AN ETHNOGRAPHIC STUDY OF THE MANAGEMENT OF MALE INFERTILITY IN EAST GONJA

BY

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DECLARATION

I, Jacob Ibrahim Abdu, do hereby declare that except for references to other people's work, which have been duly acknowledged, this thesis is a result of my own research work, carried out and submitted to the Institute of African Studies, University of Ghana, Legon, under the supervision of Professor Albert K. Awedoba, Prof. Samuel A. Ntewusu and Dr. Edward Nanbigme

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DEDICATION

I dedicated this work to the memory of my parents and children who have always urged me on in my research. My wife Lydia always reminded me of my deadlines and encouraged me to finish up the research.

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ABSTRACT

This ethnographic study examines the management of male infertility in East Gonja, Ghana, investigating how socio-cultural norms shape therapeutic pathways and experiences. The research addresses the profound social significance of fatherhood in patrilineal societies and explores how infertility threatens masculine identity, leading to complex health-seeking behaviors within pluralistic medical systems. Utilizing extended participant observation and in-depth interviews with infertile men, traditional healers, and biomedical practitioners, the study reveals how cultural beliefs attributing infertility to spiritual causes initially direct men toward traditional treatments. Key findings demonstrate that economic constraints, geographic barriers, and pervasive stigma significantly delay biomedical care access, creating therapeutic itineraries that prioritize cultural congruence over clinical efficacy. The study further documents how communal decision-making processes both support and pressure affected men, while indigenous knowledge systems offer explanatory models that fundamentally differ from biomedical frameworks. Recommendations include developing culturally-sensitive reproductive health policies that acknowledge traditional belief systems, improving rural access to biomedical services through integrated care approaches, and implementing community-based interventions to reduce stigma. This research contributes to medical anthropological literature by illuminating the understudied male experience of infertility in resource-limited settings and advocating for holistic approaches to reproductive health that address both biological and socio-cultural dimensions of care.

CHAPTER ONE

INTRODUCTION

1.1 INTRODUCTION AND BACKGROUND

Infertility presents a universal human challenge, transcending national, cultural, religious, and societal boundaries. An implicit expectation exists within many societies that marriage will be blessed with children, and the failure to conceive is often perceived as a divine disfavour or a profound misfortune. Extensive anthropological work, from the treatment of infertile women among the Ekiti of Nigeria (Ademola, 1982) to the socio-economic repercussions in Cameroon (Feldman-Savelsberg, 1994), has documented the severe social consequences of infertility across Africa. Within the Gonja context, infertility is similarly viewed as a curse, a belief embedded in pre-marital rituals such as prayers against infertility during the acceptance of bride wealth. While education has been identified as a key variable influencing health-seeking behaviour, with more educated individuals leaning toward biomedical solutions, a critical gap remains. Most existing studies tend to approach the issue from a singular perspective, either focusing solely on the biomedical aspects, the social consequences, or the traditional belief systems. This thesis, therefore, is driven by the need to provide a more integrated analysis. It specifically seeks to bridge these disconnected strands of inquiry by systematically examining the intricate interplay between cultural perceptions, belief systems, pluralistic treatment methods, and psychosocial supports within the unique socio-cultural ecosystem of East Gonja. The central rationale is that only through such a holistic lens can the complex realities of infertility and the resultant health-seeking pathways be fully understood. Management in a study by O'Brien et al. (2014). When patients are under significant stress due to pain or stigma, those with higher education levels...

Additionally, female migration to the south has also had implications for the management of male infertility in East Gonja. When women migrate to urban areas for employment or other opportunities, it can lead to prolonged periods of separation from their partners. This separation can impact the ability of couples to address infertility issues together and may also affect access to healthcare services for male infertility. These migrations are very common as a result of the high poverty levels in East Gonja. The Northern Region has the third highest poverty headcount in Ghana. The incidence of poverty is highest in East Gonja (84.2%) according to the Ghana Poverty Report 2015, as reported by the Ghana Statistical Service (GSS, 2015).

In spite of the fact that the study is about male infertility, however female migrations influence the management of male infertility in East Gonja. Overall, the intersection of enlightenment levels among men and female migration to the south can have far-reaching effects on the management of male infertility in East Gonja. Those who are informed and have a lot of knowledge of their situation tend to seek treatment either spiritually or through the hospitals. Understanding these dynamics is crucial for developing targeted interventions and support systems for couples dealing with infertility issues in the region.

Among the Tallensi of Northern Ghana, Fortes (1978) argues that parenthood is a precondition for the attainment of full adulthood. Parenthood is therefore viewed as a sine qua non for becoming a responsible adult in society. Fortes also indicates that infertility has ramifications for the individuals involved and their identities, as having children is a basic accomplishment of kinship, spiritual (religious), and political obligation to society. In African cosmological communities, children represent a link to the dead ancestors. Their birth, therefore, signifies a continuation of the family not only physically but also in religious realms. Children also play an important role as labour in an agrarian society that does not use machinery for agricultural purposes (Fortes, 1978).

Peace (1999) observed that the necessity for a woman to have a child remains basic. Motherhood continues to define an individual woman's treatment in her community, her self-respect, and her understanding of womanhood. Peace indicated that the stigma of infertility even extends to death; the burial of an infertile woman remains a problem since expenses are usually paid by the woman's son. Consequently, funeral costs for infertile women are paid for by their paternal kin, resulting in small-scale and quiet burial rites (Peace, 1999, p. 132).

Peace postulates that the requirement for a couple, especially a woman, to have a child of her own remains a basic requirement in African society. She describes motherhood as a defining concept for any married woman within her community. The stigma of not having a child or remaining infertile is evident during the burial of a woman, as the eldest son is expected to pay for the expenses. In Gonja, the eldest son lowers his father's remains into the grave during the funeral, saying *nitei nene*, which translates to "walk well, have a safe journey to the ancestral world." If a man has no biological child, the question arises of who will lower him into the grave. This issue, which was historically resolved through kin living together and offering social and psychological support, was easier for the people of Gonja in the past. With the westernization of communities in Gonja and across Africa, it has become necessary to appreciate the role of psychologists in Africa and Ghana specifically, who are virtually non-existent. People suffering from such life crises need experts to manage them (Menning, 1977).

Infertility is a major public health problem across the globe. Although it is not life-threatening, it has significant social and psychological effects on those who suffer from it, as well as their close kin and friends (World Health Organization [WHO], 1992). Infertility has several ramifications for the unity and stability of the family, society, and the community. The effects at the individual level are manifested by the personal expectations of the couple and the frustrations of achieving

those expectations through failure to reproduce. At a different level, infertility threatens the identity of both partners (Daniluk, 1991; Johansson & Berg, 2005). In Ghana, an estimated 15% of women of childbearing age are said to suffer from infertility (Donkor & Sandall, 2009), and 11.8% among women and 15.8% among men according to the Ghana National Collaboration Centre for Women and Children's Health (2012). These figures could be higher because they are sourced from those who seek formal treatment. Infertility contributes to inappropriate behaviours among those suffering from the disease and affects their relationship with the larger community. It also leads to immense stress and many psychological problems.

However, infertility in the developing world has been comparatively forgotten as a 'significant international health problem and a legitimate topic of social science and epidemiological inquiry' (Inhorn & Kimberly, 1999).

Infertility is usually defined by the World Health Organization as "a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse" (WHO, 2020). This definition serves as a benchmark for couples who want to seek treatment. After a year of unsuccessfully trying to get pregnant, a couple is advised to seek medical attention. However, epidemiological research indicates that in every normal population of sexually active heterosexual women who do not use birth control, 25% will become pregnant in the first month, 63% within six months, and 80% within one year. The results further reveal that 85% to 90% will have conceived by the end of the second year (NCCWCH, 2012). The World Health Organization has recently decided to adopt the epidemiological research time frame of two years instead of one. This change reduces the pressure on couples from parents, friends, and kin, as well as from the couples themselves, who are unable to conceive and give birth within a year. It gives couples the needed peace of mind to keep trying for another year.

Infertility is, however, defined variously by different ethnic and cultural groups and societies depending on their perspective. In Egypt, for example, Inhorn (1994) reports that Egyptian families expect pregnancy immediately after wedlock. If there is a delay in giving birth, the woman is usually suspected, and she is made to undergo the ritual of Kabsa. This infertility treatment can be very embarrassing for women. This expectation of less than a year is well below the World Health Organization's one-year benchmark. The situation is not too different in Nigeria, where the expectation of a pregnancy and a child is usually immediate and within less than a year (Okonofua et al., 1997).

Infertility comes in two forms: primary and secondary. Some men may have had children earlier in a marriage but find it difficult to have children subsequently when they want them. This type is called secondary infertility, while some men have never had children despite their efforts.

Africa is on record as having very high fertility rates, as are parts of the Middle East, Latin America, and Asia. Africa is set to grow faster than any other region by 2050. Statistics indicate that the total fertility rate in East Gonja stands at 3.94% of the population (GSS, 2010). This ratio is quite high in relation to the region's figure of 3.64 for the total fertility rate (GSS, 2010). The statistics show that many people may not have challenges with the ability to give birth; however, the challenge for the few people in the population is significant enough to attract attention from the community and researchers. The reason for the importance of the issue may be partly due to the passion that accompanies the desire for childbirth.

Implied in the meaning and construction of infertility is the "intentionality" and willingness to get pregnant by the spouse; hence, they make a conscious effort by "trying to get pregnant." The failure to achieve this objective to conceive is what creates the anxiety that he or she or both may be

infertile. Closely linked to this thinking is an examination of why the man wants to make his wife pregnant and why the woman wants to be a mother.

In Ghana, infertility can be defined in terms of the absence of male children or when women give birth only to female children. The value placed on the male child is enormous, to the extent that it is as if the female child is unimportant. *"Fukuruwei nyinbgasa"* meaning "you have given birth to a human being" is said when a woman gives birth to a boy child. A woman who continuously gives birth only to female children is erroneously blamed for her predicament, and this situation could lead her husband to practice polygyny.

Most of the time, infertility in traditional African societies is blamed squarely on the woman. Even when a woman gives birth to only one sex, such as girls, it is wrongly assumed that she is the cause of the problem. Male infertility is usually not a subject for discussion in many traditional discourses in Africa, and for that matter, in Gonja. It is generally denied, and the lack of children or the inability to reproduce is laid squarely at the doorstep of the woman. The ego or pride of the man is hurt if he is called kututu wusa by the community, which translates as "the owner of a dead penis." This obvious shameful tag makes it difficult for a male-dominated society to accept that some men have challenges with infertility.

Denial as a defence mechanism is usually adopted in many African cultures to protect and defend the image of a man suffering from infertility. Men refuse to accept that they may have an issue with their fertility. However, they may be right in a limited context because they may never know they have a challenge until they have adopted some measures to mitigate it and failed. These mitigating measures may include "changing wives" through divorce and remarrying, adding another wife, or seeking a second 'opinion' with a concubine. In rare cases, however, the wife may

have children with another man, with or without the knowledge of her husband. This situation raises issues of genetical rights, which I shall discuss under marriage.

The whole of East Gonja, which is the largest district/municipal/metropolis, has only one hospital serving a population of 135,450 (GSS, 2010). Several studies have explored the motives for parenthood around the world. In the Western and industrialized world, studies have documented that children are mostly desired for reasons relating to happiness and personal well-being. Parents have an opportunity to play with the children and go out with them. It is a significant way of lowering stress levels. These reasons are equally applicable in Africa, as children are a source of joy to both mother and father. Fortes (1978) found that in the rural areas of Northern Ghana (i.e., Northern, Upper East, and Upper West Regions), the attainment of parentage is a precondition and something indispensable and essential to an individual's wishes and aspirations of becoming a "complete person and a full adult." He maintained that infertility has momentous consequences for the persons and their identities. Other compelling reasons Fortes cited for why children were important to a family in northern Ghana included socio-political (kinship, religious, and political) responsibilities and requirements to the community (Fortes, 1978). Continuing the religious argument for childbearing in Africa, Hollos and Larsen (2008) argue that "children represent a connection to the ancestors and their birth represents a continuation of the family not only physically but also in religious terms."

However, the desire for children goes beyond joy and happiness in Africa. Dyer (2007) indicates that insight into the worth of children can be inferred from studies on infertility, as the negative repercussions of involuntary childlessness reflect the value of children to parents and the community. According to these studies, children secure conjugal ties, offer social security, assist with labour, confer social status, secure rights of property and inheritance, provide continuity

through re-incarnation and maintaining the family lineage, and satisfy emotional needs. Parenthood, therefore, appears to have more and, arguably, deeper roots in African communities when compared to industrialized countries (Dyer, 2007).

This background of challenges associated with childbirth in Gonja is very important for many reasons. The Gonja kingdom is predominantly ruled by men from various sections. The section that is unable to produce children, especially male children, stands naturally eliminated from succession to royal positions of chiefs (Tamakloe, 1931; Braimah, 1964). Additionally, the average person who gets married is expected to have children; hence, issues related to infertility have become a problem worth investigating. Male infertility is a bigger challenge because men have a feeling of strength and superiority that eventually leads them to denial regarding challenges (Goody, 1975).

1.2 PROBLEM STATEMENT

There appears to be a significant gap in the literature regarding male infertility in Ghana and other parts of Africa, with the majority of research focusing on female infertility. Several studies have explored the sociocultural perceptions, experiences, and consequences of female infertility in Ghana and other African countries (Chimbatata & Malimba, 2016; Dartey, 2020; Donkor & Sandall, 2007; Fledderjohann, 2012; Tabong & Adongo, 2013). These studies highlight the stigma, marital instability, and mental health impacts faced by infertile women in pronatalist African societies. In contrast, there is not much literature specifically examining male infertility in the Ghanaian context. One study in South Africa found that while awareness of male infertility exists, it is rarely admitted due to stigma and the perception that "a man cannot be the problem" (Dyer et al., 2004). A qualitative study in rural Malawi explored how semen analysis contributes to the

visibility of male infertility and shapes gendered relationships, but the study did not examine the management of the disease by patients (Parrott, 2014).

The pervasive lack of focus on male infertility in both research and public discourse reinforces a deeply entrenched cultural tendency to attribute infertility solely to women in many African societies. This oversight has created a significant knowledge gap, underscoring the urgent need for research to understand the prevalence, causes, lived experiences, and management of male infertility in Ghana and other African countries. While ethnographic methodologies are uniquely positioned to provide deeper insights into the sociocultural perceptions, barriers to care, and psychosocial impacts of this issue, such focused studies remain scarce. It is precisely within this critical gap that the present thesis positions itself. This research directly addresses this scholarly deficit by undertaking an ethnographic exploration of male infertility within the East Gonja municipality. Through this focused inquiry, the study moves beyond the generalized call for more research to provide a nuanced, context-specific understanding of how male infertility is perceived, experienced, and managed, thereby challenging the singular attribution of infertility to women and contributing essential knowledge toward reducing stigma and improving pathways to care.

1.3 SIGNIFICANCE OF THE STUDY

The people of Gonja have indeed been the subject of significant scholarly attention, particularly concerning their socio-political organization, with foundational work by anthropologists such as Jack Goody and Esther Goody, as well as historians like J.A. Braimah and T.H. Tomlinson. While these studies provide an invaluable macro-level understanding of Gonja social structure, they have not centrally addressed the nuanced, intimate domain of reproductive health and infertility. Furthermore, existing research on infertility in Ghana often adopts a broad national or regional perspective, which can obscure critical local variations. Therefore, to provide the necessary depth

and specificity, this research deliberately narrows its focus to the East Gonja municipality. It is not a general study of infertility "among the Gonja," but rather a targeted ethnographic investigation of infertility in East Gonja. This precise geographical and administrative focus allows for a granular analysis of how the universal challenge of infertility is uniquely mediated by the specific cultural, economic, and healthcare infrastructures of this distinct locality, thereby offering a novel contribution that both builds upon and differentiates itself from the broader corpus of Gonja scholarship.

This dissertation will seek to answer questions on issues that bother on infertility. Secondly, this study is significant in the search for ways of bringing to light the fading away of many cultural practices that they Gonja had practiced. Indeed, fostering played a multifaceted function of bringing kin to gather, providing social and psychological support for people with infertility as well as providing support to children who were orphaned. However, fostering has virtually faded away because of the urbanization and its attended issues of nuclear families and the 'westernization' of families.

This work will, therefore, be significant in pointing to some of these weaknesses in the culture and traditions of the people of Gonja. It is hoped that the research findings of this study will be valuable and worthwhile to policymakers as well as health care managers and professionals who continuously seek innovative and improved ways of promoting positive health attitudes and behaviours. It is hoped that the findings will also be useful in the understanding and appreciation of local perspectives of issues bothering infertility in particular and diseases in Africa in general as they deepen our knowledge, understanding and appreciation of alternative health management approaches and the traditional health care systems. It is hoped that this will incalculably contribute to the stock of information on traditional cultures and healing.

1.4 MAIN OBJECTIVE

The main objective of this thesis is to find out how infertility is perceived and managed by various stake holders such as the individual, family, community and the health care systems in the East Gonja District

1.4.1 SPECIFIC OBJECTIVES

The thesis has the following as its research objectives.

1. To find out how infertility is defined and perceived in East Gonja
2. To explore the belief system of East Gonja people and its interconnectedness to health-seeking behaviour of the people.
3. To explore the various pluralistic methods of treatment and the intricacies involved in such treatments.
4. Find out the various psychosocial supports that are offered at various stages by the family and community.
5. To explore the cultural and socio-economic variables such as religion and socio-economic status, that influence the health care system and health-seeking behaviour of the Gonja

1.5 RESEARCH QUESTIONS

1. What meaning and interpretations do people of East Gonja give to infertility?
2. What is the belief system in east Gonja that is connected to health-seeking behaviours?
3. What are the various methods of treatment involved in health-seeking?
4. What is the contribution of family and community in the psychosocial support of infertile people?
5. What variables such as socioeconomic status, religion affect health-seeking behaviours?

1.6 LIMITATIONS

Several significant limitations impacted the methodological rigor and scope of this research , investigation into male infertility in East Gonja. These constraints principally concerned geographical accessibility, temporal restrictions, and subject-related challenges that potentially affected the depth and breadth of data collection.

The geographical scope of the study presented considerable logistical challenges. Although the research focused specifically on East Gonja, the nature of infertility management practices necessitated investigation beyond this geographical boundary. Men seeking treatment for infertility frequently traveled to distant shrines and herbalists outside East Gonja to maintain anonymity and avoid social stigma associated with their condition. This pattern of seeking treatment outside one's immediate community meant that comprehensive understanding of infertility management practices required tracking therapeutic journeys across multiple regions of Gonjaland, creating substantial logistical complexities and resource demands that could not be fully accommodated within the research parameters (Hammersley & Atkinson, 2019).

Temporal constraints significantly limited the ethnographic engagement required for anthropological research of this nature. The structural requirements of the doctoral program, including intensive coursework and comprehensive examinations during the initial years, restricted the available time for sustained fieldwork. Anthropological methodology typically necessitates extended immersion in the research context, ideally involving continuous residence for approximately twelve months followed by additional periods for supplementary data collection during analysis and writing (Madden, 2017). The fragmented nature of the fieldwork engagement potentially limited the depth of cultural understanding and relationship building essential for investigating sensitive health topics.

Substantive challenges emerged regarding subject recruitment and participation due to the highly stigmatized nature of male infertility. The cultural stigma associated with reproductive health issues created significant barriers to identifying and engaging willing participants. Many potential respondents demonstrated reluctance to discuss their experiences openly, particularly regarding traditional healing practices and spiritual consultations. This hesitancy potentially introduced selection bias, as those who agreed to participate might represent perspectives and experiences distinct from those who declined (Liamputtong, 2020).

Furthermore, expectations of material compensation influenced participant engagement dynamics. Individuals possessing specialized knowledge of cultural traditions and healing practices frequently expected financial remuneration or material goods such as mobile phones and call credit in exchange for their participation. This commodification of knowledge potentially affected the quality and authenticity of information shared, as respondents might tailor their accounts to meet perceived researcher expectations or provide information, they believed would justify requested compensation (Guillemin & Gillam, 2015).

These methodological limitations necessarily affected the research outcomes. The geographical constraints potentially limited the comprehensive mapping of therapeutic networks, while temporal restrictions reduced opportunities for prolonged participant observation and trust-building. The sampling challenges and compensation expectations potentially influenced the diversity of perspectives captured and the depth of information obtained. These limitations are acknowledged as inherent constraints that shaped the research process and findings, suggesting avenues for more extensive future investigation into this understudied aspect of reproductive health in northern Ghana. Additionally, the stigma associated with infertility, especially male infertility, makes it quite difficult to get respondents who willing to freely participate. Most of the

persons who had in-depth knowledge of the customs and traditions of Gonja were expecting money after every single interview. Some demanded personal items, including mobile phones and call credit.

1.7 DELIMITATIONS

This research is deliberately bounded by specific geographical, cultural, and methodological parameters that define its scope. The study focuses on East Gonja in the then northern Ghana, and now Savanna Region of Ghana, a selection justified by several compelling research considerations. This district presents a particularly valuable case study due to its predominantly patrilineal social organization, where male infertility carries profound implications for social identity and inheritance structures. The choice is further warranted by the region's rich pluralistic medical landscape, where traditional healing practices remain deeply integrated into healthcare-seeking behaviours, providing an ideal context for examining the intersection of cultural beliefs and therapeutic decision-making.

This investigation specifically centers on the lived experiences of Gonja men of reproductive age who have encountered infertility challenges. To triangulate these perspectives and map the therapeutic landscape they navigate, the study also engages healthcare providers—including traditional healers, herbalists, and biomedical practitioners—operating within this specific cultural context. The research examines infertility management through an anthropological lens, prioritizing qualitative understanding of lived experiences and cultural meanings over epidemiological measurement or clinical assessment of infertility prevalence.

Methodologically, the study employs ethnographic approaches including participant observation and in-depth interviews, deliberately excluding broader survey methods or quantitative analysis that might provide generalizable statistical data but would compromise the depth of cultural

analysis. The research focuses specifically on male experiences, thereby necessarily limiting extensive examination of female perspectives on couple infertility, though spousal dynamics are considered where relevant.

These delimitations reflect strategic research choices that enable concentrated investigation of the cultural constructions and management of male infertility within a specific socio-medical environment, while acknowledging that findings remain context-specific rather than universally applicable across Ghana's diverse cultural landscapes. The selection of East Gonja thus provides a focused ethnographic window into how infertility is experienced and managed within a traditional African societal context where reproductive success remains fundamental to masculine identity and social status.

1.8 DEFINITION OF TERMS

The thesis makes use of certain terms which are defined in this section. The definitions as provided were employed throughout the entire research process and have been provided here as a guide to the reader.

1.8.1 Infertility

Infertility is medically defined as the inability (for couples of reproductive age who are having sexual intercourse without contraception), to establish a pregnancy within a specified period of time usually one year (Sciarra, 1994). In addition to this medical definition, socio-cultural definitions of infertility also exist and differ from society to society. In this study, social definitions regarding the acceptable number of children to have as well as the sex of children that one desires to have.

1.8.2 Primary infertility

Primary infertility denotes infertile (or having no children). The person has never been able to carry a pregnancy till a life birth

1.8.3 Secondary infertility

Secondary infertility refers to the inability to have an additional child after a successful live birth.

18.4 Gonjaland

Gonjaland refers to all areas that Gonja live in. This includes other parts of Gonja other than East Gonja which has its traditional capital in Kpembi and Salaga as the political capital. The rest of Gonjaland aside the study area includes North Gonja, Central Gonja, West Gonja and Bole. Major towns in these areas include Kusawgu, Damongo capital of the Savannah region, Daboya and Bole

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CHAPTER TWO

LITERATURE REVIEW

2.0 INTRODUCTION

This chapter examines related literature and some definitions and various concepts related to male infertility and fertility in general from multiple standpoints or viewpoints. This section will explore the numerous debates, discussions on the idea of African culture relative, male infertility as they apply to this study in East Gonja.

2.1 THE DISSONANCE OF DEFINITIONS: BIOMEDICAL AND ETHNOMEDICAL CONSTRUCTIONS OF MALE INFERTILITY IN GHANA

A thorough review of the existing literature reveals that this dissonance is often resolved in a one-sided manner within academic discourse, with the biomedical model frequently positioned as the objective standard against which local beliefs are measured as misconceptions. Furthermore, a significant portion of the scholarship on infertility in Africa inadvertently perpetuates the very cultural bias it should scrutinize by focusing overwhelmingly on women, thereby reinforcing the stereotype of female-centric responsibility. It is within these twin misapprehensions—the epistemological privileging of the biomedical and the empirical neglect of the male experience—that this thesis positions its critical intervention.

By centering the lived experiences of Gonja men and the explanatory models of their local healthcare providers, this work does not merely document differing views on male infertility. It actively challenges the aforementioned gaps by demonstrating how the ethnomedical perspective constitutes a coherent, logical system in its own right. The findings presented herein will therefore

collaborate with literature on medical pluralism while disagreeing with, and seeking to correct, works that dismiss local knowledge as mere superstition or that render male infertility invisible. Ultimately, this review serves to establish how the present study reframes the conversation, moving from a deficit model of cultural belief to a nuanced analysis of competing worldviews in action.The biomedical model defines male infertility through a lens of quantifiable biological dysfunction. The World Health Organization (2018) defines infertility as a disease of the male or female reproductive system characterized by the failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse. The male factor is solely responsible in approximately 20% of cases and is a contributing factor in another 30-40% of all infertility cases, meaning male factors substantially contribute to about 50% of cases globally (Agarwal et al., 2015). The biomedical diagnosis relies on objective laboratory measurements of semen parameters, including sperm concentration (count), motility (movement), and morphology (shape) (Schlegel & Sigman, 2017). Azoospermia (absence of sperm), oligozoospermia (low sperm count), asthenozoospermia (poor motility), and teratozoospermia (abnormal morphology) are classified as pathological conditions (Cleveland Clinic, 2021). The aetiology is sought in anatomical, genetic, endocrine, or environmental factors, and treatment aims to correct these biological dysfunctions through medication, surgery, or assisted reproductive technologies (ART) like IVF and ICSI (Inhorn, 2020; Schlegel & Sigman, 2017). This model is mechanistic, viewing the body as a system whose reproductive function can be measured, diagnosed, and repaired.

2.1.1 Ethnomedical Definitions: A Holistic and Socio-Spiritual Construct

In contrast, many communities in Sub-Saharan Africa, including in Ghana, understand infertility through ethnomedical explanatory models that integrate social, spiritual, and biological elements.

In these contexts, infertility is often less an individual biological failure and more a relational, social, and spiritual crisis (Tabong & Adongo, 2013).

In Northern Ghana, particularly in patrilineal societies, childbearing is a social prestige and a divine command, essential for genealogical continuity, inheritance, and securing a place in the ancestral world (Yawson, 2023). Within this cultural framework, male infertility may be explained by concepts utterly foreign to biomedicine. Spiritual causation is a frequent attribution, where infertility is seen as the result of curses, witchcraft, spirit possession, or breaches of taboo (Tabong & Adongo, 2013). A common ethnophysiological concept is that of "weak blood" or a diminished vital force in the man, which renders him incapable of successful procreation (Yeboah et al., 2022). This reflects a holistic understanding where physical health is inseparable from spiritual strength. Infertility can also be perceived as a symptom of social disharmony, such as unresolved conflicts within the family, incompatibility between the couple, or the displeasure of ancestors (Donkor, 2019; Tabong & Adongo, 2013).

These explanations are deeply embedded in cultural values that prioritize communalism over individualism and spiritual balance over mechanistic function. Consequently, the social consequences of infertility are severe, encompassing stigma, denial of inheritance rights, exclusion from leadership roles, marital instability (including divorce or polygamy), and even denial of proper burial rites (Yawson, 2023).

2.1.2 **Kleinman's Explanatory Model: Bridging the Interpretive Divide**

Medical anthropologist Arthur Kleinman's concept of the explanatory model provides an indispensable framework for analysing the clinical and cultural dissonance surrounding male infertility. Kleinman (1978) posits that patients and clinicians often operate within distinct, and

often conflicting, explanatory models. The biomedical model, as you note, is primarily concerned with the pathophysiological question of "what is the matter," while the ethnomedical model seeks to understand "what matters most" to the patient within their social and moral world (Kleinman, 1988). This theoretical distinction is powerfully illustrated in the Ghanaian context, where a man's model of infertility—naming it "weak blood," attributing it to a spiritual curse, fearing social shame, and seeking restorative traditional treatments—stands in stark contrast to the clinician's model focused on semen analysis and Assisted Reproductive Technologies (ART) (Tabong & Adongo, 2013).

However, a critical review of the literature reveals a persistent tendency to apply Kleinman's framework in a way that inadvertently reifies the very hierarchies it seeks to dismantle. Scholars often present these explanatory models as a binary, with the ethnomedical model rendered as a static set of "cultural beliefs" to be "understood" or "overcome" for biomedical compliance, rather than as a dynamic and logical system of knowledge-in-practice. Furthermore, while studies like Tabong & Adongo (2013) adeptly identify these contrasting models, they often stop at the point of description, leaving the lived negotiation of these models by men themselves as an underexplored area.

It is precisely within this scholarly gap that the present study positions its critical intervention. This research moves beyond simply cataloguing the differences between biomedical and ethnomedical models of male infertility in East Gonja. Instead, it investigates how Gonja men actively navigate this contested epistemological terrain. The findings presented in this thesis will demonstrate that men are not passive holders of a fixed cultural script; they are pragmatic agents who often develop syncretic, and at times contradictory, personal models that blend, resist, or strategically deploy both biomedical and traditional explanations in response to specific social and

therapeutic contexts. In doing so, this work serves to correct the misapprehension of local knowledge as monolithic and challenges the portrayal of patients as merely caught between two systems, arguing instead for their role as active architects of their own therapeutic pathways.

2.4 Synthesizing the Literature: Gaps and The Contribution of This Study

The existing body of literature provides a robust foundation for understanding the cultural construction of male infertility, its devastating intersection with masculine identity, and the complex health-seeking pathways men navigate in Ghana. Scholars have effectively utilized Kleinman's explanatory model to delineate the clash between biomedical and ethnomedical frameworks (Kleinman, 1978; Tabong & Adongo, 2013), while others have meticulously documented the profound social consequences for infertile men and their strategic, often sequential, engagement with pluralistic treatment options (Donkor, 2019; Yawson, 2023; Yeboah et al., 2022).

However, a critical synthesis of this scholarship reveals two significant, interconnected limitations that this thesis seeks to address. First, there is a tendency in the literature to treat men's health-seeking behaviours as a reaction to external forces—cultural beliefs, structural barriers, or stigma. While these factors are undeniably crucial, this framing often portrays men as being pushed and pulled by systemic influences, thereby overlooking their agency as strategic negotiators. The literature excellently describes the pathways but offers less insight into the real-time, pragmatic decision-making processes that men employ as they actively blend, resist, or selectively utilize different models of care.

Second, and relatedly, the rich, qualitative descriptions of "the infertile man" often risk presenting a monolithic or overly deterministic portrait. The focus on shared cultural models can obscure the internal heterogeneity among men—how variables such as their individual social capital, nuanced religious convictions, specific marital dynamics, and evolving personal biographies shape distinct experiences and coping strategies within the same cultural context.

It is within these critical gaps that the present study positions its unique contribution. This research does not seek to refute the established findings on cultural beliefs or structural barriers; rather, it aims to deepen and complicate them. By centering its analysis on the lived experiences of Gonja men in the East Gonja municipality, this thesis moves beyond cataloguing health-seeking pathways to interrogating the daily practices of negotiation that define them. The findings presented in the subsequent chapters will demonstrate that Gonja men are not passive vessels of culture nor mere products of structural constraint. Instead, they are active, pragmatic agents who engage in what can be termed therapeutic bricolage—assembling personalized, and sometimes contradictory, treatment regimens from both biomedical and traditional repertoires in response to specific social challenges and moments of crisis.

In doing so, this work serves to correct the misapprehension of the infertile man as a culturally determined archetype. It argues that while the crisis of infertility is universally profound for Gonja men, their responses are remarkably diverse and strategically nuanced. By illuminating this agency and heterogeneity, this thesis contributes a more dynamic and humanized understanding of male infertility, one that acknowledges the power of culture and structure without erasing the individual's capacity for pragmatic action and meaning-making within the complex therapeutic landscape of East Gonja.

2.4 MEDICAL PLURALISM AND THERAPEUTIC NAVIGATION IN THE MANAGEMENT OF INFERTILITY

The healthcare landscape for infertility in Ghana is characterized by medical pluralism, a system where multiple distinct medical traditions coexist and are utilized by individuals in a complementary, supplementary, or sometimes contradictory manner. This pluralistic environment encompasses biomedical institutions, traditional healing practices involving herbalists and spiritual specialists, and various alternative therapeutic approaches. Patients navigating infertility rarely confine themselves to a single system but instead engage in what medical anthropologists term "therapeutic itineraries"—complex pathways that may involve simultaneous or sequential use of different treatments based on evolving understandings of their condition, financial considerations, and social pressures (Langwick, 2018). This navigation reflects a pragmatic approach to healing that acknowledges the multifaceted nature of infertility as simultaneously a biological, social, and spiritual concern.

