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ETHICAL AND SOCIOCULTURAL CONSIDERATIONS FOR USE OF ASSISTED REPRODUCTIVE TECHNOLOGIES AMONG THE
BAGANDA OF UGANDA.

by

MARTHA MUKASA

Under the Direction of Cassandra White

ABSTRACT

Anthropological research on the sociocultural outcomes from applications of Assisted Reproductive Technologies (ARTs) for infertility, particularly in sub-Saharan Africa, is greatly lacking and much needed. Narratives from individuals, couples, families, community leaders and members are particularly germane to medical anthropological studies on the intersection of science and technology in the new millennium. With ART applications still in their infancy in sub-Saharan Africa, research of this nature may be of benefit in determining how best to apply ARTs within important cultural frameworks and allow infertile couples and other recipients the opportunity to minimize adverse results. This paper draws upon theoretical perspectives from anthropology, science and technology studies, ethnographic data from my field study in Uganda, and reviews of literature, to construct theories about how for the Baganda, the proliferation of ARTs could potentially change or disrupt cultural notions of power and identity and unseat core notions of kinship.

INDEX WORDS: Kinship, reproductive technologies, ARTs, sub-Saharan Africa, Uganda, ethics.

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MARTHA MUKASA

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Master of Arts Anthropology

in the College of Arts and Sciences

Georgia State University

2013

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Martha Nagawa Mukasa
2013

ETHICAL AND SOCIOCULTURAL CONSIDERATIONS FOR USE OF ASSISTED REPRODUCTIVE TECHNOLOGIES AMONG THE
BAGANDA OF UGANDA.

by

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June 2013

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DEDICATION

I dedicate this thesis to my late parents Sam and Ethel Mukasa who would have been so proud to have read it.

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I would like to thank all the friends and family who helped me through this process. Thanks especially to my sister-in-law Susan Mukasa for the countless hours of conversation on reproductive health, on culture and on social issues in Uganda. Thank you for also providing transportation for me while I was in the field and for introducing me to helpful contacts in Uganda. Without your help I would surely have been lost in more ways than one. Thanks also to my dear friend Josephine Kiyenje for the long distance phone calls from Kenya to give me updates on the attitudes about reproductive assistance among Ugandans in Kenya and to challenge my assumptions with excellent questions of your own. I will always cherish our conversations. Thanks to Namuyaba for your phone calls, your questions, your input and your support of my research. I thank also my sisters Miria and Samantha for their firm support and encouragement. To my brother Kiggundu, I thank you for providing me a place to stay in Uganda, for answering my emails loaded with cultural questions and for going out and finding out all the answers I needed; together we've learned a lot about our heritage. I thank my committee members for all the wonderful support and feedback. Thank you to Dr. Cassandra White my thesis advisor for all your encouragement especially when I was struggling with how to make a thesis out of the data from my limited time in the field. I also thank Dr. Jennifer Patico for taking a keen interest in my research and wanting to get involved and Dr. Lara Braff for providing invaluable feedback and advising me from afar; I appreciate you taking on my research.

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1 INTRODUCTION

This research began as a project to explore how infertility is identified and subsequently managed in my home country of Uganda where—as is generally the case in sub-Saharan Africa—resources for- and attention to women's reproductive health issues are low relative to those issues of mortality and morbidity that affect all segments of the population such as HIV/AIDS, tuberculosis, malaria and others (Inhorn and Birenbaum-Carmeli 2008). I traveled to Uganda in 2011 for thirty days, which was the time limitation under which I had to work. With the majority of my family residing in the capital city of Kampala, I was fortunate to be able to take advantage of the benefits of engaging as a *halfie anthropologist* (Abu-Lughod 1991) an anthropologist studying the non-Western culture of her birth. The benefits included recognition of my research agenda by immediate and extended family and willingness to engage in conversations about infertility and culture without having to first develop the types of researcher-informant relationships of trust which come out of extended fieldwork. This is not to say I had all the access to the informants I wanted. Indeed I was hardly able to speak to anyone directly affected by infertility as sufferers of the disease guard their privacy to avoid stigma.

Still, the benefits of having access to people who could talk about how the culture responds to the disease was invaluable given my time limitations in the field. It was one particular (informal) discussion and introduction that got me interested in what was to become the focus of this research, the question of how local concepts surrounding the legitimacy of birth, birth outcomes and identity have the potential to be disrupted by ARTs including in vitro fertilization (IVF) and insemination by anonymous donor

sperm (DI) and how the Baganda, would juxtapose such outcomes and the benefits of reproductive technologies within their own cultural framework. The conversation that started me down this path was simple. I was about to be introduced to a married couple from the Baganda ethnic group to which I also belong, who had a set of young fraternal twins. What I was told by the female relative who was to introduce us, was that the couple had tried to have children for almost seven years without success and that they finally succeeded in getting pregnant with the twins. What followed was a pronounced pause. It was suggested I try to speak to them about my research on infertility, although it was unclear to me whether a diagnosis of infertility had been given to the couple by a biomedical doctor or if infertility had simply been assumed. However, it was the weight of the pause, the way it said something without saying anything in way as to convey that a private matter not typically discussed openly, was in effect being discussed in just that fashion, openly through pauses and pronounced silences. The pause here seemed to indicate questions about the authenticity of a twin-birth outcome. The couple we were discussing were (as of 2011) in their mid- to late thirties, well-educated, of middle class and lived fairly comfortably by all outward appearances and material indications. They may well have been financially equipped to have--if they had indeed been seeking treatment for infertility-- sought assistance from a private fertility clinic where ARTs would have been applied; I visited one such clinic in Kampala offering laparoscopy, hysteroscopy and other biomedical diagnostic investigations and treatments including IVF and intra-uterine insemination (IUI). If this had indeed been the scenario and their fraternal twins the outcome, theirs would have been a story almost commonplace in western narratives of ARTs and birth outcomes and the parents would simply be “a couple with twins”. However, for the Baganda, one type of multiple birth, that of twins in particular, is highly desired and the family—including extended family and clan—to whom they were born, are socially elevated by twin birth outcomes. The same cannot be said about multiple births beyond twins. With twins being desired and triplets and others not, ARTs associated with

multiple birth outcomes can not only change the cultural dynamics surrounding twin births for the Baganda, but also create adverse economic and psychological stress for families who in their desperation to remedy their infertile state with one or two children, find themselves faced with ethical and economic dilemmas should multiple fertilizations take place. More discussion on the Baganda and twins follows in a later chapter. It is fair to ask if these considerations warrant immediate attention when the outlook for prolific use of ARTs in sub-Saharan Africa are way off in the distant future and their current applications are generally among the minority elite class and not the majority living in poverty. But I agree with one researcher who argues that it is those living in poverty that stand to benefit the most from infertility treatment as they are at greater risk for contracting sexually transmitted infections which result in infertility, and to engage in unsafe abortion practices with the same results (Ombelet et al 2008). Another of the greater considerations I discuss is the importance of Kiganda identity which is predicated upon the continuity of patrilineal bloodlines through the aforementioned clan system.

Though ARTs are not ubiquitous in Uganda, they are being applied and will continue to do so. As researchers call for the development of more simplified low-cost forms of ARTs (Ombelet et al 2008:612) for use in countries like Uganda where the majority of people live beneath the poverty line, these technologies may in just a few years become more available making this the nascent period, the ideal time for anthropological investigation on how culture is shaped by technology and vice versa. My hope is that in doing so, I will encourage Ugandan medical practitioners trained in applications of ARTs, public health legislative officers, religious leaders and other powerful and influential persons, to recognize their role in shaping the cultural and moral environment under which these technologies unfold and consider developing systems of knowledge about them that are reasonable and acceptable to recipients.

2 METHODS AND LIMITATIONS

2.1 Formal interviews

This study provides findings from several types of interviews. I conducted one semi-structured interview with three members of support group for infertility during the one-month period of field research in December 2011. The interview was recorded on tape and later transcribed. All informants signed written consent forms approved through Georgia State University's IRB process. The informants insisted, however, that anonymity was not required as they were quite willing to go on record and call attention to the social crisis that results from primary and secondary infertility in Uganda. The informants were Mrs. Rita Sembuya, Founder and Director of the Joyce Fertility Support Center Uganda (JFSCU) and a self-described sufferer of primary infertility and two of the Center's employees Christine and Nancy. Christine is a researcher of communicable and non-communicable diseases relating to maternal health and ovarian cancer as it relates to infertility, for JFSCU. Nancy is an Administrator and Program Officer for JFSCU who travels to various health clinics throughout Uganda to provide information on reproductive health. The interview lasted three hours and took place in a restaurant during a time in the afternoon when privacy to discuss the sensitive nature of these issues was achievable. The women are also a part of the African Infertility Alliance (AIA) which according to the descriptive flyer they gave me, consists of support centers around the continent--Chaired by the JFSCU-- including centers in Kenya, Israel, Zimbabwe, Malawi, Nigeria, South Africa and Zambia and whose main objective is to create a forum for public policy on infertility issues and link the issues in Africa to the rest of the world. Other objectives include: enhancing education and awareness on infertility and the causes of infertility; erasing stigma; promoting open interactions and improve the social, psychological, medical, scientific and political wellbeing of infertility sufferers; and partnering with health providers, governments and others to work towards achieving fundamental human rights to founding a family. As mentioned earlier, though consent forms

guaranteeing anonymity were signed, the women, given the nature of their involvement in education and activism, had no objections to their real names being used and as such I have chosen to use them and provide researchers studying infertility in Uganda and elsewhere in the diaspora, the names of women whose knowledge, experience and perspective may be of significant use to them.

Once I returned to the United States I found it difficult to maintain contact with my informants from JFSCU and efforts I made via email were fruitless. Certainly I had anticipated that given that we had a single meeting, follow-up exchanges, particularly across continents, would be difficult. A longitudinal study of no less than eighteen months would be ideal for researchers so as to allow for the natural development of relationships between researcher and community and informants. Because discussions of infertility are of a sensitive and private nature and further, discussions on reproductive health, social science researchers should expect to find gaining firsthand accounts from users of IVF and recipients of donor sperm will be difficult to get. It has been my personal experience that Ugandans are protective of their personal health history and discussing issues relating to infertility which for many may be associated with admitting what they consider personal reproductive failure, make it dually difficult to secure informants and researchers should spend as much time in the field as possible in order to develop relationships of trust between the two and trust by informants on the research process, including anonymity.



Figure 1(l) PI Mukasa (c) Mrs. Rita Sembuya (r) Nancy (2011)



Figure 2 (l) Christine (c) PI Mukasa (r) Mrs. Rita Sembuya

2.2 Informal interviews

I also conducted several informal interviews of Baganda women and men in Kampala from December 2011 to January 2012. These informants were members of my immediate and extended family, family friends, and acquaintances. As a Muganda¹ woman, I also contribute my own knowledge based on my own experience. My knowledge is limited mainly to childhood through to the teen years as I was raised entirely outside of Uganda, in neighboring Kenya, which has a fairly robust Ugandan population. As such, my knowledge of Kiganda² culture was divorced in many ways during my childhood years, from the day to day aspects of the larger community in the homeland. However, within my household and indeed among the community of Ugandan friends and family in Kenya, the cultural norms were still observed. My siblings and I understood our mother tongue; we were expected to observe and practice the customary greetings of kneeling to elders; we regularly ate several of the national foods of Uganda including *Amatooke ne binyebwa* (steamed unsweet bananas with peanut gravy) we learned the Kiganda dances; we dressed in the customary clothes on certain occasions; and my older sister and I performed the ritual of weaving a stick between our toes and jumping forward, that is associated with the onset of menses and marks the transition into the liminal stage between childhood and adulthood which ends with childbirth and the onset of parenthood. Generally we were raised with much Kiganda culture in the home and it informs much of my knowledge and where it does, I make clear that the claims are based on my own experience and knowledge from youth.

¹ Singular form

² Possessive form

I must disclose that I did not have one very important aspect of a Kiganda upbringing which pertains to the study of health issues relating to reproduction, that of growing into womanhood within its cultural context. As a Muganda adult therefore, conducting research on 'infertility and culture' ideally involves having experience in and a basic understanding of the larger sociocultural positioning of sexuality and reproduction, which I lacked. The information on customary practices, ritual, general contemporary attitudes about ARTs and the overall social positioning on reproductive health was therefore gleaned second-hand through informal interviews with family members during my stay in Uganda in 2011 and through ongoing question and answer sessions via email and over the phone with family members and with Ugandan friends across the United States. Many conversations were with my Baganda friends and relatives who, because they found the topic of my research interesting, would discuss their own beliefs and positioning as well as those of their friends if they had engaged in discussions on reproductive health or the use of ARTs. Because those friends and family I spoke with understood the nature of my research and wanted to be sure I understood how "our culture" thinks about many of these issues, I feel they were very willing to discuss many aspects in order to help me fill in the gaps in my own knowledge and correct any misconceptions I may have had.

The research presented is a small part of a bigger picture in that it speaks to the potential sociocultural effects of technologies which are largely being employed by the elite. Further ethnographic study is recommended for investigation on social change resulting from the application of ARTs. As a *halfie* anthropologist what I am able to offer this study in the way of ethnographic experience, is my own perspective and experience growing up as a Muganda girl now woman with access to informants on Kiganda culture, reflecting upon cultural knowledge through the anthropological gaze.

Other informal interviews I conducted included a thirty to forty-five minute meeting with a senior faculty member in the Department of Obstetrics and Gynecology at Makerere University's College of

Health Sciences at Mulago National Referral Hospital in Kampala. This interview was not recorded and no consent forms were given. Notes were taken immediately following the interview to allow for the details to be captured. I was informed by the faculty member that without the proper governmental IRB permissions from the offices of the Ministry of Health and IRB permissions from Mulago Hospital's affiliated teaching institution, Makerere University-both of which I had not anticipated needing and therefore did not have on hand--all conversation would be off the record. Following our meeting, I was invited to walk around the hospital's public spaces, and observe the goings-on though I was not permitted to conduct interviews with patients. Though ideally I would have preferred an opportunity to speak to patients attending the Fertility Clinic held at the hospital on Friday mornings, all was not lost as the observations about the basic clinic set-up, the hours of operation and even the expressions on the faces of many of the women in the waiting area, I found useful in providing if nothing else, an atmospheric sense that I could then compare and contrast with that of the private fertility clinic I later visited. I took extensive notes as I walked around the clinic and the hospital.

On December 19, 2011 I visited the Women's Hospital International and Fertility Centre, a private fertility clinic in Kampala. The clinic is one of several privately owned and operated clinics and is under the directorship of Dr. E.G. Tamale Ssali who has conducted several press interviews and is well known in social circles and among people I spoke to about infertility, as a leading authority on the disease. It was recommended I speak to him by the women I interviewed from JFSCU. Unfortunately, I was unable to speak directly to Dr. Ssali but met briefly with one of his staff physicians who did not feel comfortable talking to me without the presence of Dr. Ssali or another senior physician. The day I arrived was also a designated surgical day and the reception staff informed me that it would be impossible to meet with any other doctors and that the clinic would be closing for the holidays soon afterwards. I was told I could wait in the reception lobby for my ride back to where I was staying. I spent the time collecting and reviewing all the pamphlets and materials that were available for public consumption. These included

two pamphlets on services available at the clinic and one on an upcoming prayer meeting. The observations on the aesthetics and general ambiance of the waiting area and the pamphlet reflect a biomedical and religious culture I thought it important to capture despite the failure to secure in-person interviews. It was during these observations that I was able to note the strong Christian values infused into the medical context. I discuss this further in the chapter on religion. I discuss my observations in the fertility clinic as the visual representations in the clinic and the tenants of faith from the website as reflective of the ties that religion have to health in Uganda.

