

Transethnic itineraries for ethnomedical therapies in Nigeria: Igbo women seeking Ibibio cures

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Abstract

Although therapeutic itineraries have been studied in a variety of contexts, little research has investigated care-seekers' quests for traditional medical treatments outside their own ethnic boundaries. The present study investigated 19 Igbo women seeking traditional cures from Ibibio indigenous healers in Akwa Ibom State, Nigeria. Emerging data show that these Igbo women were uptaking Ibibio indigenous treatments primarily for health conditions that have failed to respond to initial treatments in their places of origin, were stigmatized at their own places of origin, or and were thought to have resulted from supernatural causes. Care-seeking outside patients' ethnic borders was thus both a quest for a more effective treatment and a strategy for concealing therapeutic progress or and the nature of illness from the patients' places of origin. Findings underscore the critical role of culture and place in health-seeking behaviour and the need for health care services to be responsive to the complex nature of cultural organization involving care-seekers' and the critical ways this plays out in, flows into, and is negotiated through particular places during therapeutic quests.

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The problem

The context of health-seeking in Nigeria reflects the great diversity that characterizes the country's health-care system. Western biomedicine, faith healing, patent medicine shops, and traditional medicine coexist in the country and care-seekers freely choose from them to respond to illness episodes. However, traditional medicine remains the oldest, and perhaps most accessible and subscribed therapeutic system in Nigeria. Jegede (1998), Mume (1976), and Lambo (1969) maintain that each of the over 300 distinct ethnic groups that make up the Nigerian society has its own unique indigenous healing heritage, which has evolved in response to the specific experiences and needs of its peoples.

Currently, it is estimated that traditional medicine is the only healthcare resource accessible to a third of all Nigerians. Scholars (such as Jegede, 1998; Ogunbodede, 1997; Oyebola, 1987; Aregbeyen, 1996; Owumi, 1998) suggest that the popularity of traditional medicine in Nigeria is not unrelated to its affordability, cultural responsiveness, effectiveness, and geographical accessibility. Lambo (1969) maintains that traditional medicine in Nigeria offers a somewhat holistic therapeutic option as it is often sensitive to the beliefs, practices, and socio-cultural and livelihood realities of its many users. He further notes that age, gender, class, educational attainment, religious beliefs, and income do not appear to have much influence on the utilization of traditional medicine in Nigeria. Erinsho (1989), Ogunbodede (1997), and Enwereji (1999) argue that in Nigeria, traditional medicine is used to treat a host of health conditions including mental disorder, fractures, insomnia, and infertility. In Nigeria, conditions that defy western medications are usually referred to traditional

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healers (Bodeker, 1994; Gesler, 1979; Woods, 1977; Zeller, 1979).

A common refrain in the literature is, however, that users of indigenous medicine in Nigeria tend to seek and use only the services of healers from their own ethnic groups (Erinosho, 1989; Owumi, 1998; Jegede, 1998; Oyebola, 1987; Mume, 1976). However, during a recent ethnographic survey of indigenous healing homes, their users, and practitioners in Ibibioland, southeastern Nigeria, we intercepted some 67 non-Ibibio patients among their clientele. These non-Ibibio patients had come from various parts of Nigeria to Ibibioland. Many of them had never been to Ibibioland before. They had just come to uptake Ibibio traditional treatments, and while their treatments lasted, these care-seekers resided in the homes of the Ibibio healers. Currently, we are not aware of any study addressing people's uptake of another ethnic group's indigenous cures in Nigeria and so we thought it important to engage with this evidence.

Our attempt to interview all the non-Ibibio patients we came across at the healing homes was not successful. Many of the non-Ibibio patients could not speak English and we had recruited only Ibibio and English-speaking fieldworkers. But the first-named author in this paper (and the principal investigator in the study) is however Igbo and conducted in-depth individual interviews with Igbo-speaking care-seekers intercepted in surveyed Ibibio traditional healing homes. Altogether, there were 24 of these Igbo persons with women and girls numbering 19.

The bulk of studies on therapeutic itineraries have failed to engage deeply with women's quest for therapy. Often, women's care-seeking quests are subsumed under general accounts of predictors of health-seeking for modern healthcare (Kangas, 2002; Guendelman, 1991; Underwood and Underwood, 1980; Janzen, 1978), or under assessments of broad patterns of utilization of different healing services by patients or care-seekers during illness episodes (Simms, 1992; Udoh, 2000; Igun, 1982; Izugbara, 2002a; Obermeyer, 2000). The few known studies specifically addressing women's therapeutic itineraries, have focused largely on their care-seeking pilgrimages to religious sites or shrines to secure miraculous healing (Pfleiderer, 1998; Mernissi, 1977; Betteridge, 1992; Inhorn, 1994; Early, 1993).

The present study adds to the literature on women's therapeutic quests by focusing on Igbo women seeking Ibibio traditional cures. The study asks: What are the socio-demographic characteristics of these Igbo women and girls? What were the health conditions for which they were seeking traditional Ibibio therapies? Why would they prefer Ibibio traditional medicine to their own Igbo indigenous medicine? How did they select their therapeutic destinations? What are their experiences of seeking indigenous therapy outside their own ethnic boundaries? And what can we learn from these

women's search for traditional health care outside their own ethnic boundaries? We are persuaded that answers to these questions have much broader development implications and could offer critical scope for plans and policies to deliver good health care to care-seekers in developing areas of the world.

Women and health care in Nigeria

Nigeria is Africa's demographic giant. The country has a landmass of 923 770 km² and lies in the west coast of the continent. A British colony until 1960, Nigeria has a population estimated at 130 million. About half this number is women and girls. Only about 48% of Nigeria women are in the labour force. They are also found mainly in low-income and unskilled professions. Literacy rate among Nigerian women currently stands at 50% with only 28% and 30% of all current primary and secondary school enrolments being women. Poverty is high among women in Nigeria.

