*(RÚBLÍ –ÎSÁLA)*MEDICAL BODY MARKING AND THE MANAGEMENT OF CHILDHOOD DISEASES AMONG THE *MÌGILI-KÓRÒ* OF NASARAWA STATE, NIGERIA

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CERTIFICATION

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DEDICATION

This work is dedicated to the ALMIGHTYand BENEVOLENT GOD who by HIS infinite MERCIES preserved my life toaccomplish this Thesis.

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ABSTRACT

Medical body marking is a traditional healthcare practice associated with many African societies, including Nasarawa State, Nigeria.Existing studies have focused on the patterns of utilisation for preventive and curative healing processes among adults and children. However, scant attention has been devoted to analysing the symbolic aspects of most medical incisions and scarification carried out on children, and the factors that have sustained the practice in some societies in spite of the popularity of Western medical knowledge. This study, therefore was designed to examine *rúblí-îsála*(medical body marking) on childrenamong the Migili-Koro of Jenkwe Kingdom in Nasarawa State, Nigeria. This is with a view to determining local meanings, cultural knowledge and factors sustaining the practice.

Herbert Mead and Herbert Blummer's Symbolic Interactionism and Adeoye Lambo's Culture bound Theory of diseaseswere adopted as framework. Ethnographic technique was used. Three Migili-Koro communitiesof Ashige (one of the largest Migili-Koro towns), Assakio (the spiritual centre of the Migili-Koro), and Nene (believed to be the first city established by the Migili-Koro) were purposively selected. Data were obtained through the In-depth interviews with 10 randomly selected traditional healers, 16 key informant interviews conducted with the paramount ruler of Jenkwe Kingdom, traditional heads of the three selected communities, and 12 renowned elders both. Twelve sessions of focus group discussions with young parents was also conducted. Data were analysed using the thematic descriptive methods.

*Rúblí-Isála*isutilised in the treatment of childhood diseases such as convulsion, pneumonia, polio and spleen disorder. The process of administering marks is exclusively carried out by men who acquired knowledge of the practice through inheritance, apprenticeship and spiritual revelation. Competence in medical body marking involvesdeepknowledge of the traditional religious beliefs system, membership of cult group, oath-taking and intimate relationship with the spirits of the land. Body marking patterns of specific childhood diseases are symbolic. The symbolism of each pattern of mark is embedded in the local world view regarding sicknesses as being caused either by God or malevolent spirits. Stability as a cultural and spiritual construct is depicted in various markings: three vertical marks (on the forehead and one each on both cheeks) for convulsion; six vertical marks and three horizontal marks (on the left side of the chest) for pneumonia; and three vertical marks on the knees for polio. For spleen disorder, the ten to twelve vertical marks and seven horizontal marks (on the left region of the abdomen) represent stability and perfection. Medical body marks are also symbolic means of severing the link a child has with the evil forces of illness. Although there is declining patronage of *rúblí-Isála,* poverty*,* low-level education*,* cultural nationalism, syncretism, and poor primary healthcare facilities in the communities are key factors for its resilience.

Rúblí-*îsála*atteststo the ingenuity in the Migili-Koro's perception and treatment of childhood diseases. Meanings and knowledge from *rúblí-îsála* markingscanbe helpful in developing more syncretistic approaches to managing childhood diseases.

Keywords: R*úblí-îsála,* Indigenous healthcare practice, Migili-Koro
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CHAPTER ONE
INTRODUCTION

1.1 Background to the study

This study examined how the Migili cultural group in Nasarawa State utilised medical body marking as a means for the management of childhood diseases. It attempted to ascertained the prevailing knowledge the people had on body marking as well as how their cultural beliefs influenced the construction of childhood diseases. The research further examined parents' understanding of symptoms and causes of childhood diseases and their health-seeking behaviour. Several scholars and researchers have advanced various definitions of body marking in human societies. Notably, most of such definitions emphasise the purposes for which body marking is given. According to Ayeni (2004), body marking is an all-embracing term employed to describe several methods of changing the surface of the skin through intentional and potentially-irreversible alteration. It is usually done in a unique manner that makes each cultural group to have a distinct pattern of marking on the body. Body marking can thus be defined as an art made on the body (Dennis, 2007). More elaborately, Irving (2007) opined that body marks are made on the body for purposes which are mainly medicinal, decoration, spiritual protection, lineage or family identification. In a similar vein, Ankrah (2012) stated that marks are made on the body for various valid reasons, ranging from historical, cultural, and medicinal to religious and aesthetics. Adesina (2014) submitted that, body marks are made on different parts of the body by traditional surgeons to effect healing; hence, the main purpose of marks is medicinal or curative.

