Aphrodisiacs, Phallic Competence, and Dominant Masculinity

Daniel Y. Fiaveh[1*], Michael P. K. Okyerefo[2], Clara K. Fayorsey[2]

1 Centre for Men's Health and Sex Studies, Accra, Ghana
2 Department of Sociology, University of Ghana, Legon, Ghana
*Correspondence: fiaveh@yahoo.com

Abstracts
We explore how aphrodisiacs influence the construction of phallic competence and dominant masculinity using in-depth interviews with 20 women and 16 men in a suburb of Accra, Ghana. Specifically, we explore women and men's conceptions of aphrodisiacs and phallic competence, how women negotiate male use of the former to achieve the latter, and implications of aphrodisiacs for the conceptualization of dominant masculinity. The media comprise key sources of knowledge about aphrodisiacs (locally brewed gins, hard liquor, and traditional medicines). Two main reasons emerged why men who used aphrodisiacs did so: to proof and or showcase 'real' masculinity, perceived in terms of phallic competence (the ability to sustain erection, to prolong sex, and to enhance a female partner's sexual pleasure); and female engagement with masculinity i.e. women demanding conjugal or sexual rights based on men's own perception of what it takes to be a 'real' man. *Phallic competence* was expressed in varied ways (e.g., *borsu, borsu kena*, *כרכgbכ, 'strongman'*) and depends on relationship dynamics and age. The findings show that phallic 'incompetence' is a threat to masculinity and can dislocate it as women exert indirect pressure (such as ridicule) on their men to seek sexual virility induced by men's understanding of women's notion of real masculinity. While there is the need to intensify education about beliefs that reinforce pressure on men as sexual 'performers', it is equally important to demystifying beliefs around sex and highlight the health implication of aphrodisiacs using state regulatory agencies such as the standards board and the media as key agents.

Keywords: aphrodisiac, phallic [in]competence, masculinity, sexual pleasure, sexual health

Introduction

The study explores how uses of aphrodisiacs influence the construction of dominant masculinity (the duration of sex and the stimulation of sexual pleasure) using urban Ghanaian samples. Although studies have looked at aphrodisiacs, many of such studies have focused on sexual behaviour among adolescents and young adults (e.g., Mataure et al., 2002), or concentrated on an

ethnobotanist perspective such as the medicinal values of those plants reported to be of use (Miller, 1985; Van Andel, et al., 2012), or dwelt on aphrodisiacs as alternative complimentary medicines (CAM) or herbal remedies to conventional therapy (WHO, 2003). There is a dearth of knowledge on women's conception of aphrodisiacs and how they [women] negotiate male use of the substance to achieve phallic competence, and to the resultant understanding of dominant masculinity. The study is useful in the discourse on the subject and contributes to the literature on hegemonic masculinity, men's health vis-à-vis femininity, and the negotiation of male sexuality in sub-Saharan Africa.

Aphrodisiacs contribute to understanding male sexual behaviour especially in relation to dominant masculinity as expressed in a man's ability to satisfy a woman sexually. Aphrodisiacs are in a variety of forms, such as food, drinks (e.g., hard liquor), medications (e.g., Viagra) or herbs that stimulate sexual desire, sexual drive or prolong sexual encounters (see Friedman, 2003; Gawin, 1978).

Although there are several reasons why men use aphrodisiacs, notably for medical purposes like curbing erectile dysfunction), psychosocial/sociocultural reasons (such as 'dominant' masculinity expressed in the notion of phallic competence women's demand for conjugal rights in view of male 'performativity', i.e. a man's ability to satisfy a female partner sexually) largely explain male use of aphrodisiacs (Fiaveh, 2014). There is a widely held perception that women who are dissatisfied with their male partners' inability to satisfy them could sexually seek sexual gratification outside the relationship (Fiaveh et al., 2015b). For instance, it is reported that across the globe men use a variety of traditional and modern products (notably Viagra) as means to achieve phallic competence (see Friedman, 2003) in the quest to proving masculinity, i.e. men proving their worth to women. Thus, although dominant masculinity has been understood as the

pattern of practice that allowed men's control over women (Connell, 2000; Donaldson, 1993), it also functions to subordinate men based on meanings held and self-definition (see Adomako Ampofo & Boateng, 2011; Butler, 2011; Connell & Messerschmidt, 2005; Collins, 2000; Cornwall & Lindisfarne, 2005; Howson, 2006). In this regard, the use of aphrodisiacs functions to subordinate men as they seek to live by hegemonic standards although studies (see Connell, 2005) show that not all men attempt to live out the said standards.

Although research tells us little about aphrodisiac use in Ghana, the media remains a prominent source of knowledge on aphrodisiacs and constructions of 'real' masculinity. Part of the reasons for this is explained by cultural beliefs that expect 'real' men to satisfy their women sexually. The societal values on sexuality differ for girls and boys through the significant stages of life (e.g., puberty and marriage). Girls are taught about their sexuality, especially their roles as wives and strategies to make sex pleasurable for themselves and their partners. Sarpong (1977) notes in his *Girls' Nobility Rites in Ashanti* that older women share experiences with younger women on how to strategically seek and demand sexual pleasure from their male partners. Hence, among the matrilineal Akan, the sexual dissatisfaction of a woman could constitute grounds for divorce (Akyeampong, 1997; Sarpong, 1977). By the same token, boys' virility is coterminous with a declaration of masculinity, i.e. living up to the standard of being a 'real' man' (*barima*), one who is able to satisfy a woman sexually and father a child (Adomako Ampofo & Boateng, 2011). As such, a man who is perceived to lack these qualities is an object of ridicule, frequently so during petty quarrels with his wife. Obviously, such a man isnot well placed to be a 'real' man and is referred to variously as "Obaa barima" in Akan, literally meaning a female man[1], "mele ŋutsu me o" in Ewe, meaning he is not a man, an expression also

[1] The term does not necessarily always imply a lack of sexual 'performativity'. It can also be used for men whose gender performances are neither "male" nor "female" (see Asante and Roberts, 2014).

used to express impotence. The male sexual characteristics that are approved of or encouraged include the need to ensure a woman's love and sexual fidelity through phallic competence. Metaphors such as □*y*□ □*barima* (he's a real man) are some of the symbolic meanings that inform real manliness in Ghana (see Fiaveh et al., 2015a).