Women's access to formal and quality healthcare services in Nigeria is quite low. The two main providers of western biomedicine in Nigeria are the state and private medical entrepreneurs. The efforts of these providers are, however, concentrated in the urban areas where only about 30% of Nigerian women live. Most Nigerian women live in remote rural communities and geographical mobility is also difficult owing to intractable transportation problems (Izugbara, 2000b).

Alubo (1995) contends that most private medical establishments in Nigeria are poorly equipped. They often lack basic health equipment from sterilizing units to incubators. Private medical services in Nigeria are also quite expensive. Recent studies currently put the service charges of private medical establishments in Nigeria at 800–1500% higher than the rates in the public health sector (Alubo, 1990b, 1995; Amuchuche, 1987; Jegede, 1998; Enwereji, 1999). Research conducted in the 1990s shows that only about 4% of Nigerian women have any steady access to private medical care (Harrison, 1995, 2001). The services of private medical enterprises are often on a 'pay-before-service' or 'cash-and-carry' basis. Before treatment commences, care-seekers are often required to make cash deposits. In Nigeria, there are several reports of women dying at the doorsteps of private hospitals and clinics for not being able to meet the initial deposit requirements or while their companions are still haggling over initial deposits. When such initial deposits are exhausted, treatment is frequently withheld and or patients held hostage until more payments are made (Alubo, 1995; Anonymous, 1984).

The Federal Ministry of Health and its agencies at various levels of government run the public health sector in Nigeria. Under-funding maldistribution, and

inefficiency currently characterize the Nigerian public health sector. Reflecting on this situation, Alubo (1995) magisterially notes:

Nigeria depends on imports for about 90% of medical supplies ... The availability of which is now rendered precarious because of foreign exchange difficulties and overall economic crisis ... There are (now) crippling and pervasive shortages of drugs and equipment and other basic essentials.

Government's response to the situation has been to rationalize and commercialize public health facilities. One result of this response is the introduction of high user-fees. This has had the effect of further constraining women's access to public health services. Shortages of basic essentials, the rise in the incidence of fake drugs, and the flight of formal service providers from government health establishments have further worsened matters in the sector, leading to drastic loss of faith in public health facilities among Nigerians (Izugbara and Ukwai, 2003; Alubo, 1990a, 1995; Imogie, 2001). Most skilled and formal care providers are now in the private sector where better wages and service conditions are guaranteed. Negative attitudes of public health service providers towards patients, arising largely from frustration, lack of incentives, and inadequate materials to work with, as well as poor remuneration have also continued to constitute a disincentive to women's use of public health facilities. Currently, only about 21% of Nigerian women go to public hospitals to deliver children or for other obstetric conditions. In a recent study, Asuquo et al. (2000) found the harsh attitudes of health staff in public hospitals to be the major reason for women not patronizing government hospitals for obstetric care (see also Etuk et al., 1999).

In Nigeria, itinerant medicine hawkers, injectionists, and patent medicine storekeepers are also common sources of health care for women. Iyun (1988) notes that these care providers administer or sell medicine in small quantities with very little regard for treatment procedures. Alubo (1985) observes that this category of care providers often administer injections on women for a fee, sometimes in buses, market places, streets, motor parks—with patients fully dressed. Ekwempu (1990) points out that Nigerian women go to these informal service providers because of ignorance and illiteracy and also because their services are of low cost. An intercept study of the clientele of patent medicine stores in Nigeria has shown that poor women are their major users (Izugbara, 2001b). Ukpong (2002) also shows that owing largely to distrust in public healthcare services, high cost of formal services, and lack of geographical access to modern health services, many women in Nigeria go to chemist shops to have births. Currently, injectionists, medicine hawkers, and patent medicine

stores are estimated to be the major source of health care for about several millions of women in Nigeria (Harrison, 2001; Stock, 1983; Ityavyar, 1984; Ibanga, 1992).

Spiritual healing involving laying of hands, holy water, oil, and prayer is also a prominent therapeutic option among Nigerian women. Uyanga (1979) notes that spiritual healing is sought by many Nigerians especially women. He writes:

Healing services ... are always held on Fridays and or two evenings during weekdays till late at night. Common at these services are prophecies, spiritualistic revelations, incantations, and speaking in (unknown) tongues, spiritual choruses and shouting....

Alubo (1995) adds that spiritual healing also takes place during open-air rallies and crusades and that such occasions are advertized in the mass media as opportunities for barren women to conceive, the bewitched to be freed, the blind to see, lame to walk, and demonized to be exorcised. Duke (2002) reports that about 80% of women presenting in *Tekewaris*, spiritual healing homes, among the Kalabari of Nigeria were women. Women have also been reported as the majority of those who seek healing in spiritual churches and centres in Nigeria's most populous town (Adekunle, 1999).

Perhaps, the most popular source of health care among Nigerian women is traditional medicine. Recent research shows that over half of the women in Nigeria rely steadily on indigenous treatments to meet their health needs and that over 60% of Nigerian women currently give birth with the assistance of traditional birth attendants (Imogie, 2001; Alakija, 2000; Owigar, 2000; Izugbara and Ukwai, 2003). These studies show that Nigerian women use indigenous medical services for conditions ranging from bone setting to birthing.

Izugbara and Ukwai (2003) have shown evidence that users of indigenous birth homes in Nigeria were not merely women giving birth but also those in search of abortion, family planning, cures for infertility, STDs, neonatal conditions, serial miscarriage, vaginal bleeding, etc. Izugbara and Brown (2003) uncovered also that formal health service providers in several hospitals in Nigeria often openly advise patients to seek traditional treatments when western medicine fails. Many Nigerians also actually believe that traditional medicine is capable of curing all categories of diseases and misfortunes, including HIV/AIDS (Izugbara, 2004).

