CULTURAL PERCEPTION OF MALARIA AND CHOICE OF THERAPY AMONG THE IBIBIO OF AKWA IBOM STATE, NIGERIA

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CERTIFICATION

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DEDICATION

This work is dedicated to God Almighty and to my Teachers, past and present- the windows through which the sunshine of knowledge has shone on me.

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I am grateful to the Almighty God, for by His grace, I am what I am. He indeed, brought me out of the miry clay; now I have a song to sing!

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ABSTRACT

Interpretation and management of malaria in contemporary African societies are influenced by both western and indigenous perceptions of the disease. However, existing studies have focused on causes, prevalence and socio-environmental factors of malaria, using mainly Western paradigm, resulting in lack of conceptual balance in the literature. This study, therefore, examined etymology of the local terms for malaria and how they influence aetiology of malaria in Ibibioland, southern Nigeria. The thesis examined the cultural perception of malaria in comparison with bio-medical perception. This was done by determining how cultural interpretations of malaria and beliefs surrounding the disease influence management and therapeutic choices. The aim was to foster an integration of theory and practice in the management of malaria.

The study adopted Clifford Geertz's ethno-hermeneutics which theorizes interaction between local knowledge and construction of everyday realities. Data were obtained from four purposely selected local government areas (LGAs) out of 14 mainly occupied by the Ibibio, based on their strict Ibibio identity. Forty-three malaria cases; 10 orthodox, 15 traditional and 18 self-medication practices were observed. Key Informant Interviews (KIIs) were conducted on purposively sampled 11 orthodox and 10 traditional healthcare providers. Sixteen focus group discussion (FGD) sessions each for men and women knowledgeable in local interpretations of malaria were held. Data were analysed descriptively.

Etymologically, the Ibibio describe malaria based on symbolic and symptomatic presentations, while bio-medical science describes malaria as a vector-borne infectious disease. Four manifestations were identified among the Ibibio: colour, related to u*to-enyin*, nutrition, related to *adan/akom*, bio-physical actions and spiritually-induced body temperature, related to a*tuatuak/nkpo ntokeyen* and spiritually-induced anaemia, related to *uto-enyin ekpo*. While KII, showed that the belief in multiple cau ces of malaria fever was widespread in both rural and urban centres, FGDs revealed that more than one of these manifestations could be presented in one malaria episode. Aetiologically, *uto-enyin* was believed to be caused by exposure to sunlight; *adan/akom* by excessive consumption of oil; *atuatuak /nkpo ntokeyen* by preter-natural forces such as e*ka abasi (*unidentified forces*),* and *essien emana (*spiritual age grade/ reincarnated births*),* and *uto-enyin ekpo* by witchcraft forces. Against the bio-medical position which stresses clinical diagnosis and care, KIIs revealed that there were many local remedies for malaria, and therapeutic choice depended on perception of each malaria episode. Thus, when malaria was perceived as *uto-enyin*, remedies were focused on removing the yellow matter. If it was perceived as *adan/akom*, oily deposits had to be washed from the body through herbal baths, purging and enema, while as *atuatuak, nkpo ntokeyen* and *uto-enyin ekpo*, remedies involved spiritual cleansing and rituals to appease supernatural forces. The use of herbal extracts for treatment cut across the four LGAs but their herbal contents differed from context to context. Cultural practices against malaria were widespread across the rural-urban divide.

The cultural perception of malaria with regard to etymology and aetiology, contrasts completely with Western perception of the disease. The Ibibio relate malaria aetiology to colour, nutrition, and preter-natural forces. These symbolic representations determine therapeutic choices in Ibibioland. It is recommended that, useful aspects of the cultural care

system should be integrated into the implementation of the healthcare plan for effective malaria control.

Keywords: Cultural perception of malaria, Bio-medical explanation, Ibibio people, Therapeutic choices

TABLE OF CONTENTS

CHAPTER THREE: RESEARCH METHODOLOGY

CHAPTER FOUR: ETHNOGRAPHY OF THE IBIBIO IN SOUTH SOUTH NIGERIA

LIST OF MAPS

LIST OF TABLES

LIST OF FIGURES

LIST OF PLATES

LIST OF ACRONYMS AND ABBREVIATIONS

CMM	-	Community Management of Malaria
FGD	-	Focus Group Discussion
FMH	-	Federal Ministry of Health
HIP	-	Health Integrated Project
IPTi	-	Intermittent Preventive Treatment in infancy
IPTp	-	Intermittent Preventive treatment in pregnancy
ITN	-	Insecticide treated Nets
L.G.A.	-	Local Government Area
LLITNs	-	Long Lasting Insecticide Treated Nets
MDGs	-	Millennium Development Goals
PMV	-	Patent Medicine Vendors
RBM	-	Roll-Back malaria
RDTs	-	Rapid Diagnostic Tests
UNICEF	-	United Nations International Children's Education Fund
UNDP	-	United Nations Development Programme
WHO	-	World Health Organisation

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Disease conceptualisation differs across cultures. In the Western world, disease and illness are taken to mean essentially the same thing. This is different across non-western cultures (Owusu-Boakyewaah, 2011). Every culture is unique and each culture has a system of beliefs which acts as a lens through which disease is viewed, and conceptualised. Illness is culturally defined, therefore how a person perceives, experiences and copes with disease is based on the system of meanings he employs (Okpako, 2011). This system of meanings is an intergral part of the entire world view, embedded in a particular culture.

Malaria is one of the diseases in sub-Saharan Africa that has remained resilient to deal with, partly due to non-recognition of local perception of the disease. As the interpretation and management of malaria in contemporary African societies are influenced by both western and indigenous perceptions of the disease, meanings given to the disease differ and that also explains differences in understanding and treating malaria. Thus, as suggested by Scafar (2008) culture spells out what constitutes a disease and the choice of health care system. This further suggests that responses to diseases in terms of their management remarkably differ across human societies, simply due to cultural differences attached to diseases and their meanings. Despite this, due to Christian envangelization, colonialism and other indices of globalization in sub-Saharan Africa, western or bio-medical explaination and caring for disease undermine relative cultural perceptions. This partly accounts for the resilience of malaria in sub-saharan Africa. Underlying the above, as done in the present thesis, cultural perception and paths to care in malaria among the Ibibio of Southern Nigeria are explained.

Over the years, both national and international interventions have been introduced against malaria in Africa, yet the disease remains a major threat to public health that has resulted in higher morbidity and mortality especially in tropical Africa (Sumba, Lindsay Wong,Kanzaria, Johnson and John, 2008; Maslow, Mnyusiwalla, Mills, McGowan, Aharan

and Wilson, 2009). It kills more people in the tropics than any other infectious disease (WHO, 2009, Erhun, Agbani and. Adesanya, 2010). It remains the leading cause of death in children under-five, as 33% of all childhood deaths are attributable to malaria (Galvin, Petford, and Ajose, 2011, Arulogun and Okereke, 2012). Approximately 25million pregnancies are exposed to malaria infection and an estimated 10,000 maternal deaths are attributed to malaria annually, in sub-Saharan Africa (Boene, Gonzalez, Vala, Ruperez, Velasco, Machero, Sacour, Sevene, Macete, Menendex and Munguamba, 2014).

Through mainly qualitative ethnography, the study focused on local cultural specifics, such as perception of disease arising from its local term(s), beliefs and attitudes emanating therefrom and how such cultural interpretations and perceptions of malaria influence malaria management among the Ibibio of Akwa Ibom state, Nigeria. In this study, the local knowledge of and attitudes towards malaria were investigated alongside the beliefs that enforce and enhance such perception. Through descriptive ethnography, the western ideas of malaria and bio-medical approach to solving the disease were equally investigated. Within this baseline, local ideas were critically analysed vis-a-vis the western paridigm. The ways in which the local perception affects choice of therapy among the people were also examined. All these were done with the aim of adequately engendering the local understanding of malaria in such a way that the local people's knowledge may be considered in malaria control mechanisms among the Ibibio and by extension in sub-Saharan Africa.

Following this background section of the thesis, the thesis contains five other chapters. Chapter two is on the literature review and theoretical discussion. The third chapter deals with methods used in data collection and how the data were analysed. In the fourth chapter, the ethnography of the study area is presented. The data were presented and analysed in chapter five, while the last chater summarises and concludes.

1.2. Statement of the Problem

Malaria remains a major health threat in Ibibio like in many other sub-Sahara African societies. Despite several efforts to combat it, the disease remains the cause of higher morbidity and mortality in many sub-Sahara African societies (Sumba, Lindsay, Wong, Kanzaria, Johnson and John, 2008,). The western bio-medical idea of malaria describes the

disease as a parasitic infection that is preventable and curable. Yet it is responsible for the deaths of thousands of people in sub-Saharan Africa including Nigeria. Attempts to deal with the disease are generated from this western bio-medical perception. Local perceptions bothering on the cultural specifics on the understanding of malaria and its management in sub Saharan Africa are mostly ignored, despite existing studies (Nganda, Drakeley, Reyburn and Marchant 2004, Okpako, 2011). The consequence of this approach is that malaria still remains an intractable disease that continues to affect several thousands of sub-Saharan Africans over the years (Ojewale, 2005).

Cumulatively a lot of human, capital and temporal resources have been plunged into the fight against malaria yet; it is still a dominant killer disease for both young and old, as well as men and women in many parts of Nigeria (WHO, 2009). The Millennium Development Goals (MDGs) 4 aimed at; Reduction of child mortality, 5, with the aim to; Improve maternal health and 6 which aims to; Combat HIV/AIDS, Malaria and other diseases (FGN, 2010, UNDP, 2012), target eradication of malaria. The National Policy on Malaria Prevention and Control has several home and community level management strategies such as; Indoors Residual Spraying (IRS), Intermittent Preventive Treatment in pregnancy (IPTp), Intermittent Preventive Treatment in infants (IPTi), use of Long Lasting Insecticide-treated nets (LLINs)aimed at fighting the scourge to a standstill. International agencies like Africare and JHPIEGO (an affiliate of John Hopkins University, USA), have engaged in malaria intervention in Akwa Ibom State. This is in addition to the state Government's efforts towards eradication of malaria through the distribution of free anti-malaria drugs to children under –five, pregnant women and those above seventy (70) years of age. Yet the World Health Organisation (WHO), on April 5, 2014, while marking the World Malaria Day, had to declare that, in 2012, there were 207 million cases of malaria, while it caused an estimated 660,000 and 627,000 deaths in 2011 and 2012, respectively, in Africa. The WHO further maintained that, malaria prevalence in children under-five is still as high as 45% and Africa still accounts for 90% of the world disease burden. Furthermore, as at 2013, 97 countries had an ongoing malaria transmission and of the over 200million cases that occur annually, most of them are not tested or reported. To make the situation worse,

emerging drug and insecticide resistance treaten to reverse the gains recorded in the fight against malaria, (WHO, 2014; US Embassy in Nigeria, 2014).

While previous studies (Agu and Nwojiji, 2005; Arulogun and Okereke, 2012) focused on economic, ecological and political aspects of malaria management, little or no attention has been drawn to local understanding of malaria. This situation probably suggests that lack of understanding of the local perception of malaria accounts for poor results from malaria intervention in sub-Saharan Africa. While the local perception matters in the understanding of a disease, but more important is how such local understanding influences the choice of therapy. In the case of malaria in sub-Saharan Africa, these important aspects of disease control and management have not gained the required attention. As culture is an indispensable microscope of examining attitudes towards disease (Ajala and Adejumo, 2007); the local specifics of cultural template of a particular disease can shed more light on a people's choice of therapy. Such specifics include the local terms for disease; attitudes and responses emanating from such terms; how those attitudes construct responsibility to manage the disease and the cumulative effects of all the local constructions on the community's health, arising from local understanding of the disease. Specifically, culture contributes to differences in medical care and in how health is defined. Similarly, culture culture spells out what constitutes disease and the choice of health care system (Scaefer, 2008). The social dynamics of disease and health care also differ across human societies as a result of cultural differences. Thus, etymology of disease defines the local knowledge of the disease, which in turn determines aetiology and subsequently, therapeutic choices in disease management. In addition to this, the natural environment affects therapeutic choices across different cultures, since the local fauna and flora available as natural resources to be exploited in any ethno-medical system, differ across these cultures. This perception explains the need to understand the cultural context of disease in any community for an effective fight against it.

Underlying this postulation, the following specific questions formed the main thrust of this study: What are the local terms that are used to describe malaria in Ibibioland? In what ways has the local term(s) for malaria influenced the local perception of malaria? How is the bio-medical perception of malaria related with the Ibibio local perception of the disease? In what ways does the local perception of malaria affect the choice of therapy in

malaria management among the people? What is the pattern of utilization of orthodox medical facilities vis-a-vis the traditional ones in malaria management among the Ibibio?

1.3 Aim and Objectives of the Study

Generally, the thesis seeks to explain local knowledge of malaria among the Ibibio and how it shapes their attitudes and responses towards malaria care. Evolving from the above are the following specific objectives:

i) To explore the local knowledge of malaria among the Ibibio of Akwa-Ibom State, south-South Nigeria.

ii) To investigate how the people define malaria in terms of etymology of the local terms for malaria.

iii) Investigating how bio-medical perception of malaria conflict with or strengthen the cultural percreption of malaria.

iv) Exploring how the local knowledge of malaria influences choice of therapy in malaria management.

v) Investigating how biomedical perception of malaria strengthens or conflicts with the local perceptions of the disease.

1.4 Scope of the Study

The continued prevalence of malaria in sub-Saharan Africa and vulnerability of many sub-Saharan Africans to malaria suggests that there is still a gap not yet filled in malaria research especially as it concerns sub-Saharan Africa. Filling this gap requires an ethnographic study of the local contents of malaria in sub-Saharan Africa. In this context, there is a need to understand the local conception of malaria and how such conception informs various local attitudes towards malaria. There is also the need to know how the attitudes generate practices related to malaria control in the local context. This will probably provide an insight into why the bio-medical approach has not yielded the desired results on malaria control in sub-Saharan Africa. All these formed the main thrust of this study.

This study was limited to the Ibibio ethnic group of Akwa Ibom state. The choice of this research community was motivated by the fact that Ibibio people engage disease in social, symbolic and cultural contexts

The study covered eight (8) locations in four (4) local government areas in Ibibio land. This was done in order to ensure coverage of the cultural clusters of the Ibibio across geographical divides of north, south, east and west. Communities were selected on an equal ratio across the rural-urban divide.

1.5 Significance of the Study

Considering the intractability of malaria infection in many sub-Saharan African societies, there is a need for an anthropological investigation into the local knowledge of malaria and how such knowledge shapes the local ideas of malaria management. The need for this is more imperative among the Ibibio, considering the prophylactic and therapeutic alternatives available to the people (both traditional and orthodox) on malaria management. This concern is predicated on the need to discover integrated health care delivery plan against malaria for the people. Based on a multi-lateral and case specific approach, the information generated from this study will be helpful to all the stakeholders on malaria management. It is hoped that the information will help the government to take an official stand that will help facilitate the progress and success of the efforts to rid the society of malaria.

Producers and dispensers of local remedies against malaria and their patrons will also benefit from this work. It will afford them an opportunity to have local understanding of malaria as a disease, provide them an insight of the local means of dealing with the disease and better equip them in combating malaria through the appropriation of local resources. In essence, the local understanding of the aetiology of the disease and the mode through which it is spread, expected to emerge from this study will help improve the people's health. This will in turn translate into a healthier labour force in the society. Deaths of both children and adults, resulting from malaria attacks will hopefully be reduced among the Ibibio people.

Several studies have been carried out on the incidence of malaria, local knowledge and perception of malaria, choice of therapy in many societies (Nganda, Drakeley, Reyburn and Marchant, 2004; Agu and Nwojiji, 2005; Hlongwana, Mabaso, Kunena, Governder and

Maharaj, 2009; Arulogun & Okereke, 2012). There exists scanty literature on this subject in relation to Ibibio society. This study will therefore contribute to the volume of literature on the Ibibio society in general and on the local perception on the causes of diseases and available therapeutic choices in particular. This study is particularly significant as it would go a long way in making the efforts of the government to rid the Nigeria society of malaria more effective. It will thus, help in achieving parts of the Nation's Millennium Development Goals (MDGs).

The findings at the end of this study, it is believed, will benefit the academic community by contributing to the volume of literature generally on the Ibibio as an ethnic group and particularly with regards to the local context of malaria. It is also expected to help deepen the global discourse on malaria as a social problem. It will also open up areas of research for other scholars. The aim of every social research is to solve a social problem. It is believed that the Ibibio society will benefit as recommendations will be made towards the development of better and more effective health care package for the people.

Malaria has continued to take its toll on the health of people especially in sub-Saharan Africa. The intervention programmes to curb the effect of malaria on the social andeconomic lives of the people have gulped large sums of money. It is expected that the recommendations made at the end of this work based on the findings, will help make the efforts more effective. When the effects of malaria are reduced in the short-term and eradicated in the long term, it will translate to increased man-hours for productive labour. The resources used for researches and intervention programmes can thus be channeled into developmental projects.

1.6 Limitations of the Study

Studying the effect of local perception of malaria on the choice of therapy among the Ibibio proved to be tasking owing to some of the challenges encountered in the course of the work. Since much of the data on the local perception was self reported, the study relied mostly on respondents' ability to recall experiences of malaria attacks, symptomatic presentations and management procedures. The implication was that lapses in memory tended to affect the quality of the data. Also the study bordered on the health which is culturally sensitive, because issues affecting one's health are always treated confidentially among the Ibibio. Therefore,

there existed a tendency for respondents to embellish the information given out in an attempt to either play down or exaggerate the experiences. Getting information on the local beliefs also posed another level of limitation. Some of the respondents were reluctant to give information on this as well. Besides, since the data for this work were qualitative, this fostered tendency for a certain level of lack of clarity in the data collected. This also led to the supply of conflicting information by some of the respondents. Some gave information that tended to present them as informed about the issues being studied but in the course of the interview responded to other questions with facts that contradicted earlier information given. This was more the case in Mkpat Enin Local Government Area where it was discovered that there was an intervention programme in place. The organization had done extensive mass awareness campaign on malaria based on the western bio-medical ideas of its causation, and management. The respondents therefore tended to present information as would show they knew and also practiced what they were told in the campaigns.

In addition, the researcher was suspected by some as an agent of government or personnel from an international organization paid heavily to carry out the research. To this extent, some people therefore expected financial inducements before taking part in the research. This led to unplanned repeated visits which in turn occasioned the spending of extra time, money and energy on the research.

CHAPTER TWO
LITERATURE REVIEW AND THEORETICAL DISCUSSION

2.1.0 Introduction

The subject of malaria occupies the fore front in global public health discourses. This is due to its prevalence and resilience in sub-Saharan Africa, widespread effects on affected populations and the attendant impact on human resources and development of the region. Many researchers have therefore conducted studies on malaria and related issues. In this chapter the work of other scholars will be reviewed under the following headings:

Malaria: Conceptual Discussions

Culture and Health

Malaria and medicine in other Cultures

Burden of Malaria

Malaria in Nigeria

Causes of Malaria

Transmission and Effects of Malaria

Resilience and Resistance in the Management of Malaria

National Policy on Malaria

Theoretical Discussions

2.1.1 Malaria: A Conceptual Discussion

According to WHO (2009: 1), "malaria is a life threatening disease caused by parasites that are transmitted to people through the bites of infected mosquitoes." Osobu (2009) sees malaria as a parasitic disease that is deadly and so easily contacted, caused by *hemosporidiam protozoa* of the genus *plasmodium*.

In contrast, there exists a variety of local perspectives of the disease, which suggest different meaning and perceptions in Africa generally and in Nigeria in particular. Among the Swahili of Tanzania, malaria is called '*homa'* meaning fever, which is not believed to be caused by mosquito bites (Gessler *et al*, 1995; Comoro *et al* 2003). Among the Ashanti of Ghana, it is called '*Asra*' or '*atridi'* meaning fever, believed to be caused by heat from the fire

or sun and by eating of unripe or overripe fruits as well as the consumption of alcohol (Ahorlu *et al* 1997).

The Yao of Malawi refer to malaria as *malungo*' – fever (Launiala & Kulmala 2005). The causes are believed to be fatigue from hardwork, exposure to sunlight and shortage of blood. Esse, Jutzinger, Tschannen, Raso, Pfeiffer, Granado, Koudou, N'Goran, Cisse, Girardin, Tanner and Obrist (2008) reported that among the Akan in central Cote d' Voire, malaria is '*djekouadjo'* or '*djekadjo*'. It is attributed to exposure to the sun which makes the blood to be warm. Among the people, consumption of some food items like red tomatoes, red peppers, red cooking oil and red soup can also cause *djekadjo*. Among the Goma people that bordering Burkina Faso and Republic of Togo, malaria is often attributed to exposure to cold winds, dirty environment and supernatural factors (Beiersmann, Sanou, Wladarsch DeAllegri, Kougate and Miller, 2007). The people associate many names to malaria, usually determined by the level of severity and the symptomatic representations. These local names include:

Sumaja – uncomplicated malaria

Dusukun Yelema – respiratory distress syndrome

Kono – cerebral malaria

Djoliban – severe anaemia (pp 106)

In Nigeria, the Bwatiye people of North-eastern Nigeria refer to malaria as *Zazzabi* – hot body/ordinary sickness that does not cause death, while the Yoruba of South-western Nigeria call it '*Iba*' – fever and fatigue. The Yoruba attribute malaria to hot weather; fatigue from work and a must during the growing of milk teeth in children (Ramakrishna, Brieger and Adeniyo; 1989, Salako, Brieger, Afolabi, Umeh, Agomo, Asa, Adeye, Nwankwo and Akinlade, 2001, Oreagba, Onajole, Olayemi and Mabaveje 2004). The Estako of Edo State call malaria '*egbeotomo*' – body pains caused by too much work and exposure to sunlight. Among the Urhobo of Delta State in South-southern Nigeria, malaria is referred to as '*Odo*' – fever and it is believed to be caused by evil spirits and wrong habits. Among the Ibibio, malaria is called, *'utu enyin'* – fever characterized by yellowness of the eye or *akom* – oil induced fever characterized by sleepiness. These are believed to be caused by excessive exposure to sunlight, eating of yellow and red colored foods and fruits, excessive consumption

of oil and witchcraft. Different local terms for malaria suggest the people's perception and understanding of the disease, which perhaps translate to choice of therapy in malaria. Thus, since bio-medical approach to illness and disease prevails in many societies, there seems to be counter belief in malaria and choice of therapy. It therefore suggests that a leaverage in the understanding of malaria is needed. It also suggests that malaria like many other diseases is culture-centric. Hence, as done in this study, there is a need to have a critical analysis of local terms for malaria in comparison to the biomedical conception of malaria. The juxtaposition of western medical and local medical concepts can help to achieve a more holistic understanding of the disease.

2.1.2 Culture and Health

Illness behaviour is defined as the 'way in which symptoms are perceived, evaluated, and acted upon by a person who recognizes pains, discomfort and other signs of organic malfunction' (Mechanic, 1960). It is influenced by the social organization and cultural beliefs of a community. Culture, therefore, plays an important role in health management among a people, including shaping the widely held concept of disease. These include perception of the disease, interpretation of the symptoms and the modalities of treatment seeking for the perceived condition (Ajala and Nelson, 2010). In the context of cultural conception of disease, two key issues affect decision making: the individual behavioural dimension towards disease condition and potential source of treatment for the condition (Brodwin, 1996). However, the most salient cultural issues are health beliefs regarding the causation of illness, which influence decision regarding therapeutic options. Medical anthropology deals with how people in varied cultures and social groups explicate the causes of ill-health or sicknesses, the types of treatments they believe in, and the persons to turn to if they become ill (Helman 1990:1).

