

Transethnic Sojourns for Ethnomedical Knowledge among Igbo  
Traditional Healers in Nigeria: Preliminary Observations.

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**Abstract**

Traditional medicine occupies a central place in healthcare in sub-Saharan Africa, serving the needs of up to 80% of the population in the region. More recent events including the emergence of new diseases, the resurgence of old ones, and the crisis of western healthcare delivery, etc., have tended to increase the demand placed on traditional medicine in sub-Saharan Africa. To meet the challenges posed by rising user- ship of ethno-medicine in the region, African traditional healers continue to, among other things, regularly seek more curative knowledge and skills. However, although existing research has tended to suggest that healer- healer exchange of therapeutic information and skills in Africa occurs only among healers from the similar ethnic backgrounds, data emerging from a recent study among local healers in Igboland, Nigeria shows that the search for more therapeutic information and skills sometimes takes healers outside their own ethnic homelands. This chapter draws attention to recent patterns of transethnic migrations for ethno-medical knowledge and skills among indigenous Igbo healers (dibias) in Nigeria, looking specifically at where they go, how they go, who they go to, why they go, and how their quest for healing knowledge outside Igboland impacts on their professional practice. This paper shows that local Igbo healers seek more therapeutic knowledge and skills from healers outside Igboland. This often occurred when dibias could not find another Igbo healers with expertise in what they wanted to learn. In such instances, the dibia traveled outside Igboland in quest of reputable healers in other ethnic groups. The destinations of transethnic trips for ethnomedical knowledge and skills were influenced by the type of specific ethnomedical knowledge or skill sought

by the dibia and the popularity of given healers in specific branches of ethnomedicine as well as the perceived areas of specialty of healers from particular ethnic groups. From these trips, Igbo dibias reportedly learnt more potent cures for wide range of conditions, new and reliable diagnostic and divining techniques as well as new medicines for preventing certain misfortunes, diseases, and ill health conditions. Dibias returning from such trips also often brought home seeds, stems, and roots of plants, which they grow, thereby encouraging local biodiversity. Transethnic migrations for ethnomedical knowledge and skills equip Igbo healers to meet and address the health needs of their clients more sustainably and to also participate in the wider network of ties which helps the production of ethnomedical knowledge and its transmission from one generation of healers, one group of ethnomedical specialists, and one body of ethnic healers to another. The study further discusses the implications of the findings for efforts and programmes to promote health for peoples in the global south where traditional medicine remains very active.

## **Introduction**

Ethnomedicine, the whole approach of an ethnic community to disease and illness, organized spatially, changing overtime, and including medical taxonomy, folk knowledge, guidelines, traditions and values, health behaviour rules and patterns, supportive social institutions, and identified personnel and structure for delivery of preventive and restorative therapy – occupies a central place in healthcare in sub-Saharan Africa (Izugbara, Etukudoh & Brown, 2005; Modo, 2005). The WHO estimates that up to 80% of the populations in the region make use of ethnomedicine. Indeed, in spite of widespread introduction of western-type medical services in sub-Saharan Africa; traditional medicine remains the most subscribed and accessible therapeutic system in the region. For instance, it is estimated that in Nigeria, ethnomedicine is actually the only healthcare resource accessible to a third of the population. Scholars (such as Jegede, 1998; Udoh 2000; Erinosh, 1989) have attributed the popularity of ethnomedicine in Nigeria to its affordability, accessibility, cultural sensitivity, and proven efficacy. The use of ethnomedicine in Nigeria is not the preserve of any socio-economic or cultural category. Rich, poor, literate, illiter-

ate, young, old, married, single, rural and urban-based persons, including Muslims, Christians, indigenous worshippers and several others in Nigeria have been identified as regular users of ethnomedical services.

Authorities (such as Owumi, 1996, Lambo, 1968, Izugbara & Ukwayi, 2003, 2004; Izugbara et al, 2005, Modo, 2005) note that Nigerians tend to view ethnomedicine as efficacious for most illnesses. Research confirms that even formal health services providers in Nigeria sometimes openly advise patients to seek traditional medicine, especially where formal treatment courses fail to deliver their expected results (Alubo, 1995; 2001). It has been suggested that besides its affordability, accessibility, and responsiveness to health seekers' sensitivities, a major attraction of traditional medicine in Nigeria may also be that it always has some kind of cure available for virtually any condition in contrast to the allopathic practitioners who might prescribe medications not easily attainable (Outwater et al, 2001, Izugbara, et al 2005). The uses to which Nigerians put ethnomedicine vary. In addition to use for curative purposes, ethnomedicine is also relied upon to prevent illluck, illhealth, mishap and misfortune. Nigerians also believe it can be used to increase one's chances of success in business, careers, and other activities (Owumi, 1998; Jegede, 1998; Aregbeven, 1996).

