

Cultural Etiologies of Disability in Ghana: A Case of Food Taboos in Pregnancy

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Abstract

In Ghana, most food taboos have their foundations in religious and cultural philosophies which reinforce negative etiologies and understanding of disability. Employing secondary data and personal experience; this article examines food taboos across three ethnic groups in Ghana and their cognitively held correlation with disability in unborn children and infants.

Keywords: disability, food Taboos, pregnancy, Africa

Ghana is rich in culture, religion, and philosophical values made up of animate, inanimate, and numerous unforeseen forces (Nyangweso, 2018; Abudu and Imafidon, 2019). These interact and help form the reality and worldview for many Ghanaians, helping explain and define what is expected in life (Abudu and Imafidon, 2019). This suggests that views and understandings of disability are similarly rooted in cultural, religious, and general societal perceptions with justifiable rationale and/or beliefs that are neither homogenous nor static (Roberts and Lindsell, 1997; Nyangweso, 2018). This article aims to draw attention to an overlooked perspective when it comes to consideration of disability in Ghana. This article will highlight some of the cultural underpinnings of disability in pregnancy with key references to food taboos. The contextual scope will be based on three (3) ethnic groups in Ghana: *the Ga-Adangbe, the Akans, and the Ewes*.

I draw my definition of disability from the International Classification of Functioning, Disability, and Health (ICF) model under the World Health Organization (WHO). This is because it is the definition adopted by the Ghana Statistical Service (GSS) during the 2010 population and housing census in Ghanaⁱ. The ICF modelⁱⁱ defines disability as “*the negative aspects of the interaction between an individual (with a health condition) and that individual’s contextual factors (environmental and personal factors)*” (WHO 2001:213).

Disability is therefore perceived as functional limitations and restrictions (Cobley 2018). Under this definition, three (3) components of functioning are considered: *body function and structure, activities, and participation*. The *body function/structure* correlates to the health condition/impairment such as vision or speech impairments, whereas the *activities’* function relates to the constraints in undertaking daily activities such as eating and walking. Lastly, the *participation* function comprises constrictions in aspects of life such as schooling and employment (Banks, Kuper, and Polack, 2017; Cobley, 2018; Cobley and Bezzina, 2019). The interaction of these three functions coupled with personal factors such as age,

gender, and environmental factors such as inaccessible infrastructure and negative behaviors determines the extent of disability.

This article is structured into three broad sections. The first section titled *an overview of disability, food taboos, and ethnicity* presents some background information on disability, food taboos, and ethnicity in Ghana and other parts of sub-Saharan Africa. This is followed by exploring perceived different disability-associated food taboos during pregnancy. The last section highlights some ways of addressing these purported disability-associated food taboos during pregnancy.

An Overview of Disability, Food Taboos, and Ethnicity in Ghana

Background of Disability in Ghana

In the 2010 population census, it is estimated that 3% of Ghana's population have some form of disability (GSS, 2013, 2014)ⁱⁱⁱ. Out of this percentage, 52.5% are females, whereas the remaining 47.5% are males (ibid). In Ghana, three (3) main religions are dominant: *Christian (71.2%), Islam (17.6%) and Traditional (Indigenous - 5.2%)*. Mirroring the religious structure of Ghana, 69.5%, 13.7%, and 7.8% of persons with disabilities (PWDs) are Christians, Muslims, and Traditionalists respectively. Concerning ethnicity, there are predominantly eight (8) ethnic groups in Ghana. In descending order are the *Akan (47.5%), Mole-Dagbani (16.6%), Ewe (13.9%), Ga-Adangbe (7.4%), Gurma (5.7%), Guan (3.7%), Grusi (2.5%), Mande (1.1%) and others (1.4%)*. Like the religious structure, the ethnic structure of PWDs in Ghana mimics the national pattern. 40.80% of PWDs are Akan, 18.5% Mole Dagbani, 18.4% Ewe, 5.7% Ga-Adangbe, 4.9% Gurma, 3.9% Guan, and 1% Mande ethnic groups (GSS, 2012, 2013, 2014). As indicated earlier, this article will focus on the Akan, the Ewe, and the Ga-Adangbe ethnic groups. The choice of ethnic groups is primarily based on the availability of secondary data.