Human beings as put forward by Helman (1990) are social animals in organized groups, and whose experiences as members of the social groups they belong to are moulded by their views and conceptualizations of actions and phenomenon around them. Against this backdrop, culture which was defined by Sir Edward Burnett Taylor in 1871 as "that complex whole which includes knowledge, belief, art, law, morals, custom and any other capabilities and habits acquired by man as a member of society" (Taylor in Haviland, 1999) is seen as one

of the ways human beings structure and make society to function, setting up the foundations for its social, economic and political organization. As Tylor further explained, culture is a set of rules and standards both implicit and explicit, which people as members of a specific social group inherit or receive from generations before them. The rules and standards tell individuals belonging to these societies how to experience and understand the world in which they live, and how to conduct themselves in relation to other people, supernatural forces and the natural environment. These rules and standards also furnish them with the knowledge of how to transmit the same rules and standards to coming generations. Culture therefore has a huge effect on people's beliefs, attitude to illness and pain and health in general.

Health and attitudes to health and illness are issues of serious concern to human beings. Since human beings belong to, or are distributed across diverse social groups or societies, each with its own unique body of knowledge, art, morals, laws, customs, habits and beliefs which form a system, according to Keesing (1981), of "shared ideas, concepts and rules and meaning that underlie and are expressed in the ways that we live". Each social group or society based on these inherited guidelines conceive and perceive health and issues relating to health including health care systems and illnesses in unique ways. To understand how a particular people react to health and illnesses necessitates an understanding of the type of culture in which they have inherited or have grown up.

Helman (1990: 3) posits that "culture can be seen as inherited 'lens', through which individuals perceive and understand the world that they inhabit, and learn how to live within it." This understandingly includes health and illnesses. Therefore, to put a tag on, to understand, and survey, bringing out the specific reactions of a group of people belonging to a particular society to health and illnesses can best be done through looking at how they react to health through their own "lens", or by finding the point at which their reactions to health meet with their culture. In whatever way we want to look at it, our culture determines or influences the way we perceive and interpret health issues as well as every other issue in our lives as a people with culture and identity.

Eckersley (2009:1) defines culture as "how we think the world 'works': the language, knowledge, beliefs, assumptions and values that shape how we see the world and our place in it; give meaning to our experience, and are passed between individuals, groups and

generations".Eckersley thus defines culture epistemologically. Relating this to the World Health Organisation's definition of health as "a state of complete physical, mental, social and spiritual well-being rather than a mere absence of disease" would include the knowledge, beliefs assumptions and values that shape how a people see health and health issues. That is, how people see and handle a state of mental, physical, social and spiritual wellbeing; in effect total well being, and how they go about achieving that. With regards to our present study, culture and health as related to malaria refers to the various peculiar ways people go about achieving total wellbeing or wellness, drawing from their language, knowledge, beliefs, assumptions and values that shape the way they see the world. Here, we see the relationship between culture and health in terms of how different cultures give meanings to their acquired, inherited and lived experiences of malaria and the uniqueness of their peculiar ways of handling the illness.

Health, as a state of complete wellbeing is not attainable in isolation of the environment. This explains why Jegede (1998:24) defines health as being in "harmony with oneself and the environment". He adds that "human beings give explanations to circumstances around them based on what they believe". Ogundele (2007) emphasizes that good health and survival are preconditions for the individual and collective progress (physical, mental and spiritual) of every society irrespective of time and space. He defines medicine as, "the system that a group of humans have developed over a long period of time in order to ensure its survival and good health . . . is tied to the apron strings of culture and environment". He surveyed the link between good health and the culture of the Yoruba people, shedding light on the anthropology of (indigenous) medicine in Yoruba land. He opines that "most aspects of the ethno medicine of the Yoruba are deeply rooted in spiritualism, reflecting the dual character of culture (Ogundele 2007:127). Yoruba ethno medicine is traditional because it is 'local', ethnic, and draws on the traditions of the Yoruba people. It has its own uniqueness because it is tied to and derived from the culture of the Yoruba people.

Traditional medicine is defined by W.H.O (1976) as,

> the sum total of all knowledge and practices whether explicable or not, used in diagnosis, prevention and elimination of physical, mental or social

> imbalance and relying exclusively on practical experience and observations handed down from generation to generation, whether verbally or in writing.

The Yoruba traditional medicine is characterized by the activities of traditional healers. A traditional healer is defined by W.H.O. (1976, cited in Ekong 2006: 70) as,

> a person who is recognized by the community in which he/she lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious background, as well as on the knowledge, attributes and beliefs that are prevalent in the community regarding physical, mental and social wellbeing and the causation of disease and disability

2.1.3 Malaria and Medicine in other Cultures

Yoruba traditional medicine is made up of the activities of the *babalawo* that is the *Ifa* divination priest/medicine man who, to a great extent represents the spiritual component of the Yoruba indigenous medicine, and the activities of the *onisegun* – the medical expert who wholly relies on herbs and animals in preparing medicines. He deals basically with observational and empirical evidence. It is fitting to add here, Jegede's view on the African perception of illness. Jegede (2002), citing Erinoso 1976, Ezeabasil 1981, Oke 1982, and adding his own dimension states that African societies perceive illness from four sources: the natural, supernatural, mystical and hereditary. These four dimensions mark out the African indigenous medicine from Western medicine. I would add here that, even the other three dimensions of illness sources; natural, supernatural and mystical can be hereditary as well.

Ogundele (2007) observes that the *ifa* diviners, priests or healers, who are locally called *babalawo*s are able to hear and interact with voices and images of supernatural beings through an ancient secret knowledge system – *Ifa.* The *babalawo* functions as the bridge between the patient, the people and the gods. In doing this, he makes use of artifacts like palm nuts, the *opele Ifa* necklace etc in his divinations. He further notes that the *babalawo* humanizes medicine, offering a psychological healing to his patient through his boasts to his

patients about his mystical powers as well as the large number of people he has medically helped. He remarked that this is opposed to the Euro-American conception of medical practice that is solidly planted in technologisation. That is, a process that "pays more attention to diseases through the lenses of scientific testing, than the feeling of patients" (Ogundele 2007: 129). Though *ifa* also has technological aspects; the beads and necklace used, he further argued that the technologization process is characterized by a veterinary mindset that makes the medical doctor focused almost totally on the biological disorder that is, the disease, rather than the associated illness. By illness Ogundele meant "the debilitating effects of the disease". He emphasized that the Yoruba lays more emphasis on illness rather than diseases unlike what western medicine does. Medicine as far as Africans and the Yoruba in this case are concerned is tied to (the African) culture. It is physical, mental and spiritual. Culture is more than just the physical as said earlier; it is made up of two components: a group of people's actual behaviour, and the abstract values, beliefs and perceptions of the world lying beneath the behaviour. It is expedient to note that the behaviour of a people is derived and shaped by the abstract values, beliefs and perceptions of the people. By this we mean, that the Yoruba ethno medicine cannot be separated from abstract values, beliefs and perceptions of the Yoruba people.

A people cannot be separated from their culture, nor their culture from them, despite acculturation, the Yoruba indigenous medicine which is moulded by the Yoruba culture, and which is also a part of their culture will not disappear in a long time. In fact, as Ogundele recorded, many people even the so called educated pay visits to *onisegun*s, *Ifa* priests and *babalawo*s mainly because their patients are treated almost solely with indigenous drugs gotten from extracts of medicinal plants and also from animal sources. These days, the number of Nigerians and especially the Yoruba people who patronize herbalists (*onisegun*) and even *babalawo*s has increased remarkably. The reason for this, he says, is not far from the hike in medical bills charged in these times of lingering material poverty among a wide range of people and the recent awareness for the extolling and revitalization of the African heritage.

While Ogundele (2007) made a holistic survey of the ethnomedicine of the Yoruba who occupy the southwestern part of Nigeria, observing that the ethnomedicine of the Yoruba people is deeply rooted in spiritualism, Ramakrishna *et al*. (1989) brought to light the

importance of understanding the perceptions of illness of a community particularly the disease definitions that are unique to a particular culture in order to develop culturally applicable primary health care programmes. His study focused on the Idere people of Ibarapa District of Oyo State. He opined that, rather than see malaria as "a protozoan infection caused primarily by *plasmodium falciparum and P. vivax* ... transmitted to humans by female mosquitoes of the Anopheles species", the Idere residents saw it as a condition caused by sun/heat, dust and excessive eating of red palm oil. They did not even believe that one of the major complications of malaria was febrile convulsions; rather, they categorize malaria and convulsions as part of two different disease processes. As a result of their traditional perception of malaria, only a few could mention mosquito-related preventive measures like nets, insecticides, coils and the clearing of bushes. Most of them mentioned factors related to traditional notions of causation like avoiding dust, heat, sun, excessive consumption of palm oil, and overwork; while most of them believe in the efficacy of both modern and traditional drugs for prophylaxis.

Makundi, Malebo, Mhame, Kitua and Warsame. (2006) surveyed the role of traditional healers in the management of acute malaria among children below five years in Kilosa and Handeni Districts in Tanzania. Rather than the popular belief that traditional medicine delays malaria treatment, it was found out during the Rectal Artesunate Project, that traditional healers played a vital role in the healing process by providing bio-medically accepted first aid (Makundi *et al.* 2006: 1) which leads to a reduction in body temperature, increasing the chances of survival of the child. They further discovered through their research, that traditional health practitioners and mothers did not link the local illness they called *degedege*, which is a prominent feature of severe malaria to bio medically-defined malaria. Most of the mothers believed *degedege* was caused by evil spirits. As a result, the treatment of the illness involved a complex process that began at home with the sponging or washing of the patient with warm water after which the patient was taken to a traditional health practitioner before consultation with a modern healthcare provider. The reason behind turning to modern healthcare as a last resort was due to the people's belief that *degedege* was an illness caused by evil spirits and therefore should be treated traditionally first. The essence was for the evil spirits to be driven from the child and to put the child on the road to recovery,

so that Western medicine would take its full course. Although someof the respondents would never take the sick child to the hospital because as found out, most of the caregivers believed that injections given to the children at the hospitals would result in the sudden death of the children.

Jegede (2002) through his study of the Yoruba cultural construction of health and illness avows that the explanation of health and illness is a function of culture because as he puts it, "the definition of social phenomenon is culturally determined". The Yoruba worldview which is anchored on a belief in destiny affects the people's perceptions of health and illness including the prevention and cure of ill heath. Good health in line with the '*ayanmo*' mythology signifies a" positive destiny" (*ayanmo rere*) and ill health is considered to be a "negative destiny" (*ayanmo buruku*). The study also revealed that in all the studied cases of illnesses in communities in Akinyele Local Government Area of Oyo State, members of the community rarely sought modern health care. Our beliefs and perceptions determine our attitude. People from these communities in almost all cases sought traditional treatment through the help of *babalawos.*

Furthermore, Jegede (2002) posited that man in the Yoruba community has both a vertical and a horizontal relationship. The vertical relationship involves interaction between man and supernatural powers or beings and the horizontal relationship involves interaction between man and his fellow humans. Illness just like other misfortunes is seen as being related to the malfunctioning of any of these two relationships. Hence, a man in good terms with the supernatural powers for example, through his avoidance of the violation of any taboos and laws of the land, a man who performs all the sacrifices necessary to the gods, and who is in good terms with his fellow men, having no enemies among people around him will not be sick. Usually, parents of a child go to the diviners, to find out the destiny of a child, which they believed was chosen or given to the child at or just before conception. Because of the people's beliefs, once a person is sick, even of malaria, the care givers take the patient to the *babalawo* to find out which god had been offended or neglected, which taboo had been broken, or which enemy was at work. In addition, they tried to find out the destiny of the child in relation to the illness. This perceptions and beliefs send the people to the traditional care

homes precisely the *babalawo*s for treatment and cure and to the hospitals only when the illness had defied the traditional remedies taken.

Oreagba, Onajole, Olayemi and. Mabaveje (2004) compared the awareness of malaria and its treatment among caregivers of children less than 5yrs of age in both urban and rural areas of Ado – Odo/Ota Local Government Area of Ogun State. They averred that the reactions of people to illnesses were influenced by socio-economic factors in addition to culture. Against this backdrop, they further stated that the way and manner people sought treatment, where they would go, what they would do, and things they used were related to the cost, availability and cultural beliefs about the causes of an illness or disease, including malaria.

Beiersmann, *et al.* (2007) carried out a research on local illness concepts, patterns of traditional treatment and influence on health seeking behavior in the 7 villages of the Nouna Health District in northwestern Burkina Faso. The study revealed four local concepts of illness resembling the biomedical configuration of malaria; *Sumaja* – uncomplicated malaria, *Dusukun Yelema* – respiratory distress syndrome, *Kono* – cerebral malaria, *Djoliban* – severe anaemia. This local categorization of these diseases they also found, affected both treatment and the choice of who provided the treatment. *Sumaya* was treated by a combination of traditional and modern methods, *dusukun yelma* and *kono* were treated by traditional healers and djoliban was preferably, in modern health facilities. Traditional healers were usually consulted when people had *dusukun yelma*. This was because the conceptualization of the illness can be translated as "displaced heart". The study revealed the belief among the people of northwestern Burkina Faso that the heart leaves its normal place in the human body and moves to another part of the human body, the leg or the back for instance. This, as the study found out could be caused by both natural and supernatural factors, like the action of an evil person or a sorcerer or it could be just grave *sumaya*.

Kono which can be literally translated as bird wass a disease which presented symptoms biomedically linked with cerebral malaria. The illness was conceived as and called bird that is, *kono* because of the movement of a child's arms during an attack. The study revealed that the people believe that a bird starts up the illness while flying over a woman sleeping with her child outside at night (Beiersmann *et. al.* 2007: 4). *Sumaya* is perceived to

be caused by natural factors like a dirty environment, cold or the wind and certain foods. From the study it was revealed that illnesses perceived to be induced or caused by supernatural factors were treated by traditional healers and those caused by natural factors were taken to health centres.

Launiala and Kulmala (2006) studied the necessity of understanding the local context, in this case, the perceptions and knowledge of women concerning malaria in pregnancy in rural Malawi. They observed that one major problem of malaria prevention programmes in Malawi was that little or no attention was paid to understanding the local social and cultural context of the people before the implementation of a programme. *Yao* women in rural Lungwena, Mangochi District on the eastern shore of Lake Malawi refered to malaria and fever caused by malaria as *malungo*. The word was also used as a synonym for body pains and a feeling of unwellness, which vary in symptoms, severity and aetiology. The women identified two major types of *malungo*: that caused by mosquitoes, and that caused by hard work. Some women believed that *malungo* was an illness from God. The direct association between the knowledge of women about the causes and symptoms of *malungo* and the type; the more causes and symptoms a woman knew, the more types she was able to itemize. From the results of the study, Laumiala & Kulmala stated that the local meaning of *malungo* went with an assumption that malaria was a common and rather innocuous disease for pregnant mothers.

Comoro, Nsimba, Warsame, and Tomson (2003) worked on the implications for malaria control of local understanding, perceptions and reported practices of mothers, guardians and health district workers on childhood malaria in Kibaha district in Tanzania. The study showed that although most mothers related malaria to mosquito bites, some did not. They described a severe childhood illness called *degedege*, which is consistent with convulsions, as a serious illness. In fact, some avoided mentioning the name because they believed it to be a bad omen, a condition caused by evil spirits i.e. *Shetani*. While the treatment of malaria involved the administering of antipyretics, and the sponging of the body to lower the body temperature, treating convulsions involved taking the patient to a traditional healer, locally called *fundi* or *mganga*. Treatment at home involved urinating on or fuming the child suffering from *degedege* with elephant dung. These were seen as effective remedies

while injections were considered lethal. It might be argued that perhaps the perception and fear that an injection would be fatal for children with malaria or convulsions influenced their preference for traditional healers.

Agu and Nwojiji (2005) studied the perception and treatment seeking behaviors in mothers in Igbea community in Izzi Local Government Area of Ebonyi State and discovered a low level of knowledge about the cause of malaria and related itto the fact that most of the respondents who in addition to being uneducated, had their source of information from relatives and members of the community who were most likely as ignorant of the cause of malaria as they were. It was also found out that the treatment-seeking behaviour was dependent on the perception of the illness as a minor illness, except when it had reached an advanced stage.

Gessler, Msuya, Nkwya, Heinrich and Tanner (1995) studied the traditional healers in Tanzania: the perception of malaria and its causes with the aim of investigating how traditional healers in different areas in Tanzania managed malaria. In terms of perception of malaria by the people, the study found out that there was no particular local term for the illness in Tanzania. *Homa* the Kiswahili word for fever, was well known and used in most rural areas to refer to the illness. Malaria in children was treated differently because it was perceived differently and also described using a Kiswahili name – *ndegedege*.

Granted that some of those interviewed believed that malaria was caused by mosquitoes, other insects or changes in seasons or conditions in their environment were also seen as causes of malaria. The signs and symptoms of malaria as perceived by the traditional healers had a correlation with the biomedical symptoms of malaria. Four main forms of malaria were identified in the research: *malaria ya kawaida, malaria ya kichawa, malaria ya tumbo* and *ndegedege*. These different manifestations of malaria were found to correspond to the scientific terms which describe the different types of *plasmodium falciparum malaria;* cerebral malaria- *malaria ya kawaida,* clinical malaria - *malaria ya kichawa,* or ferbrile malaria-- *ndegedege* and gastrointestinal type - *malaria ya tumbo*. The main areas of difference between traditional medicine in the parts of Tanzania and Western medical knowledge of malaria was in the causation. Especially, the conception that severe malaria

which was treated differently, may not be perceived as being associated with bio-medical malaria, but treated as a supernatural problem.

According to Deressa and Ali (2008) who examined malaria related perceptions and practices in Adam Tulu District of south-central Ethiopia, malaria in this area was referred to as *busaa*. It was percieved as the most dangerous disease affecting children. The people believed that malaria could be transmitted from one person to the other and that sleeping together could cause malaria. Other local perceptions were also widespread. For instance, malaria was perceived as air-borne, as breathe from malaria patient was believed to infect another person who was in contact with the infected person, as well as exposure to swampy areas and cold water.

As seen so far, health just like everything of concern to people is influenced greatly by the culture of the people. People cannot be separated from their culture because their culture is their norm and their identity. It is natural for people to interpret experiences and issues in and around them through their culture. Health is an important phenomenon and is highly valued in all cultures. Therefore most cultures think about health, maintaining health, the search for health and wellness and the struggle against illness and disease

2.1.4 Malaria in Nigeria

Nigeria belongs to tropical region of sub-Saharan Africa. According to bio-medical explanation of malaria, most of the countries located in the region are endemic to malaria due to climatic conditions featuring hot weather, heavy rainfall and high humidity favourable for the breeding of mosquito that is malaria fector and ecological factors such as still water, green forest and swamps conducive for all year round survival of mosquito. In addition, the agricultural practice of slash and burn creates more opportunity for breeding of mosquito in the region. Since around the 1800s that biomedical management of malaria was introduced in the region, focus on causation of malaria is mosquito as the disease fector and treatment of malaria is seen from removal of fector and its elements from the body of the infected. While the people least believed on this approach, and with undermining of the local perception, the disease becomes intractable and its impact on the sub-continent has been enormous.

Malaria is a major public health problem in Nigeria where it accounts for more cases and deaths than any other country in the world. Federal Ministry of Health (FMH) admitted in 2005 that:

> Malaria is the commonest cause of hospital attendances within all age groups in all parts of Nigeria. It is also one of the commonest causes of childhood mortality in the country. It is estimated that 50% of the population has at least one episode of malaria each year while children under 5 have on the average of 2 -4 attacks in a year. Malaria has severe negative effects on maternal health and birth outcomes. It causes maternal anaemia, increases miscarriage and low birth weight (FMH ,2005:13).

The above shows that, malaria fever has serious negative impact on the sub Sahara Africandevelopment. It is responsible for 10% of Africa's disease burden (Oghenerhaboke, 2009) that caused the continent enormous financial responsibility.Many Africans repeatedly visit hospitals due to malaria. Twenty to fifty percent (20 –50%) of all hospital in-patients' admissions and 30% of all out-patient visits are for malaria treatment. Of all deaths, 90% have either direct or indirect link with malaria inmany African countries including Nigeria (FMH, 2005; HIP, 2007; WHO, 2009).

Though malaria is preventable and curable, it has led to high mortality and morbidity among Nigerians and its impacts on Nigeria remain unquantifiable. Thus, according to Lege–Oguntoye (1992) malaria has more direct effect on women's health by its impacts during pregnancy. On the part of the adolescents and adults, many individuals have severally not been able to live up to their social responsibilities due to bouts of malaria (Umanah, 2001; FMH, 2005). Many hours are spent at health care facilities by malaria patients. Malaria also takes its toll on the time and labour of family members who are care givers and form the support unit in times of illness (WHO, 2009; Umanah, 2001).

Malaria is a risk for 97% of Nigeria's population. The remaining 3% of the population live in the malaria free highlands. There are an estimated 100 million malaria cases with over 300,000 deaths per year in Nigeria. This compares with 215,000 deaths per year in Nigeria from HIV/AIDS. Malaria contributes to an estimated 11% of maternal mortality. Malaria accounts for 60% of outpatient visits and 30% of hospitalizations among children under five

years of age in Nigeria. Malaria has the greatest prevalence of about 50.3%, in children age 6-59 months in the South Western, North Central (49.4%), South southern (48.2%) and North Western (32.2%) regions of Nigeria. Whereas, malaria has the least prevalence, amounting to 27.6 percent, in children age 6 to 59 months in South Eastern and North Eatern(30.9%) Nigeria.

2.1.5 Burden of Malaria

As at 2007, malaria caused at least one million deaths with a great majority among young children in rural areas (Beiersmann *et al*, 2007). It is the leading cause of death among children under the age of 5 years in many sub-Sahara African societies (Sumba et al, 2008). Malaria in pregnancy is estimated to have led up to 10,000 maternal anaemia- related deaths in 2004 in many of the sub-Sahara African societies - a serious problem that was still on the increase as at 2009 (Nganda et al 2004). Tanner and Vlassof (1998) and Hlongwana et al (2009) also reported that of the world's malaria burden, sub-Saharan Africa accounts for 90% and of the estimated 120 million clinical cases of malaria every year between 1998 and 2009. Since 1997, more than 80% of these cases affected all the age groups, with higher severity on the African workforce, children and the nursing mothers. According to UNICEF (2005-2009) and WHO (1997- 2009), malaria contribute to the failure of development efforts on sub-Sahara African states.

Economically, malaria further contributes to the economic wreckage in Nigeria. In 2009 alone, malaria decreased Gross Domestic Products (GDP) by as much as 1.3% (WHO, 2009). In the long run this translates to substantial differences in GDP between malaria endemic and non-endemic countries. Also, malaria takes a large percentage of income at both the individual and national and international levels, as the disease, according to WHO (2009:3) depleted up to 40% of public health expenditure in Nigeria. Thus, malaria puts more pressure on fiscal state of health in Nigeria.

All these cost huge amounts of money that could have been otherwise channelled into other profitable and development ventures. In effect, malaria worsens poverty nature of the country (FMH 2005a, 2008, HIP 2007, Umanah 2001). It decreases productivity as many

Nigerians are often down with malaria and many of such victims suffer brain damage due to the effect of cerebral malaria. Malaria causes loss of investment and affects Nigerian appropriation from the new lucrative global economic drives- tourism. Many tourists from Northern hemispheres where malaria has been drastically controlled are often sceptical in coming to Nigeria. However, Nairobi (Kenya), Cape Town and Port Elizabeth (South Africa) appropriate global economic gains from tourism as their climate is repellent to malaria infection.

Though malaria is not listed as a chronic disease, it is a disease that aggravates the patient's condition in the event of some chronic diseases such as asthma, sickle cell and some respiratory diseases. In view of this, over the years efforts have been directed towards fighting malaria in Nigeria. From the discovery of *quinny* in the early 19th century to Roll back Malaria in the 21st century the effects of malaria on Nigeria and Nigerians remain unquantifiable.

