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Migration and safe childbirth

Perceptions of Ghanaian women in the Netherlands

Abstract An exploratory anthropological study among five Ghanaian women in The Netherlands on their perceptions of safe childbirth produced puzzling and paradoxical data. The women emphasized the existence of social, spiritual and financial risks during childbirth, apart from health risks, yet they seemed only concerned about medical dangers when they unambiguously opted for delivery in hospital. The fact that the hospital does not provide effective prevention against social and spiritual jeopardy was drowned in their outspoken preference for the medical safety of hospital delivery. Not less puzzling was the women's statement that childbirth was safer in Ghana than in the Netherlands, whereas statistics show the opposite to be true.

The authors suggest that the women's distrust of the Dutch delivery system should be read as an expression of their general sense of exclusion of Dutch society. Criticising Dutch delivery and glorifying childbirth services in Ghana looks an indirect way of showing discomfort with Dutch society. CMG I (3), p. 14-25

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Key words • Ghanaian women, midwives, migrants, safe delivery, risk, exclusion, The Netherlands
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➤ Flowers are nice, but a new report from Save the Children suggests that schooling and basic health care would make better Mother's Day gifts for many of the world's women. In its fourth annual 'State of the World Mothers' report, due out this week, the group documents disparities among the 117 countries it surveyed. In the lowest-ranking countries, women die in childbirth at roughly 600 times the rate of women in the most developed countries, and their babies are 27 times more likely to perish during the first year of life... (Newsweek May 12, 2003: 8)

According to the report Sweden, Denmark and Norway topped the rankings that year. The Netherlands and Canada held the sixth position among the ten best countries to be a mother¹. The *Index* uses six indicators measuring the status of women: lifetime risk of maternal mortality, use of modern contraception, births attended by trained personnel, prevalence of anaemia among pregnant women, female literacy, and participation of women in national government. Four indicators covering the well being of children are: infant mortality, nutritional status, primary school enrolment and access to safe water. To a large extent, these statistics go far beyond mere numbers. The indicators exclude women's own experiences, their emotional states, their concept of physical and mental well-being etc. In case of the Netherlands, which has been a multi-cultural, multi-ethnic society for decades, does this ranking say how the migrant women experience pregnancy and childbirth? As expectant mothers, do they also experience this country to be the sixth best in the world?

This study focuses on the Ghanaian migrant women's perceptions of 'safe childbirth' in the Netherlands. The perception of 'safe childbirth' has been studied from different viewpoints and among various ethnic groups (e.g. Cinibulak 2002, Crébas 2001) but little is known about the views of Ghanaian women living in the Netherlands. Although in Amsterdam, Ghanaians are the third largest immigrant group, there has been hardly any anthropological study among them on this particular issue. On migrating to the Netherlands, Ghanaian women face changes in their environmental, social, political and/or economic situation. While in a different country, Ghanaian women not only have to face their own 'physical and psychological' changes during pregnancy, but also problems of 'cultural' change. The Dutch obstetric system, for example, is very different from the one in Ghana.

The study aimed to find out how Ghanaian migrant women choose their place of delivery, having *safety* in mind, in a wider Dutch context. Many factors may contribute to choosing birthplace among this migrant group. While choosing between home and hospital, socio-cultural, religious, economic, health and service related factors

¹ In 2004, however, it was reported that the Netherlands had the highest infant mortality rate of all West European countries. The reluctance of the health system to offer medical checks and interventions during 'normal' pregnancies and deliveries was suggested as the main explanation for this unfavourable outcome. Interestingly, these explanations largely overlapped with those given by five Ghanaian women in this study.

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influence the choice. This study intended to explain all those important and possible factors, which shape their decision making in choosing a safe place to deliver.

The first author is a medical anthropologist from Bangladesh who carried out fieldwork in the Netherlands as part of her training in Medical Anthropology. During her stay in the Netherlands she twice experienced the cultural and medical complications of being pregnant in a foreign society. Those experiences prompted her to focus her research on this particular topic. The second author, who supervised her during research and writing, has carried out extensive anthropological fieldwork in Ghana on various issues including perceptions of fertility².