Indeed, in many parts of Africa including Ghana, a central idea of maleness is underscored not by the mere physical features such as the penis but the ability of a man to use it to satisfy a woman sexually (see Fiaveh et al., 2015b; Ratele, 2004). Given our background as sociologists, our expectation for this paper is to bring to the fore issues such as medicine use and sexual health in the quest for men to live up to being real men by the use of aphrodisiacs.

So, how do women and men in Ghana construct phallic competence? How do Ghanaian women negotiate male use of aphrodisiacs to achieve phallic competence? And how are these reflected in their notions of real masculinity in urban Ghana? Drawing on the narratives of 20 women and 16 men in Madina, an urban community in Accra, Ghana, we provide exploratory evidence that argues that aphrodisiacs are a significant constituent of masculinity for both women and men and consist in one of those markers of vulnerability that subordinate men.

Method

Participants and procedure

Data presented in this study is drawn from in-depth interviews conducted from February 2012 to April 2012 in Madina, Ghana. The study was part of a larger project aimed at understanding sexuality in Ghana, by interrogating sexual pleasure and the construction of masculinities and femininities in urban Ghana.

Madina is a suburb of Accra and in the La-Nkwantanang-Madina Municipal Assembly, a

district in the Greater Accra Region of southeastern Ghana. Madina is next to the University of Ghana, the premier university and the largest university in Ghana with a total population of 101207 (see GSS 2012, *revised*). Madina is an urban community with mixed ethnicities such as Akan, Mole-Dagbani, Ewe, and the Ga-Dangme. It is composed of five communities, i.e. Madina Zongo, Nkwantanan, Tataana, Taatso and Madina Estate. For purposes of the research, Madina Zongo and Madina Estate were selected, a choice based on mostly on convenience. However, the researchers believe that a qualitative exploration of women and men's beliefs and experiences of sexual pleasure in Madina gives us some inkling about sexuality in urban Ghana.

The study was exploratory in character. The population of interest consisted of Ghanaians, 15 years and above, the reason being that this population includes the dominant age bracket of people who report being sexually active in Ghana (GDHS, 2008), who had ever had sex, were residents of Madina, and were willing to participate in the study. Within this population, interviewees were selected based on ethnicity, education, marital status, religion, and sexual activity. Interviewing these sub-groups also brought heterogeneity to the sample and diversity of beliefs and experiences in matters of sexuality.

There are different forms of aphrodisiacs in Ghana such as locally brewed gins (e.g., *Akpeteshie, Madingo, Herbal Afrik,* and *Alomo Bitters*), licensed traditional medicines (e.g., *GIFAS Papapaaa, Angel Natural Capsule, Kingdom Ginseng Power Capsule, Rockman Capsule,* and *Gidi Powa*), unlicensed foreign and traditional medicines (e.g., *gbamaa gbamaa, power, bura, man-woman, for men,* and *for women*), and illicit medicines (e.g., *wee* or *marijuana*) (see Fiaveh, 2014). The street of Zongo Junction, one of the study communities in Madina, is noted for the popularity of the sale of unlicensed traditional aphrodisiacs by traditional medicine healers also known as *Maimaganis* (Hausa, meaning dealers in medicines or herbs) and

Mallams[2] (Hausa, meaning traditional healers). Hence, a qualitative exploration of women and men's beliefs and experiences of aphrodisiacs in Madina gives us inkling about sexuality in urban Ghana.

Access to interviewees was in their homes and work places (based on appointment). Purposive and snowball sampling techniques were used in the study. Purposive sampling was used because of its effectiveness in identifying specific interviewees by virtue of having direct and personal knowledge of some event (e.g., had ever had sex, marital experience) that they are able and willing to communicate (Bryman, 2008). For example, there was the need to capture the sexual experiences of different demographic groups such as the married and the unmarried, the employed and the unemployed, as well as variations in ethnicity, religion and sexual experiences. The interviewer approached potential interviewees (such as female artisans at work i.e., a seamstress) with the view of having a general discussion about young people's sexual behaviour although this was not the focus of the study. Rather, it was a strategy for soliciting response due to the sensitive nature of the study. However, this approach was useful because in Ghana, adult women and men are willing to share their views on young people's sexuality, especially in relation to what they regard as the 'immoral' behaviour of the youth. Thus, we discovered that a good approach was for the interviewer to ask a female participant to share her views on youth sexual behaviour and then redirect the conversation to focus on the participant's own sexual experiences, including the use of aphrodisiacs.

We then employed snowballing to identify other interviewees who were willing to participate in the study based on referrals by other interviewees (see Biernacki and Waldorf, 1981). This method was appropriate because again the study concerned a sensitive issue, sexual pleasure, for which we required the knowledge of persons who know those who would be willing

[2] Both titles could, however, have different meanings in different contexts.

to participate. For female interviewees in particular, the interviewer started each discussion with an oral vignette technique that problematised men's control over women's sexuality. For example,

> Please, I am [name deleted for masked review], an Ewe man, but fluent in Twi, Ga, and Hausa [all these being major languages in Ghana]. I spent my childhood days and youth in Accra New-Town, Nima, Akotes, and Madina-UN. My experience in these suburbs of Accra shows that women really have power, contrary to what some people think of women. To most people, men have total control over their women. I think this is not entirely true. In order to document this and to tell the story of women from their own voices, I am undertaking this study. The study focuses on intimacy among men and women. Please, would you be willing to participate? What do you think? (Interviewer: man).

