

Quest for conception in times of HIV/AIDS – (In)fertility care in Botswana

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Abstract

The article at hand attempts to assess medical care available for infertility patients in Botswana, a country with an exceptionally high HIV/AIDS infection rate. Therefore this contribution lays emphasis on understanding the relation between HIV and infertility and how Botswana's biomedical services are catered towards these special needs. The research shows that patients' acceptance of biomedical technologies not only depend on their financial situation but also on their age and education. It further emphasizes that suffering from childlessness is not only a social problem but is also a personal suffering as biological children represent the hope for personal and social continuity. Nevertheless, infertility care is not a priority in Botswana's health politics.

Key words: Africa, Assisted Reproductive Technologies, ART, HIV/AIDS, health care, health politics, infertility.

Infertility and HIV/AIDS: introduction

The correlations between infertility and HIV/AIDS are various and complex and they are rooted in medical factors as well as in social, sexual and reproductive behaviour. HIV/AIDS may facilitate the condition of infertility as people with an HIV/AIDS infection are prone to other secondary infections heightening their physical vulnerability to other venereal diseases. These in turn may cause infertility. In a developed stage, the immune deficiency weakens the body, which may also reduce a female's childbearing capacity. Research has pointed at infertility provoking risk behaviour, as women who wish to have children may engage in unprotected sexual intercourse in order to conceive and thus expose either themselves or their sexual partner to contracting the virus. In addition, seeking to conceive through sexual intercourse with multiple partners increases the risk of contract a number of other venereal diseases, thus impacting women's fertility (Lewis et al., 2004; Dhont, 2010). On the part of social science and public health research and (inter)national health politics, there has been a strange silence on the topic that might be attributed to an unspoken assumption among health professionals, NGOs and researchers

alike that HIV positive people should not procreate in order to prevent the infection of their partners and their children (Wilcher et al., 2009). This, however, ignores the fact that fertility is of high cultural value in many societies and a matter of personal, gender and kinship identity (van Hollen, 2007).

My contribution is concerned with infertility and HIV/AIDS among educated professionals in Botswana. The country, situated in southern Africa, is one of the few middle income countries in Africa. Botswana's size is comparable to that of France but only hosts about two million inhabitants and has one of the highest HIV/AIDS infection rates, approximately 25 to 30 per cent, in the adult population. Of the women in the age group 30-34, 50 per cent have been estimated to be HIV positive (Ministry of Health, 2009). The percentage is probably smaller among the population at study as the average infection rate among women with tertiary education has been estimated to be 20 per cent. Nevertheless, these figures tell us that *a lot* of people are infected and the statistical probability of one's current sexual partner being HIV positive is, if not one out of two, than one out of five. The figures further suggest that the number of women who experience fertility problems due to other venereal infections as a consequence of

HIV/AIDS may also be considerable. In the course of my research I found that educated professionals practice safe sex even (or in particular) in their marriages, which effectively reduced the fertility of many women in my sample. Some women have remained childless due to safe sex practices (Bochow, in press).

There are no statistics about how many women experience either primary or secondary infertility in Botswana, but in the popular perception of Botswanans ‘infertility’ is a common problem and one that is feared by many. HIV/AIDS exposes women to the condition of infertility or secondary infertility in many ways so that in a context of high HIV/AIDS infection rates the likelihood to remain childless increases. Infertility, however, is a low priority in Botswana’s health politics. Even though Botswana has a fairly well functioning public health care system, there is basically no infertility care available in the public health care system.

In the following, I will describe how gynaecologists and fertility patients seek solutions for infertility in Botswana, with a special focus on the problem of (in)fertility and HIV/AIDS. Thereby, I will first assess services for the fertility care that are available before I describe patient’s expectations and specialists’ recommendations.