In the Ghanaian context, indigenous knowledge systems continue to exert considerable influence on infertility management, particularly through traditional birth attendants, herbalists, and spiritual healers who operate within localized understandings of health and illness. Traditional practitioners typically conceptualize infertility not as a biomedical condition but as a manifestation of spiritual imbalance, ancestral displeasure, or social discord (Aziato et al., 2016). Treatment protocols accordingly emphasize ritual purification, herbal preparations believed to enhance fertility, and interventions aimed at restoring social harmony within the family or community. These approaches maintain cultural legitimacy because they address the existential dimensions of infertility—the why and the why me - those biomedical explanations frequently overlook (Van der Geest, 2015).

The continued relevance of traditional systems is further reinforced by their accessibility, affordability, and cultural congruence with patients' worldviews.

Patients frequently engage in medical pluralism through what can be described as hierarchical complementarity, wherein different systems are utilized for different aspects of the infertility experience. For instance, a couple might consult a biomedical facility for diagnostic testing while simultaneously seeking traditional treatment to address perceived spiritual causes, or they might pursue assisted reproductive technologies after traditional methods have proven unsuccessful (Gyesi, 2022). This medical pluralism is not merely additive but often represents a sophisticated strategy for managing uncertainty and maximizing potential outcomes across multiple domains of well-being. The choice to utilize multiple systems simultaneously reflects both the profound desire for a child and the recognition that no single medical tradition holds a monopoly on effective intervention.

The coexistence of these systems presents both challenges and opportunities for healthcare integration. While some efforts have been made to formally incorporate traditional healers into national healthcare systems, significant tensions remain regarding regulation, standardization of practices, and epistemological differences between medical traditions (Hampshire & Owusu, 2013). Biomedical practitioners often view traditional approaches with skepticism, while traditional healers may perceive biomedical interventions as addressing symptoms rather than root causes. For patients, however, these ideological conflicts are often secondary to practical concerns; the primary consideration is which combination of treatments might ultimately lead to a successful pregnancy. Thus, medical pluralism in infertility management represents more than just the coexistence of different medical traditions—it constitutes an integrated ecosystem of care that patients navigate with strategic agency, cultural wisdom, and enduring hope.

2.5 SOCIOECONOMIC DETERMINANTS OF HEALTHCARE ACCESS IN INFERTILITY MANAGEMENT

The pursuit of infertility treatment occurs within a framework of significant socioeconomic constraints that systematically disadvantage populations with limited resources. Access to biomedical reproductive services in Ghana follows a distinct gradient shaped by income, education, and geographic location, creating substantial disparities in care quality and outcomes. Financial barriers represent perhaps the most immediate obstacle, as assisted reproductive technologies remain largely privatized and cost-prohibitive for most Ghanaian households. The direct expenses of diagnostic procedures, pharmaceutical interventions, and potential advanced treatments like in vitro fertilization frequently exceed annual household incomes for rural families (Donkor & Sandall, 2019). These direct costs are compounded by substantial indirect expenses including transportation, accommodation in urban centres where services are concentrated, and lost wages during treatment periods. Consequently, infertility management becomes a catastrophic health expenditure that many families cannot sustain, particularly when treatment requires multiple cycles over extended periods (Omran et al., 2021).

Educational attainment mediates healthcare access through multiple pathways, including health literacy, decision-making autonomy, and ability to navigate complex medical systems. Lower educational levels correlate with reduced understanding of biomedical explanations of infertility, which can delay appropriate care-seeking and reinforce reliance on traditional explanations and treatments (Boah et al., 2019). Education also influences gender dynamics in healthcare decisions, as women with higher education typically demonstrate greater autonomy in seeking reproductive healthcare independently of spousal or familial approval. This educational effect creates a

paradoxical situation wherein those most knowledgeable about biomedical options often face the greatest psychological distress when those options remain financially out of reach.

Geographic disparities compound economic and educational barriers, particularly in regions like East Gonja where healthcare infrastructure remains underdeveloped. The centralization of specialized fertility services in urban centres, particularly Accra and Kumasi, creates what amounts to a medical desert for rural populations (Ganle et al., 2020). Even when individuals overcome financial constraints, the physical distance to facilities, poor transportation networks, and inability to be absent from agricultural or informal economic activities for extended periods present nearly insurmountable obstacles. This geographic isolation reinforces dependence on local traditional healers and herbalists whose treatments, while culturally congruent and geographically accessible, often lack empirical evidence of efficacy for treating physiological causes of infertility.

The intersection of these socioeconomic factors creates a self-reinforcing cycle of healthcare disadvantage. Economic limitations restrict educational opportunities, which in turn limit income potential and geographic mobility, collectively constraining healthcare access in ways that particularly affect rural populations (Awusabo-Asare et al., 2017). This cycle explains the observed pattern of delayed biomedical consultation and greater reliance on traditional methods among lower socioeconomic groups—not as a cultural preference per se, but as a pragmatic adaptation to structural constraints. Addressing these disparities requires recognizing that improving infertility care access necessitates broader interventions in economic development, educational expansion, and healthcare infrastructure development rather than merely increasing the availability of reproductive technologies.

2.5.1 Socioeconomic Barriers to Accessing Infertility Care in Ghana

Access to infertility treatment in Ghana is significantly constrained by socioeconomic factors that create substantial disparities in care utilization and outcomes. Financial limitations represent the most immediate barrier, as assisted reproductive technologies remain largely privatized and cost-prohibitive for most households. The direct expenses of diagnostic procedures, pharmaceutical interventions, and potential advanced treatments like in vitro fertilization frequently exceed annual incomes for many families (Donkor & Sandall, 2019). These costs are compounded by substantial indirect expenses including transportation, accommodation in urban centres where services are concentrated, and lost wages during treatment periods. Consequently, infertility management becomes a catastrophic health expenditure that many families cannot sustain, particularly when treatment requires multiple cycles over extended periods (Omran et al., 2021).

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2.6 PSYCHOSOCIAL IMPACTS AND GENDERED EXPERIENCES OF INFERTILITY IN GHANA

The experience of infertility extends far beyond biological dimensions, generating profound psychosocial consequences that are distinctly mediated through gender norms and cultural expectations. In Ghanaian society, where childbearing represents a fundamental social expectation and spiritual imperative, infertility creates complex emotional distress that manifests differently for men and women within the patriarchal family structure. Research indicates that involuntary

childlessness frequently triggers anxiety, depression, and diminished self-worth among affected individuals, though these psychological impacts remain significantly under-diagnosed and untreated in clinical settings (Dyer et al., 2021). The emotional burden is particularly acute for men, who often suffer in silence due to cultural prohibitions against expressing vulnerability, creating what scholars have termed "hidden suffering" within masculine domains (Donkor, 2019).

Marital relationships become sites of considerable strain under the pressure of infertility, with traditional gender roles amplifying existing tensions. While women frequently bear disproportionate blame for reproductive failure—often undergoing diagnostic testing and treatment before male partners even consider evaluation—men experience their own unique forms of psychological distress tied to perceptions of failed masculinity (Yeboa et al., 2022). This gendered distribution of blame creates complex dynamics within couples, where communication about reproductive difficulties may become strained or avoided altogether to prevent confrontation. The marital relationship, which should theoretically provide mutual support during this crisis, often becomes instead a source of additional stress and emotional distance as both partners grapple with feelings of inadequacy and disappointment (Tabong & Adongo, 2013).

Social isolation represents another significant consequence of infertility, particularly in close-knit communities where childbearing is central to social identity and community participation. Childless couples may find themselves excluded from important social ceremonies, community decision-making processes, and even informal social gatherings where children represent a common topic of conversation and connection (Yawson, 2023). This social marginalization compounds the emotional distress experienced by individuals, creating a cycle of isolation and depression that further complicates their ability to seek support or treatment. For men specifically,

the inability to participate in conversations about fatherhood and child-rearing creates particular forms of social alienation that reinforce their sense of inadequacy and difference.

The ultimate social consequences of infertility often include marital dissolution through divorce or the introduction of polygamous arrangements. When a marriage fails to produce children, families may pressure husbands to take additional wives in the hope of achieving pregnancy, a practice that further marginalizes the first wife and creates complex household dynamics (Aniteye et al., 2021). In more extreme cases, complete marital dissolution may occur, particularly when the extended family identifies infertility as grounds for terminating the marriage. These outcomes reflect the profound cultural significance placed on biological parenthood and the relative lack of social acceptance for alternative family formations such as adoption or voluntary childlessness. The psychosocial impacts of infertility thus extend beyond individual psychological distress to encompass fundamental challenges to social identity, marital stability, and community belonging that require culturally sensitive interventions and support mechanisms.

2.7 INFERTILITY

The World Health Organization has aptly defined infertility as the inability of a sexually active, non-contraception couple to achieve pregnancy in one year (Santiago et al., 1991). The American Society for Reproductive Medicine in 2014 revised the definition of infertility as "the inability to conceive after 12 months of unprotected intercourse" (ASRM, 2014). By these definitions, the time a couple that is engaged in unprotected sex and gets pregnant was limited to 12 months. Failure to conceive after the 12-month duration, the couple would have to seek medical treatment for infertility (Kallen, 2015). Per these definitions, the ultimate purpose for unprotected sex is obvious, to get pregnant. The American Society for Reproductive Medicine, however, indicated

that for older women aged 35 or more who have tried unsuccessfully to become pregnant after six months are considered infertile. Older women are declared infertile within a shorter period because age is seen as a crucial factor in determining the clinical reasons for infertility. Women who are in their 20s and early 30s have a 25% to 30% of conceiving each month (ASRM, 2014). Evidence from epidemiological studies has shown that in any normal heterosexually active society, 25% of women who are not using birth control measures get pregnant within the first month, 63% within six months and 80% within a year. By the close of the second year, 80% to 90% will conceive by the end of the second year (NCCWCH, 2012)

It is important to indicate that these definitions that have been offered by the World Health Organization and the ASRM are Western and do not reflect the exact conceptualization of infertility in Africa. The definition of infertility in African is varied and many as the definition of infertility in Africa is contingent on the type of community. Infertile and reactions to it are mitigated by socio-cultural factors, which vary widely across societies in Africa (Ibisomi & Mudege, 2014). This cultural definition of infertility in Africa usually restricts it to females. The problem of male infertility is usually not a topic for discussion (Ibisomi & Mudege, 2014; Okonofua et al. 1997; Okonofua 2002; Van Balen and Bos 2009)

Infertility has been described by the WHO as a disease that leads to disability (that is an inability); hence persons seeking access to medical care falls under the Convention on the Rights of Persons with Disability. Disability is a generic term or word that includes but not limited to impairments, inability to take part in some specific activities and restrict the participation of activities. Disability, therefore, highlights the limitations of oneself in some activities as you interact with society and the environment. Disability is, thus not only a product of one's mind or physical space but also the interpretation that society gives to an inability to perform a certain task as prescribed by the society

in which the person lives. The WHO indicates that developing countries including Ghana have about 34 million women who have infertility challenges usually as a result of "maternal sepsis and unsafe abortion (long term maternal morbidity resulting in a disability)." Women's infertility is estimated as the 5thmost severe world-wide disability for people less than 60 years.

Closely related to the World Health Organization's (WHO) definition are the definitions from the realm of medical sciences such as reproductive health, infertility is seen as the "incapacity to fulfill pregnancy after a reasonable time of sexual intercourse with no contraception measures taken." It is also described as 'a deficiency that does not compromise the physical integrity of the individual nor life-threatening (Brugo-Olmedo et al.,2003). This definition emphasizes the reduced and sometimes absent opportunity to have conception and bear offspring. The couple will, therefore, be declared infertile or told they are experiencing infertility if they have no con conception within a year, especially at a time they so want it and engage in unprotected sex. The Medical News Today, a renowned medical journal, describes infertility as a situation where usually one of the spouses "cannot contribute to conception, or that a woman is unable to carry a pregnancy to the full term' (Brazier, 2018). All definitions of infertility must be understood within a time frame to make them relevant. Equally important to take into consideration is the fact that no birth control pills are being used by the couple within the time framework that such a couple is being defined as infertile (Nordqvist, 2018). The over-medicalization of infertility takes the shine away from preventive methods as its medicalization only focuses on treatment. Many preventive measures are able to help in the management process including healthy eating and exercising, reducing levels of stress and increasing the waiting period for expectation of pregnancy.

Research evidence available point to the fact that not less than 20 percent of infertility is avertable (Green, Robins, Scheiber, Awadalla, & Thomas, 2001; Mosher & Aral, 1985; World Health

Organization ([WHO) 1987). There is a body of research that points to critical issues such as damage to reproductive organs due to STIs, previous surgical sterilization, pelvic inflammatory disease (PID), delayed childbearing, and occupational and environmental hazards as some of the causes of infertility (Henifin, 1993). Scholars have suggested that most of these avertable causes are more common among poor rural folk women, yet they are ignored due to medicine's focus on treatment (Green, Robins, Scheiber, Awadalla, & Thomas, 2001; Mosher & Aral, 1985; World Health Organization (WHO), 1987). These causes that have been adduced are rather used as reasons to discriminate against women from rural areas from attaining medical treatments by blaming them for irresponsible lifestyles and thus their infertility.

Researchers have not paid enough attention to studying the prevention of infertility, perhaps because the rich can afford more sophisticated methods of treatment such as ART and in-vitro fertilization treatments. This expensive medical treatment limits its only acceptable treatment to one way of handing the infertility problem that is, producing a biological child (Becker & Nachtigall, 1992). On the contrary, powerful pharmaceutical companies make research funding available to researches focusing on medication just to keep them in business. Such pharmaceutical companies end up dictating the direction and scope of research with respect to infertility.

Aside the psychological perspective, infertility can be viewed as a social process, a process that is influenced by community and ethnic-based philosophies, notions and concepts that border on reproduction, motherhood, family, and perhaps health. These notions, thoughts and ideas do not only shape our understanding of what infertility is but also help to define it. Parenthood (i.e., fatherhood and motherhood) is ordinarily anticipated among all men and hopefully expected among women as well. Indeed, among the Gonja, there is no dichotomy between womanhood and motherhood to the extent that once a woman is of age and married, then she must necessarily have

children. A woman who gets pregnant by her boyfriend who has performed the introductory rites of marriage is not shunned by the community. Once the woman is put to bed or gives birth, the rest of the marriage rites can be performed. Conversely, the Gonja abhor infertile, seeing it as a curse, hence as unnatural or abnormal. Many infertility pieces of research have indicated that infertility can be understood as a "cultural disorder" because it serves as a 'mirror' of cultural norms and a 'barometer' of cultural change (Sandelowski & DeLacey, 2002)

Bledsoe (1990) work on motherhood and reproduction in her book "Contingent Lives" highlights the complexities and insecurities surrounding reproduction, emphasizing how it is often influenced by economic, social, and cultural factors, rather than solely by biological or cultural factors. Bledsoe's research challenges traditional notions of motherhood, demonstrating that women's reproductive choices are shaped by their economic and social circumstances, not just by biological or cultural factors. Bledsoe critiques the traditional life stage model, arguing that it oversimplifies the complexities of human life and does not account for the dynamic and context-dependent nature of life experiences. She proposes the concept of "vital conjunctures" to better capture the moments when established futures are called into question and actors are forced to adapt to new circumstances. There is the need to consider the social, economic, and cultural contexts in which motherhood and reproduction occur, rather than viewing them solely through biological or cultural lenses (Bledsoe, 1990)

Feldman-Savelsberg (2005)'s work on threatened reproduction and identity, as seen in her book "Plundered Kitchens, Empty Wombs," is closely related to Caroline Bledsoe's work on motherhood and reproduction. Both scholars delve into the complexities surrounding reproduction, emphasizing the influence of economic, social, and cultural factors on women's reproductive choices. Feldman-Savelsberg's exploration of the politics of reproduction in the Cameroon

grassfields aligns with Bledsoe's critique of traditional notions of motherhood and her emphasis on the insecurities and uncertainties surrounding reproduction.

Furthermore, Feldman-Savelsberg's focus on reproductive insecurity and the impact of social, cultural, and economic factors on fertility resonates with Bledsoe's argument that reproduction is always insecure and that women's reproductive decisions are shaped by broader societal contexts. Both scholars highlight the need to consider the multifaceted nature of reproduction, moving beyond simplistic biological or cultural explanations to understand the complexities of women's reproductive experiences.

In essence, Feldman-Savelsberg's work on threatened reproduction and identity complements Bledsoe's research by providing additional insights into the intricate interplay between social, economic, and cultural factors in shaping women's reproductive lives, ultimately contributing to a more nuanced understanding of motherhood, reproduction, and identity (Feldman-Savelsberg, 1999). Similarly, Bledsoe's research challenges traditional assumptions about motherhood and reproduction, highlighting the complexities, insecurities, and context-dependent nature of these experiences, and proposing more nuanced frameworks for understanding human life stages (Bledsoe, 1999).

CHAPTER THREE

RESEARCH METHODS

3.1 INTRODUCTION

This chapter focuses on the various methods that were used to traverse this study. The uses of methods are elucidated, and reasons adduced for their choices are explained and justified. These methods were employed basically to help to achieve the overarching and central objective of the study, which tries to assess the management of male infertility in the East Gonja District of Northern Ghana.

Infertility is a condition that is not normally discussed in the open, hence the researcher needed to adopt a methodology that could help elicit as much information as possible on a rather delicate issue. A qualitative approach was adopted utilizing ethnographic field techniques. Ethnography is the study of the socio-cultural contexts, processes, and meanings in cultural systems (Whitehead, 2004). Harris and Johnson describe ethnography as "a portrait of a people, ethnography is a written description of a particular culture - the customs, beliefs, and behavior based on information collected through fieldwork" (Harris and Johnson, 2000: 100). This research is an in-depth description of how infertility is perceived, how it is managed and how those who are suffering it cope with it. It, therefore, has to utilize ethnographic tools so that 'a portrait of the people' can adequately be captured. The issues surrounding infertility in the context of East Gonja can only be appreciated if the researcher reports in great detail and at length, issues of infertility from the beliefs' point of view as well as from behaviours formed thereof. It is necessary to appreciate and report whatever responses they offer, especially in Gonja, as the context of the response in the language gives it a richer value. The use of ethnographic methods is therefore very well and apposite for a study of this kind. The data collected for this interview was primarily done through

interviews where the researcher used semi-structured interviews and question guides. Regardless of the fact that Salaga, the capital of East Gonja is highly cosmopolitan, most of the interviews and focused group discussions were conducted in the Gonja language and the interviews were audiotaped with the prior permission of the interviewees. The researcher stayed in East Gonja for a total of twelfth months, personally observing the cultures, practices and behaviours of the people. These interviews, discussions and personal observations formed the bulk of the empirical and experiential evidence gathered and labelled as primary data.

Secondary data was collected from relevant, reliable sources such as the University of Leiden Library, libraries in various areas of Ghana, official records such as data from the Ghana Statistical Service, the Ghana Health Service, surveys and archival records that are related to East Gonja and infertility.

Information, facts and general data on infertility were collected through personal visits to homes, gossips from the market square. Stories, proverbs and songs that deal with infertility and Gonja culture were played, told and recounted at ceremonies such as funerals, out-dooring and installations of chiefs and naming ceremonies of babies. These stories and proverbs were recounted mostly by professional singers usually called the '*gonje*' drummers. Mostly in Africa, folktales, proverbs and myths are mostly used to pass down customs and traditions. The songs and proverbs are folk stories that are popular with the people. All these visits were undertaken from June 2016 to June 2017, which is twelfth months. Drinking bars, barbering shops, water drawing sites were all part of the areas that data was gathered. The respondents were initially uneasy, edgy and reluctant to talk on a rather delicate issue like infertility that evoke substantial social and psychological effects that account for divorce, polygamy, depression and matters of infidelity.

They felt more relaxed to talk to me as the levels of familiarities became stronger especially as the discourses were in the Gonja language (a language the interviewer is fluent)

3.2 SAMPLE PROCEDURE AND SIZE

This research into infertility used a sample that has to be purposively selected because the respondents must know issues of culture and infertility and persons who are challenged with infertility. This will help in the achievement of the objectives which have an all-encompassing aim of finding out all about male infertility in the East Gonja District. The very persons with the problem, persons who are knowledgeable in the tradition and customs amongst others, will have to be specifically targeted and sampled for their views. It then becomes imperative that the selection, the manner of obtaining data and from whom the data will be acquired be done with sound judgment, especially since no amount of analysis can make up for improperly collected data (Bernard *et al*. 1986). The main advantage that accrues when purposive sampling is used is that the researcher can easily make generalizations about the sample in the study area because all participants have the characteristics the research proposes to study. These characteristics include knowledge about the history and culture of the people of Gonja relative to the issue being investigated. Additionally, respondents have an in-depth understanding of the various ways of managing male infertility.

In an ethnographic study focusing on identifying individuals with infertility, researchers typically engage in various methods to locate and assess participants.

The first sampling technique used was snowball sampling: This technique involves initial participants referring the researchers to other individuals who may also be dealing with infertility. Through a chain referral process, the study can expand its participant pool and reach individuals who may not be easily accessible through other means.

Additionally traditional health providers play a crucial role in identifying individuals with infertility within a community who came to them for treatment. Theses traditional healers sought the permission of such persons before identifying them to me and asking them for interviews with me. They may have specific knowledge of families or individuals seeking help for fertility issues, thereby serving as a valuable source for recruitment in the study.

By combining snowball sampling with the insights of traditional health providers, researchers can create a comprehensive network for identifying and engaging individuals experiencing infertility within the community under study.

Persons or couples with infertility, persons from whom they seek help in terms of health-seeking and social support, were sampled. Some key informants were conveniently sampled for the in-depth knowledge they possess. The key informants include the traditional health healers, some medical officers, the District Director of the Ghana Health Services of the Ministry of Health for the East Gonja District and some officers of the district assembly of the East Gonja District Assembly.

The rational for selecting the traditional health healers and some medical officers was for two reasons: Their rich knowledge of the challenge and to interact with them to know exactly the nature and challenges of management that those with the challenge face. Additionally, the officials of the Director of The Ghana Heath Service in charge of health issues in the district and an interaction with them will give clues on general management of illnesses in the district. Finally, the officials of the district may interview because they move around the district and have a good understanding of some issues and where they occur. The key informants' number twenty-five.

The other category of the sample came from people or couples with infertility challenges, and they number twenty-five. Their ages range from 30 years to about 60 years. Out of this number, only seven were in the secondary infertility category while the rest of them had primary infertility.

3.3 ETHNOGRAPHY: AN IMPORTANT METHOD FOR INFERTILITY RESEARCH

Emerson et al. (1995) define ethnography as a study of people as they go about their everyday lives. As such, the community becomes a natural "laboratory" where the people are studied as they go about their natural daily lives. Johnson (2006) describes ethnography as 'a portrait of a people.' An ethnography is a written description of a particular culture - the customs, beliefs, and behaviour that results from data gleaned from fieldwork.

Ethnography is popular with the social sciences, and it is the main research strategy in Anthropology (Blau, 1955). It is mostly known as the anthropologist's main research strategy, Ethnography as a method of gaining knowledge is more than a mere set of methods for the collection of data and or a merely written account of experiences from the field. It has always been a project with humanistic ambitions that is enriched with ontologies, methodologies and epistemologies (Stoller,1989).

This definition perfectly fits into the investigations conducted into male infertility in East Gonja. I carried out the data collection by living among the people indifferent communities, including Salaga, Kpembi, Kumdi and Kojobonni. (The last two villages used to belong to the East Gonja district but are now part of the Kpandai district following the creation of districts by the Government of Ghana in 2003. They were still included in the study because of the useful cultural ties that they still have with Kpembi, the capital of East Gonja).

As already noted, ethnography has its antecedents in anthropology and qualitative research. "Ethnography investigates societies and cultures by examining human, interpersonal, social and

cultural aspects in all their complexity" (Shagrir, 2017). This research, which is a study into infertility and how infertility is managed, examines how the society of East Gonja examines its culture concerning infertility from an interpersonal perspective. Ethnography is very useful in research of this kind because it combines methodology the study adopts with the generated data, which is interpreted from the viewpoint of the researcher thereof (Sabar-Ben Yehoshua 2016; Shlasky and Alpert 2007).

Ethnography was largely the preserve of anthropologists and sociologists. However, researchers in other disciplines such as medicine have taken up ethnographic methods use in data collection in a diversity of different social groups such as ethnic groups and circumstances. Nurse ethnographers research such issues as the work of nurse practitioners in acute-care settings (Williamson et al., 2012), or nursing education (Malinsky et al., 2010), or nurses as agents of healing and social change during the political revolution (Pine, 2013).

Corsaro (1996) also finds ethnography very useful as a method that involves the rigorous and usually "microscopic" observation of small units of samples in the study of humans, especially children. The foremost objective of ethnography to make available rich and holistic insights into people's views and actions. It also affords us the nature of the location that they live in. It further affords us the opportunity of the collection of detailed observations and interviews. The ethnographer, therefore, documents the culture, the perspectives and practices of the people in these settings. It gives the researcher the prospect of seeing the world from their viewpoint. It helps in the exploration of the nature of a particular social phenomenon such as male infertility rather than testing it in the form of a hypothesis. The data that is gathered usually involves a very detailed and clear interpretation of the implications, values and purposes of human actions. This is generally done through a detailed verbal description and clarifications (Hammersley, 1992).

Ethnography has two important features, and these are the philosophical underpinnings, ontology (the nature of what is being studied) and epistemology (and how to understand this object of study best), which dictates the work of the researcher (Guba, and Lincoln 1994). This means that ethnography is not merely about methods; it also plays a role in shaping the philosophy of the researcher. This research will gain knowledge about infertility and how people seek health through empiricism. This philosophy agrees that 'knowledge is about reality and requires experience and interaction with reality' (Guba and Lincoln, 1994).

The use of ethnography by this study as a method is adequate to gather and build knowledge about infertility by examining the lived experiences of men who have the challenge and interacting with them to report into detail what their emotions are and how they handle their supposed tragedy.

Weisner (2002) justifies the use of ethnography in research like this one as he argues that the evolving pathways of a person are defined and continuously redefined by the cultural substructures of daily life. This position helped me to live among at least four different cultural communities of Gonja, Nchuburu, Zongo[1] communities and the Konkomba. This allowed the researcher to appreciate the similarities and differences in the treatment of infertility among the different ethnic groups. Among the Konkomba community, I discovered that infertility was handled like mental illnesses in the past, where the woman was beaten to exorcise the spirit that supposedly was causing infertility. A woman who had challenges with infertility had her husband constantly beating the her because she could not have a child. The woman tried various therapies all by herself until she picked a seed that was believed to be that of the healer. The rumour mill is more efficient

[1]Zongo communities are migrant communities where most of the people who initially settled there were traders from the West African sub region comprising ethnic groups such as the Gruma, Moshi, Hausa, Kotokoli. The language spoken in these Zongo communities is usually Hausa as Hausa was the main language used for commerce in the pre-colonial era. The cultural practices of these people are in some cases a little different from that of Gonja

than the modern media outlets to the extent that almost everybody who was an insider knew what the true paternity of each child is. In a conversation with more than ten adult friends through my informant on different days at different times and also to varying parts of the community, each voluntarily told me women who had children that were not of their spouse. In one instance, the woman constantly went to the same man and got pregnant four times and gave birth to four different children of the same father. This information that I gathered through the use of ethnography gave me the leads to interview some selected Konkomba men. The Konkomba men were interviewed because they live in the study area of East Gonja, and they offer infertility treatment services. Their clientele is mostly made of people from East Gonja, including Gonja (their full narratives are captured in chapter five).

3.4 SEMI-STRUCTURED INTERVIEWS

Question guides were used to conduct semi-structured interviews. The question guides were developed before the researcher proceeded to the field to conduct the interviews. They had previously been tested in the Salaga township. This pretesting allowed the researcher to rephrase some of the questions to be socially and culturally appropriate before they were finally adopted for use in the research. The questions used in the question guide were based on the research questions and hence the objectives of the overall study. They were very appropriate for this research because some of the respondents were quite aware of their predicament and clearly understood the questions. The language for the interviews was mostly in Gonja as the respondents felt more relaxed to have interviews conducted in Gonja. Even the literate ones wanted to be interviewed in Gonja, as they claim they feel more comfortable speaking Gonja to a colleague Gonja.

Each respondent was asked for permission to be recorded as well as for writing down what they said. Even though most of the interviews were in Gonja, others were in Twi and Hausa. Two in Twi and three in Hausa because those respondents had a challenge in speaking fluent Gonja but spoke Twi and Hausa fluently. Most of the respondents who were non Gonja have a basic understanding of the Gonja language, and hence difficult terms and phrases that were likely to lose their exact meanings when translated were still said in Gonja. The researcher speaks all three of the major local languages that are spoken there, that is Gonja, Twi and Hausa. This ability to speak these languages came in handy as the researcher did not need anybody to make any interpretation. Interpretations have challenges, and some words are misrepresented, and their import lost. Additionally, the respondents felt relaxed to discuss their issues with me in private because there was no third party. The ease of speaking the languages used for the research allowed the researcher to ask very intimate questions of the respondents concerning infertility and the culture of the people of East Gonja. The interviews with the Konkomba were usually in Twi as almost all those interviewed speak impeccable Twi. Respondents who were Nchuburu spoke Gonja, however I had an interpreter who cross checked some expressions they made in Gonja in Nchuburu to be sure they were accurate in what they intended.

Ethnography, therefore, is in concurrence to the involuntary aspect of social science as it becomes part of the world it studies (Hammersley and Atkinson, 1983). I was careful not to create a formal atmosphere; hence I allowed a more relaxed atmosphere where sometimes I allowed them to speak even when there was a deviation but consciously restored the conversation with no formalities.

The semi-structured interviews offered the researcher the opportunity to gain wide-ranging, nuanced perception into the lived experiences of men and women living with infertility. Their

narrations made their all-inclusive stories come alive as they recounted the entire infertility experience from scratch.

The researcher was very mindful of the fact that a male researcher will have to be 'soft' on the female respondents. "In line with established ethnographic principles for building rapport and minimizing researcher bias (Lincoln, 1997), I engaged in open conversations and participated in daily life by sitting on the floor, sharing water, and dressing akin to the participants, deliberately avoiding sophisticated equipment to foster a more equitable research environment."Some of the interviews were quite emotional, and some respondents needed some advice from me, once I was researching into issues of infertility at the PhD level, they treated me as a medical officer who should have enough information to bring their pain to an end. Some said, "We hear you are a doctor too, treat me." I, therefore, had to demonstrate empathy and made arrangements for them to easily see the medical officer at the Salaga hospital that I had some interviews with him. The questions asked the infertile men and women bordered on the historical background of their disease, how long they have known or become aware of it, whether there were any family members with similar problems, who/what could be the cause(s) of their predicaments, the choice(s) of health-seeking and why? I specifically also wanted to know about some lifestyle issues such as drinking, smoking, occupational hazards, and obesity, among others. With the medical officers, I asked questions on the weather the cases were reported to the hospital before seeking other treatments, cost of medications, and availability of andrologists and gynaecologists, among others.

The researcher interviewed traditional healers and asked a wide range of questions that border on the theoretical framework of the biopsychosocial theory. The researcher asked questions about the way they go about the healing process, including the recording of histories, physical examinations, and issues on anxiety and social relations

The interviews were equally conducted with people with special knowledge of the culture and who directed me to persons I should interview with regards to patients, healers, rumour mongers, historians. These key informants were carefully chosen, and I warmed myself into them even before the actual interviews. The issue of proverbs, mores, songs and performances of rites of passage were of key importance in a society where written and proper documentation was not kept. These proverbs, mores and songs serve as 'valuable insights into the many facets of African life' (Awedoba, 2000). The issue of reciprocity in gifts was important, hence the proverb *fowana zala,fona na chan zala*meaning; if you come empty-handed, you will return empty-handed this is a Mossi wise saying. (The Mossi are a member of the Mole –Dagbani group who normally hail from Burkina Faso. They are widespread in Ghana, especially in the cosmopolitan communities with a lot of mixed ethnic groups, where Hausa is widely spoken. These communities are usually called Zongo communities. Some Zongo communities are so named after the Mossi as Mossi Zongo. Salaga is a good example of a cosmopolitan area that can be described as the Mossi Zongo community.

Some semi-structured interviews were conducted with Christian pastors, the Catholic Church and owners of prayer camps. The study wanted to find out what help patients seek from them and what services they in turn offer. I also wanted the details of the services that they offer and what are the expectations of the patients, especially concerning the psychological stress and social stigma that these patients suffer. I visited one prayer camp and spent two weeks with them and some clients, to have a firsthand observation of what goes on. I slept in a hut, bathed and ate food with them for the two weeks.

My time at a shrine around Salaga was exciting. I lived with the shrine owner for a month, and I asked him questions on the history of the shrine and its healing activities as well as the blessings

it bestowed on production. Persons who wanted their businesses to flourish, traders who deal in petty goods as well as farmers who wished to their farms and animals to flourish came for fertility prayers and blessings. The researcher also participated in the sacrifices to the deity, *elempo* a fertility god which means, strength in Gonja. This strength refers to the power it bestows in terms of fertility to her clients concerning producing children, multiplying businesses, multiplying animals and farms: It is believed to energize people and their interests. The researcher slept in a room that had no electricity and, therefore, could not charge recorders and camera after the initial charging before the trip was embarked upon. My questions were initially not receiving satisfactory answers until after a week when I was actively participating in the slaughter of chicken and other animals as sacrifices to the deity. (Details of the interviews are captured in chapter five).