The specific objectives of the study were to describe the socio-cultural factors which impact on Ghanaian women's concept of 'safe childbirth' and to understand their decision-making process in choosing a safe place for delivery.

Fieldwork

The study was exploratory as it was carried out among only five women, all members of a Pentecostal Christian church. Criterion for selection was that they had had experience with childbirth and/or pregnancy in the Netherlands. Three of them had also delivered in Ghana before coming to the Netherlands. The fieldwork was carried out in Kraaiennest, a large apartment block in Amsterdam Southeast. Apart from the five women, one woman (who had delivered in England), four Ghanaian midwives (on a visit to the Netherlands), three Dutch midwives, one Dutch researcher and one Ghanaian pastor were also interviewed. Extended case histories were used as main data collection tool. Focus group discussions were held with the four Ghanaian midwives, one medical-assistant and ten migrant Ghanaian men. Some of the male participants were husbands of the informants. Various observations were made during visits to the midwife. The researcher also participated in Sunday church services that the Ghanaian women attended.

From the literature and the interviews it became clear that Ghanaian perceptions of risk and safety during childbirth were much wider than those held by biomedical professionals. They included worries health risks as well as concerns about social, economic and spiritual security³. These four aspects of 'safe childbirth' constitute the leading theme of our article.

Ghanaians in Amsterdam

Between 1971 and 2000 the number of migrants in the Netherlands has increased from 200,000 to more than 2,6 million amounting to 17 percent of the total population. In some cities, nearly half of the population is composed of migrants.

There are several factors that encourage Ghanaians to migrate to the Netherlands. Firstly, Ghanaians have a high level of education, which enable many of them to speak English well. Knowing an international language helps them to communicate easily abroad. Secondly, their cultural socialization also encourages pursuit of economic success allowing for separation from their initial environment and adaptation to a new one. Unfavourable political and economic factors are among those, which have caused the migration too (Ter Haar 1998). Ghanaian women migrate for the same reasons as men do. Some come to the Netherlands to join their husbands, some to join their families, but, generally, the main reason is to improve their own economic status and the status of relatives in Ghana (cf. Arhinful 2001).

The influx of Ghanaians into the Netherlands before 1974 was negligible. The significant migration that started from 1974 may be categorised in two phases as subtle and massive (Nimako 1993). The subtle phase took place between 1974 and 1983. The massive, after 1983, came as a 'natural' response to the economic crisis and drought in Ghana between 1981 and 1983 as well as the repatriation of nearly a million Ghanaians from Nigeria in 1983. Available statistics indicate that by 1990, more than 5000 Ghanaians had settled in the Netherlands. In 1992, the official Ghanaian population in Amsterdam alone stood at 4197 of which

60 percent lived in Amsterdam Southeast making Ghanaians the third largest ethnic minority group in that community (Nimako 1993). Present estimates put the population of legal Ghanaian migrants in the Netherlands at about 10,000.

To find a home away from home, Ghanaians in Amsterdam have developed strategies of 'survival' as a cultural group. There are, for instance, Ghanaian foundations for health and social issues. They have Ghanaian churches, radio and television broadcasts, food and clothing shops, etc. They are becoming a more 'closed community' by building a strong sense of Ghanaian identity (Yebei 1999).

The Dutch midwifery system

The system of midwifery and the importance of home delivery in the Dutch society are unique in the Western world⁴. The system is characterised by a two-tier system of primary and secondary care. In addition to general practitioner or family doctor, a separate independent professional group of midwives belong to the primary care tier. Gynaecologists/obstetricians or other specialists are included in the secondary care. As the midwifery care in the Netherlands is based on the principle that pregnancy and birth are essentially natural processes, Dutch midwives are trained to provide care during normal, uncomplicated pregnancies and deliveries.

