SUMMARY
Infertility is a major obstacle to good health and peaceful co-existence in many homes especially among the rural dwellers. In spite of this, the problem of infertility has not received adequate attention. Most of the discussions have centered on how to reduce fertility. However, apart from the psychological trauma an infertile woman is exposed to, the burden of infertility manifest in various health problems. The study, therefore, adopted a combination of qualitative and quantitative methods. Sampling techniques adopted were purposive and multi-stage sampling methods. Data were collected using in-depth interview, key informant interview, focus group discussions and structured interview. It was found that there is a relationship between causes of infertility and the pattern for coping with the disease. To cope with infertility, a lot of actions are taken by the victims such as divorce of spouse, remarriage, infidelity, surrogate marriage, pregnancy as a test of fertility and subsequent abortion. Data also point out that the rate of extra-marital sex is high among infertile couple. This poses great health consequences. Similarly, it is clear that infertility is caused by some diseases such as STDs and dysentery and it further leads to other diseases such as HIV/AIDS and ovarian hyper-stimulation syndrome. Infertility and some cultural practices are interwoven. This is the reason why extra-marital sex in the quest for children is high but accepted by the society. Infertility, therefore, exposes couple to dangerous sexual habits that have adverse health consequences for human society. To address this, the study on which this paper is based postulated “Disease Interrelationship Model” (DIM), whose goal is to ensure prevention of infertility at the entry point into the disease network. Furthermore, to overcome the consequences of infertility, there is need for fertility health education and mobilization programme; and treatment of infertility in hospitals should be practically free. Again, late marriage among women should be discouraged.

INTRODUCTION
One of the major obstacles to good health and peaceful family living in many Nigerian rural communities is infertility. Obviously, the problem of infertility in Africa has not received adequate consideration. Major discussions, debates and talks in family planning do not pay sufficient attention to infertility. For instance, many scholars (Caldell and Caldell, 1990; Adewuyi 1999; Mencarinin 1999; Plessis 1999; Sibanda and Zuberi 1999) were more concerned with fertility issue and how to ensure that fertility is highly reduced through the use of different family planning methods.

One major fact that most scholars of family planning have ignored is that family planning is not only “a means by which individuals or couples space the process of conception, pregnancy and childbirth”, (Delano 1988:18). This is why Akinsola (1993:170) complained that, “Most often family planning is viewed only from the point of view of the control of birth rate, fertility rate or population growth.” Family planning includes both programmes of controlling fertility and helping those who have problems of infertility.

Family planning in essence implies the efforts towards ensuring that every couple that desires to have children gets the right number of children they can cater for through the right spacing and other healthy practices.

From this standpoint, only a few scholars (Obono, 2004; Alemnji, 1999 and Singer, Davidson, Gerdes, 1988) have really investigated the problem of infertility. Few others (Campana, 2005 and Smith, 2005) have looked at the problem of infertility from the biomedical point of view.

However, it has become an established fact in medical anthropology that medical systems are cultured systems (Singer et al, 1988 and Kleinman, 1980). And since culture is an integrated whole (Oke, 1984), anthropologists cannot avoid this area of sexuality and sexual development of human life, (Aziz and Maloney, 1988). So, infertility apart from being a biological problem is also a socio-cultural issue calling for serious attention. It is the neglect of this serious bio-social problem that prompted the study towards investigating the health implications associated with human infertility.

On the other hand, it is clear that health problems are best seen through the eyes of the sufferers. However, demographic scholars (Ayoub, 2004; Sibanda and Zuberi, 1999; Isiugo-Abanihe, 2003, Mencarinini, 1999 and Chimere – Dan, 1997) see large family size especially in Africa as problem even when the owners of such families have not admitted that there is a problem. This is not to underscore the problems presented by over size family. But many people in Africa know that infertility is a more serious problem. This is why United Nations International Conference on Population and Development in Cairo in 1994 noted that in the interpretational field of reproductive health, prevention and appropriate treatment of infertility where feasible should be an issue for future action (van Balen and Gerrits, 2001). And that future is now.