Contemporary events have grossly increased the demands placed on traditional medicine in Nigeria. These include the emergence of new types of diseases, the resurgence of old diseases, the appearance of drug-resistant strains of disease-agents, and the current crisis of western-type healthcare delivery, which makes it unable to provide sufficient care in urban Nigeria and virtually no care in most remote, rural communities. Emerging research indicates that the quest and uptake of traditional medicine appears to be more vigorous now than ever before in Nigeria (Enwerji, 1999; Alubo, 1995). For instance it has been recently shown (by Izugbara, et al, 2005) that the quest for effective traditional cures in Nigeria now takes careseekers to healers outside their own ethnic groups.

The rising usership of ethnomedicine in Nigeria is a challenge, which its practitioners try to meet, among other things, by regularly seeking more ethnomedical knowledge especially

from other healers. However, although existing research has tended to suggest that healer-healer exchange of information on therapeutic skills and knowledge occur only among healers from the same ethnic groups, emerging evidence from a recent study among local healers in Igboland, Nigeria, shows that the search for more therapeutic skills and knowledge sometimes takes healers outside their own ethnic homelands. Available research on the practice of ethnomedicine in Nigeria has glossed over healers' quest for therapeutic knowledge from healers outside their own ethnic homelands. Consequently, the role of transethnic quests for therapeutic knowledge among healers in the transmission of healing skills and therapeutic information from one healer or group of healers to another in Nigeria remains poorly understood.

In this paper, I draw attention to recent patterns of transethnic migration for ethnomedical knowledge among indigenous Igbo healers in Nigeria, looking specifically at where they go, how they go, who they go to, why they go, and how their quest for healing knowledge and skills outside Igboland impacts on their professional practice. The following section is a brief recapitulation on the Igbo and their traditional medicine, which helps to put the present study in proper perspective.

### **Enframing the Igbo and Their Traditional Medicine**

The Igbo are a Negroid group living in southeastern Nigeria. The Igbo homeland lies between latitudes 4° and 7° north and longitudes 6° and 8° east. This area presently covers all of Imo, Abia, Ebonyi, Enugu, and Anambra states and parts of Rivers, Delta, Akwa Ibom, and Cross River States (see figure I). Reportedly Nigeria's third single largest ethnic group, the Igbo currently number about 14 million persons. Neighboring the Igbo on the southwest are the Ijaw, Kalabari, and Itsekiri peoples. The Ogoni and Ikwerre of Rivers States are their southeastern neighbours. Their northern neighbours are the Idoma and Igala of Benue and Kogi States, while eastwards they share common borders with the Ibibio, Annang, Ekoi, and Yakurr of Akwa Ibom and Cross River States.

There is a range of socio-cultural differences, including dialectal variations among the Igbo. Despite these differences, Igbo ethnographers, historians, and anthropologists agree that Igboland fits into a cultural area, exhibiting distinctive, political, linguistic, social, economic, ritual and other cultural traits. Five distinct sub-cultural areas are found in Igboland (Afigbo, 1986; Onwuejeogu, 1989; Uchendu, 1965); namely (a) the eastern or Cross River Igbo (b) the southern or Owerri Igbo (c) the northern or Onitsha Igbo, (d) the western Igbo, and (e) the northeast Igbo. Currently, nobody is certain about the origin of the Igbo. Scholars have merely speculated about it. One popular, but unlikely supposition holds that the Igbo are Jews and that the name 'Igbo' is an adulteration of an original ancestral family name, 'Hebrew'. Purveyors of the Jewish origin of the Igbo argue that they left their parent Hebrew family several millennia ago moving possibly through Ethiopia, Sudan, and Cameroon and finally settling in Nigeria around 7 BC. In reality, the only supporting evidence available for this theory is a handful of religious and cultural rites and traditions shared by the two people.