The midwifery system in the Netherlands discourages 'medicalisation' of pregnancy and birth. The midwives give full attention to the *social and psychological* aspects of delivery and employ only few medical technologies. In contrast, in most other European countries obstetricians argue that home delivery is less safe than delivery in hospital. Hospital delivery became significant only after World War II in the Netherlands but as late as 1960, 74 percent of babies continued to be born at home. During prenatal care, midwives and general practitioners determine which women have pathological pregnancies. They find out the possible cases that are at risk for pathology. Those women are referred to an obstetrician. Nowadays, women in the Netherlands can opt for delivery at home or in the hospital on polyclinical basis. The decision to

undergo obstetrician-assisted delivery is made by the midwife or general practitioner. What is further remarkable is that the health insurance gives preference to the midwife to assist in delivery. Only when there is no midwife available, the general practitioner is entitled to take responsibility for delivery.

Another important occupation within the Dutch midwifery system is that of the maternity home-care assistant. Giving birth at home while spending lying-in period at the same place is possible because of the availability of maternity home-care assistants, who care for mother and baby, look after other children in the family and carry out domestic tasks, such as cooking and cleaning.

How do Ghanaian migrant women experience this system and its 'naturalization' of birth? Do they also view home birth as safe as hospital birth? What is safe childbirth for them? The study tried to answer how the Ghanaian migrant women conceptualise 'safe childbirth', while in a foreign country.

Introducing the five women

The following are brief profiles of the five Ghanaian women who were interviewed. All of them were Akan⁵ and spoke Twi. Pseudonyms are used to protect their identity.

ABENA

Abena came to the Netherlands seven years ago. She is 39 years old, housewife, and has six children. The eldest are twins and are now thirteen years old,

² His publications on fertility perceptions and practices have appeared under the name of W. Bleek.

³ For discussions on wider perceptions of risk and safety, see: Douglas 1992, Gifford 1996, Lupton 1993.

⁴ The Dutch midwifery system has been described and discussed in many studies, to mention a few: Abraham-van der Mark 1996, Jordan 1993, Offerhaus et al. 2002, Wiegers 1997.

⁵ 'Akan' is the largest ethnic group of Ghana and includes subgroups such as Asante, Fante, Akuapem and Kwahu.

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the second are also twins, eleven years old, followed by a son of six years and a daughter of eleven months. Her last two children were born in the Netherlands. The eldest four were born in Ghana and live there with Abena's sister.

Abena came to the Netherlands to join her husband who is a pastor in a Ghanaian Pentecostal Church in Amsterdam. She never visited Ghana after she came here. She cannot leave this country because her 'papers' are not yet ready. As soon as she will have a residence permit she will go and visit her children. Her husband went to Ghana three times and visited them.

ADWOA

Adwoa, 27 years old, came to the Netherlands almost three and half years ago. She got married some months after she came here but does not possess legal documents of her marriage according to the Dutch law. She has one child, which was born in the Netherlands. Her husband has legal residence papers; she does not.

AKUA

Akua is 31 years old. She has two sons; one is three years and the other is fifteen months old. She is presently seven months pregnant. She works as an administration worker in a Dutch company. Akua was brought up in England. She has been in the Netherlands for almost ten years. Her father has been in The Netherlands for thirty years. She has a legal Dutch status.

AKOSUA

Akosua, 33 years old, attended secondary school and is now a hairdresser. She has three sons, thirteen years, twelve years and fifteen months old. She has been in the Netherlands since 1997. Her husband is working in a Japanese company.

YAA

Yaa came to the Netherlands in 1992 with her elder sister. She is 37 years old and mother of two children. Her 15 year-old daughter was born in Ghana and the 4 year-old son was born in the Netherlands. She completed her secondary school in Ghana. In the Netherlands she works as a housecleaner.

Significance of children among Ghanaians

Both women and men assured that the attitude in Ghana towards having children is universally positive. Children are wanted by every married couple and are regarded as 'gifts from God'. Children are greatly valued, since they help in the house and on the farm, they serve visitors, support their parents and become their heirs. As one of the men in the study mentioned.

We are proud to have children. You can go out holding the finger of your child and feel very proud. Proud because, when you will be old, your child will take care of you. In Europe, if you are old, you have no problem but in Ghana, when you are old, you depend on your children... If a woman does not have any child, the mother-in-law will come and ask her, when will you give me a grandchild? If you are married for a long time, and you do not have any child, the family people will create trouble by asking you to have another wife. The family wants a child because the child will succeed you after your death.