The researcher had initial discussions with men suffering from infertility in drinking bars and food joints and later interviews at arranged times and arranged places, usually in the night. Most people in the community knew my mission in the various communities, hence the infertile men felt emboldened under cover of darkness. The interviews had to be conducted with some circumspection, as they usually broke down in their storytelling. I accompanied one of the patients to Damongo. This Gonja town is about 150 kilometers west of Salaga to see a traditional healer to administer the concoction known as *gbrilga*, an equivalent of Viagra. The traditional healer asked me to take medicine for the one week that we spent there. Each morning, I was asked to report the physiological changes I experienced; details of the experiences are reported and discussed in chapter five.

In the long run, there are some observable differences between me as a researcher and the various persons that were interviewed. These differences need to be carefully managed in researching a sensitive topic such as infertility, which is multi-layered and multisided (Gunaratnam, 2009) The

researcher engaged the participants when some confidence was gained by them, especially on a rather sensitive topic. The participants, who had a challenge with infertility after the initial difficulties of opening up to me, were grateful to have had an interview with me as they asked for some contacts with medical personnel that the researcher knew in the Tamale, the regional capital of the Northern region which East Gonja was a part of. Many of them indicated that they never had an opportunity of talking to a researcher, and that gave them a chance to release some pain. In a study of infertility among South Asian women, the researcher was accorded the status of an "expert" rather than a researcher (Culley et al., .2007). In this research, the situation was not different as part of the expertise that arose from the personal connections the researcher has with some medical personnel both in Salaga and Tamale.

Finally, I had interviews with three Muslim clerics who have been healing people with infertility, and I asked them their mode of examination, their diagnoses, the various ingredients they use, whether there are physical examinations of the patients and whether this was exclusive to some Islamic sect. Most of these Muslim leaders or clerics have their grandfathers originally hailing from Nigeria, Niger and the neighbouring West African States. They inherited the trade of herbal medicine from their grandfathers, who practiced herbal medicine in Salaga.

3.5 FOCUSED GROUP DISCUSSIONS

One of the major instruments used in this research is the Focus Group Discussion (FGD). The focus group discussion (FGD) is a rapid assessment, semi-structured data gathering method in which a purposively selected set of participants gather to discuss issues and concerns on a list of key themes drawn up by the researcher/facilitator (Kumar 1987). It was a good methodology to use as it is very close to semi-structured interviews. "Focus group discussion is sometimes seen as synonymous with the semi-structured "one- to- one" and "group interviews" (Parker & Tritter,

2006). This tool is useful in the discovery of issues related to 'people's perceptions and values' (e.g., Hargreaves, 1967; Lacey, 1970; Mac Ghaill, 1994; Sewell, 1997; Skeggs, 1997)

These focus group discussions were held at the Community Centre in Salaga as precursors to identify and located persons with the problem of infertility. It was a very important tool for the research to manage to identify a few key informants that were very knowledgeable in the issues of culture, tradition and traditional health-seeking practices. Consultations were done with key informants, and I had some discussions with people who were willing and able to participate in the research later, on an individual or one on one basis. Many people in East Gonja, Salaga, and Kpembi inclusive were not too comfortable discussing the overarching question of male infertility. Hence, the issues discussed were general and dealt with how such matters were handled in Gonja and how they are now handled. I also discussed with them the reasons that could account for the changes.

Interestingly, the male infertile people saw me more as an expert who could be confided in and who could help in the treatment process. They visited me secretly at places they felt were more convenient for them. The infertile women were ready to talk to me in the presence of their friends shortly after the focus group discussion (FGD). The venues were usually at their homes when everybody in the shared house would have gone for work or to the farm. Some came to my room to be interviewed.

Some of the discussions had very local examples that were just unique to the persons making those statements; hence they were difficult to generalize. I had to encourage the introverts to come up with their views as some opinion leaders tended to dominate the discussions and managed to encourage the others to agree with their positions

3.5.1 Observations and Conversations

The very nature of the research demanded that some issues had to be observed, and some others needed detailed conversations. The observation came in handy as I was a student of Psychology and trained in participant and non-participant observation. It was revealing to watch keenly how most of the traditional healers went about doing physical examination before coming out with a diagnosis. They examined and felt for some important veins to check on the circulation of blood in critical areas. A traditional healer examined a gentleman who has erectile dysfunction. The healer felt to see if the major veins and arteries carrying blood to the lower part of the body were functioning. He looked for the softness or hardness of the testicles and have a feel of the skin by putting the finger on it to see if it would create a depression. The observations also included watching out to see how the herbs were prepared. They are usually prepared under very hygienic conditions, with some of them being scrape before chopping them into short stocks for burning into charcoal.

The conversations were usually carried out in the form of asking questions when any activity was ongoing. The offering of libation, for example, generated a lot of discussions as it was just another method of prayer, another way of engaging with the ancestors and gods who gave therapeutic potency to the herbs. Libation was offered by pouring out alcohol such as schnapps or water from a calabash. A piece of Kola nut is first put in the calabash before adding water to it. Conversations were with knowledgeable people such as herbalists and chiefs. The chiefs are the custodians of the culture of the people. Most chiefs grew up in and around palaces; hence most of these rituals come in handy. Additionally, the offering of libation is a regular occurrence within Gonja. Every family head would offer a libation in respect to one issue or the other at the family level for and on behalf of the family members.

Conversations were also held with drummers who recount the history and traditions of Gonja every Monday and Friday in the Kpembi wura's palace when all the sub and divisional chiefs of East Gonja or the Kpembi traditional area seated. The history they recount is in drum language and some words used are not in Gonja. Words in Twi and Hausa are frequently used interspersed with appellations. The drum history covers a wide range of issues such as political, economic and social issues. The political issues range from state history to history of individuals who have played major political roles in Gonja. Economic and social history also reveals issues on how some prominent warriors were treated in times of war. The history is oral and its source is from the generation of drummers to other generations.

Finally, the researcher had various interactions and conversations with different ministers of religion, including interviewing Catholic priests and other clergies from orthodox churches such as the Anglican and Methodist Churches. The interviews with the clergy were necessary to seek their opinion on issues of managing male infertility within East Gonja in particular and within the church as a whole. All the priests of the orthodox churches were pleased to receive me in their homes. They were African in their way of receiving visitors by doing a little presentation of gifts. I was invited to a meal at the catholic mission and had a few tubers of yam at the other missions. The Catholic priest and some of his staff already knew me in Tamale years ago; hence there was no glass ceiling to break. The discussions were open and frank as they were eager to contribute to the success of this study.

3.5. 2 Visits to Medical Officers

I visited the medical officers in the Salaga Hospital, which is located in the heart of the town and occupies a land of more than 5 acres. The doctors are two, and both of them are general practitioners. They did a consultation on all manner of illnesses and also organized specialized

clinics when they had several patients who need specialized consultation. These specialists come from the Tamale Teaching Hospital (TTH).

The two doctors have a patient ratio of 1: 67,725 as the population of East Gonja is 135, 450 per the 2010 population census (GSS, 2010). There several clinics and CHIP centres, but they are not handled by doctors. The medical officers were virtually on call all day, making it difficult to have quality time to have a good continued discussion. A number of times, my visits have to be cut short because they had to attend to emergencies. Another challenge that was unique to the doctors was their ability to retrieve information and facts due to their busy schedules. I was constantly referred to the hospital administrators for the records and I had to contact the doctors again for the explanation of those statistics.

3.5.3 Visits to Infertile Men

These were the primary respondents, and once the stigma of not having a child (ren) was high, their choices had to be done with caution. The initial focus group discussions (FGD) held exposed me to them as a researcher who was working on issues of male infertility. This allowed them to invite me over into their homes and also to have a drink while discussing the problems of infertility and how to negotiate matters of management of the issue. Initially, the visits were done at night and in areas either than their homes; however, I was gladly invited to their homes after these initial meetings outside the home. I made several visits with them to treatment and management centres, both traditional and Western hospitals. Each person was visited not less than 40 times as some of the visits were not intended for research, but socialization. Most information, however, was given during these times that the researcher did not intend to interview the respondents. Each conversation help brought out something new and exciting

3.5.4 Visits to Traditional Healers

As many as 15 traditional healers were visited. They were spread throughout East Gonja except for three who are in Kumdi and kojobni, adjoining villages to the East of the district and with these villages have historical ties with East Gonja. The third town outside East Gonja is Damongo. These areas outside East Gonja were visited because I had to travel with my respondents who were seeking treatment at herbal centres outside East Gonja. The herbalists are usually men, and I interacted with only one female herbalist in Kumdi. The herbalists were often people of an average age of 55 years, with one being as young as 35 years old. All of them indicated that they learned the trade from their parents as children. They are all not literate in the English language and could speak Gonja, Hausa or Nchuburu. I spoke Gonja and Hausa to those who spoke these two languages, but I needed an interpreter to communicate in Nchuburu.

Their examination and collection of history before making an informed decision was akin to what medical offices do. They were particularly interested in the history by asking questions such as: how long has the sickness worried you? Has anyone in your family got that disease? At what time of the day do you experience the pain? They asked to find out what treatment that has been administered to the patient before and when? After a detailed history has been taken verbally, they proceed to do a physical examination by having a feel of some points in the affected area. They will continue the diagnoses with soothsaying, if need be, or they just wanted to get a clean bill of good health from the ancestors and God. The herbs were difficult to fetch as they are located in forests and bushes, which could be far. Once most of the herbalists did not have people under apprenticeship, some relatives of the sick person had to go and look for these herbs. There was always the invoking of spirits and the ancestors to empower the herbs to make them potent

My visits became very regular such that I could visit some of the herbalists at all times without an appointment to observe the treatment process, as this will enable me to draw some generally acceptable conclusions.

Sanitation in and around some of these herbal centres was a challenge especially the healers in Kitoe. The consultation room sometimes was used in the sacrifice of birds and animals, with blood spread all over the floor, staining the room. The blood was never washed because they are the points of contact and communication between the healers and patients on one side and the deities.

3.5.5 Visits to Prayer Camps

"My fieldwork coincided with a period of notable transition in the local therapeutic landscape. I documented that several prayer camps, which were once prominent features in the area, had ceased operation by the time of data collection. While this limited the number of camps I could visit directly, their absence itself became a significant datum. This shift suggests a dynamic interplay of factors, potentially including the increased influence of biomedicine, generational changes in religious belief, and the competitive nature of the spiritual healing sector, all of which are critical for understanding the evolving health-seeking behaviours in East Gonja."The two camps are Holy Fire Ministry and Solution Prayer Camp. They are both located on the outskirts of Salaga. The first one, Holy fire Ministry has a trained. He is Konkomba, an ethnic group who are believed to have first lived in Kpembi around the 14th century that is before the arrival the Gonja that area according to Chief Chako. The pastor has no formal education except that of the bible training centre in Weija, near Accra. He preaches in Twi and holds crusades on some occasions. He is a young man of about 31 years. The second pastor is Ashanti, and he has Junior High School education. They both hold special prayers sessions on Thursdays, Fridays and Saturday with a

church service on Sunday. They have accommodation for patients and visitors, locally made round huts that number three each. The pastors also live in adjoining apartments with their families.

The unique challenge that the prayer camps had was the inability to determine how long their patients were to stay with them. Some patients run out of essential personal items such as detergents and food even though occasionally they were fed by the pastor. Additionally, the demand for the purchase of some items such as oils and holy water put some patients under financial stress.

The visits to them were regular, which is every Friday and Saturday for a period of 10 months, January 2018 to May 2018 and December 2018 to April 2019. I observed proceedings by watching and sometimes participating in the activities. I also had some questions that I posed to them for answers.

3.5.6 Visit to the Zongo Community

Three men and one woman who are Muslim clerics and healers were interviewed. All of them live in Salaga and use a combination of Islamic prayers over herbs in the treatment of many ailments including male infertility. All the respondents indicated that their parents and grant parents practiced Muslim treatment practices before them. Mallam Alhassan, aged forty, married with three children said he understudied his father in learning the secrets of the trade of healing. He said his grandfathers migrated from Northern Nigeria during the Trans-Saharan Trade. They prepared their herbs in Sokoto in Nigeria and brought them to the Salaga market. The herbs they carried with them to sell included herbal preparation for infertility, sexual weaknesses especially erection disorders, high blood pressure and diabetes. Mallam Alhassan added that after a while, his forebears settled in Salaga and continued herbal preparation and treatment. Hajia Adiza, is a fifty-two-year-old woman engaged in the Muslim healing of people. Both Mallam Alhassan and Hajia

Adiza live in Ngua Zongo, a Zongo community in Salaga. The consultation process takes place in the homes of the healers. They use a room in their homes as a waiting room and another as a consultation room. There is a confidential relationship between healer and patient as consultation is usually between the two. A relative is allowed into the consultative process at the behest of the patient. The confidential relationship enhances a free flow of information to help the patients to be more revealing of their symptoms and pain for a better appreciation of healer. It is in a setting of trust only can a patient share his/her private feelings as well as their personal history that will enable the healer to figure out fully, to identify logically, and to treat appropriately. The healers under this process sometimes do a physical examination of their patients. Some consultation is also done via phone especially with respect to male infertility by people who live outside East Gonja. The main challenged encountered with the traditional healers was that they were very reluctant to discuss the treatment processes and the herbs used with me partly because of trade secrets. They were afraid that I could engage in the production of some of the herbal preparations if I was told the main ingredients that are used. In one instance, the information that was given in two interviews later turned out to be deliberately falsified. I had to make more visits to them before they indicated to me to disregard the information that they offered in the first instance.

3.6 ETHICAL CONSIDERATIONS

Male infertility is an issue that evokes a lot of emotion and stigma. Men who have a challenge for fear of being stigmatized do not usually want to be identified with this challenge. I sought ethical clearance from the ethics board of the Graduate school, University of Ghana to ensure that the respondents do not come under any psychological challenge from my studies to mad a bad situation worse. The research, therefore, took into consideration the following steps:

1. The respondents were told that their participation is voluntary

2. They have the right to withdraw from the interviews at any point in time of the research if they wanted to do the same
3. I obtained written informed consent from those who could read and write and verbal approval from those who were not literate in English and Gonja
4. All respondents were assured that all information given was confidential and privet to the research. This means that all data collected shall be treated as such shall be kept strictly confidential. This means that the anonymity of all participants will be ensured and all names used in this work except for the key informants, who have a rich knowledge of the culture of Gonja and who themselves do not suffer infertility have their real names in this research

3.7 CHALLENGES ENCOUNTERED IN THE FIELD

The fieldwork was both exciting and challenging. Some limitations presented some challenges in accessing information. Some of the traditional healers did not want to disclose the names of the herbs, and they also did not want me to see the full complement of all the roots and barks that were used for the medication. Their excuse was that *anana naa maa shalon*in Gonja meaning our ancestors do not like us disclosing these issues to just anybody. Indeed, they firmed this point by saying that even when a non-family member comes for training as a herbalist, he is not immediately shown everything, it takes years for full disclosure.

I am a native of Kpembi, who speaks Gonja even though I was born and bred in a neighbouring town of Tamale. I was accused of speaking Gonja like a student who learned Gonja; hence I was not able to fully participate in the sacrifices, especially talking straight to the gods and ancestors. Some respondents were not willing to continue with the interview sessions and found a diplomatic way.

Additionally, the use of a tape recorder and a camera were very restricted, especially in the shrines and at the places of gods. Permission to use is usually sought and granted by the people, but during the procedure of venerating and worshiping at the shrines, one person or the other will shout that no photographs be taken.

3.8 PHILOSOPHICAL UNDERPINNINGS OF THE THESIS

This research considered several sources of tradition and understanding from various people as the various ontological perspectives of the people as far as the knowledge and truth of the culture is concerned. What this thesis did was to triangulate these various perspectives of knowledge that had been recounted. Those that were recurring and also backed by some archival documents and key informants were relied on.

3.9 DATA ANALYSIS

This research adopts a narrative framework and content analysis in the analysis of the data collected from the field. The data collected from the fieldwork can be grouped into case studies, narratives, field notes and personal observations that were recorded and seen by the researcher during the field trips. All the data were grouped into different thematic areas; this is to enable easy presentation and analysis of the data. This was necessary and relevant because of the many and varied people I worked with. The respondents were not all Gonja, but Kokomba, Nchuburu, Hausa, among others, were all interviewed, including health professionals who are in East Gonja merely for professional duties even though they don't hail from there. The different categories of people, infertile men as the primary objective, infertile women, health-seeking behaviours, health professionals including herbal medicine practitioners, persons with knowledge in the traditions etc. The data was conveniently grouped into themes after a transliteration of the audiotapes. The analysis began at this early stage because the information needed to be scrutinized, sort through

for the very relevant concerns for grouping and analysis. The reliability of the interviews was usually coming from many similar answers from a related category of respondents (some triangulation of a kind), and long conversations, where the interviewees gave detailed and vivid answers with good examples, gave a sense of reliability. I had discussions of the day's interviews with my key informants, a form of cross-checking the responses I had received. Again, I was triangulating the information to ensure the reliability and validity of the data collect. Keys issues that were identified and picked from the interviews. I particularized my field notes and added them to the data collected for analysis.

Ethnographic Content Analysis combines the in-depth, contextual insights of ethnography with the structured approach of content analysis (LeComopte et al 2012)). This allows the researcher to not just focus on what is said, but also how, why, and within what cultural/social context it occurs. Ethnographic Content Analysis emphasizes the importance of constant comparison to discover emergent patterns, emphases, and themes in the data, rather than just counting occurrences (Richardson,2014).

The ethnographic perspective in Ethnographic Content Analysis helps the researcher delineate patterns of human action and cultural behaviours, going beyond just the content itself (Krippendorf, 1989). It is well-suited for exploring the complexities of society and culture through document analysis, as it drills down into what the data reveals about cultural practices and communication.

In summary, ethnographic content analysis allows the researcher to gain a deeper, more contextualized understanding of the phenomenon being studied, by blending quantitative and qualitative approaches and centring the cultural and social dimensions. This makes it a valuable tool for ethnographic research.

3.10 CONCLUSIONS

The third chapter, under the heading of Research Methods, considered the methodological choices that were adopted, which are very suitable for a study of this kind, that was employed in the study of managing male infertility in East Gonja. More importantly, the chapter also justifies why these methodological choices were made. This chapter gives a description and a background to the medical officers, the Muslim healer, the traditional healers, a visit to the prayer camps as well as some people who are having challenges with male infertility. The use of focus group discussions to gauge the general perception of the community relative to their ideas and perceptions of male infertility was discussed in this chapter. Observations and conversations were held with community members and participants as a way of triangulation information from the focus group discussion and my readings on the subject matter. The chapter also reflected generally on the research process and discussed some of the challenges that were encountered during the research. The study also examined the procedures that were adopted for the analyses of date that were generated form broad themes that were had form the objectives and research questions. Ethnography as a research design was extensively discussed by examining how it can effectively be used for a study that involves men who are managing infertility.

CHAPTER FOUR

EAST GONJA: THE LAND AND THE PEOPLE

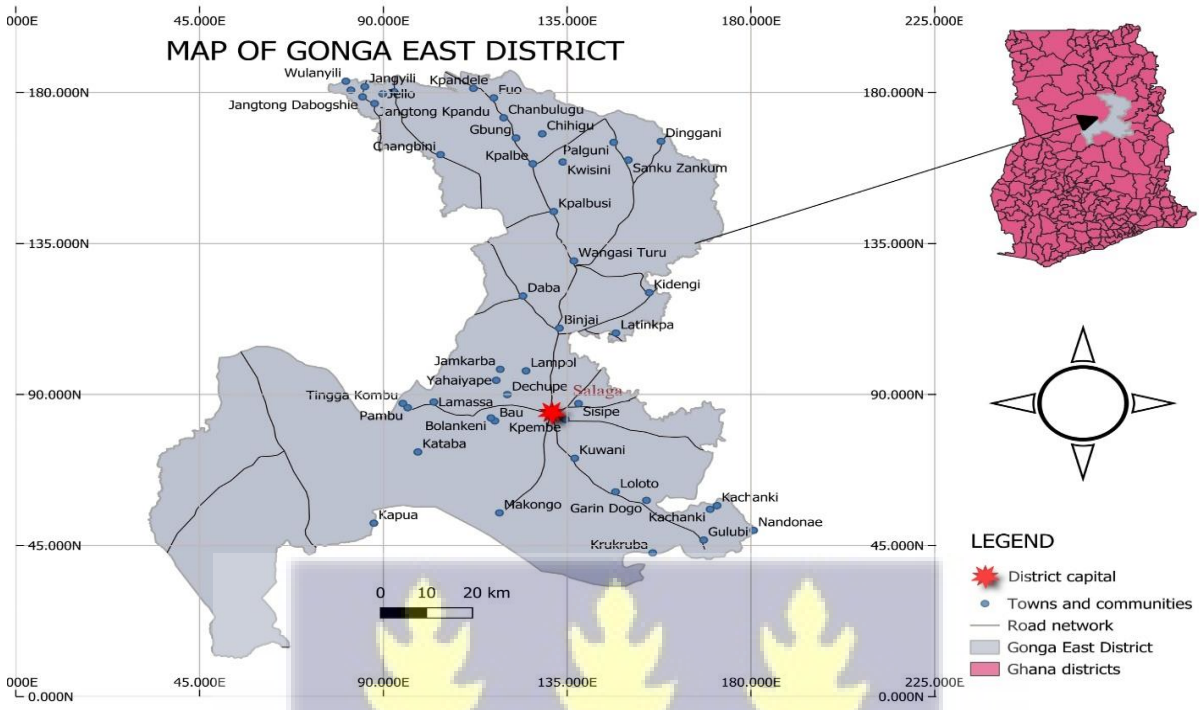
4.1 STUDY AREA

East Gonja is located in the middle of Ghana, in the Savanna region of Ghana, between two rivers, Volta and Daka. East Gonja traditionally belongs to the Gonja under one of five divisions of the Gonja, the Kpembi division and headed by the Kpembi-wura.

The Gonja people are governed by a paramount king, known as the Yagbongwura. The etymology of this title offers insight into the conceptual foundations of Gonja kingship. One interpretation posits that "Yagbon" translates to "big household," a metaphor that likens the entire kingdom to a single, expansive domestic unit over which the king presides as the ultimate patriarch. This conception emphasizes the ruler's role as a unifying figure responsible for the welfare and cohesion of his diverse subjects.

An alternative etymological analysis suggests that "Yagbon" derives from the words for "big leg" or "big foot." This interpretation carries potent symbolic weight, representing the king's absolute authority and the extent of his dominion. The "big foot" signifies that all territory within the kingdom falls under his purview; it is upon his land that subjects walk, and it is to his palace that all matters of consequence ultimately journey, demonstrating that his authority serves as the foundational support and final arbiter for the entire Gonja state. The suffix wura means owner, hence Yabgon-wura will translate as the owner of the big household. The household, in this sense, refers to the whole of Gonja, the East, West, Central and Northern parts of Gonja.

Fig 4.1 A map of East Gonja



Source: Author's fieldwork, 2019

There are varying accounts of the Gonja of Northern Ghana today as to their origins and what the original name could have been or originated from. Aside from Arabic manuscripts, the history and traditions of Gonja was transmitted orally mainly to define the royal relations and make claims to the chieftaincy office and the lands of the people. This was important for law and order as contestations for the titles to chiefdoms can be bloody sometimes.

The mid-seventeenth century Kano work, known as the *Asl al-Wanghariyyin* suggests that the 'lands of the West" were populated by Malians (Al-Hajj, 1968). This Malian connection is supported by works of early European travellers when they indicate that in the late nineteenth century that Gonja's association with Mali was very visible. In 1888, Binger was informed by

ageing men that Gonja people ‘were of Mande, that is Malian, that their migration to Gonja was an ancient one” (Binger, 1982).

A pivotal source for the early history of the Gonja is the Kitab Ghunja (The Book of Gonja), a text dated to approximately 1751. Its authorship is attributed to Sidi Umar, also known as Kamaghtay, who served as an Imam in the Gonja state. This manuscript stands as one of the earliest known written indigenous histories from the region.

Critical to any use of this source is a clear accounting of its provenance. The version of the Kitab Ghunja referenced in this research is drawn from the foundational scholarly work of Ivor Wilks, particularly as presented in his collected essays, "Forests of Gold" (1993), which builds upon his earlier translations and analysis. Wilks's work is based on Arabic manuscripts held in archives such as the Institute of African Studies at the University of Ghana, Legon. During the course of this research, specific inquiries were made regarding the precise circumstances of its authorship and the chain of custody for all extant manuscripts. However, these details remain partially obscured by time, a common challenge with pre-colonial African documents. The text's value, therefore, is leveraged with an awareness of its limitations; it provides an invaluable internal perspective on Gonja traditions and political structures, yet its narrative is necessarily interpreted through the lens of its author's position as a Muslim religious leader and the subsequent scholarly mediation of its text.

(Wilks et al. 1986). The name Gonja may have come from the ‘famous Kola country of Gondja, also known as Gwandjiowa, Gwandja, Gbadja, Gbanye. Ngbanye and Banjaue. Christtalla posits that these names can be traced to the Guan race, and the word “dja’ or ‘djaue’ may be a Hausa

word meaning red. These Hausa, just like the Arabs, were very familiar with the Gonja areas as travelled to it on account of the abundance of Kola" (Kitab Ghunja, 1751*)*

The word 'Dia' or 'Dja' is suggested by Mayerwitz as perhaps coming from the 'matrilineal Lemta Berbers who called themselves Dia or Dja. She indicates that Gonja may come from a name she associates with the Anga or M'gwa, who are the same people with the Lemta Berbers. She supports this view following an interview she had with an elder from Daboya who claimed Gonja came from Dia. She therefore assumes that the word Gonja may have been derived from the phrase Guan-Dja. There could be some credibility in Mayerwitz's claims because the Kuntunkere traditional drummer in Gonja in his verses narrates some battles that were fought when Gonja was being established. In the verse entitled *Chari,* that is the Manwura's appellation, and he talks of Dja as follows

> *It was Dja and kong towns that Chari or Saara and defeated*
>
> *Limu, the Dja and Kong town hunters*
>
> *They were two head hunters*
>
> *They burned and discharged*
>
> *This was before he Chari Manwura came to Manwule*
>
> *(*Kitab Ghunja., 1751*)*

The fact that they had some connection with Dja as recounted by Mayerwitz is reinforced in the drum language. The Kuntunkere drummer moved with the army generals who fought the wars. They, therefore, rehearsed the history of what they saw and heard and used that to urge the generals on in their appellations.

Westerman suggests that Gonja as we have it today may have been and anglicized form of the Hausa name, Gonjawa. The people of Gonja, however, call themselves Ngbanya and the singular form being Kagbanya.

Given Westernman's position of the origin of the word Gonja and juxtaposing that with what Gonja people call themselves, then the name Gonja may have nothing to do with the "Dia." This position is further supported by a linguistic view that shows that the Anga belong to the Gur language group. In contrast, Gonja belongs to the Kwa language group, just like their Guan relatives.

Gonja may have been founded in the late sixteenth century and the seventeenth century at a time when an "ancient Mediterranean world system' that virtually got all her gold supplies from West Africa was collapsing and giving way to the then-new Atlantic trade system that was critically relying on West Africa labour. Gonja is said to have played a key role in this transition

The founder of the Gonja Empire usually from the varied accounts still includes an account with a Prince from Mali, who had a prophecy from soothsayers (after he consulted them) of kaba or Kangaba to the effect that he would never be king in his own country, but in a distant land. The prince, Sumaila Ndewura Japka is rather known as by Tamakloe is rather named as Jakpa Lantav Sumaila (Tamakloe, 1931; Braimah, 1964). Upon this prophecy, the prince left Mali, as also reported in the Arabic manuscript of the Ta'rikh Ghunja, with many of his warriors and followers never to return to Mali but in search of this Promised Land that he was to rule over.

Another account has it that a prince named Namba was dispatched by a senior general of the Malian army from Bighu to Bona and perhaps further north to ensure the flow of gold and other trading articles. He, however, crossed the Black Volta and founded his kingdom, most possibly in

the fulfilment of the prophecy. He established Yabgum, the capital. This account, therefore, credits Namba as the founder of Gonja and the first ruler of Gonja. This account is recorded in the *Amr Ajdadina.*

After the expedition and consolidation of the captured lands, the Gonja kingdom was established and subsequently divided into six divisions, each headed by one of the sons or grandsons of the king (MS /263) and Tarikh Ghumja. In the Kitab Ghunja. it clearly states that Lanta divided the land among his sons. Oral tradition has it that all were divided among his sons except Wasipe, which went to one his daughters.

In one of the Archival documents of the Public Records and Archives Administration, *Japka said,* "all the country belongs to me. I will divide the country between my sons and my brother's sons" Osmanu, Lata's son, Kagbwapewura, was to be Yagbumwura. Osmanu refused the title, stating he was not sufficiently powerful. But he asked Japka to carry out the division. Japka then gave to Ewuretorma, Lata's son, Tulewe, Burelanyon, Namba's son, Bole, Saaka, Namba's son, Kumu, (Kong, Delemani, Namba's son, Kpandai, Yaya, Lemu's son, Kpembe, Seidu,Lemu's son, Kapendi,, Yaya, Jaffa's son, Wasipe, Yaya.Manwura's son, Senyo, Seidu, Wam's son, Kawsaw

All the above were eligible under the rotational style to succeed in becoming a Yagbom wura. It must be noted that some accounts have the divisions done territorially into fifteen segments, but the only seven gates were eligible to be elevated to Yagbom. The fifteen territorial areas include Tulewe, Bole, Kong, Buipe, Jantong, Kafaba, Kpembe, Kawsagu, Sonyo and Wasipe. The rest are Damongo, D'bire, Jantong, Mapkan and Kandia (PRAAD, ACCRA, ADM/58/5/6).

4.2 EAST GONJA- SALAGA

This thesis is specifically about East Gonja and how men there manage illnesses, especially infertility and the traditions thereof that support those who unfortunately do not have children. East Gonja is a part of the bigger Gonja kingdom that stretches from the West in Bole through Damongo and Yapei in the centre to Salaga in the East.

East Gonja, with Salaga as its administrative capital was created by a legislative instrument (LI 1938) in 2007 (GSS, 2010). Salaga, as the administrative capital of the East Gonja district, it is headed by a Chief Executive (Mayor) who is an appointee of the president of the Republic of Ghana. The district has an area of 8,340.10 square kilometres, 'occupying about 11.95 percent of the landmass of the Northern Region, making it the largest district in the country' (GSS, 2010). 'The district lies within Latitude 8oN & 9.29oN and, Longitude 0.29E & 1.26º W. It shares boundaries with the Mion District and the Tamale Metropolis to the North, Central Gonja District to the West, Nanumba North, Nanumba-South and Kpandai Districts to the East, and the Brong-Ahafo Region to the South' (GSS,2010)

This research has indicated that Gonja was perhaps popular partly due to the trading activities in Salaga as a result of the 'commercial expansion of Mali and the vagaries of the world of the world bullion market' (Wilks et al., 1986) The Gbipe (same as Buipe) market, which was the most popular market in the formative years of Gonja was moved to Salaga by the Hausa traders due to the high insecurity of Gbipe due to constant attacks from the Brongs of Techiman, Nkoranza and Ashanti.

Additionally, even though the kola nuts came from the forests of Ashanti, they passed through Gonja, Salaga, as reported by the Kano Chronicle (Palmer, 1928). The Kano Chronicles further

says that Hausa traders had brought Hausa merchandise such as hides, medicines and spices as early as the middle of the 15th Century. These Hausa traders preceded the coming of Japka and his forces. Gonja oral history has it that Gonja met Hausa and Beriberi traders and Muslims in Kafaba, just about five kilometres away from Salaga. The medicines that some of the traders brought from Hausaland and beyond were aphrodisiac and cured male sexual weakness and infertility in general. The "remnants" of these families still live in Salaga to date. They also again practice their medicines. I interviewed a number of them. More on their interviews in subsequent chapters

The Salaga market was protected by the Kilibuwura, (who is a regent) at Kuli with an army of about 300 horseback riders who intimidated traders who wished to cross the Volta River into Ashanti to trade, especially for cheap kola nuts. Braimah reports that those who defied his orders had their goods seized. The traders were either killed or sold into slavery (Braimah et al., 1967). The actions of the Kilibura infuriated the Ashanti, which led to the invasion of Kpembi and Salaga in 1744. This invasion to open up the trading route resulted in the death of Kpembi wura Isanwurfo Soale, who died in battle. He was buried in the Salaga market as an honour to his defense of the market (Braimah et al., 1997). There is a mythical story in Salaga today to the effect that Kpembi wura Isanwurfo Soale just vanished by penetrating the earth with his horse at where his grave is located. Be that as it may, the most important thing here is that his life came to an end in the market of Salaga in 1744.