There is however an Igbo myth of origin which suggests that the Igbo may have lived where they are presently found for a very long time, if not since the beginning of time (Acholonu, 1987). The myth holds that in the beginning Chukwu, God created and sent down a man, Eri and his wife, Nnamaku to earth (precisely somewhere in Aguleri, Anambra State). On reaching earth, Eri and his wife found the earth surface covered by water, and so they stood upon an anthill and petitioned Chukwu about the poor state of the environment. Chukwu responded urgently sending an Awka blacksmith with his fiery bellow and charcoal to dry the earth. While Eri lived, Chukwu fed him and his people with Azu Igwe, heavenly fish. This however stopped when Eri died. Chukwu then instructed Eri's son, Nri to sacrifice his (Nri's) first son and daughter and bury them in separate graves. Nri obliged and after twelve days yam, ji and cocoyam, ede grew in the graves respectively, marking the beginning of agriculture.

Recent archaeological studies in Igboland have yielded invaluable artefacts that point to a rich cultural past, dating back, at least, to the 9th century AD. Authorities (including Dike, 1973, Oriji, 1980) suggest that this may be evidence that the Igbo have lived where we presently find

them for a very long time. Emerging historical results show that the weight of scientific evidence rests mightily on situating Igbo origin within the Negro race, particularly in West Africa because of the Kwa language sub-family in which the Yoruba, Ijaw, Igbo, Igala, Edo, and Idoma are found (Afigbo, 1986). Researchers describe the Igbo as rugged republicans highly independent minded, consummate capitalists, and aggressive entrepreneurs (Uchendu, 1965), Talbot, 1926). Currently, a joke in Nigeria has it that the truest confirmatory test of death for any Igbo is when he/she hears the noise of paper or coin money and does not wake up (Ekwuru, 1999).

Igbo indigenous medicine, *Ogwu Igbo* has existed for several millennia. Both the Igbo and many non-Igbo in Nigeria currently view *Ogwu Igbo* as potent and powerful (Madukaji, 2001). Until the 20th century, *Ogwu Igbo* was perhaps the only curative resource available to all Igbo. The proliferation of western medicine notwithstanding, Igbo traditional medicine is still used by 92% of all Igbo and remains the only treatment resource accessible to over three million Igbo (Madukaji, 2001).

A practitioner of *ogwu Igbo* is generally called *dibia*. *Dibias* are traditionally viewed as competent to provide health services by using plant, animal, and mineral substances as well as several techniques based on the socio-cultural and religious background. In their work, *dibias* rely primarily on prevailing indigenous knowledge, attitudes, and beliefs about physical, mental and social wellbeing and the causes of disease and disability. Specialist professionals have evolved in Igbo ethnomedicine. They include diviners, seers, and oraculists (*dibia Aja*), and herbalists (*dibia ngorogowu*) who employ wide armamentaria of resources including pharmacologically active or ritually significant plants and mineral substances. There are also spiritualists, cultists, faith healers, priests, and priestess, and indigenous religious experts who can both heal, protect and prevent with ritual prescriptions and techniques, such as offering, incantations, sacrifices, and confessions. Others are the *dibia okpukpu*; the local bonesetter, *dibia umu Nwanyi*, the traditional birth attendant, *dibia ndi ara*; the tradopsychiatrist, the tradohydrotherapist, tradotheosophist, the zootherapist, and the traditional surgeon.

In the Igbo worldview, health and disease are consequent upon the interaction of an individual with the socio-cultural and supernatural environment. When there is a balance between an individual and all these spheres, he/she enjoys good health. Illhealth often results from an imbalance in the individual's interaction with the environment. Igbo ethnomedical cosmology recognizes three broad illness classifications; natural, mystical, and inherited. Natural causes of disease conditions include drinking of unclean water, over eating, lack of rest, over indulgence in sex, ingestion of poisonous substances, exposure to inclement environment etc. Researchers take this as evidence that the Igbo worldview acknowledges the germ theory of disease causation. Mystical explanations of illhealth exist in Igbo thought. Episodes of unwellness that defy simple remedies and cannot be immediately linked to natural causation are often attributed to the activities of gods, ancestors, deities, and spirits. Witchcraft, errors in rituals, infraction of taboos and the neglect of deities are also ever present mystical causes of illnesses among the Igbo. The Igbo frequently associate barrenness, mental illnesses and premature deaths with mystical causes. The Igbo also believe that some illnesses are hereditary, and thus transferable from parents to their offspring.