In a study conducted by the second author three decades ago the most frequently expressed idea about having children was that children enhance a woman's happiness and her fulfilment of life (Bleek 1976, 1978). Children bring companionship, and a woman without children can never become happy, she always remains lonely and sad and becomes envious of others. Closely connected with this is the idea that the child helps in the house. The help that children do in the house has as much personal as economic value; it is a kind of active companionship. A third category of associations has been grouped under the title 'social pressure'. It is felt that children are the sign of a woman's normality, femininity, and healthiness. A woman who has no children is open to various suspicions. The two most common suspicions are that she is witch and has killed her own children, or that she leads a morally despicable life. The connection between infertility and moral behaviour is laid in various ways. Some see barrenness as a

supernatural sanction by God, others think of a venereal disease. Most informants stressed the religious value of children: they are a blessing of God and human beings must pray to God for children.

As we see in Yebei's (1999) study, childbearing is sometimes valued more than marriage. Childlessness affects the stability of marriage because children are seen as indispensable for happiness in life. The matrilineal character of the Akan kinship makes the birth of a child particularly important for the woman's relatives.

The women's experiences of pregnancy and childbirth

This was Adwoa's first pregnancy. She had to wait six months before she became pregnant. On the one hand, this pregnancy brought a lot of happiness in her life, on the other hand, it caused her many physical problems. During the first months of pregnancy, she was not able to eat anything. The midwife then suggested her to drink anything she liked. So she ate only fruits and drinks containing sugar. Later when the midwives checked her blood, they found that the level of sugar in her blood went high. She had to stop eating sweet things, which she was used to. She started to eat other foods. Four weeks later Adwoa's blood sugar came down.

The case of Adwoa is not unique. Several women in the study faced physical problems like nausea, diabetes, hypertension and anaemia. Some women said they could not eat anything during their pregnancy. When they complained about this to their midwives or gynaecologists, they were told that it was normal during pregnancy and did not suggest any medication. Swollen legs in a later stage of pregnancy was another problem reported by some of the women. The only suggestion they received from their midwives or doctors was that they should not eat too much salt and should raise their legs while sitting.

The women spoke about other problems they experienced when they were pregnant. Yaa, for instance, had bleedings from the sixth month onward in both of her pregnancies. For the first

one, when she went to the hospital, the midwife told her to have an echo (ultrasonography). When the midwife checked it, she found that the baby was in good position but she could not tell her why she was bleeding. The midwife gave her iron tablets.

ANTENATAL CARE

Most of the participants went to the midwives in Kraaiennest for their antenatal check-ups. Those who gave birth in Ghana went to hospitals for their regular antenatal check-up. Most of the women consulted midwives; some of them saw a family doctor or gynaecologist. All of them had to take the regular tests like, echo, blood tests for HIV, diabetes, iron, sugar etc. Among the routine check-ups were blood pressure, weigh, and foetal heart sound. Four of the participants had a health insurance while they were pregnant in the Netherlands. Two of them did not and had to pay all expenses themselves.

Concerning medication, every participant had a different experience. In Adwoa's case, her iron level was low, so she had to take certain medicine. Akua took medicine for the same reason during her first pregnancy. During her second pregnancy, she had urine infection and she had to take medications. Akosua took Gravitamon, a multivitamin specially made for pregnant women. As Yaa was bleeding from the sixth month during her two pregnancies, she had to take iron tablet regularly. All women took medicines while experiencing physical problems. Although, some problems were normal during pregnancy, they expected that their midwives or doctors would give them medicines. They termed multivitamins and iron tablets as medicines.

PAIN AND PAIN MANAGEMENT

Childbirth experiences differed from one woman to the other. Abena's second childbirth in the Netherlands went smoothly, but other encountered various problems. Every woman in the study talked about severe pain during childbirth but none of them opted for epidural or another kind of pain medication. It was clear from the interviews that experiencing pain was considered normal during childbirth.

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WHY DO WOMEN WANT TO DELIVER IN HOSPITAL?