The stress on the ability to speak the local languages in the above quote served as a means to building a rapport with, and eliciting confidence and trust from the interviewees. It was also a means to helping interviewees feel free to discuss their sexuality in their native language without any inhibition, especially in the case of those who had difficulty in expressing themselves in, or understanding, English.

While some argue that women's difficulty in expressing their sexuality is due to religious and cultural inhibitions (the notion that women's open expression of sexual desire is "bad" or "filthy"), others such as Pereira (2003) and Bennett (2011) argue to the contrary that the silences around women's sexuality have many sources. Given the interviewer's gender as a male researcher, we had expected that more males than females would be willing to participate in the study. This is due to the popular [mis]perception that women do not discuss their sexuality with persons who have no 'trusted' relationships with them. Despite this notion, most of the women

willingly shared their sexual experiences with the interviewer. This was because he had assured them of confidentiality and the use of the data was for academic purposes only. Most of the women showed their appreciation for the study and indicated that they (some) had ever engaged in an academic research. Although, we had anticipated the unwillingness to participate for less educated women, the claim that someday they may also need other peoples help in whatever field they are motivated their participation in the study.

In addition, the respect the interviewer accorded the women, for example through the native way of showing humility such as *"Me pa wo tsew"* (Twi, I beg you), his strategies (such as cracking little jokes during the interaction and sharing with them his own sexual experiences), and the ability to communicate in multiple languages (such as Twi, Ewe, Ga, and Hausa) won his interviewees over. Although some may argue that this assertion amounts to an overstatement of his "skills" because people tend to talk to strangers (e.g., about sex, love, etc.), we believe these factors, to some extent, supported his ability to persuade some of the women in discussing their sexuality with him freely though with some limitations (such as indicating sensual areas).

In two instances, a female interviewee during the interview introduced her friend who had been curious (i.e. eavesdropping) about what was going on between the interviewer and the interviewee. The interview was paused to ensure the confidentiality of the interviewee. The intruder said *eh! meke faru nan?* [Hausa, meaning what is happening here?]. *Meh esa kun beri fera yendeh kun genni?* [Hausa, why have you two stopped chatting suddenly upon my entry?]. She then turned to the interviewer and said in Twi *eh! menaadaa menua baa no oo, marima nka nokore* [meaning, make sure you do not deceive my sister for you men are liars]. The interviewee then requested that the interviewer talk with her friend afterwards, *mepa wo kyew se ye wie a ene ono nso nkasa* [Twi, meaning please when we finish, engage her also]. All

interviews were conducted by the first author and interviewees were assured of anonymity and confidentiality.

The central question was: do you use aphrodisiac/sex enhancing medicines (probing for the choice of aphrodisiacs and for why, and awareness of sexual risk)? The Institutional Review Board (IRB) of the Noguchi Memorial Institute for Medical Research, University of Ghana, granted ethical clearance for the study (NMIMR-IRB CPN 048/11-12; Annex 1). Data were collected with informed consent and the names attributed to informants in this paper are pseudonyms to protect confidentiality.

Data analysis

Audiotape interviews were transcribed verbatim using expert translators. The transcripts used pseudonyms for interviewees while the location of interviewees and date of interviews were altered. All records (e.g., interviews and transcripts) were treated confidentially.

The transcripts were read three times since the interview focused broadly on sexual pleasure and were not only about aphrodisiacs. The first two readings were to help understand the transcript and highlight emerging codes and themes. The second reading focused specifically on aphrodisiac use and definitions of phallic competence. Notes were recorded for further use. In the final reading, a coding frame was developed. The coding was carried out using a constructivist paradigm (i.e. in terms of socially constructed power relations), interviewees' lived experiences (i.e. in terms of personality), and personal lived experiences (including our interpretations of the quotes). The themes developed include conceptions of aphrodisiacs and phallic competence, femininity and phallic competence, and aphrodisiacs and dominant masculinity**.** The segments with similar meanings were coded under one theme to avoid repetition of themes. New here means whatever we discovered that was unknown to us as

researchers and novel for existing theoretical and policy debates concerning women's negotiation skills in matters of sexuality.

The first author contacted all the interviewees three months after the interview for a meeting or telephone conversation. In this conversation, he presented individuals with some preliminary findings and interpretations of their narratives in order to seek confirmation and feedback regarding interpretations of the data. While he was not able to contact all interviewees (due to their work and busy schedules, relocation, travel, communication problems, and other reasons), the feedback from those contacted (6 women) is presented as part of the discussion. The interview extracts included in this paper were the direct translation of the interviewees in their local languages and oral ('broken') English. This is to retain faithfulness to the transcripts and to project the interviewees' own voices.

Results

Overall, 20 women and 16 men aged 22 to 79 years participated in the study. The age distribution shows that more than half of interviewees were under age 40. With the exception of two interviewees who were pursuing full-time education, the rest were working. Twenty-three were Christian, 10 were Muslims and three did not belong to any religious faith. Sixteen were married. Thirty-three had attained at least some basic education except three (Annex 2). Three main themes emerged in the discussion of the findings, i.e. the interviewees' conceptions of aphrodisiacs and phallic competence, femininity and phallic competence, and implications of phallic [in]competence.