Like most other ethnomedical traditions in Africa, Igbo indigenous medicine accepts the interconnectedness of all elements. Thus, humans are connected to plants, animals, rivers, earth, hills, valleys and mountains, etc. and events in any one of these planes have potential implications for events in other planes and spheres. Explanations of illhealth among the Igbo thus invoke a host of specific causes: germs, sins, taboo infractions, witchcrafts, retribution, spirits, ancestors, gods, deities, carelessness, poverty, lifestyle, heredity, etc.

Diagnoses in Igbo ethnomedicine may include one or a combination of the following; observations of the patients behaviours, gestures, reasoning, attributes ability to perform certain tasks, and close relations; divination and possession which often lead beyond diagnosis to prognosis and treatment plan; case history involving intensive assessment of patients socio-behavioral history and family milieu. Clinical examination such as assessing palpitation, temperature, nail and hair colour, physical signs, pulse rate, etc. Biological diagnosis; through careful examination of

stools, blood, pus, urine, discharges, sputum, saliva, etc. (Good, et al, 1979).

Igbo medicine involves a diverse array of therapeutic procedures, ingenuity, trial, and error experimentation as well as the steady accumulation of empirical wisdom over time. Igbo therapies may involve one or a combination of the following: drinking, bathing, swallowing, rubbing, incision making, enema, massaging, and chewing. Some of the medicines are also taken along with food and drinks, mixed with body creams, put in bathing water, smoking pipes, or warming fires. There are also those that are splashed on patients and care seekers, tied or hung on parts of their body, buried or kept in rooms, and compounds, tied or hung on trees etc. Good et al (1979) have noted that African indigenous medical practices such as those of the Igbo have modern equivalents; oral, cutaneous, rectal, and respiratory administration of plant preparation, hydrotherapy, massaging and psychiatric testing.

Igbo ethnomedical knowledge has historically been transmitted through oral tradition and apprenticeship. An individual may become a *dibia* by being taught by his/her healer relatives. He/she may also study under another healer who may be unrelated to him/her. There are also those who claim to have received supernatural calls to join the profession.

Even when people receive calls to become *dibias*, they often still undergo basic training under other longstanding practitioners. Even when their original period of apprenticeship is over and they qualify as *dibias*, Igbo healers continue to search for more therapeutic knowledge through personal researchers, on-job learning experiences with patient and treatment outcomes and regimens, and most importantly from other ethnomedical practitioners. It is however currently assumed in the literature on Igbo healers in Igboland that they seek therapeutic knowledge and information only from their ethnic professional colleagues. But results of a recent study among local healers in Igboland challenge this assumption and indicate that Igbo *dibia*'s quest for more therapeutic skills and knowledge sometimes takes them to healers from other ethnic groups.

The purpose of this paper is to explore the issues surrounding recent patterns of transethnic sojourns for ethnomedical knowledge among Igbo *dibias* in Nigeria.

## **A Methodological Brief**

Two interlocking issues provide the grid upon which my analysis rests. First, we examine the characteristics of Igbo dibias undertaking transethnic trips for ethnomedical knowledge and skills, and second, we explore their narrations of transethnic ethnomedical knowledge sojourns, marking the key issues that shape the itineraries and their implications for the work of the dibias. Throughout our analysis, we draw primarily upon our recent ethnographic fieldwork conducted among 38 general practitioners who confirmed having embarked on such quests within the last 10 years. The dibias were recruited (from 22 separate rural villages in Abia State, Southeastern Nigeria) through snowballing, and investigated using an open-ended, in-depth, and face-to-face individual interview schedule. The interviews were administered in local Igbo language to the participants who were guaranteed confidentiality and anonymity of their responses. Audiotaped responses were later transcribed into English Language with the help of field assistants and a few Igbo speaking persons studying English Language and Linguistics at the University of Uyo, Nigeria. Analysis of the interview data was qualitative and sought to identify and discuss the key issues that the interviews threw up. In many instances, we quote verbatim the views of participants to illustrate their responses on key issues.

## **Findings**

The characteristics of dibias interviewed for the study are displayed on Table I. Their ages ranged between 30 and 68, averaging 57. The bulk of the participants was in the 55-59 age bracket. The healers were mostly males (84%). Only 6 (16) of the dibias were females.

