CONTINUING DIALOGUE: DONOR INSEMINATION

Secrecy Still the Best Policy: Donor Insemination in Cameroon

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In their recent PLS article, Ken R. Daniels and Karyn Taylor (1993) advocate policies of openness in regard to donor insemination (DI). In this commentary, I examine openness within the social context of fertility, infertility, human reproduction, and social parenthood in Cameroon. The traditional concept of secrecy in reproductive failure, especially in the case of male infertility, is outlined. Some of the social alternatives, such as natural insemination and social parenthood, are discussed. The inappropriateness of openness in DI within a sociocultural milieu that places a high premium on male reproductive ability is highlighted.

Since infertility affects 10-15% of Cameroonians, the potential for assisted reproduction, specifically artificial insemination by donor (AID), is strong, although presently there is no known demand for it. It is a relatively new technique in Cameroon, and knowledge of its availability in the country remains low. It is little known beyond a few who read foreign magazines or follow scientific programs or articles in the mass media. AID is never advocated by clients, recipients are low in number, and secrecy is strongly advocated by them and supported by medical practitioners. In fact, AID is perceived by potential clients (both fertile and infertile) as a “fine” and “acceptable” technique to assist infertile persons—as long as it is performed in secrecy, the secrecy is maintained afterwards, and the resultant offspring are raised as “normal” children, that is, conceived as a result of the physical/genetic contributions of both parents (Njikam Savage, 1992). These conditions are especially stressed by women who feel the need to protect, maintain, and continue to project the manly image of their spouses to themselves and society. The women believe to do so is crucial to safeguard and secure their marriages, as well as to maintain a semblance of normalcy.

In traditional societies, infertile husbands were known to give their wives implicit permission to bear children by other men to avoid the stigma of sterility. Often, other males within the family—for example, brothers, uncles, and sometimes older sons (especially in the case of an old polygynist with much younger wives)—were chosen as partners. Thus, in patrilineal societies (which the majority of Cameroon falls within), the genitor and pater would be from the same family/lineage. Therefore, the resultant offspring would be in both senses, socially and biologically, a real/blood member of the family. However, this practice of substitute, or natural, insemination has largely been discontinued. Christianity perceives it as both adulterous and incestuous (when it is intrafamilial). Also, the modern woman is viewed as brazen, imprudent, and thus likely to disclose the secret in a fit of female anger, spite, and arrogance. So important was the need to maintain secrecy that women were sometimes compelled to swear oaths of secrecy before ancestral shrines.

Infertility is not socially acceptable in Cameroon. The infertile woman is perceived as “empty.” Infertility is often thought to be self-inflicted—caused by promiscuity, induced abortion, use of artificial contraceptives (especially oral contraceptives), ancestral wrath, or witchcraft. Only in the case of witchcraft is the malevolent intervention of others
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decided. Thus, traditionally, society has had little sympathy for the infertile woman (Njikam Savage, 1991). The situation is even worse for the male, for whom exists a larger number of sociocultural alternatives to ensure reproduction. If his partner is infertile (infertility is always first assumed to be a woman’s problem), he could resort to polygamy, levirate, or concubinage. However, if he turns out to be the “culprit,” this will be seen as a catastrophe and will undermine his self-image, indeed his very being. He cannot be called a “man” in the real sense of the word because he is incapable of impregnating a woman. Suicide is sometimes perceived as an acceptable alternative.

Consequently, it is still very difficult to persuade men to present themselves for investigation during the evaluation of couples for infertility. Men are socially and psychologically unable to cope with even the possibility that the “fault” is wholly or even partially theirs. Clearly, there is need for counseling, not just for AID, but also for all investigations that directly or indirectly evaluate the fertility status or reproductive ability of clients. The triad (doctor, infertile male, and fertile female) are therefore sworn to secrecy during AID. Partly because AID is still an innovative technique in reproductive health systems in Cameroon, there are no policies or laws protecting any of the parties involved.

However, there have been no indications of regret among recipients of AID, nor have lawsuits been instigated by any of those involved in the procedure. In any case, such an attempt would blow off the lid of secrecy that the couple perceive as central to their acceptance of the procedure and that they and the doctor are so committed to maintaining. Similarly, there have been no indications from donors about a desire to know the outcome of the procedure (i.e. the possibility of having fathered a child). Correspondingly, donors feel no responsibility towards the donor insemination (DI) offspring. The possibility of providing DI offspring with nonidentifying, let alone identifying, information of the genitor, or of establishing future contact, is presently unthinkable in Cameroon (this may be usefully compared with current practices in the United Kingdom, as described by Snowden, 1993).

Is the policy of openness in AID—which is so much advocated and contested in America, Britain, Europe, and Australia—feasible in Cameroon? Social parenthood is an age-old, well-accepted practice, as is child fostering (Haines, 1993). The extended family continues to contribute toward the upbringing of children, although in lesser degrees than previously. A child is therefore part of a larger social group rather than belonging exclusively to a couple. The genitor may deny or refuse to accept responsibility (perhaps because of incapacity, or because it would be unacceptable). Thus, even when the biological parents are well-known and recognized as such by society, a child may be “given” (for various reasons, e.g., barrenness, strong affection, alliance, etc.) to male or female consanguineal or putative relatives to be raised. For all intents and purposes, these are the real parents of the child. She/he bears the name of his social parent(s). All major decisions concerning her/his education, health, etc., are made by the social parents. When the child or adult finally becomes aware (by accident or design) of his biological parentage, there is no emotional or psychological trauma. His allegiance is first and foremost to his social parents. As an adult, he may be the only one among his consanguineal siblings with a different surname. There is, however, no social stigma or embarrassment attached to the revelation, nor are the genetic parents chastised by society. This practice cuts across ethnic groups and social classes.

Does the apparent need for secrecy in AID need to be reexamined, particularly within the African context, where social parenthood is a well-known and acceptable practice? Is the present trend for secrecy simply an automatic transfer and/or a blind adoption of Western models within a different social and cultural context? The possibility of advocating a policy of openness in AID remains questionable in Cameroon. Human reproduction, assisted or not, still remains a very private affair. Childbirth, on the other hand, is a social one and, consequently, so is parenting.

References