It has been observed that if the lay concept of health and illness that play a major part in determining health-related behaviour is considered, then it is
essential that any health education strategy identifies and responds to people's own perception and needs especially in this issue of infertility (Clarke, 2001). To health, the assumption of holistic perception of health, as not mere absence of disease and infirmities became recognized across the world. And so infertility which imposes both social and psychological distress on women is seen as a disease. According to Rosentock (1964), health related behaviour is determined by the perception and prevalence of a disease. Drawing from this assertion, explanation of what constitutes disease is culture specific, thus there is need for elaborate knowledge of what a disease means to a particular group of people not only in their medical context but more importantly, in social context.

In spite of the serious nature of infertility, scholars' attention has been limited to prevalence of primary infertility, causes and treatment of infertility. That is why the study on which this paper is based seeks to establish the prevalence of secondary infertility, the relationship between infertility and surrogate marriage or surrogate motherhood, the relationship between cause and treatment of infertility. Generally, this paper focuses on the basic assumption that some non-treatment strategies for coping with infertility have adverse health implications.

The first section of this paper is an exposition of concept and theoretical issues concerning infertility in a rural Nigerian community. This results from the awareness that health implications of infertility have not been properly addressed at scholarly level. In the second section, research methods and designs are outlined bringing to fore the setting of the study and scope. The next section focuses on infertility as a disease and resultant health implications.

The concluding section chants some policy suggestions for attending to the problem of infertility and its associated health conditions. This is with a view of ensuring a healthy and stress free society.

CONCEPTUAL AND THEORETICAL FRAMEWORK

It has been noted that the unique feature of medical anthropology is its relationship with medical profession, thereby providing enough cultural and social perspective for understanding, interpreting and solving health related problems. This is possible because human beings are simultaneously biological and cultural. As a result of this, functionalism and social action theories become relevant in explaining the perception, attitude and non-tolerance of infertility. According to Oke (1984), Malinowski noted that all cultural traits are useful parts of the society which posses them. He made it clear that every culture is a working whole, an integrated unit, in which every element has a functional contribution to make. The function of any institution is the part it plays within the interrelated whole in fulfilling human purposes or needs. Malinowski believed that the purpose of every culture is to satisfy seven basic human needs, that is, nutrition, reproduction, bodily comforts, safety, relaxation, movement and growth.

In his own writing, Evans-Pritchard (1962:87) quotes Montesquieu as saying that “the idea of everything in a society and its ambient being functionally related
to everything else is obvious”. In essence, infertility and other diseases can be related to other aspects of culture and should not be tackled without due consideration of this network.

Generally, Evans-Pritchard (ibid) is of the opinion that there is some kind of order, consistency and constancy in social life. He noted that it is because of this order that there is the systematization and institutionalization of social activities in which certain persons perform certain roles in them and so the activities perform certain functions in the general social life. In other words, women as part of this system are expected to have children at marriage and if not, the system is punctured. So, the functionalists believe that if one aspect of the system did not perform its role, the whole system is affected. As a result, functionalism is a necessary tool towards investigation of disruption of the human procreation system.

On the other hand, the social action theory (SAT) is interested in the analysis of the motivating force behind actor(s) in a particular social environment. According to Odiagbe (2004), Weber, a major apostle of SAT believes that an understanding of the social action is an understanding of the underlying meaning or the motivation attached to such acts. However, Rex (1951) explained that motivation alone is not enough to explain reasons for actions. He noted that the action of an individual may be integrated with that of another through the cultural patterning of elements. For him, whether an action is rational or non-rational, the ends which the individual seeks may be set for him by his cultural conditioning.

In his view, Parson (1937) believes that situational factors contribute to individual’s action. He was more interested in the societal values and norms, which guide, direct and regulate human conducts. Ajala (2002) while explaining the position of Parson posits that there are four differing interdependent systems. These systems are cultural, social, personality and behavioural. This in essence is a reflection of the individual’s response to other human beings and the environment.