The educational profile of the respondents shows that majority of them had no formal education (47%) or little formal education (42%). Only (8%) of the healers had formal education of 7 – 12 years. Average years of completed formal education stood roughly at 4. Despite their low formal education level among the herbalist could speak Pidgin English. Pidgin English is the unofficial lingua franca in Nigeria and is spoken by up to 80% of Nigerians (Modo 2004). All the healers were married. Eleven of them were in monogamous marital relationships while 27

(71%) were in polygamous relationship. Two of the women healers were however widows from a monogamous marriage.

<b>Age</b>	<b>n</b>	<b>%</b>
< 45	2	5.3
45 – 49	7	18.4
50 – 54	10	26.3
55 – 59	13	34.2
60 – and above	6	15.8
<b>Gender</b>	<b>32</b>	<b>84</b>
Male	6	16
Female		
	18	47.4
<b>Formal Education in years</b>	16	42
None	3	8
1 – 6	1	2.6
7 – 12		
7 12	11	29
<b>Family type</b>	27	71
Monogamous		
Polygamous	9	24
<b>Religion</b>	27	76
Christian		
Traditional worshipper	2	5.3
	7	18.4
<b>Length of Professional Practice</b>	17	44.7
> 5	12	31.5
5 – 15		
16 – 26		
27 - above		

Table I: Socio-demography of the Dibias

Nine (24%) of the dibias claimed they were Christians and were mainly Protestants. However, traditional worshippers formed the bulk of the participants and comprising 76% of the respondents. The majority of the dibias had practised between 16 and 26 years. In general, the dibias' years of practice ranged between 3 to 40 years and averaged 21 years.

All the dibias had undergone training in Igbo traditional medical practice under other Igbo healers. Their years of apprenticeship ranged between 7 to 14 years and averaged roughly ten years. The healers described themselves as general practitioners and claimed having cures for conditions ranging from dog bites and scorpion stings to mental disorder, infertility, and STIs.

### **Dibias' Views of Their Work**

The dibias viewed their work as very important in society observing that ethnomedical practitioners have historically occupied a central position in Igbo society. They noted that health is the foundation of societal development and individual greatness and generally considered themselves an important category because they serviced the health needs of the people ensuring continuity of the society, longevity of lives, and general wellbeing of individuals. One of them said:

Even in the past, dibias were a revered group. We were the people that catered for the people, protected them, healed them when they were sick. Even now, people rely on us for health and wellbeing. Our medicines keep people alive, protect them, and cure their disease ... We are very important in the society.

Dibias noted that people generally trusted them for therapies and cures for their conditions and that their services were uptaken by men, women, children, the rich, poor, rural and urban dwellers, Christians, indigenous worshippers, the Igbo and non-Igbo. Many of them also noted that they even provided cures for livestock and domestic animals. Dibias did not believe that formal care providers do better jobs than them. They noted that while hospitals only treat ill-

nesses with natural causes, traditional healers treat both supernatural and natural illhealth conditions. One of the women dibias said:

Hospitals cannot cure nsi, bewitchment. If you are bewitched and you go to hospitals you may die there because they cannot treat nsi. But we treat nsi and all those conditions that defy hospital treatment.

The dibias believed they continue to enjoy patronage because people still find their therapies useful and effective. Dibias said they knew that some churches preached against some of their activities. They however claimed that even pastors, elders, and other ranking members of churches often utilized their services. We were told:

Some people, especially Christians often say our activities are sinful. They say we sacrifice to the devil, ekwensu. These people say these things out of ignorance. We heal people based on the knowledge God has given to us. God is the giver of life and health. What we do is to use the knowledge of herbs, which God showed our forefathers a long time ago. Personally I have treated some big church people.

The participants agreed that there are only very few dibias still operating in Igboland. They noted that the profession is dying because there are only a few young people willing to become dibias. Other factors identified as responsible for the shrinking number of Igbo traditional doctors include modernization, Christianity, urbanization, industrialization, and the proliferation of modern health care services.

The dibias considered knowledge to be critical to their profession. They agreed that they were respected in society because they possessed a unique body of knowledge regarding plants, minerals, diseases, and the human body. The dibias agreed that the more therapeutic knowledge a healer possessed the more famous he/she was likely to be and that patients often considered the fame and reputation of healers while seeking cures for their conditions. It was noted that dibias with little knowledge of therapies often had little impressive results. One of the dibias maintained:

Care seekers want dibias who will solve their problems. You cannot solve a riddle you know nothing about. Illness is like a riddle. You need knowledge to solve a riddle. When patients come to me and I cannot satisfy them they go out and tell others 'he does not know anything'. When I satisfy them, they also tell others. To satisfy a patient means you know what he is suffering from and what can cure him.