2.3 Media and literature analysis

There are several online newspaper articles from Uganda and a few blogs dedicated to discussion of the rise of ARTs. Though not academic journals, these articles have been invaluable in providing information on how the burgeoning use of ARTs is being disseminated to the public, including the tone and positioning of the media and reflections from members of society. The majority of the articles I selected included interviews given by practitioners in private clinics where services are offered, and some included interviews with other authorities on health including counselors, ministers and health officials. The majority of articles also had a stream of responses by the online readership to the subject of ARTs in the comments section at the end. Through analysis of these media articles, blogs and the responses they generated online, I was able to identify common themes that emerged. These include identity concerns about ethics, the loss of culture, religion and the role of the government.

This research draws heavily on current and historical studies on Kiganda culture, reproductive health in Uganda and other parts of Africa, on studies in medical anthropology, the anthropology of reproduction, science and technology studies, and other social science data. These studies have been invaluable in providing insight into Kiganda culture that I did not have and in providing current findings of

studies on infertility in Uganda and elsewhere in the diaspora.

3 BACKGROUND AND LITERATURE REVIEW

3.1 Infertility

Infertility is a global phenomenon that on average affects one out of every ten individuals at any given point during their reproductive lives (Inhorn and Van Balen 2002:7) and approximately 15% of all reproductive-aged couples globally at some point during their reproductive lives (Inhorn and Birenbaum-Carmeli 2008). In medical discourse, infertility generally falls into primary and secondary categories. Primary infertility refers to the inability to either conceive a child after twelve months of unprotected sexual intercourse or the inability to carry a first child to full term and/or give birth to a live child; secondary infertility refers to the inability to have additional children after having already successfully given birth to one or more (Larsen 2000). There have been only a limited number of papers that have reported on the prevalence of infertility in developing countries. This may perhaps be due to discrepancies in definitions of infertility which may be emic and therefore may impact the estimations on prevalence and on evaluations of success rates and treatment (Boerma and Mgalla 2001). A 2008 study conducted by the European Society of Human Reproduction and Embryology reports that the overall prevalence of infertility³ in sub-Saharan Africa ranges from 9% in the Gambia, 11.8% in Ghana, 21.2% in northwestern Ethiopia and between 20 and 30% in Nigeria (Ombelet 2008: 607). Unfortunately, more recent and comprehensive infertility rates for Uganda are not readily available. However, in 2012 The Global Press Institute, an online newspaper dedicated to women's health issues, quoted Dr. Tamale Ssali, the physician

³ The study does not provide a definition of infertility as either primary or secondary, but speaks mostly to female infertility as evidenced by the heavy focus on bilateral tubal occlusion due to sexually transmitted diseases and pregnancy-related infections as the most common causes of infertility (Ombelet 2008: 605).

mentioned above, with a ten percent infertility estimate (Global Press Institute, 2013).

According to the biomedical model, factors that can result in infertility in women include--but are not limited to--untreated sexually transmitted infections (STIs) such as genital chlamydia and gonorrhea, uterine fibroid tumors, advanced age, pelvic inflammatory disease (PID), infections associated with abortions, HIV-1, unsafe delivery practices and environmental factors (Boerma and Mgalla 2001, Ericksen and Brunette 1996, Ombet 2008, van Zandvoort et al 2001, Inhorn and Birenbaum-Carmeli 2008).

A 1994 report found that in Central Africa alone, STI-induced infertility was estimated to have affected as many as one-third to one-half of all couples (Inhorn 1994:459). Infections in particular can often be compounded by endemic diseases of the region such as malaria and tuberculosis and where unsanitary conditions and contaminated instruments surround the delivery of a child, other infections such as tetanus and other bacterial infections may be present and may affect future pregnancies, resulting in secondary infertility (Zabin and Karunagri 1998: 217).

In 1989 just over a decade after the world's first IVF baby was conceived and born in Britain, a boy conceived by IVF in Nigeria was delivered at a teaching hospital in the city of Lagos marking the first successful foray into ARTs in Africa (Pilcher 2006). Since that time, there has been an increased presence of Western-developed high-end treatments available at an average price tag of about US \$2,500 for a single cycle of IVF, one of the most widely used ARTs in sub-Saharan Africa; the other is artificial insemination by husband's sperm (Pilcher 2006). According to a national survey conducted survey by the World Bank, the gross national income (GNI) per capita in Uganda in 2011 was \$510 (World Bank 2013). Thus the high cost of treatment with ARTs has resulted in deep stratification wherein only those of the upper-middle to elite classes are able to take advantage of the new technological advancements in in-

fertility management, the majority of which are available at private clinics in urban areas. In general access to biomedicine in sub-Saharan Africa is extremely limited. The World Health Organization (WHO) estimates that up to 80% of sub-Saharan Africans rely on traditional ethnomedicine as the primary source of healthcare (WHO, 2003). Though the accomplishments of the Nigerians sparked an increase of private infertility clinics throughout the diaspora, biomedical resources particularly for the treatment of infertility as a whole, were scarce (Pilcher 2006). The majority of emerging reproductive technologies, contraceptives and other reproductive resources that have become more prevalent in the region since then, focus primarily on birth spacing and population control and relatively few resources are allocated for infertility (Akande 2008, Inhorn and Van Belen 2002, Inhorn and Birenbaum-Carmeli 2008). After the success in Nigeria with IVF there was the expectation by some hopeful physicians on the continent that individual governments would increase spending on ARTs; instead, prioritization was given to health concerns such as malaria and those public infertility clinics that did exist lost funding and many were forced to shut down (Pilcher 2006). With the cost of treatment high throughout Africa, only 5-10% of those who could have benefited from fertility therapies were able to afford them in private clinics (Pilcher 2006). Overpopulated countries have been routinely discouraged from prioritizing infertility for reasons that include the perception that an increase in fertility rates would threaten demographics and the larger global community, a point driven home by medical anthropologist Marcia Inhorn. Inhorn is critical of the marginal attention given to rising infertility rates suggesting that Western population policy makers are obsessed with curbing the "hyperfertility" of non-Western peoples and that they do not see "Third World women as worthy of high-priced, high-tech Western infertility treatments" further suggesting that the sub-Saharan problem of "barrenness amid plenty" has never been treated as a high priority in international population discourse and that investing resources and providing research into the issue may be viewed as contrary to the Western interest (Inhorn and Van Belen 2002:7). Other medical technologies however are thought to be justified and are being employed for use in countries

throughout Africa including in East and Central Africa, considered Africa's "infertility belt" (Feldman-Savelsberg 2002, Inhorn and Van Belen 2002, Inhorn and Birenbaum-Carmeli 2008). The primary focus of these reproductive health resources is to save lives by preventing the harmful spread of disease, yet expansion of these resources throughout the public health sector is not thought to be justified for prevention of conditions that produce devastating *social* harm, stiff repercussions and human drama, even when they can be exacerbated by infectious diseases.

Women across the globe often bear the brunt of the blame for perceived "reproductive failures" such as infertility (Inhorn and Van Balen 2002; Inhorn and Birenbaum-Carmeli 2008) and nowhere are the *social* penalties for such failure and for childless marriages more severe and less focused on by medical anthropologists and other social science researches, than in Africa (Inhorn 1994). Infertility particularly among women should be at the top of the list of afflictions being studied in sub-Saharan Africa because of the severe repercussions women face when blamed for childless marriages. These include but are not limited to divorce or abandonment by the husband, loss of economic security and social support, less rights to property, becoming the subject of rumor, and physical, mental and verbal abuse. However, despite the repercussion infertility rates in countries like Uganda which lie in the infertility belt continue to rise and continue to receive relatively marginal attention (WHO, 2010).

Reproduction is essentially one of the most important means by which local actors are able to assert their identities and to differentiate themselves from other groups (Braff 2013) and in Uganda pronatalist sentiments are strong, especially within ethnic groups and the clan structures on which they are built. This thesis draws upon Kiganda cultural norms to construct theories about how the proliferation of Assisted Reproductive Technologies (ARTs) could potentially change or even disrupt cultural notions of power, identity and social status among the Baganda, the largest ethnic group of Uganda. One

of the greater considerations I discuss is the importance of Kiganda identity which is predicated upon the continuity of patrilineal bloodlines through the aforementioned clan system.

ARTs and the international (here Western) regulatory standards and cultural frameworks under which they are being applied in private facilities, are being applied ahead of the establishment of internal governmental regulations for the protection of patients to include requiring medical personnel administering these services to follow culturally relevant ethical protocols to minimize the risks (emotional, financial and social) of adverse effects from use of ARTs. The Baganda are very proud of their ethnic identity and as clan identity is passed through the blood line of males, social research on outcomes from particular ARTs including insemination using *anonymous* donor sperm, should include recipient/familial narratives and ideally involve longitudinal field study to determine whether donor sperm increases likelihood of stigma or in the cases where spousal sperm and not donor sperm produces a male child, whether child preferential stigma occurs within the familial context. So far there have been no studies that look at intra-familial stigma resulting from ARTs in Uganda.

3.2 The Baganda: A Brief History

In this chapter, I will include a discussion of the social implication of assisted reproduction among the Baganda by situating the beliefs, practices and traditions of the people within a historical narrative as the history continues to inform many of the core values of contemporary Baganda and provide a framework of ideologies and practices that inform Kiganda citizenship and identity. In doing so, I strive to bring clarity and context to the readership of this thesis not familiar with the history.

3.2.1 The Buganda Kingdom and the Kabaka (King)



Figure 3⁴.



Figure 4⁵.

The Buganda Kingdom is today home to the Republic of Uganda's political and commercial capital city Kampala as well as the country's main International airport Entebbe (see fig.1). Uganda is made up of almost 40 different ethnic groups with the Baganda being the largest group at approximately 17% of the total population (CIA 2002 census). The early history of the Kingdom of Buganda has for generations been passed down through oral tradition and accounts on the formation of the kingdom vary depending on the source. For the purposes of this paper I have compiled information on the history of the Kingdom from texts from the early 20th century written about the customs of the Baganda, more recent journal articles, as well as information from the official website of the Buganda Kingdom and related unofficial sites.

The Kingdom politically headed by the *Kabaka* (king) dates back to somewhere between the thirteenth and sixteenth century (Tamale 2005). Prior to the twelfth century, the region now known as the Kingdom of Buganda was known as *Muwaawa* (Buganda Kingdom, 2013) or *Muwaana* (Buyers

⁴ Buganda Kingdom (source: <http://www.buganda.or.ug/index.php/map-of-buganda.html>)

⁵ Young Kabaka Daudi Chwa II (middle) amongst the British rulers of Uganda ruled from 1898-1939 and was the first Kabaka to openly adopt Christianity (Buganda Kingdom, 2013). Photo credit: <http://www.adamse55.4t.com/photo3.html>

2012). Before it was an organized Kingdom under one ruler, the Baganda were comprised of five social groups all sharing the same language and culture but organized by common ancestry which constituted the most fundamental unit in Kiganda culture then and now, the clan (Buganda Kingdom, 2013, Buganda.com, 2013). However, despite the commonalities of language and culture, the five original clans known as *Banansangwa* or *Bannansangwawo* (the indigenous clans) were not unified under a single leader and each clan had its own ruler (Buganda Kingdom, 2013, Buganda.com, no year). *Muwaawa* became Buganda during the reign of Sse*Kabaka* Kintu⁶, also known as *Kabaka* Kato⁷ Kintu Kakulukuku, the first *Kabaka*. He was born in Bukasa⁸, one of the Ssesse Islands⁹ to Buganda Ntege Walusimbi Wanga Laba Wuuyo Nansangwawo Beene, who was the *Kabaka* of Muwaana (Buyers 2012). One account states that upon becoming *Kabaka*, Kintu unified the five clans under his rule and named the area Buganda after his ancestor (Buyers 2012). The five original clans went on expanding and by 1966 had reached 52¹⁰ (Buganda Kingdom, 2013, Buganda.com, no year, Tamale 2005). Under the *Kabaka* system of monarchy, hierarchical social structure was shaped by gender, the relationship people had to the *Kabaka*,

⁶ Not to be confused with Kintu the mythological first man to the Baganda though there is one account on the origins of Buganda that attempts to connect the two as one. It is believed *Kabaka* Kintu gave himself the name Kintu

⁷ The name Kato is reserved for a twin male who is born second. Kato Kintu had an older twin brother named Wasswa Winyi. Wasswa is the name reserved for a twin male born first. See section on twins for further information on twin names.

⁸ According to British missionary John Roscoe's *The Baganda: An Account Of Their Native Customs And Beliefs*

(1911)

people from Bukasa are referred to as Mukasas. Please note that Mukasa is a very common name in Uganda and not all Ugandans with the name—such as myself—can trace the origins to this island. It is unclear why the name is pervasive.

⁹ Ssesse Islands are a cluster of eighty-four islands in the northwestern part of Lake Victoria in Uganda.

¹⁰ “46 clans are officially recognised by His Majesty's government as constituting the clans of Buganda, as of August 1996. Oral history has always maintained that there are 52 clans in Buganda. This anomaly may be because some clans have not been able to establish their claims legitimately, or possibly that some clans may have died out, with no heirs to carry on the clan heritage” (Buganda Kingdom, 2013).

and by the means of production (Tamale 2005). The following passage from the website of the Buganda Kingdom highlights the centrality of clan structure to the Baganda:

The clan essentially forms a large extended family and all members of a given clan regard each other as brothers and sisters regardless of how far removed from one another in terms of actual blood ties. The Baganda took great care to trace their ancestry through this clan structure. A formal introduction of a muganda includes his own names, the names of his father and paternal grandfather, as well as a description of the family's lineage within the clan that it belongs to. The clan has a hierarchical structure with the clan leader at the top (*owakasolya*), followed by successive subdivisions called the *ssiga*, *mutuba*, *lunyiriri* and finally at the bottom the individual family unit (*enju*). Every Muganda was required to know where he falls within each of these subdivisions and anyone who could not relate his ancestry fully was suspect of not being a true Muganda (Buganda Kingdom, 2013).

3.3 Kinship

Studies and analysis of kinship have been prevalent in anthropology for over a century. Contemporary studies on kinship focus mainly on three areas: how kinship social structures relate to culture, the intersection of kinship and biology and the process of kinship (Stone 2014). All of these foci are essential to the question of how ARTs will impact the Baganda and vice versa. Historically, anthropologists have struggled to bridge the divide between these abstractions about kinship in general, and the realities of how kinship is conceptualized, processed and practiced on the ground by local peoples (Stone 2014:22). Even as a *halfie anthropologist* with a fairly strong grasp on Kiganda culture and kinship, I have in the course of conducting this research found that the clan foundational social structure, the most essential element to Kiganda kinship, does not necessarily hold up to scrutiny give the contemporary realities that ARTs are creating in Uganda leading to the ultimate question of whether biological relatedness of at least one parent—for example in the case of donor sperm to a couple or single individual--defines kinship among contemporary Baganda or whether clan affiliations still do. And if clan affiliations still do, then how couples or single women using donor sperm reconcile the divide is an essential question which can only be answered through further ethnographic studies on how families are being locally re-

conceptualized and reconstructed as a result of ART outcomes in Uganda. Anthropologists generally agree that cultural constructs of kinship have always been fluid and adaptive within a culturally-specific space and over time and that local kinship is often interwoven with economic relationships, religion and politics (Stone 2014: 24, 55) which I have found to be the case at the local level among the contemporary urban Baganda who have used ARTs or who are open to the use of ARTs. One informant relation of mine in Kenya stated that her single Ugandan friends who are in their late 30s are seeking out donor sperm with little concern about the clan identities of the sperm donors and by default any potential offspring they produce, insisting that it is more important to have a child before time runs out and that concerns about how society identifies the children will be dealt with and addressed in the future. The social pressure to reproduce therefore is so extreme that having to consider clan identity would simply add a burden to already desperate situation.