The understanding of disability in Ghana is rooted in cultural and religious beliefs that are mostly negative and discriminatory in their conceptions of disability (Abudu and Imafidon, 2019; Leshota and Sefotho, 2020; Naami, 2015; Nyangweso, 2018; Ocran, 2019; Opoku et al., 2019). For instance, the Ashantis sub-ethnic group (from the Akan ethnic group) killed infants born with physical differences such as six (6) fingers^{iv} upon birth (Rattray & Christaller, 1969). Again, children with Down syndrome, autism and other neurodivergent spectrum were seen as “animal-like” and would often be abandoned by the riverbanks or near the sea so they return to what is believed to be “their kind” (Bayat, 2014; Nyangweso, 2018).

In exceptional cases, where the discriminatory behaviors are reversed, PWDs are deified and idolized, rarely affording them the opportunity of living like everyone else (Abudu & Imafidon, 2019; Nyangweso, 2018). For example, the Gas sub-ethnic group (from the Ga-Adangbe ethnic group), revered neurodivergent individuals with awe and wonderment as they were believed to be a reincarnation of a deity (Field, 1937; Nyangweso, 2018); hence they are treated with immense kindness, gentleness, and patience.

Food Taboos

Taboo is a bigger concept than sacred or secular and clean or unclean (Douglas, 2002; Salihu et al., 2019; Sigmund, 2003). It means any ritual prohibition to which an automatic sanction is attached (Douglas, 1966, 2002). Taboos exploit an innate, irrational fear in the human psyche (Sigmund, 2003). According to Douglas (1970, 2002), taboos are screaming headlines, and one should be wary of imputing latent and rational functions to taboos, for example, medical reasons for the Judeo-Islamic taboo on pork (ibid).

Food taboos simply mean the avoidance of certain foods based on personal, religious, cultural, and health reasons. Food taboos could broadly be categorized into two (2) groups: *temporal* and *permanent*. Temporal food taboos are foods that are generally consumed but,

due to certain activities or situations such as religious fasting, pregnancy, etc. are not consumed (Arzoaquoi et al., 2015; Asi & Teri, 2016). Permanent food taboos are foods that should never be consumed mainly because such foods may cause serious health issues (such as allergies resulting in death) or such foods are seen as sacred (for instance, totems, [some of the totems of the Lafe sub-ethnic group under the Ewe ethnic group are the antelope 'se' \[in Ewe\] and sparrow 'atsutsræ' \[in Ewe\]](#)) (Chakona & Shackleton, 2019; Kuzma et al., 2013).

The avoidance of certain foods could have positive or negative implications. For instance, an individual avoiding peanut, groundnut, and other types of nuts due to established allergic reactions ensure the safety and health of that individual. Alternatively, abuse of human rights occurs when food taboos are imposed against the wishes of individuals within a sub-ethnic group (clan) or ethnic group. For instance, a pregnant woman from the Ga-Adangbe ethnic group is asked (sometimes openly or through implied customs and practices) not to eat mudfish because she is pregnant. This limits her agency and instills fear and anxiety as the consumption of mudfish during pregnancy is purported to lead to health impairments of the foetus. These food taboos and others will be discussed further in this article.

Food taboos (in both written and unwritten social rules) exist in one form or another in every society. Religion, culture, and health stipulate foods that are fit and unfit for human and animal consumption. Food taboos, among other beliefs and practices, have a long history and are based on centuries of trial and error (Gadegbeku et al., 2019). On a comparative basis, many food taboos seem to make no sense at all, as what is declared unfit by one group may be perfectly acceptable to another (Meyer-Rochow, 2009). Food taboos are conscious actions taken to avoid certain foods based on causal explanation – logical, supernatural, or difficult to explain rationally. According to Meyer-Rochow (2009), one ought to expect a sound explanation for the existence (and persistence) of certain dietary customs in each

culture. Food taboos are part of complex attitudes relating to the sense of taste, feelings, and abstentions which are concerned with the creation and maintenance of cultural differences, male authority, and gender inequalities (Whitehead, 2003). This article presents some of the gendered dynamics of food taboos related to disability among pregnant women in Ghana.

The original link between people and land produces traditions and practices in specific environments, and in this instance, food taboos and other held beliefs and practices concerning pregnant women (Shorter, 1998).