About the research

I conducted my research on educated professionals with fertility problems during several visits to the field from 2009 to 2011 and recruited respondents at the Gaborone Private Hospital and at Bokamoso Private Hospital. As an independent researcher, I had limited access to patient consultations and no access to health records but rather interviewed patients and specialists separately. Most of the patients I met paid for their treatments themselves. As such, most of them represented upcoming groups in society; they differed, however, according to their status, their (ethnic) origin and their income. In my research on reproductive challenges among elite women in Botswana, I collected the reproductive histories of 70 women and about 15 men during three separate visits to the field in the years 2009, 2010 and 2011. For interviews, I met respondents mostly in public spaces, cafés or restaurants. The interviews, lasting between 45 minutes and two hours, represent specific forms of female subjectification as they resemble intimate chats that urban women are used to conducting. Twenty-five of these women sought medical assistance in order to conceive; only nine women had not given birth at all so far. I knew the HIV status of five of these women. All of them were guaranteed anonymity of data and signed a consent form.

Childlessness and educated professionals in Botswana

In the past fifteen years, the literature on childlessness in Africa and elsewhere has repeatedly pointed at women’s suffering from being childless emphasizing women’s experiences of being stigmatized, ostracized by their kin and communities, and threatened to be divorced and to be left with nobody to take care of them in old age (Gerrits, 1997; Feldman-Savelsberg, 1999; Sundby, 1997; Inhorn, 2004). On top of this, motherhood is considered to be of utmost importance for female personhood as has been recorded throughout the 20th century in Botswana (Schapera, 1966; Mogobe, 2005; Upton, 2001). Becoming a mother is seen as being the most important goal of every woman. Desires for children, however, have changed among educated professionals. While in farming communities ‘having many children’ was and is associated with wealth and prosperity, educated professionals plan and monitor their reproduction and reduce their fertility to two or three and sometimes even only one child. Nevertheless, remaining childless is experienced as severe personal and social suffering. Women who remain without children feel stigmatized and excluded from many important social activities that structure women’s everyday life as well as their social interactions with their friends, kin and neighbours. They receive hostile ‘comments’ from people around them, be it in church, from their own family, and from their colleagues.

In the context of high HIV/AIDS infection rates, in which many people have experienced the loss of close kin, friends and lovers, children represent social continuity and are an important link in the otherwise disrupted kin relations. The imagination of ‘genes’ or ‘DNA’ passing from parents to children has replaced a procreative imaginary of male and female bodily fluids mixing and making the child (Schapera, 1966), speaking about the ongoing process of biologisation of parenthood in this region. By passing on their DNA, people believe they will pass on not only physical features but also their personality and soul. The same way they wish to have somebody who inherits their property, they wish that their achievements are cherished by coming generations. People’s fear of remaining childless is not only directed towards their future and the question of who will care for them in old age. Rather they fear that when they die without a child, they will cease to exist. A child will continue their existence on earth after they died. Educated professionals suffering from childlessness are not so much concerned with their material well-being but rather with the social suffering as well as spiritual suffering that

threatens the cosmic order of social and individual continuation.

Technologies, infertility and HIV/AIDS

Studies on the appropriation of assisted reproductive technologies (ARTs) by patients have shown how specific the appropriation of these technologies can be in local populations (Hörbst and Hadolt, 2010), but also that they impact people's cultural and gender identities (Inhorn, 2004; Pearce, 1995). How people use and appropriate ARTs depends greatly on the availability of information and fertility services (Hörbst and Hadolt, 2010) as well as their affordability (Ginsburg and Rapp, 1995). While some researchers have recorded ethical and religious objections against ART procedures at various places, ARTs seem to be regarded as a solution to people's suffering from being childless in many places in the world and to be highly desired rather than rejected (Ombelet and van Balen, 2009).

In the context of HIV/AIDS, ARTs gain new importance as they offer not only a hope to conceive for those experiencing fertility problems but also the hope to conceive *safely* for those who are HIV positive *and* experience fertility problems without transmitting the virus to the partner. This is relevant also for a couple in which both partners have a seropositive status, as they can infect each other. So called cross-infections represent a considerable health threat as the virus tends to become more aggressive. The Fertility Clinic Vitalab in Johannesburg, for instance, advertises their fertility services also to HIV/AIDS positive patients with conception problems (Vitalab, 2010). They mainly address people with fertility problems in general, pointing out the various treatments and services available. However, browsing through their website one finds advertisements in which they address HIV positive people with unfulfilled desires for children. Here, they indicate their responsible attitude towards this specific group of patients by not only offering counselling to the couple but also by taking special precautions in dealing with HIV infected material. Their announcement already indicates some of the reservations that HIV positive people experience when faced with fertility problems, which I will come to speak of later on. It is important to note that not all HIV positive people with desires for children need to rely on ARTs.