As ARTs are helping couples and single women fulfill the obligation to produce more children or to move into adulthood as it is culturally defined, by having a child, in just a few years the Baganda may find that the core concepts of kin are becoming blurred as the terms which define motherhood and fatherhood broaden at local levels to include those already in use in the West: Genetic mother/father, Social mother/father, and in the case of surrogates, Carrying mother (Stone 2014: 282) I argue that although contemporary upper-class Baganda may dismiss concerns about clan identity when using ARTs, what may actually be at play is a trend already documented by anthropologists, one in which every effort to focus kinship around biological reproduction become the ways in which the offspring can be fully accepted as members of the familial kin network that is in place. However, as previously stated, the Baganda are currently still focused on preserving clan continuity as ARTs are still relatively expensive and available to the few who have the financial resources to partake in them.

3.4 Kiganda Clans and Kinship

The social structures characteristic of Kiganda family and marriage life have been rooted in Baganda history. During the reign of the first kabaka Kintu, the original five clans began expanding and with the expansion came the development of specialized skills within the growing kingdom. These skills included iron-working, the cultivation of plantain trees, knowledge of the art of bark-cloth making and the keeping of domesticated chickens and cattle as a result of the agricultural revolution of the period (Musisi 1991:764). The agricultural period led to a growth in population and to the emergence of corporate clans involved in securing and developing arable land (Musisi 1991). With the population growth the sons of clan leaders left their fathers' lands to establish their own lands, resulting in the creation of new sublineages; the various lineages, settlements and sublineages made up the clan (Musisi 1991). The heads of the clans held the clan land in trust for clan members. Thus early in formation of the Buganda state, families and their dispersed clans came to be associated with land and with the titles for owning and guarding the land (Musisi 1991).

As the internal organization and structure of the clan developed, it became a social, political and economic entity with an administrative function that also judged, protected and taxed its members (Musisi 1991). As an economic entity, common clan ownership of land, cattle and sheep was passed down by right to descendants of the lineage securing a common labor pool within the clan; social authority and claims to labor and products were determined during this period not by gender, but by kinship which contributed to an increased politicization of clans (Musisi 1991). Over time, the development of clan land has affected social and gender relations within and among clan members with patriarchy and patrilocality becoming the most salient factor as the emphasis on unilineal descent and clear identification of corporate clan members heightened (Musisi 1991). "The assigning of clan names and identification insignia (or totems) and several rituals—especially *okwalula abaana* ("to hatch the chil-

dren”) and *okusika* (succession rituals)—clearly distinguished clan from nonclan members” (Musisi 1991: 766).

3.4.1 Clans and ARTs

As previously noted, the Baganda are socially organized under a patriarchal model supported by a patrilineal line of descent. Within this structure lies a patrilineal system of 52 recognized totemic clans, each clan forming a large extended family (Tamale 2005). Every self-identified Muganda² belongs to one of the 52 clans. Because each clan consists of a family which traces its origin to one male ancestor, intra-clan marriages and sexual relations are generally forbidden (Tamale 2005). As a patriarchal culture, men are at the top of the social hierarchy and their status in adulthood is linked to the quality of children produced, with male children being the most desired outcomes from pregnancy (Kiyimba 2005; Tamale 2005). Succession is through the eldest male child. Because children take their father's clan, girls are less valued in familial hierarchy because as adults they marry into another clan and in doing so, essentially become the property of their spouse's clan as do all children they bare. Baganda women are socially pressured to produce a male child for both their spouse's image and for the continuity of his clan. A fair amount of anxiety about the sex of the fetus often exists between a woman and her immediate family members during pregnancy as they hope for a boy which secures their collective position in the father of the child's family (Kiyimba 2005). The value of male children to the Baganda cannot be overstated and continuity of the clan through the maintaining the sanctity of blood lineage is of great importance even in contemporary times.

Girls are mainly valued as a form of income because they bring in bride price or dowries, which the boys can later use to get their own wives. Controlling a woman's sexuality in order to guarantee the paternity of one's sons came out of the colonial era when British colonists brought the capitalist eco-

nomic structure to Uganda and tied economic domination by men, to the domestic arena and to the bodies of their wives (Tamale 2005: 10). Beyeza-Kashesya and her colleagues in their study found that “Most discussants agreed that a home without a male child was like the home of an infertile couple, where there is a lot of misery and quarrels...a woman who has not produced any boy is referred to by the society as someone who has no children” (Beyeza-Kashesya *et al.* 2010). In the United States, a childless couple may officially stop using biomedicine or any other alternative medicine and decide to try and adopt a child in order to create a family unit. In Uganda however, adoption is not considered a solution to the problem of childlessness; an adopted child does not fulfill the obligation to maintain the continuity of the bloodline. As one informant who had adopted her husband’s daughters from a previous marriage told me:

“In Africa when you don’t have a child, that marriage is dead. Yeah. And someone will be told “Get another woman! If you keep that one, she’s yours, but as a family, we want a woman who will be able to give birth to children because this is our continuity, we need a lineage... if the wife doesn’t produce a child who will take over your name, then you have no cause with that woman because she has not continued your..., your name!” (Rita, speaking with PI Martha Mukasa, December 23, 2011).

In my personal social experience and observation, the achievements and accomplishments of clan members even when one does not know the individual socially, brings great pride and bragging by others of the same clan because it is a positive reflection on their lineage.

With clan identity being at the core of Kiganda identity, and a preference for male heirs to extend familial lineage, I argue that children resulting from assisted reproduction involving donated sperm may suffer stigma by immediate family members in the home and among the extended family if they become privy to the information. Questions of legitimacy of bloodlines may come into question and even more so if matters of inheritance and familial social position are at stake. Although childlessness among the Baganda is highly stigmatized, the use of ARTs may indeed introduce a new stigma when a male child's genealogical past is unknown, as are his clan, tribe, and whether there are other half-

siblings etc., too are unknown. In the cases where women from the wealthier classes choose to use DI whether to fulfill a social obligation to reproduce or to take on motherhood as a single mother and in doing so, be recognized as an adult, considerations of their child's clan identity may not be of utmost importance in decision-making, and indeed the anonymity of the sperm donor may seem to satisfy concerns about privacy, but because these technologies are available for the most part to those of the upper class, what considerations will have to be made when the child is older and is ostensibly to marry within his/her class and the background of the child is unknown? What is yet to be determined for the Baganda is whether a proliferation of ARTs and ART outcomes will diminish the importance of maintaining clan lineage in lieu of a prioritization of the biological blood continuity achieved by child-birth.

3.5 Female-Male Relations

According to Kiganda custom, women are subordinate to men with two exceptions, the mother of the Kabaka and the Kabaka's co-heir who is usually his older sister (Tamale 2005). A prime example of this subordination is physically enacted in the traditional greetings. When a Muganda woman greets a man or any elder of respect regardless of their gender, she is supposed to kneel¹¹. Baganda women still do this today although often times they will do something more like a deep curtsy as if to kneel, especially when outdoors where conditions on the ground may be dirty.

Sexuality is another key site for the maintenance of women's subordination in Uganda and elsewhere in postcolonial Africa (Tamale 2005). Associate professor of Law at Makerere University in

¹¹ More traditional Baganda observe these formalities even with familiar men of their own age group including male siblings, cousins, etc. But in contemporary times, it is common particularly in Kampala for young people to greet each other with a hug, soft handshake, small bow or nod. Kneeling formalities are still observed when greeting elders or showing respect to those of higher social status.

Uganda, and resident authority on gender relations in Uganda and sub-Saharan Africa, Dr. Sylvia Tamale notes that it was as the result of a perceived hyper-sexuality of female African bodies by the British during colonial era that fueled what would result in further subordination of women through regulation of female sexuality (Tamale 2005). In her article *“Eroticism, sensuality and ‘women’s secrets’ among the Baganda: A critical analysis”* she argues that it was through discourses of medical health and hygiene that policies and regulations were created to suppress women’s sexuality, erotic culture and sexual expression and reduce that expression to one function—reproduction (Tamale 2005). She uses Marxist feminist theory to argue that in capitalist societies—like those of the British—men work to regulate women’s sexuality and reproductive capacity by asserting themselves as the head of the household, dominating and controlling economic and other resources and taking charge of the lives of women and children who essentially become their property (Tamale 2005). The patriarchal traditional customs of the Baganda—which when the British arrived were already skewed in favor of male control—were only further reinforced by the rhetoric of hygiene and medical health the British introduced, and Baganda men were encouraged to guarantee the paternity and legitimacy of their children when bequeathing property to their male children; this could only be accomplished by controlling the sexual behavior of the women (Tamale 2005:11). So where the clan system was already in place tracking lineage, regulating women’s sexuality by demanding monogamy was heavily reinforced, while men were free to have polygamous relationships (Tamale 2005). We see these attitudes about the sexual behavior of men and women still prevalent today in recent studies on childbearing in Uganda. A 2010 qualitative study published in the *African Journal of Reproductive Health* titled *“Not a Boy, Not a Child”* looked at views on childbearing by 126 young participants ranging from 15-19 years old (62 males and 64 females), the majority of which were Baganda youths from rural Wakiso district and Kampala, the Capital. In the study informants talked about the importance of male children and the repercussions to women who failed to produce heirs for their husbands. The youths concurred collectively that a “woman who has not pro-

duced any boy is referred to by the society as someone who has no children” (Beyeza-Kashesya *et al.* 2010). The researchers go on to note that such pressure to produce a male child often results in both spouses engaging in high-risk sexual behavior in order to get a child of the desired sex and men often go outside their marriage to produce a male heir when the wives fail to do so (Beyeza-Kashesya *et al.* 2010). The following discussion confirms the presence of these attitudes among the contemporary youths who participated in the study:

Respondent 4 - There I get a solution if I had decided to have two girls and two boys and I have only one woman, and I am having four girls, then I might try another way round. I look for another lady because I am looking for the boy child.

Moderator - Is this common?

All- Yes [in unison from the whole group]

Respondent 8- I also consider that if you fail to give me a boy, I think maybe I try my luck elsewhere; to see if I find there a boy.

Moderator- What if you find a girl?

Respondent 4- [laughter from many] I don't give up of course. I keep that one but ...

Moderator- Even the other woman gets a girl, what happens and what do you do?

Respondent 5- I just give up [others interject, others laugh]

Respondent 4- I just go ahead; if I am financially stable, I make an increment¹² in ladies and they become three. [-laughter] I try that one.

Moderator- You try the third lady?

Respondent 4- Yes

Moderator- And she gets a girl?

Respondent 4 - I make an increment, [-Laughter prolonged.] If my target is a boy and I don't get him then I am to blame.

Moderator- While you are there getting the fourth woman the first woman gets the tenth child who is a boy what do you do?

Respondent 4- I relax...I declare [the

¹² The word is being used to mean adding one more woman into the social equation, as opposed to adding several women at a time.

battle is won]. [Males, 15-19 years, FGD *Kampala*] (Beyeza-Kashesya *et al.* 2010).

The study goes on to note that for women, negotiating how many children to have and when, is challenging because many are fully dependent on their husbands. The young women in the study stated that attempts to negotiate whether or not to have large families and voicing their opinions about wanting fewer children while the husband wants more could result in violence or in the men threatening the women with banishment which—without resources of their own—could result in economic hardship for the women and that the best policy was to not “dare to question the husband’s decisions” (Beyeza-Kashesya *et al.* 2010).

Such sentiments in recent times have also been recorded in the traditional oral literature of the Baganda which also reflect the inequality of gendered female-male relations and expectations. Several Kiganda proverbs, myths, legends, folktales, riddles, songs and other forms of oral tradition—which the Baganda enjoy sharing and participating in—speak to the sentiments expressed by the youths in the Beyeza-Kashesya *et al.* study. In his study on the oral traditions and gendering, researcher Abasi Kiyimba (2005) of Makerere University in Uganda notes that scholars of the oral literature unanimously agree that it marginalizes women and has been put in place “by men for the purpose of controlling women” (Kiyimba 2005: 254). The running themes in much of the literature are the idealization of mothers of boys, gender inequality at birth, the lower value of girls, success as linked to gender, etc. I have provided the following examples from his study with his direct translations included, as my Luganda is not as fluent as his:

Theme: Social triumph for the mother of a boy and the inadequacy of she who has not, as stated in the proverb.

Proverb 1: *Anaaganja, asooka ddenzi*

Translation: One who will become a favorite, begins by giving birth to a baby boy.

Proverb 2: *Ataayale mu kika, azaala bawala.*

Translation: She who gives birth to (only) girls, is not assured of a place in her husband's clan.

Theme: the right of a woman to be buried at the clan site of her husband because she has achieved social status by having a male child.

Proverb: *Ndifiira ku biggya bya baze, nga y'azaala omusika*

Translation: 'I will die at the graveside of my husband,' so says the mother of the heir.

Theme: The unfortunate wife whose co-wife has fulfilled her marital obligations by producing a male while she herself has not.

Proverb: *Ekuba omunaku tekye, ng'omugole azadde eddenzi.*

Translation: 'The rain that drenches the unfortunate one, does not stop,' so says the senior wife when the newly married co-wife has produced a baby boy.

Proverb 2: *Bakidambya kye kizaala eddenzi.*

Translation: The woman that is despised, is the one that ends up producing a baby boy.

Theme: The value of girls as strictly social and material wealth as it is generally expected that they will grow up, a suitor will then pay the father bride-wealth to marry her and then he will take her off as a member of his clan.

Proverb: *Omwana omuwala mutuba; ataagusimba y'asuubula.*

Translation: A female child is like a *mutuba*¹³ tree, it is harvested by one who did not plant it.

Theme: Social success or failure as determined by gender.

Proverb: *Omuguwa gw'omwana ow'obuwala, gubeera mu kisasi.*

Translation: The rope of a female child is always on the porch

The author notes that the above refers to "popular Ganda speech" in which boys are referred to as *Naatuukirira* which means "I will persevere to the very end" while girls are referred to as *Ganne-meredde* which means "I cannot go on any further." (Kiyimba 2005: 260)

So again, I provide these examples from traditional proverbs and the excerpt from the Beyeza-Kashesya *et al.* study to emphasize the traditional ways in which Baganda women and men through time have viewed themselves.

I would also like to add an example from my own personal experience while in Uganda doing my research. My family and I had attended a baptism of a baby boy who had two older sisters. The baptism was a great affair followed by an elaborate reception party at the home of the parents. At one point in the festivities, the music was turned down so that the father of the children could give a speech. Of the fact that he had two girls before his son he said into the microphone for all to hear "After two mistakes,

¹³ The valuable tree from which traditional kiganda clothes and bedding materials are made (Kiyimba 2005: 258)

we succeeded in getting a boy!” Laughter and applause ensued. I was quite taken aback at the time because I did not expect that such things could be stated so publically and in front of the little girls. They girls hardly noticed and everyone found the statement amusing and even more interesting, valid! I would like to emphasize at this time that although these words were said, they were not meant to insult or hurt the girls, but rather, to state what the above proverbs and the Beyeza-Kashesya *et al.* studies have reflected about Kiganda culture, that the value of boys can simply not be understated. It is important to contextualize ARTs and the sociocultural ramifications of their outcomes within the cultural lens. Because of the gender bias towards boys, genetic testing often used to check the viability of embryos before implantation into the uterus, may be used to identify and exclude female embryos. Preimplantation genetic diagnosis (PGD) is one such screening test that is in use in the West to detect abnormalities in IVF- and Intracytoplasmic sperm injection (ICSI)- created embryos outside the woman’s body so that only the most desirable, mutation-free embryos are implanted (Inhorn and Birenbaum-Carmeli 2008). Among the Baganda, PGD may allow anxious parents such as the couple who teased about their two daughters being mistakes, to guarantee that the next child is a boy. Clan affiliation and identity may help shape how best to apply ARTs in Uganda. By providing a history on the Buganda kingdom and on the structure of Kiganda relations through time and space the following chapter will provide information on how unique social forces have allowed infertility to be under prioritized as a health issue needing immediate attention.