In Ghana, the understanding of disability and its formation is deeply rooted in religion and culture. Disability in Ghana is understood and defined within the realms of spiritual forces – test of faith, unique gift, curse, and punishment. For instance, ancestral violations of social norms such as incest and breaking food taboos are deemed to result in the birth of children with atypical and neurodivergent developments such as autism and dyslexia (Gadegbeku et al., 2019; Nyangweso, 2018). In Ghana, Christians and Muslims alike combine Christianity and Islamic practices with some Indigenous (Traditional) practices. For example, outdoorizing new babies and new mothers are typical amongst most ethnic groups in Ghana. This practice takes place on the eighth day after birth and involves formally presenting a newborn baby to the gods, society, and ancestors. Before the eighth day, it is not permitted for the newborn to be brought outside to avoid negative influences that may adversely affect the health of the child. After this and other Indigenous (Traditional) practices, a Christian family will later take the newborn to church for baptism.

This mixture of religions sometimes reinforces positive attitudes, behaviors, and practices or exacerbates negative ones. In Ghana, a pregnant woman is seen as a treasure, a demi-god, and at the same time vulnerable. In some cases, pregnant women are expected to behave in certain ways to ensure that it does not affect the unborn baby.

I have experienced some of these dynamics during my own pregnancy. An encounter in 2016 in a market in Ghana demonstrates some of the contradictory associations (both negative and positive) assigned pregnancy. I had wanted to buy two fingers of plantain. I, therefore, asked the plantain seller if she would divide the five fingers of plantain she had arranged and give me two. During that time, her back was facing me. She said “No,” and I gradually turned around to leave while she turned to face me. Realizing I was pregnant (by then I had a big belly and some swollenness on my face), she immediately retracted her earlier stance of “No” and said, “please come and get the two fingers before you go and steal it (because you are craving for it) and make your unborn baby suffer a bad omen or curse me.” Clearly this evidences some of the contradictions associated with pregnancy in Ghana.

Lastly, monumental situations of life such as pregnancy and childbirth continue to be notoriously surrounded by food taboos relating to disability and good health (Gadegbeku et al., 2019; Getnet et al., 2018). Moreover, these foods are linked to the same or similar food taboos across sub-Saharan Africa, affirming the centrality, gendered and cross-cutting nature of the neglect of food taboos linked to disability among pregnant women in Ghana and other parts of sub-Saharan Africa such as Nigeria, Cameroon, Ethiopia, and South Africa (Asi & Teri, 2016; Chakona & Shackleton, 2019; Ekwochi et al., 2016; Getnet et al., 2018).

Ethnicity and Culture

The classification of ethnic groups in Ghana is provided by the Bureau of Ghana Languages (BGL) and has been used since the 1960 census (GSS, 2013). Ethnicity refers to a sense of kinship, solidarity, and common culture (Hutchinson & Smith, 1996) which often nurtures positive feelings of belonging to a cultural group (Guibernau & Rex, 1999).

In Ghana and most parts of Africa, human groups created their societies and traditions within environments which represented multiple adaptations to different and similar ecosystems (Shorter, 1998). These ethnic groups were categories of interaction, representing

clusters of groups and dialects, masking together (ibid). Centuries of trade and slavery “ethnicized” groups with colonialism politicizing them further, resulting in radical or structural change within these ethnic groups (Dwyer & Drakakis-Smith, 1996; Guibernau & Rex, 1999; Hutchinson & Smith, 1996; Shorter, 1998). Ethnic groups remain classifications of interaction and distribution with old and new fields of application in both pre and post-colonial states (Shorter, 1998). Ethnic groups are seen as a whole society, having a high degree of self-sufficiency, politically autonomous, with their distinctive language, culture, and identity such as the Asante kingdom within the Akan ethnic group (McCaskie, 1995; Shorter, 1998).

Ghanaian traditional ethnic societies and other parts of sub-Saharan Africa are often associated with a mentality that differs from the science of modern societies (Shorter, 1998). Different labels have been given to this mentality – primitive morally and culturally, unable to differentiate between subject and object, magical, impervious to logic, etc. (ibid). Nonetheless, these ethnic groups continue to foster a sense of belonging and development within communities.

Ghanaian Ethnic Groups (In Focus)

The ethnic groups under discussion comprise 11 out of 16 regions in Ghana. These ethnic groups found across 11 regions are situated within the southern and some parts of the middle belt of Ghana represented in regional map depicted in Figure 1 below.