Conceptions of aphrodisiacs and phallic competence

The media (TV and radio) and billboard adverts were the main sources of knowledge for the

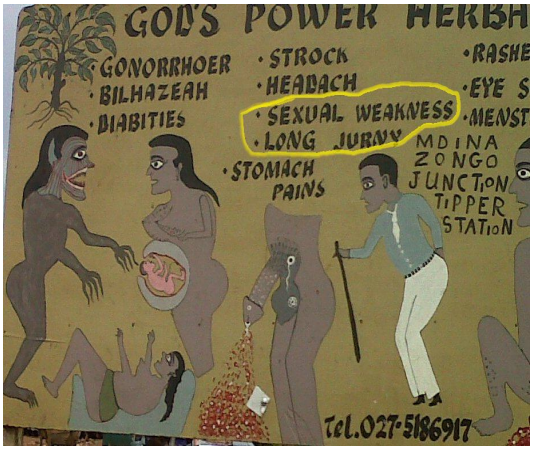
majority of interviewees regarding aphrodisiacs, with men reporting more knowledge than women did. In particular, younger men reported media messages that focused on the declaration of the masculinity than older men (those above 40 years) and women did. Messages also strengthened stereotypical sexual beliefs and were constructed in varied ways such as *borsu, borsu kena, ɔgbɔrɔ, barima, ele ŋutsu me, efɔna zaame* (in local parlance, meaning real men) and '*strongman'* based on the ability of a man to have sustained erection in order to prolong sex and to satisfy a woman sexually. The construction of phallic competence also depends on relationship dynamics and age. Unmarried and younger men were seen by women and men as sexual 'performers'. While women stressed that sex is about love and should be guarded (that is ideally occur in marriage) they also stressed that sex must be enjoyed, with views steeped in religious explanations.

The interviewees (women and men) indicated that phallic 'incompetence' induces aphrodisiac use. They mentioned different types of aphrodisiacs such as liquor, herbs/concoctions, drugs (liquid, powder, tablets, lotion). The source of the aphrodisiacs had both foreign (e.g., *man-woman* with Chinese origin) and local source such as traditional medicine sold by *Maimaganis* and Mallams e.g., *power, soldier, matso,* and *bura* (Hausa, meaning penis). The choice of aphrodisiacs, according to the male interviewees, was based on *potency, i.e.* sustained erection/penile elongation, prolonged sex, and pleasure. The main sex aphrodisiacs common to the interviewees were those of *Maimaganis* partly due to the proliferation of such persons along the streets of Madina especially the Zongo Junction, one of the study areas. The medicines of *Maimaganis* are from 'traditional' trees with sources in Ghana, Niger, Mali, Burkina Faso, Nigeria, and Senegal. A *Maimagani* had this to say about the source of his medicine:

> This is from a pounded tree I manufactured from Niger. It is not a tablet but a tree I pounded. This tree is not in Ghana except in Niger. The name is "anza" [name of the tree in a Nigerien language], it prolongs erection. (Man aged 46 years, married, no formal education, Muslim).

Among the unlicensed traditional medicine dealers, it was possible to distinguish their religion based on their expressions and language used in their advertisements such as on billboards. For example, a non-Muslim *Maimagani* typically has an inscription such as *God's Power Herbalist* (see Figure 1), thereby appealing to Christians (mainly men) with sexual '*weakness'*.

Figure 1 Advert of an Unlicensed Non-Muslim Traditional Medicine Healer



Source: Fieldwork, 2013 *'Jurny' is journey, meaning sexual duration

Men indicated that because the unlicensed ones are most often locally manufactured, they have more 'potency' than the foreign ones. A man had this to say:

> Some think that the local ones are the best. For that one [locally manufactured aphrodisiac] is not good….it prolongs sex too much and you even get tired. It gets to a time you don't feel the thing "sef" again [you experience fatigue because it over prolongs sex]. I can conclude boldly that it is the orthodox one that is more effective with me. (Wiafe: 38 years,

unmarried, higher education, Christian).

Femininity and phallic competence

Aphrodisiacs are associated with the construction of phallic competence, i.e. the ability to satisfy a woman sexually. In Ghana, especially in male-female sexual unions, men are expected to satisfy their wives sexually in order to qualify in the scheme of socially constructed norms as 'real' men. Such expectation exerts pressure on men to seek help with sexually enhancing medicines than women do. Although several reasons were offered for the use of sexually enhancing medicines (such as adventure), men who used aphrodisiacs did so because they wanted to delay their ejaculation to prove their worth to women. Women also engaged with men by demanding their conjugal and sexual rights directly and indirectly depending on relationship dynamics (e.g., married or steady dating relationships), age and partners' open-mindedness. Directly here means being blunt about their partner's sexual weakness via communication of sexual dissatisfaction (e.g., through text messages or face-to-face conversations), ridicule, and in a few instances, ridicule in the form of 'insult'[especially when a male partner is also perceived not to be living up to other obligations e.g., financial obligation, as expected by the woman]. For example, ridicule was often associated with male early ejaculation. The meanings attached to 'early' ejaculation were located in issues of 'failed' masculinity (e.g., *Seisei ara na chrodododododo dee 'ye enim goasie* [an onomatopoeia in Twi, meaning releasing too early is very shameful], *onye na se dee se marima* [Twi, meaning he has 'failed' in his duty as a man]). Men who are able to sustain erection to satisfy women or wives sexually were described in local parlance by women and men in particular as *borsu kena* [Hausa, meaning you are the boss],

borsu [PG meaning performer], כרכgb[3] [Ga meaning 'performer' or boss], '*strongman'*, etc. Married men in particular, who were unable to live up to the expectation of satisfying their wives, were the object of ridicule in the media and were often admonished to seek sexual verity with the help of their female partners. A male interview had this to say

> Charlie, the women dey laugh we all the time am oo [Pidgin English, some men are ridiculed for not being able to satisfy their wives sexually]. The adverts all over the place. You see some pastor telling a husband that "ei my man this is not prayer matter oo, pe aduro bi ye [seek sexual help]. Hahahahha, oh charlieee [stress] (Nuru: 40+ years, married, higher education, Muslim).