3.6 Large-scale Social Forces

3.6.1 Sociopolitical History

Medical anthropologists interested in reproductive health in sub-Saharan Africa would be remiss in the analysis of the marginalization of infertility if they did not take a more holistic view of the challenges in sub-Saharan Africa that have kept and continue to keep rising infertility rates from being priori-

tized. We must be compelled as medical anthropologists to continue to look at how “large-scale social forces” (Farmer 1997) including ways in which poverty, economic inequality, political disruptions occlude sub-Saharan infertility from achieving the relatively high level of attention afforded other health issues like HIV. From the late 1800s until her independence in 1962 Uganda was a British colony and during colonial rule, the British allowed all the four Kingdoms¹⁴ in Uganda to remain intact and they were all given a large amount of autonomy (Buganda Kingdom, 2013, Tamale 2005). However, when Uganda got her independence in 1962 and became a Republican government in 1966, the new government immediately abolished the kingdom thereby dismantling the largest Kingdom in Uganda (Tamale 2005). Milton Obote was appointed Prime Minister and later became the first President of the country. He was deposed via military coup by General Idi Amin Dada in 1971 giving what would become a tumultuous start to Uganda's history as a self-governed nation. The 1970s through the early 1980s were notoriously dark times economically and politically for Uganda whose people found themselves suffering under the tyranny and dictatorship of Idi Amin Dada throughout the 1970s and the brutality of Milton Obote the first President, who returned to power in the early 1980s. The brutal rule of the Idi Amin in the 1970s unraveled the burgeoning social and economic strides that had in the short years following independence, been made by the newly independent country once described by Winston Churchill as the “Pearl of Africa.” The year prior, 1972, has since been described as the year in which the “Economic War” began (Obwona 2001: 50, Nayenga 1979:130). Marked by the expulsion of all non-Africans-- particularly Asians from India and Pakistan—from the country, the Economic War threw the economy into a state of chaos.

In one inexplicable mandate Idi Amin ordered the eviction of all Asians giving them 90 days to comply and vacate the country. Many Asians had been living in East Africa for generations, having origi-

¹⁴ The kingdoms of Buganda, Bunyoro-Kitara, Busoga and Toro are the four traditional kingdoms of Uganda.

nally been brought over by the British colonists as indentured laborers to build the Kenya-Uganda railway. Other Asians had arrived in more recent years seeking various other opportunities. Because many industrial and commercial businesses in Uganda were Asian-owned and -managed, the sudden expropriation of their assets by Amin's mandate left an economic void that needed to be filled by experienced individuals. Filling the void interested foreign investors however they were quickly discouraged from investing in-, and controlling these businesses by yet another of Amin's mandates, this one requiring they first become naturalized Ugandan citizens (Obwona 2001: 50). With few foreign investors willing to acquiesce to the mandate, inexperienced Ugandans lacking the capital, expertise and access to professional connections critical to the continued success of industries, were tasked with trying to keep the economy afloat. What followed was the near collapse of the industrial and commercial sectors, the breakdown of social services including mass shortages of essential commodities, and later, massive inflation (Obwona 2001: 50, Nayenga 1979:130).

Corrupt governments often drain public funds, and Amin's regime throughout the 1970s continued to negatively affect the country. War and civil unrest often led to worsening problems in terms of food production as people are unable to produce their own food under the conditions as hand, nor afford the inflated cost of food, and other social necessities like education and healthcare. When his military government was overthrown in 1979, things worsened. Milton Obote was publicly elected back into office in 1980 marking the start of more years under bloody, tyrannous rule. Although with a promise to return properties that had been expropriated, Obote appealed to foreign investors to return to Uganda during his presidency, distrust of the government by investors still ran high and it would take the actions of a new government almost ten years later, before improvements in foreign relations would begin to take effect and the economy start the long road to recovery (Obwona 2001: 51).

As previously stated, large- scale social forces such as political and economic disruption affect health and healthcare outcomes. I argue that Uganda as a fairly young independent nation, continues in the 21st century continues to be impacted by the economic and political unrest of the 1970s and 1980s and that healthcare reforms during the recover from the Amin and Obote regimes have largely been in response to infectious and communicable diseases that threaten the stability of social and economic systems. A broken economy following the turbulent years left Uganda heavily reliant on foreign investments and aid which are essential elements to achieving political and economic stability, financial independence and solvency. The 1980s and 1990s were a time when severe economic crises affected several sub- Saharan African countries bringing declining formal sector employment and poverty and resulting in crises-like measures including privatization and fiscal austerity (Leon and Walt, 2001). The East African region saw extended family networks take over services to which social sectors were unable to respond. Education and healthcare deteriorated in quality and availability throughout the region (Leon and Walt, 2001).

3.6.2 *Repercussions for health management*

In my view since the 1980s, aid and other monies intended to bolster the economy have ostensibly--government corruption and an overwhelming mismanagement of funds aside (Wendland 2008) -- been allocated to address the most immediate and critical needs of the people writ-large, including combating old and newly emerging infectious diseases like HIV which arrived in the 1980s and began to ravage Uganda and much of the rest of sub-Saharan Africa. Non-communicable diseases like infertility, though costing much in personal suffering, do not yet get the same level of attention as infectious diseases even when infectious diseases like HIV can present alongside infertility and exacerbate decreased fertility rates, when the country is taxed with recovering from the social and economic fallout of decades of political instability. As Uganda is still very much a country with an overwhelming majority of its citizens living below the poverty line, available resources as a whole are greatly outnumbered by the

demand for them. Urban areas are becoming more numerous and more crowded, and the resources within them are being stretched. It continues to be a country where in terms of healthcare, access to necessary resources for the management of chronic or acute conditions is not always readily available to patients due to high cost, shortages and other disruptions. In order for a larger range of biomedical testing and treatment for infertility—including low-cost IVF (Pennings 2008) and interventions of lower technical nature-- to become readily available in rural and urban areas and accessible to those in need, infertility would first have to be better understood by an informed general public and secondly, that public would have to put pressure on local officials and the health department to prioritize the disease. Uganda is not quite there as of yet, though recognition of infertility as a problem has been on the rise and local media outlets have covered the subject in recent years. Public awareness is slowly increasing thanks in no small part to such media coverage. As the political situation continues to improve as well as the basic structure of healthcare provision, the climate should become more favorable for ARTs to become more widely available (Pennings 2008).

3.6.3 *Present state of the kingdom*

In 1993, thirty years after the government disbanded them, the four Ugandan Kingdoms were reinstated by the newly elected democratic government. *Kabaka* was reinstated as the head of the Buganda Kingdom. All the sub-National kingdoms of Uganda were reinstated in strictly symbolic terms and their political power was marginal. The country was and still is headed by the president and his cabinet; the title of *Kabaka* therefore, was largely ceremonial when he was reinstated and his political clout in Uganda greatly diminished (Tamale 2005). The return of the king though, triggered a deep nostalgia among the Baganda who wanted to once again to take pride in their culture and their traditions though the socio-political repercussions from the abolition of the kingdom and the ceremonial status of the *Kabaka* had

irreparably reduced the overall strength of culture (Tamale 2005). Still, the Baganda today remain very proud of their identity and their language, Luganda, remains the primary majority language of Uganda¹⁵. The current *Kabaka*, His Majesty Ronald Muwenda Mutebi II, is the 36th *Kabaka* and he has been the head of the Kingdom since 1993 when it was reestablished. Though his office is largely ceremonial, he is a central figure in contemporary times. The current *Nnabagereka (queen)*, is Queen Sylvia Nagginda (Buganda Kingdom, 2013). The *Kabaka* holds more than thirty titles, two of which reference twins which I shall discuss in the next chapter. Some of his titles have been added with the introduction of more recent technologies, though many of them including the ones I discuss later, have been passed down. See figure 5.

Luganda	English Translation
Chuucu	On top of all grass
Ssabasajja Kabaka	On top of all men
Bbaffe	Husband for all people including men
Musota	Biggest snake
Mpologoma	He is a lion
Ssebuufu bwango	Commander of leopards
Ssebuufu bwamusota	Chief of all types of snakes
Lukoma nantawetwa	No human being can bend him
Beene	King of clans
Serwatika lwattaka	Dangerous land slide
Maaso moogi	Sees everywhere
Ssemanda agamenya embazi	Charcoal that can break an axe
Sabalongo*	Boss of all people who produce twins
Nantalinya mu kateebe	Person who never steps in swamps
Mutadibwamu	When he talks nobody is supposed to say no
Omuterega	Father of all languages
Nnanyini mu	Owner of all homes and people
Sebataka	Owner of all property
Nantakubirwa simu	No surf or peasant is allowed to call him on phone
Nantabbipingwa	No one is allowed to beep him on phone
Ssabalongo*	Father of all twins
Taata wa Buganda	Father of Buganda and Uganda
Nnanyini nsi	Owner of the earth
Magulu nyondo	Person with iron legs

Figure 5 Selected Titles for *Kabakas* (*) See Chapter on Twins for further information **Disclosure:** Not all titles are verified (Source: <http://www.weinformers.net/2012/07/24/30-names-of-Kabaka-of-buganda/>)

¹⁵ English and Swahili are the official national languages



Figure 6 His Majesty Ronald Muwenda Mutebi II, Kabaka of Buganda and **(Figure 7)** The Nnabagereka (Her Royal Highness, the Queen) Sylvia Nagginda both in traditional costume. Photo credit: Buganda Kingdom website <http://www.buganda.or.ug/> (Accessed June 20, 2013)

3.7 Twins

Of the myriad titles held by the *Kabaka*, two hint at the importance of twins to the Baganda; *Sabalongo* (Boss of all people who produce twins) and *Ssabalongo* (Father of all twins). Indeed the first *Kabaka*, as mentioned earlier, was himself a younger twin. As such, when he became the *Kabaka*, his many titles included two which referenced twins and the title remains one for all the *Kabakas* after him. In contemporary times, the birth of twins is an event that brings great pride to a family and to the father's clan and special social status to the parents of the children. This reverence for the birth of twins has its roots in Kiganda religious beliefs and social tradition. From a traditional perspective, the birth of twins marks the direct intervention by the god *Mukasa*^{16 17} on the family and by extension on the

¹⁶ "Mukasa held the highest rank among the gods of Uganda. He was a benign god who never asked for the life of any human being but animals were sacrificed to him especially when the Kabaka wished to consult him. He had nothing to do with war but sought to heal the bodies and minds of men. He was the god of plenty giving the people an increase of food, cattle, and children. It appears as though he was a human being who, because of his benevolence, came to be regarded as a god. His chief temple was on the island of Bubembe in Lake Victoria Nyanza..."(Roscoe 1966).

¹⁷ "Mukasa was the son of Wanema, whom the people on the island called Mairwa; his mother's name was Nam-bubi, of the Lungfish Clan; his younger brother, Kibuka, became the famous war god....While he was still a child, Mukasa disappeared from home and was later found on the island Bubembe, sitting under a large tree near the

family clan, and as such special care and attention must be given to the children and the family to mark the miraculous feat (Roscoe 1966:64). In pre-colonial days, the birth of twins was marked by elaborate ceremonies including a purification ceremony for the parents and a ceremony for the naming of twins (Roscoe 1966). When twins were born, they and their placenta were thought to have dangerous powers (Kyeyune 2012:320). The placenta was not buried as that was considered disrespectful of it and it was instead placed in a cooking pot and taken to the forest and left there; anyone who came upon the pot and disturbed it or the contents, would be burned by the twins' power and this was the explanation given for people who appeared to have skin pigment defects (Kyeyune 2012:320). Upon the birth of the twins, the father *Salongo/Ssaalongo* was required to go to his in-laws and announce the birth (Kyeyune 2012:320). The twin babies were then placed in a special part of the house called a *buyungu* where they and their parents stayed in seclusion until all taboos had been performed (Kyeyune 2012:320). The *Salongo* and the mother of the twins, *Nalongo* were not permitted to touch each other or have sexual relations during the taboo period and could only leave the house in the case of an emergency (Kyeyune 2012:320). Drumming and singing would be continuously performed until the umbilical cords of the twins fell off at which point the cords were wrapped together with cowry shells and other ritual plants associated with magical powers and used in the rites which welcomed the children into the clan (Kyeyune 2012:321). Because the twins were considered spiritual beings, there were ceremonies for their birth, their initiation into the clan and their death (Kagwa 1934:105, Kyeyune 2012:321). It was believed that twins did not die like other people and pronouncing them dead was forbidden; instead, it was said they were taking a long flight into the spiritual world and that their bodies would not decompose but turn white and remain that way (Kagwa 1934:105, Kyeyune

lake. The elders who saw him concluded that he had come from Bukasa, and called him a Mukasa (that is a person from the island of Bukasa), and this name attached to him from that time" (Roscoe 1966).

2012:321). Twins were expected to be handled with great care by the parents and any mismanagement, including refusal to observe any of the formalities, rituals and rites surrounding twins would result in dire consequences in the form of skin problems for the parents and also close relatives (Kyeyune 2012:321). Parents could not handle the twins until they first touched the ritual plants associated with twins, which were also believed to have the power to stave off diseases of the skin like measles and smallpox (Kyeyune 2012:321). Twins also had the power to protect their parents from witchcraft (Kyeyune 2012:321).

The birth of twins was considered such a miraculous feat that the entire lifestyle of the parents and the extended family changed (Kyeyune 2012:320). The parents would abandon their own names for the honorary titles of *Nalongo* and *Salongo* and the twins themselves were given special names depending on the order of their birth and the time. These titles and names remain in use today. The first born boy is called *Wasswa* and the first girl is called *Babirye*. The second boy is called *Kato* and the second girl *Nakato*. If the twins come after an older male sibling, that sibling's name becomes *Kigongo* and the child born after the twins is called *Kizza* and children that follow *Kizza* are called *Kamya* (m) or *Nakamya* (f) (Kyeyune 2012:320). According to tradition, the children of the brother of the *Salongo* are also bestowed these names of honor extending the accolades beyond the nuclear family (Kyeyune 2012:320). Parents were also permitted special social favors as a result of the twin birth including being able to pick food from the gardens of others without obtaining prior permission (Kyeyune 2012:322).

Although the parents of twins were regarded as having special powers, they were still obligated to give special praise and offerings to the ancestral god *Mukasa*—who is responsible for reproduction—with the words “*bweeza bwa Mukasa*” or risk insulting the deity (Kyeyune 2012:322).

The initiation of twins into their father's clan involved rites that were quite elaborate and expensive, costing about the same as a wedding (Kyeyune 2012:323). Oral tradition states that the birth of the first set of twins in the Buganda Kingdom under Ssekabaka Kintu's reign was considered so unusual, that the gods, through their medium¹⁸ declared that unusual things were allowed to happen including public vocalizations of obscenities and the physical contact between the parents of the twins and their in-laws, including a "bum-bumping dance" which is forbidden at all other times (Kyeyune 2012:323). Other rituals also took place during the initiation. One of these involved taking their umbilical cords which had been preserved since their birth, and placing them in two baskets of water, then they later wrapped them in bark cloth which the paternal grandmother would then decorate with cowry shells and beads (Kyeyune 2012:323). This ritual was believed to protect the twins from witchcraft and it was believed that anyone who harbored ill-will towards the parents and then touched the bark cloth, would die (Kyeyune 2012:323).

Today, regardless of whether they revere and worship the ancestral gods or are Christians or Catholics which the majority of Baganda are (CIA 2002), a high level of respect, honor, reverence and status for twins and their parents is still thoroughly ingrained in Kiganda³ culture. Parents who give birth to twins are still referred to by their special given titles which—particularly in oral introductions--supersede other titles of honor or distinction; social introductions must always include these titles and names. The naming of the siblings following the twins or preceding them is less common today as is the bestowing of special names of honor for cousins to the twins.

For the parents and the twins themselves, titles and names also apply in cases where a twin may have been miscarried or lost in-utero; the parents and surviving twin are still assigned the names and

¹⁸ All the traditional gods spoke through Mediums to the King.

titles as the miraculous feat which allowed for conception is not necessarily diminished by death; examples of this fact can be found in my own family with a first cousin whose wife miscarried a twin in her second trimester. The amount of elevated respect and accolades afforded the parents of twins in general is only exceeded by one thing, that of the birth of twin boys; the birth of two male children at once, which solidifies continuity of bloodline and lineage in Kiganda patrilineal descent, is above all the most desired birth among the Baganda.