But as earlier noted, the bulk of literature on the utilization of traditional medicine in Nigeria has tended to assume that care-seekers utilize only their own ethnic group's indigenous medicine. But now we have evidence suggesting otherwise, which offers us the opportunity to investigate the nature of transethnic itineraries for ethnomedical therapies.

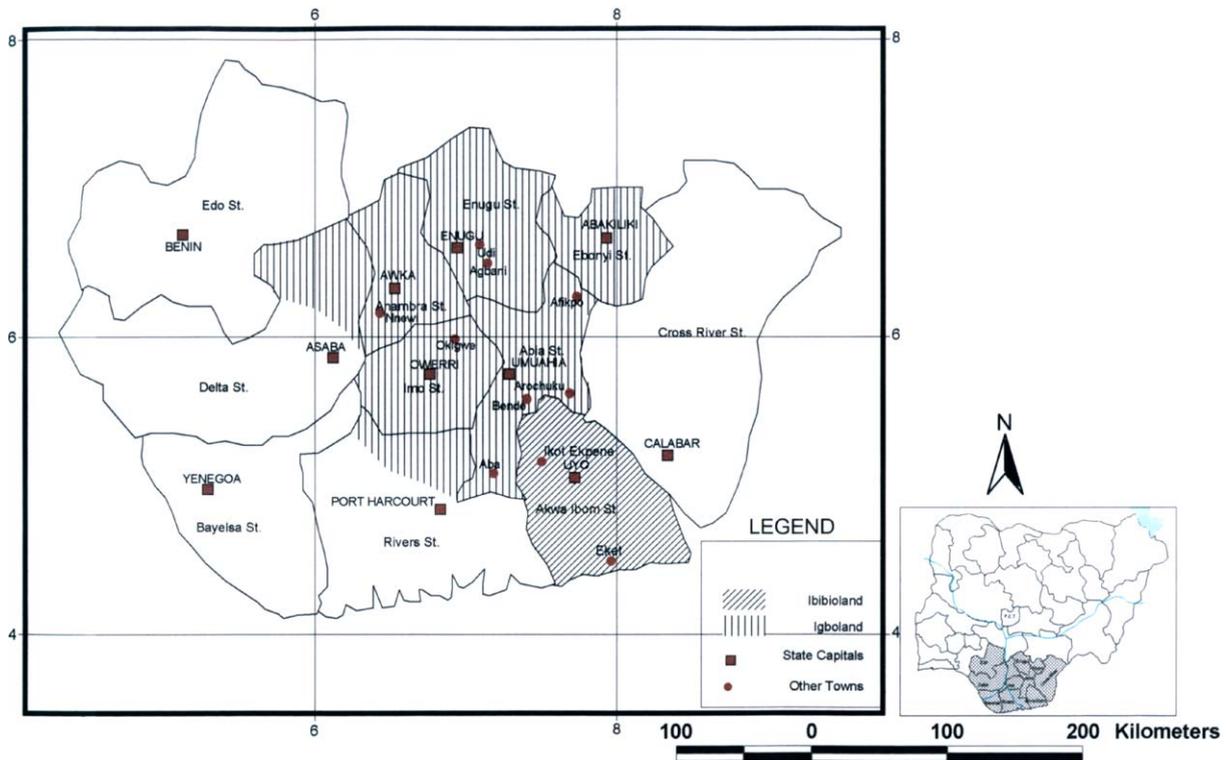


Fig. 1. Southern Nigeria showing Ibibioland and Igboland.

Study site and methodology

The study area

The present study was carried out in Ibibioland. The Ibibio are found in Akwa Ibom State, in the south-eastern flank of Nigeria.¹ Ibibioland lies between latitudes $4^{\circ}25'$ and $5^{\circ}30'$ north and longitudes $7^{\circ}30'$ and $8^{\circ}30'$ east (see Fig. 1). The people are bounded in the northwest by the Aro and Ngwa-Igbo peoples. The Efik are their northern neighbours. In the west and southwest, they share a common boundary with the Ijaw while to the east, they share mountainous borders with the peoples of western Cameroon. The oil-rich Bight of Bonny bounds Ibibioland in the south (Ekong, 2001). The Ibibio language belongs to the Sudanic-Niger-Congo family. Historical and anthropological studies lend credence to a rich body of oral history suggesting that the Ibibio are a semi-Bantu people who travelled

¹In the second edition of his path breaking work, *The Sociology of the Ibibio: A Study of Social Organization and Change* (2001), Professor Ekong Edem Ekong writes that 'a succession of political changes in Nigeria ... led to the creation, in 1987, of a state—Akwa Ibom State—for the Ibibio, and its peoples'. In this paper, we rely largely on his use of the term 'Ibibioland'.

through the Cameroons possibly from central or south-western Africa to settle first in Arochukuwu town in present day Abia State of Nigeria (Etim, 1973; Ekong 2001; Esen, 1982). In Talbot's (1926) estimation, between 1300 and 1400 AD, the Igbo invaded Arochukuwu, most likely with the help of the Efik and Ekoi, to drive away the Ibibio further southwards—beyond the Cross river—where they have settled since then. The Ibibio currently number about 3 million persons.