Figure 1*The Map of Ghana*

Source: [Ghana Districts, 2019](#)

For the Akan ethnic group; nine (9) regions broadly fall under this: Brong Ahafo, Bono East, *Oti (parts of the Oti region), Ahafo, Western North, Western, Central, Ashanti, and *Eastern (parts of Eastern regions), Ashanti, Eastern, Western, Central, and Brong Ahafo regions. Secondly, the Ga-Adangbe ethnic group encompasses two (2) regions: Greater Accra and parts of the Eastern region. Thirdly, the Ewe ethnic group is situated mainly in the Volta and parts of the Oti region. Almost all important aspects of these three (3) ethnic groups:

Akan, Ga-Adangbe, and Ewe have been documented by several authors and credible web pages^v (Agbodeka, 1997; Kissi et al., 2017; Lawrance, 2005; R. S. Rattray & Christaller, 1969). The duplication of their work is not necessary; however, a brief overview would provide readers with some background information and context to the article.

The Akan Ethnic Group

The Akan people constitute the largest ethnic group in Ghana (GSS, 2012, 2013). About 44% of the Ghanaian population speak Akan as non-native speakers (Agyekum, 2006). The Akans occupy a greater part of the southern sector of Ghana, precisely 9 out of 11 southern regions. Some Akans are also found in Cote d'Ivoire as well. One major food among the populace is boiled pounded cassava and plantain ("*fufu*") with green or tomato soup served with bush meat.

The Ga-Adangbe Ethnic Group

The Ga-Adangbe make up about 7% of the Ghanaian population (GSS, 2012, 2013). Some Ga-Adangbe's are also found in Togo and Benin (Dakubu, 1972). They live primarily in the Greater Accra region and some parts of the Eastern region. Fermented blended and moulded boiled corn ("*kenkey*") and fried fish served with hot and spicy chilli sauce are common food found among the Ga-Adangbes.

The Ewe Ethnic Group

Constituting about a tenth of the Ghanaian population (GSS, 2012, 2013), the Ewes occupy predominantly the Volta region and some parts of the Oti region. The Ewes could also be found in Togo and Benin (Agbodeka, 1997; Lawrance, 2005). Cornmeal ("*akpele*") and okra sauce or soup served with fish or meat is a common meal found with the Ewes.

Disability-Associated Food Taboos During Pregnancy

Ghanaian Disability-Associated Food Taboos During Pregnancy

In Ghana, there is a widespread belief that pregnant women should refrain from eating certain foods or risk giving birth to children with disabilities. I discuss below broadly three (3) food taboos in the form of snails (among the Ga-Adangbe ethnic group), bush meat (duiker (antelope) and greater cane rat (grasscutter) (among the Akan ethnic group) and mudfish (among the Ewe ethnic group).

Snail

Snails are herbivores found in most parts of West Africa, Spain, France, Portugal and a few other countries and are seen as one of the cheapest sources of proteins in West Africa (Adeyeye et al., 2020; Fagbuaro et al., 2006). Snails have a 37 to 51% protein content compared to guinea pig (20.3%), poultry (18.3%), fish (18%), cattle (17.5%), sheep (16.4%) and pig (14.5%). They are also low in fat and are a source of iron, magnesium, calcium and zinc (Adeyeye et al., 2020; Eton, 2022). Zinc is involved in body processes which helps to reduce fatigue, and promote good skin and a healthy heart (Eton, 2022). Although snails are among the rarest foods to produce allergies and health complications (de la Cuesta et al., 1989), there are however snail-borne parasitic diseases, such as schistosomiasis, which causes immune reactions and progressive damage to organs (Lu et al., 2018; WHO, 2022). Schistosomiasis is an acute and chronic parasitic disease where people become infected when the larvae of the parasites (released by freshwater snails) infiltrate the skin during contact with infested water (WHO, 2022); it is very prevalent in areas without access to safe water and adequate sanitation.

The snail taboo is being discussed within the Krobo sub-ethnic group which falls under the Ga-Adangbe. This taboo although prominent among the Krobo people is largely acceptable among pregnant women in Ghana and elsewhere in West Africa such as in Nigeria (Arzoaquoi et al., 2015; Ekwochi et al., 2016; Gadegbeku et al., 2019). Snails' prohibition as

food during pregnancy has been motivated by their association with poor saliva control and the dribbling mouth of a baby whose mother ate snails during pregnancy. It is widely accepted that the consumption of snails during pregnancy by the expectant mother could lead to cerebral palsy, intellectual disability, and other neurological impairments (ibid).