The reverence for twins and parents of twins does not extend however, to triplets and other multiples. Indeed such births are rare to begin with the most common multiples in humans occurring as twins. However, very little is discussed or written about the reception of other multiples among the Baganda, but one twentieth century account of Kiganda tradition suggest that in more traditional settings in which twin-birth ceremonies are performed, all ceremonies for the expected birth of the twins are called off in the event a third child is also born.

The following account comes from John Roscoe, and Anglican missionary who at the turn of the twentieth century studied the Baganda and other East African ethnic groups using anthropological methods. He submitted the following to the London Times and it was later printed in the *West Virginia Medical Journal (Volume 15)* in 1920:

Where Triplets Meant Crime

The old Uganda marriage laws condemned to death any woman who gave birth to triplets, because the natives considered the occurrence due to witchcraft.

The old marriage laws here have taken me some forty hours to note down, and I have discovered today how dreadful it was in the olden times for any woman to have triplets. One case which my informant had witnessed will suffice to make you understand the horror felt by the people when such an event occurred. A woman gave birth to triplets, and the event was duly related to the king, whereupon he sent men to take the woman with the children, and also the maternal grandparents, into the wilds, and had them all speared to

death. The husband of the woman had his eyes gouged out, lest he should ever look upon the king and bewitch him. These people are closely allied to the Baganda and are, I think, a different branch of Hamitics from the Ankole Bahima” (CSH 1920).

Accounts such as these seem fantastic and cannot be corroborated as the Baganda and others did not document them themselves and it is unclear which ethnic group in Uganda he refers to. Still, it is clear that triplets have never been especially significant to the Baganda as there are there are no special honors, titles or names for multiples beyond twins and their parents. This could simply have been because the occurrence of triplets, quadruplets and other multiples is so rare that contingency scenarios were not considered and developed. But ask any Muganda what they want in terms of reproductive outcomes and the vast majority will respond that they want a boy, or twins, or better yet, twin boys!

While in Uganda I met an American woman who I was surprised and thrilled to find out was living in Uganda conducting ethnographic research for her PhD in Anthropology. We have since become good friends and communicate quite often. This friend is single. Shortly after I left Uganda she posted pictures on Facebook of her new daughter, a Ugandan infant of about a year old, whom she had adopted; the child was a triplet; the other two sisters had been adopted by a couple in New York. My friend decided to raise her daughter in Uganda for the next few years to give her a solid foundation in Ugandan culture for as long as possible. I was shocked though, first that she as a single White woman who is not a celebrity, was able to adopt a baby in Uganda, and second, that multiples had been put up for adoption in the first place. It’s just something that would be unheard of for twins! I called my brother to find out why triplets would have been adopted. He explained that they are simply not considered as special as twins; in fact, they’re often considered a burden. He gave an example of a news account of a Muganda father who abandoned his wife and the triplets she bore him due to the financial burden he perceived them to be.

I did a Google online search for “Ugandan man abandons wife triplets” and found several recent news stories written about two such abandonments and a third one had a video news clip on YouTube.com. In all cases, the appeal to the public was to donate money to help the women. One account tells of a couple from Kayunga a rural district in the Buganda Kingdom. In the account the 30 year old wife had no idea that she was going to have triplets; none of the doctors or nurses had ever told her she was carrying three and her 32 year old husband, upon seeing her holding three baby girls, fainted and then when he recovered, he abandoned her (Nsubuga 2012). Another account is from Masaka district, also a rural district in Buganda. The account is of a 40 year old man who abandoned his 22 year old wife after she gave birth to triplets; he left her in the hospital, sold the house and their banana plantation, and absconded with a new woman and the money from the sales leaving his 22 year old wife to her own defenses. The mother, who lost one breast to cancer and was attempting—unsuccessfully-- to adequately breastfeed her triplets is quoted as saying “I only have one breast and my babies look sick because they do not get enough milk since I starve at times,” (Buregyeya 2010). The YouTube story is of a woman named Jacqueline from Kasese district, in Western Uganda--outside of the Buganda Kingdom-- whose husband abandoned her as soon as he heard she was carrying triplets “because he was so scared of the news and the responsibility” (YouTube 2011). I mention this story of the triplets from outside of Buganda because my friend’s daughter also came from outside Buganda; she’s from Northern Uganda and what is clear, is that in a country where the majority of people live in poverty, triplets are a financial burden, especially if one already has other children to feed and sadly, the women or the children who are the most marginalized and disempowered segment of Ugandan society writ large, usually are the ones who suffer. If ARTs that have an increased likelihood of resulting in multiple births, including beyond twins, are to be introduced to Uganda, I argue that they must be used in a way as to reduce the likelihood of multiples if for no other reason than the economic stress they put on already financially stressed people. Though infertility is highly stigmatized, the burden of triplets, quadruplets and other

high order multiples is a worst case scenario as solution. These stories do not indicate a cultural bias against triplets per se—there’s no talk of witchcraft associated with such births, but what they do indicate is the burden they put on financial resources in a resource-poor country. Most families in Uganda simply do not have the financial capital to care for high-end multiples.

3.8 ARTs and Multiple Births

Between 1980 and 1997 in the United States, the number of twin births for women 30 years of age or older increased by 52%, which rose to 75% by the year 2000, while between 1980 and 1997 the number of triplet births increased by 404% with research showing a correlation in these increases between the older age at bearing, and the increasing availability of ARTs in the United States; the medical community has recognized the alarming trend as a serious complication of ARTs (Fauser et al.,2005, Ryan et al. 2004). This increase has prompted the American Society for Reproductive Medicine to declare reduction in *multifetal pregnancy* due to ARTs as a goal for both ART programs and their patients (Ryan *et al.* 2004). Because of the high cost of the treatments for IVF and Intra-cytoplasmic sperm injection (ICSI),-- which involves injecting a single sperm directly into an egg in order to fertilize it—and non-IVF procedures like ovulation induction/hyperstimulation therapies usually associated with IUI and which enable the generation of multiple embryos (Ombelet et al. 2004, Fauser et al.2005), the aim of fertility treatment as stated by Dr. Tamale Ssali of Women’s Hospital International and Fertility Centre Kampala, “is to produce as many eggs as possible, on the chance that one or more get fertilized” (URN 2009). Dr. Ssali also states that multiple pregnancies tend to increase the chances of miscarriages, and that the uterus is designed to hold and provide oxygen to only a certain number of fetuses, with multiple fetuses increasing the risk of babies born underweight or with varied abnormalities (URN 2009). Indeed research does show that multiple gestation increases several risk: pregnancy-induced low-birth-weight, hypertension, preeclampsia, anemia, antepartum and postpartum hemorrhage, maternal death, increased risk of miscarriage, growth retardation, preterm delivery, an higher rates of caesarean section (Fauser et al.2005,

Ombelet et al. 2004, Pilcher 2006, Ryan *et al.* 2004) Despite recognition of this, the claim on the homepage of Dr. Ssali's website, <http://www.womens-hospital.net/>, is that he and his team are experts in the delivery of twins and triplets, indicating that such outcomes are becoming increasingly common with IVF and other treatments offered there as well (Women's Hospital International & Fertility Centre, 2011). The minimum cost of IVF at his clinic, which is arguably the most reputable fertility clinic in Uganda, is, according to one 2011 news report from the country, approximately US\$15 million; about US\$6,000 in today's market (Daily Monitor 2011, XE 2013). Given that the cost of treatment in Uganda is high and—again as stated by Dr. Ssali—the success rate for fertility treatment is 30% ((URN 2009), I conclude that patients and doctors find it imperative that each IVF cycle has the most potential for success and therefore, as he earlier stated, the trend is to “produce as many eggs as possible, on the chance that one or more get fertilized (URN 2009). Patients and doctors both want to secure the maximum chance of success in the first cycle of IVF because after all, how many Ugandans can afford multiple cycles of IVF at a cost of US\$6000 per cycle? Certainly not the poor, and yet it is they who are most likely to suffer from untreated STIs which can lead to infertility and who largely lack sufficient education on STIs, have less access to regular STI testing and follow-up care are unable to afford access to the treatments at private facilities like the Women's Hospital International & Fertility Centre. So on one hand you have the wealthy either producing more twins—and receiving all the social accolades—or more triplets, which are less socially valued and cost more to care for in terms of physical and economic efforts, and carry the greater health risks of miscarriage, birth defects, etc., and on the other, you have the marginal poor, suffering increased rates of infertility due to STIs, lacking proper education on STI prevention and access to care, and arguably dealing with the most stigma, and the social fallout that accompanies all of this. This is a good illustration of some of the complicated issues that surround infertility in a highly stratified society.

3.8.1 *Low-Cost alternatives*

Low-cost fertility treatments have been proposed by several researchers as a possible solution to the adverse effects of multiple pregnancies from ARTs (Pilcher 2006, Ombetlet et al. 2004, Fauser et al.2005). I argue that they also allow those of lower socioeconomic status the opportunity to seek biomedical treatment for infertility should they desire to do so. With lower-cost options, the small health clinics and birth control clinics that have a massive presence in Uganda, could offer the low-cost treatment of infertility and help expand knowledge about the disease, and provide tests and treatments. This would allow for less stratification in access to healthcare and raise the quality of life for the marginalized poor.

Some proposed low-cost solutions include: extensive education of the public and infertility doctors about the risks associated with multiple pregnancies, postponing ART use in couples with a “reasonable outlook for spontaneous conception without intervention” (Fauser et al.2005), alternative treatments to induce ovulation including weight reduction, laser surgery of the ovaries and lifestyle changes for women suffering from polycystic ovary syndrome which is a common hormonal disorder among women of reproductive age (Fauser et al.2005), reducing the cost of IVF by replacing expensive drugs and high-tech equipment with low-cost alternatives-like using cheaper alternatives to hormone injections; “most women use 30 ampoules of gonadotropin per treatment cycle, resulting in about a dozen eggs at a total cost of US\$300-450...the dose couple be reduced or replaced with clomiphene citrate [which] produces fewer eggs and 15 tablets cost about US\$1” (Pilcher 2006, Ombetlet et al. 2004), replacing expensive equipment like the laminar flow hood needed to fertilize and nurture the eggs with humidicribs which are plastic boxes commonly used to keep newborns snug which cost a tenth of the price and can be modified, and instead of using carbon dioxide to incubate embryos in an expensive cylinder, the alternative would be “exhaling across the culture media before sealing it in a plastic bag, a technique commonly used in veterinary IVF. Then remov[ing] the need for an incubator by dropping the bag containing the

Petri dish into a warm bath. Such ‘submarine’ incubators have been used for cow embryos for more than a decade. “People didn’t think to use it in an IVF setting because it’s not seen to be sophisticated enough” (Pilcher 2006:977). These suggestions are based on my review of the available resources for ART in other countries. I would argue that they be considered for use in low-resource countries like Uganda where infertility is on the rise and biomedical treatments and preventative measures are expensive and hard to come by. I do not know to what extent any of the suggested alternatives are being used and further research on current biomedical alternatives currently in use in private fertility clinics in Uganda is highly recommended.

Regardless of the use of alternatives, current research on science and technology and the cultural changes that occur from applications of ARTs have produced significant ethical questions that should be considered even in low-resource areas I argue, where the use of ARTs is still in its infancy relatively speaking. The ethics surrounding ARTs in Uganda have already become a consideration for many in the general public as evidenced by the responses posted in the comments Section of online news articles about ARTs which I shall draw particular attention to in a later chapter.

3.9 Sociocultural and Ethical Considerations

3.9.1 In the News: Ethical challenges

For the Baganda, “unnatural” twin conceptions are not the only considerations resulting from applications of ARTs. As a patrilineal group, the Baganda put a lot of value on male children as they are the authenticators and preservers of ancestral continuity and lines of lineage. The question of the authenticity of twins and the preference for male children among the Baganda must be considered as there are risks that ARTs may be applied unethically which can result in exploitation and abuse of patients, as studies on ARTs in sub-Saharan Africa have recently shown. One of the greater considerations in terms of prac-

tice is the absence of regulations to protect patients from being taken advantage of by physicians. The imbalance of power between physicians and patients have led to increased cases of medical malpractice in the management of infertility care in the developing world (Pennings 2008). On the very day I arrived to conduct my research in Uganda, The New Vision newspaper, one of the leading papers of the country, printed a report that I accessed online which detailed an example of one such case. It involved the death of a patient of Dr. Ssali Tamale of the private fertility clinic I was to visit just days afterwards, with the hope of interviewing him. The report states that Dr. Ssali admitted responsibility for the 2010 death of Mercy Ayiru, a patient of his who was undergoing surgery for the removal of intra-uterine fibroid tumors. Fibroids are often responsible for infertility and surgical removal of them is quite common practice. Dr. Ssali was appearing before the Uganda Medical and Dental Practitioners Council—a supervisory council overseeing doctors in Uganda. The 34 year old patient, who was employed as a financial administrator died during the operation which was carried out by a “Prof./Dr”. Rafique Parker, a visiting doctor from Kenya who was not registered with the Uganda Medical and Dental Practitioners Council and by law was not permitted to practice in the country but who Dr. Ssali reportedly admitted had “served in numerous hospitals in Kampala, [though] ineligible to practice in Uganda” (Candia 2011). According to the report, Dr. Ssali had been present at the surgery which he called a “total disaster” where due to “wrong intubation” the patient suffered cardiac arrest under anesthesia (Candia 2011). Another report from the Uganda Radio Network (URN) provides more information: “Dr. Ssali together with an anesthetist at Nsambya Hospital, Christopher Kirunda and a Nairobi-based surgeon, Prof. Rafique Parker, are said to have caused the death of Mercy Ayiru. The trio allegedly failed to ensure that a tube meant to supply oxygen to her lungs was properly inserted before embarking on an operation while at Dr. Ssali’s clinic in Bukoto” (URN, no year). The most shocking part of the New Vision report—to both myself and the “stunned” council—was that when asked what procedure he used to recruit external medical practitioners like Dr. Parker, Dr. Ssali said that he relied “on word of mouth and did not check their CVs for

their competencies” and said “I could rely mostly on information I got from doctors I interact with” (Candia 2011).

Sadly, I’m not convinced that much has changed in terms of how Dr. Ssali may be managing his practice. When I visited the clinic’s website (<http://www.womens-hospital.net/our-team.html>) I found listed under the About Us tab, a team consisting of six staff members of whom four are non-native and—by all outward appearances—are of European descent and are listed simply as “Doctor” with no other qualifications or biographical data provided to visitors; the two Ugandans listed are Dr. Ssali himself whose credentials are provided, and his wife who along with her husband, is also listed as a Director of the clinic (Women's Hospital International & Fertility Centre, 2011). In light of the events which unfolded in the death of the patient reported in the news, I was surprised that bios were not provided for these foreign doctors as if to suggest that their being White doctors was all that was needed to prove a high quality care and that African patients shouldn’t need to know more about the team including why they are practicing in Uganda as opposed to in their own home country, or the details of their educational training including their medical specialization and professional background including any histories of malpractice. My own family had dealings with an Austrian doctor practicing in Kenya who ran a clinic in which he regularly abused clients with impunity. He would not have been able to continue the abuse had he been Black African. I do not want to suggest all foreign doctors in Africa are up to no good, but instead to suggest that just as one would want to know the background of Dr. Ssali’s training, which he provides, one should demand the same information be provided about the foreign doctors as well. Instead, the focus on Dr. Ssali’s the website is on the history of success the clinic has had and on the Christian values they observe:

“Our Achievements

We are on record for producing the first IVF baby in East & Central Africa.

We have also delivered over 400 babies both natural delivery and caesarean section in our ultra modern, state of the art delivery room and theatre. We recently deliv-

ered triplets and a healthy baby for a 58-year-old lady. One of the oldest women to have successfully given birth through our IVF clinic was 65 at the time.