2.1.6 Causes of Malaria

Malaria, as a disease has plagued humanity for several hundreds of years. The term malaria originated from medieval Italian: malai aria-bad air (Umanah 2001). It has also been referred to as "ague" or marsh fever (WHO, 2009) in reference to its association with swamps and damp vegetations. Scientific studies of malaria had started as far back as 1880 and have continued down the ages. That malaria is transmitted by mosquitoes was finally proven in 1898 by a British doctor, Sir Ronald Ross in Calcutta.

Bio-medically, malaria is believed to be caused by parasites that are transmitted to people through the bite of infected anopheles mosquitoes (WHO 2009). This is in direct contrast to what is ethno-medically believed in different African cultures as the causes of malaria. Though the symptoms used to describe diseases translated to mean malaria in different cultures are the same with that of bio-medical perception of malaria, malaria causation is attributed to a wide variety of factors ranging from, exposure to sun, hard work fatigue and shortage of blood (Launiala and Kulmala 2005) dirty environment, inhaling of dust and growing of milk teeth in children (Oreagbu et al 2004), to the consumption of some food items and fruits (Ahorlu et al: 1997).

In essence, in traditional African societies, the aetiology of malaria can be seen as behavioural; when it is linked with the lifestyle of the individual, ie. Exposing oneself to causative factors like sun, climatic; when it is believed to be linked with the weather,ie. the rainy season, nutritional; when it is believed to by the diet of the individual,eg.the consumption of oily foods, and preter-natural; when it is suspected to be caused by supernatural forces.

2.1.7 Transmission and Effects of Malaria

Malaria is a vector-borne infectious disease caused by protozoan parasites accompanied by a cyclical course with periods of acute febrile attacks and paroxysm-free intervals (Umanah, 2001). People usually get infected with malaria by being bitten by an infected female anopheles mosquito that can transmit the malaria parasites. The mosquito must have been infected by feeding on the blood of an infected person. The incubation period of the parasite ranges from 10 to 15 days during which the plasmodium multiplies in the liver and attacks the red blood cells. Out of the many: species of plasmodium parasites only 4 of them can infect human beings, namely, *plasmodium falciparium*-which causes the most severe form of malaria, *plasmodium vivax, plasmodium ovale and plasmodium malariae*. The last three cause milder and less fatal forms of malaria. Malaria parasite is mostly transmitted at night due to the nocturnal feeding habits of anopheles mosquitoes. In Nigeria, transmission of malaria is higher in the wet season than in the dry season and this difference is more striking in the northern part of the country than it is in the south (FMH, 2005).

Malaria is the commonest cause of hospital attendances within all age groups in all parts of Nigeria. It is also one of the commonest causes of childhood mortality in the country. It is estimated that 50% of the population has at least one episode of malaria each year while children under 5 have on the average of 2 -4 attacks in a year. Malaria has severe negative effects on maternal health and birth outcomes. It causes maternal anaemia, increases miscarriage and low birth weight (FMH 2005).

The above shows that, malaria fever has much negative impact on the population of Nigeria. It is responsible for 10% of Africa's disease burden (Oghenerhaboke, 2009), 20 – 50% of all hospital admissions, and 30% to 60% of all outpatient visits, and 90% of all deaths

due to malaria occur in sub-Saharan Africa (WHO 2009, Wikipedia, 2009, FMH, 2005, HIP; 2007) where Nigeria is located. Though malaria is preventable and curable, it has led to high mortality among Nigerians. It causes millions of cases of fever and deaths annually which takes its toll on the socio-economic life of the people.

Lege –Oguntoye (1992) opined that malaria has a direct effect on female health by its impacts during the course of pregnancy. She further said that malaria parasitaemia is significantly more frequent in pregnant than in non-pregnant women. Malaria infection of the placenta has been associated with adverse effects on the foetus and newborn baby. Specific adverse effects of malaria in pregnancy include; premature labour and maternal anaemia (FMH, 2005) miscarriage and low birth weight (FMH, 2005, 2008; HIP 2007) School children are often kept from school by malaria fever.

Socially, malaria has done a lot of havoc among Nigerians. Many individuals have severally not been able to live up to their social responsibilities due to bouts of malaria. (Umanah 2001, FMH, 2005) Much man hours are spent at health care facilities by malaria patients. Malaria also takes its toll on the time and energy of family members who are care givers and form the support unit in times of illness. (WHO 2009; Umanah, 2001).

Economically malaria wrecks significant havoc in high-rate areas. It decreases Gross Domestic products (GDP) by as much as 1.3% (WHO, 2009). In the long run this translates to substantial differences in GDP between malaria endemic and non-endemic countries. Also, malaria takes a large percentage of income at both the individual, national and international levels as according to WHO the disease accounts for:

- Up to 40% of public health expenditure
- 30 to 50% of inpatient hospital admissions.
- Up to 60% of outpatient health clinic visits (2009:3).

All these cost huge amounts of money that could have been otherwise channelled into other profitable and development ventures. It therefore causes or worsens poverty (FMH 2005, 2008, HIP 2007, Umanah 2001). Deceased productivity due to brain damage from cerebral malaria, loss of investment and tourism (Wikipedia, 2009) are also part of the damages malaria does to any population it attacks.

Though malaria is not listed as a chronic disease by WHO, it is a disease that aggravates medical conditions in the event of chronic diseases such an asthma, and other respiratory diseases. It also helps to aggravate the medical conditions of sickle cell patients, besides other effects.

2.1.8 Resilience and Resistance in the Management of Malaria

One of the greatest challenges facing effective malaria control in the world today is the spread and intensification of anti-malaria drug resistance forms of plasmodium (FMH, 2005a) which has been discovered to result from use of fake drugs (that have been found out to abound in the country) non-compliance with prescription, among other factors. High cost of anti-malaria drugs which has made it beyond the reach of the poor is another factor that has rendered the fight against the malaria scourge. Many Nigerians live in squalor, unhygienic mosquito–infested damp environments. The dirty and damp environments are good breeding grounds for mosquitoes and thus enhance the spread of the disease.

The first effective treatment for malaria came from the bark of cinchona tree which contains quinine. The natural product was made into a tincture and used for the treatment of malaria, till 1820 when the active ingredient (quinine) was successfully extracted, isolated and named by French Chemists, Pierre Joseph Pelletier and Joseph Bienaime. Through the years several drugs have seen discovered and used in the prevention and treatment of malaria. These include Chloroquine which is very cheap and until recently, was a very effective anti-malaria drug of choice. This fact has been altered by the resistance of *plasmodium falciparium* to chloroquine. Currently, dugs of choice in the prevention and treatment of malaria are those that contain a combination of different ingredients e.g Artesunate- amodiaqirne, Artemether-lumefartrine (Commercially presented as coartem).

Insecticides have also been used, over time as direct attack on the vector-mosquito. Traditional herbal remedies have also been used severally, in different parts of the country to treat and prevent malaria. The producers and users attest to the efficacy of the remedies and there are ongoing researchers to prove this. In recent times mosquito nets have been used in many countries, the latest being the use of insecticide-treated nets (ITN) which are currently in use in several parts of Nigeria. Indoor residual spraying (IRS) is carried out and

recommended as a better way of preventing malaria. Malaria chemoprophylaxis is also recommended for individuals living in areas of low transmission or non endemic areas who want to visit endemic areas as well as sickle cell patients.

The importance of preventing or curing malaria in Nigeria has led the Federal Governments to lunch several interventionist programmes with a view to reducing the incidence of malaria in the short term and eliminating it in the long-run. These include the roll-back malaria campaign, National guidelines and strategies for malaria prevention and control during pregnancy and others. International organizations are not left out. They partner with Non-governmental organization (NGOs) institutions and governments to find a solution to the malaria scourge. Researches are ongoing for the development of a vaccine against malaria.

2.1.9 National Policy on Malaria

Nigeria as a country in the tropics where the weather conditions are conducive for the breeding of the vector-female anopheline mosquitoes suffers under a heavy burden of malaria. This, according to the federal ministry of health, is not justifiable since malaria is a preventable, treatable and curable infection. (FMH, 2011). Premised on 2000, the Heads of Government and international agencies met in Abuja for the African Summit on Roll Back Malaria where they signed the Abuja Declaration, committing themselves to the targets among which stipulated that "concerted efforts would be made to ensure that by the end of 2005 at least 60% of the vulnerable populations in Nigeria would have access to good quality, affordable and efficacious antimalaria medicines." The benchmark was raised at the end of 2005 to 80% in order to achieve the goal of reducing the burden of malaria by 2010(FMH, 2008, 2011).

The national policy on malaria is geared towards steady reduction and ultimate elimination of the burden of malaria through the employment of quality, appropriate diagnosis, avoidance of overuse of antimalarial medicines, provision of best practices and rational the use of antimalarial drugs to avoid the development of drug resistant strains of the parasite. The

policy thus aims to institutionalize evidence-based diagnosis and therefore provide a quality assurance programme for malaria diagnosis, treatment and control thereby ultimately reducing morbidity, halting the progression of uncomplicated malaria into severe and potentially fatal disease, thereby reducing mortality. It also aims at reducing the impact of placental malaria infection and maternal malaria associated anaemia and minimizing the development of antimalerial medicine resistance. From the foregoing, it was obvious that gaps still exist in literature regarding socio-cultural perspectives of malaria in sub-Saharan Africa.

The implications of local names of malaria on malaria control have not been fully explored and explained.

How the naming of disease affects its perception is ignored.

Also, the influence of local names of the disease on utilization patterns of healthcare services and facilities is not prominent.

2.2 Theoretical Discussion

As a culture specific study that examines the contents of local perception of the etiology and management of malaria, hermeneutics explanation of local paradigms (Geertz, 2003) is employed as a theory to argue and explain the reality of the study theme.Ethno-hermeneutics arose from the combination of ideas from culture bond theory of disease (Kiev, 1972, Erinosho, 1998 and Ajala, 2003); ethnoscience model of field investigation (D'Ambrosio, 2000) and hermeneutics explanation of local paradigms (Geertz, 2003).

Hermeneutics as a theoretical orientation, based in Aristotle's groundwork of theories of interpretation and semiotics, is the art and science of text interpretation. It holds that words, spoken or written, are signs and symbols of affection and impression and are not the same for all races of men. Understanding these signs and symbols could only be achieved when they

are interpreted in the context of the culture in which they are used (D'Ambrosio, 2000, Wills and Jost, 2007).

Heumeneutics has a long historical antecedent. It was used in the apostolic age in the interpretation of the Pauline epistles. In the medieval era, it was employed in the Medieval Christian interpretation of texts, while in the modern era; it had been applied in humanist education of the 15th century. Martin Heidegger used it in the 20th century to explain the classic philosophical issue of 'other minds'. In contemporary times it has been severally applied byAndres Ortiz-Oses in the explanation of the meaning of the symbolic healing of the injury, Karl-Otto Apel, in the discourse ethics of political motivations, among others. Lambell (2011), criticised Aristitelian hermeneutics for being excessively optimistic or idealistic and overly romantic.

From the understanding of the concept of culture as distinctive patterns of behaviours, attitudes and practices, an assumption that culture is relative emerged. In essence, cultural relativity assumes that each cultural element has its own local domain and that the working of culture is sustained within the context of the distinct cultural actors (group or/and individuals). Cultural actors thereby apply their local knowledge to construct and rework the reality of culture and nature into behaviours, attitudes and practices that continue to shape their entire worldview. This underscores Herzfeld's idea (1981) that indigenous theory of meanings is of necessity in the evaluation of performative culture.

In furtherance to Herzfeld's idea (1981), Geertz (1983) maintained that a particular cultural action is a make-up from both local-insider (emic) and external-outsider (etic) knowledge. While Geertz Clifford has been talking about the influence of local action in shaping both the structure and function of culture quite for over two decades before 1983, he does not however ignore reference to emic and etic as the two main domains of culture. Outsider view can perhaps influence insider view and shed more meaning on the cultural construction of the outsiders. As this perspective is very fundamental to the understanding of the role attached to each of these cultural domains, our theoretical approach in this study follows emic-etic perspectives of malaria in Ibibio culture.

For an understanding of the local contents of malaria in Ibibio, both the etic and emic knowledge are indispensable. Nonetheless, since every culture has corpus of knowledge

established as a system of explanations and ways of doing things which are accumulated and passed on through generations, emic knowledge remains more crucial than etic perception in the analysis of local contents of culture. Thus, discourse and componential analysis as well as the cultural grammar of the Ibibio, in the light of the (subjective) meanings given to malaria management become the fundamental framework of reference in this project. In this approach attempts will be made to locate local meanings and perceptions underpinning the aetiology and management of malaria among the Ibibio. The desire to explain the people's worldviews bordering on the classificatory model of malaria, and the implicit cultural structures associated with the malaria infection as well as how control devices are generated locally, form another basis for the use of ethno-hermeneutics ued in this thesis as theoretical point of reference.

In agreement with Geertz (2003) the cultural repertoires and the interpretation of local beliefs, knowledge, and attitudes related to malaria among the Ibibio will become obviously explainable. As observed among the Ibibio, names suggest action that accompanies the name. Thus, the commonest terms for malaria is *uto enyin*- yellow eyes, a*kpa mbubi* (shortened form of *akpa mbubi adaka ada ubaha usen*) stranslated to mean "you die in the evening, and wake up in the morning", *akom/ adan*- oily deposits, *udongo ukang nnyin* refering to it as an indigenous disease, and *uto enyin ekpo*- that is, malaria caused by ghosts/ spirits. These terms are used to reflect the ethno-medical etymology and aetiology of the disease.

Information about malaria is part of the corpus of knowledge passed on from one generation to another and shapes the indigenous theory of meanings. Ibibio cultural actors apply *their* knowledge of malaria to construct and rework reality in the event of malaria attacks.

CHAPTER THREE
RESEARCH METHODOLOGY

3.0 Research Design

The study was designed as a descriptive ethnography. Relying exclusively on qualitative methods, both the individual and community served as the units of data collection and interpretation. The need for this arose from the desire to capture a multi-lateral perception of local culture that surrounds the aetiology and management of malaria in Ibibio land. In addition, an inter-subjective non-systematic selection of the respondents was adopted. Rationale for this was based on the fact that infection of malaria has non-spatial restriction. There is likely not going to be anybody in Ibibio land that has not experienced malaria infection, thus, everybody must have something to say aboutthe disease. Hence, to grasp as many local perceptions as possible, rather than systematic selection of the respondents, purposive selection was favoured. An extensive ethnographic study of Ibibio people and their responses to malaria as a disease was carried out in the cultural context. The local language, Ibibio, was used in the field and interviews were conducted using the emic perception of data. Local knowledge and beliefs associated with malaria were interrogated, using folk or local terminologies based on the cultural context of the disease. The cultural explanations of malaria were also studied. The pre-field was held to localize the field techniques and get more acquainted with the field structure before the actual field work commenced.

3.1 Entering the Field

Arising from the gaps identified in literature is the need for an ethnographic study of the Ibibio of Akwa Ibom State, south-south Nigeria, focusing on the cultural perception of malaria and its implication on choice of therapy. For this study, a pre-field study (pilot study) was conducted to test the validity and reliability of the research instruments. This provided an avenue for readjustments and preparation for the actual field work.

The researcher had to go the selected study sites before the commencement of the fieldwork to familiarise with the environment.Before such visits, the researcher would have found out and familiarised with either an indigene or a government worker residing in the

study location. This contact would then be the one to introduce the research team to the community leader. During these visits, the community / village heads would be consulted and shown the ethical approval and introduction letters from the ministry of health. This was done to intimate them of the desire to conduct the field work in their domain. Thereafter the community head would inform the team of the day to repeat the visit in order to meet and be introduced to unit heads in the community. The unit heads would, after such introductions advice on the days that would be convenient for the interviews to be conducted or focus group discussions held.In some communities, the team were refered to government health centers where the personnel would help to facilitate entry into the community

At any house household visited, the team requested to see the head of the household. In the absence of the head, his representative/ next in commant would be met. The request for an interview would then be made. Some of the household heads either presented themeslves to be interviewed or referred the team to another person in the household for the interview. In other instances, participation was declined. The purpose of the research was then explained to anyone that agreed to participate in the research. Such a person was also presented with the informed consent forms. Some of them read it and signed, some were read to and they signed while some said they were not interested in signing the forms though they agreed to participate in the research. The head of the household or the person interviewed would at the end be asked to suggest the next household/compound to be visited. Most of them obliged while a few declined. In such instances, the team would go to the nearest compound.

3.2 The Research Sites

(i) Ikono Local Government Area

Ikono Local Government Area was created in 1976 out of Itu division. Its administrative headquarters is at Ibiaku Ntok Okpo. It is bounded in the north by Ini L.G.A; Obot Akara L.G.A. in the north west and in the east, by Ibiono Ibom L.G.A. It shares its western boundary with Ikot Ekpene and Essien Udim L.G.As; while its southern border is shared with Uyo and Abak L.G.As.

The population of Ikono L.G.A. is two hundred and fifty thousand, two hundred and forty-five (250,245). It is made up of sixty-two (62) villages, divided into four clans and 10

political wards. The people are predominantly Christians, though there are still some adherents of the traditional religion who hold fast their belief in the local deity; *Etefia Ikono*. Traditionally, the major occupations of the people include, hunting, trading, local crafts, fishing and farming; the bilk of food produced in the state-rice, cassava, yams, plantains, bananas, cocoyam and fruits, come from Ikono L.G.A.

(ii) Mkpat Enin Local Government Area

Mkpat Enin is one of the 31 Local Government Areas in Akwa Ibom State, South-southern Nigeria. It lies in the southern part of the state. Its southern boundary is shared with Eastern Obolo LGA and the Atlantic Ocean, while it shares the same boundary with Oruk Anam LGA. To the North-east. Etinan LGA is on its North-western boundary, while to the south east and south west, it sharers its boundary with Onna LGA and Ikot Abasi LGA respectively. The land mass is approximately. There are 87 villages in the local government area, which is made up of four clans. It has a total population of two hundred and seventeen thousand, five hundred and eighty-six (217,586) people. The population is mostly homogenous in terms of ethnicity. The indigenous language is Ibibio. The people are predominantly Christians as evidenced in the presence of many churches in the area.

Traditionally the major occupations are farming and trading in the hinterland while people in the riverine communities engage mostly in fishing and trading. However in the present times, due to development and modernization, there abound different tradesmen/ women as well as Civil servants within the Local Government Area.

(iii) Nsit Ibom Local Government Area

Nsit Ibom Local Government Area with its headquarters at Afaha Offiong was created 23rd September, 1991. It is located between latitude $4^{o}48^{'}$ and $50^{o}1'$ north and longitude 7^{o} 51' and 7^{o} 57' east. It covers a total landmass of one hundred and eighty-three thousand, one hundred and five square kilometers (183,105sq km). The landscape is an undulating terrain and the vegetation is the tropical rain forest interspaced with erect and numerous trunks and a high concentration of oil and raffia palms. It is bounded on the north

by Uyo Local Government Area and on the south by Nsit Ubium Local Government Area. On the east and west, it shares its boundaries with Ibesikpo/ Asutan Local Government area and Etinan Local Government Area, respectively.

Going by the 2006 National Census figures, the population of the local government area is one hundred and eight thousand, six hundred and eleven (108,611) and the population density stands at 522 persons per square kilometres. The local government area is made up of fifty (50) villages, divided into four (4) clans and ten (10) political wards. The population is mostly homogenous and the people trace their ancestry to a common stock. There is however a handful of people from other parts of the state /country residing within the local government area.

Ibibio language is spoken by the people who are predominantly Christians, with a negligible minority practicing the traditional religion. The local population engage mainly in farming and trading. Craftsmen, artisans and civil servants are also found within the population.

(iv) Uyo Local Government Area

Created in 1959 by the colonial administrators, Uyo Local Government Area is one of the 31 Local Government Areas in Akwa Ibom State today. It plays the dual role of a local government area and state capital. It is located between latitudes 5^{o} 05' north longitude 8^{0} 0'east. It is bounded in the north by Itu Local Government Area, in the south by Etinan and Ibesikpo Asutan Local Government Areas. It shares its Western boundary with Uruan Local Government Area, while Abak and Nsit Ibom Local Government Areas share its eastern and south-eastern boundaries, respectively.

Uyo local government area is made up of 4 clans, divided into 10 political wards. It has a total population of three hundred and nine thousand, one hundred and forty-six people (309,573) Uyo L. G. A. Official manuscript (2013).

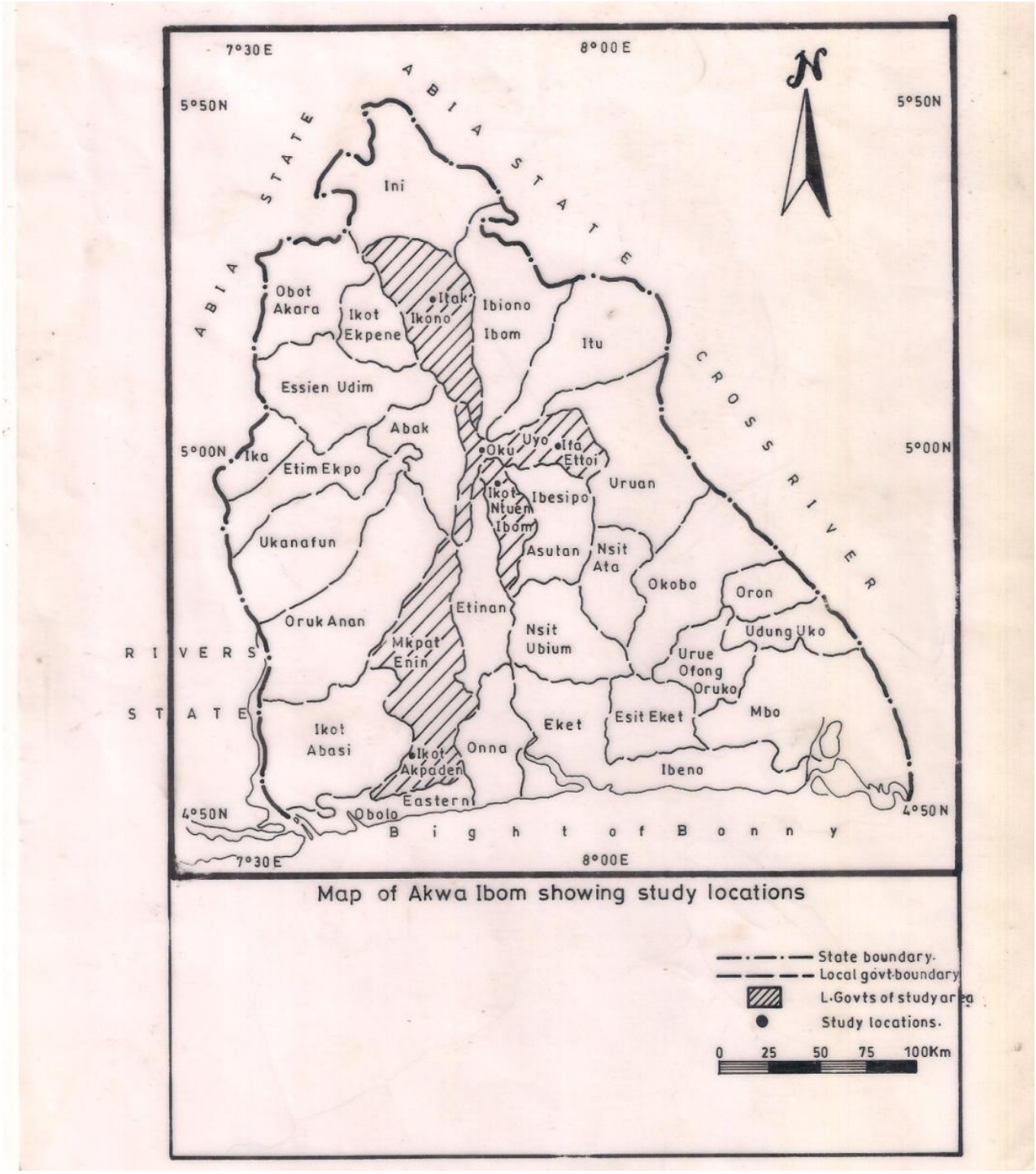


Fig 3.2: Map of Akwa Ibom State Showing the Research Sites

3.3 Study Population

The study population involved three sets of people as follow:

(i) Adults aged 18 years above;

(ii) Health and Medical practitioners both traditional and modern; and

(iii) Children between age 10 and 17 years that can narrate their previous experiences of malaria.