Abena did not want to deliver at home. When asked why, she almost cried out, 'No! No! At home, something can happen, which I do not know. So, hospital is safe for me'. She did not have any complications during her pregnancies, but still she preferred to deliver in the hospital: 'Yes, I had no complication. However, you know, in this world things do not give you information before it happens. All of a sudden, it happens. We prefer to go to the hospital, in case there is any complication. Then the doctors will be there to help me. Moreover, I did not have an insurance (*Ziekenfonds*). Even if I wanted to deliver at home, the midwife might refuse to come.'

Adwoa too preferred to go to the hospital for delivery, also when she was in Ghana where no ambulance was available. She feared complications. She related the following incident in Ghana:

After completing my training college, I was sent to a village, a remote village, where I was supposed to teach. There, a lady was about to deliver. The baby was not in a normal position. When it was time for her to deliver, they kept her in the village for two days. Later she was sent to the hospital. She almost died and lost her baby.

When one woman (not in the sample) was asked where she wanted to deliver if she had no physical problem, she replied without any hesitation:

In the hospital. I cannot risk my life. If anything happens, there will be emergency in one minute. The doctor can come immediately. But, when you are at home, before the ambulance comes, it's too late. So, personally, I have never dreamed of having a baby at home, putting my baby's life at risk. If you are in hospital and anything is wrong with your baby, they will put it in the intensive care. I am not saying that it will happen, but you never know... Five or ten minutes can make a difference. I think it's better to go to the hospital, because they can help you any moment.

Being in the Netherlands, all women still preferred

to go to the hospital. The reasons they mentioned were the same: safety.

FAMILY AND SOCIAL SUPPORT

Most respondents agreed on the importance of family and social support. The support and help they had received in Ghana was very different from what they experienced in the Netherlands. In most cases, they stayed alone with their husband and children. It was also not possible for them to bring their mothers from Ghana. Nevertheless, getting support was very important for them while they were pregnant. Abena got lots of help and support from her 'Christian Mother' during her pregnancy. She visited her almost every day and took care of everything. She called the lady 'Christian Mother', because she is an elderly woman, like her own mother and they go to the same church. Although her own mother was in Ghana, Abena felt she received almost the same support from her 'Christian Mother'. Not only the mother, but also her husband helped her a lot. He always went for shopping, cleaned her when she had vomited, swept the house and sometimes cooked for them.

Adwoa got much support from her husband and sister-in-law. There is a big community of Ghanaians in that area but she hardly got any support from them. The reason she mentioned was: 'You know, here everybody is busy and they always work. So, the support is not as much as you can get in Africa. We go to the Church and sometimes in weekends, we meet. That's all'.

Although Akua's mother was with her during her pregnancies, she did not get much help from her. She got much support from her colleagues. Akua's colleagues are all mothers. She believes only a mother can feel the problem of another mother.

Akosua got almost every support from her husband during her pregnancy and also after childbirth. He cooked, he did all the shopping, and he was the one who did everything. When she was nine months pregnant, he stopped working. He stayed at home with her until she delivered. Even in the night, when the baby was crying, he took the child, fed him and put him back to sleep. She added:

Here, if you are a member of an association, they will come to visit you and bring you presents. They will come to greet you. If you are alone, I think it would be a problem.... Like in my case, I know many people from the Church, the women's fellowship group, also those who come to make their hair. So, I have many people around me. I get much support from them.

In Yaa's case, her sister supported her all the time, because her husband was always busy with his work. He worked the whole week.

During a discussion with a group of Ghanaian men, one of them said: 'Compared to Ghana, here we help our wives more'. Other men present at the discussion confirmed that. One of them explained:

You have to understand that we try to blend our culture with European standard. In Ghana, even if your wife is pounding with work, you do not help her. Because if your friend or any body will see you, they will laugh at you. But here, it is a closed society. Nobody interferes in another's life.

FINANCIAL MATTERS

The Ghanaian women as well as men were very concerned about financial matters concerning antenatal care and delivery. Those who did not have a health insurance had to pay almost double the normal amount. It was difficult for some women to arrange for that money. One of the participants mentioned how she avoided the money matters. In her last trimester of pregnancy, she always told the midwife that her husband left Amsterdam and went somewhere she did not know. So, it was not possible for her to pay the rest of the amount. Although her husband was staying with her, she had to use this trick to get the consultation fee waived.