Kpembi may have derived its name from the word *agbambi* meaning roads. The roads are the seven roads that were said to be coming into Salaga from different directions: Salaga to Yendi, Salaga to Kpembi, Salaga to Daboya, Salaga to Bole and Salaga to Kotokoli. The rest are Salaga to Kintampo and Salaga to Kete Krachi. These seven roads were used to describe Kpembi as the centre of ways, hence Kpembi. Others have it that Kpembi comes from the work *n'kpem bia* in

Gonja, which translates into the English language as “rotten children” or “spoilt kids” as a result of the behaviour that was put up by some children at the outskirts of the village Japka was visiting. He asked these children where their parents were home, the kids ignored him and continued to play, Japka, therefore, is said to have described the Village as a village of “rotten children, which was later corrupted into Kpembi (Braimah et al., 1967).

The people of Gonja have lived in compound houses where a large family of siblings and kinsfolk live. A household could have as many as twenty people living in it; this comprises a father and mother, the father’s sisters and aunts as well his mother. He will have his wife and children joining this family house in which he may have lived in with his siblings since he was born. Kinship relations and ties are of paramount importance to Gonja

4.3 KINSHIP

As a group of people, kinship ties and relations play an important role in Gonja. Kinship ties are important in the determination of many important issues in Gonja, including inheritance and succession. Among the Gonja, inheritance and succession is generally determined by the patrilineal ancestry and descent, hence the social organization of the people is organized along the patrilineal lineage. This is evidenced during the major festival of the Gonja, the Damba festival, where any Gonja man dancing holds a tail or staff in his right-hand whiles dancing. This not to say that the matrilineal line is completely ignored. The matrimonial descent may not be very important, but it is shown when a man has a tail in his right hand and doing a dance during Damba. A person who dances with both tails is showing off that he is totally and fully Gonja, but has such a person got any advantages over the one whose father alone is Gonja? The answer is obviously no, as the most useful factor in determining who qualifies for any political position, for example, is patrilineal

Almost all the chieftaincy (*ewura, ewuriche*) positions, both male and female, are organised along with the patrilineal inheritance. Membership of a family or clan is acquired by birth and by adoption; however, an adoptee has not got all the privileges that (*ebi)* child by birth has. These positions, therefore, are hierarchical and the occupants move upwards when promoted until they reach the head of clan, village, division or kingdom. Nonetheless, some of the chieftaincy titles are given to some claimants based on their matrilineal ties. Such chieftaincy positions are those that do not allow their occupants to higher titles. The occupants cannot be promoted to higher levels than what they occupy. The significance of such titles is that the mother of a child ought to be recognized and appreciated; hence it helps in making kinship relationships closer and firmer as well as making the relations stronger. When a person is wealthy and influential, everybody wants to be related to him or her in one way or another; hence such persons can easily benefit from a chieftaincy by the conjugal rights.

There is a high-level collective responsibility in the clan or family, as well as among the individuals of the family who are seen as one people. The regulation of behaviour is therefore crucial as the family name can be soiled. Behaviour such as stealing, prostitution and witchcraft accusations are the most serious, and this ought to be avoided by members of a clan. Members of a clan cannot marry among themselves, and they are seen as brothers and sisters once they are related patrilineal. Persons that are related matrilineal can marry if they are even first cousins.

4.4 MARRIAGE

Marriage among the Gonja has evolved over the years, and it is virtually moving away from the traditional rites that were observed to being Islamized. Chief Chako explains that in Gonja, marriage was consummated when a prospective suitor rendered some services such as farming for his in-law and gives gifts to the wife to be. Once you saw a woman and you were interested, the

chances are that some other suitors may have shown interest as well. It therefore becomes very competitive, and the woman and her parents have a role in deciding who marries the woman. The more serviceable a suitor was, the better his chances of winning the heart of prospective be bride and her mother. It was a game that was won by the highest bidder even though genuine love for a man by a woman was a crucial factor as well. The parents of the bride-to-be had better chances of selecting her husband, unless the bride was a child who had great influence on her parents.

One critical thing that was secretly investigated about the prospective groom's family had to do with his health history. The aunts and sisters of the prospective bride may have friends in the prospective groom's village. In instances where they did not have friends in the village, they secretly made friends for the sole purpose of investigating the health background of the prospective groom and his entire family. They studied for diseases such as find lunacy, leprosy, infertility challenges and epilepsy. Subsequently, the woman was giving to the man, and he welcomed her with a feast. This investigation is usually carried out by both the man's family and the woman's family. The woman or man is ruled out, once it was established that one of the diseases existed. Vices such as stealing, pathological liars, rapists were equally disqualified. A family that was notorious for witchcraft was also avoided.

Chief Chako indicated that with infertility, there is some association with how potent men of the family have said that the enjoyment of sex is one of the reasons why we marry. Men who are weak in bed are likely to turn out to be suffering from secondary infertility. Chief Chako says in Gonja, very obese men are believed to be sexually weak; hence they have a good chance of developing secondary infertility. When women married to that family begin to complain later in the marriage of their husbands' low sexual drive later in marriage, it usually confirms their suspicion that they had about such families. Some families with such problems got their slaves promoted, especially

those with good physical qualities, to sleep with their wives. There is a joke about men who are tall and huge, and they could be of slave ancestry they always say. Good slaves who served their masters well, were equally given wives, and they were integrated into the family. Such descendants, however, are providing some challenges in chieftaincies as they vie for vacant positions. We did some selective breeding when we realized that the men were handsome, says Chief Chako.

The requirements for the consummation of a marriage of a woman, which is a dowry, changed around the 1970s to include three visits to your potential in-laws when you have indicated to them that you intend to marry their daughter. The gifts of kola nuts are usually accepted with consultation with the bride to be. In some cases, now quite rare, a man could give his daughter's hand in marriage to a friend's son. This was discouraged, according to Chief Chako, because divorce in such a marriage subsequently led to a break in the friendship between the parents, who took sides.

In such cases, Chief Chako says, "the men are usually cool-headed, but the wives easily get angry and ask for a divorce when there were no issues for a long time, or the man's parents will ask him to take another wife. When the man remarries, and it becomes apparent that he cannot give birth, the wife may sleep out to save the man from embarrassment. This arrangement is sometimes made with the consent of the man in such scenarios.

The woman is likely to make some loose statements to annoy the man at the least provocation. The overall behaviour of the woman is likely to be indicative of her powerless husband. It is in very few and rare cases that the woman will show some sobriety and humility. This arrangement to

have a man make her pregnant is described in *Ngbanyito* (Gonja) as *e be bu lunwe so na*, meaning she is covering his shame.

The people of Gonja say they are able to tell that the child does not belong, and such children are called *kuyiribi,* which translates as a bastard. Such children are known, and sometimes in cases of competition for chieftaincy, we may not tell the contestant that he is a bastard; however, he is rejected based on those grounds, especially when the contestants are many.

However, Chief Chako was quick to indicate that Gonja respect genetricial rights, rights that accrue to a man in a marriage with respect to the children that are born. In Nbayinto, they say, *eyu mu kor kebia*, meaning a thief has no child. Even though these rights may accrue, the rumours about the real paternity of the child are sometimes raised even by the father when such a child annoys him. You will often hear a man say to his child that he is a *ka Sheji bia,* a Gonja word with Hausa origins, which translates a bastard.

The Gonja will privately tell you that it is only the mother of a child who knows who the father of the child is. There is this popular saying in Salaga, which is said to have originated from a legendary Fulani man who was taking a stroll with his son; he was asked if that was the son, and he replied, 'that is what his mother said.' This saying has become popular in Salaga because many men are skeptical about the real parentage of their children, perhaps rightly so because of the high level of promiscuity.

Within the Dagomba traditional area, who are neighbours to Gonja, a test of whether a chief's wife had some children outside matrimony is determined with rites that are performed on her after his death. These rites are akin to the rites that are performed on a surviving widow. If the wife of the chief was not faithful, the said rites ill reveal her infidelity and reveal that of the children who were

not legitimate. If the chief's wife and her children refuse to avoid such rites and went ahead to perform the rites, they will die if there was any infidelity.

The gods of the lands will never allow a supposedly illegitimate child to become a chief. Usually, the chiefs have many wives, and they are typically advanced in age, it, therefore, becomes quite difficult for an older man to service about 4 to 10 wives sexually. Chiefs who have many wives have the first wife playing the role of the arrangement and fixing of a schedule for the wives. The first wife, therefore, decides which of the wives should sleep with the chief. The chief may have a favourite wife or two; he will consequently bribe the first wife for a particular wife's services, and the other women may be under-serviced and may resort to having sexual satisfaction outside matrimony.

Additionally, when a chief is given skin wives, these women may be very young as compared to a chief in his late fifties and beyond, hence he may not be able to see to her sexual needs as the woman may want it, this may result to extramarital affairs. Age is one of the criteria used in the selection of chiefs in Dagomba and Gonja, and once a clan has been given the opportunity to pick and choose a qualified person for a vacant chieftain, the clan may not under normal circumstances prefer a younger person to an older person, it smacks of disrespect.

In Gonja however, there may not be such rites, however, the soothsays will tell a person, especially a chief that his wife will give birth to a bastard and that will help his chieftaincy to be great, however, he the chief will have to ensure that such a bastard does not rise to become a chief, lest he will be 'polluting' the institution as he is *eyirepi* or dirty in the eyes of the tradition. Soothsayers are often visited for divination. It is believed that when one continues to divine, the person gets to know what the gods and the ancestors require of him or her. Once the gods and ancestors are happy

with a person, all goes well with him. Chief Chakon, however, indicates that too much divination could lead to a person suspecting many people of being the cause of his predicaments. This is so because they soothsayers or diviners could get the divination wrong, or some may not be too knowledgeable in their vocation.

In furtherance of the marriage rites in the traditional Gonja, the rites will continue with yet another visit, the third one. After the third visit, the kola is accepted and given to family members, near and far, to attest to the fact that they are now aware that their daughter is now married. Those who eat the kola, therefore, become witnesses to the marriage.

The tradition and rites thereof were strictly observed until about twenty years ago. Three visits, where three different rites were performed at each stage, were important in the transfer of conjugal rights to a man. In the recent past, however, the rites thus observed have seen a nose drive, in their place is the Islamic way of marrying a woman. The suitor, after identifying himself to the family, is officially given a bill, a bill that is popularly and called *ásadachi*, a Hausa word. The *asadachi* is not fixed, and the requirements show how rich a suitor is and how rich a family could be coming from. Some men who live outside East Gonja and perhaps outside Ghana may just send a delegation to the family of the bride to be and introduce themselves after the bride to be has informed her parents of an impending visit of the groom to be. The general requirements include clothes, underwear, shoes and personal items for the woman to wear and look beautiful after the wedding. Motorbike keys or car keys are added with huge sums of money, such as twenty thousand cedis, an equivalent of about three thousand six hundred euros.

Chief Chako says that these changes are influences from Nigeria and usually, from their films, which have dominated the West African English-speaking countries. A deluxe party is held on a

Sunday or on rare occasions, on Fridays to consummate the marriage officially. Continental dishes such as fried rice and chicken are served with assorted drinks. Some traditional meals like *Tuo Zaafi (TZ), fufu* and *banku*may be served as well.

Ahmed Bakari, a drummer in the palace, said that sexual relations are not limited to marriages alone, even though that seems to be the case. Gonja men can be very promiscuous, and some also boast about it saying that when a Gonja man is accused of stealing, the chances are that it is not true. However, if a Gonja man is accused of having sex with your wife, it may be true. Gonja men get into conversations with women and use very profane language, suggesting to them that they will like to have sex with them. Some of these sexual relationships end up in illegal abortions, which cause a lot of infection, as was observed by Dr Sherriff of the Salaga Hospital. Dr Sherriff indicates that some of the women who came for treatment had infections from such illegal abortions, which are usually not carried out in a hospital environment.

The next heading will be examining the ultimate reward of marriage that is children, who are seen as a blessing to the marriage. This blessing, however, seems to elude some couples, hence the challenge of infertility

The concept of the spirit and the soul is very rich in the oral traditions of Gonja as they believe they affect every facet of one's life. The Gonja call the spirit *akilbi* which means one's fate, destiny or providence. Chief Chako says Gonja believe that *akilbi* is not physical, but it is an integral part of the human being that is not visible. It is in the spirit that we have or 'DNA', that is everything that will happen to us as we live are recorded on the spirit. It directs our inner feelings that we express outwardly, that is our passions and defines exactly who we are with respect to our behaviours and characters that we exhibit in our everyday life.

The Gonja believe that every human being has a *kuyulyul*, 'the basic and material for life' which he presence of life is the presence of the soul, The absence of life or death means that the *kuyulyul* has departed through the person's nose and leaves the body lifeless, Kuyulyul is the soul and *Akilbi* is the spirit. *Akilbi* may also mean one's destiny or fate.

The soul as a concept therefore refers to the human being in his or entirety whether physically alive or in the afterlife. The Gonja therefore believe that *kuyulyul,* the soul goes to *ebore* God while the spirits go to the ancestors

The Gonja believe that God is a spirit and made us in His kind, hence the very original source of the spirit that lives in the human being. This idea is similar to Evans- Pritchard's explicit opinion of God, with respect to the Nuer people of Sudan. He says 'the Nuer word we translate 'God' is Kwoth, Spirit' which means the concept of God is that of a spirit being (Evans-Pritchard, 1956)

The spirit of an individual in Gonja may be different from another person's spirit, however, all spirits in a family are linked and interwoven into the family spirit, where all the individual spirits are said to have come from. This is the reason why dead persons who are Gonja may have to be sent to their ancestral home for burial if they died outside their hometowns. Mbiti says that the 'spirits are what remains of human beings when they die physically', hence the belief is that the spirit of a human being takes over from the physical bodies humans have (Mbiti,1979). The spirit will have to reunite with the ancestors. The reunification of the spirits with the ancestors is believed to take place a few days before or after the fortieth day subsequent to the death of the person. This is why a funeral called *nchie adena* fortieth day is observed in Gonja. Special prayers for the forgiveness of the sins are said so that *eborebei yege ashen n pan mu*, God will forgive the dead person and all who died before him/her their sins. This funeral, *nchie adena* is largely aprivate

funeral which is restricted to family members as each member offers a prayer for the dead. This belief is akin to the ascension of Jesus "Ascension, in Christian belief, the ascent of Jesus Christ into heaven on the 40th day after his Resurrection (Easter being reckoned as the first day). ... Prior to that time, the Ascension was commemorated as a part of the celebration of the descent of the Holy Spirit at Pentecost."

In the event that it may be difficult to send the corpse for burial, a piece of clothing, that the dead man or woman that was worn by the dead person is used for the performance of the funeral because the spirit of a person is believed to be living in everything that a person wears and in the footprints of a person. In other to demonstrate that the spirit is always with the person, even his/her footprints can be used as a point of contact to the person. By extension, if the earth on which a person's footprints appear is fetched, his spirit can be hurt and ultimately his physical body

The spirit of a person therefore can be unhappy as an expression of support for a communal sin that may have been committed by a sibling, a spouse or a close family relation. The spirits are usually live in a body of human being in and they have what they want and what they dislike. The well-being of a person solely depends on how satisfied his/her spirit is with him/her. The spirit may have to be atoned because the body has done something that it may not be comfortable with. For example, the individual may have refused to help a poor person and incur the displeasure off the spirits or the spirits do not like its own to wear a particular colour such as red. When the person continues to wear that colour in 'defiance' to the spirit, he may be punished by a mishap such as barrenness, accidents and drunkenness.

Chief Chako makes a point that some divorces took place because the divorcee would say *anye be Akilbi ma sha abre,* our spirits are unable to get along or coexist, hence grounds for divorce. In

such a case if divorce is not granted, the couple may never have children or they have children who will become miscreants. The reason is that the spirits would not have blessed such a marriage and hence they may not be fruitful or blessed with children.

The search for reasons for any unfortunate predicament such as infertility may lead a person to trying to soothsay for reasons responsible for his predicament. For the Gonja say matin *wu esa kamushei kitenten breto* you cannot see the smile of a person in the dark, which means that the 'state of mind' of the spirit can only be ascertained through soothsaying. This makes psychological sense because once a person is in a state of harmony with himself, the production of cortisol; a chemical responsible increasing stress rises. Cortisol is a hormone responsible for regulation stress in a human and it is released by the adrenal glands. Cortisol plays a significant role in helping the body deal with stressful situations, as the brain triggers its release in response for many different kinds of stress, Muller & Wrangham, (2004)

It is worthy to note that the words soul and spirit are often times used interchangeably in Gonja despite the fact they have different names and perhaps functions. The main distinguishing feature is that the soul is the conscious or breathing life and therefore the source of all our senses, emotions, passions and perhaps our characters while the spirit is that part of the human being that connects us to our ancestors and therefore a seat of our destinies.

4.5 WITCHCRAFT ACCUSATIONS

The witchcraft belief among Africans in general and Gonja, in particular, has a great influence on the lives of the people to the extent that for one to understand every traditional social system of the Gonja, then one has to understand the role of the witch in the operation of that system. One system that has been very much influenced by the belief in the supernatural is the health care

system. Evans-Pritchard (1937) gave an insight into what the beliefs of Africans are concerning witchcraft in his study of the Azandes. However, witchcraft is a belief that cuts across all societies in the world (Frazier, 1992). The witchcraft concept does not easily lend itself to one definition partly because it has a debatable meaning and usage in different contexts in different societies because witchcraft is usually described as a supernatural practice that involves the use and practice of magic and sorcery to affect or negatively influence an event without the consent and wish of the person (Archibong et al., 2017). Illiteracy and lack of contact were cited for the pervasive belief in witchcraft in Africa, but the belief is not exclusive to the illiterates (Archibong et al., 2017).

Anxiety and obliviousness are usually cited for the growth and development of the concept (Radford 2013). Witches are often men or women who cause illnesses, poor harvests and deaths, among many other misfortunes. No matter how much attached an African is to the practice and belief of Christianity or Islam as fate when the person is faced with challenges or mishaps, the cause is attributed to witchcraft, and he consults the oracles or gods through divination and subsequently makes sacrifices (Berlich, 2002). This feared phenomenon in some African societies is still a reality to date as many people are wired to become preoccupied with the fact that it does havoc to people. Witches are said to have the inherent psychic power to send out their spirits invisibly, or through lower creatures to harm others (Sanders, 2015). Even when the person does not believe in witchcraft as the cause of a difficulty, his parents, uncles or relatives living in the village will consult and divine on his behalf and make the necessary sacrifices to counter the effect of the witchcraft (Berlich, 2002). Perhaps this is so because witchcraft is still rooted in community beliefs despite the advancement in science and technology (Douglas, 2013).

When it comes to the causation of diseases in Africa, the most likely explanation as to the cause of the disease is witchcraft, especially when the condition is still under investigation and the cause

has not yet been established (Charles, 2003). From a survey that was held, Charles (2003) concluded that witchcraft is said to be the cause of diseases, usually where western medical care is inadequate. The explanation of illness outside Africa is common in Jamaica and the United States especially among the native Indians and African Americans. In Jamaica, for example, the sick consult the diviner or traditional healer who is known as the "Obeah" for the diagnoses and treatment of their disease because they believe most conditions have spiritual causation. Nigerians still link the cause of their illness to the existence of witches and their activities, and this is important in determining where to seek treatment. The issue of infertility and sicknesses associated with pregnancy are still associated with witchcraft (Jegede, 1998; Erinosho 1998 and Vander-Zenden 1990). Interestingly, it was observed that some of the beliefs that people living in small communities have are at variance with modern medical practice, and this keeps them from seeking advanced medical treatment (Vander-Zenden,1990).

Marwick (1965), explains the concept of witchcraft by the use of accusations with quarrels. These accusations arise mainly in the 'natural arena' for squabbles such as succession to a chieftaincy title and inheritance and disposal of property and infertility. It is usually difficult for a chief to use his judicial powers to settle issues of witchcraft accusations if no evidence can be adduced in such matters. Some of the allegations are made to reflect sorcery instead of witchcraft. The dichotomy between these two terms is difficult to make; however, both have a bad name of causing harm to negative things such as infertility.

Nadel uses the friction theory of witchcraft to explain why witchcraft is used as a reason to clarify issues of challenges to individuals in Africa. "Witchcraft beliefs are conspicuously related to specific anxieties and stress arising in social life' (Nadel, 1954). He tries to pinpoint the spaces for witchcraft accusations and relates them to the beliefs such persons may be holding. This

relationship was confirmed by Monica Wilson in her study among the Pondo and the Nyakyusa and found out that once someone or a group of people were frustrated in getting a goal achieved, they accused others of witchcraft.

Another person who is readily accused of witchcraft in times of crises such as sickness, infertility and a relationship gone bad is a co-wife. The relationship between co-wives is always one of deep suspicion arising out of jealousy. The wives try to outdo each other for more attention from their husbands. If your children were doing well in school or if their farms were doing very well, then it appears the children and their mother are successful; hence the husband may compare the ones that are not doing well to the successful ones. It is, therefore, common knowledge that once a woman's child or children suffer any ill fate, then the co-wife was responsible for such ill fate because she is suspected of having bewitched them (Bleek, 1975). This point has been raised by Goody in her study of the Gonja. *Chamina or Chamna,* is the Gonja word for co-wife or rival and the *chamina* is said to be the cause of the failure by her rivals' children (Goody, 1975).

4.6 WHAT IS INFERTILITY?

After the consummation of a marriage in Gonja and Africa, children are expected. Some couples have tried unsuccessfully to have children or may have one or two children and try to get more afterwards, this them becomes an issue of worry. Infertility is, therefore, an issue that bothers some marriages.

The definition of infertility in Africa is varied and many. It is usually community-based. The meaning is diverse because it depends on the aggregate conceptualization of infertility of the given society. The collective thought of the individuals is reflected in that given community. This cultural definition mostly is a female definition as the problem of male infertility is usually not a

topic for discussion (Ibisomi & Mudege, 2014; Okonofua et al. 1997; Okonofua 2002; Van Balen and Bos 2009).

The definition and meaning of infertility in East Gonja basically is one that specifically belongs to that community, but glimpses of it can be seen in Northern Ghana. First and foremost, an infertile woman in Gonja is called *Egbentipo,* which literally means a tired person. A male infertile person is called *kututu wusa wura,* which translates literally as the owner of the dead penis. Both terminologies for infertile persons in Gonja are very derogatory, to say the least. They classify both primary (infertile) and secondary infertility (inability to have another child when needed) as infertility. Infertility means not having a child within two years of trial. Their definition is irrespective of infertility couples or otherwise. They, therefore, distinguish the types of infertility as primary (infertility couples or barren) and secondary infertility (couples who have a child before). Maabu-wura, who is second in rank to the Kpembi-wura, the paramount chief of East Gonja traditional area, explains that the time limit before a couple starts seeking medical help it differs or varies.

Once a couple desires to have a child, and they are unable to have one within two years, then they may begin seeking treatment. We consider two years as enough because most of our men were engaged in wars of conquests and possible may not be home for a while; hence their wives may not pick seed too early. He added that children are a gift of God through the ancestors, and one has to be patient waiting for the child. The waiting period is usually and traditionally done through divination. The gods and ancestors will tell you when it is necessary to start seeking health services and from which cardinal point. It could be a village to the West, *epayin torpka, meaning* where the sunsets. The couple would have to seek further and better particulars about the West for example. Wumnaya says otherwise, the village people begin to gossip about the fact that the newly-wed

couple if they do not see a pregnancy within six months. There is this joke among persons who have a joking relationship with the man and the woman (respectfully) miyen*dina?*-Are you people sleeping? *Mekoso ensun kusun!*-Get up and work.

A person's cousin(s) (your maternal uncles' and aunts' children) has a joking relationship with him or her, and what it means is that he/she traditionally can say anything playful to offensive conduct, which ought to be considered as a joke. Interestingly, issues and advice that many family members could find it difficult to say are said with impunity by such cousins. One reason for this relationship is to allow frank discussions in a tradition where diplomacy is employed considerably. Kayensi-wuriche Adishetu Seidu, who is a female chief in-charge of women affairs of the Kayensi gate, one of the three gates that ascend to the throne of Kpembi indicates that the concept of infertility is a fluid concept of late. It all depends on the level of anxiety that a couple has. Even some couples begin to worry about why the woman is not pregnant even after two to three months of their desire to get pregnant and them working assiduously and sedulously at it. Kayensi-wuriche Adishetu indicates that hitherto, a couple could be waiting for as long as two years before seeking medical help, usually in a traditional way. She, however, states that pluralistic medical treatment is more common than before; hence you never know when the couple starts some medical treatment other than what we are used to.

However, Okonofua and Larsen writing on infertility in Nigeria and Cameroon and Nigeria respectfully defined infertility" as the failure of a couple to establish a pregnancy after one year of having sexual intercourse, be it that there was a pregnancy before or not, i.e., secondary or primary infertility respectively" (Okonofua 1996, Larsen 1995). This definition is not too different from the World Health Organization definition of infertility, which also stresses a couple who are said to be infertile after a year. The World Health Organization capped it at one year so that couples

could start seeking medical health for infertility. However, it is strange that Okonofua (1996) and Larsen (1995), after collecting data from communities in Nigeria and Cameroon, also capped it one year with any evidential support.

The World Health Organization meanwhile has aptly defined infertility as "the inability of a sexually active, non-contraception couple to achieve pregnancy in one year…" (Semen manual, 5th Edition). The American Society for Reproductive Medicine in 2014 revised the definition of infertility as "the inability to conceive after 12 months of unprotected intercourse." (ASRM, 2014). These definitions limit the time a couple that is engaged in unprotected sex and getting pregnant to 12 months so that they could start seeking treatment or help at that stage (Kallen,1989). These definitions emphasize the fact that the couple intentionally wants to get pregnant and therefore engage in unprotected sex and yet the woman does not get pregnant after a year of trying to become pregnant. The American Society for Reproductive Medicine, however, indicated that for older women aged 35 or more who have tried unsuccessfully to become pregnant after six months will be considered infertile. Older women are declared infertile within a shorter period because age is seen as a crucial factor in determining the clinical reasons for infertility. Women who are in their 20s and early 30s have a 25% to 30% of conceiving each month. (ASRM, 2014). Evidence from epidemiological studies have shown that in any healthy heterosexually active society, 25% of women who are not using birth control measures get pregnant within the first month, 63% within six months and 80% within a year. By the close of the second year, 80% to 90% will conceive by the end of the second year (NCCWCH, 2012)

In East Gonja, Kayensi-wuriche Adishetu Seidu indicates that 'it is very difficult for a woman who is a little advanced in age (30 years) to be unmarried, and she is not a divorcee'. She quickly adds that 'these days some of the girls or women delay unnecessary because of education'. It is usually

believed in Gonja tradition that when a woman fails to marry early, then she could be married to a deity or some powerful celestial person.

Infertility has been described by the WHO as a disease that leads to disability (that is an inability); hence persons seeking access to medical care falls under the Convention on the Rights of Persons with Disability. Disability is a generic term or word that includes but not limited to impairments, inability to take part in some specific activities and restrict the participation of activities. Disability, therefore, highlights the limitations of oneself in some activities as you interact with society and the environment. Disability is therefore not only a product of one's mind or physical space but also the interpretation that society gives to an inability to perform a certain task as prescribed by the society in which the person lives. The WHO indicates that developing countries such as Ghana have about 34 million women, who have infertility challenges usually as a result of "maternal sepsis and unsafe abortion (long term maternal morbidity resulting in a disability)." Women's infertility is estimated as the 5th most severe world-wide disability for people less than 60 years.

Infertility is a major public health problem across the globe, and it has several ramifications on the unity and stability of the family. In Ghana, an estimated 15% of women of childbearing are said to be suffering from infertility (Donkor & Sandall, 2009). It contributes to many inappropriate behaviours among those suffering from the disease as well as their relationship to the larger community. It also leads to immense stress and many psychological problems.

The next chapter will examine how the people of East Gonja conceive health and what, in their opinion, could be the reasons why they may be afflicted with one illness or the other.

CHAPTER FIVE

THE HEALTH CARE SYSTEM

5.0 INTRODUCTION

The previous chapter examined who the Gonja people are. This chapter looks at the health care system that is provided in East Gonja, and specifically addresses the various pluralistic methods of treatment for infertility and the intricacies involved in such treatments which includes all the three health care sectors which are over-lapping as well as inter-connected. Western medicine, traditional medicine and popular medicine. Each of the three segments has its unique ways of explaining and going about managing illnesses. The core objective of all three sectors is to help resolve the healing of the people as well as their emotional needs.

5.1 THE CONCEPT OF HEALTH AND ILLNESS IN GONJA

The dominant health care system of any community cannot be studied in isolation as it's a part of the holistic part of all the aspects of society. The health care system is usually an expression of the values and social structure of the community it arises from. Illnesses are sometimes culturally construed and experienced (Berlich, 2002). Through the delegitimization of chronic fatigue syndrome, the author explores the suffering caused by socially constructed illness. Interactions with others reflect cultural meanings for mental and physical illness, resulting in a construct of illness in which chronic exhaustion syndrome is labelled as psychosomatic or non-existent. The disconfirming of subjective experiences of illness can lead to suffering disorders, alienation, or the guilt of being incorrect in the definition in the of reality. The patients also developed strategies to contest the" not-real" definition of illness syndrome. Our sociocultural milieus shape our attitude regarding health and illness, and this is expressed in our thinking of the disease as well as how to feel about the illness and what actions we take thereof. Conceivably, more remarkable is how

individuals recount their physical experiences, and signs also appear to be ostensibly shaped by their sociocultural environments (Berge et al,1995). One good example of how the socio-cultural environment shapes the thoughts of Gonja is demonstrated in how they treat someone who accidentally uses a broom to touch a man. The man will run after the woman with the broom until he catches up with her and steps on the broom. The belief is that she would have used the broom to take away the fertility of the man by transferring *eyuripe* or dirt onto the man's manhood. However, once the man steps on the broom, he has exorcised himself of all the impurities that may have blocked him from being fertile. Chief Charkon indicated that the man actually may be infertile or will get some illness of a kind granted that woman is spiritually strong and can spiritually harm the man causing him temporal or permanent infertility.

Nonetheless, it is difficult to tell who is spiritually strong and who has an intention to harm you. Additionally, a mother or any other woman could make a man infertile if she uses a stick that is used in steering *Tuo Zaafi*, otherwise known as TZ. This hot thick porridge is made from maize or millet. It is a staple food for the Gonja and almost all the ethnic groups in Northern Ghana. This is how social-cultural beliefs can affect the concept of illness in Gonja. Indeed, once the person comes under these influences, it is very difficult to help the person appreciate that the illness he is suffering could be coming from natural sources.

The belief in God is a culturally accepted fact that affects the understanding of health issues as well as how they are dealt with. This belief in God (monotheistic) stems from two or more angles. The first is that Gonja traditionally, they still acknowledge God as the creator of the universe, many and this is demonstrated in the socio-cultural set up of the communities. Each family has *edema* or *nlingni*, referring to the gods of the family. Above this level is the clan gods and the community gods as well as the gods of the division. The belief system is hierarchical with the

ancestors at the lower echelon followed by the family gods, community and division gods. The second reason is that Salaga, which is the political capital of East Gonja and just a little over a kilometre away from Kpembi is highly Islamized due to trading activities that date as far back as the trans-Atlantic slave trade era. Official data indicates that East Gonja has a Muslim population of 65.5 percent, with only 2.3 being affiliated to other religions like the traditional religion (GSS, 2010). However, for every Gonja person who professes to be Moslem or Christian, he or she has deep-rooted affiliations to the tradition and its religion that is intrinsically interwoven into the traditions and culture. At least, the people seem to be practicing Islam/ Christianity for all to see, but they are still stuck to their deities and gods that each household, clan, community and village has. In the event that a person may not want to be associated with the worship of the gods and ancestors, his kin may make some sacrifices for and on his behalf in the event of a calamity or impending calamity.

The Gonja believe that some sicknesses are just as a result of things going wrong in the environment, such as ingesting some food that may have gone bad, one's body system rejecting some food (*kiman so fu kpaga*, meaning it does not agree with the internal balance of fluids in your body). This also means that some foods may not be good for some people as we have individual differences. This thinking is close to the biological and psychological concept of homeostasis, where it refers to the overall sense of body stability, balance or equilibrium as the body attempts to establish a good and constant internal environment. In some illnesses, especially those whose causes are inexplicable and enigmatic, Chief Chako says *alor ba ako, amuayuri dunia be karman na*, which literally translates as 'for some of the illnesses, we have to steal the back of the world.' All he is saying is that they have to resort to soothsaying to establish the cause of the illness and find the appropriate treatment for it. The gods have to be consulted to reveal the true reason why

the person is sick and whether it is curable. Even if it is treatable, through the divination, the diviner can tell if he is the appropriate person to cure or not. The diviner or soothsayer will usually do a referral to a proper healer because he knows time is of the essence in the treatment of illnesses. This referral is generally dictated by what is revealed through the divination

Nonetheless, Chief Mabuwura says Gonja believe that the world adopts a uniform pattern and all phenomena and events have a logical and empirical relationship to one another. If the wind seizes to blow *afuu yili* or birds seize to fly *mbubi ma frigi*, then it is interpreted as all not being well. This, therefore, calls for an urgent need to find causes of things and events as well as ill-health, especially when the source or origin is suspicious, thought of as 'unnatural.' This motivation to find out is an integral part of the life of the Gonja despite Islam. The Gonja have a maxim or saying *kishen mawura jiiga*, meaning something happens to make other things happen. There is always an action before a reaction, hence there was some action in the spiritual world that has affected the physical world. As such, even though they believe illness is part of normal lived experiences, it does not occur at random, especially if the illness is protracted or is unusual. Even in Western medical philosophies, other philosophers claim that the concept of health, together with the other medical concepts, is essentially value-laden. To establish that a person is healthy does not just entail some objective inspection and measurement. It presupposes also an evaluation of the general state of the person. A statement that he or she is healthy does not merely imply certain scientific facts regarding the person's body or mind but implies also a (positive) evaluation of the person's bodily and mental state (Harris, M. & Johnson 2000).