It was observed that professional healers continue to search for ethnomedical knowledge indefinitely. The frequently mentioned sources of new ethnomedical information among the healers included intuition and revelation, personal experimentation, and other healers. Respondents accepted that in the past, healers maintained contact with each other, exchanging and comparing information about cures, conditions and diseases. They agreed that healers, in the indigenous background often traveled far and wide, seeking out reputed healers and acquiring more therapeutic knowledge and skills from them. Many of the respondents affirmed that the Igbo healers under whom they studied indigenous medicine did also embark on such trips. They noted that such journeys sometimes took healers outside Igboland. The dibias said that in the past, a healer would disappear without any trace, carefully making his/her way to another distant reputed healer who, for sometimes, houses him/her and teaches him/her newer skills and cures. When this period of internship expires, the healer also quietly makes his/her way back to his/her community, and may sometimes claim that he/she was visiting the land of the dead, taken away by the gods, or was invited into the depth of the sea by water spirits for more knowledge. The respondents agreed that such events helped revive peoples' faith in healers.

Majority (39%) of the dibias had been on at least two such trips within the last ten years. Eleven (29%) of them have only undertaken such trips once. A few of them had also made such trips four to five times in the period under study.

Ibibioland/Annangland in the neighboring state of Akwa Ibom were the most common destination of migrating Igbo healers. Seventy-six percent of the healers in the study reported having visited the area in search of more knowledge and skills. Yorubaland, in southwestern Nigeria was also another popular destination of the dibias in their search for ethnomedical knowl-

edge. Forty four percent of the healers reported having been there. Other frequently mentioned destinations were Biniland in Edo State, Ijawland in Bayelsa State, Efikland in Cross River State, and Ogoniland in Rivers State. Others, including Urhoboland and Itsekiriland in Delta State and Tivland in Benue State were also mentioned. Eleven (29%) of the dibias confirmed that they have also hosted healers from other ethnic groups.

Frequency in the last 10 years	n	%
Once	1	29
Twice	15	39
Thrice	7	18.4
Four times	6	16
Five times and above	2	5.3
<b>Destination of Healers*</b>		
Ibibioland/Annangland	29	76
Biniland	10	26.3
Yorubaland	17	44.7
Ijawland	4	10.5
Efikland	11	29
Ogoniland	6	15.8
Others	3	8

Table II: Frequency and destinations of transethnic quests for ethnomedical knowledge among dibias.

\* Multiple responses allowed

The duration of healers' stay in their destinations ranged from three days to six months, and averaged roughly twelve days. Dibias reported learning more potent anti-witchcraft medicines, love portions, cures for mental disorder, epilepsy, infertility and erectile dysfunctions, spell and curse-relieving medicines, cures for asthma and different types of coughs, newer diagnostic, divination and oracular practices etc. More potent cures for snake, cat, and dog bites as well scorpion stings were also reportedly learnt, as were anti-cut, gunshot and acid attack medicines. There were also those dibias who revealed having learnt medicines for stopping or causing rain or thunder, preventing certain diseases, misfortunes and theft, determining culprits in a case, and

for tracing lost items. Healers' destinations were influenced by a number of factors; reputation of particular healers, perceived area of expertise of ethnic healers, circumstances surrounding specific illness episodes, etc. Many of the dibias noted they choose to move to particular places after having heard that specific healers in those places were specialists in certain aspects indigenous medicine. One of the dibias told us that he went to a popular Bini oraculist and diviner because he wanted to strengthen his own oracular skills. He notes:

About four years ago, I needed to learn newer divining skills to help my work. The other dibias around here were using the some techniques I was using. But I needed something new and with more precise results. While searching for information about a good oraculist that I can learn from, I was directed to Biniland, to Owewe, he is an oraculist of great powers.