The choice of the above population was to ensure a wider coverage of respondents across ages. This was intended to establish a holistic view of local contents of malaria in the study area.

3.4. Sampling Techniques

The study relied on non-systematic. Hence a sizeable number of respondents were selected to achieve objective and generalized data from the field. Specifically, the sampling began by dividing the local government areas that make up Ibibio land into 4 geographical clusters of North, South, East and West. Then the names of the Local Government Areas (LGAs) in each cluster were written on pieces of paper. The pieces of paper with the names in each cluster were then put into a bag and one selected through a lucky dip in form of simple random style. The selected LGAs were thus taken as the study location. Each of the four selected LGAs represented each cluster of Ibibio communities in Akwa Ibom State. Similar process of randomization was repeated for urban and rural wards in each LGA and at the village levels.

At the level of individuals, different sampling procedures were employed. The key informants were purposely selected among the healthcare providers, community leaders and traditional medical practitioners. The respondents for in-depth-interview were selected through snow-ball sampling technique. Each of the selected respondents was engaged in deep and intensive interview. The sampling produced the selection of:

(i) 8 research communities both rural and urban on equal divides from 4 local government areas;

(ii) 21 respondents for Key Informants Interview; 10 othordox and 11 traditional healthcare providers

(iii) Thirty-two (32) sessions of Focus Group Discussions; four in each location. One each for young mothers, grandmothers, young fathers and grandfathers

(iv) 12 episodes of malaria caring through observations.

(v) 20 household heads/ caregivers for in-depth-interview.

3.5 Inclusion and Exclusion Criteria

The choice of the different sets of people to participate in the field work was aimed at obtaining balanced information on the issues studied across all strata of Ibibio society. Children between the ages of 10 and 17 were included because they could recount their experiences of malaria fever or those of close relations. Younger children i.e. below 10 years of age may not be able to render such accounts, and thus were excluded.

Both male and female adults (mothers and fathers) were included due to the fact that over time, they have had personal experiences and offered care for malaria pateients. They would therefore be able to give information from both perspectives.Only people who have resided in the study locations continuously for up to 5 years were involved in the study. This was occasioned by the fact that this length of time would afford them enough opportunity to have learnt the specific cultural context of malaria for that location. This helped in ensuring that data collected for any location was to a large extent, a true reflection of what obtains in that location. Thus, getting information that was not indigenous to any particular location was reduced to the barest minimum.

3.6 Methods of Data Collection

Secondary data were sourced from textbooks, academic journals, magazines and government and organizational publications. These were sourced from surface libraries as well as from the internet. Primary data were collected from the field relying on triangulation of key informant interview, Focus Group discussion (FGD) and Non-participatory Observations.

3.6.1 Key Informants/In depth Interview

A total of 21 key informants were used across the 8 study locations at an average of 2 key informants in each of the locations. They were purposely selected among traditional and orthodox health care providers. Some of the informants were identified during the pre-field visit and others during the FGD and singled out for interview. They provided information on the traditional treatment regimes and processes involved in the preparation and administration of traditional remedies in malaria management. Caregivers as well as malaria patients were selected and intensively interviewed on a one -on -one basis. The instrument used for the key informant interview consisted of 12 open-ended question guides that allowed the respondents to freely express their opinion on the issues under investigation.

3.6.2 Focus Group Discussion (FGD)

Thirty two (32) sessions of Focus Group Discussion (FGDs) were held across all the study locations. FGDs served as avenues for self expression by the participants. Information so gathered was used to complement the data gathered through other methods. Each session was limited to between six and ten discussants and discussions often lasted at most an hour. This was to make sure that there was enough time for each participant to air his/her views while not being too long. Thus, we were able to arrest boredom and unnecessary tasks on the discussants. The sessions were made interactive in order to elicit comments and responses that clearly brought out the local terminologies associated with malaria and the cultural significance of the disease. The sessions were moderated by the researcher, assisted by a research assistant. A tape recorder was used to record the sessions, this was done in order to capture all the information offered through the sessions that may be missed by manual recording.

The instrument for the FGDs was in four parts. The first part was a warm- up segment on the general health challenges in the locality. The second part dealt with knowledge of malaria and consisted of four (4) open-ended questions while the third section asked questions on the perception of malaria. The fourth and final part of the instrument with 12 questions, dealt with the management of malaria. Participants in the FGD sessions included mothers,

grandmothers, fathers and grandfathers. Their inclusion was based on their knowledge of malaria relying on past experience, both personal and as home care givers

3.6.3 Non-participatory Observation

Non-participatory observation was also used to gather information for the study. The people were observed on how they respond to malaria in order to gather first hand information. Specifically, the people were observed to gain information on issues such as local knowledge and conceptualization of malaria, beliefs associated with it, ways of diagnosing malaria, responses to malaria symptoms, care given to malaria patients and the pattern of utilization of both traditional and Western medical/healthcare facilities. The activities of malaria patients and care-givers were observed and thereby, the content and processes of preparation of traditional remedies were learnt. The people observed, were sampled mostly through snow-ball sampling technique. In all, 43 case studies were observed , for this study.

3.7 Methods of Data Analysis

The generated data in the field were analyzed through qualitative method. Thick descriptions were undertaken on the information obtained from the field. Data analysis commenced with the transcription of the recorded tapes, followed by translation of the transcribed tapes from the local language to English. To allow some degree of data quantification, the qualitatively generated data were transformed to simple percentages which were presented in frequency tables as shown below. The reported data were arranged thematically following the study of objectives.

Full report also incorporated verbatim quotations from the respondents to enrich the descriptive nature of the ethnography. A thick description of ethnographic events and contexts were therefore engaged in such a way that the full report contained very minimal bias. Validity and objectivity of the presented data were thus guaranteed through ethnographic reflexivity.

Specifically, the data analysis started with daily discussions with the field assistant to compare and subsequently merge the field notes. These were read and harmonized at the end

of everyday of the field work, for familiarization with the information gathered. The electronic storage devices used were also checked daily to confirm and be sure of proper storage. At the end, the tapes were listened to, several times over, to get the stored information properly before the transcription. Gaps were filled through call back to the field and checks from the field dairy. After the transcription, the information was translated from the local language into English. This was done with the help of a linguist to ensure proper translation of the text without losing the meanings expressed. These were also harmonized with the handwritten notes. The data were subsequently sorted into objective sheets based on the study objectives. Data gathered by the different methods were sorted separately, compared and then merged for the final analysis to prune the data and avoid overlapping.

While the data were mainly qualitative, frequency tables were drawn to present socio-demographic characteristics of the respondents. The tables were based on simple percentages, thus reflecting simple statistics meant for ordinary inferences. Explanatory elaborations were engaged in qualitative data presentation. This was thematically done on the basis of the study objectives.

3.8 Ethical Considerations

As a study that involved human subjects, ethical protocols were observed during this study. There was an application for ethical approval from Ministry of Health, Akwa Ibom State. The application was successful and certificate of bioethical approval was issues as contained in appendix 6 below. Relying on the bioethics approval ethical issues considered included:

Confidentiality of Data: Data gathered in the course of this research are to to be treated confidentially. The names of the participants will not be mentioned without their permission and no information will be traceable to any of the participants/respondents without their knowledges.

Right to brief and debriefing: The Research Instruments were translated into the local language before being administered in the field, for a proper understanding of the questions by the respondents/participants.

Right to protection against injury and harm during the interview: Nobody was interviewed when operating machinery or working with sharp objects that could cause injury. Also, any critically ill or weak person was not interviewed. Rather, the interview session was rescheduled or cancelled in consideration of the person's well being.

Beneficence to participants: During, the FGDs, the participants were given light refreshments. The findings of this research will in the long run help to develop a better health care plan for the people.

Non-Maleficent: This research will not cause any harm to the participants/respondents

Right of withdrawal: Any participant had the right to withdraw from this research at any point in time without any harm or threat of harm to his person.

Avoidance of coersion of respondents/ The use of the Informed consent Form (see appendix v). The informed consent form was read and explained to each of the participants/ respondents to obtain their voluntary consent before being interviewed or participating in the focus group discussion.

CHAPTER FOUR

ETHNOGRAPHY OF THE IBIBIO IN SOUTH- SOUTH NIGERIA

4.1 The People

The people commonly known as Ibibio in South-south Nigeria are the groups of Bantu speaking people residing in the south coastal region of Nigeria. However, due to cultural configuration of the region that saw close affinity among several distinct groups in the region, Ibibio are often confused to be Anang and Oron. This also results due to linguistic similarities existing among the three cultural groups. Nonetheless, there seems to be no consensus even among few scholars who have written about Ibibio and intercultural relations in south coastal region of Nigeria, about who are the Ibibio. According to Udoma (1987:X) sees Ibibio are the indegenous people of south coastal Nigeria occupying the administrative districts of Abak, Eket, Ikot Ekpene, Ikot Abasi (formerly Opobo), Itu, and Uyo in the old Calabar Province of the British Colonial Administration. Forde and Jonnes (1962),Okon (2001), support this position.

The cultural contestation about Ibibio, however, peculiar of many cultural groups in Nigeria, is connected with competition for resources such as land and political power. Thus, in the recent, for effective control of its region, Ibibio seems to be more identifiable considering the distinct brand of Bantu origin of its language and the environment which the people occupy. Thus, Esema, (2002:3) sees Ibibio as distinct from Annang, Oron, Eket, Ibeno and Andonni/Obolo who are its close neighbours in south coastal Nigeria.

In consequence of the above, distinction in dialect and settlement form the model used in this research to identify Ibibio against its neighbours in south coastal Nigeria. As implied in this thesis, Ibibio refer to all the people who are indigenous to Uyo, Uruan, Ibesikp/Asutan, Etinan, Ikot Abasi, Nsit Attai, Nsit Ibom, Nsit Ubium, Onna, Itu, Ibiono Ibom, Ikono and Ini local government areas of Akwa Ibom State. The name "Ibibio" is generally accepted and used for both cultural descriptions of the people.

Oral tradition and written evidence point to the fact that Ibibio people migrated through the highlands of the present Cameroon, through the lower Cross River basin to settle

at a place known as “Ibom” in the present Arochukwu Local Government Area of Abia State. Internecine war later forced them to move to the different parts of their present location. Ibibio people presently occupy 14 out of the thirty one (31) local government areas of Akwa Ibom State. They therefore form the majority ethnic group in the state.

4.2 Geographical Location

Ibibio people presently occupy Akwa Ibom State of Nigeria. The area lies roughly between latitude $4^0$25” and $5^0$30” North and longitude $7^0$30 and $8^0$30 East. The state is bounded in the North by Cross River State. It is bounded by the Bight of Bonny in the South. To the West, it shares a common boundary with Abia State.

The land is mostly flat and gently undulating with the highest point lower than 300 feet above sea level. The major rivers are the Qua Iboe and Cross River that both empty into the Atlantic Ocean (Ekong, 2001:1). The vegetation is the thick tropical rain forest. This has been replaced in some places by secondary forest and fallow system. The relative humidity is about eighty percent (80%) and the temperature ranges between a maximum of 30^0C and a minimum of 17^0C. The annual rainfall is about three thousand eight hundred and fourteen millimeters per annum (3814mm.PA).The mean annual rian fall decreases gradually from 4050mmPA around the coastal region to 2100mm PA in the northen part. The mean annual temperature is 26.9 degrees Celcius (Ekpenyong, 2013). The area noted for its wetlands, sandy coastal ridge barriers, brackish or saline mangroves. There are both fresh and salt water swamps as well as lowland rfain forests. The land is criss-crossed by a number rivers and streams.

Ibibio land lies within the vegetation belt of the tropical rain forest. This vegetation belt is known to be a conducive breeding ground for mosquitoes due to the dampness of the place for most parts of the year. In western bio-medical paradigm, malaria is therefore endemic to the area. The vegetation presents a wide variety of plants (trees, shrubs and herbs) which the Ibibio harness extensively in the preparation of herbal remedies for the treatment of illness and disease.(picture)

Fig.3.1: Vegetation of Ibibioland

Source:AKS Official website

Soure: Google Map

4.3 Language and Communication

Ibibio language in general is classified as semi-bantu**.** The Ibibio speak dialects of Efik-Ibibio, a language of the Kwa Branch of the Niger-Congo Family. Being the best-known dialect, Efik has been established as the literary language, and is understood by most educated Ibibio. Because of its remarkable assimilative power, Efik spread throughout the Cross River area and even into the Cameroons. The language is a tonal one where one word can stand for, at times, up to three or more things, the difference only being in their pronunciations. For example, *okpo* can either mean bone, plastic or talisman depending on how it is pronounced. Some of the words can only be understood in the context in which they are used as their spellings and pronunciations remain the same. For example, *ikang* may mean fire, light or a gun.

There are many dialectical variations of Ibibio language, each of which is spoken by a particular sub-group or area. The dialectical variation that Ekong, (2001:2) refered to as Eastern or proper Ibibio can be seen as a central or general dialect. Every person, which ever sub-group he comes from, can speak and understand it with ease. This is not so with other dialects. Some need to be learnt by people from other sub-groups while those who speak them can easily understand others. The most basic difference among the many dialects of Ibibio is in the vocabulary. To a lesser extent, the sound system, tone, and grammar can be distinguished. Comparative studies have shown considerable similarity between the Efik and the Ibibio proper, Oron, Eket, Anang, and Ibeno dialects. Even within each of the sub-groups, there exist slight variations depending on the area one comes from. For instance, the people from Mkpat Enin can easily be differentiated from Uyo people, because of how they pronounce certain words. Ibibio language is rich in folklores, songs and proverbs A proper Ibibio man is one who spices up his speech at all times with proverbs. Elders are particularly expected to make their speeches filled with more proverbs than plain words in the traditional setting.

The language is gradually losing its richness especially with its disuse by the elite and people in the urban areas. It is also improperly used in villages. It is common to hear even an old village woman make a statement like "*Keben* basin *nsok*". This means "go and bring me

basin". The Ibibio word for basin- *asit* is unknown to many Ibibio people. A few other words that are disappearing include:

Akpakaha/Akada -stool

Akpesa/ ikat - basket.

Nkpana - bed

This is the result of mass education and the mentality that anything "foreign" is superior. This makes it difficult to hear anyone, even illiterates, speak up to two sentences without English words coming up. This language acculturation is seen as a pathetic situation by many adherents of Ibibio culture.

4.4 Economic Organization

Traditionally, the economy is organized around an eight (8) day week of *Obo, Uruabom,* (*edemobo*) *fiongaran, Edemetaha, ataetaha, Uruaukat,* (*edemetaha*) *Fiongetok and Ederebo*. The economic activities were in the main formally subsistence with trade by barter as the mode of exchange. The occupation of the people was mostly determined by the area of residence: those in the mainland engaged in farming, hunting, carving, craftwork and trading while those from the riverine areas engage mainly in fishing and farming.

In the pursuit of ways of eliminating hunger most times a single individual goes into many different occupations. This makes for difficulties in occupational classification. The modern Ibibio land (Akwa Ibom State) has a civil service driven economy in urban centres. Many are engaged formerly in white collar jobs while formerly engaging in other venture like trading, transportation, etc. Government workers found in the rural areas are mostly teachers and agricultural extension officers.

In many communities, there are big markets attached to each day of the week. Some areas value *Obo* days while others hold their markets on *Ataetaha*. This is dependent on the deity of the area as the week days have religious undertones.

Traditionally, wealth acquisition was done through the use of under privilege relatives as labourers. Wives and children and the land were seen as the most viable means of wealth creation through farming. Investments took the form of land purchasing-pledged or outright

sale, marrying of many wives and having many children as well as livestock raising, especially ruminants.

Saving was and is mostly through *Etibe*, the traditional way of club saving-*afe etibe* (Akpan 2003:127). A group of people would agree to contribute whatever item they wanted to save or money on a particular market day. Each of the participants took turns to take the proceeds either monthly or weekly. Banks are used today especially by the elite and in the urban centres.

Originally, the people engaged in trade by barter which was later replace by cowries shell and shittim (copper wire), *okpoho* (manilla)- introduce by the Portuguese (Esema: 2003:95) which remained for many century as the acceptable medium of exchange until it was replace by British Pounds, Shillings and pence and later modern day Nigeria currency of Naira and Kobo in the 1970's.

The Ibibio, especially the Anang, are well known for their skill in wood carving and are considered masters of an adroit professional technique. Weaving is generally done by youths of both sexes, whereas women are responsible for mat making. Yams are traditionally considered to be the chief crop of men, and cocoyams the chief crop of women. Men do most of the clearing, planting, and harvesting of the yams. Women weed, plant, and tend other crops. They also collect the harvested yams into baskets and carry them to the market.

In collecting the produce from palm trees, men generally do the climbing, and the women collect and carry the fruit to the market. The extracting and processing of palm oil is usually done by women, who retain the palm kernels. Also, raffia palms may be tended by men, but are usually owned by women, and are used to make wine, mats, and poles.

With a strong emphasis on the patrilineage, the male members form the dominant nucleus of the hamlet and have collective rights to its land. The lineage head allocates the land for farming among its members on a yearly basis.

4.5 Social and Political Organization

Socio-politically, the family is the lowest level of organization with the husband as the head. His wife (wives) and children play subordinate roles. The extended family system, hitherto predominant, is today rapidly eroded by the effects of modernization. Social

relationships are most often built along the lines and biological and marital relationships. These affiliations extended to, and affect other facets of life.

Traditionally, membership of secret societies (cults) conferred honour and prestige on the people. Membership of such cults is either by choice or heredity. The roles of these cults transcended all facets of life. Men and women belonged to different cult groups which were also seen as social organizations (Ekong, 2001:72)

Politically, the Ibibio society can be said to have a three- fold structure:

Ufok (household)- the lower level

Otung (Extended family)-intermediate level

Esop Idung (village Council) - highest level.

The village council is usually made up of heads of large extended families-*epuk* and selected elders from these families or patrilineages, kingship was not present in traditional Ibibio society. Kingship, where it exists today is a modern institution. The Ibibio had a decentralized political structure before coming of the Europeans.

In recent times, there are associations formed that were not part of the traditional social or political structure. It is common to hear of sectional associations. For example, *Nka Iberedem Ndito Uruan*, Ibiono Ibom development Union" for the Uruan and Ibiono people respectively, etc.

The emergence of party politics at the national level had also impacted the political structures of Ibibio land. Many people are now members of political parties. Such consciousness extends to the rural areas as well. Political organization of most villages (even rural ones) has been changed to reflect this democratic arrangement. Most members of village councils are democratically elected by their lineages. The elders' council made up of family heads in the village vote for nominees after nomination by each family head. A member of the village councils can be recalled in case of dissatisfaction by his kinsmen, with his representation or in case of criminal offences or accusation against him or her. The lineage head (ete ekpuk) and the town head (*obon ison*) are traditionally regarded as the main sources of justice for their respective groups, but the *ade facto* (council of elders) also meets for judicial purposes in the village court.

Cooperation and social control outside the family is most effectively achieved within the patrilineal and exogamous lineage. The ete ekpuk maintains moral authority and ritual obligations over a wide field, as he *is* the guardian of the ancestral shrines. In theory, he maintains the right to assign farming plots on lineage land, although in practice these duties are usually carried out by the ete otun

4.6 Religious Organization

Ibibio people are naturally very religious. Traditionally, there exists the belief in the existence of *Abasi Enyong* (God of the Sky/Heaven) and *Abasi Isong* (god of the earth). The sky God is regarded as supreme and a single entity while the earth is believed to have many gods, each of which controls different aspect of life. The names and functions of these gods differ with each Ibibio sub-group and locality (Ekong, 2001:30).

The spirits of ancestors are seen to be the nearest entities to the sky God. They are also believed to act as intermediaries between human beings and the spirit world. This informs the pouring of libations to the spirit of the dead during social occasions. Ancestor worship is also occasioned by the belief in reincarnation. This is also why extensive and expensive rites are usually accorded the dead.

Worship of the ancestors is a very important part of Ibibio religious culture. Sacrifices are often made at the ancestral shrine, which is kept at the house of the eldest member of the lineage group. Disgruntled ancestors may wander among the living, causing harm until the ceremony of Obio Ekpo ("world of the dead") is performed so that the spirit can enter the world of the dead. The Ibibio have a concept of good (*eti*) and evil/bad (*idiok). A* person has two souls, the immortal soul (*ukpong*) and the animal-linked soul (*ukpong ikot),* which can live in lions, leopards, bush pigs, antelopes, and pythons. The latter also dies at death, whereas the former is reincarnated or becomes a malevolent ghost troubling the living.

The lesser gods can be seen as either benevolent-*ndem* or malevolent- *ibok*. They are commonly and continually propitiated through sacrifices performed by the elder(s) of a family, lineage or clan, for effective performance of their duties for the people (Ekong, 1983 in Wilson: 1999:30).

The whole act of traditional worship consists of the offering of sacrifices at different occasions especially when tragedy strikes and season like planting and harvesting. The belief in totems is evidenced in folklores and taboos. Three distinct lesser gods are especially revered:

Abasi eyeyen -god of ancestral derivation or god of the child of a daughter(grandchild)

Abasi ukot- in-law deity

Abasi imaan- god of inter communal alliance. Essn(1980:133).

The prominence of these deities in the traditional belief system makes it a taboo to harm, in any way, anybody that one shares any relationship with on the basis of *eyeyen, ukot or imaan.*

Today, most of Ibibio are adherents of the Christian faith and a few others Islam, Buddhism, etc. many different denominations dot the land. Some in spite of this religious acculturation practice the traditional religion secretly and in times of calamity.

4.7 Fashion and Dressing

Ibibio people are resourceful and hardworking. They used available raw materials to make dressings for themselves. These raw materials include leather and raffia apparels, breads and shells. Cosmetics were traditionally made from the barks of trees, stones shells, charcoal, palm oil, clay, flowers and leaves. Dressings for adults are traditionally different from those for younger people. Royalty has a different type of dress and there are special outfits for different occasions like fattening, marriage coronation ceremonies, etc.

Outing or formal dressing for women consists of two wrappers *ndod iba* with headtie and blouse. For the men, it consists of three piece loin cloth -*usomo,* a long-tailed shirt-*mbem-mbem ntie/anyan isim* and a cap- *uyat/itam*. Chiefs and distinguished citizens are identified by the addition of breads- *mmeng/nkwa* and a special kind of hats -*itam ubong* to their apparel. Young women wear iron loin clothes and used beads to cover their upper bodies while young men make do with only loin clothes.

Today, suits are worn by both men and women, young and old. Young girls and a few older women now wear trousers. The fashion reflects moistly western culture. Borrowed

culture now seems to overshadow the traditional dressing of the Ibibio and its rich cultural expression.

Plate 4.2: Ibibio Traditional Dressing

Source: Field 2011

4.8 Education

Traditionally, oral tradition was the most prominent in passing on knowledge from one generation to another, through proverbs, riddles, tales, folklores and informal lectures. Such subjects are History, Geography, Mathematics, Social Interactions (relationships and responsibilities), beauty and cookery (for women) and character development received priority attention in informal lectures (Esema 2002:70).

Initiation into cult groups and societies was another avenue for the impartation of knowledge. Vocational knowledge and skills were imparted through the process of initiation into specialized groups and societies. Apprenticeships also provide an avenue for skill acquisition and vocational education. Young men and women were attached to learn under the tutelage of master craftsmen and women (Ekong, 2001:101)

Formal education gained prominence through contact with Europeans (the white men). This was initially not full accepted. Only wayward children and those of unloved wives were sent to school-to be maltreated by the teachers (Okoko, 1988:54). Western Education gradually gained acceptance and now over shadows the traditional modes of education. Most people today send their children to schools, colleges and Universities. Public and private schools abound throughout Ibibio land and their registration is on the increase. Those few children of school age who are not in school suffer this fate as a result of poverty and not lack of awareness by the parents or guidance.