A female also showed the interviewer a text message [through a social media known as *WhatsApp*] she had sent to her partner regarding her persuasion that he patronize a locally manufactured aphrodisiac in order to enhance her sexual pleasure. She claimed that she is able to tell her partner to do 'something' so they could both enjoy sex. This was what she said, including the text message:

> Let me show you a text ok, but please it's between you and me oo. See this [interviewee shows the text message to the interviewer]. "Miss U paaa. Our romance is good but when it comes for U [you] to penetrate, U don't last even ten minutes. U do come too early. What makes U come early like that? Or should I get U a natural medicine?" (Akofa: 30 years, unmarried, higher education, Christian).

Female engagement with phallic competence was also indirect (i.e. discrete) in the form of anger for no reason, refusal of sex, conversation with friends and 'religious mentors', especially for those who were married and had strong commitments to religious beliefs. All these are still associated with male early ejaculation. Therefore, it is not surprising that considerable numbers

[3] This is a common expression in Ghana and pertains in other local languages.

of aphrodisiacs advertised target men and premature ejaculations. Even unlicensed traditional healers who sold aphrodisiacs to females, the target were ultimately their men. Thus, the idea was to prolong sex by dealing with men's premature ejaculation, make sex pleasurable, and possibly propel conception for partners in need of children. *Aduro wora*, a female Maimagani said:

> I've been doing this work for thirty years. I work at Makola. I've helped a lot of people to give birth. As soon as I get to 37 or Korle-Bu they start saying that's the woman coming. Then they will tell me that they will tell their friends that this woman is very good. She can [i.e. her medicines] make you go ten rounds. "Wɛ ni bɛ gye. Wo bɛ wo afa wo hun afa wo ba" [Twi, you will have pleasure, and bear a child without any complications]. After some time, may be next month, you'll tell me that the woman is pregnant for you and I will say, I told you so. (79 years, widow, no formal education, not religious).

To our mind, inasmuch the use of aphrodisiacs is meant for men is to have a 'delayed' ejaculation, in the process women also have 'delayed' sexual pleasure. Thus, women strategically engage masculinity as men seek to prove their phallic competence. Phallic 'incompetence', therefore, is a threat to masculinity and can dislocate masculinity (e.g., ridicule, and loss of respect).

Implications of phallic [in]competence

The findings show that phallic [in]competence has both sexual health and social consequences for masculinity as well as lead to male vulnerability and intimate partner violence. The male interviewees mentioned challenges in relation to 'uncontrolled' erection as a result of the use of aphrodisiacs. Those who patronize herbal remedies and concoctions by *Maimaganis* indicated that there are difficulties that result from the right dosage of the concoctions and timing in terms

of when a female partner is available for sex. The challenges are based on the marital status of a man and whether a female partner is ready for sex in terms of being in the right mood for sex, in her menstrual cycle, or has accepted sexual overtures, especially for those in dating relationships who did not live with their partners. An unmarried man, for example, recounted his experience of "blue balls" upon taking the concoctions of a *Maimagani* in anticipation of his 'girlfriend' who after a long wait, indicated that she was experiencing her 'menstrual period' and that she was unable to have sex because it contravened her religious and cultural beliefs. Wiafe, a man aged 35 years had this to share:

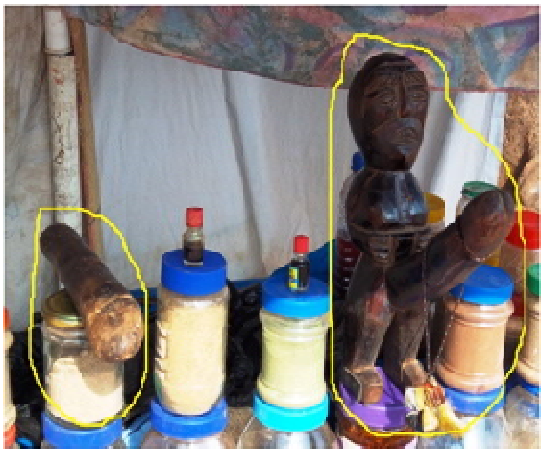
> Charlie, the thing [the concoction] hmmm ino be easy ooo. Charlie, a dey on like 30 minutes. You know waitin happen? The girl come ah e say e dey in menses, hahahah [both laugh uncontrollably] way a talk am say a beg am waa in forgo wash down. Charlaaaaey [stress]. "blueballs" be what. A force am put am but she no agree. So me a vow say that thing dieer no way for me again. Kont na hand, power for ground [both laugh uncontrollably] [in Piggin English, the medicine is too powerful. I erected for 30 minutes and when the 'lady' finally came, she said she was menstruating. I tried persuading her to wash her vagina so we can have sex but she refused. I even forced her but to no use. I tell you the medicine is too powerful and so I vowed never to take such medicine until I have a woman with me who has agreed to have sex] (Unmarried, higher education).

Although this could be a lame excuse to be violent and does not happen to all men, the use of aphrodisiacs and female sexual refusal has implications to intimate partner violence due to 'uncontrolled' erection leading to "blue balls", i.e. a prolonged state of sexual arousal. Surely, the men had knowledge of the health implications regarding the use of sexually enhancing drugs, but '*manpower' i.e. sustain erection* (see Figure 2) took precedence over sexual health. This shows that although people may have sexual health knowledge, knowledge does not often

translate into behaviour.