Discordant couples and HIV positive couples with an unfulfilled child wish and no recorded fertility problem could also try conceiving without sophisticated technologies. According to what has become known as the 'Swiss Declaration', an article authored by a team of Swiss medical doctors, HIV

positive people can conceive naturally without putting the partner at risk if they are on ARV treatment and the virus is undetectable (Vernazza et al., 2008). The paper is highly contested: critics point at the level of risk still involved in this practice; some believe it serves the interests of the pharmaceutical industry producing anti-retroviral medicaments (ARVs)⁽¹⁾ rather than the health of the patients, while it represents a hope to many to conceive 'naturally'.

Botswana has a comparatively well-functioning public health care system. There are, however, only minimal possibilities to diagnose and treat infertility in the public health system. Botswanans who wish to have a child and cannot conceive can seek help at private clinics where they need to pay the costs of consultations and treatments themselves. The costs are not covered by health insurances⁽²⁾. Therefore, there is a market for private fertility care of which educated professionals are the main beneficiaries. Gaborone hosts two private hospitals that offer gynaecological services, the Gaborone Private Hospital (GPH) and the Bokamoso Private Hospital, with a staff of 14 private gynaecologists. The specialization of biomedicine is quite new in Botswana, which may partly be attributed to the fact that with its two million inhabitants the amount of patients requiring health services is still considerably small. The first gynaecologists started practicing in Botswana in the 1980s at the National Hospital Princess Marina.

Both private hospitals offer general gynaecological services including deliveries. Opened in 2010, the Bokamoso Private Hospital hosts specialists, among them trained gynaecologists/obstetricians and a theatre, as well as specially trained nurses and midwives (Women's Health Nurse). Many of the necessary tests, such as an HSG (hysterosalpingogram)⁽³⁾ are administered there. Both hospitals offer fibroids operations, which were identified some years back as a common cause of conception problems in Botswana as elsewhere. Many gynaecologists who do not have special facilities or skills to diagnose the causes of infertility treat their patients with clomid, a hormonal treatment enhancing ovulation. One

¹ ARVs suppress the virus and therefore enhance the immune system, thus considerably prolong the lives of HIV patients. Botswana ensures each citizen in need of treatment has access to ARVs.

² Botswana is one of the few African countries with a health insurance system. Banks, the insurance industry and the public service sector insure people working in these sectors.

³ A hysterosalpingogram (HSG) is an X-ray test that looks at the inside of the uterus and fallopian tubes and the area around them. The x-ray can show problems such as an injury of abnormal structure of the uterus or fallopian tubes, or a blockage that would prevent an egg from moving through a fallopian tube to the uterus.

practice – the Gynae and Care Clinic – specializes in fertility care; having trained at an infertility research centre in a European country, they analyze the hormonal menstrual cycles of their patients thoroughly and are able to fine-tune hormonal therapies.

IVF or ICSI are generally not available in Botswana in either the public or private sector, which reemphasizes the lack of services, and patients who desire to conceive through IVF have to seek treatment in South Africa. Private clinics and hospitals in Botswana cooperate with fertility clinics in South Africa where individual gynaecologists attend to patients differently. Most gynaecologists just point to the possibility, refer patients to the clinic in South Africa and give minimal information on the procedure. Others accompany the treatment very closely such as the Gynae and Care Clinic. They discuss with the patients the results of all tests they undergo, offer them appointments before or after working hours so that their patients who are indispensable at the work place are able to combine the treatments with their work and most importantly keep close communication during the IFV or ICSI treatment itself.