Abena received financial help from a Dutch lady. The lady wanted to know about her pregnancy and delivery, and asked how much they had to pay altogether. She came after some days and told them that she had negotiated with the hospital which had agreed that they would pay only € 450 instead of € 700. Some men during the focus group discussion mentioned similar examples of external support.

PRAYER: GOD'S PROTECTION

Almost all participants prayed regularly while they were pregnant. They believed that they had to pray for God's protection for themselves and for their children. As Abena said, 'During childbirth anything can happen. Some mothers go to deliver but they don't come home. Some mothers will deliver the baby, but the baby will die and the mother will come home. We have to pray all the time that there will be a safe delivery for the mother and the child'. Akua prayed a lot especially during the first pregnancy. Sometimes she fasted. She regularly went to Church, even on the day she delivered.

Women also pray to become pregnant. As we see in Akosua's case, she wanted to become pregnant for a long time, but the pregnancy did not come. She went to specialists. After checking her, they found that everything was ok. They did not give her any treatment. So, she prayed until she got pregnant and continued to pray after delivery asking God to protect her son and to 'put the Holy Spirit on him so that he can grow and become a good person.'

Yaa had a strange dream that she was sleeping with another man. She told this to her pastor. He said that the dream was bad and he prayed for her. He told her it might be an evil spirit. When a pregnant woman sees in her dream that she is sleeping with another man, it's not normal. He said that if people have this dream, they may have a miscarriage. She said that prayer helped her and she never had that dream again.

Pregnancy and childbirth in Ghana and The Netherlands: A comparison made by the women

Abena experienced many differences between Ghana and The Netherlands. In Ghana, she said, they check urine, stool, and blood pressure; they also take blood tests and after that they give the pregnant woman some medicine, like iron tablets, vitamin B complex, etc. In the Netherlands, 'When you are pregnant, they will not give you any medicine'. During her two pregnancies in the Netherlands, she felt very weak. Whenever she went to the

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hospital, they checked her blood, but did not give her any medication.

Most women said that in Ghana midwives might not have equipment, but they have experience; they work more than the midwives do in the Netherlands. In addition, the way they relate with the patient is different. As one of the Ghanaian midwives said, 'The most important work for us is to give 'emotional support' to the women'. The workload situation became clear during the focus group discussion with the midwives. The work they do includes antenatal care, labour and delivery, postnatal care, family planning, post abortion care, child welfare, training of the midwives and traditional birth attendants, management of STD's, treatment of minor illnesses, adolescent and school children's health.

Asked about their opinion on 'home birth', they said it was good for a woman to have her family around during delivery. It would be better but it was not possible for most women to deliver at home in Ghana. First of all, there is lack of privacy. Moreover, the midwife not only deals with one patient, but also has to take care of other women who do not have private cars. So, it would be impossible for a midwife to go to a pregnant woman's house and wait 24 hours for the woman to deliver.

Four women were unhappy with the midwife consultation in the Netherlands. They gave as reason that Dutch midwives spent too little time with them. Akua:

They didn't even feel the baby. They were busy chatting about their salaries, about their payment. You know, at that time, the Euro was coming... so, I just lied down on the bed, and they were busy talking with other colleagues. As soon as the midwife removed her hand, I felt the baby moving inside me.... Every time I go there, they listen to baby's heartbeat, check my weight and blood pressure and say everything is ok. Then I come home. It's just like that.

She wanted more attention. When she complained about her problems, they said it was normal. Akua

expected them at least to say, 'Ok, let's check the baby as you are complaining'; but they don't say anything. Her first childbirth experience with the midwife also disappointed her:

When I told the midwife that I was in labour, she said 'Oh! This is your first time; you have to wait so many hours...' I said no, and I felt that the baby was on its way. They said, 'No, you have to wait, you have to wait...' They asked me 'Is there any water?' I said no. They said 'you have to see water first'. I said, no, it's not for everybody that you have to see water first. I learned that already from my mother.