Following from the above, it is worthy to state that for the purpose of this study that body marking**,** as a curative method, is made on an individual, in any part of the body, based on cosmology, ancestral beliefs and cultural construction of diseases in a society. Body marking is a long-standing indigenous health-care practice of different human groups that has been integrated into their cultures. The desire of these different human groups is to manage their health problems within their limited knowledge and environmental resources. Also, body marking is identified among some indigenous people in West Africa. According to Cullivan (1998), it is identified both on the faces and bodies of West Africans still living

and in various works of ancient art, such as poems, short stories, terra-cotta figurines, artistic wooden masks and carvings.

Before the advent of Western scientific medicine in Africa, traditional medical practice involved the administering of body marks, bone-setting, massage therapy, hydro-therapy, coupled with the use of assorted herbal remedies and divination. The role of divination in healing the sick may be complemented with the use of certain protective objects such as wearing amulets to achieve a holistic healing for children in extreme situations (Saba, 1996). In this regard, Elujoba, Odeleye and Ogunyemi (2005) argued that traditional medicine is a major socio-cultural heritage that must have existed in Africa since time immemorial. They further affirmed that traditional medicine is the first choice of health-care treatment for children who suffer from varieties of ailments such as fever, measles, and convulsion especially in rural Africa communities. As long as Africans regard sickness and misfortune as religious or spiritual experiences, traditional medicine will continue to play pivotal role in the healing processes of both children and adults.

Several studies have indicated that cultural belief is an underlying factor that must have influenced parents' continuous desire to give marks to their children as a method for managing diseases (Salami and Irekpita, 2011; Kayombo, 2013; Ebeheakey, 2015). The belief is linked to the desire to protect a child from untimely death when the treatment is administered because, once the child receives the marks he/she is expected to live longer, and this is a common belief among the Yoruba cultural group in Nigeria (Jegede, 2002).

Also, the continuous transmission of cultural beliefs from one generation to another has been identified as a major factor in preservation of body marking practice in some African societies. Gebrekirstos; Abebe, and Fantahun (2014) reported in their study of Axom town in northern Ethiopia that mothers who had body marks also had their children marked. This is also a common phenomenon in Migili society where some parents are prone to pass the legacy of body marking to their children. The presupposition of some parents is that body marking is a tradition powerful enough to cure their children of diseases and this attitude cuts across generations. This explains the strong attachment of the people to their cultural

belief on the efficacy of body marking for the treatment of some childhood diseases. It also demonstrates it as an enduring aspect of the indigenous health practice of the Migili people.

Apart from cultural beliefs, people's consciousness also influences the administration of body marking on children. For example, Ebeheakey (2015:94) argued that, among the Dangmes of Ghana, there exist strong subconscious beliefs, which greatly influence the practice of administering marks to children, and this have been passed down from generation to generation. Parental thoughts and consciousness are known to be highly effective, such that they are believed to be potent enough to protect and heal children of every possible mysterious disease even when they do not bear body mark at all. This attitude cuts across many African communities whether consciously or unconsciously, in (Ebeheakey 2015; Ibadin, Ofili, Airauhi, Ozoma, and Umoru, 2008). When beliefs are passed on to the younger generation, they thus become part of societal cultural system, very difficult to discard.

The administration of body marks for curative and protective purposes is common among the Migili people of Nasarawa State. Marks are given to children for treatment of diseases such as splenomegaly, convulsion, polio and pneumonia. The marks are made on particular parts of the body where the ailment resides, and various herbal remedies are applied on the body where incisions are administered to heal the child (Igube 2005). The herbal remedies are administered on the sick child based on expert knowledge of the herbalist or diviner. This is practised among the people because of a widely-held belief that hidden malevolent forces like sorcerers, witches and unseen spirits could cause sickness or misfortune on innocent children. This have provided basis for some parents to embrace the indigenous health-care practice.

In another vein, the socio-economic status of many households reflects illiteracy and poverty while their major occupations are farming, hunting, fishing and petty trading. Therefore, accessing better and functional modern health services for children in the study area is usually out of the reach of most parents. For example, the primary health centres in the two communities of Ashige and Assakio are mere consulting clinics, in the absence of qualified

medical professionals. The available health personnel are auxiliary nurses and social workers. In Nene town, there is no primary health-care centre, but a substandard private clinic owned and managed by a graduate of the School of Health Technology. Plate 1.1 on page 5, provides a picture of the private clinic operating in Nene town. Called *Umaru Clinic*, it is a one-room facility of 10 by 10 square metres. It contains just an iron bed for in-patient. The window is made of wood and it has no mosquito net. It does not meet the basic standard of a primary health centre, with regard to required medical personnel and facilities. And more importantly, the state of child health-care in these communities is bedeviled with endemic problems of poverty, high rate of illiteracy, malnutrition among children and women as well as poor hygienic and sanitary conditions in and around many households. For these reasons as well as other health issues, this thesis sets out to explore a way of conceptualising and explaining the relevance of (*rúblí-îsála*) medical body marking, its effectiveness and the implications of good health-seeking for the children of Migili society in Nasarawa State, Nigeria.