4.9 Food and Nutrition

Principal sources of food for the Ibibio man include plants, herbs, vegetables animals and sea foods such as crayfish, fish, periwinkle, etc. such foods are pounded yam- *usung udia* eaten with *afia efere* and *foofo* or *usung iwa* eaten with *efere afang* are special dishes which are always served during occasions as delicacies and other times, to important visitors.

The quality of soup is what portrayed the affluence of the *ete ufok* (master of the house) other foods include different types of pottages and porridges made from such food stuff as water yam, plantain, banana and pepper soups made with different traditional and local spices like *ntong* (basil leaves-ocimum basilicum) *iko* (curry leaf-hyptis gratissimum),

odusa (Guinea black pepper-piper guinensis), *uyayak* (aiden tree-tetrapleura tetatera) are made and mostly taken with rice- *edesi*, plantain-*ukom* and yam *udia* Esema, (2003:87).

There are different dishes for different occasions. E.g. Nursing mothers are mostly served pepper soups and porridges in the first few months after delivery. Women undergoing fattening- *mboppo* are also served these types of food.

Dishes from other cultures, even outside Nigeria are also eaten these days, especially by the elite in the urban areas. Traditional dishes are seldom served in commercial food centres. Nowadays, fast food consumption is rapidly gaining prominence and more so among the youth.

4.10 Kinship and Marriage

Polygamy and Exogamy were common in traditional Ibibio land. In contemporary times, especially in urban centres, Ibibio men are tending towards monogamy. This is as a result of economic realities rather than belief. Incest taboo is widely upheld. Adultery is prohibited (this applies only to women in Ibibio cultural milieu), hence the presence of *ekpo nkaowo* (the spirit or ghost of adulterous women). It is believed that if a woman commits adultery, she would die at childbirth through attacks by the ghosts of other adulterous women if she does not confess fully and give a she goat, to be killed as a scape goat, to her husband. If she is past child bearing age, the ghosts as believed will pluck off her hair and kill her children one after the other till they are all gone, after which she will die a disgraceful death. If she still does not confess and pay the required ransom. This, more or less, gives the men the right to extramarital affairs and the chance of taking more wives or concubines as far as it is not with another man's because, the husband could place a curse on him.

The marriage institution is a complex of social, political, economic and religious systems and therefore affects all aspects of life in the society. Marriage involves sex and reproduction which are paramount in Ibibio traditional context with uxorial and genetrical rights properly transferred to the husband and his lineage (Mitchel, 1976). It transcends the mutual affection and union of the individuals concerned and includes the union of their families. Betrothal before the age of 14 was common in olden days. Marriage payments were

made to the prospective bride's parents. The marriage payment was shared among the bride's kin, with the father keeping the largest share. The marriage payment traditionally had to be completed before the marriage could be consummated; it was supplemented by services rendered by the husband to the bride's father

Decent is patrilineal and residence is patrilocal. Despite this, there are some people who live with their maternal relations for one reason or the other. Many maintain close relationships with their agnates and affines who are supportive on occasions such as marriage, childbirth, building of houses, farm work and burial.

4.11 Property and Inheritance

Personal property in Ibibio land can be divided into two categories landed and moveable property. Individuals acquire property either through inheritance, bride wealth, gifts or personal purchase. Ibibio people attach much importance to land and as such, each family jealously protects its interest in the family land (Esema, 2002:14).

Sale of land may be perpetuity (*nsobo*-which involves the payment of a she goat in addition to money, drinks, yam and clothes) or mortgage (which may take either of two forms):

> Pledges for debts and money needed in emergency situations. Such land could be redeemed by the person or his family members.

> Temporary sale or lease where a person buys and holds land only for a period of time after which the owner or his relative redeems it- *oto owuo ikot*.

At the death of any individual, his sons inherit all of his landed property. The daughters are not allowed to inherit their father's property, except in special cases. This is so since they would be eventually married out of the lineage. In some cases, they are given some of the household property especially in the event of their mother's death. The rule of primogeniture is strictly followed in sharing a deceased's property and the largest and best portions go to the eldest son.

Widows are not allowed to inherit their husband's property (Ekong, 2001). A man's property belongs to the lineage and only the male children are allowed any right to the lineage's property. If the children are very young, at the time of their father's death, the deceased's brother or any other member of the lineage will hold it in trust for them until they grow up. In most cases, such a trustee is expected to also inherit the widow. This makes room for wicked men to throw out the woman and her children and claim the property for personal use, especially if the women refuse advances of love from the man. The children often have to fight for their father's property when they grow up. This is usually through the mediation of elders of the lineage or village.

A man's house is inherited by his eldest son who moves into it at the death of his father. In cases where the house is large enough to accommodate other children some rooms are allocated to other siblings. Daughter-in-law traditionally inherits her mother-in-law's parcel of land and household items.

The idea of will is alien and today is being prepared by the elite. Traditionally, old men only share their property to their children before death. Others who also benefit from a dead person's property are those who contributed to the funeral expenses or took active part in mourning the deceased like the *adiaha urua ikpo* (a female chief mourner) a close relation of the deceased whom he chooses while alive, or adopted relatives, servants and slaves.

4.12 Law and Social Control

Social values and norms are the primary sources of order in a society devises a set of norms and values against which behaviour within the society is judged. Successive generations are taught the norms of society, albeit, its entire culture e through socialization.

In traditional Ibibio land, there were no formally written laws. Actions were judged mainly with reference to the mores of the society. These were devised to regulate and control matters touching upon fundamental human drives. Deviant behaviours in Ibibio society could be classified as follow:

Sinful and sacrilegious

Criminal and unlawful

Resulting from sickness and unwholesomeness

Alienable and unsociable

Arising from mental abnormality. (Udo,1983:129)

Sacrilegious deviant behaviour was seen as capable of invoking the wrath of the gods, like multiple births and killing of a clan's totem etc. This required disposing of the person or animal through killing and banishing or excommunication in addition to special sacrifices for cleansing. Behaviours which threaten the life chances or rights of an individual or group were seen as criminal and unlawful. These included stealing, adultery, dishonesty, witchcraft, etc. punishment for such varied according to the magnitude, of the offence.

4.13 Gender Relations

The gender of any individual is not determined by the person. It is rather an incident of birth. One is always born male or female. The gender category (male or female) plays very significant role in social interaction in the society, as many things, activities and roles are all influenced by individual gender group. Ibibio society is predominantly characterised by a patriachial and patrilineal social system with beliefs and norms legitimizing and perpetuating unequal treatment towards women. This results in expectation for every woman to be married as the ultimate goal.

Marriage is therefore an essential role for every woman and it is interwoven with motherhood and homekeeping. Thus, women as home keepers are the primary care givers to both the children and adults in the family in times of illness. Gender norms and values influence division of labour, leisure patterns and even sleeping arrangements in the household. It also influences resources allocation and financial authority within the household.

4.14 Health and Illness

Traditionally, medical practice among the Ibibio was carried out in the context of the traditional religion. The traditional religious priests also doubled as healthcare providers. The Ibibio traditional medicine involves the use of both natural and supernatural means to maintain good health and to prevent and cure diseases (Ekong, 2007). The people also believe in curing diseases without using herbs. Inform of magic, they cursed the disease to

leave the body of an infected person. Thus, medicine and magic were practiced hand in hand by traditional healers in the quest for good health among the people. In the case of herbal medicine plants and other natural substances were heavily relied on for the prevention and caring of physical ailments while magic and religious rituals were used for those suspected to have supernatural undertones (Esema, 2002; Ekong, 2001). Till today, Ibibio people are known to believe in the efficacy of herbal remedies and ritual practices in the prevention and cure of certain diseases. The notion of the germ theory of the aetiology of disease is alien to Ibibio culture. In Ibibio land, it is believed that diseases are caused by a person's lifestyle/habits of consumption and supernatural factors. In Ibibio cosmology, animals, insects and other natural elements do not cause or transmit diseases except when they are used by the gods as a punishment against a person, or group of persons.

Illness behaviour, defined as the 'way in which symptoms are perceived, evaluated, and acted upon by a person who recognizes pains, discomfort and other signs of organic malfunction' (Mechanic, 1960), is influenced by the social organization and cultural beliefs of a community. The Ibibio people, just like other ethno-cultural groups in Nigeria, attribute disease and ill-health to natural, supernatural/mystical and hereditary factors (Izugbara, Etukudo and Brown, 2005). Certain diseases, such as malaria, diarrhoea, dysentery among others, are often attributed to natural events such as drinking unclean water, fatigue, insect bites, living in an unhygienic environment and ingestion of poisonous substances. Thus, natural causes of disease parallels the biomedical model to the effect that it is widely accepted that germs can cause diseases. Perhaps this led Abia-Williams (1994) to posit the existence of germ theory of disease in the ethno medical system of the Ibibio people. Some diseases (such as epilepsy, asthma and measles) are thought to be caused by heredity, and are transferable from parents to their children. For example, the Ibibio believe that mental problems are caused by heredity. This ethno medical belief affects social relations because the Ibibio will not marry from or into a family that has a history of mental problem because of the belief that the children produced by that union will suffer from this sort of illness, since it is transferable from parents to offspring.

Furthermore, certain diseases are linked to supernatural or mystical causes, such as witchcraft, ancestral spirits, curses, infraction of taboos and incest among others. Witchcraft,

in particular, is considered an ever-present cause of disease conditions, particularly those diseases that are considered defiant towards simple remedies, including bareness, mental illness, AIDS, stroke among others. As earlier stated, Ibibio people acknowledge the existence of witchcraft. Witches are reputed for using diabolical powers to inflict harm on people. It is also widely believed that sorcery, which is sympathetic magic, can also be used to inflict illnesses on people. Sorcerers are said to reach out to their victims through the latter's personal items, such as clothes, nails or hair strands (Erinosho, 2006). Diseases may also result from the malevolent activities of neglected or offended gods, errors in rituals or infraction of cultural taboos. Ancestor veneration is an integral part of Ibibio traditional religious practice. Failure to honour them through periodic sacrifices could occasion dire consequences for a lineage or any of its erring members, and affliction of a serious illness is one of such consequences.

Among these factors, explanation of disease conditions based on supernatural aetiology is the most dominant and widespread among the Ibibio people. Natural factors, which are central to biomedical theories of disease, occupy a marginal position in Ibibio health beliefs. The ultimate explanation for incidences of disease is rooted in religio-magico explanations. Witchcraft, sorcery, ancestral vengeance and other mystical forces are often invoked as the real explanations for disease occurrence even in the face of empirical evidence linking the disease with natural factors. The case of a dog bite (a natural factor) can be explained to be as the result of witchcraft machinations (supernatural factor), so that the natural factor is explained by means of the supernatural thereby making the latter the ultimate cause.

In the local culture, when Ibibio people attribute disease to supernatural causes, they mean that the condition is inflicted on the sufferer by malevolent spirits associated with witchcraft. The operation of these spirits is mediated by human agents, who target people they envy or towards whom they bear grudges. They are believed to be close relations of the victim, hence the Ibibio saying, *mkpo ato ufok anam owo* (people are harmed by those close to them). It is also widely believed that people can diminish the vital force of a fellow man through the use of such elements as roots, herbs, animal and mineral substances. Therefore, upon sensing any symptoms of bodily discomfort Ibibio people will immediately suspect that

someone has used some hidden means to inflict illness on him or her. They will then seek out a local diviner or 'witch-doctor' to ascertain who the agent behind their affliction is and what are the modalities for addressing the condition, including the appropriate therapy.

The proliferation of modern healthcare services notwithstanding, the majority of Ibibio people still rely on their indigenous healthcare system to meet their health needs (Ajala and Nelson, 2010). Indigenous medicine (known as ethno medicine) is part of the informal health sector in modern Nigeria. Among the Ibibio, and most ethnic groups in Nigeria, indigenous medicine constitutes a rich blend of dynamic medical knowledge, ancestral experience and localized methods and practices. Although ethno medical practice in modern Ibibio society incorporates elements of western medicine, it still retains its traditional outlook, and is grounded in local notions of social relations. For example, in Ibibio ethno medical practice disease conditions are diagnosed and explained using metaphors of social relationships, especially those involving the kin group. Life-threatening diseases such as ulcer, cancer and pneumonia, are attributed to the violation of the norms governing social relations. Similarly, those who offend the ancestral spirits are believed to be visited with deadly diseases, unless they adopt ritualized measures to placate the spirits and avert the danger. Furthermore, health-seeking for disease conditions among the Ibibio people is influenced by social relationships. Since health is an informational good (Izugbara, Etukudo and Brown, 2005), where the Ibibio people obtain care when they are sick, the type of treatment they uptake and the financing of healthcare are all informed by the therapeutic information he/she receives from the people in her network of social relationship. Indeed, even every day greetings and exchange of pleasantries can provide veritable opportunity for the giving and receiving of valuable health-related information (Ajala and Nelson, 2010).

The influence of local health beliefs and social relationships on health and treatment-seeking is very evident in the current study with rural Ibibio people. For example, as will be shown shortly, the people's beliefs regarding disease aetiologies reflect local ethno medical beliefs, especially the dominant mystical model of disease origin. Furthermore, their health-seeking practices is shaped by gender relations at the household and community levels, including balancing between the demands of childcare and seeking care for their health needs. It will also be observed that ethno medical therapies is the most widely used

healthcare option for the women, even though they also utilize modern medicine. The attraction of ethno medical treatment for urban Ibibio women lies in its responsiveness to the socio-cultural realities of their lives. The above therefore, provides an important backdrop for understanding patterns of healthcare service utilization for the Ibibio within the context of pluralism.

CHAPTER FIVE

DATA PRESENTATION AND ANALYSIS

5.1 Socio-demographic Characteristics of the Respondents

Table 5.1 below presents the socio-demographic characteristics of the respondents.

Table 5.1: Socio-demographic Characteristics of the Respondents.

S/N	Variables			Frequency	Percentages
1	**Age**	**Rural**	**Urban**		
	10-19	38	33	71	22.1
	20-29	35	41	76	23.6
	30-39	26	20	46	14.3
	40-49	58	40	98	30.5
	50-59	11	10	21	6.5
	60 and above	6	3	9	4.08
	Total	161	160	321	100
2	**Sex**				
	Male	72	69	141	44
	Female	92	88	180	56
	Total			321	100
3	**Religion**				
	Christianity	148	141	249	77.5
	Traditional Religion	63	16	69	21.4
	Atheist	0	3	3	0.9
	Total	161	160	321	100
4	**Education**				
	No formal	28	6	34	10.5
	Primary	35	20	55	17.1

	Secondary	61	64	125	38.9
	Tertiary	37	70	107	33.3
	Total	161	160	321	100
5	**Marital Status**				
	Married	92	61	153	47.6
	Single	34	34	78	24.2
	Divorced	23	50	73	22.7
	Widowed	14	3	17	5.2
	Total	161	160	321	100
6	**Occupation**				
	Student	30	28	58	18.6
	Traditional Healthcare Provider	20	10	30	9.3
	Farmers	13	1	14	4.3
	Businessmen	12	14	26	8.09
	Civil Servant	20	46	66	20.5
	Artisans	20	22	42	13.08
	Healthcare provider	22	25	29	9.03
	Medicine Vendors	10	19	16	4.9
	Unemployed	8	8	20	6.2
	Clergymen	16	4	17	5.2
	Traders	10	7	13	4.04
	Total	161	160	321	100

A total of 321 respondents were involved in the field work. The age range of the respondents was between 10 and 92. Of this number, 56% were female while 44% were male. Two hundred and forty-nine of the respondents (77.5%) were Christians, 69(21.4%) practiced traditional religion while only one 3 (0.9%) of the respondents claimed to be atheists.

Educationally, 34(10.5%) had no formal (western) education, 55 (17.1%) had attained only primary level, 125 (38.9%) had secondary level education and 107 (33.3%) had attained tertiary level of education. Seventy-eight (78) respondents representing 24.2% of the respondents were single, 153(47.6%) were married, while 73 (72.7%) and 17 (5. 2%) were widowed and divorced respectively. Occupationally, the respondents included artisans, housewives, civil servants, students and business men and women.

The study participants represented a wide spectrum of the study population. The findings of the study therefore would be fairly representative of what obtains in the study area.

5.2 Local Knowledge and Etymology of Malaria Terms

Generally in Ibibioland, malaria has many local terms and concepts such as *uto enyin* as shown in table 5. 2.

Table 5.2: Local Names for Malaria in Ibibioland

Names of Malaria	Meaning
Uto enyin	Yellow eyes/colour
Akpa mbubi adakada ubahasen	Die in the evening resurrect in the morning
Akom/Aran	Oily deposit
Udongo ukang nnyin	Indigenous disease
Ufiop idem	Fever
Uto enyin ekpo	Malaria caused by ghost /supernatural forces
Nkpontokeyen/atuak atuak/eka abasi	Malaria in children, which causes childhood convulsion

Uto means yellow and *enyin* means colour / eyes. Taken together *uto enyin* therefore, can be translated as, 'yellow eyes' and its used to refer to any sickness that brings about yellow discoloration of the eyes. According to a respondent:

> *Ekot enye uto enyin sia adoho enye ama umum fien, enyin mfo ediba uto uto. Ikim fo nko ibighi isana aba, edinyung aba uto uto.Even ikpa idem fo ayanie etuk ufongo uto uto enyin. Ukpu use mme nwup uto enyin uyie idem, aya kit ke*

se ibiwuo ke idem fo abi ba ndana ndana. Edeme fo nko, aya umum, adiba nte akedia ndisi adan.[1]

Translated:

It is called Utoenyin because when you are infected with it your eyes will turn yellowish. Your urine too, will not be clear again. It will have a yellowish coloration, even your skin will be slightly yellowish. If you use the anti-malaria herbs to bath, you will even see that what come out of your body will will not have a clear colour. Your tongue too will be affected; you will feel as if you licked uncooked oil

.

The yellowness of the eyes/urine is believed to be caused by deposits of yellow substance from the sun, dust and/or yellow food items like oil and yellow fruits. Thus, it is believed that the required treatment would be to wash off the yellow matter that causes the discoloration. This informs the idea of washing/bathing as one of the first aid against malaria. The washing thus implies cleaning off the yellow substance, both inside the body and on the skin. In the words of a respondent in Ikono:

Nsido uto enyin emi, idoho owo ama adia ndana ndidia mme okposong adan. Amakut eben anye abo, sokoro ibohoke enye. Amanam utom ke essien, eyo amia enye, onyung enwek ntong. Uto enyin ama adi, enyen owo okpuho, akpuse enye ikpa idem, ibaha danga akpeba, akpetok ikim, abiot lipton. Se enye abinam ado adiyet afid nkpo ado, mme abi yie yie, anwong odung, mme akakebe man ado anwam enye atok afid uto enyin ado asio[2].

Translated:

What is this malaria? Is it not when somebody eats reddish food and eats too much oil? When he sees pears he collects and orange will not pass him by. When he works outside, the sun beats him and he is also exposed to dust. When malaria comes, his eyes change colour. If you look at his skin, it does not look normal. If he urinates, it looks like Lipton. What is needed is to wash off all those things whether by bathing, drinking of root or enema to enable him urinate out the whole malaria.

Another respondent recounted his experience through narration of memory of malaria encounter at his youth age in an urban community of Uyo also responded that :

Uto enyin ado common udongo adoho isongo adikok enye. Idaha nkedoho etok eyen, se ekam mi akesenam akedo adinsio mien ubahausen idaha utin

asok asiahake, ayanam ami nsoro nse iso utin anye anyet idem ye red key soap. Akpedo ntokeyen se imana ikpoon, eya esin Epsom salts ke mmong oro. Ayakid nte afid uto enyin ado awuo udot udot nte eyet ekwong. Ema ema afo adiyayaka ntom. Ema ema ado, eya eben tea ema eketem lipton ye ebana okoneyo enim uno afo anwong. Uyie idem ado aya eyet uto enyin ado asio ke ikpa idem fo, tea ado aya uyet esit idip. Ado ayanam afo aka ikim ndien ndien. Uto enyin ado aya anyong, afo akan adia nkpo, sia adoho uto enyin itanga ibanga mi ama unam, ubuho ukan ndidia udia[3].

Translated:

> Malaria is a common disease that can easily be cured. When I was small what my grandmother used to do was to bring me out when the sun is rising. She will make me to squat down and face the sun while she bathes me with red key soap. For the older ones they will put Epsom salt in the water to bath. You will then see all the malaria coming out slimy as the saliva comes out of the washing snail. When they finished, one will feel very light. Then they will give me tea made with lemon grass and Lipton boiled the previous night to drink. The bathing has cleansing power that neutrilised skin colouration from inside. You will then be urinating frequently. The malaria will be gone and your appetite will come back, because this malaria we are talking about, when it attacks you, you cannot eat very well.

Malaria is also known as *akom/adan (*adan means oil. Episodes of malaria referred to by this term, are believed to be caused specifically by oil). According to a respondent in Nsit Ibom L.G.A., *Adan akpeduk owo, ekpebisobo yak ofon, ana ekwok idip yak ayakka, emaema ediyie ye nwup or enwenwek ufiop nwup eteme do, mbemiso adimen ibok ndomokiet*[4]. Translated "*If oil enters anybody* (i.e. if anyone suffers from malaria caused by oil), *to treat it properly, you will have to purge to lighten up the stomach, then you bath with leaves or inhale the steam of the boiled leaves before taking any drug*.

Another term for malaria is *akpa ndubi adaka ada ubahasen (*commonly shortened as *akpa ndubi).*Translated, to mean 'die in the evening and rise up in the morning', being a description of the bouts of fever occasioned by malaria infection which is more acute in the evening, through the night, but seems to give the patient a reprieve in the morning. It is therefore seen as a minor health condition that does not affect a person's chores duties to a large extent. It is believed that since it is more serious in the evenings when most must have returned from their daily engagements as farmers and artisans. The person is expected to be

capable of performing his duties for most parts of the day, even when he has malaria fever. This belief informs the timing of some treatment regimes. Oral remedies are often taken in the evenings with the aim of reducing the intensity of the fever at night and help 'soften' the malaria residue in the following morning.