Interview results show that Igbo dibias also went to healers from particular ethnic groups when they felt that healers from that ethnic group were known for their expertise in a given area of traditional medicine. For instance, many of the dibias who went to Ibibio/Annang healers went in search of cures for diseases caused by evil machinations and powerful witchcraft. They agreed that Ibibio/Annang healers were popular for their anti witchcraft medicines and cures for strange, supernatural conditions. When patients presented with rare conditions such as those that fail to respond to initial treatments, dibias often consulted other Igbo healers around them. But when the prescriptions of these other dibias also fail to deliver their expected impact, healers sometimes sought for cures outside Igboland. In such situations, the dibias went to those healers outside Igboland who were reputed for expertise in given branches of ethnomedicine. Participants also reported that in some instances, a group of dibias would pool resources together and send one or two of their members in search of therapeutic information and skills from healers in other ethnic groups. Often, the dibia that is sent out will return to share, with colleagues, the new things he/she has learnt.

Herbal medicine fairs, which are currently very popular and frequent throughout Nigeria, also emerged as a very crucial forum through which Igbo healers sought information about potential destinations. During these fairs, which are often well publicized and patronized (Okoh,

2003), local healers from different ethnic groups meet to display their products and attend to careseekers. Respondents confirmed that these fairs often gave them the opportunity to meet and interact with healers from other ethnic groups in the country. They use the opportunity to ask questions, exchange addresses, and arrange for the trips. One dibia observed:

Last two years, I travelled to Yorubaland to learn a new medicine. The Igbo healers do not have that medicine. It is a medicine that helps you to avoid contracting sexually transmitted infections ... any body can use it, man or woman. It is administered through incision. If the medicine is given to a man and he wants to have sex with a woman that has gonorrhoea syphilis, HIV, etc, he will not have an erection. Any man that is infected with any sexually transmitted infections will not also get an erection when he is in bed with a woman that has obtained the incision. I heard about the medicine during a herbal fair which I attended in Cross River State. I discussed with one of the Yoruba healers that attended the fair, and he invited me over to his village to learn it.

The dibias also reported relying on in-and out-migrants, long distance traders, and other Igbo dibias for information about likely destinations for particular therapeutic skills and knowledge.

Such trips, dibias reported, were not merely opportunities to learn from healers in other ethnic groups but also to teach them what one knows. One of the dibias who reported having made three of such trips in the past years told me:

As you go to learn about what healers in other places are doing, what they are using to cure particular diseases, what herbs they know and the uses to which they put the herbs they will also ask you about what you know about some illhealth conditions and herbs and you will also teach them. So while you may go to a particular healer to learn, you may also end up teaching the person the things you know.

Transethnic trips to seek ethnomedical knowledge and skills also afforded Igbo dibias the opportunity to be formally initiated into the professional guild of ethnomedical practitioners in other ethnic groups. Some dibias in the present study reported that there are instances where they had to formally initiate into another ethnic groups' guild of healers before they were taught

the therapies and cures they had come to learn. Often, this involved elaborate initiation rites, which accorded rights, duties, and privileges to the learners. It was reported that such initiation rites could also cost initiates a lot of resources. Dibias returning from transethnic trips in quest of ethnomedical knowledge also usually came back with many things including rare plants, which they grew in their own compound. For instance, one of the dibias told me:

When coming back from such trips, one can bring home for planting, seeds, roots and stems of medicinal plants that do not grow in Igboland. This is why when you visit the compound of any dibia you will find trees and plants that are not ordinarily found in the community. Dibias get most of them from healers elsewhere. This may be how some of these medicinal trees got here, (i.e. Igboland), who knows?

Transethnic trips for ethnomedical knowledge were viewed as very challenging by the dibias. They noted that apart from the problems involved in selecting and identifying good healers to go to, travelling down to meet them, and getting them to accept to teach one their own skills and cures, there was often the issue of language barrier between visiting dibias and the host healers. Very often, the problem of language was solved by the use pidgin English or by an interpreter who moderates the learning process. But such interpreters, it was agreed are often very hard to come by. The participants noted that language barrier was perhaps a major constraint to such trips in the indigenous background.

Dibias who cannot speak pidgin English may also travel with an aide, often one of their own children or relations who could at least, speak pidgin English to help him ask for directions and get introduced to the host-healer. Going with an aide, however, often meant more expenses for sojourning dibias. One of the respondents tells us his experience:

Last year I sojourned to Yorubaland ... I stayed 8 days there. I went with one of my children. I have not been to Yorubaland before. After gathering information about the healer I wanted to see, I travelled with my son who speaks English. Through my son's help I traced the man. When we arrived, I told my son to tell the man what I wanted. The man himself does not speak English and does not understand Igbo language. So he also got one of his sons to explain to him what I was saying through my son. That's how we did it ...