Throughout Nigeria, the Ibibio are known for their powerful and highly potent local cures and treatments for many disease conditions (Akpan-Umana, 2001; Abia-Williams, 1994). Ibibio traditional medicine, *ibok ukanyin*, has many specialisms and is undergirded by the theory that disease conditions are not merely organic phenomena (Abia-Williams, 1994; Mume, 1976). In Ibibio ethnomedical cosmology, three broad illness categories are recognized; natural, supernatural/mystical, and hereditary. Certain diseases are usually attributed to natural events and causes—such as the drinking of unclean water, overeating, lack of rest, overindulgence in sex, ingestion of poisonous substance, etc. Abia-Williams (1994) sees this as evidence of the germ theory of disease in Ibibio ethnomedical heritage. Supernatural/mystical explanations of illness episodes are also found among the Ibibio. Illness conditions whose signs and symptoms defy simple remedies are

often attributed to the activities of neglected or offended deities, gods, and spirits, errors in rituals or and infraction of cultural taboos. Ekong (2001) and Inyang (1994) agree that among the Ibibio, there is a strong belief in witchcraft (*Ifot*) as an ever-present supernatural/mystical cause of all disease conditions. Barrenness, premature deaths, and mental illnesses are often associated with supernatural causation among the Ibibio. Some diseases are also believed to be hereditary. The Ibibio view such conditions as transferable from parents to their offsprings.

Abia-Williams (1994), Inyang (1994), and Essien (2001) document the following broad specialisms in Ibibio ethnomedical heritage: (a) the general practitioner, with competence in the use of various environmental resources in diagnosis, divination, and therapy for a wide range of illness episodes that may have natural, hereditary or and supernatural basis; (b) the herbalist, with expertise in the use of herbs to diagnose and treat all kinds of diseases; (c) thetrado-psychiatrist, a specialist in the diagnosis and treatment of all forms of mental disorders and psychic imbalances; (d) the traditional surgeon whose specialty consists in circumcision, tribal marking and other forms of surgical operations; (e) thetrado-bone-setter (*Abia okpo*), a specialist in the treatment of broken and malformed bones and strained nerves; (f) traditional birth assistants (*Abia Umum Uman*), often older women, with expertise in obstetric care; (g) thetrado-hydrotherapists, local healers with far-reaching expertise in the use of water in the diagnosis and treatment of physical and psychological conditions. Other Ibibio ethnomedical specialists include thetrado-thesophists, thetrado-occultist, thetrado-zootherapist, the local faith healer, and the indigenous recreatologist.

There is evidence of the 'like cures like' theory of healing in Ibibio indigenous medicine (Abia-Williams, 1994). Thus, in Ibibio indigenous medicine, dog blood and saliva syrup is considered effective against dog bites, snake venom extracts against snake bites, and mad people's urine against madness. Another key aspect of Ibibio ethnomedicine is the belief in the psychic interconnectedness of all elements, which assumes that the world of humans is connected to those of plants, animals, rivers, earth, hills, valleys, mountains, etc. Events taking place in any of these planes are viewed as potential causes of events in other spheres and planes.

Among the Ibibio, a host of specific causes go into explanations of diseases; germs, sins, taboo infractions, witchcraft, retribution, spirits, ancestors, gods, deities, etc. The diagnostic tools employed to uncover the factors responsible for given illness episodes in Ibibio ethnomedical system vary. Udo (2000) lists the major tool for diagnosis in Ibibio indigenous medicine to include cowries, beads, woods carved from certain trees, alligator pepper, bitter kola, palm frond, kolanuts,

feathers, eggs, gin, animal horn, teeth, bones, skins, human skulls, exotic coins, sands from hills, valleys, streams, water, mirror, egg, clay, iron pieces, etc. Oral interviews with patients and or their relatives, oracular practices and divination are also often used among Ibibio indigenous healers to identify the cause of disease conditions and the treatment or therapeutic course to be pursued. The treatment may involve one or a combination of the following: drinking, bathing, swallowing, rubbing, incision making, enema, massaging, inhaling, and chewing. Some indigenous Ibibio medicine are also taken along with foods and drinks, mixed with body creams, put in bathing water, smoking pipes, or warming fires. There are those that are splashed on patients, tied around parts of their body, buried or kept in rooms, compounds tied or hung on properties, etc. Ibibio traditional healers often practice their profession in their homesteads. Often patients come to consult and seek treatments from them. Depending on the nature, urgency, and severity of conditions, patients may have to move into the homestead of the healers. And Ibibio local healers often have large compounds to cater for the housing needs of patients.

The study

Between August 2002 and February 2003, we conducted fieldwork among Ibibio indigenous healers and healing homes. Our original objective was to profile the characteristics of indigenous Ibibio healers, the health services which they offer, and the characteristics, health conditions, and motivations of their users. We used local key informants to identify five indigenous healing homes in each of the three senatorial districts in Ibibioland (Uyo, Eket, and Ikot Ekpene). Each of the healers whose healing home was sampled was interviewed. We also sought the healers' permission to interview peoples presenting at their healing homes. Four hundred and twenty patients presenting at these healing homes were surveyed. Sixty-seven were however non-Ibibio. But as earlier noted, we were only able to hold in-depth individual interviews with 24 of the intercepted health seekers who were Igbo.

The participants

Altogether, a total of 24 Igbo respondents were surveyed for the present study. They gave verbal consent to the recording of their interviews and were granted confidentiality of their responses. They were interviewed once using an unstructured interview schedule seeking information on their social and demographic characteristics, conditions for seeking cure, how they selected therapeutic destinations, reasons for choosing Ibibio ethnomedicine, and their experiences with seeking indigenous medicine outside Igbo society. Where

patients were not old, sane, or physically fit enough to respond to us, we relied on information obtained from their companions. Although data were collected from all 24 Igbo respondents, the present study only considers information gathered from 19 of the Igbo care-seekers who were women.