> **Interviewer**: Did the medicine [sexually enhancing drug] from the Maimagani make your penis large?
>
> **Fonyeh**: No, those ones are there, I did not go for that one. They are different, different, different, if you want the penis enlargement ones, they have it. This one I took, they call it 'power', they call it power…It gives power because the guy told me himself that he will not use [it]. I asked him why and he says he is a small boy, he will not do that thing. It tells you straight away that it has side effect. (Man, 39 years, married, higher education, Christian).

Figure 2 prolong erection of phallic competence from local aphrodisiacs



Source: Fieldwork, 2013

While women also had concerns about the health risk of aphrodisiacs, some encouraged the men to patronize the services. The benefits women derive out of men's use of aphrodisiacs are to delay men's ejaculation in order to prolong sexual intercourse and stimulate sexual pleasure. Pressure from their female partners indirectly induced men's use of aphrodisiacs. Such pressure came in subtle ways through conversations after sex and through text messages. In most cases,

the imports of these messages were expressed as *today deɛ why?* [What happened today or made the difference today?]. Alternatively, *what makes you come early?* The import of these conversations, coupled with the notion of being a 'real' man, made men patronize aphrodisiacs. Yet, these men do not recognize the power of women regarding the subtle ways (verbal and nonverbal) they "control" them in using these medicines to enhance their pleasure. Nuru, a married Muslim man, aged 40+ had this to say:

> You see these things are just for the fun of it oo. When it takes long it's nice to them and you too you want to… She [wife] does not complain of any extraordinary thing, she hardly talks about those things but maybe her question "today deɛ why?" [PG, what made the difference today] can speak volumes (Higher education).

Discussion and Conclusion

The study explored how uses of aphrodisiacs influence how women and men perceive real masculinity. The interviews were conducted by a male researcher who was discussing culturally sensitive topics on sexual pleasure with female and male respondents. There is a possibility that some respondents were inhibited in their answers or simply provided what was perceived to be culturally acceptable answers. However, the interviewees (both women and men) willingly participated in the study and had no inhibitions or difficulty in expressing their sexuality. Those who had difficulty in discussing aspects of their sexuality either chose to withdraw from the study or preferred to be indirect in their responses to questions.

What is evident in the study was that the media remains key sources of knowledge about aphrodisiacs in Ghana. Two main reasons emerged why men use aphrodisiacs: to proof phallic competence (such as ability to sustain erection, to prolong sex, and to enhance a female partner's sexual pleasure) depending on relationship dynamics and age; and women demanding conjugal

or sexual rights based on men's own perception of 'real' masculinity. Inasmuch as the meanings of real masculinity in relation to phallic competence for men is to have a "delayed" ejaculation in order to satisfy a woman sexually, then, the primary object of sex from the perspective of men is not mainly about the satisfaction of their own sexual desires but women's based on men's notion of real masculinity and the quest to prove their ability to women as real men. Indeed, men have the 'burden' of masculinity, i.e. ensuring that the penis is able to erect, able to sustain erection in order to prolong sex, and to ensure that they are able to satisfy a female partner sexually. Consequently, they would resort to the use of all kinds of concoctions, with no scientifically proven effects and side-effects.

Phallic [in]competence has implications for men's sexuality. Although women had concerns about the burden that men had taken upon themselves, which is a threat to men's sexual health, the women equally expect of their men to live up to their masculinity, i.e. satisfy them sexually. How easy is it for, say, a husband or a 'boyfriend' to contest his wife's or girlfriend's request to seek sexual help, or to decide not to worry if his concubine tells him "*What makes you come early like that?* These are neither unimaginable nor impossible acts, but they carry heavy social and individual costs: ridicule, lost of respect, exposure to psychological or physical pressure, and very likely, tension, infidelity or worse. This emphasis on men's sexual weakness shows how dominant masculinity can subordinate men due to phallic "incompetence".

We conclude that dominant/'real' masculinity creates different kinds of individual realities for men and women as women strategically engage men's sexuality based on men's own views about masculinity vis-à-vis women's sexual pleasure. By implication, therefore, dominant masculinity is a threat to men's sexuality and does not only function to subordinate women but also men themselves based on the meanings of the situation (such as men proving to women that

men are capable of meeting women's 'unmet' needs sexually, i.e. becoming 'sexual performers') and how women engage with it (see Adomako Ampofo & Boateng, 2011; Bennett, 2011; Butler, 2011; Collins, 2000; Connell & Messerschmidt, 2005; Cornwall & Lindisfarne, 2005; Howson, 2006; Pereira, 2003). Dominant masculinity has implications for men's vulnerability; they become dislocated for fear (e.g., being 'weak' or 'failed' or ridiculed) of not matching up to the social standards of male identity construction, i.e. to be sexually fit as a 'real' man (see Connell & Messerschmidt, 2005; Fiaveh et al., 2015a) and harm (right dosage and timing of medicine use including possible weakness of sexual drive; see Shamloul & Bella, 2011). Harm reduction, therefore, implies the need to first educate men to be aware of the pressures of desperations that are coercive on their sexuality, as well as formulate policies to regulate the use of aphrodisiacs and advertisements. In this regard, then, there is the need to intensify education about beliefs that reinforce pressure on men as sexual performers and for gender advocates to highlight men's sexual health and rights in relation to their perceived and or stereotypical dominant sex roles. Demystifying beliefs around sex and highlighting health implication of aphrodisiacs, using state regulatory agencies such as the standards board and the media as key agents, will be useful. At the same time, healthy sexuality programmes particularly by churches, in view of the notorious religiosity of Ghanaians, to educate partners, men and women, would help promote a healthier lifestyle for all.