From the stand point, it can be seen that individuals within the system can be analysed based on their social status. This status could be a husband or a wife. Culturally speaking, social status of husband and wife is supposed to be complementary. This pattern of analysis was adopted to determine whether this complementary posture between husband and wife still exist when infertility sets in. Another relevance of this theory is in the analysis of motivation for seeking an end to infertility or the reasons for such rational actions.

On the other hand, explanation for health condition differs from one society to the other. All human societies have different ways of classifying disease or ill-health. Usually, this is in line with their health belief system. That is why health belief model (HBM) suggests that the beliefs and attitudes of people are crucial determinants of what they call disease and “their health related actions” (Jegede, 1998: 38). Therefore, a person’s perception of his health condition and the actions he is likely to take depends on his vulnerability to the illness; severity of the illness;
benefits derived by reducing the severity or vulnerability to the illness; and his evaluation of possible barriers associated with the proposed action (Rosenstock, 1966). Consequently, the action a person will take when faced with a health problem depends on the perceived effects and consequences of such diseases.

A close look at infertility through the eyes of the HBM shows that it has high susceptibility especially among women. However, their marital status will determine the action to be taken. So, it becomes imperative to understand the underlying belief of a people concerning a disease such as infertility before seeking for action plan that will enable one to tackle the problem.

Health system is obviously an essential aspect of the cultural system. However, it has been observed that apart from anthropologists, others scholars tend to describe medical systems in a way that portrays increasing embarrassment to the problem of terminology. At times, disease is regarded as an object in itself, which has no relationship with social behavior of the sufferer, (Fabrega, 1975; Clarke, 2001 and Oke, 2002). Oke (ibid) was quick to add that the most useful definition of disease must encourage bio-cultural orientation in order to be relevant for research purpose.

According to Kleinman (1980) in every culture, illness, the response to it, and the social institutions relating it are all systematically interconnected. A holistic approach therefore becomes necessary in the study, discussion and treatment of disease of which infertility is part. As a result, disease can be seen as an abnormality in the function and/or structure of any part, process or system of the body or a socio-cultural classification which involves change in behaviour or role when compared to other members of the culture or the very way in which a person perceives or judges himself in relationship with others and the various institutions (Oke, 2002).

In spite of the position of infertility as a disease, the problem has not been assessed everywhere, (Middleton, 1997). However, there has been huge interest in reducing the fertility rate in developing countries. The programmes involved have never originated from the family’s own point of view but rather from a political “top-down” perspective, (Hamburger and Janson, 1997). In other words, infertility care has received only little attention and concern (Obono, 2004).

However, there has been a positive change in attitude towards infertility since the 1994 United Nations International Conference on Population and Development in Cairo. But no policy guideline has been formulated.

It has been noted that the negative consequences of infertility are much stronger in developing countries than in the Western societies and these are mainly characterized by personal suffering and social stigmatization (Van Belen and Gerrits, 2001). In developing countries particularly African countries, children are of great value economically, socially and culturally. In these areas, infertility has been an unbearable problem for the couple, the extended family and the entire community. In particular, childless women suffer a lot because women are always blamed for childless situation and motherhood is often the only way for a woman
to stabilize her position within her husband’s family and community (Odebiyi and Aina, 1996).

The causes of infertility have both biological and cultural undertones in Africa. However, the causes of infertility could be biological, psychological and cultural. In a recent study, it was reported that infertility could be caused by fumes and soot from power plants and vehicles exhaust in towns and cities, (Oguntola, 2008).

According to Smith (2005), the treatment of infertility actually depends on the cause, the duration of the problem, the age of the partners and their specific wishes. That is why Akinsola (1993) opines that although medicine whether Western or traditional cannot cure all cases of infertility. So, every case of infertility must be well investigated and treated according to the cause. Some studies even show that when and where modern medicine is available, accessible and inexpensive or free, patients still consult traditional Practitioner, (Katz and Katz, 1987; Campana et al, 2005). In fact, Mogobe (2000) observed that people in developing countries use traditional remedies more because they have some advantages over Western style medical and paramedical remedies.