Our Work Ethic

Our experts strictly maintain the patients' privacy, dignity and individual requirements in our comfortable rooms, including VIP treatment for patients that prefer it. The WHI&FC develops and implements the latest treatment for women related health ailments using traditional and holistic methods.

Our Values

Our lifestyle is Integrity

A mandate to speedy action

A commitment to teamwork

A standard of excellence

A culture of service and innovation

A language of faith in Jesus Christ

An attitude of gratitude and love" (Women's Hospital International & Fertility Centre, 2011).

I have no doubts that Dr. Ssali's clinic is successful as just about everyone I spoke to in Uganda about my research instructed me to try and get in touch with him, and informants I spoke to in the U.S., Kenya also spoke highly of him. However, that he has not --given his previous admission of not checking the CVs of the foreign doctors he hires--listed the qualifications of his doctors on the website, after a previous one caused the death of a patient, is of great concern. I do not believe my concerns to be unfounded as other news reports have emerged that also question regulation and my informant Rita also spoke of the issue and of the need in Uganda for better medical training of doctors to include extensive training on infertility diagnosis, testing, treatment and management.

A 2013 report in the New Vision online paper asks whether Ugandan egg and sperm donors are being exploited. The report states that a number of fertility centers have been established around the city of Kampala and "huge moral question" have arisen (New Vision 2013). The main concern in the report are that egg/sperm donations will becoming a "booming" business in Uganda as it has become in other parts of the world and that at this time, it remains shrouded in secrecy and stigma with "no available research or even statistics on the issue" (New Vision 2013). Certainly the reporter--whose name is not listed because she went undercover to interview doctors at clinics in Uganda--should be concerned given that research that has been

conducted speaks to the legal debates surrounding ARTs, including a rising trend of *reproductive trafficking* (Inhorn and Birenbaum-Carmeli 2008). Inhorn and Birenbaum-Carmeli, in their article “Assisted Reproductive Technologies and Culture Change” have noted a trend in which minority women in poor countries are being recruited and in some cases coerced to become the new wave of domestic servant, the gestational surrogates (Inhorn and Birenbaum-Carmeli 2008). ARTs are creating a new form of body commodification that medical anthropologists interested in science and technology are paying attention to. I would argue that sperm donation can also become an issue of ethics in Uganda if regulations are not put into place to prevent sperm donors from peddling their sperm at each rising fertility clinic, for profit.

The 2013 New Vision report states that the Ugandan Ministry of Health has to date formulated no policy on egg/sperm donation, IVF or surrogacy and quotes the Minister for Primary Healthcare, Sarah Opendi as saying “Right now, there is no policy. We shall consider looking into the issue. But I understand there are contracts. So if there is a problem, one could sue using the contract act.” (New Vision 2013). The website for the private clinic run by Dr. Ssali boasts that “WHI was officially opened In September 2005 by His Excellency, The President of the Republic of Uganda, Yoweri Museveni after becoming the first Hospital in East and Central Africa to register the first IVF (Test Tube) baby in 2004” (Women's Hospital International & Fertility Centre, 2011). This means that for the last nine years, clinics have been self-regulating. With Ugandan government officials like Sarah Opendi only “considering” looking into the issue of regulations, and more and more fertility clinics reportedly becoming established Ugandans may fall prey to what Pennings (2005) calls a private for-profit system in which unregulated doctors more interested in wealth than in “good practice” are free to run the clinics at the ethical levels of their choosing and patients who are desperate, uneducated and willing to invest all their money, may become victims (Pennings 2005: 19). Though there is a Contract Act ostensibly allowing patients to sue in cases of malpractice, getting a lawsuit through the court system in Uganda is an onerous task at best and one which few individuals—if they even knew of the Act—would be willing to

go through. Just getting one's case to court can take several years. In Dr. Ssali's case, he appealed to the family of his deceased patient to allow him to compensate them (Candia 2011). I was unable to find any information online regarding the outcome of his plea or to what extent he was punished for the malpractice.

Dr. Ssali's practice is not the only example the media has called attention to. Another fertility specialist practicing in Uganda has also generated concerns about ethics. The aforementioned New Vision local newspapers in Uganda, published an article which I located online, about a Dr. Patel Prakash of the Endoscopy Fertility Clinic in Kampala who met with a female undercover reporter posing as a patient interested in becoming an egg donor and wanting to know the process. I will speak of this doctor again later on as he has given several interviews about his fertility treatments; the article I refer to here entitled "Are Ugandan egg/sperm donors being exploited?" and is the only one in which an undercover reporter was presenting herself as a patient; the rest of his interviews he gave on record. The article outlines what he told the spurious perspective egg donor. He told her that in terms of the cost of the procedure, there would be none to her as the donor or to the recipient, but that the recipient would have to pay the cost of checking her reproductive system though he would not reveal exact numbers. He then went on to collect details about her skin color, the texture of her hair, color of her eyes, weight, interests and hobbies among other things. The reporter does not mention whether any cultural-specific details such as ethnic group and clan were recorded. None of the details he collected caused me immediate concern except what followed. He apparently then asked her whether or not she had a passport and she lied and responded that she was in the process of getting one to which he supposedly said "Please do that as fast as possible, because I do a lot of my work I in India. Everything is free of charge—the visa and the air ticket and accommodation and operation costs...endeavor your passport by the end of April" (the interview was published on April 14)... and he goes on to reveal that he "he plans to open a center in South Africa where he can take his clients for operations" and that he follows the international standards for egg donation (New Vision 2011). The concern with what is supposedly said by the

doctor is that without governmental regulations in place for the conduct of private fertility clinics in Uganda, there are no protections in place for patients, especially if they need to travel abroad for procedures that are risky. Without adequate regulations to protect patients, private fertility clinics run for profit, may start to generate concerns and behaviors similar to the ones raised by medical anthropologist Nancy Scheper-Hughes (2004) about scant regulations and the international organ trafficking. About organ trafficking as a new capitalist venture Scheper-Hughes noted a systematic practice of harming “one population of bodies in order to bring vitality to another (more privileged) population of patients (Scheper-Hughes 2004:31). She noted that as organ (including reproductive) transplant technologies have moved from the developed world to the developing world, they have created a frenzy of desire for the technology and an “abundant new source of organs in the bodies of the living, as well as of the dead, especially among the poor, the naïve, the medically illiterate, the displaced and the desperate—those whose social frailty and all too evident ‘bioavailability’ have proven too tempting to bypass or overlook...transactions range from consensual contracts (formal and informal), to coerced deals, to criminal trafficking verging on transnational kidnapping by local and international brokers...”(Scheper-Hughes 2004:33). I argue that the absence of regulations for ART use in Uganda, coupled with the increase number of private fertility clinics in the country, may potentially create a situation similar to that of organ trafficking wherein ‘bioavailable’ patients are taken advantage of by private fertility doctors, and as is the case with Dr. Patel, taken out of the country for nebulous procedures, that could result in serious consequences or death. On June 8, 2013 I had a phone conversation with a female cousin of mine living in Kenya about ARTs in Uganda. She stated that one of Dr. Ssali’s associates in his Kampala clinic is rumored to have left and begun his/her own fertility practice which is now competing with Dr. Ssali’s and is offering the same services at half the cost. If true, the claim raises questions about how costs can be reduced for procedures that are inherently expensive. Unless the new clinic has new forms of technology that are low-cost, I have to wonder if patients are not risking their safety by going to a competitor clinic where savings in cost may correlate with cost in quality of service and care.

In my discussion with my informant Rita, she mentioned some of the ethical concerns and ways in which patients are attempting to tackle the hurdle that regulations present:

PI: Is the government at all involved in regulation?

Rita: Regulations? It's not yet involved but there are general rules that are for working in international communities and since Uganda is following the British kind of thing, those are the same rules that the doctors are trying to adopt.

PI: Ok

Rita: But as patients we had started a, uh, we had come up with an idea which we floated to the doctors about the Fertility Society and Dr. Ian Cook is here, he's our patron. We are coming up with a patients' forum to float issues concerning what happens when you go through treatment.

PI: Mmm-hmm

Rita: There are different cases that are coming up, for example the, as you go through treatment, the stress, the right to have a counselor, the right to have information prior to the treatment, how to handle Hyperstimulation Syndrome, how to understand the kind of drugs that are being used in these exercises, and for patients to know their expectations and all that.

PI: Right. Patient rights are very big. (Rita speaking with PI Martha Mukasa, December 23, 2011)

In regard to the training of doctors she stated:

Rita: In my experience as a patient in this country, I'll start with the medical personnel. They train after they have specialized. They don't go deeper in the medical technologies and it has been, it will be the patients to demand for quality and the doctors will take the charge of going into the developments of advanced technologies. We have one doctor [Ssali] who is doing in vitro fertilization, but up to now, it has taken seven years, and you don't see another one coming up. Umm, technologies in management of infertility, laparascopy, they seem not to be interested! So as a patient, we want to have a forum and speak about what we have discovered and what we think is best for us. We want a quality treatment, we would like a one-shop investigation. We wouldn't like doctors to say 'if you had gone to the developed world, you would have been helped.' That is nonsense to me, I mean, why tell me after 20 years of struggling? You know as a woman you have a biological clock. You start these treatments at 20, by the time you're 40, the chances are almost nil. And then you start telling me 'if you could go to the developed world...' So, I think we need a lot and I think it will be us patients to spearhead this when we demand for quality."

PI "mm-hmm"

Rita: What we are doing at Joyce Fertility is to try to see that we make much awareness to couples to understand what they *should* have, what is available in other countries. So when we go to the medical schools, that kind of speciality in reproductive diseases is not there. I am looking at adolescents, they have their conditions, girls now start getting fibroids at age 18...but we don't have specialized doctors for adolescents! And this is a special category of people because infertility begins at that age. So it is something that we wanted, to interface with the doctors, through the Fertility Society and under the Patients' Forum, to show them that they're still short of what our expectations are.

PI: Oh, sure! (Rita speaking with PI Martha Mukasa, December 23, 2011)

My conversation with Rita clearly speaks to a growing demand among advocates and patients for quality care from Ugandan doctors, better training, comprehensive regulations and better education of doctors and of patients on their rights.

3.9.2 ARTs and challenges to clan identity

Because clan identity and ethnic identity are essential to kin structure, further field work in Uganda is needed to determine to what extent they are addressed in the clinical setting and whether providing gamete donors from varying ethnic and clan groups is a prioritized service provided by IVF clinics, or whether gametes are expected to be donated by extended family members to keep the familial ties intact. In her research study on ARTs in Mali and Togo, Viola Hörbst made several observations about how Malian men and women responded to the suggested use of donor gametes. She determined that there was a preference by men to either foster or adopt a child born from their sibling, or when possible, attempt other “traditional” methods such as an infertile husband having one of his fertile brothers sleep with his wife in order for conception to occur; this they would prefer to using the donor sperm of complete strangers (Hörbst 2012: 171). Among the Malians she found that Islam played a role in men’s rejection of donor gametes because the use of donor gametes was seen as analogous to adultery and they also felt that the donor gametes presented the possibility of future problems of incestuous relations between related offspring (Hörbst 2012: 177).

Knowledge is an important aspect to understanding kin relations. Because of the stigma of infertility, the trend in Uganda is for couples who have used ARTs to produce children, to keep the information private. This is understandable as to reveal the inner workings of how a child may have been

conceived is to risk inviting criticism over whether or not the child is legitimate, which as I've already argued, is not what those who are trying to produce children and fulfill the marital obligation, would want to invite upon themselves. This is also suggested by my informant Mrs. Rita Sembuya of JFSCU who stated that unlike in neighboring Kenya where couples who have successfully overcome their infertility through the application of ARTs and go on record to say as much, in Uganda, the use of ARTs is rarely admitted to even by those couples who may have once been members of support groups such as hers, for infertility. Only one couple had publicly come forth and it was during the launch and dedication of Dr. Ssali's clinic in 2005, which was attended by the President and the couple were featured as an example of a success story. She went on to say that rather than come forward, many former patients of Dr. Ssali have sent pictures of the children, which are displayed in his clinic (in a part of the clinic that I did not see) as a type of "Wall of Success" and Nancy added that "Like last time we were at Dr. Ssali's, they had put a notice 'congratulations'. So sometimes they don't put photos, they just put numbers." (Rita and Nancy speaking with PI Martha Mukasa, December 23, 2011)

Rita attributes the perpetual reticence of those who have had ART success, to stigma surrounding the use of ARTs and to the recent death of a patient under the care of Dr. Ssali, who died during a procedure and the public denunciation in the media following the death.

Rita: "Recently they put the doctor in the media, that some woman died in his hospital and now they've sort of depublicized him. But if the women could come out and speak! [But] they don't want to show their babies. They don't want to associate anymore...but I took it to be a cultural issue because the Kenyan women do, they do share but the Ugandans do not."

PI: “It’s interesting then to look at the ethical part because people will say ‘oh that was unnatural’ you know, even though the pressure to reproduce is there, now they start to judge you for having gone through this process that they consider unnatural.”

Rita: “Mmm, yes. People will ask “is the child normal? Is it a normal child¹⁹? And then they can associate it that you picked the eggs from [just] someone!”

(Rita speaking with PI Martha Mukasa, December 23, 2011)

Rita goes on to say that Nancy is working on a magazine that they will publish, that tells of success stories, with the hope of working towards eliminating the stigma.

In the essay *Strategic Naturalizing: Kinship in an Infertility Clinic*, Charis Thompson makes note of an important point in terms of egg donation. She highlights a case in which a woman chose to use a donor egg from a friend of the same ethnic background as herself, rather than an anonymous donor egg, because she felt the similarity in their Italian-American identity assured her that the resulting child would have “enough genetic similarity” to her (Franklin and McKinnon, 2001: 181). The interest in genetic similarity raises an important point about what agency a patient has in selecting donors with an ethnic identity close to their own, if the reproduction of ethnic identity is a critical element in the perception of familial continuity. It is an interesting point because Dr. Ssali’s private fertility clinic which offers IVF and gamete donation, but does not mention in any of its informational materials, whether the ethnicity of donors can be matched to patient families seeking to use them; in Uganda, ethnic identity is significant as is clan identity within the ethnic group.

¹⁹ “Normal” here referring to real and viable; a real human being, not some kind of lab experiment.

3.9.3 *Modern body and mind*

As mentioned earlier (see Methods Section), much of the imagery on the informational pamphlets available at the clinic, depict White bodies, which I argue may have historical roots in colonization as suggested by Dr. Sylvia Tamale, which underscore hygiene, cleanliness, proper health behaviors and an deeply embedded authoritative knowledge on how best to control the female African body (Tamale, 2005). I argue that in contemporary times it perhaps does two things, 1) It assures the patient that the technologies have come out of the West and are therefore “modern”, and 2) It likely encourages the elite, educated patient to refrain from concerning themselves with non-western, non-modern issues like local ethnic norms--though religious concerns are seemingly permitted and are assuaged by the literature and on the website (See section on Religion). So why not depict the black African body in the pamphlets at a private clinic? Perhaps the patients who for the most part are educated and of the elite class, want reassurances that the practices of the clinic are sanctioned in the West and are not just the result of Black African doctors experimenting on Black African bodies. Unfortunately Whiteness still represents superiority and “development” while African Blackness represents “developing” and sub-par. We see this in the language used to describe countries like the United States and Great Britain, which are regularly referred to as the Developed countries or the First World, while sub-Saharan Africa is referred to as the Third World. Even on the African continent there is the divide between the lighter skinned peoples of the North in countries like Egypt where applications of ARTs are more ubiquitous as are health resources, and those whose geographic locale, below the Sahara not only makes them “sub-Saharan” but also “below” in terms of their economic and health resource development, and they also have darker skin. When emerging medical technologies are introduced therefore, it is almost with sub-conscious intent that a level of Whiteness be attached to their imagery as a form of validation.