Bushmeat (Duiker [antelope] and Greater cane rat [grasscutter])

The duiker (antelope) and greater cane rat (grasscutter) form part of a wider group of animals referred to as “bushmeat.” The antelope and grasscutter are omnivores and herbivorous animals respectively and are seen in most parts of sub-Saharan Africa (Animalia, 2022a, 2022b). Bush meats are generally expensive in West Africa but similar to the snails, have very high protein content (Jori et al., 1995; Niyi, 2014). In addition, the feces of the greater cane rat taken directly from the caecum and colon are also used in soups and sauces due to their high iron and mineral contents (Jori et al., 1995). The feces could be compared with nutritional contents in cocoyam leaves (called “*kantomire*” in Ghana) or spinach. Bush meats have been linked to endemic cases of diseases from animals spread to human beings such as the Ebola Virus Disease (Onyekuru et al., 2020; Subramanian, 2012).

Bushmeat is a common delicacy among the Akans and rapidly growing in popularity in Ghana and across sub-Saharan Africa (van Vliet et al., 2011). The greater cane rat (grasscutter) is seen as a totemic animal for twins among the Akuapims sub-ethnic group of the Akan ethnic group (Arzoaquoi et al., 2015; Gadegbeku et al., 2019). Pregnant women and twins are prohibited from eating greater cane rat as it is believed to cause intellectual and other developmental disabilities (Gadegbeku et al., 2019). In addition, the Akuapims also believe that the duiker (antelope) causes leprosy (ibid). Therefore, people who belong to the Akuapim sub-ethnic group, including pregnant women, are prohibited from consuming duiker (antelope). Unlike the snail food taboo, there seems to be no explanation directly linked to the food itself, rather than its totemic symbolism.

Mudfish

Mudfish (also known as bowfin in some parts of the world) is present in the waters of West Africa, the Americas, Asia and Australia (Cleaveri, 2003). Mudfish is high in protein, iodine, omega-3 fatty acids and minerals (Amegovu et al., 2017; Weyant, 2022). Similar to other finned fish such as tuna, and salmon, mudfish can trigger fish allergies such as hives, nausea, indigestion, diarrhea, asthma and in extreme cases anaphylaxis—a life-threatening reaction that impairs breathing (ACAAI, 2022). These allergies can be managed through strict avoidance and medication, as with other allergies with nuts, lactose, gluten, etc.

The Ewe ethnic group forbids pregnant women carrying twins and twins from eating mudfish. This is because it is believed to cause mental health issues such as schizophrenia and bipolar disorders (Gadegbeku et al., 2019), although there is no explanation for this food taboo based on the literature reviewed. Is it possible that the prohibition is attributed to the name of the fish (“mud”) with the homophonic word “mad”? This question is worth exploring to contribute to the accumulation of Ghanaian knowledge on gendered food taboos and disability.

As indicated earlier, food taboos exist in almost all ethnic groups in Ghana. For instance, the Grusi ethnic group prohibits the consumption of animal (cow) hide (called “*wele*” in Ghana) (Arzoaquoi et al., 2015; Gadegbeku et al., 2019). The Grusi ethnic group are mostly found in Northern Ghana. In Northern Ghana, when chiefs and kings are enskinned, the treated and dried animal hide is a symbol of chieftaincy and kingship. Although there are controversies surrounding the nutritional values of “*wele*” such as negligible protein content (Agbeka, 2020), “*wele*” is a Ghanaian local delicacy present in foods such as tomato sauce, green sauce, okra sauce, soups, etc. (This is incidentally a personal favorite of the author: I consumed [and continue to consume] in pre-pregnancy,

during pregnancy and post-pregnancy phases.) It is believed to cause miscarriage during pregnancy and delay to the detachment of the umbilical cord, thereby posing health complications for both the unborn baby and expectant mother (Gadegbeku et al., 2019; Getnet et al., 2018; Whitehead, 2003). Food taboos associated with disability continue to exist among pregnant women in Ghana and other sub-Saharan African countries.