Furthermore, Chief Mabunwura believes that usually, there is an unexplained reason for infertility, especially male infertility. Whatever the case may be, the Gonja say *kuwule nta kudr wale*, meaning, it is always better to start treatment as soon as possible before things get out of control.

Usually, when one is taken ill, the believed cause is often the supernatural cause, an object that could mean the person is being bewitched. Chief Chako says that once the sick person believes that the reason is supernatural, he divines and he is usually asked to expect some pointers or signs such as a relative will visit during the month of fasting, you will receive a gift from a female in the morning, or you will meet a blind man on the way home. Other cues are that before you get home, you will be told of a funeral, the death will be that of a woman.

Perhaps the Gonja may have a point here as even in science and medicine, 5% to 10% of the cases of infertility are inexplicable (Brown et. al., 1995). This view is supported by Harris et al (2011) when they argued that although numerous tests are available for diagnosing infertility problems, an average of 10% of all couples who seek medical treatment are diagnosed with unexplained infertility

This is where the belief in witchcraft comes in handy and strongly. Once a situation, whether sickness or any misfortune results from inexplicable reasons, then the obvious answer is that of witchcraft. There is a saying in Ngbanito that *Kinishe konwule maa wu kenyiso be ed3,* meaning one eye does not see the night fire; this refers to the communal belief in witchcraft, the belief is not restricted to one person or a small group of people.

The belief in spirituality and witchcraft is widespread because it can be predicted by powerful spiritualists. For example, there is a saying in *ngbayinto* (Gonja) that if your friend is a cat, you never lack raw meat (*Fo nepka la jiblan, for ji eblan bunbun)*. If you have a powerful spiritualist, he will be able to tell you that in the spiritual world, he has seen that individual A or B is attempting to bewitch you. My challenge with this belief is that some of the spiritualists are not honest and maybe lying about what they claim to have seen individual A or B is bewitching you according to

Chief Mabun wura. He says that some people have challenges with their biological mothers and siblings because a spiritualist has claimed that they were responsible for a predicament, which may not be through. He says this situation is accountable for witch camps as many unfortunate people, especially the vulnerable who have no voice to be accused of witchcraft and end up in witch camps. Fortunately, in Gonja, these accusations are regulated as the chiefs are believed to have the capacity to determine who a witch is and exorcise those who are 'certified' to be witches, according to Chief Mambuwura.

Alternatively, the Gonja assumption that the world is orderly is to assume that ill-health and chaos are not likely and probable, but that as much as they are anticipated, their causes should also be predictable or even projected. A normal functioning human being will expect to get sick or be taken illness, suffer some misfortune at some time in his/her life. Nevertheless, at the same time, he/she expects and even anticipates the cause of this illness or misfortune. As such, it can only be seen as very normal for people to seek the causes of their future mishaps or illnesses before they occur to find remedy or antidote ahead of the misfortune/illness. This is the underlying reason why people seek to diviners; to find out about their ill health and among other things such as their future, prospects of business ventures, enemies and mischievous or envious associates etc.

A great number of physical and psychological illnesses are blamed on the supernatural. It may be said that almost every illness can be blamed on the supernatural. The general belief is that the human body and soul, just like any other natural entity, is in a state of peace with nature. There are some physiological steadiness and symmetry in which the organ systems are functioning well, and the person is said to be normal or healthy. However, this equilibrium can be distorted by both physical and spiritual entities. The supernatural agents that cause illnesses include witches, spirits *egba, mbuibi* ancestral spirits *bunumu*, gods/spirits *k'bgril*, personal gods *agbral wuribi*, and so

on. The belief in this supernatural is not too different in the sub-region in the story of John Pepper Clark-Bekederemo's song of a Goat. *The storyline in the song of a goat exemplifies the fact that causes of diseases in Africa may not be due to just natural reasons but either witchcraft or some spiritual force. In the story of Zifa, the main character in the story,* who is a fisherman by profession and occasionally ship pilot for part-time living, in a remote part of Nigeria, the Niger delta during a timeless age is cursed with impotence for having violated a cultural taboo, leading to tragic consequences for his entire community. The story is set in an eternal age because it has and is the belief of the people that curses work

It is therefore imperative, to divine or soothsay, if a person intends to diagnose illness caused by the supernatural as the cause can be sort only through divination. There are several ways or forms of divination in Gonja. They include consulting a deity or oracle (*agbral*), consulting a soothsayer, consulting a *mallam*, *afa* (Islamic clairvoyants or telepathists), consulting a *jin wara* (individuals, mostly women, who are seers and specialize in treating and preventing illnesses caused by human beings and supernatural forces), and other spiritualists. Chief Mabuwura believes that a dream can reveal who could be hunting you. He gives an example of a person trying to kill you, especially by strangling or putting poisonous substances in food or water. The interpretation is that he is afflicting you with an illness or killing you softly and slowly in the spiritual realm, which will ultimately manifest in the physical realm as an inexplicable illness. Chief Mabunwura lists some illnesses that Gonja belief that those have a spiritual cause epilepsy,diabetes *sichiri be kulor,* madness and infertility.

In some cases, a person who has scores to settle with another person may bewitch the person. *Etor kulor nsamu nko nlem mu,* they have bought a sickness for him, or they have thrown a sickness on him.

The most dangerous way of inflicting illness on someone is to step on an object that has been put around or sprinkled for the person to step on. This in *Ngbanito*, is called *krutor*. People who have suffered from *krutor* may have a swollen limb, many little boils or bad rashes. These do not lend to easy diagnoses and treatment even in the hospitals, and they Gonja say these illnesses are very allergic to injections. Interestingly, many who have they and have tried injections have died, says chief Mabunwura. There was a funeral of a young man who was ill for a long time, Abdullah, who I visited in the company of Chief Mabunwura several times. This middle-aged man, who was about 52, had his throat swollen and visited the hospital many times, both in Salaga and Tamale.

The Ear, Nose and Throat (ENT) specialists said he was developing a type of cancer that was peculiar to people who lived around the coastal areas and ate salted fish, *koobi and momoni.* This young man has never lived on the coast and indicated that he does not consume such fish. A biopsy was taken from his throat and given to a pathologist for analysis. The ENT doctor who took the biopsy said it was clear from the physical examination that the man was developing cancer and would soon need radiation, however, the biopsy report will indicate the kind of radiotherapy that would be used for the treatment. The pathologist's report showed no cancerous tumour developing, and a second biopsy was taken and given to a different pathologist in a different laboratory. A non-reactive result was returned, and the disease was managed until he finally died. Chief Mabunwura had warned that once biopsies have been taken, a procedure that as a kind of surgery, the chances of Abdullah surviving were very slim, this is so because the believed cause of the ill health was a supernatural, and such sicknesses do not like surgeries nor injections. After Abdullah's death, the diviner told us that his death was spiritual because his wife in a desperate search for the treatment of her infertility, had sex with the herbalist, who believed Abdullah was the cause of their infertility. Abdullah's wife, therefore, brought *'dirt'eyiripi* in Ngbanito. The diviner told us that

Abdullah's wife should be bathed with some herbs so that she could be exorcised. My subsequent interviews with many other informants in Kpembi indicate that the supposedly flirtatious behaviour of Abdullah's wife was an open secret

5.2 DETERMINANTS OF HEALTH-SEEKING BEHAVIOUR

Determinants of health seeking behaviour in East Gonja play a crucial role in shaping the overall health outcomes of the community. Understanding the factors that influence how individuals seek and utilize healthcare services is essential for developing effective interventions and healthcare policies. In this introduction, we will explore the various sociocultural, economic, and geographical factors that impact health seeking behaviour in East Gonja, providing a comprehensive overview of this important topic.

In this research, health-seeking behaviour is viewed as both a self-motivated process and a process that is dictated by close kin and friends where the dynamics involved in when and where to seek health care are structured consecutively, steps in health-seeking. These steps include the signs, indications, symptoms the ill person is feeling and reporting and the subsequent decisions thereof. These subsequent decisions are taken by the patient himself or herself, close kin, spouse or close friends. Who takes the decision is greatly influenced by a couple of factors. A married woman, for example, cannot on her own start seeking treatment, especially herbal treatment, lest she may be accused of using that as a cover-up to engage in sorcery or witchcraft. The suspicions and subtle accusations would be more serious if you had a rival or if her husband was in the process of marrying a co-wife. Her educational background as a woman may not be too important because she is under the care of her husband. The traditional herbal doctor will be equally keen to know if she is married, and if she is, why she is not coming for treatment accompanied, at least by her husband's appointed person. In any case, such a designated person seeks the medicine on the

woman's behalf. The husband's appointed relative or friend tells the herbal doctor that he has been asked by the husband of the woman to seek medicine for her because she has not had a child or for some other reasons.

The resolution and or judgment to seek treatment is usually an outcome of the evaluation and recognition of symptoms that have been reported by the sick person. The person or persons who will take the decision to seek treatment for the sick and where to seek treatment will be reached after a re-interpretation of and evaluation of the signs and symptoms. Additionally, the experiences of others concerning similar or same signs and symptoms, as well as where they had their medical encounters, will help in the determination of the choice of therapy and who the therapist should be.

Furthermore, how sick the person is will determine if the sick person can contribute to the health-seeking issues of his or her health. A very sick person who may hardly be able to talk, see or move, may have decisions of health-seeking taken for and on his or her behalf irrespective of his or her level of education and gender. This is not too different in the western world as well as the sophisticated communities (that are highly educated and western-styled Ghanaians) in Ghana and Africa.

The choices that are made by those who have health problems, or the factors that influence those who decide as to what health-seeking behaviours to adopt have far-reaching implications on where health is sought. The sick person usually may not be happy with where health is sought, but he may not be able to complain because he is not financing the health.

The nature of health-seeking behaviour can be difficult to follow as it is not a simple standardized and identical behaviour even for a homogeneous people like the Gonja from Salaga. The choices

they make are contingent and perhaps hinged on their thought processes with respect to the cause, how much is available to them financially and the nearness or closeness of the healer. One single reason can therefore adequately explain their various choices of health-seeking behaviour

However, Foster and Anderson (2015) have indicated that the lack of patronage of western medical services may not necessarily have to do much with the local belief systems of a people, but the cost and availability factors. As this assertion may not be entirely true, it is important in my study of male infertility because the poverty levels of the people East Gonja (the poorest district in Ghana (GSS, 2010), the behaviour of medical staff especially the nurses can be very unfriendly and appalling to say the least. In my numerous visits to Salaga Hospital, it was very clear in the way the medical staff, especially the nurses, behaved rudely towards clients, was a big disincentive to go to the hospitals. The doctors were nice and patient, at least while I was around, the patients indicated that they did not have many problems associating and relating with the doctors, but with the nurses. In a study by Khalil about the attitude of nurses towards patients, he concluded that in South Africa, nurses were nice to patients they thought were good, not the bad ones. The bad and difficult ones were deliberately delayed (Khalil, 2009).

It is imperative to say that the satisfaction of the patient or client satisfaction is very crucial to health-seeking behaviours. Indeed, a patient who is dissatisfied with one service in the same category, such as one hospital, will opt for another hospital, possibly due to poor services. Equally, a patient who is dissatisfied with one herbal doctor could opt for yet another until he is satisfied.

In the case of infertility, especially male infertility, there is pride to be associated with being a man, which is, being able to make a woman pregnant. It is, therefore, quite embarrassing, even stigmatizing; hence the men who have challenges with having children will prefer to seek medical

treatment far away from Salaga or East Gonja. They prefer to let the society think it was the woman's problem, as it is the usual thinking anytime any couple is infertility or are unable to have more children when they already have just one or two.

5.3 INDIGENOUS TREATMENT TECHNIQUES

Indigenous treatment techniques in East Gonja represent a rich and diverse array of traditional healing practices that have been passed down through generations. These techniques reflect the cultural heritage and unique knowledge systems of the community, offering alternative approaches to healthcare that are deeply rooted in local traditions and beliefs. In this section, the research will delve into the fascinating world of indigenous treatment techniques in East Gonja, exploring their historical significance, cultural relevance, and potential impacts on the overall health and well-being of the community.

The health system that is dominating in Gonja and East Gonja is the excellent combination of a herbal medical system and spiritual healing, both drawing heavily on the social structures of the local people and products available within their environment as well as religious beliefs of the people. In some instances, the same person does both. Both offer the patient the opportunity to remain within the community and by his friends and family, unlike in the orthodox medical centres of hospitals and clinics. They do not have to stay in a hospital ward full of strangers that can be quite discomforting and perhaps depersonalizing. This is so because they may be staying at home and visiting the healer or may stay temporarily with the healer. They may also stay with a relative who is residing in the same community as the healer. Patients have the privilege of remaining in the continuous passionate care of close kin, friends and community. There is usually no restriction of visits when the patient is at home or under the temporal care of the healer. The communal nature of the atmosphere around gives one a sense of a healing centre rather than a business centre that

current hospitals in Ghana have become where even a folder has to be paid for especially in private hospitals and in state-owned hospitals for persons who are not registered under the health insurance scheme. The discomforting bureaucracy and formalization of each process that is associated with the orthodox hospitals are missing under the indigenous system of healing.

The healer and his clients usually come from the same socio-cultural background; hence their understanding or opinions about illness are mostly the same. They have the same viewpoints which are grounded in principles such as divination as a system of proof.

Mallam Iddrisu, who is about 46, living in Ngua Hausawa in Salaga, is a herbalist who has two rooms that he is using as his clinic and treatment centre. He tells me his father, Mallam Yahaya was a herbalist and a Muslim spiritualist who lived in Salaga and treated people. His special area of treatment has to do with infertility for both men and women. He, however, does the treatment of other ailments that can be equated to the work of a physician in modern-day medicine. Mallam Iddrisu is married to two wives. He has five children, three of them are boys aged between 12 years and 25. He uses his children to get herbs from the nearby forests and thickets. He adds spirituality when the patient has given him express permission to do so. His first contact with his patients is usually conducted under the auspices of herbal treatment. He starts with a request of a history of the sickness or ailment. I visited him with Hamza, who had a problem of infertility:

I have been having this problem for the past five years, and I have a good erection, but the water is not much. I have dated many women in the past, and I had unprotected sex. Yes, I can remember I had some pain in my penis some time ago when I slept with one of the women, but that was a long time again. My penis itched quite badly then but stopped after a while. I got some *tupaya*(apparently referring to antibiotics) and took. The *tupaya*was prescribed to me by my very

good friend, who had suffered a similar faith and got healed. He went on to have children anyway. I took the medicine for two days, and when I felt better, I stopped taking the medicine. This problem was more than five years ago, but I never went to see any doctor or herbalist.

The herbalist scolded him saying that sickness is ought to have been looked at a long time ago. Mallam Iddrisu took Hamza into one of his rooms where he does his examination. It is the last room on the stretch of rooms in the house, and it's about 12 meters squared and has a double-sized mattress. It is covered but has no bedsheets. There is a set of stuff chairs, dark old brown leather that is weak, old and dusty. He examined Hamza's penis and testicles with his bare hands and for about three minutes trying to feel if there was any unusual growth. After the examination, he sent one of the children to the forest at dawn the following day to get some herbs for him. Hamza's consultation fee was determined by Hamza because Mallam Iddrisu told us that his father never took money from the patients that he healed. Hamza gave him 20 Ghana cedis, an equivalent of about 4 euros. Hamza was asked to come in a few days with a white chicken for his herbs. The herbs were in the form of stocks neatly cut into fine pieces, and the bigger ones were about 10 centimetres big and 100 metres long. The bigger ones were placed first and the smaller ones on top. The smaller ones were coming from a different tree stock from the first ones. Some neatly tied leaves were added to the herbs. He was asked to boil them in a clay pot, and when it is boiling, he can put the pot down on the floor with the boiling stuff and squat over the hot water covered with a cloth, *kushi amu* in Gonja meaning covering yourself with a cloth and exposed to the steam from the hot herbs. He did this twice a day for one week. He was to return after the week and tell what changes he would observe.

In the second week, Mallam Iddrisu had a friendly chat with Hamza and told him how some other persons had come to him with similar problems were healed. He asked of his health and if he was

able to use the medicine the way he asked him to do it. He asked Hamza for changes he had observed and indicated that the itching feeling he had in and around his testicles was an indication that his medication was working. This time around, Mallam Iddrisu gave Hamza a black powdered substance that had spices in them and asked him to fetch a spoonful and add it to beverages he takes in the morning and evening. Mallam Iddrisu took a spoon full and put it in his mouth and sucked it away, ostensibly to demonstrate to us that it was not dangerous. I, as a researcher, was offered some of the black powered substances with the explanation that it was also an aphrodisiac as well. It was salty and spicy and had some meaty chunks in it.

The psychological context of all of these is that the friendly relationship that existed between the 'doctor' and patient was good to give him a sense of healing. The Gonja saying, *anishi anyo bee shaa abar* means people love each other when they are together. Once the 'doctor' is virtually at the beck and call of the patient, the camaraderie is strong, hence suitable for the healing process. The house of the 'doctor' acts as a refuge as some patients felt more comfortable staying back a few days to a few weeks if they thought they just could not cope with the outside world immediately due to high-stress levels or physical ill-health. Additionally, the chance that the patient had to report his signs and symptoms anytime he had to them was a right way of relieving him of his stress, and this also goes a long way in the healing process. The financial implications of the treatment were such that it gives Hamza some space to reduce his stress. A recount of the history confirms the healers' predictions (diagnoses) about the kind of illness his patient may have. Aside from the aide of spiritual powers to help in diagnoses and healing, these healers have had years of experience, and hence it is easy to know when one symptom follows another in any ailment. They make decisions on any case of a disease based on the cumulative descriptions of previous similar clinical cases they have handled. It is worth noting that the healers have an

excellent memory base despite the numerous cases that they handle. They remember all the medical facts, herbs and symptoms of each case that they handle. They ask questions on how the patient dispensed the herbs to be sure that they did the way they were instructed to do.

The medicine that is dispensed under this treat is unlike those under the orthodox western-styled medicine where the drugs are usually based on 'scientific rationality' where they are tested and certified under independent and experimental conditions. The medicine under the indigenous system is also tested under different conditions such as 'time tested medicines' as a result of continuous usage by persons having the same symptoms that have been treated; additionally, they are also some are tested under 'spiritual guidance.'

The second example of indigenous treatment techniques I will want to discuss has to do with my experience with Yabubu Seidu, who heals by using his deity in kito. Kito is a distance of about twenty Kilometres from Kpembi. Hamza's choice of Kito was to ensure he did not confirm to those who suspected that he was infertile that he actually was, hence seeking medicine. The man-in-charge of the deity Yakubu Seidu is uneducated and in his early fifties and very friendly. He gets an average of about four clients a day and spends about 20 to 30 minutes with each client. He has a waiting room and a room where the deity is. He tells me the deity is many hundreds of years old, and he calls it Nana, a title that southern Ghana chiefs are known and called. The deity takes alcohol hence we bought a bottle or a litre of hard locally brewed liquor, popularly called *akpketesi.* This local liquor was banned during the colonial era for apparently being unsuitable for consumption. Yabuku pours about a glass full of the drink over his deity and lights a cigarette and blows the smoke over the deity many times before getting some of the alcohol into a glass and slowly running it down his throw and coughed a couple of times. He consulted his gods and told Hamza his predicament was as a result of a disease that he got after sleeping with one of his

girlfriends that had been betrothed to someone else. This man was angry and cast a spell to the effect that Hamza will never get a child. Yakubu Musah asked that Hamza provides a white ram to be slaughtered and cut into 101 pieces and given to people for abetment of the spell.

The cost of the ram was about 400 hundred Ghana cedis, an equivalent of about 80 Euros. Hamza was getting quite broke and could not immediately afford the purchase. Hamza lost his job with a government organization a few years ago. He asked if a smaller ram could be purchased, one that will cost about 300 hundred Ghana cedis. Yakubu was not impressed because he said it is difficult to get as many as 101 pieces from a small ram. Yakubu eventually agreed, and Hamza provided the 300 hundred Ghana cedis, and the ram was bought and slaughtered. The meat was cut and divided into the 101 pieces and shared the following day. That day was a Friday, a good day for sacrifice to the gods we were told. Usually, Saturdays and Wednesdays are not used for slaughter, as they said not to be good days. What this means is that they have observed and realized that Wednesday and Saturday sacrifices do not yield the required results. The reason why the meat is cut into many parts and shared is that each recipient of a lump of meat is likely to say thank you and a prayer to God, and at least one person's prayer and intervention may be acceptable. Some of the meat was given to Hamza for the preparation of soup that will be eaten for a week. He also got to barks of a tree that was to be pounded into powder for him to mix with porridge. Finally, some herbs were to be boiled and bathed as part of the treatment. Hamza's wife was very useful if the preparation of the medicines once she was not in her menses. This is important for the preparation of the medicines, lest it will lose its efficacy and potency

The deity can be aptly described as a factory or an industrial institution where medicines and cures are manufactured and produced. The raw material is usually the patients who are cured of their diseases from the deity. The deity is now looked at as more or else as a temple by both the persons

serving and the sick as well as the people of Kito. The priests serving there and the people of Kito see the deity as a healing tradition and an unmatched power over diseases and perhaps death. This feeling is a good way of psyching up those who come up for treatment. An interaction with indigenes of Kito will make any potential medical tourists a high sense of hope and feeling that may be unparalleled.

It is difficult in some cases to draw a fine line between spiritual aspects of care from the herbs per se, as healers do combine these in treating illness. It is not just the herbs that he uses to heal, and he needs to have the spiritual power to empower the herbs to work. In the process of *kicho kudurl* (processing of roots and leaves into herbs) the healers recite incantations calling upon the spirits and the ancestors to heal the sick person and to make medicine potent. Divination is also employed to diagnose illness and find out the possible outcome of therapy even when herbs are used for the treatment. The techniques by themselves are necessarily traditional healing but steps towards becoming whole, balanced and connected. as pointed out by Hollos (2008), all systems of healing share some theory of affliction, defined roles for patients, specified place and time for healing rituals and expectations for recovery. Where illness is understood to be as a result of mechanical or physical injury, healing may include the use of herbal, animal and mineral origin.

Hamza in his quest and anxiety to get healed quickly visited a Christian prayer camp in Salaga with help of a friend of his, Michael. Wichael is Christian and friends with the pastor who has helped others to get children. This prayer centre is manned by Pastor Isaac. Even though Hamza is Moslem and comes from a home that has no Christian, he sought help from a prayer camp through his friend. In this camp, Hamza was not the only Moslem who had come to seek help. Pastor Issac indicated that such 'clients' may not be regular church attendants but come to seek help when they have health and spiritual challenges.

Seeking multiple sources of treatment is not uncommon when people are critically ill. Even with one particular method such as the Western biomedical method of treatment, very desperate patients will seek what is described as a second opinion by contacting other medical officers, repeat laboratory tests and other investigations with the hope that at least one of them will be successful. This desperation is leads patients to seek help from herbalists after seeing a medical officer, cross over religious beliefs all in a bit to find solutions to their predicament (Adekson,2016)

Herbal treatment takes several forms, but the process is generally referred to as as*kudul be ke fin.* Almost every natural material can be part of the ingredients for the *kudulr*, including, leaves; roots; animal parts such as skins, bones, tails, horns; nails or iron; cowries etc. These are processed into various forms; herbal charcoal *kudul lembrl,* herbal tea, herbal tablets, herbal cream *be abgiti,* herbal meal *amunu be gee,* herbal bath *brel,* herbal steam inhalation etc.

Spiritual healing usually involves the invoking of the spirits, and sometimes you can hear the healer talking to the spirits. The spirits are in different types. There are the spirits of the ancestors, the spirits of the forefathers of the land, the spirits of the sea (popularly called mame water) and the spirits of the forests, also known as the dwarfs. The spirits can be sent on their own, especially the forest spirits, to go and look for medicine for a sick man; this kind of medicine is reported to be very potent. This view is supported by Adekson (2016) who explores the relationship among religion, spirits and healing in the Tehuledere community in the north-eastern part of Ethiopia and focuses on how this knowledge can inform primary healthcare reform. The findings revealed that members of the community perceive health, illness and healing as being given by God. Many of the Tehuledere people attribute illness to the wrath of supernatural forces. Healing is thought to be mitigated by divine assistance obtained through supplication and rituals and through the healing interventions of nature spirit actors.

The unending practice of meeting the physical, emotional, social, mental and spiritual needs of the patients by the healers and close kin of the patients is essential for their healing. Social support is, therefore, essential in the healing process, and it is usually provided for by close kin. In the case of Hamza, for example, his paternal Uncle, Mallam Ibrahim Anyass was very instrumental in the choice of a therapist. He also provided means of transport, a motorbike to convey him around. The therapist equally provided social support. They had spare rooms where their patients could be accommodated. These accommodated patients were fed from the healer's house until he returned home. Some of the patients were very well integrated into the families of the healer such that a first-time visitor will find it difficult to tell that the patient did not belong to the healer's family.

Several studies have examined the relationship between social support and recovery from mental illness, and have found out that social support is a key source of psychological health and has been identified as a specific aid (Halos, 2016, Becker, et all,1992, Berlich, 2002). The size of social networks as measured by the number of friends was correlated to recovery, but satisfaction with was not. Participation in meaningful social life is a major goal for many persons in recovery, and therefore relationships among recovery, social support and social activities are important areas for healing. Social support has been shown to significantly impact psychological distress, quality of life, loneliness, and burden of illness. Nursing researchers have also investigated social support in the nursing profession with increasing interest (Halos, 2016, Becker, et all,1992, Berlich, 2002).

Most of the people seeking medical treatment from the herbalists and who were in-patients had a relative or two with them. These relatives bathed those who were too weak, ground medicine for the patients and fed them as well. Some also went with the relatives of the herbalist to the forest to look for the medication.

While the relatives who came around were doing nothing, they engaged the patients in conversations and this social support was seen in almost all the herbal treatment centres that I visited in East Gonja and beyond. However, for very sick patients, they had a relative or two who accompanied them rendering support services such as cooking for those who were in-patients. They washed their clothing, bathed them and helped in the preparation of the herbs: They helped in the collection of the herbs, burning them, boiling them and massaging their relatives. On the other hand, the young men who were healthy and were keen on avoiding stigma travelled alone to distant places for treatment.

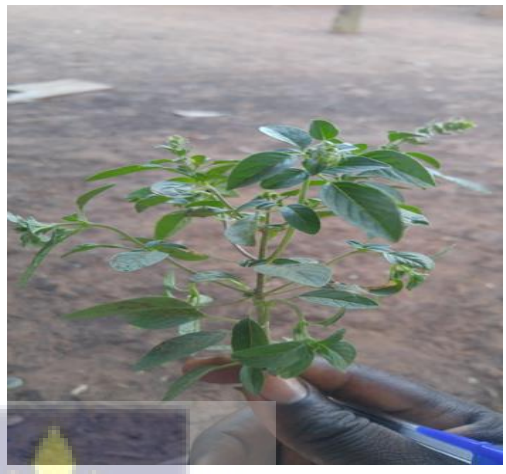
It is necessary to discuss one other illness, among many diseases that are treated by the traditional healers, is sexual weakness. I am especially choosing to discuss this illness because of the closeness of this illness to impotence and those who treat this combine the illnesses of sexual weakness and impotence as well as general male infertility. Drummer Ahmed, who treats sexual inclinations and infertility, gave me a background to this treatment. He indicates that chiefs were given skin wives; hence a chief could have as many wives as ten to fifteen or more. Most of these chiefs were advanced in age, between 40 years and 80 years or more. The chiefs need to have sex or 'service' these women and even give birth with them. Hence, they need persons who they could trust as herbalists who will prepare herbs that will make their manhood strong, produce very strong and viable sperms.

Drummer Ahmed says about from some dietary restrictions such as sugar and too much alcohol, and the chiefs were given gbrilga (which is scientifically known as *tragia brevipes pax*, it is a plant species classified under the *Tragia genus*)., a preparation that is not very uniformed in the herbs in and around Gonja. Very detailed preparation of the gbrilga will be provided in East Gonja, Salaga.

Plate5. 1 Herbs for the preparation of Gbrilga.

Source: Author's fieldwork, 2018

Plate 5.2 Kamufinyinbe



Source: Author's fieldwork, 2018

(Tragia brevipes pax)

The picture above shows the herbs used for the preparation. They include the light brown sticks lying or herbs in the top of the photograph is called *Nchanto be ke lingi,* that's grave herbs. They were dug out in lands where graves were being dug. While digging a grave, they come across some roots of trees, they cut these roots and keep them waiting for the preparation of herbs. The belief and thinking are that an impotent penis or flaccid penis, which is a sexually weak person can be compared to the roots in a grave, signifying the weakness of supposedly 'dead' penis (that is a penis that may be suffering from erectile dysfunction or low sperm count or both).

The deep dark brown sticks are called *epkato be ke lingi,* meaning a root that grows a path or road. The implications of *epkato be ke lingi* are that everybody uses that road, hence they impotent person benefits from more potent energies that pass there. The last one is the green plant, which appears on the right hand of the first picture, which is plate 2, is a close shot of the third plant or herb, *Kamufinyinbe.* The scientific name for *Kamufinyinbe* is *Asparagus africanus Lam*. It is a

plant species known as *African asparagus*. It is a type of asparagus plant native to Africa. It is a strongly scented plant that restores power of the penis to function effectively.

A ruffled chicken is offered as a sacrifice to God through the ancestors. The chicken is held over the herbs, and a libation is poured over the herbs saying

Nyinpe ebore ne ye eba en bachi Kasamudei

Ntutu Bakari, baso nchu

Mere nkpa wei fore kaliana,

Kuti Ibrahim e sheli mba tuma, ne for so mu nto

The translation of the libation is as follows:

My master God, I come to you with a special request

My father Bakari, come and take some water

You own all the medical herbs and make them potent

You son Ibrahim has come to me with a problem of birth,

Make his penis healthy and make the water in it potent

Let him have twins, and we shall thank you and give more water

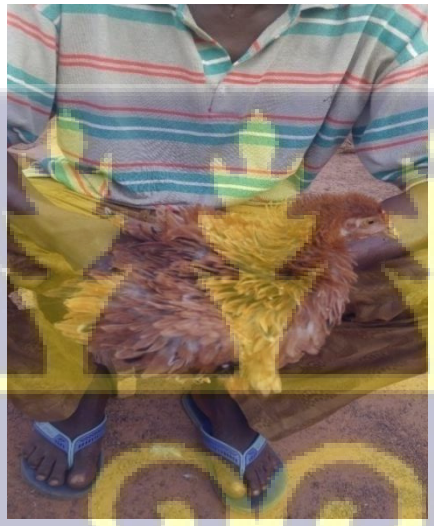
I know you will never disappoint me as you always answer our prayers and grant our requests

In the libation, he acknowledges that God is the ultimate healer, and the herbs are not potent unless they are blessed and made potent. Drummer Ahmed says even if I get all the 'ingredients' without the appropriate prayers, they will not be therapeutic. I took some of the medication at home, and my key informant and I shared it. We both used it for about a week, and it increases the appetite for sex by arousing and sustaining an erection. On the part of making the sperms strong and fertile,

I had to rely on another client who was seeking help from Ahmed. His wife was not yet pregnant from the start of medication in May 2018.

The herbs are burned into a charcoal medication, and some put in a medicine bag and hanged in front of his house. Medicine bags are containing all kinds of medicine in front of every household, and the medicines could range from anti-snake medication, pain reliever to anti-poison medication for the immediate household as well as neighbours who may need it urgently.

Plate 5.3. A ruffled chicken



Source: Author's field work, 2019

5.3.1 Herbs

Herbs are generally referred to as *nlingi,* and they are to treat diseases. They include roots, branches and barks of trees, which are used not only for therapeutic*kechei* purposes but also for preventive *adurl ne aba kun* and offensive uses *kusunlibi pei*, translating into English as the medicine for evil works. Chief Chobbie, a chief in Kpembi who is a herbalist as well, says all these various types of herbs are used or allied through bathing *bre amu*, drinking *ba nu,* eating *ba ji*, massaging *ba ayishi amu na* it in or through inhaling *ba kufi amu na* them.

The herbs that are used as medicine must be coming from trees that bear fruits that humans eat, or they must be coming from trees that termites eat the trees. This is very crucial because there some plants that can destroy the internal organs of a human being when ingested through eating or drinking.

For the herbs that are used to rub in or massage them onto a body part, they may not come from a fruit tree or a tree that termites eat. The user is usually warned as *choncho ma dun, amaemu wale wondo* to' Even though an earthworm does not bite. They may not be harmful to the internal organs; however, we strictly warn users not to eat it by say *ki ma bita konno*, it does not touch the mouth. The herbs may be procured from various places including the backyard of the home, in the farms *ndortor*, nearby bush, forests or even in old graves *Nchantor*.