Seeking conception: infertility patients and gynaecologists

Experiences of patients

Patricia⁽⁴⁾, at the time of the interview age 47, belongs to the few privileged in Botswana who can afford the costs of IVF that is not offered in Botswana. She has undergone IVF twice in the past three years. She married at the age of 30 and had no children by the time she started treatment. She remained childless in her short-lived marriage, and started fertility treatments only after her divorce. She underwent IVF for the first time in 2008 at the Cape Fertility Clinic in Cape Town, South Africa. It failed. The treatment cost her 60,000 BWP⁽⁵⁾, excluding the cost of the flight and the guesthouse where she stayed.

Patricia belongs to the first generation of women I interviewed, of whom were in their prime fertile years in the 1990s. In these years, fertility medicine was less advanced and less known than in contemporary Botswana. At the beginning of the 1990s, fertility problems were treated by General Practitioners (up until today). Complicated cases were sent to South Africa to see specialists. Patricia sought treatment first in the mid-1990s and was diagnosed with ‘fibroids’. The excrecent in the uterus was known to prohibit the settling of the foetus into the uterus. While medical research has advanced and does not

attribute the main cause of infertility to fibroids anymore, in popular medical knowledge fibroids came to be known as the main cause of infertility.

Trying to recall the many specialists, Patricia had difficulties remembering all their names and she often confused them. Her narrative resembled that of many other women I interviewed (of all ages). She, like others, often felt that the specialists she saw were not competent in dealing with the issue of infertility. She received contradicting diagnoses from different doctors. On top of that, Patricia and others felt hidden or open discrimination by the treating doctors: their way of looking at them with disinterest, rejecting faces, short questions and statements that were breaking the ‘news’ that there was nothing that they could do for them after they heard their ages. One woman reported that she received comments such as: “You will never give birth. You are a useless woman.” These experiences add to their personal and social suffering of not being able to conceive and their low self-esteem, as well as their feeling of helplessness.

Close follow up and frequent communication in the process of seeking conception is therefore highly appreciated. Patricia for instance recalled that her doctor called her everyday enquiring about the process of her treatment. “He has my number on his phone and I have his number on my phone.” This quote suggests a strong personal relationship and identification between her and her doctor. Being available on the phone, according to which many relationships are evaluated in the city, makes Patricia’s doctor an ally in her fight for a child, and, even though she is aware of the limitations of her chance to conceive this knowledge releases her psychological anxiety.

The second generation of women I interviewed faced slightly better conditions concerning fertility treatment. Even though biomedical knowledge about fertility treatments was (and is) still confined to a few specialists, gynaecologists are more aware of the various aspects of fertility treatment. The possibilities of undergoing IVF or ICSI are better known even though by far not affordable to all of my respondents. Depending on their educational background, women of this second generation are better informed about their own health and use other sources of information such as books and the internet to find out more about possible causes of infertility, and they even suggest possible solutions to their specialists. Women of that age group exhibited a strong

⁴ All names are changed and other markers of people’s identity are disguised.

⁵ Approximately 6,000 euro.

trust in biomedical knowledge and technology, believing it would help them to conceive, as well they had a strong sense that it was their responsibility to seek out all possible options.

Other women showed less determination in dealing with their reproductive wishes. Some of the younger women had a history of repeated miscarriages and ectopic pregnancies, which damaged one of their tubes. They had gone through several gynaecologists before coming to Bokamoso and were insecure and timid. If the hospital could not diagnose a reason for their infertility, they were advised to go for IVF not to lose time. During the IVF treatment, many special tests are conducted that may show the causes for their infertility. Younger women often also do not have the resources to pay for IVF, including travelling costs. Some of them considered taking out a loan in order to be able to cover the costs for one ICSI cycle hoping that this would resolve their childlessness.

Patricia, at the age of 45, had the financial means. By then, she had a good position at the institution where she worked and a supportive husband. It seems however, that this help came too late for her. During her last IVF cycle, no eggs could be extracted. She was offered a donor egg but her husband did not want to have a child of ‘foreign DNA’, as Patricia expressed it. Her husband especially felt that he did not want her to carry the child of a stranger.