On the other hand, it has also been noted that apart from their expensive nature, some of the modern treatment for infertility (In vitro fertilization, electro ejaculation, surgical sperm aspiration, intracytoplasmic sperm injection and assisted hatching) have some complications. These include multiple pregnancy (Septuplets), ovarian hyper stimulation syndrome (over enlargement of ovaries), bleeding or infection and birth defects, (Smith, 2005). Reports by Inhorn (2000) confirmed that the modern methods of treating infertility such as IVF are out of the reach of the lower economic class.

Apart from treatment, some scholars (Akinsola, 1993 and Smith, 2005) advised that it is more ideal for people to do everything possible to prevent infertility.

From this stand point, it can be seen that infertility is a disease which has biological, psychological and cultural causes. The symptoms are more obvious in female than in male. Similarly, it is clear that prevention of infertility should be a thing of paramount importance. This is to ensure that the time, resources and energy expended on the treatment is channeled into other productive ventures.

**RESEARCH METHOD AND DESIGN**

**Scope and Setting of the Study**

This study focused on women who could not bear children within the first two years of marriage. This is because by this time consequences of infertility have begun to manifest. In essence, women who could not bear children early in their marriage but later had children are also included in the study. The scope of the study also includes women who had their first children successfully but could not have another child after three years. This helped to establish the rate of secondary infertility. Women are chosen for the study because in Igboland like
other parts of Africa, women always bear the brunt whenever a couple could not have a child.

The study was conducted in Mbano, Imo State, Nigeria. Mbano is a traditional Igbo rural setting. It is made up of two local government areas: Isiala-Mbano and Ehime-Mbano. It should be noted that Mbano occupies a land area of about 352 square kilometers (Spotlight on local government in Imo State, 1989). According to the 2006 census, the population was about 329,667 people, (National Population Commission, 2006).

The residential pattern is cluster of houses in one compound. Each compound may accommodate between 1-5 families. Extended family unit is the basis of kinship relation which has the obligation of providing and protecting the members, who reciprocate by giving corporate support to the family. Any newly married couple lives within the family compound. This helps to ensure that the new wife receives adequate attention especially when it comes to pregnancy and child-birth.

Traditionally, the economic pattern is based on subsistence production of food crops such as yam, cassava, cocoyam, beans, grains and leafy vegetables. Some elderly people practice a kind of modified gathering activities. Due to the problem of insufficient land, some people tend to depend on gathering of plant and animal food for survival. These gatherers usually leave home in the morning with their baskets and/or bags and return in the evening with their containers filled. In Mbano, it is no crime to collect fruits which had fallen to the ground even if the tree is not yours. But any attempt to pluck any fruits belonging to another person without due permission attracts severe penalty.

Due to the same problem of inadequate land, many people engage in trading. Others engage in various craft works such as pottery, mat making, basket, blacksmithing and so on. The people of Mbano also strive through hunting and fishing. Others also practise traditional medicine. The people of Mbano can best be described as farmers, craftsmen and traders. They have a zest for industry and hard work.

The basis of every human social activity is the family. In Mbano, the structure is the extended family system. Monogamy is the basic form of marriage but custom does not frown at polygyny. Family residence in Mbano is patrilocal and the people also practice unilineal principle of kinship and patrilineality.

Social activities in the area which include story telling, moonlight shows, wrestling, hide and seek begin from the household level. Marriage is traditionally arranged by the parents of the groom with their son’s consent.

Politically speaking, towns and villages in Mbano are divided into quarters, that is, descendants of common ancestor. The various quarters have distinct geographical boundaries. A group of quarters make an “Ama” (Village). Every “Ama” is headed by an “Amala”. A group of villages make man autonomous community or town. Each autonomous community is headed by an “Eze”. The Eze-in council, which is made up of the Eze and all the Amalas makes laws and
adjudicates in disputes among their subjects. The Eze’s court is the final appellate in the traditional setting.