References

Adomako Ampofo, A. & Boateng, J. (2011). Multiple meaning of manhood among boys in Ghana. In S. Tamale (Ed.), *African sexualities: A reader* (pp. 420-436). Cape Town: Pambazuka Press.

Adomako Ampofo, A., Okyerefo, M. P. K. & Pervarah, M. (2009). Phallic competence: Fatherhood and the making of men in Ghana. *Culture, Society & Masculinity*, 1, 1: 59-78.

Akyeampong, E. (1997). 'Sexuality and prostitution among the Akan of the Gold Coast c. 1650-1950'. *Past and Present*, 156:144-173.

Asante, G., & Roberts, M. N. (2014). Reliving oppression: Becoming black, becoming gay. In S.

C. Howard (Ed.), *Critical articulations of race, gender, and sexual orientation*: Lexington Books.

Bryman A. (2008). *Social research methods* (3rd ed.). New York: Oxford University Press.

Butler, J. (2011). *Gender trouble: Feminism and the subversion of identity*. New York: Routledge.

Collins, P. H. (2000). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment* (2nd ed.). NY: Routledge. pp. 2-299.

Connell, R. W. & Messerschmidt, J. W. (2005). Hegemonic masculinity: Rethinking the concept. *Gender and Society*, 19, 829-859.

Cornwall, A. & Lindisfarne, N. (2005). Dislocating masculinity: gender, power and anthropology. In A. Cornwall & N. Lindisfarne (Ed.), *Dislocating masculinity: Comparative ethnographies* (pp. 11–47). London: Routledge.

de Costa, C. & Moore, M. (2003). *Dick: A Guide to the penis for men and women*. Australia: Allen & Unwin.

Dillon, B. E. Chama, N. B. & Honig, S.C. (2008). Penile size and penile enlargement surgery: a review. International Journal of Impotence Research 20: 519–529. Doi:10.1038/ijir.2008.14.

Donaldson, M. (1993). What is hegemonic masculinity? Theory and Society, 22:643-57.

Fiaveh, D. Y., Izugbara, C. O., Okyerefo, M. P. K, Reysoo, F. & Fayorsey, C. K. (2015a): Constructions of masculinity and femininity and sexual risk negotiation practices among women in urban Ghana, Culture, Health & Sexuality: An International Journal for Research, Intervention and Care, DOI: 10.1080/13691058.2014.989264.

Fiaveh, D.Y. (2014). Sexual Pleasure and the Construction of Masculinities: Understanding Sexuality in Ghana. PhD Thesis Submitted to the Department of Sociology, University of Ghana, Legon.

Fiaveh, D.Y., Okyerefo, M.P.K., Fayorsey, C.K. (2015b). Women's Experiences with Sexual Pleasure in Ghana. Culture and Sexuality. (DOI) 10.1007/s12119-015-9290-5.

Friedman, D.M. (2003). *A mind of its own: A cultural history of the penis*. New York: Penguin.

Ghana Demographic and Health Survey (GDHS) (2008). *Preliminary report (April, 2009)*. Accra: Ghana Statistical Service. pp. 1-41.

Gillen, B. (1981). Physical attractiveness: A determinant of two types of goodness. *Personality and Social Psychology Bulletin*, 7, 277-281.

Howson, R. (2006). *Challenging hegemonic masculinity*. New York: Routledge.

Mataure, P., McFarland, W., Fritz, K., Kim, A., Woelk, G., Ray, S., & Rutherford, G. (2002). Alcohol use and high-risk sexual behavior among adolescents and young adults in Harare, Zimbabwe. *AIDS and Behavior*, *6*(3), 211-219.

Meyers, D. T. (2002). *Gender in the mirror: Cultural imagery & women's agency*. Oxford: Oxford University Press.

Miller, R. A. (1985). *The magical and ritual use of aphrodisiacs*. Inner Traditions/Bear & Co.

Nnuroh, D. F. (2006). Marital morality and sexual vulnerability in Ellembelle Nzema society. In C. Oppong, M.Y. Oppong, & I. Odotei (Ed.), *Sex and gender in an era of AIDS: Ghana at the turn of the millennium* (pp. 91-112). Accra: Sub Saharan Publishers.

Pereira, C. (2003). Where angels fear to tread? Some thoughts on Patricia McFadden's sexual pleasure as feminist choice. *Feminist Africa*, 2, 61-65.

Ratele, K. (2004). Kinky Politics. In S. Arnfred (Ed.), *Rethinking sexualities in Africa* (pp. 139-154). Uppsala: Nordic Africa Institute.

Sackey, B. M. (2006). The vanishing sexual organ phenomenon. In C. Oppong, M.Y. Oppong & I. Odotei (Ed.), *Sex and gender in an era of AIDS: Ghana at the turn of the millennium* (pp. 287-302). Accra: Sub Saharan Publishers.

Sarpong, P. (1977). *Girls' nubility rites in Ashanti*. Tema: Ghana Publishing Corporation.

Shamloul, R., & Bella, A. J. (2011). Impact of cannabis use on male sexual health. *The journal of sexual medicine*, *8*(4), 971-975.

Tamale, S. (2010). The right to culture and the culture of rights: A critical perspective on women's sexual rights in Africa. In C. O Izugbara, C. C. Undie, J. W. Khamasi (Ed.), *Old wineskins, new wine: Readings in sexuality in Sub-Saharan Africa* (pp. 53-69). USA: Nova Science Publishers, Incorporated.