The washing occurs in the morning, which is aimed at cleansing both internal and external parts of the infected body against the serious 'bout' of malaria action believed to be caused by the treatment held at the preceding night. The concentration of the malaria 'matter' is believed to have been stirred up by the fever and having been softened by the oral concoction taken the previous evening; it is easily cleaned out of the system and from the skin. According to a community leader in Nsit Ibom:

> *...Se enying mbufo ekokot enye, ado kpa nkpo kiet. Ado udongo ukang nnyin. Nyin ikemeke adifehe mboko anye. Se ifon ibanga enye ado ke tongo ke ini mme ete ete nnyin, usung se ekama enwana ye enye ewak. Akpe anie uto enyin, nte isukko itie mi, ofim osuk otuk mbio mfen danga utuuk fien, ado etise, afo ametongo inyeng nte nsek eyen. Se ebinam ado, eya eke ko mfang isim eyiot, mba enang enang, mme nkpe mango ye mme mfang mfen, nkemeke adiyara ofut mmo mi. Eya etem ofid mmo ke akamba eso. Ema eteme, eya edad ofong se idopo ufuk fien. Afo aya okupo eso oro, akama enye. Ufiop oro aya umia, utippe ikpo Danga ikpo oro awuo oro, asanga ye uto enyin. Ama ediyie idem ama, ikpa idem fo edimemem, odono nmte eke nsek eyen. Afo ayakut ke ofut ufiop idem ye edinyenyen oro aya onyong.*[5]

Translated:

> …whatever name you call it, it is the same thing. It is our own disease that we cannot run away from. The good thing about it is that from the time of our forefathers, there are many ways of tackling it. When you have malaria, as we are sitting down here air is touching every other person as it is touching you but before you know it, you start shivering (demonstrates) like a baby. What they will do is to go out and pick isim eyiot leaves, mba enang-enang (Hippocrates africana), mkpa mango (bark of mango tree) and other leaves, I cannot reveal them all here. They will boil all of them in a big pot. When it is put down you will sit close to the pot and they will cover you with thick clothes. You will open the pot and stir it the heat will then beat you and cause you to sweat. As the sweat is coming out it comes out with the malaria. After you have bathed your skin will be so soft and smooth like a baby's own. You discover that all that fever and shivering is gone

As *udongo ukang nnyin* (indigenous disease/ our native disease), it is believed to be an indigenous disease that is not preventable but with its treatment being a common

knowledge in Ibibio land. A respondent stated that *malaria is indigenous to this our area. You can't prevent it no matter what you do, its cures are common knowledge and abound everywhere*[6]. Still another respondent emphasized that*; any salt consuming* (i.e.normal/living) *person can have malaria*[7]. The inference here is that malaria has been well known to the people and different local therapies have been developed to combat it. These local therapies are believed to be potent enough to deal with any episode of malaria without recourse to orthodox medicine. Malaria's indigeinity is linked with the weather and environment. Since malaria cases are more rampant during the rainy season, it is believed that climatic factors like cold, contribute to its resilience. As such, it is widely held that malaria will exist, and afflict people, as long as the rainy season comes in its time. Also the people believe that exposure to sunlight and dust cannot be avoided during the farming season, which invariably coincides with the outset of the rainy season. Manual labour, which people engage in, during farming is another reason people believe that malaria is indigenous since it is widely held that the stress of farmwork also makes one susceptible to malaria attacks. It is also linked to nutrition on the grounds that, the available resources, due to climatic conditions which favour the thriving of specific plants at different seasons, restrict people to particular diets at such times.

When malaria is perceived as *ufiop idem,* (fever), it is believed that the best course of action is to bring down the body temperature of the patient. Bathing and drinking of cold herbal tea is expected to suffice as treatment for such an episode of illness. According to a respondent,

> *Owo ama enie ufiop idem, ana ayem usung enam idem amo adenge. Mkpo se ifon ikan edinam ado, akpedo etok eyen, men enye wuo esien ata ubahasen, mbemiso utin asiakka. Yem ukom mme mboro ema ekekpikke, sio awong esid ado nnyimme mmong ado duok eyen ado. Nam usuk mmong ado aduk eyen ado inua nam enye emen. Sana enye yak, out bop enyin utat,ayabo ke ikot idong. Ama Akaka ikot akang ket mme iba, ufiop idem oro onyong….Akpedo akamba owo, ama eyie idem ama ubahausen, yak anwong mfang, ado yak ado ndedeng. Ado aya denge enye tongo ke esit idem. Ama aka ikot itok ikim ukpa ifang, aya ono enye unwam.*[8]

Translated:

> When one has fever, he has to find a way of getting his body to cool down and the best way to do that is, if it is a child, bring him out very early in the morning, before the sun rises. Look for a plantain or banana stem that had been felled down, cut it and remove the outer layers. Take the innermost part, crush it and pour the water on that child. You will try to make some of the water to enter the child's mouth and make him drink it. Leave the child for some time. Before you can close your eyes and open, he will say that he is pressed to stool. Once he passes stool once or twice, the fever is gone… If it is an adult, after bathing in the morning, let him take herbal concoctions, but let it be cold. That will cool him down from inside. When he stools and urinates a few times, he will be relieved.

A variant of malaria is also sometimes referred to as *utu-eyin ekpo* (malaria caused by ghost/spirit). Reference to this term suggests that malaria is caused by ghosts, which is an element of preter natural. Such malaria is severe and seriously threatened those affected. This term is used when a particular episode of malaria is suspected to have gone beyond the ordinary. Mostly typhoid fever is often classified as *utu-eyin ekpo.* Though *uto-enyin ekpo* is used bio-medically to refer to typhoid fever, the local belief is that this type of malaria is a more acute form of malaria that is caused either by spiritual attack, by one's enemies or as a punishment for wrong doing. This informs the resort to spiritual remedies from native doctors and in recent times, faith healers/prayer houses. In Ikono rural comunity a respondent commented:

> *Idaha nnyin ikisehe ibo ke ifot ase ano owo uto enyin, mbia ibok mbakara ekebo ke idoho akpaniko. Idahemi mmo edikana ebo ke ntoro ke ado…Thyphoid amo etanga ebanga mie? Utu ke ekpebo ifot ata, amo ebo ata ifot, ado nnyin imidiongo ibo kea fid awuongo kpa nkpo ket.*[9]

Translated:

> When we used to say that witches can afflict one with malaria, orthodox medical practitioners said it was not true. Now they have turned round to agree with us that it is so… this thyphoid that they are talking about. Instead of saying ifot ata (eaten by witchcraft), they say ata ifot,(thyphoid) but we know that it means the same thing.

Among the children, a number of local terms point to the people's understanding of malaria references in child illnesses. For instance, *atuatuak or nkpo ntok eyen* refers to malaria that occasions convulsion in children. This is expected to be dealt with by herbal extracts of *utime nse* or *ntok idot nkong(obiok obung ndisa)*. In some of these cases incantations are made to drive away the evil spirit that is frightening the child to make him/her convulse in fear.

Eka abasi refers to any episode of ferbrile malaria associated with preter-natural causes. Such malaria are said to be caused by spirits or witchcraft. Such malaria incidence will require spiritual cleansing as remedy. There are specialists who are always consulted in such cases. According to a nursing mother in Nsit Ibom rural;

> *Nkeben eyen emi ndi ufok ibok yak edino usobo. E test enye ebo ke anie malaria. Mmebo ibok se mbino enye. Nkeben enye ndi mi koro akenie nkanga ufiop idem. Akpedo asong odudu odo, enye ado idoho nkpo ufok ibok o. Iminie mme owo se idiongo nkpo ibanga uto ando… Anye ado akpenam etok eyen, afo ayadiongo. Eyen ado aya atongo adinyaan ubok ye ukot, enyin amo aya turn, afo adikut mfia ado ikpong. Ama atippe ntoro, ubuhu uda ubo udodoko, aya aben eyen oro ebine mme eka ado ediongoke se esenam.ammo eya ennuak mfang, mmme utimme nse o, mme obiok obung ndisa, mme mfang mfen, ammo ediongo.eya eben eduok eyen ado, enam enye anwong usuk.nanga esuko enam do, ammo ediongo se ebitang inno spirit ado yak esana eyen ado eyak.*[10]

Translated:

> I brought this child to the hospital for treatment. They have tested her and say she has malaria and I have collected the drugs to give her.I brought her here because she has ordinary fever. If it is the serious one, that one is not a hospital case o. We have people who specialize in treating such… that one if it affects a child you will know. The child will start stretching the hands and legs, the eyes will be turning you only see the white. When it happens like that, you don't wait to be told, you will just take the child to any of those mothers who know what to do. They will squeeze the herb, whether utime nse o, obiok obung ndisa(chromelena odorota) or any other herb, they know. They will now pour it on the child making him swallow some of it. As they are doing this, they know what to say to the spirit to make it leave the child alone.

The use of the categories*; ordinary fever* and *serious one* to describe malaria by this respondent is significant. The Ibibio word translated as ordinary, *nkanga*, connotes emptiness, while the word for serious, *osong odudu*, connotes powerful and strong. This implies that when they are talking about ordinary malaria, they refer to a mere illness that has no depth or spiritual connotation. The "serious" one on the other hand refers to an illness that is powerful, i.e. has the power to kill or destroy its victim because it has its strength rooted in the supernatural. The efficacy of (orthodox medicine) is believed to be limited to the realm of the ordinary or 'empty' illness. It thus cannot handle the strong one which transcends the realm of the ordinary. The serious one therefore, it is believed, should be handled by spiritual means, which makes a case for the patronage of traditional healers.

Out of the above mentioned local terminologies used to describe malaria among the Ibibio, four could be said to represent the local beliefs with regard to the etymology of malaria:

(i) *Uto enyin*, which is related with colour, is believed to originate from depositions of yellow matter through the skin, when one is exposed to the sun or inhales dust,

(ii) *Adan*/*akom*, related with nutrition. It is believed to originate from a person's eating habits.

(iii) *atuatuak*/ nkpo ntokeyen, which is linked with bio-physical actions(convulsive episodes), and spiritually induced body temperature. This is locally associated with febrile illnesses, and

(iv) *uto enyin ekpo*, linked with spiritually induces anaemia, associated with preter-natural forces.

Local knowledge of malaria in Ibibioland runs contrary to the western bio-medical ideas of the disease, which present malaria as an infectious and killer disease. Among the Ibibio, malaria is known as a minor ailment that can be easily treated. Some extremists do not even see malaria as normal disease that forms part of life, thus, everybody is expected to encounter the disease from time to time. Forming part of this belief is the people's perception that malaria is not preventable as conceived in local term-*odu uwem owo*- meaning that every living person must have malaria. As malaria is seen as indigenous disease, it further informs

the use of local remedies. Similarly it is believed that there are different kinds of malaria and each has to be handled using different care systems. As opined by a female participant in one of the FGD sessions in Nsit Ibom, there is a malaria *from the dark world, believed to be caused by God. Another type of malaria is the one not from God, that one seriously disturbs its patients*[11]. Another male respondent in an urban community of Ikono commented thus: *malaria is of different types, there is ordinary malaria (nkanga uto enyin), which can be treated by taking simple herbs. There is also the bad one, caused by forces (uto enyin ekpo).The bad malaria often kills.*[12]

5.3 Ibibio's Attitudes towards Western Ideas of Malaria

Among the Ibibio, local knowledge of malaria runs parallel to the western bio-medical ideas of the disease. The local beliefs about malaria include that: malaria is a minor ailment that can be easily treated. Some cultural extremists do not even see malaria as a disease but as a normal part of life and everyone is expected to have it from time to time. It is also believed that malaria cannot be prevented because *odu uwem owo (*a living person) must have malaria. Malaria is an indigenous disease that is better treated with local remedies .According to a polytechnic student in Uyo urban (earlier quoted); *there are very many herbs and roots that have been discovered to treat malaria. You choose the one that suits you. All this swallowing of this and swallowing of that, does not help*.[13] In agreement with this is a male respondent (Ikono Rural) who is of the opinion that, *malaria is our own disease, the herbs you need to treat it are behind your house*.[14]

Malaria is of different kinds and each has to be handled differently. A female respondent in Nsit Ibom opines, *the malaria from the dark world, we have it, the one from God, we have it, the one from this world, we have it. The one that is not from God, that one will disturb you.* [15]. Implying that ordinary malaria is 'an act of God', i.e a natural occurrence and invariably cannot be avoided. Therefore it holds that it is only when evil forces afflict a person with malaria, that it could kill a person. A male respondent in Ikono urban commented thus; *malaria is of different types, there is ordinary malaria that you just take small herb and it will go. There is the bad one, caused by forces. That is the bad one that when it affects somebody, it will kill*.[16] It is generally believed that the different types of

malaria are caused by different factors and each typeshould therefore be treated differently. The response to any episode of illness depends on the suspected cause. If an episode of illness is suspected to be caused by; exposure to sun, eating of oily/yellowish food – washing (both internal and external) is recommended; stress - rest is recommended; super natural forces- spiritual solution is recommended; sugary food items- drinking or enema of bitter herbs is recommended.

These beliefs being an integral part of the culture therefore shape attitude towards the western bio-medical ideas of malaria. Since most of the respondents either did not believe that malaria is spread through mosquito bites or that mosquito bites constitute one of the several causes of malaria, they tended to hold suspect other aspects of the western ideas of malaria. People's behaviour are to a large extent shaped by their traditions, values and socio-culture beliefs. These factors influence their perception of illness and disease. Their interpretation of symptoms and how they manage the disease are also highly influenced by these variables. The people tend to rely more on local remedies against malaria. This is informed by their holistic conception of health and illness, based on their cultural milieu. The people see orthodox medicine as alien to their culture and abstract since the processes of their production are not well known compared to the traditional remedies. A total of 67 (56%) of the respondents believed that local remedies were more effective against malaria, 30 (25%) believed orthodox medicine to be more effective while 17 (14%) believed that, for malaria to be effectively cured the traditional and western medicines should be combined. Most of those in the last group believe that, the local herbs must be taken first, *you drink the local herbs first or use them for enema to purge the residue of malaria before you take the tablets* , [17] says a respondent. Still, another respondent had this to say;

> *Ofon edika ufok ibok sia mmo modo eba adisobo nnyin, ado the point is that, mme ibok mmo ese no do ikpong ikemekekeme edikok malaria ofid ofid.Adan a? Ekeme adiyet adan nsio nnyin ke idem? So akpebi isio aran unyong, ana afo eyie mme ebi kekebe nwup ukang nnyin.*[18]

Translated

> It is good to go to the hospital since they are there to treat us. But the point is that these drugs that they give cannot on their own cure us totally of malaria.

> What of the oil, can they wash the oil from us? So to get rid of the oil, you have to bath (steam bath) or take enema with our herbs.

The popularity of indigenous medicine owes to the facts that it is indigenous and the people can readily identify with it. Orthodox drugs on the other hand are seen as inferior to the local remedies due to the fact that, they are believed to have lost their medicinal value in the course of production. These beliefs and the attitudes emanating therefrom cut across the urban-rural divide, though more of the respondents were forthcoming in expressing them in the rural study sites than in the urban sites.

5.4 Aetiology and Local Explanation of Causation of Malaria

Aetiologically, each of the four manifestations is linked to different causes. Thus, *uto enyin* is believed to result from exposure to sunlight and dust that is the reason it is believed to be more prevalent during the farming season, when people need to work under the sun for prolonged periods of time. *Adan/akom* is believed to be the result of excessive consumption of oil/ oily foods, while *atuatuak/nkpo ntokeyen* are linked to preter-natural forces like *eka abasi* (unidentified forces- spiritual mother) and *essien emana*(spiritual age grades)as the cause. Witchcraft forces are believed to be the cause of *uto enyin ekpo*.

The above local causations of malaria are age long among Ibibio, and it is orally transmitted from one generation to another. However, there exist different media of information on malaria. A total of 81(67.5%) of the respondents got all information about malaria from family members, friends and neighbours, especially in the rural areas. Only 39 (32.5%) of the respondents claimed to get information about malaria from sources like mass media or othordox healthcare personnel. While the interpretation of words may give rise to action and feeling, local diagnosis of malaria arises from inferences drawn from local names given to malaria in Ibibio land, e.g.*uto enyin, udongo ukang nnyin, akpa mbubi, akom, atuatuak, and utoenyin ekpo*. Diagnosis is mostly based on the symptomatic or physical symptoms such as yellow discoloration of the eyes and urine, fever, headache, high body temperature, loss of appetite, body itching, pains, nightmares, insomnia, and constipation among others. A respondent observed: “whenever anyone is sick or complains of discomfort, the first question he will be asked is ‘how long is it since you last treated yourself for

malaria?"[19] As noted in the field during the observation of malaria episodes, there was a common knowledge of how an individual feels health wise in Ibibio community if attacked by malaria. The occasion of ill-health due to malaria is often measured from the eyeball. When the eyeball looks pale and yellowish, accompanied by body fatigue and passing of yellow urine, manifestation of malaria is real. Thus, part of the sick role is to inform the infected that he or she, *anie uto enyin*, meaning that the person has yellowish disease. To be sure, the body temperature will be measured using the back of the palm placed on the neck, forehead or chest of the infected as the improvised local thermometer. Table 4.3 below presents the frequency of different modes of diagnosis of malaria in the study communities.

Table 5.3: Modes of Diagnosis of Malaria

Mode of Diagnosis of Malaria	Urban	Rural	Total	Percentage
Symptomatic/ physical Diagnosis	150	123	273	85
Blood test/hospital	11	37	48	15
Total	161	160	321	100

Of all the people observed of malaria episode during the fieldwork, only 15% of the respondents were diagnosed of malaria through medical tests by modern health care professionals. The remaining 85% were self-diagnosed or by family, friends and neighbours, based on the above procedures.

Knowledge of causes of malaria, though varied, is influenced by local perception of malaria. According to a respondent in Mkpat Enin urban,

> *Ndiongoke o! Ebo ke obong. Ami ndiongoke. Nsena ke idak net amo eboho yak ena. Window ye usung ufok mi afid mmedong net, nkannkuk mi ado ami asana, so ndiongoke idaha obong akandomo. Ukuere se ndiongo ado ke ini nkeniehe malaria akedo ini utom inwang,mma nam okposong utom ke eyo nnyng nwew ntong uwak uwak. Idem akedimbiak yak nka ufok ibok, ekenam test ebo ke mmenie malaria.*[20]

Translated:

> I don't know-oh! They say it is mosquitoes. I don't know. I sleep under the net that they say I should, my window and doors are all netted and my environment is clean. So I don't know when the mosquitoes bite me. All I know is that at the time I had malaria it was farming season and I had done much hard work under the sun and inhaled a lot of dust. Then when I became ill, and went to the hospital, they conducted tests and said that I had malaria.

It became obvious that though she went to the hospital, she does not believe that mosquitoes transmit malaria. Rather from her response, it can be safely deducted that she believes that hard work, exposure to the sun and inhalation of dust cause malaria.

Forty-eight percent(48%) of the respondents believe that malaria is caused by eating habits/lifestyle, while 16.6% are of the opinion that it was caused by mosquitoes while 35% believe that mosquito bites constitute just one of the causes of malaria. Others attributed malaria to witchcraft, eating of yellow food items, exposure to sunlight, inhalation of dust, stress, excessive consumption of sugary foods/soft drinks, and exposure to cold/wet weather. It is generally believed that most of these factors combine in different variations to cause each episode of malaria, even in the same individual. Table 4 below shows different causes of malaria in Ibibio land.

Table 5.4: Identified Causes of Malaria

Mosquito bites
Witchcraft
Eating of unripe fruit
Eating yellowrich food item
Explore to sun light
Explore to dust
Excessive consumption of oil
Hard work/stress/fatique

5.5 Local Therapies for Malaria in Ibibioland

Among the Ibibio, there exist a wide variety of therapies used against malaria. These include,

(a) local herbal remedies; prepared with either a single herb or a mixture of two or more herbs.This can be taken as herbal infusions made by soaking/ boiling the herbs in water and taking as tea, either hot or cold. Herbal extracts are derived by pounding the leaves into pulp, mixing with the required quantity of water and filtering out. The extracts are either taken as drinks or used for enema. These are mostly home made. Packaged herbal products(especially anti-malaria) are part of recent developments in ibibio ethno medical system and are more readily available in the urban centres.

Table 5.5: Selected Herbal Anti Malaria Remedies in Ibibioland

Herbal Remedies	**Mode of preparation**	**Mode of Administration**
Bitter leaves+fever plant+Guinea black pepper leaves	Extract	Chemical
Eggwoman leaves + local gin	Infrusion	Drinking
Mba enang enang+siam weed+*isim eyiot*+Mango tree bark	Boiling	Steam bath
Vinegam (+Local gjin)	Boiling/ Extract/ Infusion	Drinking/Enema
Water leaves	Extract	Drink/enema
Lemon grass+Lime(+Local gin)	Infusion/Boiling	Enema/drinking
Brazilian Tea Leaves	Extract	Enema/drinking
Fever plant leaves	Extract	Drinking
Obiok Obung idisa/ntok idot nkong (+local gin)	Extract	Drinking/Enema

Plate 5.1: Some of the Items for Herbal remedies against Malaria

a. Lime and Guinea black pepper seeds (Field work 2011)

b. Bitter leaves, Fever plant leaves and Guinea Black pepper leaves (Feild Work 2010)

Plate 5.1 A child being given enema

Source: Feild Work 2011

(b) Orthodox drugs which are mostly procured from Patent medicine Vendors (PMVs) and unlicensed street vendors. These often give arbitrary drug dosages to their patrons. They often " mix" the drugs and it is not odd to see more than one brand of anti malaria drug in the prescribed dosage.In the ubarn and semi-urban centres, they are also purchased from Pharmacy shops. Majority of the people use these without professional prescriptions. Some of the people get their drugs through hospitals and these are duly prescribed by trained health care professionals.

(c) Faith healing which is a fast growing sector of the ethno medical system in Ibibioland, in recent time The people, especially in rural areas, patronise pastors and prophets/ prophetesses, who prescribe spiritual "assignments" for their patrons as cure for their ailment.

(d) Traditional Healers, who are mostly patronised when any episode of malaria is suspected to be spiritually indused. Their modes of operation include rituals and sacrificed to appease gods/ ancestors or ward off enemy attacks.

(e) Still a lot of the people creatively combine these different therapies or aspects of them, depending on the perception of the particular episode of malaria.

5.6 Choice of Therapy and Pathways of Care in Malaria Management

Malaria is seen as an indigenous disease that needs and responds faster to indigenous medicine. As noted by a key informant: *malaria is our own disease, it does not need orthodox medicine*. He concluded with a rhetorical question: *if you go to the hospital for malaria, what will you do when you have a disease that requires surgery?*[21] Although 91% of the respondents believed that malaria is life threatening, most of them were of the opinion that if treated promptly with the local herbs, there would be no need for orthodox medicine. They also believed that fatality sets in when malaria is left untreated for long. Four (3.33%) of the respondents believed that fatality is caused by the use of orthodox medicine instead of herbal remedies. For instance, a respondent in Uyo rural opined:

> *Mboho ke edika ufok ibok ifonno. Odo aba mme mfina ayama ufok ibok ado malaria idoho ket ke otu mmo. Even ke edemesa ufok mfo, nwup abanga se ekeme edida n treat malaria. Ndien nsinam afo adika ufok ibok? Ami mboho ke ufok ibok ifonke, but ekpeyem usiakidem or mme anie accident, afo aka ufok ibok, ado idoho for malaria. Nte okutde mi do, ndo fifty-four years ado akanam, nkaha ufok ibok. Neke tim nse, nsinam idem? Nsuk mba idem nsong nsong. Ndohoke nte nkemeke ndika ufok ibok tutu mkpa. Mkpenyene udoho se iyomde ufok ibok, nyeka, edi idighi eke malaria. Ndusuk mbio emi mbufo ekutde nte eka ufok ibok mi, yak udokko,emaedadat ibok nkan nnyin ke ufok. Mmo eka do man nkpo okpotibe ono mmo, owo ndomo kiet edidoho ete, akpana mmo ekeka ufok ibok. Edi, edi ke ufok ibok ke mmo esikpanga koro mmo emaeka, doctor ayabo ke mmo enid mmong.Ema enyung esin mmong oro, do ke owo oro ebikpa, koro uto enyin iyeme mmong. Edi udongo nkang nnyin oyomde ibok ukang nyin, idighe ibok mbakara.*[22]

Translated:

> I am not saying that going to the hospital is not good. But there are problems that require medical care but malaria is not one of them. Even by the side of your house, the herbs are there, that you can use and treat malaria. Why then do you go to the hospital? I am not saying hospital is not good. But if you need surgery or you have accident, you go to the hospital, but not for malaria. As you see me, I am 54 years old and I have not been to the hospital even once. Look at me very well, what is wrong with me. I am very strong. I am

> not saying that I will never go, till I die. If I have a sickness that needs the hospital, I will go, but certainly, not for malaria. Some of the people you see going to the hospital, let me tell you, have already taken local remedies at home. They only go there so that if anything happens, no one will say they should have gone to the hospital. Yet it is in the hospital that they die because when they go, the doctor will say they need water (drip) and when they put the water that is when the person will die because malaria does not need water. It is a local illness that requires local remedies and not the white man's drugs

Thirty-eight percent (38%) of the respondents were also of the opinion that malaria fatality can only be caused by witchcraft or other supernatural causes.