Perhaps in an effort to present the practice and the technologies therein as “modern”, Dr. Ssali has chosen to refrain from any mention of cultural concerns. The procedures discussed in the pamphlets I picked up at the clinic were extremely complicated and intimidating. Looking at them, I knew that patients without a medical background would be ill-equipped to understand the processes involved and would probably feel somewhat backward in bringing up ethnicity and esoteric cultural concerns like considering how to incorporate continuity of ethnic identity by way of donor gametes, in the context of a “Western” clinic with doctors whose knowledge is authoritative. When we as analysts speak of “authoritative” we understand it not to refer to the correctness of that knowledge, but to its status and power within a particular social group and to the work it does to maintain the group’s understandings of morality and rationality; the power of authoritative knowledge is not that it is correct, but that it counts (Davis-Floyd and Sargent 1997: 58). The terminology within the pamphlet is medical jargon, the language, English only and the frame, scientific: Diagnostic Laparoscopy, Hysteroscopy, Myomectomy, sperm, chromosomes, fallopian tubes, eggs and embryos. If the images give pause to patients, if they wonder at doctors risking their lives while playing God with bodies, they need only look around to the images on the walls, the pictures of happily pregnant couples, the sign posted on the door announcing the success rate of the previous month in percentages. I would argue that these contrasting images of outcomes offer comfort and reassurances that the alien-like processes involved are not to be feared, they are progress, modernity. Ginsburg and Rapp (1995) argue that procedural images help legitimize new reproductive technologies and effect new common sense notions about the “facts of life” and this in turn has significant cultural consequences in the wider systems of knowledge. They also help to legitimize the health practitioner. In their study on maternal health, war and religious tradition in Sierra Leone, researchers Jambai and MacCormack (1996) note that people invest legitimacy in the healers to whom they turn whether they are scientifically trained or traditional practitioners; it is through this investment that they are able to reassure themselves that the system of healing has mean-

ing and go forward to undertake their quest for health with conviction (Davis-Floyd and Sargent 1997). The ontological politics I mention here just briefly but they are certainly worth further investigation in future studies especially as ARTs become available in rural areas where they will have to compete with more traditional views of healing including ethnomedicine and local frameworks therein. But my point here is that there are power dynamics at play in the private clinic setting that encourage the patient to have faith in these modern processes and perhaps to leave more traditional concerns at the door.



Figure 8 Clinic pamphlet



Figure 9 Clinic wall art



Figure 10 Clinic wall art

3.9.4 Considerations for single females

In recent years there have been several Ugandan online newspaper articles about the increased interest in conception though DI specifically among socially elite single women who have no children and are in their late 30s and early 40s, years considered advanced for reproduction (Wandawa, 2012 and Okoth, 2012) Whether married or not, single women are still expected to produce children at some point in their adult lives according to Kiganda culture. Women who fail to go through the biological process of reproducing children are regarded as incomplete adults. In becoming a mother, a Muganda woman

moves out of the liminal stage between childhood and adulthood and fulfills cultural expectations of what adulthood entails. However, given the importance of clan identity, I would argue that single women who conceive children by DI should be prepared to consider the clan identity of their children as well. The adverse economic and social effects produced by multiple pregnancies (triplets and beyond) should also be a consideration for application of IUI and IVF especially for single women in resource-poor nations such as Uganda (H. van Zandvoort et al 2001). Certainly by producing twins a Muganda woman according to custom should be referred to as *Nalongo* and receive the elevated social status that accompanies the title. But with no father of the children to embody the *Salongo* whose clan will the accolades be awarded to? How will society adjust to the increase in twin births by the social elite who are single and whose children are essentially clanless? Will the children be given the customary names identifying them as miraculous twins or will a new category of twin birth develop? The experiences of these women as they undergo these medical procedures as well as the responses they receive from their peers, family and community are worth further study. One such article shows an increasing concern for stigmatization of children born to single mothers by the use of ARTs:

“What will you tell that child in the future?”

Joseph Musaalo, a counselor at the Uganda Christian University, Mukono, is skeptical about the new trend in Uganda and notes that not only does it have no place in our culture, considering that the society is patrilineal but has consequences, particularly in the future, when children start asking about their paternity.

“Today, you are looking for a child, so you settle for intrauterine insemination, but in the future, that child will be looking for its father, and what will you tell them?” Musaalo asks. He adds that on discovering that they have no fathers, such children are likely to suffer psychologically. “There is a high risk of breeding a generation of people with low self-esteem because they do not know where they belong,” he says.” (Wandawa 2012).

Concerns can go beyond what stigma the child may experience, and I would argue the mother too, to more serious considerations including place of burial. Baganda clans usually have land set aside for burial of members (Roscoe 1902). It is conceivable that children conceived by ARTs may not be permitted burial in the clan land of the mother as she may expect them to be

buried in, in the absence of a father. I would argue consideration of clan is of great importance even in contemporary times and that the future of children born from donated sperm should include knowledge about which clan and people they belong to. Medical practitioners should verify if clan affiliation is of importance to the couple or to the single woman, and determine through further conversation how best to proceed and minimize the risk of social rejection of resulting children. Certainly additional ethnographic study is needed to determine how couples or single women using donated sperm for conception are grappling with the local identities of their children.

3.9.5 *Public responses*

Three recent articles have been posted online and have generated public responses in the comments section that are worth noting. These responses though not as rich in their content as interviews would be, provide some insight into how readers of the local papers in Kampala feel about the way ARTs are being applied. In each article, the same doctor, a Dr. Prakash Patel a gynecologist at the Fertility Endoscopy Clinic in Nakasero a suburb of Kampala, has been interviewed. In one article entitled “Ugandan men donate sperm to wealthy women”, the doctor describes the type of patients he sees and what is entailed in DI. Patel states that his patients described in the article as “educated and career oriented” are the new wave of woman, no longer considered inferior in society as they were in the past (Okoth, 2012). He goes on to say that “according to international law, every fertility clinic is required to limit every sperm donor to no more than eight children” the reason being “In case the half-brother and half-sister resulting from sperm donation have children , there is a high chance of genetic abnormalism and incest among those children” (Okoth, 2012). Patel does not offer the reporter any evidence however, or

statement that international laws are being observed in Uganda or that regulations exist to prevent a donors from seizing the opportunity to make profit from the commodification of sperm and engaging in what has earlier been referred to as *reproductive trafficking* thus increasing the likelihood that his sperm is available at several clinics and, that he produces more than eight children. The criterion he provides for sperm donors include: “check-ups on the family history, hereditary diseases like diabetes and sickle cells, mental problems, and behaviors...he should be a person who neither drinks or smokes. Such a person must also be intelligent and must have good hobbies (Okoth, 2012). The article states that the anonymity of the donor and recipient are heavily guarded and when pressed on the cost of treatment, he declined to discuss the matter except to reveal that “the amount of money [also] depends on the type of sperm donor a woman wants to father her kid” (Okoth, 2012). It was the statement about cost being tied to quality that caught my attention in this article because of what was said in the next article called “Career Women in Uganda Choose to Miss Out on the man and Buy Sperm” (Wandawa 2012). In this article, Dr. Patel spoke of the growing number of women in Uganda requesting donor sperm stating that “there are single women who want babies with specific characteristics such as particular skin tone, hair and eye color and find it easier to achieve this through sperm donors” and that “[interestingly] he receives a big number of Ugandan women asking for White sperm donors” (Wandawa 2012). This is an interesting new trend because it speaks of a new way that single women using ARTs are attempting to set themselves apart from Others by having children of mixed ethnicity and creating a potentially new social class of elite Ugandan mother; one with light-skinned children with different hair and eye features that set them apart and leaving a legacy of light-skinned descendants. As is the case with many other cultures where the majority of the population are dark-skinned, light skin in Uganda is admired and desirable. As my own mother was quite light-skinned, I am well aware of how much admiration, praise and even jealous comments it can draw. The trend Dr. Patel notes is not surprising but interesting that

women would prioritize sperm from White males to assure that their children receive admiration for their skin color, without consideration of other cultural factors. The motives behind this growing trend is also worth further ethnographic research to determine why this is happening and also how the children are viewed if they have no clan/father ties to Uganda and they have no White father to account for them either. It would be interesting to determine whether these mothers more often than not, disclose to their children the circumstances surrounding their conception simply because they appear different from other Ugandan children and have no father. Studies on the social outcomes for offspring of DI have found that not knowing one's biological parent and biological roots has been the main source of discomfort for DI children (Beeson et al 2011). I would suspect by what Dr. Patel disclosed about the cost of insemination through anonymous donor sperm, that White sperm is the most expensive kind. That a number of women are seeking White sperm is demands further social analysis.

What I argue women may have to consider is that with few regulations on sperm donation, a man may be donating his sperm at several of the fertility clinics in Kampala and that although there are international standards in place that doctors should be observing to prevent a single donor from fathering too many offspring, there is no evidence that men—especially those whose sperm may be in high demand because of their profile such as White men—are not engage engaging in reproductive tourism so that if the lighter children are a preference, there runs the risk that children born from their sperm could end up marrying others light-skinned from the same social class who may also be their half-sibling. There are certainly many considerations and concerns as indicated by the comments left by readers. The main themes involved the identity of the children, the quality of the sperm, and mistrust.

The following comments were posted under the article “Ugandan Men Donate Sperm to Wealthy Women” (Okoth 2012). 46 comments were posted. 8 were men interested in becoming donors and providing their contact information.

Clan/Identity concerns:

*“Hey, those forms that require father’s names, even if they are dead, what will the poor chaps write? N/A? Artificial F**cking should remain purely therapeutic when hubby n wife fail to get children. Practitioners will never leave counseling rooms I swear.” –Steve*

“According to African tradition we consider the clan very vital, if one uses such method which clan will the kids belong? Let us not take things for granted...”-Harriet Biira.

“Hilarious just...so what happens when the kid dies? Will they be buried in the cemeteries coz they gat no ancestral homes???? Poor kids!”-Sweetie

“I just pity kids born out of that arrangement...not knowing their fathers.”-Adeye

“What do you tell the kids when they grow up. Father is anonymous or you came from test tube?-Sarah

“THAT’S MADNESS. A CHILD SHOULD HAVE A KNOWN FATHER, CLAN, RACE AND TRIBE.”-Guma

“Artificial insemination is known fro pigs ans goats not fro human beings. I AM a psychologist and I can tell you a child who has no father in Africa has no belonging and can grow into a monster and their first²⁰ are likely to be their mothers.”-Aloysius M.

“JUST THINK ABOUT THE FUTURE OF SUCH CHILDREN WHITH UNKNOWN FATHER, UNCLE OR RELATIVES FROM THE FATHERS SIDE. HOW WILL THEY FIT IN SOCIETY? I AM SURE THEY WILL STRIVE TO KNOW THEIR FATHER AND THOSE MOTHERS ARE EXPECTED TO GIVE SATISFYING ANS TO THEIR CHILDREN, FAILURE TO CONVINC THE CHILDREN MAY LEAD TO BIG HATRED AND DEATH. LET US FEAR GOD AND LEAVE NATURE THE WAY GOD CREATED IT.” -George O.

Mistrust, Threat to Culture and Call to Action :

“Wazungu (Foreigners’) culture penetrating the African continent. The uneducated may think it is cool and may want sperm donated from any Tom, Dick and Harry. So many bastards with anonymous fathers will walk the earth. I myself would have wanted to know the donor, his name, age, education, family background”-Jenny

“Patel is very dangerous, what if he(Patel) becomes a lone sperm donor and he wants to change all the Africans/Ugandans to to his race?! Every woman may produce a muzungu (white child) even

²⁰ I believe this refers to a first sexual encounter.

against her will. Otherwise people are evading God nowadays and he knows what to do with them.”-Grace

“THIS IS INSANE. OUR LEADERS PLEASE WAKE UP AND FIGHT SUCH ROTTEN CULTURE THAT IS EATING UP OUR SOCIETY. PLEASE ASK PATEL TO PACK AND GO HOME BEFORE THE SITUATION GETS OUT OF HAND. WHAT WILL YOU SAY BEFORE GOD ABOUT THE PEOPLE U LED. THINK AND ACT.”-Edward

“The government needs to investigate who this Patel is; these are the people who leave their home countries after committing crimes, and they come to manipulate our poor countries. You might find that he owes child support and he does not even have a medical degree. These women have a problem that needs to be addressed, but a fatherless child is a desperate solution, and it is not a solution. It will create more problems in the future.”-Bet

“Register the pregnant women and said responsible man to avoid future problems in IDs. That is: -all who take artifi...insem.will have to tell reason or show permission from the state”-Kagezzi

“Liberalism indeed! It reminds me of the “Le Clone” movie currently serializing on UBC TV. Very soon you will have human beings being manufactured like chicken broilers and layers. How different is this from homosexuality which the Ethics minister has condemned as unethical? Why is he still quiet about it? But of course, I had forgotten that this Patel is an important investor and he should not be disturbed, otherwise, the economy will suffer!”-Sulayman

“I hope that due diligence has been taken to ensure that this new phenomenon in Uganda is not abused”-Grace

“hmmmmmm that means soon or later there will be no black people in Uganda, simply because all women would desire to have white kids hence buy sperms from white guys. Tufudddeeeeee (we’re dead) Bishop n the Kabakazzz (King) plz help on that issue” –Steve

3.9.6 Male infertility and donor sperm stigma

Artificial donor sperm insemination (DI) either through intra-uterine insemination (IUI) or through in vitro fertilization (IVF) may result in outcomes that create new social stigma should the means of conception be revealed to extended family members or the larger social community. The stigma may be severe for the children who without knowledge of their clan identity, may feel a sense of limbo about who they are and how they relate to others. An online research survey of 741 DI offspring--including respondents from Uganda-- was conducted by a research team from the Department of Sociology and

Social Sciences at California State University, East Bay, notes that men who are the social fathers to children born out of DI may feel shame about their infertility and want to maintain secrecy to avoid stigma including stigma from social children (Beeson *et al* 2011). Male infertility is highly stigmatized and handled with extreme discretion in Uganda to protect the dignity of afflicted men (H. van Zandvoort *et al* 2001). Studies have shown that male infertility is associated with diminished masculinity, marital instability and additional psychological consequences (Beeson *et al* 2011, Inhorn 2009, Ombet *et al.* 2008). With identity among the Baganda tied to patrilineal clan, men may find it beneficial to have information on donor clan identities when selecting a potential donor, in order to select an appropriate donor from their own clan or one they find acceptable. Not knowing one's biological parent and one's biological roots was stated as the main source of discomfort by the respondents to the survey conducted by Beeson *et al* (2011). One particular respondent stated ""It makes me angry that I am denied the basic right of knowing who my father was and what ethnicity I am."" (Beeson *et al* 2011:2419). I would argue that by prioritizing the inclusion of ethnic and clan identity in anonymous donor information, children born out of DI who learn that their donor father belonged to the same clan as their social father, may feel less alienated and more like a member of an extended family. In the absence of ARTs, men in developing countries have been known to disguise their infertility problem by claiming children elsewhere or by having their partner engage in sexual intercourse with other men including relatives (H. van Zandvoort *et al* 2001). I argue that having to take these measures could still result in stigma for the infertile man should the relative in question speak out or publicly claim a child is theirs. However, I suggest that by collecting ethnic and clan affiliations of sperm donors, couples would still be able to select an anonymous clan donor from the patrilineal clan and avoid risking parental claims by the donor while dually satisfying the expectation of clan continuity through reproduction.

3.9.7 Religious considerations

Religion is an important aspect of life in Uganda. According to a 2002 census, more than half the population identify as either Roman Catholic 41.9%, Protestant 42% (Anglican 35.9%, Pentecostal 4.6%, Seventh-Day Adventist 1.5%), Muslim 12.1%, other religions 3.1%, with only a small percentage, 0.9% having no religious affiliation at all (CIA 2002).

Several studies have documented the important role of religion in influencing reproductive decision-making (Bledsoe 2002, Braff 2013, Inhorn 1994, Ombelet et al. 2008). A study in the Middle East found that policy-making was often influenced by Islam, Judaism and Christianity and that among these religions specific ARTs-- such as insemination with husband's semen—were permissible while others were not (Inhorn 1994, Inhorn and Van Balen 2002, Ombelet et al. 2008:610).