Van Andel, T., Mitchell, S., Volpato, G., Vandebroek, I., Swier, J., Ruysschaert, S., ... & Raes, N. (2012). In search of the perfect aphrodisiac: Parallel use of bitter tonics in West Africa and the Caribbean. *Journal of ethnopharmacology*, *143*(3), 840-850.

WHO (2003). Traditional medicine: Fact sheet N°134 revised May 2003. http://www.who.int/mediacentre/factsheets/2003/fs134/en/. Retrieved on July 08, 2015.

Annex 1 Ethical Clearance

NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH

Established 1979 *A Constituent of the College of Health Sciences*
University of Ghana

INSTITUTIONAL REVIEW BOARD

Phone: +233-302-916438 (Direct)
+233-289-522574
Fax: +233-302-502182/513202
E-mail: nirb@noguchi.mimcom.org
Telex No: 2556 UGL GH

Post Office Box LG 581
Legon, Accra
Ghana

My Ref. No: DF.22
Your Ref. No:

30th January, 2012

ETHICAL CLEARANCE

FEDERALWIDE ASSURANCE FWA 00001824 **IRB 00001276**

NMIMR-IRB CPN 048/11-12 **IORG 0000908**

On 30th January, 2012, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) reviewed and approved your revised protocol titled:

TITLE OF PROTOCOL : **Sexual Pleasure and the Construction of Masculinities: Understanding Sexuality in Ghana**

PRINCIPAL INVESTIGATOR : **Daniel Yaw Fiaveh (PhD Candidate)**

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 29th January, 2013. You are to submit annual reports for continuing review.

Signature of Chairman: .....
Rev. Dr. Samuel Ayete-Nyampong
(NMIMR – IRB, Chairman)

cc: Professor Alexander K. Nyarko
Director, Noguchi Memorial Institute
for Medical Research, University of Ghana, Legon

Annex 2 Table 1. Demographic characteristics of interviewees

Res #	Pseudonyms	Gender	Age	Marital Status	Duration of Relationship	Education	Religion	Occupation
R1	Sumaya	F	36	Never Married	1 year	Primary	Muslim	Seamstress
R2	Fonyeh	M	39	Married	10 Years	Tertiary: Postgrad	Christian	Lecturer
R3	Asantewaa	F	43	Married	8 Years	Middle School	Christian	Trader
R4	Memuna	F	35	Remarried	2 years	SSS/SHS	Muslim	Trader
R5	Naa	F	37	Remarried	3 months	Tertiary: Postgrad	Christian	Lecturer
R6	Sitsofe	F	31	Married	2 years	Tertiary: Postgrad	Christian	Teacher
R7	Dism	M	25	Divorced	2 years	Tertiary: Undergrad	Christian	Social Worker
R8	Dogl	M	28	Never Married	Not in relationship	Tertiary: Undergrad	Christian	Medical Doctor
R9	Dzidzor	F	38	Never Married	2 years	Vocational	Christian	Social Worker
R10	Natuama	M	31	Never married	7 years	Tertiary: Undergrad	Muslim	Consultant
R11	Babaana	M	28	Never Married	4 years	Tertiary: Postgrad	Muslim	Civil Servant
R12	Kun	M	28	Never Married	Not in relationship	Tertiary: Undergrad	Christian	Medical Doctor
R13	Aida	F	37	Married	11 Years	Tertiary: Postgrad	Christian	Lecturer
R14	Hajia	F	53	Married	26 years	Never attended any	Muslim	Trader
R15	Zu	F	26	Never Married	6 Months	Tertiary: Undergrad	Muslim	Student
R16	Azetiska	M	33	Never Married	Not in relationship	Tertiary: Postgrad	Christian	Teacher
R17	Akosua	F	32	Never Married	Not in relationship	Tertiary: Postgrad	Christian	Business Woman
R18	Rev	M	67	Divorced	20 Years	SSS/JHS	Christian	Pub. Servant/Pastor
R19	Uncle	M	73	Divorced	8 years	Primary (Three)	Not religious	Retiree
R20	Nuru	M	40+	Married	5 Years	Tertiary: Postgrad	Muslim	Health Admin

R21	Anti Nurse	F	56	Divorced	10 years of Divorce	Post Secondary	Christian	Nurse
R22	Oko	M	33	Never married	1 year	Tertiary: Undergrad	Christian	Student
R23	Koshie	F	36	Married	1 Year	Post Secondary	Christian	Admin Assistant
R24	Gyamfua	F	25	Never married	6 years	Tertiary: Postgrad	Christian	Student
R25	Akofa	F	30	Never married	2 years	Primary	Christian	Health assistant
R26	Korku	M	33	Married	6 years	Tertiary: Postgrad	Not religious	Teacher
R27	Gustaf	M	42	Married	5 Years	SSS	Muslim	Businessman
R28	Baba	M	53	Married	10 years	Technical	Muslim	Contractor
R29	Maimagani	M	46	Married	12 years	Never attended any	Muslim	Sells medicine
R30	Aduro wora	F	79	Widow	25 years	Never attended any	Not religious	Sells medicine
R 31	Oye-Mansa	F	22	Married	4 months	Tertiary: undergrad	Christian	Student
R 32	Maame	F	30	Never married	5 months	Tertiary: Postgrad	Christian	Teaching Assistant
R 33	Adwoa	F	33	Married	10 years	Undergrad	Christian	Teacher
R 34	Jun	F	31	Never married		Postgrad	Christian	Nurse
R 35	Wiafe	M	38	Never married		Postgrad	Christian	Businessman
R 36	Absu	F	42	Married	8 years	Postgrad	Christian	Administrator

*****Senior Secondary School/Senior High School