The people of Mbano believe in the Supreme Being addressed as “Chukwu” (Great God). The people believe that Chukwu is so awesome that they are not worthy to have direct contact with him. For this reason, they also believe in intermediary gods who serve as a link between man and “Chukwu”. These gods serve different purposes – “Ezeala” (god of land), “Ajoku” (God of Yam), “Ogwugwu” (god of health) and “Mbaa” (God of rivers). The people believe in ancestral worship on the basis that man is made of a body which is physical, temporal and mortal, and of a soul, which is invisible and immortal. They do believe in mystical powers such as evil persons, charms and supernatural forces. However, they do not believe in the existence of witchcraft. Death and sickness are not explained in line with pathology theory but are often ascribed to extramundane cause especially evil men and women.

Social amenities in the area include primary health centers, one general hospital (Mbano Joint Hospital), pipe-borne water, electricity, tarred roads, primary and secondary educational institutions, post offices and recreational centers. Most of these amenities were obtained through self-help efforts of various communities.

**Methodology**

The challenges and consequences of infertility among Mbano women are identified by the study of eight communities in the Isiala and Ehime Mbano. Data collection was by a combination of qualitative and quantitative methods. The qualitative methods helped to provide data about how people think, about opinions, attitudes and actual practices regarding infertility.

Quantitative methods were invoked to measure and analyse the prevalence of infertility in the study area as well as corroborate and complement data provided by the qualitative methods.

Sampling technique adopted was purposive sampling (for selecting subjects for in-depth interview and key informants) and multi-stage sampling (for selection of subjects for focus group discussions and structured interviewed).

The key informant technique was the first data gathering method used. It made entry into the field easier. It was used in retrieving information regarding cultural lives that have gone into extinction or have been modified overtime. This is to ensure that no vital information is lost. In-depth interviews were conducted with childless women, husbands of childless women, former infertility sufferers, sufferers of secondary infertility, hospital medical practitioner, traditional medical practitioner and spiritual healers. Similarly, 24 focus group discussions were held in the eight communities. The discussions were held in a relatively informal setting which allows discussants freedom and greater participation. The setting was semi-circular to avoid “high table effect.” Structured observation was also used to differentiate professed and observed attitudes. On the other hand, structured interview was conducted through a questionnaire which was administered on 320
respondents to elicit information about the challenges and health implications of infertility.

Data were generated through analysis of emic and etic perceptions. The unit of the study was the household. Analyses were done at two levels using descriptive statistics.

**INFERTILITY AS A HEALTH TRAP**

The major concern of this paper is to show that infertility is a disease which if not properly managed has adverse health consequences. Therefore, the assumptions of this paper are (a) that some non-treatment behaviours for coping with infertility have adverse health consequences; (b) that some diseases lead to infertility while infertility results to other health problems. The first assumption is supported by the analysis of causes of infertility and non treatment strategy for coping with infertility. The factors utilized in the analysis include the rate of the following measures; divorce, suicide, extramarital sex, child fostering, child adoption and surrogate marriage, to cope or avoid the stigma of childlessness.

It should be noted that causes of diseases are better viewed from the point of the people’s culture. Again, it can be understood that causes of diseases have something to do with the pattern for coping with the disease. In Igbo culture, there are some basic sacred and secular beliefs which provide meaning to causes of disease such as infertility. As a result of this, there had been attempt to synchronize the views of the traditional infertility healers (TIHs) with those of the hospital infertility healers (HIHs).