That was Sunday evening, around 12 midnight. I slept one hour, from 1 to 2 in the morning. I felt I was in labour and I called the midwife. She told me the same things again. I waited until 10 o'clock in the morning. I could not sleep throughout that night and they said, 'Oh, it's not the time yet. Go to sleep, take a bath.'

It was February 2, when Akosua was due, but the womb was not opening. That day, the midwives told her to see a midwife after three days. When she came back, the midwife checked her and found that it was not time to deliver. Her pain started on 6 February and she waited one day. On February 7, when she called the midwife, she told her to wait further. Akosua waited and around seven in the evening, she called the midwife again. The midwife assured her that she was coming. She came after two hours. Akosua:

I said it's painful, I can't stand it any more but the midwife said I should try. The midwife wanted me to deliver at home. I refused; I wanted to go to the hospital. We had a lot of discussions before she allowed me to go to there.

All women said they preferred to deliver in 'Africa' (Ghana). One of the reasons they mentioned was that during delivery, not one but two or three midwives would attend. They would help the woman pushing. One midwife would stand in front, the other beside her. But in the Netherlands, it was only one midwife and that one did not even help.

'She will only stand and say 'Ok now you can push. Stop, now you can push.' She will not even hold your leg or your hand. In Africa, they will hold your hand or leg and say 'now you have to push. It's coming. It's coming. Push! Push!'

Family support is another reason why women wanted to deliver in Ghana. There is happiness around when a woman delivers in Africa. One of the women said she felt like a 'new wife'. Everybody will come to greet the new mother. They will talk to her or give her advice; bring many presents for the mother and the baby. The woman's mother has a great role after the baby is born because she cooks for the new mother, takes care of the child, washes clothes and does almost every household work until the woman is fully recovered.

Why childbirth is safer in Ghana

The immigration status of Ghanaians in the Netherlands is a major factor in getting access to health care. In 1998, a new Dutch law, the *Koppelingwet* was established. It permits the linking of databases in order to ensure that immigrants without legal documents would not benefit from basic social services such as health care. A research project carried out in 2000 showed that people who do not have legal permission to stay in the Netherlands have only limited access to health care. They are only entitled to medically necessary care and are mainly dependent on a relatively small group of 'illegal-friendly' doctors and midwives, most of whom are found through networking. Especially for women without legal authorization insecurity, poor socio-economic conditions, lack of information and lack of access to available services explain their distrust in the Dutch health care system, particularly maternity care services.

In addition, the Dutch medical 'philosophy' shows a reluctance to prescribe drugs, to make less use of routine check-ups and tests (instead people are encouraged to come when they have a problem). The culture of communication (doctors provide patients with little medical information unless patients ask for it) may also cause problems to migrant patients, not accustomed to this (Ascoly et

al. 2001). These reasons roughly overlap with some mentioned by Boschman and Verheul (1997: 9) who point at cultural, organizational, financial and communication barriers, between migrants and the Dutch health care system.

There are various reasons, however, to be surprised at the outcome of this explorative study. The statements of the five women seem contradictory to 'common sense', established statistics and their own opinion on safe childbirth. Firstly, infant mortality and maternal mortality rates in Ghana are far less favourable than in The Netherlands (cf. Geelhoed 2003). How should we then understand their univocal preference for delivery in Ghana? And secondly, why should they insist on hospital delivery in The Netherlands if they attach so much importance to social, spiritual and financial security of childbirth? Dutch hospitals are hardly places where social support by relatives and friends is easily provided nor do they favour spiritual assistance. In contrast to Ghanaian hospitals where religious expression is common (cf. Van der Geest & Sarkodie 1998) prayer and religious ritual are increasingly out of place in Dutch hospitals. Finally, from a financial point of view, the costs of hospital admission in the Netherlands are prohibitive for non-insured patients.

The solution to this string of paradoxes should not be sought in the 'objective' quality of health care. The statements of the Ghanaian women seem first of all expressions of discomfort and anxiety about their position in an alien and often hostile environment. Their idealisation of health care in Ghana, their home country, is probably best understood as an implicit protest against the inhospitality of Dutch society and a logical result of their maladjustment to its rules and norms (cf. Arhinful 2001: 39-43).