Prolegomena on Igbo culture and people

At this juncture, some insight into Igbo culture and way of life is necessary as background for understanding the behaviour of the study participants. The Igbo are Nigerian's third largest ethnic group. They presently number over 12 million. Igbo land lies between latitudes 4° and 7° north and longitude 6° and 8° east. This area covers Imo, Abia, Anambra, Ebonyi and Enugu States and parts of Rivers and Delta States of Nigeria (see Fig. 1). Neighbouring the Igbo on the southeast are the Ijaw, Kalahari, and Itsekiri peoples. The Ogoni and Ikwere of Rivers State are their southeastern neighbours. Their northern neighbours are the Idoma and Igala of Benue State, while eastwards they share common borders with the Ibibio, Ekoi, and Yako of Akwa Ibom and Cross River States.

The true origin of the Igbo is not known and has therefore merely been speculated upon. One of such speculations bravely suggests a possible affinity with the Jews of Israel, claiming that the name 'Igbo' may well be an adulteration of an original and perhaps ancestral family name 'Hebrew'. Recent archaeological fieldwork in Igboland has, however, unearthed invaluable artefacts that point to a long rich cultural past, dating back, at least, to the 9th century A.D. Several authorities argue that this may be evidence that the Igbo have lived where they are presently found for several centuries, if not since the beginning of time (Acholonu, 1987).

Several Igbo anthropologists, such as Uchendu (1965) and Talbot (1926), describe the Igbo as rugged republicans, highly independent minded, consummate capitalists, and aggressive entrepreneurs. Indigenous Igbo religion, in keeping with this independence, is thus neither organized nor proselytised. Religion, to the Igbo is a very personal relationship between humans and the gods, a way of life.

Nicknamed the 'African Jews', the Igbo are great travellers. They are currently found living, working, and doing business in every part of the world from Alaska to Zimbabwe. The number of Igbo who live outside their homeland is currently put at 5 million. With this large number of Igbo in Diaspora, the Igbo at home are often abreast of information about other cultures and developments in other societies.

Among the Igbo, health is valued above wealth. One Igbo anecdote lends credence to this: *Ahapu ndu kpaaku onye iro erie ya*—if you pursue wealth at the expense of health, the accumulated wealth will ultimately be

enjoyed by your enemies. In the Igbo worldview, health is the foundation of societal development and individual greatness. Thus, it is considered a thing of shame for one to die of a disease which is curable due to lack of money. The Igbo often go at length, sometimes selling off properties to treat themselves. (One story has it that in the indigenous background, children were even pledged or sold off by parents trying desperately to raise funds to finance treatment courses. Another holds that some people who could not pay for treatment also stayed back at the homes of healers to work for them after they become well in order to indemnify the healers. Daughters were also given in marriage to healers as payment for successful treatments.)

Igbo people seeking health care are usually pragmatic and turn to different therapists for treatment. They go from one practitioner to another seeking treatment for different symptoms of the same disease (Wood, 1979; Zeller, 1979). The Igbo have different categories of diseases. They differentiate between diseases caused by supernatural factors and those that have natural origin. Supernatural causes of disease conditions in Igbo cosmology include the gods/goddesses, evil spirits, deities, and witchcraft. When cultural taboos are infringed, the Igbo believe that the gods may also respond by visiting individuals with diseases. To cure conditions with supernatural causation, the Igbo believe that strong traditional treatment must be sought. Natural causes of diseases include accidents, excessive toiling, staying out in the cold or sun, exposing oneself to the elements, eating bad food, unclean environment, contact with infected people and animals, poor personal hygiene, etc. The Igbo also believe that certain conditions are hereditary, passing from parents and fore-parents to offspring. Such health conditions are believed to require strong traditional and magical medicine to cure.

Among the Igbo, some ill-health conditions such as those suspected to be caused by involvement in witchcraft, occultism, and infraction of taboos are stigmatized. Igbo persons who suffer stigmatized conditions often attempt to conceal them from the public while seeking cure. Enwereji (1997) observes that among the Igbo, the way symptoms are identified and interpreted determines the type of therapy the people seek and that the people typically proceed from the cheapest and most accessible form of treatment to one that is more expensive and harder to procure. Witchcraft is also popularly believed to be a major cause of ill health among the Igbo. Witches and wizards are perceived as dangerous people who can deal with their victims in several ways. A condition caused by witchcraft is believed to be curable only by strong indigenous medicine.

In present-day Igboland, as in many other parts of Nigeria, traditional medicine remains that most

affordable and accessible healthcare option (Enwereji, 1997). Igbo people of different socio-economic backgrounds use the services of traditional healers extensively. Generally, the Igbo believe that Ibibio traditional medicine is very strong and effective. They see the Ibibio as master medicine people. In several Igbo folktales, Ibibioland is depicted as the home of peerless healing and magical powers. In a popular Igbo folktale, one strong Igbo wrestler's 6-year reign as champion is brought to a shameful end by a one-armed challenger who has fortified himself with Ibibio charms. In another, a revered Igbo medicine man is turned into a lizard by a mere trainee in Ibibio healing and magical art, and all efforts to return him to human form by other Igbo medicine men were abortive. The trainee, the story goes, then simply spat on the lizard. The lizard ran into a nearby bush, and no sooner, from the bush emerged the hapless Igbo medicine man dragging the body of a freshly shot antelope. This is a sketch of the culture of the Igbo of southeastern Nigeria from where the women who provided data for this study came.

Analysis of the data they provided involved reading through each of the transcribed interviews in order to take note of significant themes. We made a conscious effort to re(present) each of the respondents as a woman negotiating with social and cultural reality rather than to try and make gross generalizations about their views. By (re)presenting each woman as an individual, we were able to tease out idiosyncratic patterns as well as similarities in their views. Table 1 summarizes the socio-demographic characteristics and health conditions of the study participants.