Malaria is seen as a normal sickness, with the belief that a person who does not have occasional malaria attacks is dead. *Death* in this sense refers to an abnormality. Thus, malaria is seen and accepted as a part of everyday life. Indeed, a person is actually expected to have malaria attacks from time to time. Due to these beliefs, the Ibibio have common knowledge of malaria and resort to local means of treatment. The community engages mostly in symptomatic diagnosis of malaria which is personally done or by family members/friends and neighbours of the infected person(s). Only a few of the respondents that claimed to have had malaria or had a close relation who suffer an attack claimed to have been diagnosed by trained medical personnel at the hospital through blood test.

The symptoms of malaria, identified by respondents varied. They include yellow discoloration of the eyes/urine, paleness of the skin, headache, generalized body pains, cough, catarrh, body itching loss of appetite, excessive sweating, constipation, excessive thirst, nightmare, stomach upset, high body temperature and vomiting. Of all the symptoms of malaria, the yellow discoloration of the eyes and urine seemed to be the most significant. Hence, the name, *utoenyin.*The paleness of the skin is also locally classified as yellowness-*ototongo* (which is a derivative of the word, *uto*).

At the onset of some of these symptoms, the infected person(s) resume disease culture, which includes a number of inabilities such as not eating, sleeping, walking, playing, and other incapabilities suspending normal active practices and behaviours. As these inabilities create fear of economic loss, dissociation from the community functions, bewitch and possibility of death, both the infected and the relation engages in sick role including sourcing

for care and supporting the patients in his/her sick behaviours. The conditions open up a pathway of care which is set in the following stages:

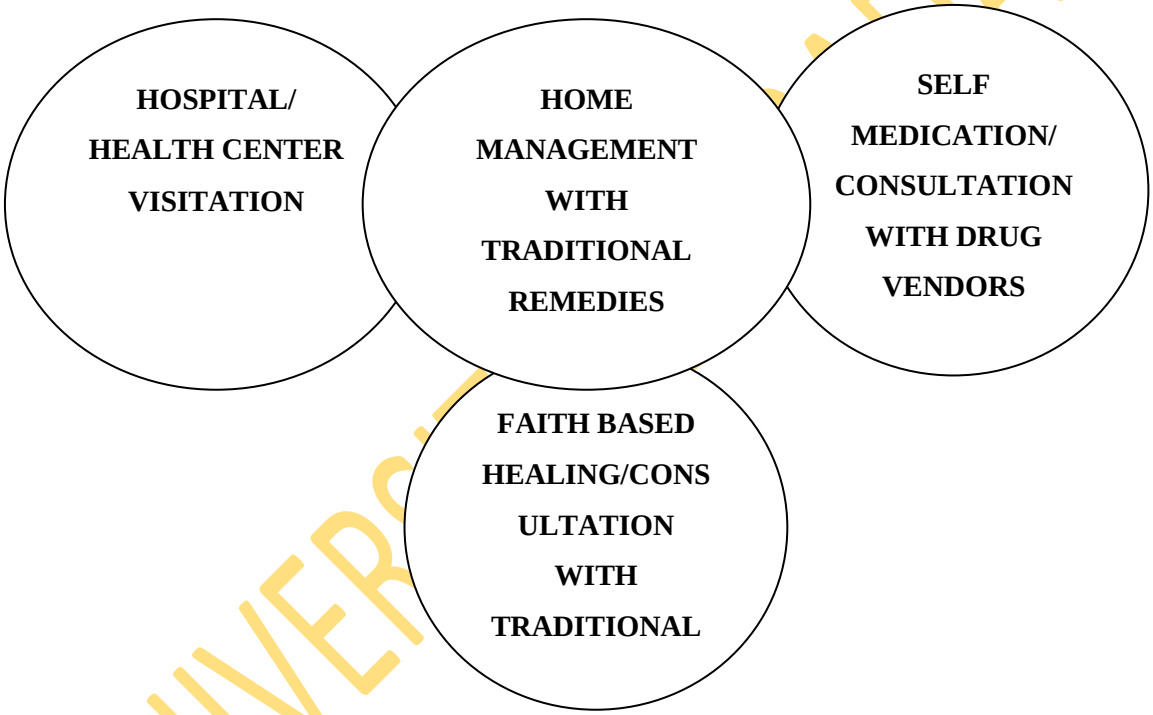
Stage 1: Home management with the use of traditional remedies

Stage 2: Self medication /Consultation with drug sellers

Stage 3: Consulting faith-based healing/traditional healers/ herbalists

Stage 4: Consulting Hospitals/health centres.

Figure 5.1: Pathways of Malaria care in Ibibio land.



Home Management with Traditional Remedies

At the onset of malaria symptoms, the patient begins to exhibit disease culture. Here, the patient takes any or a combination of a wide variety of traditional remedies. As explained by a respondent;

> *Usobo uto enyin isongo song. Enye ado udongo ama ake baba and mme ete ete nnyin, mmo ema enyene ifiok eti eti. Mmo emaenie mme usung se enwana ye enye. Mme afo eyem edikekebe,mme edinwong nte tea, mme edi soak ke ukot mmong*

> *mme ufofop, even if eyem ediyeyie enye, emenyene uwak nwup ye orung ke mme ikot nnyin mi ekemeke ndi treat utoenyin mfon mfon. Mmo inionkeniong usung and unyeneke ndika mbine owo nteket mme itie ndibo usobo uto enyin. Usobo esie ofuri owo ediongo*.[23]

Translated:

> Treatment of malaria is not difficult. It is a disease that has always been there and our forefathers were very wise. They had ways of meeting it head on. Whether you want to take enema, drink as tea, or soak them in palm wine or local gin, even if you want to bath it, you have enough herbs and roots in these our bushes that treat malaria effectively. They are not farfetched and you do not have to go to any particular person or place for the treatment of malaria. Its treatment is common knowledge.

The above underscores the fact that though there are many traditional medical practitioners, the case of malaria is different, as the contents of, and the processes involved in the preparation of the traditional remedies are never hoarded or shrouded in mysteries. These are rather freely passed on to the next person in the family/ neighbourhood.

The first course of action is often enema. This is prepared mostly with water leaves or Brazilian tea. Other remedies taken depend on individual preferences or choices made by care givers (in the case of children).

Self Medication/Patronage of Drug Vendors

When the use of traditional remedies fails to give the patient the expected reprieve, the next action taken is the purchase and use of over-the-counter drugs. These are often bought at local drug stores. Sometimes the individual knows the drugs to buy but in some cases, he consults with the medicine vendor. The pattern here is for the vendor to give a mixture of anti malaria, pain relieving and multi vitamin tablets. The medicine vendor makes prescriptions after symptomatic diagnosis of the patient or based on answers given to his questions by the caregiver. If at this stage, the signs of recovery fail to manifest, there will be progression to the next stage of care-giving.

Consultation with Faith-Based/Traditional Healers

In the event that a sick person fails to recover after the first two stages, the next stage will then be engaged as part of the efforts to get him to recover from the illness. At this stage, since the sickness would have been at an advanced stage, the symptoms will be more severe. The belief then is that the disease is not ordinary but has spiritual roots, so the person needs to; "go home and cut down trees." The cutting down of trees in this instance being used figuratively to refer to the destruction of the stronghold of the spiritual power(s) that inflicted him with the disease. This is based on the belief that witches and wizards often use big trees as their covens. There will therefore be wider consultations and in some cases, beyond the immediate family. The choice of therapy at this stage is based mostly on the religious inclination of the patient or the head of the family. Professing Christians especially the Pentecostals will seek help from churches while most of those in the orthodox churches tend to go to prayer houses for help. Adherents of the traditional religion will most likely consult with traditional healers. There are exceptions to the rule though. In some instances, professing Christians consult with traditional healers for solution to malaria and other ailments. The traditional healers go beyond the use of herbs and roots to engage in rituals in attempts to cure the patient.

Consultation with Biomedical Centres (Hospital)

*Th*is often comes as a last resort. When all efforts to get the patient healed has failed. This accounts for patients that visit the hospital/health centres at very advanced stages of malaria infection. This occasions fatality which results in morbidity and mortality.

The stages in the pathway of malaria care in Ibibio land are not always followed serially neither are they mutually exclusive. There are cases when a patient is being treated simultaneously with traditional remedies and orthodox drugs. It is not uncommon for a person to take enema with herbal extracts early in the morning before visiting the hospital for treatment. This leads to fatalities in some instances. Furthermore, there were cases where consultation with both faith-based healers and traditional healers were done hand in hand; some people consulted traditional healers while at the same time going for prayers. While some people go through these stages one after the other, some can engage two or more of the

stages at the same time. Others still can skip any of the stages or even revert to a particular stage that had been earlier engaged during the same illness episode.

5.7 Utilization Patterns of Health Care Facilities in Malaria Management

Participants identified western and traditional medicine as the key treatment choices for malaria. Faith healing was also identified as one of the ways malaria is managed though only few people professed to relying on faith healing in malaria treatment. In Ibibio land, malaria was perceived by a greater number of people as an indigenous diseasethat does not need the use of bio-medical treatments. Majority of the people have not accepted that mosquito bites cause malaria. As such, the management of malaria based on the western bio-medical ideas is not widely accepted. According to one of the participants,

> *Akpa nkpo se enie edinam ama oyom edi treat uto enyin ado, kpuho inua ndidia. Tre edidia udia se isine adan ofuri ofuri. Dia nkong, in short, dia nkpo se idi umemem idip, koro enye aya ufaak ikot. For instance, yak ebok nkong odo kusin aran, esin isobo, dia enye ke ufiop and ke entetem enye yak akpa oboho. Yak edi ndisi ndisi.Afo oyokut nte enye anam afo otipe ibibiak enye odo udot udot. Adan odo edi oro, uto enyin oro awuo oro ke idem fo. The next thing ado afo ediyem mfang ye orung. Afo omodiongo ke malaria edi udongo ukang nnyin, ama aba ye mme ete ete nnyin mbemiso afia owo edi. Idaha ibok mikibaha, mmo ema esi use mme nkpo emi, mmo enyene odudu. Ebot idem nnyin eno mme nwup nnyin idoho ibok mbakara. So yem mme odung ye mfang idem fo edinyime dad enye, mme ebikekebe, enyenyin onwong , mme ebi dodugho. Ekpedi osong ibuot odo, bine enye ke odudu ke uwak uwak usung.*[24]

Translated:

> The first step in the treatment of malaria is for you to change your diet/eating habits. Stop eating oily foods altogether. Eat vegetable (fluted pumpkin leaves); in short, eat things that will soften your stomach because it will give you hard stool. For instance, let the vegetable be cooked without oil, with crabs and crayfish, eat it while it is hot, and it should not be overcooked. Let it be half done. You will see that it will cause you to sweat, it will feel slimy. That is the oil, the malaria oozing out of your body. The next thing is for you to look for herbs and roots. You know that malaria is our local sickness it was there with our ancestors before the white men came. When there were no drugs, they were using these things and they were potent, our bodies are made for our roots and herbs and not for the white man's drugs. So look for the roots and herbs that your body will respond to and take it whether as enema

infusion or steam bath. If it is the stubborn type pursue it strongly with more than one ways.

The above narrative, suggests that the informant believed that oil causes malaria. So the remedies he suggested were merely to combat and extract the oil. He strongly believed that traditional remedies were more effective against malaria than othordox drugs. Other people shared the same sentiments with regards to the treatment of malaria. Not masny people, it was discovered, believed that there was any other effective way to prevent malaria attacks. They employ many different methods and concoctions and mixtures in the traditional treatment of the disease. Some used herbs and extracts for enema, others infused it in local gin (kai kai) or made herbal teas to drink and some others used them for steam bath.

Local remedies and home management were mostly resorted to in the management of malaria. These local remedies were believed to be more effective against malaria. A total of 56.7% of the respondents believed that local remedies were more potent against malaria, while only 25.5% of the respondents believed that bio-medical care was more effective. In the words of a respondent;

> *Ama su suspect ke amenie malaria, sosop ka ufok ibok, kubiat ini. Ema uno usobo ke ini, aya unwam. Akpetie abo yak itreat ke ufok, you are playing with death. The herbs afo a take ke, amediongo the content? How do you know the dosage to take? So ado better afo adika ufok ibok nke treat malaria so that u diagnose properly enyung u treat.*[25]

Translated:

> Once you suspect that you have malaria, go to the hospital without waste of time. Timely treatment will help you. If you wait to treat it at home, you are playing with death. The herbs you take, do you know the content. How do you know the dosage to take? So it is better you go to the hospital for malaria treatment so that you could be properly diagnosed and treated.

Only 14.1% of the respondents believed that both were equally effective and 5% declined to give any opinion on the issue.

Table 5. 6: Effectiveness of Malaria Therapy.

Therapy	Raral	Urban	Total	Percentage
Local/traditional	120	62	182	56.6
Orthodox	27	63	80	25.5
Both	5	40	45	14.01
No idea	9	5	14	4.3
Total	161	160	321	100

In Ibibio land, home management of malaria, using local remedies was mostly preferred. Only 20% of the infected people during the fieldwork preferred to use bio-medical care. This category of people even used this as a complement to traditional remedies. In all, 40% combined both bio-medical and traditional therapies in the management of malaria.

Table 5. 7: Therapeutic Preferences in Malaria Treatment

Type of therapy	Raral	urban	Total	Percentage
Traditional	76	64	140	43.6
Orthodox	10	54	64	20
Both	57	36	93	28.9
Faith-based Healing	18	6	24	7.4
Total	161	160	321	100

Most of the respondents who indulged in this combination went to the hospital or drugs vendors, after having taken traditional remedies. Of the 64 people (20%) who preferred to use only western drugs for the management of malaria, 42(66.8%) of them got the drugs from medicine vendors while only 22(34%) went to a health facility tor treatment. In all, the emerging preferred pattern of malaria management was self medication both with traditional and orthodox remedies. Hospital treatment for malaria management was limited to a few and mostly in the urban centres due to factors ranging from beliefs, cost effectiveness, time consideration, to accessibility and availability.

Therapeutic syncretism, involving the creative combination of elements of traditional and western medicines based on the demands of each given situation was the dominant pattern of care seeking among the people. According to a male nurse in Uyo Urban;

> *What we see here ado that most people ese ema edi treat idem ke ufok ekpekere ebo ke iminie malaria. Emaekekit any of the symptoms attribute to malaria, pam! Edido suto ibok ukang nnyin esesime, enwong. Iwakka owo se ise idi ufok ibok emi for treatment. And ntokeyen ke ese eben edi mi.Uwak mbio se ise idi mi edibo usobo, ese edi when their efforts at home iminoho mmo unwam. Ado esin uwak mmo ese edi at an advanced stage of the illness. Usuk mmo, ema edi afo edikut abo ke ikidoho malaria in the first place.Se mmo esenam ado trial and erro and ado dangerous.*[26]

Translated:

> What we see here is that most people like to treat themselves at home if they suspect that they have malaria. Once any of the symptoms attributed to malaria is present, pam! They try any available traditional remedies. Only a few people come here to the hospital for treatment. And it is mostly children that are brought here. Most of those who come here for treatment come only after their efforts at home have not yielded results. That is why most of them come at an advanced stage of the disease. Some of them, when they come, you realize that it was not malaria in the first place. What they do is trial and error and it is quite dangerous.

The above is a reflection of what obtains across all the study locations. Further enquiries into why it is mostly children that were taken to the hospital for treatment revealed varied responses. Some of the people were of the opinion that malaria advances and gets more serious as a person grows, and as such, the children's own are still little or young and can easily be dealt with by taking orthodox drugs. Others tended to believe that it is because most children do not like to take herbal remedies since most of them are bitter, so the parents usually take them to the hospital for treatment. Others still, were of the opinion that, it was only the wealthy that took their children to the hospital for treatmen when there was malaria attack. This raises the issue of poverty, but the question is; is it financial considerations that actually keep some of the people from going to the hospital for treatment? Considering the data gathered, it can be reasonably concluded that this is not true. It was discovered that, even before most of the children were taken to the hospital they had been been given enema of lukewarm water or waterleaf extract.

The major concern of this study was to examine whether there was any relationship between the local perception of malaria and the level of prevalence of the disease. Responses from the field revealed that the continued high rate of prevalence of malaria among the Ibibio is resultant of the fact that, a group's belief system shapes the worldview of members of the group. The beliefs associated with malaria among Ibibio people are quite numerous and varied. Some of the beliefs like:

Malaria is a minor health condition,

It is indigenous and therefore better combated with local remedies,

Every living/ normal person is expected to have malaria, as a matter of course and that

If any episode of malaria does not respond to local remedies, it is not ordinary,

are universal beliefs held by the majority of Ibibio people. Since some of the respondents were of the opinion that malaria was not caused by mosquito bites, or that it was in itself, a life threatening disease, they tended to treat it with kids glove. This, in many instances, according to othordox healthcare professionals, resulted in fatalities. A nurse in Ikono L.G.A confirmed this position when he said, *malaria is serious it causes death, but the people do not know it. They attribute it to witches and wizards so morbidity and mortality is high.*[27]

Despite efforts to combat malaria through such programmes as distribution of free anti malaria drugs, distribution of long lasting insecticide treated nets and awareness campaigns, the IDSR report from the ministry of health has shown that rather than drop, reported cases of malaria rose from 60,633 in 2005 to 94,629 in 2007 (SMOH, 2010). Most of the respondents (58%) believed other factors were responsible for the spread of malaria and not mosquito bites. They therefore tried to manage the disease, based on their believe:

> *Se owo esenim ke akpaniko ase influence edinam amo. Nte afo ankite mien mi, nkaha ufok ibok tongo mmana.Mboho ke ifono edika ufok ibok o. Mbo ke akpedo uto enyin ikpong, owo ndomo ket ineedke edika ufok ibok. Nwup oyoyoho edem eko mfo akemeke edikok enye. Ebo ke obong a cause, ami ndiongoke, ado mme ete ete nnyin ekese e use mme mfang emi, anye a work ono mmo. Ami nse n use mme mfang emi kea fid uwem mi, enye o work. Akpedo a use mfang ono muto enyin enye ibaha ufon, kuka ufok ibok ukuwot idem fo,keyem se unam ke ufok*[28].
> What a person believes will certainly influence his actions. As you see me, I have not been to the hospital in all my life. I am not saying that it is not

> good to go to the hospital oh. What I am saying is that if it is only malaria no one needs to go to the hospital. Herbs abound in your backyard that can, deal with it. They say it is caused by mosquitoes, I don't know but our forefathers used these herbs and it worked for them. I have been using them all my life and they work. If you use herbs for malaria and they do not work, do not go and kill yourself at the hospital, just look back home for the cause.

The above being the words of a respondent, clearly show that he does not believe in the bio-medical ideas on the aetiology of malaria. His response in the event of any malaria attack is based on this belief and the same goes for a great number of respondents.

"Looking back home for the causes", implies that the person should check if he has brought any curse on himself or if any evil force from his home is afflicting him. This is informed by the belief that some episodes of malaria have supernatural origin. The belief that malaria is mostly caused by the consumption of oily foods and fruits informs the use of and the popularity of enema as the first course of action against malaria across Ibibio land. This helps to, wash off the oily deposit in the stomach and soften the stomach for whatever other herbal remedies may be taken orally. If an episode of malaria is believed to be as a result of spiritual attack the patient is expected to go home and "cut down trees". The trees in this case refer to the strongholds of witches/wizards and other supernatural forces. The person was therefore expected to deal with the supposed 'enemy' that inflicted him with malaria, spiritually. This tends toaccount for the high patronage of traditional medicine men and in recent times, prayer houses as therapeutic choices.

5.8 Discussions

Names given to diseases are created from symptomatic experiences of those diseases and thereby provide understanding about the people's perception of the disease and its treatment. Among the Ibibio, malaria is generally known as *uto enyin*. *Uto enyin* is a generic name that is commonly used to cover a wide spectrum of diseases that manifest similar clinical symptoms. These symptoms include yellow discolorations of eye balls and urine, fatigue, body pains, body itching, night mares, vomiting and abdominal pains. All these symptoms define malaria in Ibibio land. Locally, the term also expresses malaria as a minor

disease condition that is easily controlled using any, or a combination of many different traditional remedies. As malaria is endemic among the Ibibio, everyone is therefore expected to experience occasional episodes of malaria attacks. From the name, *uto*-yellow, *enyin*-eyes/colour it is generally believed that malaria has to do with the infection of body system and its treatment is just to wash off the colouration of the infected parts of the body, which the disease has incapacitated. Anybody who does not suffer from malaria is said to be abnormal. Malaria is believed to aid growth in young children. Any child who does not suffer from malaria is sometimes suspected to be *eyen essien emana*, who will die in infancy, possibly, at the slightest unset of any ther disease. On the other hand, a child who suffers from 'too many' episodes of malaria is still considered as *eyen essien emana*. This is also applicable to adults. "Any living human being must have malaria", is the generally held belief. If anyone does not have malaria attacks occasionally, he will be perceived as being 'abnormal'. The abnormality, in this case refers to a number of health conditions which have both physical and spiritual implications.

There exist a variety of discourses and counter-discourses on the issue of malaria as a disease. In some instances, it is regarded as a disease condition, while in some other instances, it is not. It is viewed as a very minor health disturbance in such cases, and as such, commonly ignored to the peril of the patient(s), family members, friends and neighbours. These beliefs cut across all social classes or strata of the society. The local knowledge of malaria is often the common knowledge of disease in the community. What anyone knows about malaria and the beliefs they hold are based on information passed on from one generation to another as an integral part of the general corpus of indigenous knowledge. Ibibio people seem to cling to these beliefs despite the availability of information to the contrary, given by Western health care practitioners. This arises from the fact that they identify with the beliefs, mostly based on social bonds and trust built over time with the sources of these information who are their family members, friends and neighbours.

The beliefs associated with malaria are quite varied and even in some cases contradictory. However, these beliefs help to re-enforce the local practices and the attitude of the people towards malaria. They often set against the bio-medical conception of malaria and any other actions against the disease that are based on foreign knowledge. An important

effect of Ibibio perception of malaria is that responses to malaria are in favour of the curative rather than prevention of the disease. Ibibio believe that malaria is a must disease which an individual must experience from time to time. Similarly, malaria is perceived as a minor health condition and in most cases, a normal part of everyday life that is unavoidable. While the people recognize varieties of diseases associated with malaria symptoms, all the diseases sharing these symptoms are referred to as malaria. In Ibibio, classification of these diseases is fuzzy and not analytical. Rather it is only descriptive with all types of fever classified as malaria. Thus, typhoid, malaria, hepatitis, cold among others, are often classified as malaria. Local classifications are based on the local etymology and knowledge of disease. This affects both perception and therapeutic choice. Hus the findings confirm the position of Biersmann, et al (2007).The effect is the use of similar treatment regimen mostly home remedies relying on local herbs to cater for these diseases, or the combined use of different treatment regimes and syncretism.

Most of the local practices related to malaria are of common knowledge across Ibibio land, albeit very few others that is specific to certain communities. For instance, enema is used by many across all the study locations as the first course of treatment for malaria. The difference is only that a number of different herbs/ roots are favoured in the different localities. Another universal element of the enema is that across all the study locations, it is prepared with warm water for younger children, confirming Comoro,et al(2006), that the content of traditional remedies for children are different from those for adults . This is due to the perceived low level of malaria in children, which they believe can be easily washed with water and that the potency of the herbs/ roots used by adults could be too toxic for the children. Also some of the local herbs/ roots like waterleaves, Brazilian tea, purge weed, fever plant, limes, meam tree, lemon grass, bitter leaves, paw-paw, mango, lemon and *utasi* (*gongronema latifolium*) were mentioned in all the study locations as herbs used in the treatment of malaria across Ibibio land while in some other communities there are specific herbs of local origin that are used in the treatment of malaria. Specifically, Guinea black pepper, *isim eyiot, ntok idot nkong/obiok obung ndisa and* egg woman were encountered in Mkpat Enin. *Mboko* (sugar cane) *vinegar* and tangerine were encountered in Nsit Ibom, *mfang ibong* (kola leaves), *ikong ekpo* (Indian hemp) were encountered in Uyo. Steam baths with

certain boiled herbs are also common, although with some varied types of herbs in a number of the studied communities.