An example of which could be found in the prayer meeting announcement and on the flat-screen TV in the waiting area. The prayer meeting announcement was an invitation to participate in the “6th Annual National Prayer Day”. This pamphlet was of particular interest to me because not only was it an “invitation” but it had a stated theme in bold print which read “THEME: Present your case, says the Lord; bring forth your strong reason, says the King of Jacob. Isaiah. 41:21”. There were three other bullet points that instructed followers in both English and Luganda, the predominant native language, to 1) Write their 2012 prayer request on the back of the card. 2) Put their first seed offering (monetary offering) of the year 2012 in the envelope. 3) Hand in the envelope at the event “at the time of giving”. The final point was only written in Luganda and it instructed attendees to not forget to bring two thousand Ugandan Shillings as an entrance fee. There was a place provided for both the donor/attendee's name and telephone number. The bishop overseeing the event was to be Bishop David Kiganda who, “togeth-

er with the family of Christianity Focus Centre” was sponsoring the event (see fig 3.)

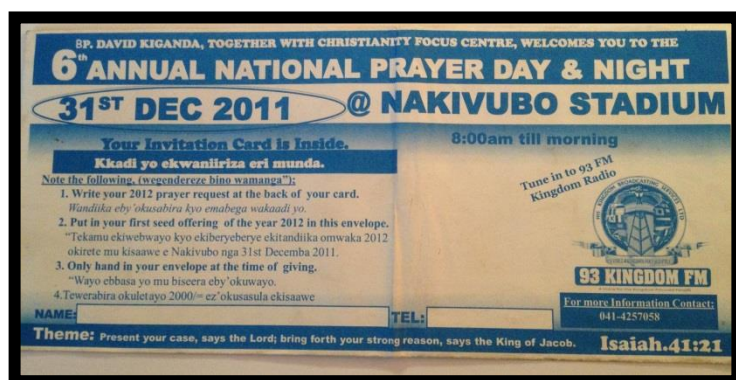


Figure 11 Prayer Envelope

The TV in the waiting room was tuned in to a station called LTV which appeared to be an evangelical Christian station. I asked the receptionist if it played all day and she said it did. An internet search on “LTV” informed me that “Light House Television” provides “religious inspirations with daily preaching, religious songs and films spreading Christianity across the country and the world (http://www.africatv24.com/uganda?tv_feed=27: no year). A later search on the “About Us” tab of the clinic’s website contained tenants of the beliefs held by the staff and medical personnel—four of the six of whom are non-native and of European ethnic descent and are listed simply as “Doctor” with no other qualifications or biographical data provided; the two Ugandans listed are Dr. Ssali whose credentials are provided, and his wife who along with her husband, is also listed as a Director of the clinic. The tenants stating their beliefs are as follows:

“We believe in One God, eternally existing in three distinct persons: Father, Son and Holy Spirit (Deut 6:4; Matt 28:19; I Cor 13:14; John 10:30). We believe that the Bible, the Word of God; in its divine verbal, plenary inspiration; and in its inerrancy and infallibility in the original languages; and in its supreme and final authority in faith and life (2 Tim 3:16; 2 Pet 1:20-21). We believe that Jesus Christ is the Son of God, and the Savior of the world. We believe that the blood Jesus shed on the cross allowed us to have an intimate relationship with God. We believe in water baptism and baptism in the Holy Spirit. We believe that God wants us to have a full life, free from poverty, sickness and disease. It is through

our faith in His selfless act of love that we are saved. We believe that Salvation is by grace through faith in Jesus Christ apart from works (Eph 2:8). Christ rose from the dead and is coming again to His people home. For further information, please visit: Science And Faith” (Women's Hospital International & Fertility Centre, 2011).

As the private clinic and its goings-on remain largely shrouded in stigma, secrecy and mystery, the Church and religious leaders in Uganda may not be vehemently opposing the use of ARTs and their outcomes at this time. However, with reports out of New Vision and other papers expressing concern about the rise in fertility clinics, outcomes such as an increase in “unnatural” multiples alone may lead to censure and distrust of the biomedical methods and discussion on the ethical dilemmas created when multiple pregnancies occur and decisions need to then be made about how to resolve the intended outcomes of one child or twins, from actual outcomes of more. With little research available on the actual practices in private clinics in Uganda, it is impossible to determine at this time how many patients have had to reduce the number of multiples in the womb and the psychological effects those decisions have had, especially for people who are religious and do not believe in abortion, which is illegal in Uganda. Such outcomes will surely be addressed by religious leaders as they become more prevalent in Uganda a country where ethics and moral standards are often informed by religion. Informant Rita Sembuya, of JFSCU stated in her article on the experience of infertility in Uganda “Patients’ Voice” that some of the churches in Uganda are strongly opposed to the use of ARTs (Sembuya, 2008).

Preimplantation genetic diagnosis (PGD) is a screening test that is in use in the West to detect abnormalities in IVF- and Intracytoplasmic sperm injection (ICSI)- created embryos outside the woman’s body so that only the most desirable, mutation-free embryos are implanted (Inhorn and Birenbaum-Carmeli 2008). The use of this screening process has raised ethical concerns about the sanctity of life in its early stages, the potential culling and disposal of female embryos, the right to life for those who are

genetically impaired and the creating of *designer babies* (Inhorn and Birenbaum-Carmeli 2008, Inhorn and Van Balen 2002). I can find no evidence that these services are being offered in Uganda but certainly such screenings could herald the beginnings of a new form of eugenics if applied unethically, especially if there are no regulations in place and doctors and patients are left to set their own ethical standards in regards to how they are applied with the woman's body supplying the canvas for experimentation. With a preference for males being so prevalent among the Baganda, such a technology could be used as a form of sex selection with potentially devastating social outcomes. I argue this based on the finding from research done about how the use of prenatal technologies in India resulted in feticide, the selective abortion of female fetuses; ultrasound and amniocentesis procedures in India-- where gender imbalances exist and a strong preference for boy children over girls--were found to be responsible for the increase in female feticide; the intended use of the technology when it was introduced, was to determine whether a fetus was healthy, not to select boys over girls and the Indian government responded by attempting to introduce regulations for the use of prenatal diagnostic techniques (Ahmad 2010, George 2006). As mentioned earlier, abortion is illegal in Uganda, but were PGD technology be introduced without accompanying governmental regulation, we could see it used in a rather insidious manner. In a multiple pregnancy of quadruplets or more, we may see the culling of only the female embryos. I do not argue that the technology not be introduced, but rather that it be regulation. Certainly, the benefits of being able to determine that healthy embryos are implanted during an expensive procedure like IVF, makes sense. Having suffered infertility and then having successfully undergone IVF, one would hope the fetus was at the very least viable and healthy! I can find no indication that genetic testing is currently being conducted at fertility clinics in Uganda. In the absence of these technologies, I would recommend further research be conducted in Uganda on the number of children born from ARTs with genetic abnormalities and the social and psychological consequences to families. With religion providing much

guidance on ethics and social positioning in Uganda, further study on how these issues will be addressed by the Church should also be a consideration for researchers. I argue that were cultural norms, values and expectations be recognized by the biomedical community as being germane to technology, Ugandans could actively work towards adapting technology to cultural norms instead of vice versa, while also protecting the patients and unborn children from harmful outcomes. In doing so, modernization by technology will not necessarily come at the perceived cost of sacrificing aspects of cultural heritage and identity and result in creation of new forms of stigma for children and parents alike. Without regulatory boundaries and standards being set by the public health sector or ethical committees of Uganda, Ugandans have no way of assuring that they are protected from receiving care of poor quality and no legal recourse for malpractice should they require it. The standards that govern the current application of ARTs are the international standards and do not emphasize the importance of cultural identities and traditions. As I have demonstrated, discussion of these factors with patients during these nascent stages would be ideal for ethnographic study.

4 CONCLUSIONS

What actionable data can anthropological research contribute to discourse on medical ethics and bioethics? When bioethicists concern themselves with the moral implications of the limits of applied technology in medicine, they often rely on the ELSA model established in the 1960s with the development of the field--which calls for the interdisciplinary consideration of the ethical, legal and social aspects of biotechnological outcomes-- to establish research standards and guides (Rip 2009). Anthropology as a social

science concerned with social dynamics and the relativism of specific cultural ways of knowing and being, is well-suited to offer much perspective based on ethnographic methods, of how biomedical technologies directly impact relations of power, knowledge and social hierarchy and how these relations can themselves create arguments for the culturally-specific applications of biomedical technology. Yet the contributions made by social science to the ELSA model thus far, those relating to the social aspects of biotechnological outcomes, have been largely criticized for their inability to effect change. Indeed the contributions made by the social sciences have been largely dismissed by ethicists for conveying facts and making observations when what are called for, in their view, are concrete plans of action (Haimes 2002). With the increased interest in the effects of science and technology on society, medical anthropologists are particularly well-suited to provide actionable data based on their observations of how cultures are shaping and are themselves being shaped by science and technology.

I have argued that in terms of the application of reproductive technologies in the developing world, a cultural ethos can and should be applied and further, I have provided examples of actions that can be taken to do so and I have demonstrated why such actions would be necessary given the cultural frameworks I have laid out about the Baganda.

To date, discourse on the ethics of applying reproductive technologies for infertility in developing countries often focuses on debating the pros and cons on two fronts, those representing the views from the Western countries—ostensibly the developers and providers of the vast majority of reproductive technology-- and the perspective of reproductive health advocates representing the interests of those afflicted by infertility in the developing countries. The extent of much debate seems to revolve around a general opposition--largely stemming from the West-- to applying reproductive technologies in

“overpopulated” countries with few health resources in lieu of the prioritization of those health issues and pandemics that continue to threaten and impact the larger population (Inhorn and Van Balen 2002, Pennings 2008). The opposing argument in support of providing biomedical interventions for infertility cite reproductive autonomy, and the huge social burden and suffering, particularly by women, that result from the inability to successfully reproduce (Inhorn and Van Balen 2002, Pennings 2008). What is not being discussed and yet I argue is of equal value is the question of how technologies *should* be applied at a local level with consideration of the cultural fabric in which it will undoubtedly be reconstructed and interpreted; that is, how the biomedical gaze will be filtered through a cultural lens. Medical anthropologist and physician Paul Farmer has noted the need for the discipline and discourse of medical ethics to include what he refers to as a view “from below” (Farmer 2004: 18). He argues that in developing countries it is the poor who are often the ones most interested in rights to healthcare and the sharing of scientific advances, yet have neither the access to the research journals--where dissemination of such research takes place, nor in many more cases, the education level needed to understand the outcomes of research they themselves may have participated in--verification of which is solidified in signed ethics-related consent forms--were they accessible to them in the first place (Farmer 2004).

Medical anthropologist Marcia Inhorn (1994) has conducted research on infertility among women in Egypt that has looked at how local meanings and interpretations of the processes and outcomes from biomedical technologies have been constructed. She found for example that as the application of in vitro fertilization (IVF) became more prolific, questions and misconceptions increased among Egyptians about how test-tube babies, “babies of the tube” were conceived and gestated with the greatest concern regarding the perceived artificiality of the process versus the intentions of God and nature and, and whether the processes involved are morally sound (Inhorn 1994:338). I have demonstrated through

my ethnographic interviews and the current literature that such concerns are not limited to Egypt and elsewhere but are taking firm root in Uganda. I argue that transparency about the processes involved in ARTs and the risks involved, including an increase in multiple births, is necessary for larger acceptance in Uganda and education will be the key. Patients should be fully educated and should be encouraged to ask questions that are important to them about how to utilize ARTs in ways that do not compromise their cultural values if indeed those values are important to them. The unknown factor in ARTs will certainly result in further stigma and suspicion. In her research, Inhorn found that the technical aspects of IVF were not fully disclosed by doctors in a way that could be understood by the majority of patients and that those with less information often relied on outside sources, including incorrect depictions of IVF in local television soap operas, to arrive at conclusions about what they themselves would undergo. These and other questions about whether the IVF processes were sanctioned by Islam too were of great concern to patients (Inhorn 1994:340). Inhorn stated that for many of those undergoing the procedure, anxieties about Islam's acceptance of IVF were laid to rest by the sanctioning of the procedure by a popular televised Muslim cleric who saw it as an acceptable last resort; however, those (fertile) Egyptians not familiar with matters of infertility and less attuned to the discourse when asked, overwhelmingly indicated that they felt IVF was indeed forbidden by Islam (Inhorn1994:340). Inhorn states that one particular event, the birth in Cairo of IVF quadruplets to a woman who had been infertile for seventeen years, received a lot of publicity in Egypt, as the birth of IVF-Multiples (IVFMs) often does (Inhorn 1994:336). Inhorn does not reveal any other details of how the outcome of quadruplets was interpreted by Egyptian society, the woman, her family and extended social network and whether the response would inform medical practice and infertility treatment. I speak to Inhorn's research and the experience by-- and questions from-- Egyptians and their religious leaders as they seem to reflect many of the questions and concerns that are developing in Uganda. Questions such as how many fertile embryos to implant during

IVF procedures and other such technical considerations which I address are essential, involve opening up the discussion to include modeling bioethics around culture so as to construct a culturally-specific rubric for applying Assisted Reproductive Technologies.

In order to give those most in need of relief from infertility stigma, women of lower socio-economic class and the poor in rural areas, low-cost fertility treatments must be explored. The current system of private fertility clinics caters to the wealthy and reinforces stratified health and structural violence. It allows only those with social, political and economic capital the agency to take advantage of the present advancements and—in terms of political capital—allows only the government officials the power to make the necessary recommendations about whether or not to regulate the technology. The poor have no seat at the table where these discussions, would take place if they were to take place at all. With the introduction of low-cost treatments, they would then have a way to voice their concerns, educate practitioners about their own cultural beliefs and generally be a part of the process of assuaging infertility *and* stigma.

During my field research, I was particularly surprised at the number of small birth control clinics all over Kampala. My informant Rita and her associates also mentioned their work at these clinics and that the focus is rarely on infertility, but on controlling birth rates. They stated that the poor referral system in Uganda worked against those in rural areas who would have to travel miles and sometimes days to get to Kampala's Mulago Hospital for further diagnostic care or treatment, and once they arrived, there was no guarantee the clinic would be open, resulting in a day's worth of lost time. Many women then give up and just go home and forget about coming back to the city for treatment. With low-cost fertility treatments available at the birth control clinics, which are more numerous and more accessible in rural areas, sufferers of infertility would have a better way of getting the help they need.

Recognizing cultural norms and situating them directly into treatment design for infertility will allow for input at a local level that may help assuage patient and community concerns about the hazards of unethical conduct in medicine or by biomedical practitioners. I argue that by allowing cultural factors, concerns and interpretations to inform medical practice in the developing world, patient autonomy increases and compliance with treatment recommendations may also improve.

In closing I argue that as ARTs become prolific in sub-Saharan Africa their use be guided by comprehensive regulations to protect patients from being taken advantage of by doctors who may be driven by capitalistic interests and a growing competitive market. As noted in the Scheper-Hughes (2004) study on organ trafficking, patients may pay the price in lower quality care as they become commodities in the new ART market. Scheper-Hughes cautions of the 'rotten trade' that has come out of the capitalist-driven industry that is organ trafficking. In her study she notes a trend in late 20th- and early 21st century globalization in which immigrant workers and others traveling to seek employment, are falling into the hands of unscrupulous persons in positions of power such as surgeons, who even in their malpractice, remain protected and are able to continue to take advantage of the bodies of those with less power and protection (Scheper-Hughes 2004). I believe that reproductive trafficking including surrogacy, and egg/sperm donation could become the new capitalist venture for those interested in participating as surrogates and donors and that in their desire to be financially rewarded for their efforts, donors and the patient recipients may further risk their lives and health. Regulation of ARTs therefore, is the most fundamental element to establishing a sustainable biomedical effort towards improving infertility treatment in in sub-Saharan Africa.

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