Results

Coming to Ibibioland in search of indigenous treatment

From the accounts of the care-seekers or and their care-givers (companions) several reasons lie at the heart of their decision to seek Ibibio indigenous treatments. We summarize these into three broad categories:

(a) *Failure of initial treatments at patient's home:* We found out that in a number of cases, patients sought Ibibio ethnomedical services after unsuccessfully using various treatments in their own communities of origin. The failure of these initial treatments, which often included Igbo traditional medicine, western biomedicine, and chemists often led to a search for something or information on something that will be more effective. In this regard, coming to Ibibioland, was thus a quest for a more potent and powerful treatment regimen. One of the care-seekers presenting for vaginal bleeding noted:

...it is one Ibibio woman that is married in my village. We are very close. When all the initial treatments I

took did not seem to be helping matters she came and told me 'so person in my town handles this sort of condition effectively'. My family considered it and we agreed that I should come down.

A mother accompanying one of the girls presenting for psychiatric disorder also tells us:

... it was a our previous healer that brought us here ... He told us after he tried treating my daughter for six weeks without much success, that my daughter's case will be best handled in this place. He already knew this man and trusted in his abilities. So my husband and I arranged transportation and we came down here.

(b) *Need to maintain secrecy over therapeutic progress:* Another issue emerging from interview results is that many of the respondents sought treatment outside their places of origin as a way of concealing therapeutic progress. Many of the participants informed us that witchcraft was responsible for their condition and that when they became aware of this (many said through divination), it became necessary to seek far-away treatment destinations where the persons and forces responsible for the conditions will not find it easy to monitor or disturb therapeutic progress. A woman presenting for sudden excessive swelling of the breasts remarked:

This my disease is due to witchcraft ... We came to this place (Ibibioland) because those who are responsible live near us in the village. We don't want them to know what progress we are making with treatment ... They could use their witchcraft to interfere with my recovery process.

Another care-seeker noted:

... my condition is caused by witchcraft ... the healer here (referring to the Ibibio medicine man) has also confirmed it. When it started, I sought cure in a herbal home in my place. My former healer, he did his best, but while I was still there, those responsible for my condition were coming to see me and will go back to revitalize my ill-health through their witchcraft. My family therefore decided I had better come over here where they will find it difficult to know how I am doing.

There was also a woman who revealed she had come to Ibibioland because she did not want her church to know she was relying on traditional medicine to treat her daughter's epilepsy. If her church knows, she said:

I might be excommunicated ... my church preaches against the use of indigenous medicine ... But I can't leave my daughter to grow up with this terrible

Table 1
Summary of participants

S/no.	Patient's age	Educational level	Marital status	Religion	Place of residence	Characteristics of companion	Source of payment	Time spent in Ibibioland	Types of treatment initially sought	Conditions	Occupation
1	50	No formal education	Married	Catholic	Aba (rural) Abia State	Daughter age 18, secondary school student	Husband, self, brother	2 weeks	Hospital, Igbo indigenous therapies	Stroke/paralysis	Farmer/petty trader/housewife
2	48	Primary education	Widowed	Protestant	Umuahia (urban) Abia State	Daughter age 15, secondary school student	Son, self, relatives	6 days	Igbo traditional (medicine) chemist shops	Swollen body	Farmer/housewife
3	41	Primary education	Married	Protestant	Aba (urban) Abia State	Sister-in-law, age 12, secondary school student	Husband, self	8 days	Igbo traditional medicine, chemist shop	Sudden/excessive swelling/enlargement of breasts	Farmer/housewife
4	19	Secondary school student	Single	Protestant	Bende (rural) Abia State	Mother, age 46, trader, housewife, farmer	Parents	4 days	Chemists, hospital, traditional Igbo medicine	Psychiatric disorders	Student
5	39	Tertiary education	Married	Catholic	Udi (rural) Enugu State	Son, age 12, primary school pupil	Husband, self	1 week	Hospital, Igbo traditional medicine	Strange crawling movement on the body	Civil servant/housewife/farmer
6	24	Secondary education	Single	Protestant	Awka (urban) Anambra	Brother, age 14, secondary school student	Parents	3 weeks	Igbo traditional medicine	Bone-setting	Business woman/trader
7	36	Primary education	Married	Catholic	Mbaise (rural) Imo State	No companion	Husband, self	2 days	Hospital, Igbo traditional medicine	Strange rashes over the body	Housewife/farmer
8	49	Secondary education	Married	Catholic	Nkwere (rural) Imo State	Daughter, age 18, secondary school student	Husband, self	4 days	Chemist shop, hospital, Igbo traditional medicine	Chronic/wasting cough	Housewife/civil servant
9	17	Secondary school student	Single	Protestant	Afikpo (rural) Ebonyi State	Mother, age 48, farmer, housewife	Parents	16 days	Hospital, Igbo traditional medicine	Psychiatric disorder	Secondary school student