Sub-Saharan Africa Disability-Associated Food Taboos During Pregnancy

Food taboos are enshrined in cultural and religious heritage and cut across sub-Saharan Africa. Briefly presented in this section are disability-associated food taboos during pregnancy across sub-Saharan Africa. In East Africa, Ethiopia (Awabel District) specifically, *bananas* are prohibited foods among pregnant women because they are believed to produce a uniquely shaped head of a fetus (Getnet et al., 2018). In other parts of West Africa such as Nigeria (Enugu, South Eastern), snails are food taboos among pregnant women because they are believed to trigger poor saliva control causing intellectual and other developmental disabilities similar to the Ghanaian case (Ekwochi et al., 2016). Furthermore, in Southern Africa, precisely South Africa (Kat River Valley-Eastern Cape), orange or orange juice is a prohibited food among pregnant women because it is believed to produce yellow skin, yellow pimples/rash, yellow eyes, and cracked lips resulting in albinism (Chakona & Shackleton, 2019). Lastly in Central Africa, with particular reference to Cameroon, the meat of wild animals such as leopards, crocodiles, and monkeys are food taboos among pregnant women as are believed to cause mental and behavioral health conditions such as schizophrenia, bipolar disorder among others (Asi & Teri, 2016). These disability-associated food taboos are prevalent in the African continent and particularly within ethnic and other cultural groups in sub-Saharan Africa. The shared experiences and customary practices inherent in our African culture and religion continue to promote the understanding of disability within the space of pregnancy food taboos.

Implications of Food Taboos for Disability

Food taboos are generally monopolistic and skewed mainly towards females, in the case of pregnancy. If a pregnant woman has sexual relations with a partner who consumes these forbidden foods, does it also cause disability? I have more questions than answers about the gendered dimension of these food taboos. Additionally, these food taboos are deeply rooted in cultural beliefs passed on from one generation to another and are prevalent in both rural^{vi} and urban areas, although a bulk of cases are found in the rural areas. Currently, there is no data to confirm the perceived disability associated with food taboos in pregnancy. This brings to the fore the culturally gendered perspectives of disability in Ghana and other parts of sub-Saharan Africa and the need to claim rightly the understanding of disability and disability justice by researching and disseminating information on disability-associated food taboos during pregnancy. Again, these also unearth the geographical dynamics of food taboos associated with a disability during pregnancy.

Some food taboos prevent pregnant women from accessing a well-balanced diet, resulting in a high prevalence of low birth weight and harm to mother and baby (Asi & Teri, 2016; Kuzma et al., 2013; Whitehead, 2003). Therefore, one could argue that in upholding or strictly adhering to food taboos during pregnancy, unborn babies face a greater risk of health issues that could lead to impairment rather than the reverse.

Further, the typology of disability-associated food taboos during pregnancy differentiates between disability typologies. This affirms the African disability typology proposed in “The Handbook of African Philosophy of Difference,” edited by Imafidon (2019). From this book, two broad African disability typologies exist: “*persons with universal disabilities*” such as the visually impaired and the physically challenged who fall within the categorization of common or widespread human difference; and “*persons with*

particular disabilities” such as persons living with albinism and persons with angular kyphosis who fall within the categorization of uncommon human difference and perceived as “mysterious beings with special powers” (persons within this category are mostly slain and maimed to amass wealth in the spiritual realm) (Abudu & Imafidon, 2019, pp. 395–398). These disability typologies associated with pregnancy food taboos fall broadly under particular disabilities.

Recommendations and Conclusion

Way-Forward for Disability-Associated Food Taboos During Pregnancy

The typology of food taboos comprises homogenous and heterogenous foods across Ghana and other parts of sub-Saharan Africa (national/continental issue). Different approaches will be needed for different food taboos and different geographical spaces.

- i. Education through sensitization and communication through the dissemination of disability and disability-related research could be a way to go. For instance, national institutions, civil societies, Non-Governmental Organizations (NGOs), religious institutions, educational institutions, think tanks, etc. need to periodically sensitize and share information on disability and its causes. Using where possible the lived experience of PWDs such as Farida Bedwei (<https://www.weforum.org/people/farida-bedwei>), a Ghanaian software engineer with cerebral palsy, could help people understand disability better.
- ii. At the community level, engagement with traditional and religious leaders as facilitators are key. They are the custodians of traditions and customs. A transformative approach is important here, which takes time; this is because culture and perceptions are not easily broken; education needs to emanate from community leaders and members themselves with support from experts.