Some of the trees talk and would ask for a sacrifice if they have to permit you the herbalist to have all the medicinal values that are inherent in them. This is the point where the introduction of spirituality comes in. The herbs per se may not do the therapeutic job that we require them to do. Chief Chobbbie gives me an example, *Nlingema le nlinge amu* be *ta amu nke kudrl na*.Roots, barks and branches remain as such unless power and life are breathed into them. This means these roots and barks have to be empowered. The empowered comes in several forms. The trees that they are taken from may ask for a red, black or white fowl depending on the kind of sickness it would cure. On the part of male infertility, he explains that most of the trees may require a red fowl, among others, because they intend to take the '*kinishi pre'* red-eye as literally translated or the problematic challenge and pain that the person is facing. The ailment is severe to the extent that it is described as the red-eye, which is dangerous for the person suffering from the illness.

Herbs may be used alone or used alongside spices, oil, skins of healthy wild animals and kola nuts.

Kushun wura, a herbalist based in Kitoe, a village 15 kilometres West of Salaga, also in the East Gonja district tells me that they add the teeth or bones of lions or tiger to herbs for physically weak children; as a result, walk quite later than the expected time. With male infertility, he says he adds bones of antelope because they have a high spiritual value. The antelope is the counterpart of the domesticated goat according to Kushun wura, and herbs that are being administered will lose their therapeutic strength if a goat eats or chews a part of the herbs. It is better to go for fresh herbs if you were sure a goat had eaten a part of it.

Kushun wura in explaining how herbs are stored indicated that some of them could be pounded into powder, and this can be stored for months. He says some herbs for a man who has difficulty in maintaining a proper erection and therefore cannot have children, are stored by mixing them with spices such as ginger and *ferri gisheri*, a salty substance that is usually sold by the traders from the West Africa sub-region, Hausa and Wangara. Some others are stored in the form of balls, and these are called *Muuji*. *Muuji* a ball made of grounded herbs is used in rubbing on a piece of cleaning grounding stone with a little water; the paste thereof is applied to a body part for healing. Boils, for example, are cured with the use of *muuji*. Kushun wura says that it is essential to store these medicines in such forms because, when the raining season is over, some of the herbs are difficult to get as. After all, some plants may have withered off and may never be available until the start of another raining season. In between time, when these herbs are needed, that is during the off-raining season, we can only rely on what has been stored, chief Kushun said. Herbs that are collected within the raining season are more potent than those are collected during the dry season

There herbs that are solely intended for the treatment of ailments of children *Mbia be kudrul*, others for women *benyin be kudrul* and women, be *chei be kudrul*. However, there are yet others that can

be used by all. The medicines meant for children may not be too keen to cure the same ailments for adults and women. The separation is basically due to the level of potency of the herbs. However, those that are solely intended for the use of only men are usually aphrodisiacs and fertility herbs. Most of the men herbs are heavily spiced. The meat of a Ron antelope, specifically the testicles are critical to the herbs. When the testicles of a Ron antelope cannot be gotten, the testicles of a goat may be substituted. The explanation for the use of Ron antelope is that it the only animal in the wild that can have sex for the longest time. In Gonja, a man who has many girlfriends is nicknamed *kaboi lotte,* meaning a he-goat. The he-goat has gained notoriety, or it is noted for running after female goats all the time in search of sex. A he-goat usually spends a little time looking for food to eat as it's always engaged in sexually related activities—a young man who is losing weight and becoming skinny maybe liked to a he-goat.

Most medicines are administered by the person who may be sick or applied onto a sick person while reciting a prayer or a wish to God, invoking his healing powers over the medicines. For example, this recitation may be heard by a man who issues with infertility:

Nyinpe awura bore' kabre me ashu atere for

Kudur ere me le kudur amu for wura kusha kusha kusha

Be sor me nto, sekema be amushe mu na

Kakul ma na aye mu kor nbia,

Kabre lera mu anushu nyun era tor,

Se na be kra ma nti bututu so

Madi, Byinpe awura Bore, madi….kusha kusha,

Ne ase ana wura ma oo, eyin, eche, lerimu ayunshurun tor

Kusha kusha kusha…..'

This recitation translates as My master God, this medicine will be no medicine unless you bless it. Come and take me away from shame. I hardly sleep. I need your blessings, more blessings. If my ailment is caused by a man or woman, I do not know, but I need healing from you. I am blessed and healed by these herbs I am using because you wished it.

5.3.2 Preparation and Storage of Herbs

The herbs that are collected from trees and other plants are used for the treatment of many diseases. With some of the diseases, the herbs or medication will have to be prepared outside the house by men. Herbs for fortification during wars, such that gunshots cannot penetrate the person, are prepared at midnight and only by men. The herbs for invisibility, that is, if a person is caught in a challenging or stressful situation, and wishes to disappear, will have to be prepared by a water body or by *Npkacheri* crossroads. The herbs are subsequently administered in the bush at *Npkacheri* or crossroads. If some were left and had to be stored, they are stored in the farms and not brought home. The potency of it will be gone if they got close to the village or a community inhabited by people. The reason why they are not stored at home, according to Chief Chobbie is that they tend to pose a danger to people who did not seek such protection if they used them. Such persons could vanish in case of a war or an accident and will go and come no more. They may not know where they are and could be lost for years. Herbs for infertility treatment are equally classified as a man's medicine; however, it is of a lower threat than that of those for invincibility. Men prepare infertility medicine but at home. The men are warned to ensure that boys do not get access to these medicines because they are usually sexually active, and their *nchu* water, referring to the sperms, is very strong as well as an excellent herb for the erection of the penis. If boys or unmarried young men were to take the herbal medication mistakenly, they would make many girls and women pregnant. Kushun wura says that not only will the potency of the boys who mistakenly

take it rise, but also boost their sexual drive or their appetite for sex will increase more than fivefold.

Women medicines are those that are for common cold, toothache, indigestions, headaches, snake bites, and fevers. These are aptly described as medicines for everyday ailments *alor wuribi* which is literally translated 'small small' diseases. These herbs are prepared into medicines either by boiling them and extracting the liquid thereof or by burning them into a charcoal form. Some others are grated, and the power dried and stored in unique bags, which are usually made of animal skin and have a lock and a small handle. These medicine bags could contain medicine for many years are refilled when they are getting empty. They collect a lot of dust around them because they are usually hanged in the thatched roof or the rafters of a house. The issue of hygiene is of paramount concern to the people of East Gonja now; hence they tie the herbs in plastic bags before putting them in the medicine bags.

5.3.3 Mode of application

Usually, the external and internal symptoms will help to determine the mode of application. Some of the herbal medicines are applied externally to the areas that may show symptoms such as a swollen foot, an engorged tummy, or a broken limb. If the ailment is from within the body, *epuntor be kulor* then the sick person will drink and inhale the herbs. The sick person, in the case of infertility, will drink, inhale, and rub in some of the medication. Most medicines are used for a week, and the sick person is reassessed. In the case of herbal medicines for infertility, the man is asked to observe his erection and the amount of sperm that comes out. He is also asked to look at the colour of the sperm and its odor. The male person treating his infertility has some other herbal gratings missed with coconut oil, which was massaged into the genitals.

5.3.4 The Modern Health Care System

The modern health care system in Ghana encompasses the orthodox, biomedical practice introduced during the colonial era. At independence, the Ministry of Ghana was established to oversee national health services, a role in which mission-based organizations have also been historically and continuously significant. Other entities, including the military, police, and the Social Security and National Insurance Trust (SSNIT), also contribute to this pluralistic system.

The Ministry of Health and the Ghana Health Service maintain a formalized bureaucracy of institutions, hospitals, and clinics staffed by doctors, nurses, and paramedical personnel. This system has undergone significant reforms, including a shift from curative to preventive medicine, the introduction of cost-recovery mechanisms, and more recently, a community-based mutual health insurance scheme. These changes have promoted greater community involvement through the training of village health volunteers, traditional birth attendants, and community-based surveillance workers under the primary health care programme.

The Salaga Hospital is the sole government hospital serving the East Gonja community, a population of approximately 135,450 (GSS, 2010) dispersed across 8,340.10 square kilometres (GSS, 2010). It is staffed by two medical officers, resulting in a doctor-patient ratio of 1:67,725—a figure that is considerably worse than the national average of 1:10,450 and the Commonwealth standard of 1:1,320 recommended by the World Health Organization. Specialist gynaecologists and andrologists from the Tamale Teaching Hospital visit periodically. The two General Practitioners (GPs) at Salaga Hospital perform specialized procedures, including caesarean sections, and refer complex cases to Tamale. The hospital also employs a scientifically trained herbal doctor, a role regulated by the Traditional Medicine Practice Council (TMPC) after a degree from Kwame Nkrumah University of Science and Technology and a two-year internship.

Dr. Mohammed Sheriff, the 34-year-old medical superintendent with an interest in gynaecology, handles most infertility cases. He reports that while he sees 10-15 patients monthly for fertility issues, approximately 95% are women. This pattern directly illustrates a core challenge in managing male infertility: men rarely self-present. Dr. Sheriff must typically request men through their wives, an invitation many decline. He attributes this to stigma in the small, interconnected community, noting that some women cease treatment when their husbands discover their hospital visits. This demonstrates how cultural norms surrounding masculinity create a significant barrier to engaging men in the biomedical management of infertility.

The female patients, aged 21-35, often present with fibroids, ectopic pregnancies, or heavy bleeding. Dr. Sheriff suggests that high hormonal imbalances may be linked to poor nutrition, as cash-crop farming has replaced the local consumption of legumes and seeds. He posits that poverty-driven dietary changes and an illiteracy rate of 67.3% (GSS, 2010) contribute to a public health context that exacerbates reproductive health issues for all, including underlying factors in male infertility. He notes that nearly 100% of cases present as a second choice after traditional care, often in advanced stages where treatment is less effective. This late presentation, driven by a preference for anonymity to avoid stigma, is a critical factor in the poor outcomes of male infertility management.

Dr. Sheriff also identified high testosterone levels in women, potentially linked to strenuous agrarian labour and stress, the latter being a common experience for infertile women who report abuse and familial pressure. These social pressures on women are often a direct consequence of the couple's infertility, which is frequently presumed to be female in origin, thereby indirectly highlighting the need for a couple-centred approach that includes male diagnosis. Conditions like sterility from pelvic infections, often resulting from unprotected sex, crude abortions, or poorly treated home births, were also noted. A significant issue is Rh sensitization, where women with negative blood groups require Anti-D injections after birth or abortion to prevent future infertility, a preventable complication often missed.

Regarding the few male cases, all involved secondary infertility. Erectile dysfunction was a primary complaint among educated, middle-aged men with unhealthy diets, whereas physically active rural farmers presented less frequently with this issue but sometimes with genetic anomalies requiring referral. Dr. Sheriff observed that 80% of infertility patients had first consulted a traditional or spiritual healer, delaying effective biomedical intervention. The herbal doctor attached to the hospital, Nurideen Koomson, provides an alternative therapeutic perspective. He described treating a case where a woman, Kanyiti (pseudonym), showed no physiological issues. It was only upon his insistence that her husband was tested and found to have a low sperm count, demonstrating how a female-focused diagnostic paradigm can obscure the male factor. Koomson theorized that patients' treatment choices are influenced by finances, vicarious experiences, and spiritual beliefs about causation, particularly when a cure is elusive. This pluralistic health-seeking behaviour, while rational for patients, fundamentally complicates the coherent management of male infertility

5.3.5 Popular health care and drug use: Drug peddlers, commercialization of indigenous medicine.

The number of modern health care institutions and the medical staff available to provide medical care may be promoting the commercialization of both western medicine use by drug peddlers and the sale of indigenous medicines. The distance of the only health facility and the formalization of procedures is also promoting the use of popular medicine. The use of popular medicine usually arises from old ladies who have used some medications, both herbal and western, to treat one disease or the other. When a health complaint is raised in the compound, the person who intends to prescribe one drug or the other may ask for some symptoms; sometimes, they ask leading

questions as far as the signs and symptoms are concerned. For example, do u feel tired? Do you vomit? Do you suddenly lose erection when you want to make love? The folks who prescribe these medicines may have suggested them to some family members, and they may have been relieved from their ailments.

One popular group of medication that was prescribed was antibiotics. This included Flagyl, amoxicillin. The medicines are popularly referred to as *tupaye,* a Hausa word for capsules. They are usually described by the colours in which they are packaged. They are 'prescribed' for many ailments from a cut where they are opened and poured on the cut to a common cold, boils, and a running tummy. There are also locally prepared herbs that are usually stored at home. These are typically prescribed and shared when one makes a complaint about a situation.

Many of the male respondents indicated to me that men might complain to many a friend when it comes to any ailment except with sexually related issues except when they are in their inner circles, and they feel safe. As Cowards put it, 'men are generally far more reluctant than women to face up to and respond to physical and psychological problems. (Cowards, 1999). Within the inner circles, some still fear to open up and may say their story as if it was someone else's situation that they were reporting. However, once they know each very well, they can tell when such a scenario is being painted

With specific reference to the management of male infertility and popular care, lifestyle changes usually suggested. Sadat tells me that two of his friends asked him to stop eating sugar and surgery foods, *aba emo kututu,* meaning they kill the penis. Some of the respondents also indicated that exercises are very good in allowing good circulation of blood, and walking barefooted was also good for the flow of blood. They believe that infertility has something to do with a good erection.

Coconut oil is very therapeutic for male infertility when used to rub into the male organ, says Sadat. Sadat says when they sit down in the evening as a group of friends, they discuss sex and its associated issues.

There is a popular saying in Gonja that says that when you do not sell your sickness, you do not get its treatment, *Ne for me far for kulor, for ma nye kumpr kudur* if one is sick, one of the things one has to do is to sell the sickness to people.

There is a Gonja maxim that says every disease has a medicine man who will treat it, *kulor kama ne kumuedulkpor.* As one continues to make known his disease, one medicine man or the other who peddles drugs will visit every money with a basket of drugs, using antibiotics and pain killers. The drug peddlers listen to each complaint and prescribe some medication from the basket of medication that they have. Some of them even administer injections to their patient. One popular drug peddler in East Gonja is Baba Mu, not his real name, though. He visited one of my respondents and prescribed and sold Astaxanthin and Selenium to help in his infertility. Baba Mu sells is 'medical officer' and a 'pharmacist' who has been engaged in this practice for well over twenty years. He is in his early fifties and has been an intern in a pharmacy in Tamale before. He is very familiar with the people of East Gonja, and they have a lot of trust in him. He moves around with his old bicycle and makes his sale without gloves. He feels his patient and listens to them with keen attention. He asks for more signs and symptoms by suggesting some of them.

Yet another category of drug peddlers, especially when it comes to male infertility, is Fulani drug peddlers. They walk in pairs, and they are usually men. They usually sell aphrodisiacs but also claim to *mu yia mu tashi bura* (we wake up a penis). They have about twenty different powered herbs that treat almost every male problem from low sperm count to many erectile dysfunctional

problems. I had a discussion with one of them in Yabubu's house when they came there to sell their medications. I asked them exactly what could be the cause of a man not having children or not having the ability to make the wife pregnant. Meideiri, one of the Fulani women, explained that with some men, they had too much fat, which means they were obese. The other reasons she outlined include the speed with which the sperm flows, the free flow of sperm in the sperm duct, how erect a penis can be, among others. Essentially, their reasons were biological in nature and they had various herbs for such causes they had listed. Meideiri had an ointment that was applied to the area between the penis and the testicles, apparently aimed at the sperm duct, which carries the sperm from the testicular region into the vagina. She also had a black powder that was used around the glans of the penis to delay the onset of ejaculation. She explains that in some women, they need to be stimulated for a while to get her pregnant. She indicated that men are impatient when they are sexually aroused and do not engage in enough foreplay. About three teaspoons full of the herbs for making the sperm stronger, for example, is ten Ghana cedis, that is an equivalent of about two euros. My efficacy of the medicine they sold was a concern to me, and they indicated that they ask for results from their clients as they go around to visit them. Most of their herbal preparations that were to be taken orally had to be taken with a lot of protein; beef and milk. This was quite interesting to me because, with gbrilga, the locally acclaimed herbal preparation in Gonja went with protein as well. Gbrilga goes with a chicken, antelope testicles some other bush animal's testicles depending on where the gbrilga is prepared. Meideiri's clients cut across age groups as she has many students from 14 to 20 patronizing her medication. These are children who are in the upper part of the Junior High School or in the Senior High School. They prefer to patronize these peddlers because they cannot be guaranteed their privacy if they visited a government hospital.

Afi, a native of Kalende in East Gonja, about twenty minutes away on bicycle from Salaga says,' I visited the Salaga Hospital because I suspected I was pregnant. My menses had seized for two months. It worried me so much that I could not concentrate in class. I was just afraid and embarrassed to be found to be pregnant by my colleagues. At the hospital, the nurse, after asking me what could be wrong with me, said I am a bad girl to have gotten pregnant at the age of fourteen. She embarrassed me before many people in the outs patient department (OPD) in the Salaga hospital. I subsequently approached Fulani (that is Meideri), and she assured me of terminating it safely for me. She did, and I felt comfortable later on. I do not like the use of condoms because I do not get the full excitement when my boyfriend is wearing one. He also complains that he does not excited about the use of the condom. We actually start sex with the condom and later pull it off to have good sex. I am not usually the only one who does not get satisfaction from sex using a condom. Most of my colleagues say these things when we are in the dormitory in Salaga Senior Secondary School. Meideiri observed that as young as 14-year-olds were approaching her for medicines to have a long erection to impress their girlfriends. She told me the young boys and girls are very sexually active, and they impregnate the girls very frequently. *Mu na bata chiki deyewa.* We keep helping them to perform abortions for about 40 Ghana cedis with this blue ball, which can terminate a pregnancy safely in three days. Unprotected sex and abortions cause a lot of infections as some of the girls complain of smell from their vagina. Meideiri gives them another medication for a washout to reduce the infection. A few of them report to the hospital for a proper diagnosis and treatment.

Meideri also visits all the drinking bars to meet men of kind who are drinking. They usually patronize her products, usually the aphrodisiacs. Some men have also bought some infertility

medications for their wives because they say their menses are not regular, and the flow is not regular. These are signs of infertility in women too.

Anti Akosua, who is about 44 years, is a native of the Asante or twi speaking areas of Ghana who sells herbs in a plastic basket and peddles around the villages in East Gonja. One of her popular medications is called *Nyame dua,* meaning God's tree. This herb or branch of a tree is usually good for virtually every ailment; it is generally grounded in a watery light medication that is used as an enema. It is pumped into the anus and kept in the person for about five minutes, and it is a cleansing agent for all ailments, including infertility in both men and women. She sells another herb, and this is a dark brown bark of a big tree which helps women to pick seed. Andaratu, 21, says she was finding it challenging to pick seed until she started patronizing that medication from Anti Akosua.

Her herbs are usually from forests in the Southern regions of Ghana, such as Ashanti, Brong Ahafo, Western and Eastern regions of Ghana. She travels to these regions to buy them from farmers and returns to sell them.

She has a couple of herbs she says are perfect for men to have healthier sperms and a good erection. She has Nyame dua. It's a dry long brown stick, perhaps branch of a tree that is as big as a pen, and it is chewed by a man who has a low sperm count in the evening before sexual contact with his wife. The man swallows the juice or water that is coming from the chewing stick. He can make his wife pregnant after chewing it for a couple of days, says Anti Akosua.

5.3.6 Continuity and change

Some changes are taking place concerning the kind of therapies that are available, as well as the therapies that are used by the people of East Gonja as a result of education, globalization, and transformation among others. They appear not to be usually influential in all aspects of the Gonja

health care and practice. There is still a marked distinction between what is called *Nbroni be kudul,* white man's medicine, and I (Gonja or black man's medication). The people of East Gonja, irrespective of their ages or education nor gender, seem to have agreed that some illnesses are deemed suitable for treatment with *nbroni be kudlr* while others are best treated with *basa lembril be kudrl.* Inguinal hernia, benign prostatic hypertrophy, and several anomalies that require surgical intervention are viewed as suitable for hospital treatment. At the same time, boils, fractures (especially simple fractures), and mental illnesses have to be treated by Gonja herbal medication as the treatment of choice. Conversely, when progress is slow with a particular treatment option even with fractures, the patient and his relatives may seek a second opinion. It is therefore very common to find a poorly repaired fracture by the hospital being re-fixed by the herbalists or another herbalist re-fixing a poorly mended fracture that was done by another herbalist.

The growing trend in East Gonja for people of all walks of life to seek traditional, alternative or complementary healing when faced with infertility is perhaps due to the psychological methods that are employed by the therapists in the treatment of their clients. They seem to create some semblance of peace and harmony with a holistic medicine using the synergy the mind, the spirits, and the body. There are more significant interactions between the spirits and the client, and the healer has all the time for both the client and the spirits as the clients ask more questions of the spirit through the healer. Perhaps this is easy because the healers and the clients come from the same cultural background, irrespective of the ethnic orientations of the clients as the customs in Ghana are very much alike. The understanding, worldview, and views of illness, disease, and what a problem entails with their clients'" is the same as the healers' (tr, 2013). There is therefore, a beautiful interface with the views of the illness, whiles exploring into the issues of his/her somatic,

social and mental well-being of his or her patient or client, bringing them to a beauty counselling session.

It is believed that when little was known about them, they were looked at as primitive, then they operated only in the rural communities (Adekson, 2016). They are now seen as offering more holistic health care than the western health care practitioners. The latter have little or no time to interact with the patients, get to know them better, offer counselling that will help in reconciling their thoughts and fears, their emotions as well their social life to the illness that has been reported.

CHAPTER SIX

LIVED EXPERIENCES

6.0 INTRODUCTION

In this chapter, the research focuses on a crucial yet often overlooked aspect of healthcare: the psychosocial support offered to men dealing with male infertility. It is essential to recognize the emotional and psychological impact that infertility can have on individuals, particularly men, and the importance of providing holistic care that addresses their mental well-being alongside physical treatment. Moreover, it will also explore the pluralistic methods of treatment available to men facing infertility challenges, examining the complexities and nuances involved in tailoring care to the individual needs of each patient. It delves into the intersection of psychosocial support and pluralistic treatment options for male infertility, uncovering new insights and strategies to enhance the quality of care in this vital area of men's health.

This chapter also explores the issue of how men who have challenges with infertility feel and act. The way they express their inner feelings outwardly in the form of their lived experiences. The purpose of this chapter is to give a voice to men who are directly experiencing infertility and what their lived experiences are. This is done through a discourse analysis, as this is the only way that we can appreciate what is in existence and real (Irving, 1999). It is only through discourse analysis that we can recognize what experience and insights that they feel, what can be observed about them and how far they can go with these experiences (Geertz, 1992).

Musah and his wife blamed each other for four years as to who was the cause of the infertility in their family. They never sought treatment because Musah's wife had a child earlier when she was a teenager. The fact that Musah is educated up the University level meant he had read a lot of literature on issues pertaining to infertility. The only intervention they employed, according to

Musah was to continue hoping that there will be a pregnancy. In the fourth year, when Musah was planning to take another woman to help solve the matter, he realized for the first time his wife had conceived and, after two months, had a miscarriage.

It was clear to them that there could be some infertility issues that are inexplicable and can be resolved on their own. However, Musah said his wife never picked seed for about a year after that incident. He subsequently married yet another woman, a 22-year-old graduate of the Senior High School. The second woman has been married for about 18 months now without a seed. Musah said rumours were abound that he was infertile. Fortunately for Musah, his first wife is about six months pregnant now. Musah said he was encouraged by a Muslim scholar that infertility that he and his wives were facing were temporal, and he will have children.

Even though the reasons for the infertility are not known, the lifestyle of Musah while in school with multiple partners and the fact that he has had several issues with the infection, including yeast infection, which were treated through self-medication is suggestive of the fact that he could be having challenges with childbirth due to infection which was not well treated. Damayathi (2018) suggests potential effects of lifestyle factors on male reproductive health. Evidence of a global decline in human sperm quality over recent decades has been accumulating. Environmental, occupational, and modifiable lifestyle factors may contribute to this decline. The findings focus on key lifestyle factors that are associated with male infertility such as smoking cigarettes, alcohol intake, use of illicit drugs, obesity, psychological stress, advanced paternal age, dietary practices, and coffee consumption. Other factors such as testicular heat stress, intense cycling training, lack of sleep and exposure to electromagnetic radiation from mobile phone use are briefly discussed (Damayathi, 2018).

Musah had a lot of help from his uncle, Bayaka who stayed in the neighbourhood. His uncle was a younger brother to his mother and he always called Musah into his parlour to encourage him. His uncle who was a big-time farmer was quite well resourced and helped out with the cost of some of the sacrifices.

'It is a proud 'game' among the youth in Gonja, both in the local community setting in Kpembi and in school to show manhood and strength by boasting about how many different women you have slept it. Tradition in Gonja 'rewards' boys and men who can show their prowers with lovemaking with the saying *abibisheng e kra ko ma ne n ya tu loge n to kiya n sala mo* means its only childishness that will make a young man see a rabbit and kick it with the foot instead of eating it. A young man is, therefore, at liberty to eat any rabbit that comes his way. The platforms or arenas where traditionally these men meet their lover's or *njipo* is at moonlit nights where games and dances are performed. There are, therefore, no customs or traditions that limit or regulate love making among the youth, except for married women. Lovemaking before marriage is acceptable, as some women get their first children through such kind of loos relationships. However, these days according to Musah, the young girls have some herbs that can abort the foetus within 3 days. Interestingly, even though sex among young adults is not prohibited, a woman who has multiple male sex mates is seen as a morally weak person.

From Musah's narrative, it is clear that infections resulting from sex or sexually transmitted infections are high for both men and Musah. The medical officer-in-charge of the Salaga Hospital confirmed that sexually transmitted infections for persons between 18 and 35 years are very high. The medical officer said most of them report to the hospital with such infections after they have failed to treat it by either taking medicine from hawkers or some herbs that do not treat them but may reduce the symptoms.

In my many visits to some selected students of the Salaga Senior High School and T.I Ahamadiya High school, most of the girls I spoke to have at least two boys each. These respondents were carefully chosen from the science class, who supposedly will have some knowledge of male and female sexual reproduction.

The girls were from East Gonja, but from communities that were far away from Salaga had a least two male sex partners at a time. These sex partners were located in different places. One in her village and another one in Salaga town with a few located in the school, that is teacher friends or student boy-friends or both. The girls, whose ages were averagely between 14 and 19 years, all had unprotected sex before. They assigned various reasons for their multiple partners as financial, duress, and fun. The financial reason was cited by all the girls as their parents could not afford to take care of all their needs, including school fees. The free Senior High School programme implemented by the government of Ghana in 2017 meant some students, those in years one and two, were not paying fees. However, they indicated to me that even though they were not fee-paying, they were day students who were not accommodated on campus and had to pay rent and feed themselves. The free school fees programme, therefore, was not a panacea to their financial challenges. The fact that some of these children were not under any parental control at the houses that they had rented for purposes of schooling, they had the leverage to engage in sexual activities mostly due to peer influence. All the girls had cell phones, and they had videos of pornographic material that they showed to me. These pornographic materials were sent to them by teachers of the school, and men living in Salaga township.

The rent was about 30 cedis a month exclusive of utility bills such as water and electricity and telephone. Water is quite scarce in Salaga township. It has been described as a town with a thousand wells by historians. The cost of water is therefore high since it is served in gallons by

tricycles. Each student buys an average of about fifty Ghana cedis (Sachet water for drinking and water in gallons for cooking, bathing, and washing). They spent more on telephone bills as they derive maximum satisfaction from downloading videos. On average, a student spent fifty Ghana cedis maintain their phones. On average, each paid about 400 hundred cedis on their upkeep. Most parents could not raise these amounts for their wards, and they had to find money elsewhere to fund these activities.

Most of the girls indicated that they left most of the clothing they bought in their rented apartments; their parents would question them to show how they got them if they sent them home.

The answer to the question of why they did not have protective sex, even though, as science students, they were aware of the ramifications such as sexually transmitted infections and pregnancy, they said sex with a condom was like eating a banana with the peals on. The actual feeling or sensation was lost. 'Some of the men will start sex with a condom but later take it off to have the natural feeling.'

It is therefore conclusive that, sex with multiple partners by the girls meant that they boys who even had just one female sex partner were at a high risk of getting infected with sexually transmitted diseases because their partners had a high rate of contracting these sexually transmitted diseases. Dr. Sherif (not his real name), medical officer-in-charge of Salaga Hospital, confirmed that most of the school girls who attended hospital in Salaga, including the young men in town, had contracted STIs more than two times in a year.

The Public Health Unit of the Ministry of Health in East Gonja and in conjunction with donors have organized several public lectures for the students of the senior high schools, but because it is an attitudinal problem, it has still remained a challenge as of now.

Dr. Sherif (Not his real name)was quick to conclude that incidence of infertility in the East Gonja district partly due to unprotected sexual activities

The story for the boys was not too different, as some of these girls had to get extra tuition and explanation from the boys who were their mates. The boys had sex in return for their services that they rendered to these girls. Some who were very poor had some money from the girls who have really fallen in love with these young guys. The girls got money from mature men in town and "sponsored' these poor boys who were their mates in school.

6.1 KUMAH'S STORY

Kumah Francis, (not his real name) is 48 years old and a native of Adidome in the Volta Region of Ghana who was born and bred in Salaga. He speaks Gonja fluently and says he is both Gonja and Ewe because of his attachment to Gonja traditions. He is popularly known as a teacher, because of his profession and runs a shop where he sells provisions including sachet water. He is considered as "petite bourgeoisie" in Salaga as his shop is full of activity, buying and selling all the times I visited him. He has no issue with his wife despite the fact that they have been married for well over 20 years now.

> Kumah says *"I am distraught that I have no child with my wife and the rumours in Salaga why I do not have children are just worrying. I hear people say I used my right to have children spiritually to get the money that is to do 'juju.' I went to Adidome last year for a funeral, and I happened also to attend a naming ceremony of a friend's child. In our culture in the Volta Region, a man who has no children is publicly ridiculed when alcohol is served. I was poured half a glass, while others were given a full glass of palm wine. The server said to me,' Kumah, you are of*

age, and you must grow up and show the world that what you have in between your legs make you a man and not half a man.' I went home earlier than I should and cried till an uncle entered my room to explain why that public ridicule. He said that it was a right way of publicly exorcising the spirits that were preventing me from having children as this was usual practice at public places for those who do not have children. My uncle said some people who were ridiculed were able to have children later.

Kumah came back to Salaga with a promise never to go for any public event back in Adidome again. He said men in both Gonja and Ewe traditions do not cry in the open for everybody to see. Men are trained to keep pain to themselves, and with the challenge of not having children, you try as much as possible to refuse that that is what is happening to the person, believing and expecting a miracle to happen just anytime soon.

He said he felt real pain when my first wife left me after five years of marriage because we could not have children. He said he had nightmares for well over a year because he loved her dearly. He remarried after about a year; however, he still does not have a child with her. His first wife Anita, has since given birth to 3 children. When he sees her and children walking around, he has a tingling feeling in his head, a feeling that something is moving in and around his brain. He feels a pain that makes him drowsy, a feeling that makes him sleep immediately. This short sleep is usually for a short period of about five minutes. He went to bed one evening after seeing her with a child behind her, and laid awake virtually the whole night. His wife woke up many times to find out why he could not sleep. He lied to her that all was well, and did not know why sleep was not coming. She woke up the third time and still realized that he was awake. She asked him to confide in her why he could not sleep. He was not only awake, about he was also sweating, especially around my fore

heard and the middle part of his head. He could also hear his heartbeats and said to himself' why is this happening to me?' He refused to tell his wife anything about the reasons why he could not sleep. He finally slept off around 4 am after lying in bed since 11pm. This sleeplessness happens to him a lot of the times, at least four to six times in a month. He takes some drinks and tablets to knock me off in the night to sleep. The alcohol that he used to take before sleeping is increasing gradually. He could manage two bottles of club beer before sleeping. This year, he has have moved to three bottles, and he sometimes take tramadol before sleeping.

He started taking tramadol when he complained to a druggist who peddles drugs around here that he was finding it difficult to sleep at night. He gave me some tramadol, and it worked very well in the first few months of taking it. Subsequently, he increased the intake to 20 milligrams from 10 milligrams every night. Now my problem is that it is becoming challenging to get the tramadol since the government and the Ministry of Health, Ghana, started a crackdown on the usage of the drug. His druggist says they he now gets his supplies outside Ghana and it is getting very expensive to buy. When he moves out with friends, he drinks till late in the day, and this makes him forget my worries. He has gained some weight since he started drinking.

Kumah's worry is that none of his brothers has this problem. He has three older brothers and a younger brother, and all of them he says are happily married with children. His elder most brother, Kojo, who happens to also live in Salaga, has advised him to try and get a woman out of wedlock pregnant for him. Kumah says that his sexual appetite since he started drinking, has waned.

It is very clear in Kumah's situation that the cost of treatment is an issue when it comes to managing male infertility and any other disease for that matter. The economics of disease treatment plays a significant role in its management. Chronic diseases have significant health and economic costs,

and management of these diseases are partly dictated by the ability of the patient or their relatives and friends to pay for one treatment or the other (Damayathi,2018)

6.2 SADAT'S STORY

Sadat says a neighbour wanted to ask of him from a common friend of theirs and asked him if *Ebgantopo* was in the house. *Ebgantopo* in Gonja translates as a tired buyer. When who are infertile are commonly referred to as such, however, they do that in their absence. *Ebgantopo* is one who has tried many times without success to have a child; hence he is tired of trying. Sadat felt sad the whole day and reminisced the challenges that his cousins had before getting children.