10	40	Primary education	Married	Catholic	Idemili (rural) Anambra	Daughter, age 19, secondary school student	Husband, self	2 days	Hospital, Igbo traditional medicine	Vaginal bleeding	Housewife/patty trader/farmer
11	10	Primary school student	Single	Protestant	Arochukwu (rural) Abia State	Mother, age 37, civil servant	Parents	3 days	Hospital, spiritual healing	Epilepsy	Primary school student
12	36	No formal education	Married	Catholic	Edda (rural) Ebonyi State	Sister-in-law, age 19, secondary school student	Husband	4 days	Hospital, chemist Igbo traditional medicine	Sudden loss of vision	Housewife/farmer
13	47	No formal education	Widowed	Catholic	Okigwe (rural) Imo State	Son, age 17, secondary school student	Self, husband	1 week	Igbo traditional medicine, hospital	Swollen body/sudden loss of speech	Farmer/housewife
14	42	Secondary education	Married	Protestant	Umuahia (rural) Abia State	Daughter, age 14, secondary school student	Self, husband	13 days	Igbo traditional medicine	Bone-setting	Housewife/civil servant
15	32	Primary education	Married	Protestant	Nnewi (urban) Anambra State	No companion	Self, husband	1 day	Hospital, spiritual healing, Igbo traditional medicine	Infertility/childlessness	Housewife, petty trader
16	19	Secondary school student	Single	Catholic	Aba (rural) Abia State	Mother, age 48, civil servant	Parents	3 days	Hospital, spiritual healing, Igbo traditional medicine	Psychiatric disorder	Student
17	19	Primary education	Married	Protestant	Agbani (rural) Enugu	Daughter, age 19, secondary school student	Husband, self	5 days	Igbo traditional medicine, hospital	Diabetes	Housewife, petty trader
18	54	Secondary education	Widowed	Protestant	Aba (rural) Abia State	Daughter, age 14 years, secondary school student	Self, daughter	18 days	Igbo traditional medicine, hospital	Partial paralysis	Housewife/petty trader
19	38	Secondary	Married	Protestant	Owerri (rural) Imo state	Daughter, age 11 years secondary school student	Husband, self	13 days	Hospital, Igbo traditional medicine	15-month pregnancy without labour	Housewife/petty trader

disease. Prayers in my church have failed to cure her ...

(c) *Need to maintain secrecy over nature of health condition*: The third major reason care-seekers gave for seeking Ibibio indigenous medical therapy was that they wanted to ensure that the nature of their conditions were concealed from persons at their communities of origin. Most of the respondents who said this, noted that their conditions were stigmatized in their home communities and revealed that coming to Ibibioland was part of their efforts to conceal the nature of their conditions from their communities while treatment lasted. A woman presenting for swollen body and strange rashes told us:

... well in my place (village), they believe that if your body swells it is a bad disease. They say perhaps you have been practicing witchcraft. So when my condition started, we immediately felt the best thing to do was to seek treatment where people won't easily know how I am faring.

Another said:

We came all the way from Abia State. In my place, madness is seen as a bad disease. So when it became evident that my daughter's condition was madness, my family arranged to bring her here where she can quietly undergo treatment.

In all case, however, care-seekers confirmed having information about other potential therapeutic destinations. So why did they prefer to come to Ibibioland? Response to this question highlighted various issues regarding how decisions about therapeutic destinations were made.

Emerging from the interviews in evidence that the families of the patients rather than the individual patients themselves selected therapeutic destinations, respondents noted that their families made the decision only after carefully weighing the costs and benefits of each of the potential destinations. In making such decisions, respondents revealed that premium was often placed on service characteristics such as therapeutic reputation, responsiveness of destination to patients' socio-cultural needs, popularity of healers, etc. The fame enjoyed by Ibibio indigenous healers in Nigeria often formed a critical aspect of the narratives on service characteristics that ultimately drew the care-seekers:

... in my place, we often hear how powerful Ibibio native healers are. Such stories particularly encouraged me to come here ... (woman with overdue pregnancy).

Well ... yes before coming here, we heard of other equally good places ... but we chose to come here because people said it was about the most reliable place for my condition (woman with diabetes).

The mother of an epileptic girl also had this to say:

We heard of lots of reputable places where my daughter's condition would be treated ... but we chose to come here because of the things we heard about here...

But how and where did the information on which care-seekers and their family based their choice come from? Social networks—friends, relatives, co-workers, and acquaintances and even previous healers were the key sources of information upon which care-seekers and their families acted.

... it was our previous healer that brought us here
 ... one Ibibio woman married in my village, she directed us here...
 ... one of my husband's co-workers directed us here ...
 ... I heard about this place from one of my customers ...

Experiences with transethnic therapeutic care-seeking

Seeking ethnomedical care outside one's own ethnic boundaries was reportedly characterized with setbacks. Patients and their caregivers frequently mentioned linguistic difference between them and the healers as often interfering with their ability to communicate directly and freely with healers and people around them. Respondents also reported that they had to borrow money, pledge their properties, and sell off important personal items to raise money to finance the trips. Additional costs were also incurred as patients or and their accompanying relatives shuttled between the healing centres and patients' homes to get more money, food items, clothing, or/and exchange information with family members at home. Care-seeking outside one's base also meant loss of productive hours for patients and those accompanying them. Farming and other economic activities of care-seekers and their companions also reportedly suffered during therapeutic sojourns. One woman notes:

... as I am here now, my shop is closed. I lose money daily. There is nobody to sell for me ... you see how bad this could be.

One young girl accompanying her mother also reports:

I am a student ... I left school to stay with my mother here ... we have stayed two weeks here ... I can't wait to get back to school. I miss school but what can I do ...

Patients and their companions also reported missing home, religious activities, and the company of friends. Seeking care outside one's society also reportedly robbed households of patients vital contributions to family care and upkeep. It also reduced household

income and exposed household members especially children to undernutrition, ill-health, inadequate care, and even disabilities. One mother notes:

Ever since I came down here for treatment about a month ago, my husband has borne the burden of sustaining me (here) and my four children at home. My family misses me, my children are suffering they do not feed well any more ... my old mother too ... she is suffering due to my absence.

There were, however, reports of having gained from seeking care outside one's ethnic boundaries. The patients and their companions reported making new friends, learning Ibibio songs, and how to greet in Ibibio language. Some said they had gained some insights into Ibibio culture and way of life. Others said they were fast learning Ibibio language. One young girl accompanying her mother told us she has made lots of Ibibio friends and learnt some Ibibio local games.