- iii. Disability sensitization activities and programs should not only target persons with disabilities but persons without disabilities as well as men and women.
- iv. Health services centers such as reproductive health clinics, ante-natal, and post-natal services are good hotspots for discussing issues of disability. Pregnant women (with and without disabilities), new mothers (with and without disabilities), men (with and without disabilities), etc. could serve as facilitators depending on the local context to discuss issues further.
- v. It is important to encourage women (with and without disabilities) to share their pregnancy journeys. This will take time as this is very uncommon in Ghana and many parts of sub-Saharan Africa due to the myths and traditions surrounding pregnancy and childbirth.
- vi. There is the need for periodic and several medical research pieces to debunk the disability-associated-food taboos in pregnancy. Funding would be a key catalyst to ensuring its materialization.

Conclusion

The understanding of impairments and disability deeply rooted in beliefs translated into myths, stories, and folktales needs to be rejected as it produces mental health issues such as anxiety, inferiority, self-consciousness, fear, marginalization, exclusion, etc. (Wright, 1960) among pregnant women. The experiences of PWD in Ghana and other regions of sub-Saharan Africa are of serious concern. And their being stigmatized and marginalized, etc. is rooted in cultural and religious beliefs (Nyangweso, 2018).

In the Global North, particularly the UK, the medical model^{vii} of disability which defines impairment and disability as a medical or health condition has been greatly criticized by several authors (Michael Oliver, 1990; Finkelstein, 2001; Mike Oliver and Barnes, 2006;

Morris 2001; Garland-Thomson, 2017; Shakespeare, 2016). At the same time, perhaps it may be leveraged for evidence-based explanations into the ontological perspectives of impairments and disability in Ghana and other parts of sub-Saharan Africa. In strategically applying some aspects of the model, conscious efforts must be made to ensure that disability is not viewed as a personal/individual or family tragedy or issue but rather as shared social responsibility (Barton & Oliver, 1997; Imhoff, 2017; Nyangweso, 2018; Shakespeare, 1997).

These restrictive etiologies need to be questioned through evidence such a model may arguably present. Understanding disability is key to ensuring inclusivity. Such an understanding in Ghana and elsewhere in Africa is deeply rooted in culture. Culture and ethnic identity are basic aspects of what it means to be human. As such, they are wedded to basic human rights (Wagner, 1981) in Ghana and Africa as a whole. Moreover, through disability-associated food taboos in pregnancy, a system of acculturation in the form of cultural aggression and domination occurs. Addressing such abuse of human rights for both pregnant women and PWDs requires continuous research, sensitization, and dissemination; all are key to debunking the negatively held correlation (or otherwise) between food taboos and disability during pregnancy.

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Endnotes

ⁱ I draw on statistical and non-statistical data from the 2010 Ghana population and housing census conducted by the Ghana Statistical Service.

ⁱⁱ The ICF Model does not go without criticism. Disability is perceived as functional limitations and restrictions (Cobley, 2018). Some authors argue that persons with disabilities should have the freedom of achieving functioning feasible to them- act, participate or live on behalf of what matters to them; something currently absent from the ICF model (Mitra & Shakespeare, 2019; Sen, 1999; Whiteneck, 2006).

- ⁱⁱⁱ In contrast, the 2011 world report on disability puts the disability prevalence rate at 12.8% (WHO, 2011). This disparity is largely due to how disability was measured. The 2010 Ghanaian census adopted a binary (yes or no) format in measuring the disability prevalence instead of using the recommended Washington Group Short Set -WG-SS (WG, 2021). Although the WG-SS is without criticism, it can expand the scope to capture more aspects of disability. In the just-ended 2021 census, Ghana however used the WG-SS (GSS, 2021). Preliminary reports from the 2021 census push this percentage to 8% (GSS, 2022). The issue of measurement goes beyond the scope of this article; however, it is an important driver.
- ^{iv} Polydactyly (individuals with extra fingers/toes) is present in 1 in 1000 births globally, with a higher incidence of 1 in 150 births in the black population (Rathjen et al., 2017).
- ^v Some of these web pages include GhanaWeb (www.ghanaweb.com), Ghanadistricts (www.ghanadistricts.com), Britannica (www.britannica.com), among others.
- ^{vi} Rural areas are geographical locations where most persons with disabilities live. In Ghana, 3.3% of PWDs live in rural areas compared to urban areas (2.7%).
- ^{vii} The model sees disability as something to be cured and/or treated by health professionals. Disability is seen as emanating from biological or physical or neurological imperfections. The medicalization of disability has been criticized in terms of its individualization of disability, among other criticisms.

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