From the perspective of gynaecologists

“Infertilities? I don’t like them,” said one of the gynaecologists at GHP when I phoned him to introduce myself and my research to him. During our first meeting at the clinic, I asked him why. “These are frustrated people. It is difficult to deal with them,” he explained to me. Some of his colleagues shared his experience. People would expect a quick cure when they came to the gynaecologists. They believed they would get a pill that would instantly cure their condition. But infertility treatment is a long process and needs patience, something that people do not understand. Rather, if they do not see an immediate result they move on to somewhere else. From the perspective of gynaecologists, some people’s expectation of biomedicine resembles faith in miracle healing.

Gynaecologists indicated that they had HIV positive patients who wished to have children and were concerned about infection or cross-infection. Their recommendations vary on this point. The Gynae and Care Clinic recommends artificial insemination. In this procedure the sperm cells are removed from the semen and only the core remains. As the virus is outside the core of the cell it will not be infectious

anymore. Another gynaecologist recommends lubricating and inserting the sperm with a syringe so that the mucous membrane would not break. The more common handling of such cases is to suggest to couples to not use a condom during the fertile days of the woman’s cycle. While some clinics recommend to their patients to go on ARVs and control their virus load, others do not.

Two gynaecologists, however, expressed strong concerns about HIV positive women becoming pregnant. They feel these parents might not live long enough to raise their children, somewhat reflecting official politics. In Botswana’s National HIV/AIDS Treatment Guidelines from 2008, it is recommended that HIV positive people should be counselled to adopt if they wanted to have a child, thus expressing the priority for not supporting HIV positive people’s reproductive wishes.

Despite their reservations, the Gynae and Care Clinic offered one of their female HIV positive patients a possibility to conceive. The woman had stopped ovulating, her general health condition was not very good and she was already 47 years old. However, she was desperate to have a child. They found a donor egg for the woman and presented this option to her. The patient rejected the solution. I do not have any information referencing to this patient as the one I introduced at the beginning of the paper. But considering the similarities of both cases let us assume they are. In both cases, donor eggs were rejected as these offered a possibility to experience pregnancy and birth in addition to motherhood but did not appeal to the couple’s conceptualizations of reproduction.

Conclusion

Social anthropologists and public health research have shown that ‘childlessness’ is a severe form of female suffering and should be acknowledged as a serious problem for public health (Feldman-Savelsberg, 2002). Access to adequate fertility care is however, in a landscape of stratified reproduction, not only restricted by economic possibilities as Ginsburg and Rapp (1995) have shown but also women’s age and education impacts on their access to fertility care as shown in this paper.

This study further reveals that selected gynaecologists expressed reservations against HIV positive women becoming pregnant, somewhat reflecting official health policies, which do not recommend HIV positive people to become pregnant. Despite medical reservations, HIV positive people with a wish to carry out a pregnancy do receive medical assistance, whereas the care and information individual specialists invest into these patients varies greatly. The

realm of fertility care represents a health market that operates largely outside Botswana's public welfare system, and gynaecologists meet HIV positive patients' desires for children. These desires are greatly informed by the growing biologisation of parenthood, in which the 'gene' becomes an icon of social and personal continuity in the context of death and dying so that the context of HIV/AIDS adds urgency to these desires to see life going on. And this, I suggest, will not concern only relatively privileged parts of the population but many others who suffer from both HIV/AIDS and infertility.

The case study in Botswana clearly demonstrates that in the context of HIV/AIDS the needs for fertility care are heightened, not only because the problem of infertility is epidemically induced and therefore most likely to be higher in these settings but also because the personal-emotional needs for children appear to be more pressing for childless HIV positive people. Making ARTs available in a country like Botswana would be one of the many important steps to be taken. Gynaecologists in Botswana have often stressed the need for ARTs in Botswana; however, the complex problem of infertility in the context of HIV/AIDS needs to be addressed on many levels. It needs more political and public attention and should become a priority in health policies and health practices such as counselling services and general health services of HIV positive people.

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