Sadat told me he and his male siblings could not make a woman pregnant once they marry the woman officially, however, they can make a woman pregnant and have children if they do not officially marry a woman.

Sadat, in his early thirties, has been married for about eight years now without an issue. He says he had made two of his girlfriends pregnant before but asked them to each abort because he was afraid, he would be described as a bad boy by his parents at the time. He was in high school then and aged between 15 and 18.

Sadat said he hears comments like *Shaka be nasekug matue kalanto*. It means Shaka's (male name) club (hoe stick) cannot fall into a hole of a tree. Nobody will mention the same of the person who has infertility for fear of being accused of being rude hence the popular use of Shaka. When Shaka throws or aims at a target, he misses it. A man who has no child is said to be missing the target of getting children. He said even his friends' use the phrase as if they were discussing someone else other than him and that it can be very offensive.

Sadat says that the financial burden of treatment can be very heavy and leads to stress and depression. He consults both the orthodox medical practitioners and the traditional medicine practitioners. He explained that because he is a nurse and has quite a good knowledge of human anatomy, he feels some attachment to orthodox medicine. His doctors have run several tests on him and his wife separately and declared both of them medically fit. Sadat says has equally sort treatment with traditional healers' time he travels to see his mallam in Damongo, he rents a hotel room for an average of 100 Ghana cedis a night and he usually spends three days

It is clear that in Sadat's case he has a challenge in financing his treatment and this is an issue with most of the respondents that I interviewed especially coming from a district that is said to be the poorest in the country. As a result of the financial constraints and the burning desire to have treatment, Sadat seeks a solution in a prayer camp despite his Moslem faith. He visited a Christian prayer camp in the company of his Christian friends to seek support.

Kasha, is 46 years old and has one child who is 16 years old. He is a farmer and has never been to school. He lives in Kpembi in the family house and has many of his external family living with him. He has married another woman in an effort to get another child. The second wife has had a child in her first marriage before. Kasha says that he and the second have demonstrated that they are not infertile for having a child each in their previous marriages. Kasha is a chain smoker, and he has been diagnosed with having type II diabetes. He describes himself as a moderate drinker of alcohol. He has been to a number of traditional healers to find out who the cause secondary infertility could be. The herbalists have assured him that he will have children in future. He, however, disclosed to me that he has started suffering from erectile dysfunction, but he will not see a medical officer because they will not be able to help him solve his problem. The second

reason he assigned for not seeing a doctor is that the procedures to follow when one is seeing a doctor are too many.

Kasha demonstrated to me how he castrates his animals on the farm. He buys two big sized cubes of a seasoning used for cooking and dissolves it for the male animals to take three times in a week. The male animal, according to Kasha begins to lose its potency within two weeks. This technique of castrating male animals is common knowledge in East Gonja, and it seems to be a popular way of castrating the animals. I was asked to observe two different experiments of this seasoning. I subsequently spoke to one of the Veterinary officers in Salaga who confirmed that he was aware of that technique of castrating animals. He, however, indicated that he did not know the chemical in the seasoning that was able to castrate the animals.

Kasha and many men I interviewed were very suspicious their wives who had rivals or were co-wives could be using this seasoning intending to make them infertile such that they would not have children with their co-wives. This suspicion has led to Kasha's refusal to eat from home. He says in Gonja there is a saying that *fomuwu ebonpo, fo ashe mu?*This means 'if you do not see the mad man, would say that you want to shave him? If his wife does not see him, can she put anything in the food? His refusal to eat the first wife's food is making the relationship between them to deteriorate. The first wife, Aisha, who leaves in the same house with him and her co-wife is very angry and jealous about the turn of events. Aisha has laid a complaint to Uncle Kelly, Kasha's uncle. Uncle Kelly, Kasha's mother's younger brother, lives in the same neighbourhood as Kasha. The complaint was in two parts, one part being that she had been accused of witchcraft and secondly her food was not being eaten by her husband. *Edenmaka gba na* meaning I have been labelled a witch and that is usually a good and acceptable grounds for divorce. Uncle Kelly found a solution to the impasse by first divining to find out the authenticity of the accusation. People

usually will seek the truth or otherwise of an accusation of this magnitude from a diviner. The result of the divination revealed that Aisha was not a witch and therefore could not be held responsible.

Kasha has asked two of his sister's children to come and live with them while hoping that they would bring in some luck.

The story of Adamu and his wife Vida is unique (not their real names). They are Bimoba whose parents were born and bred in Salaga. Adamu and his wife are therefore Bimoba from Bunkurugu in the newly created region of North West. It used to be part of the Northern Region of Ghana until the creation in January 2018. They regard themselves as Gonja and speak Gonja fluently. They are however attached to Bimoba as they still practice a lot of the traditions and visit Bunkurugu, their hometown. Adamu's wife. At the eve of the traditional rites of marriage in Bunkurugu, a room is usually made available to the bride to be, and many young men visit her in the compound.

The young men are at liberty to play with her, and if anyone of them is appealing to her sexually, the young man is at liberty to make love to her. The men come around, and it is the right of the bride to be to choose a man out of the many men to make love to her. This man must be sexually appealing to her. These rites are performed to mark the end of the woman's sexual freedom and to restrict such rights subsequently to her husband. Vida says these rites are also performed to ensure that in the likely event that her husband to be is infertile, she could pick a seed that evening before the marriage. She can decide to even sleep with a couple of men that even ad she is not necessarily restricted to one man. The choice of a date for this right is usually chosen at a time the woman is ovulating. The firstborn of women of Bimoba origin may not be the biological children of their husbands, on the other hand, no man can lay claim to such a child aside from the husband,

Genetical rights, therefore, accrue to him alone; hence there is no argument as to who owns the child.

Similarly, among the Sisalas, there is no illegitimate child in marriage. Even when a woman is married and gets pregnant by a man outside wedlock, the child belongs to the husband of the woman. The man who made another man's woman pregnant may be subpoenaed to the chief's palace and slapped with a fine of ram if found guilty. He is, however, given due notice to the effect that he does not have any rights as far as the child is concerned. Indeed, this is allowed according to Chief Chako to help curb the incidence of male infertility among the Sissala. Chief Chako says once the man is infertile and that is found out by the wife, she may continue to get children for the man. Chief Chako says, *kasawulei ba belto, me esa ana kanne kitri a di kedibi*, which means when the ground is too hot, nobody advises the lizard to climb a tree. This case is not too different in the detailed description that is offered of the Nuer of Africa by Evans-Prichard (1951) where he discusses several types of marriages that can be contracted by the Nuer in the form of transfer of cattle from the groom to be and his kinfolks to that of the bride to be and her family. Once these transfers are made, they give proprietary rights in the wife and the children she may bear after that to the man, notwithstanding of who real genitor may be.

Similarly, a man may pay cattle to obtain proprietary rights for a child his concubine has delivered. However, these proprietary rights, in this case, are limited the child that has been delivered only. They do not know the extent to other children the woman may have subsequently. The proprietary rights in the concubinage scenario, shall not extend to her nor or other children born thereof even if he fathered them.

The man may have full proprietary rights if he pays the full dowry to the family of the woman. This helps in the distinguishing of uxorial rights, that is, rights in a woman as a wife and genetical rights, that is, rights in a woman as the bearer of children and her children (Evans-Prichard,1951). In Gonja, Sissala and Bimoba, uxorial and genetical rights accrue once a marriage is consummated; hence the real genitor of the child is inconsequential. Perhaps, this idea of genetical rights may have been practiced in Africa in a bid to lessen the effects of male infertility and also as a managing technique for men who may be unfortunate to be suffering from issues relating to male infertility.

In the case of Vida, a young man who happens to be her husband's cousin made love to her, and she became pregnant. However, genetical rights accrue to her husband and the child born to them belongs to Adamu. The genetical rights accrue because a thief has no child he said: *eyu mukor kebia*. Three years on and Vida is still not getting pregnant even though they have been trying to have a baby. Vida says her husband has had many tests run on him in Tamale and Accra but it is difficult to get a child as the husband has been diagnosed of having a low sperm count. Vida has indicated to me that her husband's attitude does not show that he wants to be treated. He was warned by doctors in Tamale not to smoke cigarettes anymore and cut down on his alcohol intake.

However, the intake of alcohol and cigarettes rather seem to have increased. In conversations with the man, Adamu, he indicated to me that he drinks and smokes to reduce the high level of stress that he is going through. The high levels of stress have also led to overeating which seems to have worsened his obese nature. The forty-five-year-old Adamu says he has developed type two diabetes. His wife confides in me that he is not sexually active in bed as he hardly gets a good erection. Vida said, "he has just a decoration in front of him representing manhood, but in the actual sense of it, he is not". Rumours in town have it that Adamu's cousin, Yelpab who is staying with him and his wife are dating and this seems to be a natural sequence for a person in need.

kasawulei ba belto, me esa ana kanne kitri a di kedibi, when the ground is hot, no one advises the lizard to climb a tree is the situation in which Vida finds herself.

Yelpab is 22 years old and a trained teacher. He is, however, awaiting postings to start work. He, therefore, has time to help in the trading activities of Vida's business. Many people have indicated seeing Vida and his cousin Yelpab in a compromising position. They have travelled together for trading purposes many times to buy items that Vida sells. She deals in cosmetics and female clothing, which she buys from across the Ghana Togo border.

The story of Adamu and his wife, which was first gathered through gossips in and around town, was subsequently fleshed by Chief Chakon and Adamu when I was able to establish a working relationship with Adamu. Chief Chako says that the Sissala and Bimoba have a playing relationship or joking relationship with Gonja; hence a Gonja can play with a Sissala man or Bimoba man by saying 'I know you Bimoba or Sissala have no manhood, what you have infront of you is for decoration purposes; hence I will come and make your wife a woman. Chief Chako indicated that the Sissala and Bimoba have virtually 'licensed' their wives to make babies when their husbands are incapable of making children with them. The Gonja have not formalized this behaviour into their traditions and culture; however, it subtly goes on, according to Chief Chakon. He also indicates that just like the Sissala and Bomoba, in Gonja, a bastard may not exist as children in a marriage are legitimately owned by their parents, especially the man of the household. This assertion of Chief Chakon confirms the fact that in Gonja, an infertile man, *ebantopo,* may have his wife making children for him either with his subtle endorsement quietly or without his notice. For those who have a good erection and produce some semen, they may never know that their wife is making children for them with someone else. They only begin to suspect when they marry another woman, and she does not bring forth children. There is usually some peace in such

a marriage if the woman can be sexually satisfied and the husband is financially sound to take care of her needs and that of the children.

The case of Issahaku is very close to that of Adamu above; however, Issahaku is Gonja from Salaga, and he is married to Baasu. They are both not literate, and farming is their main occupation. The couple has four children, the oldest being 16 years. When this research started in 2016, gossips were going around town that Issahaku's children may not be his biological children as the woman was seeing someone else in a village called Nakpaye. While all these gossips were going on, Baasu had one more child to make her children four. The rumours got to her husband Issahaku and in his conversations with me indicated that he knows he is a man enough. He bragged about how he had many concubines while he was growing up. He pointed to a couple of women who are currently married in Salaga as his former concubines and challenged me to find out about his prowess as a man. In later conversations with these women, they confirmed dating him before, and they liked him so much. One of the women, Adisa told me that she desperately needed a husband; hence she deliberately wanted to get pregnant with Issahaku when they dated. She unsuccessfully tried for two years, but there was no pregnancy. Adiza said she had her doubts about the fertility of Issahaku, especially following the rumours that some other women had complained.

From Adisa's account, once the complaints were many and spreading in a small community like Salaga, it became an open secret that Issahaku's prowess as a man was questionable. Matters were made worse when Issahaku decided to marry yet another woman to add to Baasu. He has been living with the second wife, Atu, for the past three years without an issue. Issahaku says once he has children with Bassu, hence he could not be the cause of the infertility in the marriage between him and Atu.

In Salaga, wife infidelity is not an organized cultural or traditional phenomenon, but either due to the ingenuity of such women who are into it or they may have 'condoned and connived' with their husbands. Despite the rural setting in which Salaga and for that matter, East Gonja is located, the fear of being found out because of the closeness of people living in a rural community is overlooked with impunity.

Additionally, one would have expected that women who are not exposed and not literate would have been living and respecting the ideals of the society. The issue of how this rural folk could be 'innovative' worth finding out. Chief Chako says that the effect of *Kayayee* could be the answer. He indicated that some women in the rural areas had gone to Kumasi and Accra to serve as *Kayayee* that is head porters, where they made some money all to buy a few personal effects for the fantasied marriages they see in Nigeria films.

6.3 PSYCHO-SOCIAL SUPPORT

Infertility is a significant issue that affects couples worldwide, including East Gonja. While infertility is often framed as a female problem, men also experience emotional distress and social stigma. In this part, the thesis explores the psycho-social support offered by family and community for men with infertility problems in East Gonja. It highlights the positive impact of familial and communal support systems, and discuss the challenges that men face in seeking help and overcoming societal expectations.

In Gonja culture, families play a pivotal role in providing much-needed psycho-social support to individuals facing various challenges, including infertility (Braimah,1969). Men with infertility problems often experience anxiety, depression, and a sense of inadequacy. By offering empathy, understanding, and emotional support, family members help men cope with these emotional

burdens. Respondent 16, Musa indicates that his cousin who has a challenge in having children for 15 years now is always getting psycho social support from the larger family or extended family in various ways. He said “many our of relatives visit him and offer their children to come and stay with him He has so far refused to take anyone of the children offered him to be fostered though’. The other support offered can be said to include visited and many Family support acts as a buffer against the psychological distress associated with infertility, fostering a sense of belonging and reducing feelings of isolation (Adekson, 2016). Some family members will travel with the persons seeking the medicine and sleep with them until they have received treatment. The family members, especially the women will help in the preparation of the helps by grating, ponding and making soups and boiling some for the sake of bathing them. This support is not peculiar to East Gonja as evidence abounds in other parts of Africa when it comes to support from kins men. Anokye et al, (2017) cite reliance on family members for emotional support as well as avoidance of sensitive conversations was the main coping strategies adopted by the couples to cope with their conditions. Infertility has psychological, emotional and social consequences on individuals as well as couples. Families supported and encouraged infertile individuals in every way that they can so that they will not be isolated.

Furthermore, in Ghana, family bonds are strong and extended families live in close proximity, encouraging inter-generational acceptance and support. This support system allows men to openly discuss their infertility issues with their parents, siblings, and other close relatives. This openness generates an environment that facilitates seeking medical interventions, reduces shame, and encourages the use of available resources for treatment.

Beyond the familial framework, Gonja also benefit from a strong sense of community support (Goody 1975). In rural areas, community members often constitute an integral part of an

individual's social fabric. This interconnection fosters communal sharing of experiences, advice, and resources related to infertility. Support groups formed within communities create a safe space for men to express their emotions, share coping strategies, and receive guidance from others who have undergone or are undergoing similar experiences. These support networks also facilitate access to relevant information about fertility treatments available in their locality.

Despite the overall positive outlook on psycho-social support, Gonja men with infertility problems face certain challenges. Stigma surrounding male infertility remains prevalent within Ghanaian society, leading to shame and silence among affected individuals. This often stems from deeply-rooted cultural beliefs that equate masculinity with fertility. The fear of being stigmatized discourages men from seeking emotional support and discussing their concerns openly.

Moreover, limited awareness and understanding of male infertility disrupt the provision of comprehensive support. Traditional beliefs and misconceptions may prevail, causing people to attribute infertility solely to women. This ignorance perpetuates the stigma surrounding male infertility and further isolates affected men from communal and familial support systems.

In conclusion, psycho-social support provided by family and community plays a crucial role in helping men with infertility problems in Ghana navigate the emotional, social, and cultural challenges they face. The openness and support offered within families foster an environment where infertility issues can be openly discussed, reducing stigma and enabling access to appropriate treatments. Similarly, community support networks offer valuable spaces for shared experiences and knowledge. However, it is important for Ghanaian society to challenge existing misconceptions and cultural beliefs, promoting understanding and empathy regarding male

infertility. By doing so, it can create healthier and more inclusive support systems that empower men to seek the help they need.

The healthcare system and health-seeking behavior in Gonja are shaped by a variety of cultural and socio-economic factors. Understanding these variables is essential to improving healthcare delivery and accessibility in the country.

6.4 CULTURAL BELIEFS

Cultural beliefs strongly influence health-seeking behaviours in Gonja. Traditional beliefs, such as attributing illnesses to spiritual causes, may lead individuals to seek help from traditional healers or spiritual leaders before accessing formal healthcare services. The perception of supernatural causes of illness often delays or hinders individuals from seeking timely medical treatment (Braimah, 1975, Beynon, J. (2002). Most of the respondents (15) of them unanimously said that ‘every true Gonja person knows that most sicknesses that we suffer are not of a natural cause” They added that children born in East Gonja are bathed with protective herbs because parents want to ensure that sicknesses that are not of a natural cause are prevented as much as possible. A key respondent, Bawa told me that royals are always targeted with attacks because the fewer people who qualify to be chiefs the better. Hence once one is born a royal, the person needs a lot of protection. He added that male infertility and erectile dysfunction can be can be acquired spiritually and used to attach persons who are potential chiefs. A number of ten(10) also added that one of the major reason why people in East Gonja go to see diviners before picking the place of treatment is as a result of the cultural beliefs they hold relative to causation of diseases and illnesses.

6.5 CONCLUSION

An examination of the treatment options available to the respondents shows that infertility as an ailment is managed in various forms, including traditional treatment options, biomedical, and spiritual treatment options. Which option that is to be adopted for the treatment depends on a large extent on the individual and his friends or kin. What the beliefs of these people are concerning religious, cultural and social are important in the choice of a treatment option.

The all-encompassing yearning for children of their own is never in doubt. Any management technique that does not include an infertile person getting his own child is not a good enough management technique.

The excellent combination of the various options of herbal treatment combined with biomedicine as well as spiritual is indispensable collaborations that complement each other because the ultimate goal for each one of them is to help an infertile man to get a child of his own. The attention paid to biomedical is, however, not too good for several reasons. The first reason is that western medicine, especially the assisted reproductive technologies, is absent in East Gonja and its immediate environs. Additionally, the cost on the average is beyond the people, and finally, the believed cause of the infertility is believed to include spiritual problems. This view is supported by the findings of Kothari (2012) where the respondents in Rural Nigeria found treatment using western techniques very expensive especially when their income levels are very low.

The experiences of Mantenso, a forty-nine-year-old man who has been married for over twenty years, were recounted to me at prayer camp, Solution in Kito. Mantenso is a Christian but a member of the catholic church, and he says he met with his reverend father over the issue and wanted spiritual help from the reverend father. He visited the reverend father for about ten times,

and he was asked rather to see a medical officer. The reverend father was prepared to pay his fare to Tamale, the regional capital to see a doctor. He did that a couple of times but was not able to offer him any spiritual help that Mantenso really needed. A friend of his, therefore, directed him to Solution prayer camp after someone there gave a testimony of how he was healed of infertility by God during a prayer session.

Mantenso decided to try his luck with the prayer camp. The head pastor, Rev. Issac Kumadei,

decided to first listen to Mantenso in his living room after a prayer committing the whole problem to God. He was directed to sow a seed. This means paying an appropriate amount of money for prayers towards a resolution of a particular need. On a Saturday after he met with the head pastor, there was a prayer meeting which was held in a thicket. About forty people attended, mostly women with a few men. There were many prayers said by the pastor and his wife and some other senior members of the church. The head pastor anointed his head with oil and chrism and prayed for all for about an hour. After the powerful prayer session, the pastor prophesied to Mantenso and told him that he loved him, and he will have a child.

Mantenso has been going to the prayer camp for about six months now. He has however been using some herbs from a herbalist from Kumdi, about 30 minutes' drive from Salaga. Mantenso has informed the pastor that he is using some herbs as well. The pastor says he has the blessings of his and Mantenso is at liberty to combine.

The results from the prayers are yet to bear fruits; however, Matenso says he has dreams that have been interpreted by the pastor to indicate that his predicament will be over soon.

In an article on spirituality in the Ghanaian Times; however, Dr Hiadzi has indicated that seeking treatment from prayer camps is a waste of time. Dr Hiadzi is the president of the Fertility Society of Ghana (FERSOG) says that persons with infertility challenges do not seek early attention for their medical problems and seeking "medical care for infertility early to avoid severe complications which could completely obstruct childbirth". Dr Hiade is a medical specialist in issues of infertility, and he believes that 'infertility was not a spiritual problem but a medical condition which could be treated when couples consult experts on time'.

The position of the president of the fertility society is interesting because at least two people have testified that they have successfully been put to bed after they were prayed for by the pastor. The fact that the people of East Gonja are notoriously religious and spiritual perhaps predisposes them to have faith in spiritual healing; hence they adopt a positive thinking approach which ultimately helps in the healing process.

The pastor, Reverend Isaac, indicated to me that it would be a fantastic job of healing persons with infertility and other ailments if they could have a collaboration with the medical doctors and biomedical staff. Healing has two components, the mental or psychological component and the physical component. They come together to heal a person according to the pastor. He said they the reverends can provide the spiritual aspect of healing while the bio-medics provide the technical support that would be needed in the treatment of all diseases in their camps. He further indicated that collaboration would have seen the provision of infrastructure, which is a major shortfall in their camps.

There would be a challenge if technical support were provided in the prayer camps, perhaps, it would be better if the pastors were allowed some time in the hospitals to offer spiritual support and healing for ii patients.

One of the ways of healing in the prayer camp for Matenso, a staunch moslem and his colleagues was what the pastor describes as *awanchire.* This is a Twi word that means directions that may come from the Holy Spirit through the pastor. One major *awanchire* is fasting. This means abstinence from food and water from morning till sunset. During the fasting period, the patients may fast for three days or a week, and intense prayers are said at this time,

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> We pastors know and believe the same to be true that God gives man knowledge to treat and practice medicine, either the western biomedical or the traditional folk herbal treatment. We also use the grace of God and his power to heal. The bible says 'My son, pay attention to what I say; turn your ear to my words. Do not let them out of your sight, keep them within your

> heart, for they are life to those who find them and health to one's whole body (Isaiah 53:5). We therefore, do not have a challenge working with other persons who provide treatment.
>
> When we do things together, we are expressing how God created himself in many forms. There are spiritual and physical sides to everything that lives on earth. Let us, therefore, give unto Ceaser what is Ceaser and onto God what is Gods. Let the pastors heal the spiritual side and the doctors the physical.
>
> —Pastor Isaac

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Dr. Sherif of the Salaga Hospital says that fasting may be good for a person; however, it may not be advisable for a person who is not well. Abstinence from food and water could make a patient's condition worse as this may lead to poor health outcomes

CHAPTER SEVEN

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

7.0 INTRODUCTION

This chapter delves into a detailed overview of the findings and insights gained from the ethnographic study on the management of male infertility in East Gonja. The research aimed to provide a comprehensive understanding of the cultural, social, and medical factors influencing the management of male infertility within the specific context of East Gonja. The thesis was guided by five specific objectives: to investigate local definitions and perceptions of infertility in East Gonja; to examine the indigenous belief system and its connection to health-seeking behaviour; to analyse the pluralistic methods of treatment and their associated intricacies; to identify the psychosocial supports provided by family and community across different stages; and to explore the cultural and socio-economic variables, including religion and socio-economic status, that influence the local healthcare system and health-seeking behaviour of the Gonja people. within the formal health system.Through a combination of participant observation, interviews, and document analysis, the research sought to uncover both challenges and opportunities in addressing male infertility in this region.

7.1 KEY FINDINGS

Infertility can be a challenging issue for many couples, and in some cultures, the pressure to bear children can be particularly intense. In East Gonja, the indigenous population has developed unique coping strategies for male infertility that are deeply rooted in their culture and traditions. These strategies provide important insights into how different societies approach and address this complex issue.

The findings show that the people of East Gonja have unique beliefs and perceptions that surround male infertility. They have multiple meanings for male infertility and they include the inability for a man to make his wife pregnant when they are co habituating and secondly when a man has no male child (Van Balen, 2012).

The research found out that the issue of male infertility is a topic that is seen as a taboo and not openly discussed because men feel embarrassed to be said to be suffering from infertility (Wischmann & Thorn, 2013). Women are therefore the easy target when children are not born to a family. Because of its embarrassing nature, men do the discussions on how to manage it secretly unlike diseases like common cold, malaria that can be openly complained about.

Another finding of the research is that the concept of main infertility in East Gonja is closely linked to spirituality and mystical beliefs, suggesting that the likely cause of it is spiritual (Romeiro et. al., 2017). This perception is underscored by the type of prognosis used in the identification and treatment options that are open to the patient. Additionally, the belief system of the Gonja is that unexplained diseases are a due to reasons other than natural causes. The concept of people being cursed or bewitched is a reason why they may suffer a disease such as infertility (Tabong & Adongo, 2013).

On the issue of the belief system and its interconnectedness with the health seeking behaviour of the Gonja in the East Gonja district, the research found out that Gonja believe in their traditions even though they may profess Islam or Christianity (Salifu,2012). This strong belief in tradition shapes their behaviours, attitudes as well as the choices that they make when they are sick. The choice of where to seek medical attention is often suggested and closely associated to the perceived source of the disease. Most of them respondents (8 out of 10) indicated that once they soothsay

and get to know where they should seek medical attention, they will seek medical attention there till they hit glitch. Other areas that men with infertility may seek for treatment may also depend on vicarious experiences that friends and loved ones share.

Additionally, the belief that male infertility is caused by spiritual or mystical forces influences health seeking behaviour, as many men turn to traditional healers or spiritual leaders for treatment rather than modern healthcare providers. The concept of "bad luck" or "curse" is often associated with male infertility, leading some men to seek help from spiritual leaders who can lift the curse and restore fertility.

Some other key findings that this research found are those that relate to psychological support offered by family and the community. Family members, particularly women, play a crucial role in providing emotional support to men experiencing male infertility. Cousins are very close friends and they are people that can be trusted with secrets including health challenging issues. The community also offers psychosocial support through social networks and communal gathering (Goody, 1975). Traditional healers and spiritual leaders may offer counselling and guidance to help men cope with the emotional and psychological challenges associated with male infertility.

Poverty and lack of access to modern healthcare facilities are significant factors influencing health seeking behaviour in Gonja, leading many men to seek traditional or informal remedies (Tabong & Adongo, 2013). The cultural significance of masculinity and the pressure to conform to societal expectations can also influence health seeking behaviour, with some men feeling embarrassed or ashamed to discuss their fertility issues. The high value placed on children and family planning in Gonja culture can lead men to prioritize finding solutions to male infertility over seeking formal medical care. These findings highlight the complex interplay between cultural beliefs, social

norms, and economic factors influencing health seeking behaviour related to male infertility in Gonja.

Finally, the key findings also include coping strategies that men adopted in the management of their infertility. The coping strategies adopted include men often seeking guidance and treatment from traditional healers and spiritual leaders when facing infertility. These individuals may employ a variety of traditional remedies that incorporate local plants, herbs, or spices. These men believe that these herbal concoctions can enhance fertility, improve sperm quality, and even alleviate stress associated with their condition.

Additionally, men frequently turned to prayer and meditation as coping mechanisms for the emotional distress associated with infertility. Spiritual practices serve as important avenues for managing their feelings and seeking solace during challenging times. Some visited shrines or sacred sites dedicated to fertility deities as part of their efforts to conceive. These visits typically involved prayers, rituals, or offerings, aimed at invoking divine intervention in their journey toward parenthood.

7.2 CONCLUSIONS

This thesis has sought to shed light on the multifaceted understanding and experiences of male infertility and how they manage these experiences within East Gonja. The findings reveal a complex tapestry woven from cultural beliefs, socio-economic realities, and familial dynamics.

Firstly, the research discovered that male infertility in East Gonja is not merely a biological condition, but rather a deeply personal and societal issue laden with stigma and shame. This perception is intricately linked to the local belief system, which often attributes infertility to spiritual causes like witchcraft, curses, or ancestral imbalances. This understanding profoundly

shapes health-seeking behaviours, pushing individuals towards traditional healers and spiritual interventions before considering modern medical practices.

Secondly, our exploration of pluralistic treatment methods unveiled a rich and intricate system practiced within East Gonja. These treatments, encompassing herbal remedies, divination rituals, and spiritual cleansing ceremonies, are deeply embedded in the community's cultural fabric. While often effective for addressing perceived spiritual causes of infertility, these practices lack scientific validation and may delay or hinder access to evidence-based medical solutions.

Thirdly, this thesis highlights the crucial role of family and community in providing psychosocial support throughout the infertility journey. Families offer unwavering emotional support, sharing burdens and navigating societal pressures together. Community networks provide a sense of belonging and shared experience, reducing feelings of isolation and fostering resilience.

Finally, we identified significant socio-economic variables influencing health-seeking behaviours in East Gonja. Poverty, limited access to healthcare facilities, and prevailing cultural norms regarding masculinity all contribute to the preference for traditional treatments over modern medicine. Furthermore, religious beliefs can either complement or contradict medical advice, further complicating decision-making processes

This research underscores the need for culturally sensitive approaches to addressing infertility in East Gonja. Bridging the gap between traditional practices and modern medicine through community engagement, education, and accessible healthcare services is crucial to empowering individuals and families facing this complex challenge. Further research should delve deeper into the specific efficacy of traditional treatments and explore ways to integrate them with evidence-based medical interventions for a more holistic approach to infertility care.

7.3 POLICY IMPLICATIONS AND STUDY RECOMMENDATIONS

It is recommended that there is an integration of traditional and biomedical approaches to infertility management. It is imperative that government recognises the importance of traditional health beliefs and practices in Ghanaian communities, and work to incorporate them into formal healthcare systems. This can involve training traditional healers on evidence-based infertility treatments and establishing referral mechanisms between traditional and biomedical providers.

Additionally, there must be an increase in access to infertility services. Government must establish dedicated infertility clinics or services within the existing healthcare infrastructure in the Northern Ghana for a start. This can improve availability and affordability of treatments for both male and female infertility.

Furthermore, the state should render targeted health education campaigns especially in the rural areas where access to medical care is difficult. The Ghana Health Service must develop and disseminate culturally-appropriate educational materials to address misconceptions about the causes and management of infertility, particularly targeting men. This can help reduce stigma and encourage early care-seeking behaviour.

It is further recommended that the Ghana Health Service trains health care providers on male infertility. Equip physicians, nurses, and community health workers with the knowledge and skills to diagnose, counsel, and manage male infertility cases. This can improve the quality of care and support available to affected individuals and couples.

The promotion of couple-centered care at health facilities will help reduce the stress associated with the management of the management of male infertility. The Ghana Health Service should encourage joint consultation and treatment-seeking for infertility, rather than focusing solely on

the woman. This can help address the cultural norms that often place the burden of infertility on females.

The Ghana Health Service should strengthen data collection and surveillance They need to establish robust systems to monitor the prevalence, causes, and outcomes of male infertility in the region. This can inform evidence-based policymaking and resource allocation for infertility management.

Addressing the socioeconomic barriers to care in the form of a health insurance will go a long way to help in the management of male infertility. The GHS must implement financial assistance schemes or insurance coverage to make infertility services more affordable and accessible, especially for marginalized populations.

There is the need for state actors to engage community leaders and influencers in the bid to managing male infertility. They must collaborate with traditional authorities, religious leaders, and other respected figures to destigmatize infertility and promote help-seeking behaviour among men.

There is the need to conduct further research on male infertility. The support for interdisciplinary studies to better understand the cultural, social, and economic factors influencing male infertility in the selected districts. This can guide the development of tailored interventions.

It is finally recommended that there is a national-level infertility policy. Policymakers must develop comprehensive national strategies and guidelines for the prevention, diagnosis, and management of infertility, including the specific needs of men.

7.4 RECOMMENDATIONS FOR FUTURE RESEARCH

Based on the research findings presented, here are the key recommendations for further studies on managing male infertility in East Gonja, Ghana:

Investigate how perceptions and beliefs around male infertility are transmitted and evolve across different generations within the Gonja community. This could provide insights into cultural change and inform more targeted interventions.

Analyse the gendered dimensions of infertility within the Gonja society, including the social and psychological impacts on men, as well as the role of women in supporting or stigmatizing their male partners.

Assess the capacity of the local healthcare system to address the needs of Gonja men dealing with infertility, including the integration of traditional, faith-based, and biomedical services. Identify opportunities to improve access, quality, and cultural sensitivity of care.

Compare the management of male infertility in East Gonja with other regions or ethnic groups in Ghana to identify similarities, differences, and potential best practices that could be shared.

Based on the research findings, design and pilot test culturally-sensitive interventions to improve the physical, mental, and social well-being of Gonja men affected by infertility, in collaboration with the community.

By addressing these areas for further research, scholars can contribute to a more comprehensive understanding of the complex, multifaceted issue of male infertility within the Gonja community of East Gonja, Ghana. This knowledge can inform the development of holistic, culturally-

appropriate strategies to support men and their families in managing this significant health and social challenge.

BIBLIOGRAPHY

Abarikwu, E. (2013). “Evidence for decreasing quality of semen during past 20 years.” BMJ, 325(6221), 609–613.