In the eyes of the TIHs, there are causes of infertility which are peculiar to female or male and there are others that affect both. Causes of infertility peculiar to female include fibroid (Ehe-afọ), black menstruation, irregular menstruation, abortion, spiritual husband (“di-uwa”), hot womb and sperm mixture. On the other hand, causes of male infertility according to traditional view are spiritual wife (nwunye-uhwa), epilepsy, hot waist, consistent driving of long distant trucks, consistent sexual intercourse with menstruating women, “ibi” (swollen testicle), lack of circumcision and dysentery (afo obara). Other causes of infertility common to both sex include destruction of children’s toy curses, breaching of cultural taboos, mystical attack by enemies, worms, natural defects, accidents and sexually transmitted diseases.

On the other hand, the biomedical view about causes of infertility includes inflammation, uterine defect, female circumcision, cervical hostility, diabetes, kidney disease and malnutrition. However, there are some areas in which the traditional view and biomedical view of causes of infertility agree. These include sexually transmitted diseases, abortion, natural defects, fibroid, ovarian defects and accidents, (Fig. 2).
Fig. 2: A set showing trado-biomedical views of causes of infertility

S = All element of the set
A = Union of traditional view
B = Union of biomedical view
C = Intersection of the sets

It has been established that the treatment of a disease depends on the cause, and by extension the best healer for any case of infertility also depends on the cause of the disease. So, this study being aware of the problem of overlap in other classifications of causes of disease, gave the following classification: (a) behavioural causes, (b) disease (illness) cause, (c) non-illness cause and extra-mundane cause. The underlying principle of this classification is to assist in the prevention and/or treatment of the disease. For instance, where the cause is behavioural, avoidance of such behaviour directly means prevention of infertility.

It is quite clear that in spite of the causes of infertility, not all cases of infertility can be successfully treated by either or all of the various healers, be it Western medicine, contingency (traditional) medicine and spiritual homes.

As a result of this knowledge, it can be said that a lot of actions are taken by infertile couple, divorce of spouse, remarriage, polygyny, infidelity, pregnancy as a test of fertility and subsequent abortion in order to fight against infertility. Socially speaking, these are rational actions embedded in the socio-cultural belief of the people which further influence their knowledge, perceptions, attitudes toward infertility and other resultant diseases.

From the study, it was found that the rate of extra-marital affairs among infertile couple is high (54.3%) when compared with that of their fertile counterparts.
In effect, infertile women in the process of test-running their fertility level, end up sleeping with numerous male counterparts and most times unprotected. However, it was found that husbands of childless women engage in extra-marital sex more than their wives. The rate of extra-marital affairs of the husbands of infertile women is 91.6%.

Five other options were discovered that the people use to cope with infertility either during treatment or when treatment fails. The option frequently used when treatment fails is surrogate marriage or surrogate motherhood. In the former, the childless woman marries another woman in her own name and hands her over to her husband or where the husband is dead, allows the new wife to sleep with any man of her choice in order to get children in the childless woman’s name. It is the responsibility of the childless woman to take care of her “wife” as a husband does except in sexual affairs. In return, the newly married woman and her prospective offspring belong to the childless woman and bear her husband’s name and also inherit his property. It is important to note that the childless woman’s “wife” is not restricted by culture or any law on who she should have sexual intercourse with as far as she can produce children especially male children.

In the case of surrogate motherhood, a man who noticed that he is infertile may ask his brother or friend to have sexual affairs with his wife in order to produce children for him. The children of such affair belong to the husband of such a woman. This is accepted by the culture even though it is done with some high level of secrecy.

As a result of the acceptability of these coping strategies in the society, the study sought to know the people’s level of awareness concerning the health consequences of sex with multiple partners. It was revealed that the level of awareness was high. However, the people strongly believe that getting a child is worth any risk one may encounter on its way.

On the other hand, the second assumption that some diseases lead to infertility which further leads to other health problems is supported by the analysis of the rate of extra-marital affairs and the causes of infertility. The factors utilized in the analysis include the differences in the rate of extra-marital sex between fertile and infertile women, the difference in the rate of extra-marital sex between infertile women and their husbands as well as the trado-biomedical views of causes of infertility. From this standpoint, it was found that some diseases such as pile and STDs could lead to infertility while infertility itself could result to HIV/AIDS through the high rate of extra-marital affairs in a bid to get children. This frequent changing of sexual partner in order to have children does result into some health problems.