Two of the women also told us that they are using the opportunity to negotiate with their Ibibio healers to fortify them against future attack of witchcraft, mishaps, and bad luck. One woman also noted that she has convinced her healer to help her avenge her conditions after treatment by also causing those responsible to suffer similar fate. These women noted that they may not have easily expressed these needs to medicine men in their own communities as it was not proper for women to make such requests to medicine men in Igbo culture.

Discussions

The present study is limited by the small size of its sample, restricted focus on Ibibio ethnomedicine, and reliance only on those intercepted at the service location points (healing homes), which could impinge on the generalizability of its findings. These notwithstanding, our analysis reveals potentially critical issues of note.

Place matters in health-seeking

Care-seekers in the study did not just go anywhere. They chose Ibibioland because they felt at 'home' seeking care in the place. As a place, Ibibioland was imbued with, and held forth a certain intrinsic social value, part of which was the promise of protecting the care-seekers from certain unfavourable and negative social values at their own places of origin. In going 'out of their places' in order to utilize Ibibio ethnomedical capabilities, care-seekers were really negotiating with multiple cultural meanings of self, place, and ill health; they were in fact searching for another 'home away from home'. This suggests that the meaning of illness and poor health conditions is intricately linked to the

manifold context and nature of social interactions and the dynamics of flows between places. Eyles (1983) contends that places have symbolic content either in their own right or because of the sentiments they represent. These are often shared and may be based on a place's reputation or on people's activities in or memories of a place. Being sensitive to how care-seekers' frame their health conditions in relation to the places they live and or seek care and the flow between places rather than place as a static entity should be important features of healthcare services.

Place-specific health notions have implications for care-seeking for certain illness episodes: Care-seekers operate within social spaces circumscribed by cultural notions and beliefs. These beliefs are at the heart of community meanings or constructions of disease conditions and may transport certain disease conditions to the domain of the stigmatized. Place-specific traditional beliefs (such as those associating certain illnesses with meddling in witchcraft) therefore play out in interesting ways during therapeutic quests. The crystallizing of community meanings of disease conditions was a major push factor for trans-ethnic ethnomedical quests. Agencies and persons working to promote sounder healthcare practices among peoples in the developing countries need to be conscious of how community meanings may mediate care-seeking decisions for certain health conditions.

Care-seekers have needs for culturally sensitive services: Emerging from the study is evidence that even when seeking cure outside their ethnic boundaries, patients place premium on services that will respond closely to their socio-cultural sensitivities, values, and needs. Patients and their companions in the reported study revealed choosing their therapeutic destinations only often satisfying themselves that such will be responsive to their cultural needs. Public health officials who aim or are working to promote peoples' utilization of modern health services therefore need to ensure that these services are responsive to the values, needs, and sensitivities of care-seekers.

Health is an informational good: Another issue of note from the study is that health is largely an informational good. Information and narratives on Ibibio indigenous medicine provided patients and their relatives in the reported study the basis for making decisions regarding therapeutic destinations. Mackinnon (1997) suggests that the role of information in health and well-being goes well beyond the issue of where to seek cure for conditions to include all that people know and will do about their health generally. To translate into observable realities, health promotion efforts in the developing areas will involve making quality and reliable health information accessible and available to underserved peoples.

Ethnomedicine remains a critical health resource: In taking all these health conditions to local healers,

care-seekers point out to us the fact that indigenous medicine continues to be relevant and useful to the lives of many women in the developing world, and that women can go at length, including leaving one's own ethnic boundaries, to get the best of it. Against this backdrop, public health schemes that aim at sustainability need, among other important things, to develop strategies for mainstreaming ethnomedical therapists, if such schemes are to answer to the needs of all categories of expected beneficiaries (Izugbara and Ukwai, 2003).

Social networks mediate care-seeking behaviour: Social networks—the complex of interpersonal links within which people are enmeshed—mediate peoples' health choices and decisions. Social networks provide one pathway through which patients access information on therapeutic destinations. Such networks can reinforce existing health norms and behaviours. They can also raise questions about them. Riley (1997) suggests that people often rely on these networks and ties to mediate difficult situations or to get advice about a bothersome health circumstances. In dealing with care-seekers therefore, whether in the matter of health or in other programme to deliver change, the individuals alone should not be the focus of action, as a decision unilaterally taken by an individual may be nullified by social networks and ties (Abasiokong, 1981).

Conclusion

This study, focused on the underexplored issue of trans-ethnic itineraries for ethnomedical therapy focusing on Igbo women seen in Ibibio traditional healing facilities in southeastern Nigeria. The study found evidence that the conditions for which these women sought cures outside their ethnic boundaries were primarily those that have failed to respond to initial treatments at home, stigmatized in their own communities, or and viewed as having supernatural or mystical causes. The therapeutic reputations of traditional Ibibio medicine and the responsiveness of Ibibio healers to care-seekers' socio-cultural and economic sensitivities about which information was accessed through social networks and ties emerged as key predictors of therapeutic destinations. Care-seeking for ethnomedical therapy outside patients' ethnic boundaries also had its costs as well as benefits.

In summary, while we consider our results important, we also consider them preliminary as they raise further questions that need to be addressed. Specifically, more need to be learned about similar itineraries among men and in other ethnic groups. For instance, we will want to know if Ibibio people also seek Igbo indigenous medicine. We also need information on how households of care-seekers and their companions cope with their absence. Further, concrete information is needed in

respect of the extent, implications, and weight of relevant parameters set by particular cultural systems on care-seeking outside one's ethnic boundary or place. These are however, tasks for other times.

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