Health and health care are politics in disguise. The women's criticism of the – widely appraised – Dutch midwifery and home delivery system should therefore be interpreted as a political comment on their partial exclusion from it.

Ironically, the same public health care services that are praised by these Ghanaian migrants in a

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foreign country, are severely criticised by Ghanaians at home, in the popular press as well as in scholarly publications. Senah (1989: 265) complained some years ago 'that the political will to provide a health system which reaches most Ghanaians is missing.' For people in urban centres who can afford private health care the situation is much better, but for the less-well-to-do, whether urban or rural, medical facilities leave much to be desired. More recently, Senah wrote a biting critique of Ghanaian medical professionals' contempt of patients and the lack of trust, respect and communication between doctors and lay people, which severely hampered diagnostic and therapeutic activities. Patients and their relatives turned desperate and cynical in reaction to the arrogance of the medical profession (Senah 2002).

A 'neutral' observer would be inclined to believe that the exclusion from adequate health care is more severe for Ghanaians at home than for those in The Netherlands, but migrants themselves have a different perceptions as we have seen. Van Dijk and Van Dongen (2000: 48) write that 'Health is a measure of the integration of migrants in society.' Our study suggests that health – in this case: safe childbirth – should be taken in its most subjective meaning of perceived well-being, being at ease.

Our conclusion is bound to be tentative as it is based on interviews with only five women and a few other people. Such an exploratory approach is valuable as it is able to bring out less obvious ideas and sentiments as suggestions, which need to be validated on a larger scale. The suggestion rising from this research is that the Ghanaian women's dissatisfaction with Dutch midwives and their insistence of home delivery is a measure of their non-integration in Dutch society.

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Samenvatting

Dit explorerend onderzoek naar opvattingen over veilig bevallen bij vijf Ghanese vrouwen in Nederland leverde paradoxale uitkomsten op. De vrouwen benadrukten naast medische ook sociale, spirituele en financiële risico's tijdens zwangerschap

en bevalling. Toch leken ze alleen aan medische gevaren te denken toen ze eensgezind de voorkeur gaven aan bevallen in het ziekenhuis. Het feit dat het ziekenhuis onvoldoende bescherming biedt tegen wat zij sociale, spirituele en financiële risico's noemden, leek ineens niet mee te tellen. Een andere paradoxale bevinding was dat de vrouwen bevallen in Ghana veiliger vonden dan in Nederland, terwijl de statistieken toch duidelijk het tegenovergestelde laten zien. De auteurs suggereren dat het wantrouwen van deze vrouwen ten aanzien van de Nederlandse zorg beschouwd kan worden als uitdrukking van hun gevoel van uitsluiting van de Nederlandse samenleving. In hun kritiek op de Nederlandse zorg en hun verheerlijking van de zorg in Ghana tonen zij op indirecte wijze hun ongemak met de Nederlandse maatschappij.

Résumé

Cette enquête exploratoire au sujet des opinions de 5 femmes Ghanéennes sur l'accouchement sans risque a remporté des résultats paradoxaux. Les femmes ont accentué, à part de l'aspect médical et en durant de la grossesse et de l'accouchement, l'aspect de risque social, spirituel et financier. Pourtant elles ne semblaient penser qu'aux risques médicaux au moment qu'elles ont toutes préférés l'accouchement à l'hôpital. A ce moment, le fait que l'hôpital n'arrive pas à offrir une protection suffisante contre les risques sociales, spirituelles et financiers, semblait perdre son importance. Un autre résultat paradoxal était le suivant: les femmes Ghanéennes ont évalué l'accouchement au Ghana comme plus en sécurité qu'aux Pays-Bas. Pourtant les statistiques font preuve du contraire. Les auteurs suggèrent que la méfiance des femmes concernées face au soin néerlandais peut être considéré comme l'expression d'un sentiment d'exclusion de la société néerlandaise. Dans leur critique du soin néerlandais et dans leur glorification du soin Ghanéen peut-on apercevoir, soit de manière indirecte, leur désagrément avec la société Hollandaise.