CONCLUSION

Infertility and some cultural practices are interwoven. This is one of the reasons extra-marital sex in the quest for children is high but accepted by the society. So, infertility exposes couple to dangerous sexual habits that have
adverse health consequences for human society. It is a disease that needs to be checked to save human race from total contamination. This is because in spite of the fact that most husbands of infertile women are aware of the consequences of their indiscriminate sex, they still cannot but do it in order to save their family from extinction. With this zeal, if infertility is not addressed urgently, it may pose a dangerous blockage to human existence.

On the other hand, infertility exhibits its complexity through its varied causes. So, it is a disease that most times results from other diseases and it could also lead to other diseases. Based on this point and looking forward to prevention of infertility, the study on which this paper is based formulated “Disease Interrelationship Model” (DIM). This model believes that no disease is in isolation. Every disease belongs to a network of causal and resultant infirmities. The major implication of this model is that if any disease in the network is checked at the point of entry into this network, the entire system may be truncated leading to a reduction in the resultant disease(s). For instance, if pile is checked, it will cause a reduction in infertility and subsequently STDs. In other words, if STDs are successfully prevented, surely infertility will be reduced.

It is the belief of DIM that most diseases whether in humans or even animals have a network. It is this network and its expanse that determine the severity and complexity of such disease. This study has established a clear-cut definition of disease networking. This network of diseases and associated consequences is referred to as “Disease Union” (D’union). So, a D’union is a group of diseases that belong to the same network in terms of etiology and consequences. In other words, this study was able to establish an infertility D’union. A D’union is named after the disease at the center of its network. Therefore, it is also possible to have an “AIDS D’union”. This line of thinking is essential in order to isolate disease networks with the aim of disorganizing such networks with resultant effect of achieving and promoting good health.

It is essential to emphasize that every D’union has an entry point. The entry point may involve multiple diseases while the exit has only two possible outlets – restoration of health or death. However, the aim of Disease Interrelationship Model (DIM) is to achieve and sustain good health for all through prevention of the entry-point-diseases in a D’union. This is important because diseases are not studied for their own reason, but to rescue their victims from their pangs.

This paper has exposed some of the health implications of infertility and the networking of diseases. It is also clear that a healthy society is a wealthy society. As it is presently, millions of women in Africa are heavily pressed under the heavy hands of infertility while millions of others are suffering from diseases resulting from infertility. A lot of others are being exploited daily and economic resources wasted in the quest for child. Therefore, if societies and their functional units are to be maintained; and if infertility and its attendant health consequences are to be prevented or positively adjusted; it is important that intervention efforts move beyond the present strategy.
RECOMMENDATIONS
So, fertility health education and mobilization programme, which has been identified as a catalyst to reducing the influence of socio-cultural factors affecting utilization of infertility health care services, should be encouraged. The expected programme should enlighten people on how to avoid or overcome problem of infertility and empower women economically to be able to cope with the financial requirements that infertility may create.

Similarly, infertility treatment in hospitals should be practically free. This is possible if billions of dollars could be spent on contraceptives, why not for the treatment of infertility. As part of the effort towards treatment of infertility, contingency medicine should be separated from traditional religion. This is because medicine could not advance in Europe until it was separated from their traditional religious belief. And effort should be made to integrate contingency medicine with modern Western medicine.

On the other hand, late marriage especially for women should be discouraged. Again, prospective couple should be encouraged to go for ABO Rhesus compatibility test. This is because a woman whose rhesus factor is negative will have problem if she marries a man with positive Rhesus factor. However, when this is dictated early, the woman must be given Rhogan injection within 72 hours after every delivery. This prevents secondary infertility. Family planning programmes should incorporate prevention and treatment of infertility if it is to be meaningful to all. All these will surely go a long way to improve the lives of women and reduce their psychological trauma especially as regards childbirth.

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