afford the additional costs.
10. While pleased with the outcome, Gloria was, however, not only positive about the clinic. In particular, she felt that the clinic staff should be more informative about clinic procedures.

**Acknowledgments**

I want to thank the directors and staff of the fertility clinics in Ghana for their openness and hospitality; the patients for sharing their experiences and concerns with me; and the University of Amsterdam for supporting me to attend several conferences. Moreover, I am grateful to the anonymous reviewers for their inspiring comments and the editors of the special issue for inviting me to contribute to this volume.

**Funding**

The author thanks the ‘Fundação para a Ciência e a Tecnologia’ for funding the research project [PTDCAFR/AFR/110176/2009].

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