Syncretism is common especially in the urban and semi urban centres. This is resultant of the fact that in most of these places, awareness campaigns have been mounted both by government agencies and non-governmental organizations. Such people therefore go to the hospitals or procure drugs from vendors, which is more rampant, only after taking the local remedies that they are used to, aligning with the position of Izugbara, Etukudo and Brown (2005). Those who depend entirely on the use of orthodox drugs are a negligible percentage (25%) of the population.

Poverty is one of the causes of continued reliance on traditional medicine/ practices in the fight against malaria. Most of those who would like to go the hospital for treatment are discouraged from doing so, because of the "exorbitant" fees charged in the hospitals, while the local remedies can easily be prepared at home by the individual, often at no monetary cost. This confirms the position of Oreagba, et al, (2004) and WHO (2014) that poverty is a major factor in the prevention and control of malaria. This was discovered to apply only in the rural villages where one can easily collect the substances for the preparation of the remedies from family members, neighbours or friends. Those in the urban centres who have to buy all the items end up in some instances spending more money than they would have used in going for treatment at public hospitals. In these cases, the cultural beliefs are what inform the choice of therapy though they claim that it is poverty.

Time spent at the hospital is another reason the people prefer to manage malaria at home. They believe that having to go and queue to see a doctor for something as common as malaria is not worth their time.

END NOTES

1. Mr. Asuguo Ita, a 62 year old retiree interviewed at Ikono urban in May, 2011
2. Ekaete Harry, a 32 year old polytechnic student interviewed at Uyo urban in March 2010.
3. Ubong Akpan, a 35 year old seamstress interviewed at Mkpat Enin Urban in November, 2010
4. Okon Udo Inwang, a 48 years old community leader interviewed in Mkpat Enin rural in November, 2010
5. Victor Effiong, a 44 year old Youth leader interviewed at Uyo rural in July 2010
6. Eka Emem, a 60 year old house wife interviewed at Mkpat Enin rural in November, 2010
7. Theresa Udoma, a 50 year old teacher interviewed at Mkpat Enin urban in November, 2010
8. Udo Sunday, a 40 year old auto mechanic interviewed at Ikono rural in March, 2011
9. Mary Archibong, a 38 year old housewife interviewed at Nsit Ibom urban in April, 2011.
10. A key informant from Mkpat Enin who opted to remain anonymous. Interviewed in November 2010.
11. Aniekan Udo, a 27 year old patent medicine vendor interviewed in Mkpat Enin urban in December, 2010
12. Ekaete Harry, see notes on 2
13. Cletus Idem, a 54 year old business man interviewed at Ikono rural in May, 2011
14. Eka Nna, a 42 year old trader interviewed at Nsit Ibom rural in March 2011
15. Idongesit Udoaka, a 21 year old student interviewed in Mkpat Enin rural in December, 2010
16. Ntiense Akpan, a 28 year old trader interviewed at Ikono urban in February, 2011
17. Ette Sunny, a 54 year old herbalist interviewed at Uyo rural in July 2010
18. Eteidung Efanga, a 62 year old village head interviewed at Uyo rural in August, 2010

19. Peter Ukpong, a 43 year old registered nurse interviewed in Uyo urban in March, 2010
20. Ufot Etim, a 30 year old registered nurse interviewed at Ikono urban in March, 2011.
21. An anonymous FGD participant from Nsit Ibom, March 2011.
22. Ekong, a respondent from Uyo, interviewed in July 2010.
23. Utibe Ukpong, a key informant interviewed in Ikono in 2011.
24. An anonymous respondent, interviewed in Uyo, March 2010.
25. Uduak Effiong, a 40 year old housewife interviewed in Mkpat Enin in 2010.
26. An anonymous male nurse interviewed in Uyo in March 2010.
27. Philip Okon, interviewed in Ikono in 2011.
28. Kingsley Ebong, interviewed in Uyo in 2010.

CHAPTER SIX
SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1 Summary

This work studied the effect of local perception of malaria on the treatment of malaria among the Ibibio of Nigeria. The thrust of this work was to find out how local knowledge, beliefs and practices relating to malaria construct to attitudes and practices relating to malaria management. It examined how these attitudes inform responses during malaria attacks.

The background of the study was explained in chapter one and the research questions stated. These guided the formulation of the study objectives. In chapter two existing literature were reviewed on; malaria in sub-Saharan Africa, causation of malaria, transmission of malaria, effects of malaria and resilience of malaria. The theoretical frame of reference was also stated in chapter two. The research methodology, design and methods were extensively explained in chapter three. The field work was carried out in eight (8) study locations across Ibibio land. A multi-staged sampling technique was employed. This involved a combination of cluster, random and purposive sampling techniques. In Chapter four, the ethnography of the study area was presented. Chapter five dealt with the presentation and analysis of data; the aim was to answer the research questions.

Significantly this study has established that the local beliefs associated with causes and management of malaria are different from the western/bio-medical ideas of malaria. It was discovered that local beliefs, customs and practices associated with malaria determined to a large extent the choice of malaria management strategies. Though malaria is commonly referred to as ‘uto enyin’; there are many other local names by which malaria is known. Each of these names, based on its connotation and local interpretation, directly impacts the attitude towards the western/bio-medical paradigm towards malaria and choice of therapy for specific episodes of malaria attack.

Local and orthodox (western) therapies were identified as the two major types of therapy engaged in the management of malaria. While the orthodox therapy involved hospital treatment and purchase of drugs from local drug stores and pharmacies, local/traditional therapy on the other hand involved the use of natural and supernatural (spiritual) ways of

treating the disease. The traditional treatment regimes included; enema, steam bath and, oral herbal remedies, among others. The choice of therapy was based on the recommendations of the individual and family members/ friends/neighbors during the particular episode of the disease. The traditional therapy was popularly relied upon by the people. In most cases, the use of orthodox medicines came either as a complement of traditional medicine or a last resort after the failure of the traditional treatment regimes. This pattern of treatment seeking was discovered to be reinforced by the accessibility and affordability of traditional medicine as well as its cultural identity.

There is a need for government to take a keener interest in the local/traditional medicine. This could be done by sponsoring researches into the local/traditional remedies with a view to ascertaining their content; both cultural and chemical, as well as the actual efficacy or otherwise of these remedies. The traditional medicine/practitioners should be integrated into the health care system in practise as already contained in theNational Primary Health care(PHC) policy for the betterment of the health of the people. This will go a long way to control the production and use of traditional medicine. Hazardous practices would also be thereby, stamped out.

6.2 Recommendations

Based on the findings of this work, it is recommended that:

(i) The Government needs to look for ways of integrating the traditional medicine into the healthcare plan for the people.

(ii) There is a need for more researches on the traditional remedies used in malaria management in Nigeria. This should be done with a view to determining the potency or otherwise of the several roots, herbs and other substances used in malaria management. This would make for a differentiation between what is useful or otherwise and what is actually injurious to the people's health.

(iii) The Nigerian healthcare plan/ policy needs to be made more culturally adaptive in order to give the people a sense of partnership and identity in such a scheme. Thus, it would be more readily acceptable to them.

(iv) Nigeria also needs to restructure its health education geared towards intervention programmes against culturally sensitive diseases. Health education should be more culturally adaptive in order to eliminate some confusions and misunderstanding that may arise due to cultural differences.

(v) There is also a need for Nigerian healthcare development of a plan/ policy to put the people first. Consultation is necessary with local people in order to incorporate their their perceptions, beliefs, attitudes and practices related to in the formulation of healthcare policies and plans. This will also engender the peoples' support for and acceptance of such a scheme.

6.3 Conclusion

Western bio-medical science portrays malaria as a vector-borne disease caused by plasmodium parasites and transmitted through mosquito bites. Ibibio people hold the belief that malaria is caused by a plethora of many different socio-cultural phenomena ranging from eating of too much oily foods, exposure to sunlight and witchcraft attacks. Based on this belief, interview and observation data indicated that the traditional ways in which malaria is managed are parallel to western bio-medical ideas. The people repose much confidence in the efficacy of traditional therapies. Reliance on traditional therapies was a function of factors such as: the indegeneity, affordability and accessibility of these local remedies. Malaria management, this study has discovered, is a sort of "free-for-all". No individual is seen as a novice in the management of malaria. Though traditional healers often deified the substances they used in plying their trade, the reverse was the case with malaria remedies, except in cases where the illness was suspected to result from supernatural factors. Information about malaria was freely given to the next person. In instances of malaria attacks people would not hesitate to try different remedies until, they stumbled on the one that really worked for them.

Hospital visits for malaria fever was quite low, especially in the rural areas. Most of those who went to the hospital did so at an advanced stage of the disease, especially when the local remedies had failed to give the patient a relief from the illness. Others, it was discovered,

did so just because they felt that they were expected to do so, but not out of conviction. This was more rampant in urban centres and in areas where intervention programmes have been/are being carried out. They therefore would go to the hospital only after having undergone traditional treatment regimes. The general acceptance of malaria as a normal part of life made for docility during malaria attacks which in turn led to malaria fatality in many instances.

Continued reliance on traditional medicine for the treatment of malaria makes a strong case for the integration of traditional medicine into the health system. It calls for attention by government and other stakeholders to look in the direction of sponsorship of researchers into the various traditional remedies used in the management of malaria. As observed in this study, there is a need to understand how names determine actions in malaria among the Ibibio. Hence to achieve this, it is imperative to engage in researches that will examine how local perceptions of diseases, especially malaria are translated to actions. This enterprise will create opportunity to scientifically assess traditional medicine used in treating malaria. This should be done with a view to determining the potency or otherwise of the several roots, herbs and other substances used in malaria management. This would make for a differentiation between what is useful, useless and what is injurious to the people's health. This would go a long way to ascertain the efficacy or otherwise of these remedies. It would also help to control the use of these remedies in order to stamp out hazardous practices among the people. While total reliance on bio-medical care in malaria has failed to solve the health crises due to malaria, the exclusive use of local therapy cannot also solve the problem.

The healthcare plan/ policy needs to be made more culturally adaptive in order to give the people a sense of partnership and identity in such a scheme. Thus, it would be more readily acceptable to them. In this case, educational components of malaria intervention programmes need be restructured to be more culturally oriented in order to eliminate some complexities and misunderstanding arising from home management of malaria. In view of the fact that some of the local notions surrounding malaria in the research community are scientifically erroneous but culturally factual, community health education programs should be mounted to educate people on the aetiology of malaria, preventive measures and treatment. Such health education should be devoted to correcingt misinformation and erroneous ideas arising from local perceptions and interpretation of the disease and promote utilization of

appropriate healthcare services. There is also a need for the development of a people-oriented healthcare policy, evolving from the people. This approach should integrate useful local ideas of the perception of the disease and illness. Since ideas are creations from people's total world view, it is imperative to recognize the local ideas and built the useful in the treatment regimens. This will also engender the peoples' support for and acceptance of such a scheme. The research findings relating to cultural attitudes about malaria, choice of therapy and patterns of health service utilization generally suggest the need for healthcare services for the local population to be responsive to the social, cultural and economic realities of the people. Among other things, this involves making healthcare services affordable and culturally-sensitive, and integrating traditional medicine with orthodox healthcare. There is also a need for the provision of free anti–malaria drugs to people to encourage availability and use since the availability and accessibility of the local remedies help to enforce reliance on them.

Agenda for Further Researches

Despite the recognition of malaria as a public health problem, there is relatively little literature on malaria that takes into account, the possible influence of gender and gender relations. Effective malaria treatment depends mainly on behaviour at the individual and household levels. It starts with the early recognition of symptoms and signs that are interpreted as a malaria episode. Such an episode however is culturally and socially defined and may not correspond to the biomedical definition of symptoms and signs in many endemic areas. Several researches have observed, for example that while women recognize early signs such as fever and chills to be malaria, they attribute convulsion to spiritual intervention. Recognition of malaria based on local concepts forms the framework through which people consider seeking help and care. The above aptly explains the need for more researches on malaria. This need is more urgent in the area of relating anti-malaria programmes to the local understanding of the disease as the success of any intervention programme depends on tailoring the programme to suit the community's knowledge of perceived health problems . The knowledge of the extent and character of traditional beliefs and traditional healing and its underlying concepts with respect to malaria is limited. So, further researches into this subject

are needed to help in planning projects which will be both effective and socio-culturally acceptable

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APPENDIX I: GLOSSARY OF LOCAL TERMS AND CONCEPTS

Abasi - God

Adan -oil

AkIom -malaria

Akpa mbubi adaka ada ubahasen –die in the evening, rise up in the morning

Akpene die –how long

Anie uto enyin –has malaria

Atuatuak – convulsion

Eka abasi – spirit mother

Ekpo - spirit/ ghost

Enyin – eyes/ colour

Esien emana- Spiritual peer group/ reincarnated births

Mfang - leaf

Mbubi -evening

Mmong - water

Nkanga -empty/ ordinary

Nkpo ntokeyen -childhood ailments

Ntong - dust

Nwup -herbs

Obong - mosquitoe

Ofum - air/ wind/breeze

Ubahasen/ ubahausen – morning

Udongo ukang nnyin -indegenous disease

Ufiop idem -fever

Uto -yellow/ unclear

Yet - wash

Yie - Bath

APPENDIX II: GLOSSARY OF SELECTED CONCEPTS

i. **Attitude**: Mental disposition towards a phenomenon or the value placed on any phenomenon which influences behaviours towards it ie, the way an individual or group responses to the phenomenon. This depends to a large extent on the perception of such a phenomenon.

ii. **Beliefs:** Ideas, notions and opinion, especially of a group, held about any phenomenon.

iii. **Choice:** The decision to adopt or accept a particular therapy rather than the other, preference of one therapy over another.

iv. **Culture:** The totality of a group's way of life whether material or immaterial, which is socially transmitted. It services as a guideline for the group's behavior or the behavior of individuals within the group.

v. **Local Knowledge:** A body of facts, information, ideas and opinions about phenomenon which originates from a particular community or society. A collection of facts, skills, understanding and explanations about fundamental aspects of everyday life, based on experience, embedded in a particular culture. It is dynamic.

Perception: Views, ideas, and attitudes about the world. It is the process of attaining awareness or understanding of sensory information. Cultural perception is therefore used to refer to developing views or Attitudes about phenomenon based on a particular cultural milieu, adding meaning to sensory information based on past experience, which is greatly influenced by the collective norms of the group. It also refers to the construction of ideas or mental mapping of symbols and structures into a body of knowledge based on the culture which involves organization and interpretation of phenomena in the context of a particular culture.

vi. **Therapy:** A form of medical care. It refers to an attempt to mediate a health problem, or a means of treating a particular illness. It could be traditional, orthodox, spiritual or a combination of some or all of them.

APPENDIX 1II: INTERVIEW GUIDE

SECTION A

1 Age:

2 Sex

3 Marital Status

4 Educational Qualification

5 Occupation

6 Approximate Annual Income

SECTION B

7 Have you suffered any episode of malaria in the recent past?

8 Has anyone close to you suffered from malaria in the recent past?

9 How did you know that it was malaria?

10 What course of treatment did you follow?

11 Why did you choose this treatment?

12 What do you think caused the illness?

13 What is/are the local name(s) for malaria?

14 What does/do the (se) names mean?

15. What are the causes of malaria?

16. What kinds of malaria therapies are available in your locality?

17. Which of the malaria therapies is more effective?

18. Why do you think so?

19. In what ways is malaria treated traditionally?

20. How do you get information about malaria?

21. Is there any segment(s) of the population that is/are more susceptible to malaria attacks?

22. Why do you think so?

23. What are the traditional beliefs associated with malaria in your ocality?

24. Do these beliefs affect people's choices of malaria therapy?

25. Why do you think so?

26. What is the pattern of utilization of health facilities in malaria management in this locality?

27. What do you think informs this pattern mentioned above?

28. Do the traditional beliefs affect the people's responses to malaria?

29. Why do you think so?
30. What other factors affect the choice of therapy/attitudes towards malaria in this locality?
31. Why do you think so?
32. Is malaria a life threatening disease?
33. What are the reasons for your answer?

APPENDIX IV: FGD GUIDE FOR MOTHERS AND FATHERS.

1. Warm Up: What are the major health problems in this community?
(Probe for malaria, if not mentioned)

2. **Knowledge of Malaria**

i. What can you tell me about malaria?
(Probe for Local name(s) and meaning(s)

ii. What are the different types of malaria that you know?

iii. What are the causes of malaria?
Mention the symptoms of malaria that you know?

iv. Who are the most affected by malaria and why? /is there any particular segment of the population that is more susceptible to malaria attacks?

3. **Perception of Malaria**:

i. How serious is the problem of malaria in this community/locality?

ii. What are the consequences of malaria? (Probe beyond the health-related consequences.

iii. How do people see malaria? I.e. is it a life threatening diseases?

iv. What are the local beliefs associated with malaria in this community?

4. **Management of Malaria**

i. What do people in this locality do when they have malaria?
ii. Where do they go to for treatment?

iii. Who influences the choice of treatment and why?

iv. What influences the choice of treatment and why?

v. Which types of malaria treatment is the best/would you recommend and why?

vi. What types of treatment for malaria are available in this locality?

vii. What factors influence the choice of treatment in this locality?

viii. Is there any relationship between the beliefs associated with malaria and the choice of treatment? Why?

ix. Mention the different ways that people treat malaria traditionally?

x. Discuss the processes involved in each of these treatments.

xi. Is there any difference in the way men, women or children are treated when they have malaria?

xii. Which segment of the population is involved most in the management of malaria (men, women, old, young, etc.)?

APPENDIX V: KEY INFORMANT INTERVIEW GUIDE

1. Please tell us some of the major health problems in this locality (Probe for malaria if not mentioned)

2. What are the local names for malaria? What do they mean?

3. What are the symptoms of malaria?

4. What are the causes of malaria?

5. Is malaria a serious sickness?

6. What do people do when they have malaria?

7. Where do people go for treatment when they have malaria? and which of these places offers the best treatment?

8. Why do you think so?

9. What/who influences the choice of treatment?

10. What are the beliefs associated with malaria in this locality? And how do they influence the choice of treatment?

11. Is there any relationship between the belief(s) and the choice of treatment?

12. How malaria treated traditionally, and what is are the processes involved?

APPENDIX VI: LIST OF SOME PLANTS USED IN MALARIA MANAGEMENT IN IBIBIO LAND

Native name	English name	Scientific/Botanical Name
Adan umon	Brazzilian tea	*Stachytarpherta cayennensis*
Akom sharrap	Meam tree	*Azadirachta indica*
Akpod	Pawpaw	*Carica papaya*
Eba enang enang		*Hippocrates africanum*
Ebana/ nsan	Lemon grass	*Cymbopogon citrates*
Effiad	Bitter kola	*Garcinia kola*
Etidot	Bitter leaf	Vernomia amygdalina
Ibong	Kola nut	*Cola acuminate*
Ikong ekpo	Indian hemp	*Cannabis sativum*
Isim eyiot		-
Iwa	Cassava	
Manko	Mango	*Mangifera indica*
Mboko	Sugar cane	*Sacctarum officinarum*
Mkpri osokoro	Lime	*Citrus quarantifolia*
Ndia ke garri	Purge weed	*Eupherbia heterophilia*
Ntong	Fever plant	*Oscimum basilicum*
Obiok obung ndisa /ntok idot nkong		-
Odusa	Guinea black pepper	*iper quinensis*
Okwoko akpa	Siam weed	*Chloromena odorota* Or *Eupatorium odoratum*
Oyomo ke iso aman ke	Egg woman	*Phyllantus amarus*
Tangerine	Tangerine	*Citrus reticulate*
Sokoro	Orange	*Citrus sinensis*
Udang aya	Lemon	*Citrus limon*
Utasi		*Gongronema lactiforium*
Utime nse		*Chromolena odorata*
Vinegar	Vinegar	*Andrographis paniculata*

APPENDIX VII: THE INFORMED CONSENT FORM

a. Title of the Research -Cultural perception of malaria and choice of therapy among the Ibibio of Akwa Ibom State, Nigeria.

b. This study is being conducted by Mrs. Nsikanabasi Udofia Wilson of the department of Archeology and Anthropology, university of Ibadan, Nigeria.

c. This research is privately sponsored.

d. The purpose of this research is to find out the correlation between the local perception of malaria and management of malaria among the Ibibio of Akwa Ibom State.

e. Purposive sampling will be used to select respondents from 3 subsets of the population namely; adults 18 years above, children between 10 and 17 years old and health care workers. They will be required to answer the questions on the interview guide or Participate in a focus group discussion.

f. You will be expected to be involved in this research for 1 year. The interview session should last for less than one hour while participation in the FGD will not take more than one hour.

g. Risks: There will not be any risk to your health or personal safety during the interview or FGD sessions

h. Cost: Your participation in this research will not cost you anything.

i. Benefits: The goal of this research is to find ways of eradicating the incidence of malaria and we hope the findings at the end of this research will help to achieve this.

j. Confidentiality: All information collected in this study will be treated confidentially, your name will not be mentioned without your consent in this report and it cannot therefore be traced to you.

k. Voluntariness: Your participation in this research is entirely voluntary.

I. Alternatives to participation: You can choose not to participate in this research without any harm to your person.

m. Consequences: You can also choose to withdraw from the research at anytime. Please note that some of the information that has been obtained from you before you choose

to withdraw may have been used in reports. These cannot be removed any more. However, the researcher promises to make good faith effort to comply with your wishes as much as is practicable.

n. Modality: If you suffer any injury as a result of your participation in this research, the cost of treatment will be borne by the researcher.

o. You will be informed about any information that may affect your continued participation in the course of this research.

p. This research will not lead to any commercial product and there is no plan to contact any participant to share financial benefits now or in the future.

q. This research is an academic work. I am not aware of any other information that may cause me not to do this work with fear or favour.

I have fully explained this research to.....

and have given sufficient information including about risks and benefits to make an informed consent.

Date……. Signature……..

Name……

This research has been approved by the health Research Ethics Committee of the Akwa Ibom State ministry of Health, Block 7 Idongesit Nkanga Secretariat, Uyo

In addition, if you have any question about your participation in this research, you can contact the researcher, Nsikanabasi Udofia Wilson of the department of Archeology and Anthropology, University of Ibadan.

Phone: 08023772192

e-mail:nsidofzion@yahoo.com

You can also contact the supervisor Dr. A. S. Ajala of the department of Archeology and Anthropology, University of Ibadan.

Phone: 08034906801

e-mail: asajala@yahoo.co.uk.

APPENDIX VIII: ETHICAL APPROVAL LETTER

GOVERNMENT OF AKWA IBOM STATE OF NIGERIA

Telephone: 085-204091
Telegram: HEALTH

Our Ref: MH/PRS/99/VIII/23
Your Ref:

OFFICE OF THE HON. COMMISSIONER
MINISTRY OF HEALTH
IDONGESIT NKANGA SECRETARIAT
BLOCK 8, P. M. B. 1030
UYO.

7th April, 2010

Mrs. NsikanAbasi U. Wilson
Dept. of Archeology and Anthropology
University of Ibadan

RE:ETHICAL REVIEW APPROVAL

I wish to refer to your letter dated 30TH March, 2010 requesting for an ethical approval from the Hon. Commissioner, Ministry of Health, Akwa Ibom State on your proposed study: "Local Perception of Malaria among the Ibibio of Akwa Ibom State", and to convey the Consent of the Hon. Commissioner to you to carry out your research. This approval is based on your complying with the following conditions which you have stated in your proposals that:

(i) The instruments you are employing are focus group discussions, interviews and personal observation of the respondents,
(ii) Informed consent of the respondents shall be sought,
(iii) There shall be no invasive procedures,
(iv) Confidentiality of the respondents shall be maintained.

Please note that should you intend to change any of the following conditions, the written consent of the Hon. Commissioner should be sought and received before you continue.

Congratulations.

Dr. Francis B. Okon
Chief Medical Officer
For: Hon. Commissioner.