The dibias I spoke to believed that the trips were both costly and risky but that the gains from such trips may outweigh their risks involved. One of them said:

I know one may die during such trips or get harmed. But if you succeed you stand the chance of acquiring knowledge and skills that may make a big difference in your work and in the lives of the people you serve. It may mean more patronage, more success, and more fame for you.

When asked about the identifiable impacts, which such trips have had on their work, the dibias spoke of relying on such trips to acquire more information and skills related to curing, preventing, and diagnosing illhealth. The dibia also believed the trips and the things they learnt have helped them solve many problems for their clientele and bring more fame, patronage and wealth to themselves.

The trips also afforded the dibias an opportunity to participate in other cultures, and glean insights into perceptions of health and illness in those cultures. Such insights into other cultures broadened the healers' understanding of their own work and culture increasing their expertise. Transethnic trips also broadened Igbo healers' network of professional ties beyond the local context where they worked, linking them up with the under community of indigenous healers in Nigeria.

## **Discussion**

This study examined current patterns of transethnic migration for ethnomedical knowledge and skills among Igbo dibias. Emerging from the study is evidence that, in the past as well as in the present, Igbo local healers go seeking more therapeutic skills and knowledge from healers outside Igboland. This often occurred when dibias could not find other Igbo healers with expertise in what they wanted to learn. In such instances, the dibia travelled outside Igboland in quest of reputable healers in other ethnic groups. The destinations of transethnic trips for ethnomedical knowledge and skills were influenced by the type of specific ethnomedical knowledge or skill sought by the dibia and the popularity of given healers in specific branches of ethnomedicine as well as the perceived areas of specialty of healers from particular ethnic groups. From

these trips, Igbo dibias reportedly learnt more potent cures for wide range of conditions, new reliable diagnostic and divining techniques as well as new medicines for preventing certain misfortunes, diseases, and illhealth conditions. Dibias returning from such trips often brought home seeds, stems, and roots of plants, which they grow, thereby encouraging local biodiversity. Trans-ethnic migrations for ethnomedical knowledge and skills equip Igbo healers to meet and address the health needs of their clients more sustainably and to also participate in the wider network of ties which help the production of ethnomedical knowledge and their transmission from one generation of healers, one group of ethnomedical specialists, one body of ethnic healers to another.

These findings have critical implications for policies and plans, which aim to promote better health for people, especially in the global south where traditional medical practitioners are very active. For instance, the current effort in most developing societies to ensure that local healers adopt safer and healthier practices, such as sterilizing their blades, needles, and knives before use, are more likely to succeed if healers are used to teach healers rather than relying on cost ineffective media campaigns that hardly reach their target audience. Essentially, healers' reliance on each other for information and knowledge offers critical opportunities for efforts to educate the, more sustainably, on healthier practices.

It is evident also, judging by the current research, that the key motive of healers embarking in transethnic quests for ethnomedical skills and knowledge is to equip themselves to deliver good result to their clients. Healers' willingness to see themselves impact more positively on careseekers' realities is a crucial social capital to be harnessed in efforts to mobilize traditional healers in the struggle to deliver good health to people in marginal areas. It suggests that traditional healers may also be willing to go the extra mile needed to shore up their skills and be integrated into mainstream health delivery structures.

Also emerging from this study is the urgent need for recognizing the complex linkages that may exist within and across indigenous medical traditions in contemporary societies as well as the importance of caution when employing rigid definitions that may obscure the 'globalizing' nature of 'indigenous' medical knowledge and practices. There is, however, also need

for caution in accepting the results of the present research, as they are limited in many respects. For instance the study only focused on a few Igbo healers. Expanding the size of the sample and investigating healers from other ethnic groups in Nigeria may yield more critical insights into the nature of these itineraries. Where Igbo healers in search of ethnomedical knowledge and skills do not go and why, and the role of distance in shaping these trips also need to be more closely studied. Further it would be interesting to know, for instance, if Ibibio, Yoruba, Hausa etc healers in Nigeria also undertake similar trips and where they often go. More research is also needed to tease out the future impact of healers' transethnic trips for ethnomedical knowledge on the practice of indigenous medicine in a multi-ethnic Africa.

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