Abarikwu, S. O. (2013). “Causes and risk factors for male-factor infertility in Nigeria”. African Journal of Reproductive Health, 17(4), 150–166.

Adekson, M. O. (2016a). “Similarities and differences between Yoruba traditional healers (YTH) and Native American and Canadian healers (NACH)”. Journal of Religion and Health, 55, 1717–1728. https://doi.org/10.1007/s10943-016-0305-9

Adekson, M. O. (2016b). “Traditional healing and mental health counselling”. JSM Health Education & Primary Health Care, 1(2), 1011.

Ademola, M. M. (1982). “Cultural considerations in male infertility management”. Andrology, 5(6), 995–1004.

Adofo, M., Okyere, J., & Oduro, P. (2022). “Religious interpretations and responses to infertility among Christian couples in Ghana”. Journal of Religion and Health, 61(3), 2145–2162. https://doi.org/10.1007/s10943-022-01549-x

Adongo, P. B., Akweongo, P., & Binka, F. (1998). “Female genital mutilation: Socio-cultural factors that influence the practice in Kassena-Nankana, Ghana.” African Journal of Reproductive Health, 2(2), 25–36.

Adongo, P. B., Phillips, J. F., & Binka, F. N. (1998). “The influence of traditional religion on fertility regulation among the Kassena-Nankana of northern Ghana.” Studies in Family Planning, 29(1), 23–40.

Adongo, P. B., Phillips, J. F., Kajihara, B., Fayorsey, C., & Debpuur, C. (1997). "Cultural factors constraining the introduction of family planning among the Kassena-Nankana of northern Ghana". Social Science & Medicine, 45(12), 1789–1804.

Agarwal, A., Mulgund, A., Hamada, A., & Chyatte, M. R. (2015). " A unique view on male infertility around the globe". Reproductive Biology and Endocrinology, 13(1), 37. https://doi.org/10.1186/s12958-015-0032-1

Akinloye, O., Arowojulu, A. O., Shittu, M., Jayne, M., Sibley, L., & Bowser, D. (2006). "An analysis of Nigeria's traditional birth attendant (TBA) policy/programme in the context of increasing skilled birth attendance: What works, what doesn't and why?" Health Research Policy and Systems, 12(Suppl 8), 70.

Amoateng, A. Y., Kalule-Sabiti, I., & Oladipo, S. E. (2015). "Psycho-social experiences and coping among caregivers of people living with HIV/AIDS in the North-West province of South Africa". South African Journal of Psychology, 45(1), 130–139.

Ampofo, A. A., Mensah, K. A., & Gyasi, R. M. (2025). "Societal reactions to male infertility among the Ga's in Ghana". PLOS ONE, 20(8). https://doi.org/10.1371/journal.pone.0330529

Andreoni, N. E. (1989). "Effects of prenatal exposure to estrogenic substances". Hormone Research in Pediatrics, 49(Suppl. 1), 25–310.

Aniteye, P., & Mayhew, S. H. (2021). Beyond the biomedical: Social and cultural dimensions of infertility in Ghana". Social Science & Medicine, 285, 114295. https://doi.org/10.1016/j.socscimed.2021.114295

Aniteye, P., O'Brien, B., & Mayhew, S. H. (2021). "Dimensions of women's empowerment and their relationship with maternal healthcare utilization in Ghana". Health Care for Women International, 42(1), 34–52. https://doi.org/10.1080/07399332.2020.1781121

Archibong, E., Enang, E., & Bassey, G. (2017). "Witchcraft beliefs in diseases causation and health – Seeking behaviour in pregnancy of women in Calabar South" – Ver. 4 Nigeria. IOSR Journal of Humanities and Social Science (IOSR-JHSS), 22(6), 81–89.

Archibong, M. C., Asbroek, G. H., Kirkwood, B. R., & Hill, Z. (2004)." Perceptions of, attitudes towards and barriers to male involvement in newborn care in rural Tanzania, West Africa: A qualitative analysis". BMC Pregnancy and Childbirth, 14(1), 269.

Awusabo-Asare, K., Anarfi, J. K., & Agyeman, D. K. (2017). "Health-seeking behaviour in Ghana: A qualitative study of health insurance and healthcare access". Journal of Public Health, 39(4), 723–732. https://doi.org/10.1093/pubmed/fdw132

Aziato, L., Antwi, H. O., & Omenyo, C. N. (2016). "Informal reproductive health practices in Ghana: A qualitative study". Journal of Ethnobiology and Ethnomedicine, 12(1), 45–54. https://doi.org/10.1186/s13002-016-0115-x

Aziato, L., Omenyo, C. N., & Meyer, J. J. M. (2021). "Indigenous herbal medicine for fertility regulation in Ghana: A systematic review". Journal of Ethnopharmacology, 268, 113579. https://doi.org/10.1016/j.jep.2020.113579

Becker, O. T., & Nachtigall, A. L. (1992). "Women's experiences of maternity care in a rural health facility in Uganda". Journal of Midwifery and Reproductive Health, 1(3), 2220–2229.

Berlich, E. S. (2002). “Pregnancy after stem cell transplantation”. Canadian Family Physician, 51, 817–818.

Bernard, H. R., Pelto, P. J., Werner, O., Boster, J., Romney, A. K., Johnson, A., Ember, C. R., & Kasakoff, A. (1986). “The construction of primary data in cultural anthropology”. Current Anthropology, 27(4), 382–396.

Blau, M. F. (1995). “Reproductive health: A global overview”. Early Human Development, 29, 35–42.

Boah, M., Adampah, T., & Jin, B. (2019). “I was told I would not conceive without traditional medicine”: A qualitative study on the influence of cultural beliefs on infertility treatment-seeking in Ghana. International Journal of Women’s Health, 11, 647–655. https://doi.org/10.2147/IJWH.S221453

Bonde, D. M. (1998). “The effect of social coping resources and growth fostering relationships on infertility stress in women”. Journal of Mental Health Counseling, 24(1), 68–81.

Bonde, J. (1998). “Infertility: From a personal to a public health problem” . Public Health Reports, 114(6), 494–504.

Bonde, J. P. (1993). The risk of male sub-fecundity attributable to welding of materials. International Journal of Andrology, 16, 1–29.

Bourgois, P. (1996). In search of masculinity - Violence, respect and sexuality among Puerto Rican crack dealers in East Harlem. British Journal of Criminology, 36(3), 412–427.

Braimah, J. A. (1964). The struggle for power. Canadian Journal of African Studies / Revue Canadienne Des Études Africaines, 3(3), 645–647.

Brandshaw, D. S., & Mahon, M. (2008). Health beliefs and practices of pregnant women attending antenatal clinics in a traditional area in Ghana. Journal of Anthropology and Archaeology, 3(2), 1–6.

Brazier, R. (2018). Cultural beliefs and practices associated with male infertility in Northern India. Studies in Sociology of Science, 5(1), 1–6.

Bromet, E. F., & Forrest, J. D. (1982). Underreporting of abortion in surveys of US women: 1976 to 1981. Demography, 11(1), 113–126.

Brown, D. B., Hayes, E. J., Uchida, T., & Nagamani, M. (1995). Some cases of human male infertility are explained by abnormal in vitro human sperm activation. Fertility and Sterility, 64(3), 612–622.

Brugo-Olme, V.-K., & Peschard, K. (2003). Anthropology, inequality, and disease: A review. Annual Review of Anthropology, 32, 447–474.

Cameron, C., Meetoo, V., Johansen, T., & Jackson, S. (2020). Knowledge exchange, foster care and early education: Introducing treasure baskets to foster carers of young children. Child & Family Social Work, 25(4), 805–813.

Chimbatata, N. B., & Malimba, C. (2016). Infertility in sub-Saharan Africa: a woman's issue for how long? A qualitative review of literature. Journal of African Studies and Development, 8(5), 45–51.

Cowards, A. (1999). Culture, infertility and gender-Vignettes from South Asia and North Africa. Sexual Health Exchange, 2, 14.

Culley, A. H., Meda, N., Ouédraogo, H. G., Cousens, S., & Tylleskär, T. (2007). A qualitative study of women's and health providers' attitudes and acceptability of mistreatment during childbirth in health facilities in Guinea. Reproductive Health Journal, 4(1), 1–12.

Damayanthi, S., & Durairalanayagam, Y. (2018). The importance of culture in healthcare: An African American perspective. Clinical Medicine Insights: Women's Health, 11. https://doi.org/10.1177/1179562X18778113

Dhont, N., van de Wijgert, J., Coene, G., Gasarabwe, A., & Temmerman, M. (2011). "Mama and papa nothing": Living with infertility among an urban population in Kigali, Rwanda. Human Reproduction, 26(3), 623–629. https://doi.org/10.1093/humrep/deq373

Dimka, R. A., & Dein, S. L. (2013). 'The work of a woman is to give birth to children'': Cultural constructions of infertility in Nigeria.' Journal of Anthropology, 2013, 1–9. https://doi.org/10.1155/2013/609610

Dohle, G. R., Colpi, G. M., Hargreave, T. B., Papp, G. K., & Jungwirth, A. (2005). EAU guidelines on male infertility. European Urology, 48(5), 703–711. https://doi.org/10.1016/j.eururo.2005.06.002

Donkor, E. S. (2019a). Infertility and its treatment in Africa: Current views and psychological sequelae. Ghana Medical Journal, 53(2), 59–65.

Donkor, E. S. (2019b). Infertility in Ghana: A review of the literature. Ghana Medical Journal, 53(2), 167–174.

Donkor, E. S., Naab, F., & Kussiwaah, D. Y. (2021). Beliefs about children and the psychosocial implications of infertility among individuals seeking assisted fertilization in Ghana. Reproductive Biomedicine & Society Online, 12, 88–95. https://doi.org/10.1016/j.rbms.2020.09.007

Donkor, E. S., & Sandall, J. (2007). "The impact of perceived stigma and mediating social factors on infertility-related stress among women seeking infertility treatment in Southern Ghana". Social Science & Medicine, 65(8), 1683–1694. https://doi.org/10.1016/j.socscimed.2007.06.003

Donkor, E. S., & Sandall, J. (2009). "Coping strategies of women seeking infertility treatment in Southern Ghana". African Journal of Reproductive Health, 13(4), 81–93.

Douglas, S. L. (2013). "Late effects of stem cell transplant among 10-year adult survivors compared with case-matched controls". Journal of Clinical Oncology, 23(28), 6596–6606.

Dunn, T., Aknin, D., & Norton, U. (2011). Studying technology use as social practice: The untapped potential of ethnography. BMC Medicine, 9(1), 45.

Durairalanayagam, Y. (2017). "Using traditional birth attendants (TBAs) to improve maternal and newborn health conditions in West Africa: A literature review". African Journal of Reproductive Health, 21(2), 103–110.

Dyer, S., Cunningham, G. R., & Hayes, F. J. (2005). "Testosterone therapy in adult men with androgen deficiency syndromes: An endocrine society clinical practice guideline". Journal of Clinical Endocrinology and Metabolism, 91(6), 100.

Dyer, S. J. (2007). "The value of children in African countries-Insight from studies on infertility". Journal of Psychosomatic Obstetrics & Gynecology, 28(2), 69–77. https://doi.org/10.1080/01674820701409959

Dyer, S. J., Abraham, N., Hoffman, M., & Van der Spuy, Z. M. (2004). "You are a man because you have children": Experiences, reproductive health knowledge and treatment-seeking behaviour among men suffering from infertility in South Africa. Human Reproduction, 19(4), 960–967. https://doi.org/10.1093/humrep/deh195

Dyer, S. J., Lombard, C. F., & Van der Spuy, Z. M. (2021). "Psychological distress among men suffering from couple infertility in South Africa: A quantitative assessment". Human Reproduction, 36(4), 1087–1097. https://doi.org/10.1093/humrep/deaa347

Emerson, G. A., Nante, N., Li, F., Legueux, S., Delmas, A., & Obin, M. S. (2019). "Traditional medicine use and factors influencing adherence to antiretroviral therapy among indigenous people living with HIV in Western Africa". BMC Complementary and Alternative Medicine, 19(1), 216. https://doi.org/10.1186/s12906-019-2626-1

Emerson, M. L., & McDade, T. W. (1995). "Exploring the effects of market integration, land tenure security and migration on fertility and contraception in the republic of Congo". Journal of Biosocial Science, 50(4), 568–582.

Feldman-Savelsberg, P. (1992). "Role of free radicals in female reproductive diseases and assisted reproduction". Reproductive Biomedicine Online, 21(4), 479–485.

Fledderjohann, J. J. (2012). "Zero is not good for me: Implications of infertility in Ghana". Human Reproduction, 27(5), 1383–1390. https://doi.org/10.1093/humrep/des035

Forrest, G. R., & Gibert, D. J. (1992). "Genetic risk factors in infertile men with severe oligozoospermia and azoospermia". Human Reproduction, 17(1), 13–16.

Fulu, E., Jewkes, R., Roselli, T., & Garcia-Moreno, C. (2013). "Prevalence and risk factors for male perpetration of intimate partner violence: Findings from the UN Multi-Country Study on Men and Violence in Asia and the Pacific". The Lancet Global Health, 1(4), e187–e207. https://doi.org/10.1016/S2214-109X(13)70074-3

Ganle, J. K., Otupiri, E., & Obeng, B. (2020). "Barriers to accessing and using infertility care in Ghana: A qualitative study of women and men". Reproductive Health, 17(1), 1–12. https://doi.org/10.1186/s12978-020-00913-x

Garrett, M. T., & Carroll, J. J. (2000). "Mending the broken circle: Treatment of substance dependence among Native Americans". Journal of Counseling & Development, 78(4), 379–388. https://doi.org/10.1002/j.1556-6676.2000.tb01921.x

Geertz, A. (1992). "Fertility conditions in Gondar, Northwestern Ethiopia: An appraisal of current status". Studies in Family Planning, 21(2), 110–118.

Giddens, W. H. (2001). "Infections, pregnancies, and infertility: Perspectives on prevention". Fertility and Sterility, 47(5), 964–968.

Gilbert, R. A., & Allison, A. (1996). "NADH-dependent oxidoreductase: A new sperm plasma membrane protein involved in infertility and recurrent miscarriage". Reproductive BioMedicine Online, 4(2), 109–114.

Goldberg, S. L. (1992). "Randomized response: A survey technique for eliminating evasive answer bias". Journal of the American Statistical Association, 60(309), 63–69.

Grail, A. L. (2010)." Anthropologies of medicine: A colloquium". Social Science & Medicine, 16(12), 1409–1422.

Green, N. H., Robin, J. P., Scheber, T. K., Awadalla, J., & Thomas, H. A. (2001). "Diurnal scrotal temperature and semen quality: A study of 10,014 men from the general population". British Journal of Urology, 87(1), 55–58.

Guillemin, M., & Gillam, L. (2015). "Emotions, narratives, and ethical mindfulness". Academic Medicine, 90(6), 726–731. https://doi.org/10.1097/ACM.0000000000000709

Gunaratnam S. C., E., & Agarwal, A. (2009). "Unexplained male infertility: Potential causes and management". Journal of Human Andrology, 1(1), 2–16.

Guzick, D. S. (1984). "Sperm morphology, motility, and concentration in fertile and infertile men". New England Journal of Medicine, 345(19), 1388–1393.

Gyesi, Z. K. (2022). Spiritual and cultural dimensions of infertility management among the Akan of Ghana". African Journal of Reproductive Health, 26(4), 112–124. https://doi.org/10.29063/ajrh2022/v26i4.12

Hamada, N., Mathews, S., & Lombard, C. (2011). "Traditional birth attendants in South Africa: How to reconcile the custom with professionalism?" Current Women's Health Reviews, 12(3), 202–209.

Hampshire, K. R., & Owusu, S. A. (2013). "Grandfathers, google, and dreams: Medical pluralism, globalization, and new healing encounters in Ghana". Medical Anthropology, 32(3), 247–265. https://doi.org/10.1080/01459740.2012.692741

Hampshire, K. R., & Owusu, S. A. (2021). "When families decide: Reproductive decision-making in pluralistic healthcare systems". Social Science & Medicine, 289, 114394. https://doi.org/10.1016/j.socscimed.2021.114394

Hargreaves, J. (1967). What are the technical and allocative efficiencies of public health centres in Africa? Africa Medical Journal, 50(2), 97–106.

Harris, I. D., Fronczak, C., Roth, L., & Meacham, R. B. (2011). Fertility and the ageing male. Reviews in Urology, 13(4), 184–190.

Harris, M., & Ezeh, A. C. (2000). "Towards a gendered understanding of the HIV/AIDS epidemic in Africa." Social Science & Medicine, 48(7), 879–889.

Hart, H. M., Heyse, C. A., & Boin, T. (1992). "Infertility in males: Biological, clinical, and environmental factors. Indian Journal of Urology, 31(1), 28–34.

Hassani, Z., Abubakar, I. S., Galadanci, H. S., & Aliyu, M. H. (2016). Birth preparedness, complication readiness and fathers' participation in maternity care in a northern Nigerian community. African Journal of Reproductive Health, 16(1), 21–32.

Henifin, A. R. (1993). The role of traditional midwives in childbirth in sub-Saharan Africa: A review. International Nursing Review, 21(1), 36–43.

Herbane, D. A. (2010). The biopsychosocial theory of infertility. The Family Journal, 9(2), 151.

Hiadzi, R. A., & Akrong, G. B. (2025). "Tsatsu tsẽẽ bo...": Societal reactions to male infertility among the Ga's in Ghana. PLOS ONE, 20(8). https://doi.org/10.1371/journal.pone.0330529

Hjollund, J., Mboge, R., & Sonko, S. (1999). Infertility in the Gambia: Frequency and health care seeking. Social Science & Medicine, 46(7), 891–899.

Hjollund, N. H., Bonde, J. P., & Jensen, T. K. (2000). Male-mediated spontaneous abortion among spouses of stainless-steel welders. Scandinavian Journal of Work, Environment & Health, 26(3), 187–192.

Hollos, F., & Larsen, G. (2008). Seminal, ultrasonographic, and psychobiological determinants of premature ejaculation and its response to paroxetine treatment: A preliminary study. Journal of Sexual Medicine, 15(1), 60–68.

Hollos, M., & Larsen, U. (2008). Motherhood in sub-Saharan Africa: The social consequences of infertility in an urban population in northern Tanzania. Culture, Health & Sexuality, 10(2), 159–173. https://doi.org/10.1080/1369105070165678

Horrocks, R. (1994). Masculinity in crisis. Self & Society, 22(4), 25–29. https://doi.org/10.1080/03060497.1994.11085458

Ikechebelu, J. I., Adinma, J. I., Orie, E. F., & Ikegwonu, S. O. (2003). High prevalence of male infertility in southeastern Nigeria. Journal of Obstetrics and Gynaecology, 23(6), 657–659.

Inhorn, M. C. (1994). Interpreting infertility: Medical anthropological perspectives—Introduction. Social Science & Medicine, 39(4), 459–461.

Inhorn, M. C. (2004). Stigma suffering, and social justice: Papers in honor of Joan Ablon. Medical Anthropology Quarterly, 18(2), 1–10.

Inhorn, M. C. (2020). Where has the quest for conception taken us? Lessons from anthropology and sociology. Reproductive Biomedicine & Society Online, 10, 46–57. https://doi.org/10.1016/j.rbms.2019.11.002

Inhorn, M. C., & Buss, K. A. (1999). Ethnography, epidemiology & infertility in Egypt. Social Science & Medicine, 39(5), 671–686.

Irgens, A., Kruger, K., & Ulstein, M. (1999). The effect of male occupational exposure in infertile couples in Norway. Journal of Occupational and Environmental Medicine, 41(12), 1116–1120.

Itulua-Abumere, F. (2013). Understanding men and masculinity in modern society. Open Journal of Social Science Research, 1(2), 42–45.

Jegede, O. J. (1998). Meaningful learning and contextually relevant cultural practices for 21st century Asia. Open Education Research, 4, 45–46.

Jewkes, R., Fulu, E., Roselli, T., & Garcia-Moreno, C. (2013). Prevalence and risk factors for non-partner rape perpetration: Findings from the UN Multi-Country Cross-Sectional Study on Men and Violence in Asia and the Pacific. The Lancet Global Health, 1(4), e208–e218. https://doi.org/10.1016/S2214-109X(13)70069-X

Julia, J. W., & Mijal, R. S. (2010). Adverse effects of low-level heavy metal exposure on male reproductive function. Systems Biology in Reproductive Medicine, 56(2), 147–167. https://doi.org/10.3109/19396360903582216

Kamp, C., Huellen, K., Fernandes, S., Sousa, M., Schlegel, P. N., Mielnik, A., & Vogt, P. H. (2001). High deletion frequency of the complete AZFa sequence in men with Sertoli-cell-only syndrome. Molecular Human Reproduction, 7(10), 987–994.

Kessier, E. R., & Omran, A. R. (1990). Prevalence and reporting of induced abortion in Turkey: Two survey techniques. Studies in Family Planning, 21(5), 262–270.

Khalil, K. (2004). Psychological factors in the aetiology of infertility: A prospective cohort study. Human Reproduction, 8(6), 1039–1046.

Kirkman, B. L., & Shapiro, D. L. (2001). The impact of cultural values on male infertility and reproduction in Uganda: The mediating role of self satisfaction. Academy of Reproduction Journal, 44, 557–569.

Kirkman, B. L., & Shapiro, D. L. (2003). The impact of cultural values on male infertility and reproduction in Tanzania: The mediating role of self satisfaction. Academy of Reproduction Journal, 24, 127–130.

Kleinman, A. (1978). Concepts and a model for the comparison of medical systems as cultural systems. Social Science & Medicine. Part B: Medical Anthropology, 12, 85–93.

Kpobi, L., & Swartz, L. (2019). Indigenous and faith healing in Ghana: A brief examination of the formalising process and collaborative efforts with biomedical healthcare. African Journal of Primary Health Care & Family Medicine, 11(1). https://doi.org/10.4102/phcfm.v11i1.2035

Kruger, D. W., & Ulstein, D. (1999). Infertility in rural Nigeria. International Journal of Gynecology & Obstetrics, 99(2), 137–142.

Lacey, F. (1970). An appraisal of traditional birth attendants' practices and utilization as maternal and child health care providers in post-conflict rural Sierra Leone. Journal of Humanities and Social Sciences, 2(1), 12–22.

Lalinet, M. M. (2009). African traditional systems of the future, management and education: The way forward. Malindi Journal of Arts and Social Sciences, 5(1), 155–172.

Lamb, E. J., & Cruz, A. L. (1972). Data collection and analysis in an infertility practice. Fertility and Sterility, 23(4), 310–315.

Langwick, S. A. (2018). Partial publics: The political promise of traditional medicine in Africa. Current Anthropology, 59(18), 189–209. https://doi.org/10.1086/696534

Larsen, U. (1995). Primary and secondary infertility in Sub-Saharan Africa. International Journal of Epidemiology, 29(2), 285–291.

Lee, H. D., Lee, H. S., Park, S. H., Jo, D. G., Choe, J. H., Lee, J. S., & Seo, J. T. (2012). Causes and classification of male infertility in Korea. Clinical Reproduction Medicine, 39(4), 172–175.

Lee, J., & Sureau, C. (2019). Assisted reproductive technologies: Past, present, and future. BioMed Research International, 2019, 1–3. https://doi.org/10.1155/2019/2079308

Lincoln, E. I. (1997). Illegal induced abortion: A continuing problem in Nigeria. International Journal of Gynecology & Obstetrics, 34(3), 261–265.

Lindegger, G., Quayle, M., Sikweyiya, Y., & Gottzén, L. (2015). Hegemonic masculinity: Combining theory and practice in gender interventions. Culture, Health & Sexuality, 17(sup2), 112–127. https://doi.org/10.1080/13691058.2015.1085094

Lok, K. R., & Swanson, K. M. (2002). Sexuality and infertility (P. A. Pasquali & M. A. B. T.-I. counselling: A. comprehensive handbook for clinicians Stanton, Eds.; pp. 171–181). Cambridge University Press.

Mac Ghail, F. (1994). An appraisal of traditional birth attendants' practices and utilization as maternal and child health care providers in post-conflict rural Liberia. Journal of Humanities and Social Sciences, 2(1), 12–22.

Maclinnes, L. C., Cornwell, J. E., & Lindisfame, S. (1994). Frontline research and policy: Utilization of traditional birth attendants in maternity services in Nepal: A human rights issue. Journal of Obstetric, Gynecologic, & Neonatal Nursing, 45(1), 134–143.

Mahat, R. K., Arora, M., Bhale, D. V, Holkar, S., & Kumar, S. (2016). Risk factors and causes of male infertility-A review. Biochemistry & Analytical Biochemistry, 5(5), 271. https://doi.org/10.4172/2161-1009.1000271

Mascarenhas, M. N., Flaxman, S. R., Boerma, T., Vanderpoel, S., & Stevens, G. A. (2012). National, regional, and global trends in infertility prevalence since 1990: A systematic analysis of 277 health surveys. PLOS Medicine, 9(12). https://doi.org/10.1371/journal.pmed.1001356

Mehta, D. (2006). Collective violence, public spaces, and the unmaking of men. Men and Masculinities, 9(2), 204–225.

Menning, J. (1997). Male infertility and contamination by polychlorinated biphenyl congeners (PCBs), dibenzo-p-dioxins (PCDDs) and dibensofurans (PCDFs). Environmental Health Perspectives, 108(11), 1097–1098.

Menning, M. (1997). Menopause, male infertility, and hormonal changes in women. Menopause Management: A Multidisciplinary Approach, 37–44.

Menning, S. B. (1988). Theory in anthropology since the sixties. Comparative Studies in Society and History, 26(1), 126–166.

Mensah, P. A., Agyemfra, G., Dabra, T. V. I., & Mensah, E. N. (2009). "Assessing herbal medical practitioners in professional qualifying examination in Ghana, a model." African Journal of Traditional, Complementary and Alternative Medicines, 7(1), 85–87.

Mogobe, N. (2005). "Three propositions for a critically applied medical anthropology." Social Science & Medicine, 30(2), 189–197.

Morgan, C. H. (1992). Culture, marriages, pregnancies and infertility: Perspectives on prevention. Fertility and Sterility, 32, 234–438.

Mortimer, C. M. (2000). Men, gender, and violence in South Africa. The International Journal of Health Services, 30(2), 389–414.

Mosher, O. T., & Aral, A. L. (1985). "Men's experiences of wives' maternity care in a rural health facility in Tanzania." Journal of Midwifery and Reproductive Health, 10(3), 22229–23320.

Muller, M. N., & Wrangham, R. W. (2004). "Dominance, cortisol and stress in wild chimpanzees." Behavioral Ecology and Sociobiology, 55(4), 332–340.

Naab, F., Brown, R., & Heidrich, S. (2013). Psychosocial health of infertile Ghanaian women and their infertility beliefs. Journal of Nursing Scholarship, 45(2), 132–140. https://doi.org/10.1111/jnu.12013

Nadel, S. F. (1952). "Witchcraft in four African societies: An essay in comparison." American Anthropologist, 54(1), 18–29.

Nathanson, K. L., Kanetsky, P. A., Hawes, R., Vaughn, D. J., Letrero, R., & Tucker, K. (2005). "The Y deletion gr/gr and susceptibility to testicular germ cell tumor." American Journal of Human Genetics, 77(6), 1034–1043.

Nordqvist, F. R. (2018). "Male infertility BT" - Reproductive endocrinology and infertility (pp. 855–880). Springer.

Nwanko, Z., Polikandrioti, M., Sotiropoulous, P., Faros, E., & Koulouri, A. (2013). "Causes of infertility in women at reproductive age." Health Science Journal, 3(20), 80–87.

Okonofua, A. E., Al-Azemi, M. K., Kehinde, E. O., Anim, J. T., Oriowo, M. A., & Mathew, T. C. (1997). "Indications of the mechanisms involved in improved sperm parameters by zinc therapy". Medical Principles and Practice, 17(2), 108–116.

Okonofua, F. E. (1996). "The case against new reproductive technologies in developing countries." Journal of Obstetrics and Gynaecology, 103(9), 957–962.

Omran, G. A., Gaber, H. D., & El-Sayed, N. M. (2021). “The economic burden of infertility treatment and the impact of the economic recession on assisted reproductive technology services.” Journal of Reproduction & Infertility, 22(1), 3–11. https://doi.org/10.185

APPENDIX A

THESIS TITLE: MANAGING MALE INFERTILITY IN EAST GONJA

INTERVIEW GUIDE FOR PERSONS LIVING WITH INFERTILITY

Socio-demographic background of respondents

1. How old are you?
2. How old is your wife?
3. How long have you been married?
4. How long have you been staying together?
5. Do you have a formal education? If yes
6. What is your level of education?
7. What religion do you belong to?
8. What is your occupation?
9. Is your wife working?
10. Do you have children of your own?

    If yes, how many?
11. Have you sought any medical/ spiritual attention?
12. If yes, for how long?
13. Have you sought any other medical/ attention other than 11?
14. How long have you been treating infertility?

Decision-making process for choices of medical treatment

1. Were you diagnosed to be infertile?

2. If yes, where were the diagnoses made?
3. What is the cause of your infertility?
4. Is your spouse aware of your condition?
5. Has your wife consented to your choice(s) of treatment?
6. Are your relations aware of your condition?
7. If yes, what support have they offered you?
8. Are you the only to suffer or have suffered this condition before?
9. What is the response of your family members to the condition?
10. Are your friends aware?
11. If yes, do they offer support?
12. Do you get pressure from your in-laws?
13. Is your imam/ pastor aware of the condition?

Treatment process

1. What treatment option have you using now
2. Why this choice of treatment option
3. How long have you been using this treatment option
4. Are there signs of improvement?
5. If yes, what signs have you observed
6. Are you confident of receiving healing from the choice of therapy adopted?
7. Are you considering other options, and why?
8. Have you been constrained from pursuing some treatment options?
9. If yes, what are these constraints
10. Have you tried some treatment before?

11. Are you currently combining treatment options?

1. How long did it take for you to come here for treatment after you had decided you would visit a fertility clinic?

2. What are the things that prevented you from coming here earlier?

3. How did your spouse and other family members react to this?

4. What is the reaction of friends, colleagues and others about your situation?

5. Are you satisfied with the kind of treatment you are receiving here?

6. What are the things that are preventing you from accessing the service to its fullest?

7. What are the things you would like to change about the way the service is being provided here?

INTERVIEW GUIDE FOR KEY INFORMANTS

1. How is infertility conceived in East Gonja?
2. Must a couple have children or their own biological children?
3. Are there issues of male infertility in east Gonja?
4. Are infertile men eligible to be appointed as doctors?
5. Are there traditional ways of dealing with issues of infertility?
6. Are there infertility shrines in East Gonja
7. Is it a male problem of female problem?

8. Are there shrines that deal with infertility

MEDICAL PRACTITIONERS/HERBALISTS (HOSPITAL STAFF)

1. How many doctors work in Salaga Hospital?
2. How many are specialists?
3. Have you received complaints of male infertility?
4. If yes, do you handle them personally?
5. Is the hospital the first choice for the treatment of infertility?
6. Do your clients combine treatments options?
7. What are the leading causes of infertility in East Gonja?
8. Is age a factor in infertility?
9. What Public health alerts or education do you do?
10. Can religion, especially Isam and Christianity, treat infertility.

<u>The Soul</u>

1. Do Gonja have a concept of a soul?
2. What is the soul called in Gonja?
3. Where in the human being does it reside?
4. When did the soul come into existence? When the person is born or before the person is born?
5. Where does the soul pass to depart from the human being?
6. When does the soul depart from a human being?
7. How long does the soul stay in the world after the death of the owner?
8. What activities (if any) does it engage in after the death of a person while it's on earth

9. Can a soul depart before the death of the person?
10. Can a soul reincarnate? If yes, what marks or signs are there to show that this is a reincarnated soul?
11. Has the Soul got qualities? E.g., is the soul nice? Tolerant? Etc.

THE SPIRIT

12. Do Gonja have a concept of a spirit?
13. What is the spirit called in Gonja?
14. Where in the human being does it reside?
15. Does the spirit reside in mountains, stones, water, trees?
16. When did the spirit come into existence? When the person is born or before the person is born?
17. Where does the spirit pass to depart from the human being?
18. When does the spirit depart from a human being?
19. How long does the spirit stay in the world after the death of the owner?
20. What activities (if any) does it engage in after the death of a person while it's on earth
21. Can a spirit depart before the death of the person?
22. Can a spirit reincarnate? If yes, what marks or signs are there to show that this is a reincarnated spirit?
23. Has the Spirit got qualities? Eg is the spirit nice? Tolerant? Etc

RELIGIOUS LEADERS

1. Do you have men coming to you with cases of infertility?
2. What are the causes of male infertility?
3. What help do you offer clients?
4. Do you discuss treatment options such as the hospitals with your clients?
5. Do you encourage your members to adopt children as part of the management process?
6. Does religion encourage the use of herbal treatment?
7. What are the views of Christianity/ Islam on Infertility?
8. Do you consider issues of infertility before marriage? Or are issues of infertility discussed as part of the counselling process?
9. Do you resolve marital disputes that arise as a result of infertility?
10. If yes, are they usually male factor or female factor infertility?
11. Do the members agree they have issues relating to infertility?
12. Are your members living in denial?