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Plate 1.1. A substandard private clinic in Nene community. (Source: Fieldwork October,2015).

1.2 Statement of the Problem

In the study communities of Migili, children were exposed to environmental challenges that have adversed effects on their health. This was due to deplorable condition that made children slept on cold bare floor. Most households are surrounded by bushes which encouraged the breeding and spread of mosquitoes, a reality made worrisome due to parents' inability to access treated mosquito nets in their homes. Studies reveaved that all these resulted in persistent ill-health among children, have thus led to prevalence of childhood diseases like diarrhoea, malaria, measles, pneumonia, and polio (Fayehun and Omololu 2009; National Demographic Sturvey 2018). Similarly, notable, the continuous prevalence of these ailments among children is locally attributed to environmental factors such as high frequency of rain falls and density of the forest in the study area.

It is pertinent to note that little of the processes involved in administering medical body marking on children in several African communities have been explored by scholars and researchers, hence the need for this research. Existing studies have focused on the patterns of utilisation for preventive and curative healing processes among adults and children. Thus, this research is to ascertain the underlying motives of parents' continuous use of medical body marking in the management of childhood diseases, despite the advent of modern medical practice.

The point to note is that (*rúblí-îsála*) medical body marking is an indigenous health care practice associated with both solutions to health challenges and their debilitating effects on children. Available evidence suggests that medical body marking (*rúblí-îsála*) administered on children in some African communities have been linked to health-related complications (Tabona, 2007; Salami and Irekpita, 2011; Kayambo, 2013; Gebrekirstos, *et al.* 2014). Similaely, medical body marking on children results in the development of unsightly *keloidal* scars that further manifest in bodily complications. It also can adversely affect the quality of life of a child while growing up. Besides, the wounds that emanate in abdominal region that is marked affect children that could develop a higher risk of *hypertrophic* scars. This implies that, marks administered on children as a means of treating certain diseases,

can also endanger their health and well-being. Bearing in mind that, in the course of administering marks on children, very elaborate process is required by the traditional healer,

However, scant attention has been devoted to analysing the symbolic aspects of most medical incisions and scarification carried out on children, and the factors that have sustained the practice in some societies in spite of the popularity of Western medical knowledge. This study therefore was designed to examine *rúblí-îsála*(medical body marking) on childrenamong the Migili-Koro of Nasarawa State, Nigeria. This is with a view to determining local meanings, cultural knowledge and factors sustaining the practice. Also, scholars have stressed the health and well-being of children's medical body marking in traditional approach for the management of childhood diseases (Tabona, 2007; Wagbatsoma *et al*, 2007; Ibadin *et al.* 2008; Omokhoa and Iyeikhian 2011; Kayombo, 2013). For example, Salami and Irikpita (2011) aargued that the making of incisions on abdominal region of children with spleen disorder is the most effective measure to treat it. It is essential to explore the symbolism involved in administering medical body marking on children regarding their experiences as well as the interpretations of their experiences by parents and other stakeholders involved in dispensing health care. Consequently, this study conceptualised the health seeking behaviour of parents as it relates to their children's health needs in Migili-Koro society. This necessitated the exploration and explaination of child health care practices in Migili society.

1.3 Research questions

The study sought to answer the following questions:

i) How do the Migili-Koro acquire knowledge of body marking?

ii) How do parents understand symptoms and causes of their children's diseases?

iii) How do parents understand symptoms and causes of their children's diseases and seek health?

iv) What are the cultural beliefs of the Migili-Koro and how do these influence their construction of childhood diseases?

v) What are the implications of body marking on the health of Migili children?

1.4 Aim and objectives of the study

The general aim of this study was to examine the health seeking behaviour of parents as it relates to their children's health needs in Migili-Koro society. This aim is pursued through the following specific objectives:

(i) Investigate the prevailing knowledge people have on body marking in Migili society.

(ii) Identify parents' understanding of symptoms and causes of childhood diseases in Migili society.

(iii) Examine parents' understanding of symptoms and causes of childhood diseases and the influence on health seeking behaviour.

(iv) Examine cultural beliefs and their influence on the construction of childhood diseases in Migili society.

(v) Ascertain the implications of body marking on the health of children in Migili society.

1.5 The study area

The Migili-Koro are mainly found in parts of Awe, Lafia, Obi, Doma and Keana Local Government Areas of Nasarawa State, in North Central Nigeria. Studies reveal that they migrated from Adamawa region and later moved to the Benue Valley Area (Na'ibi and Hassan, 1969; Igli 1982). The origin of the Migili group is basically traced to the ancient Kororofa Empire, which dates back to the 13th century AD. It was a multi-ethnic empire dominated by the Jukun. The migration of the Migili from the Kororofa Empire was reported to have been instigated by chieftaincy tussle. According to Igli (1982), they might have founded basically 14 settlements with the capital at Chalago. The National Population Census of 2006 puts Migili-Koro population at 251, 844 (NPC, 2006).

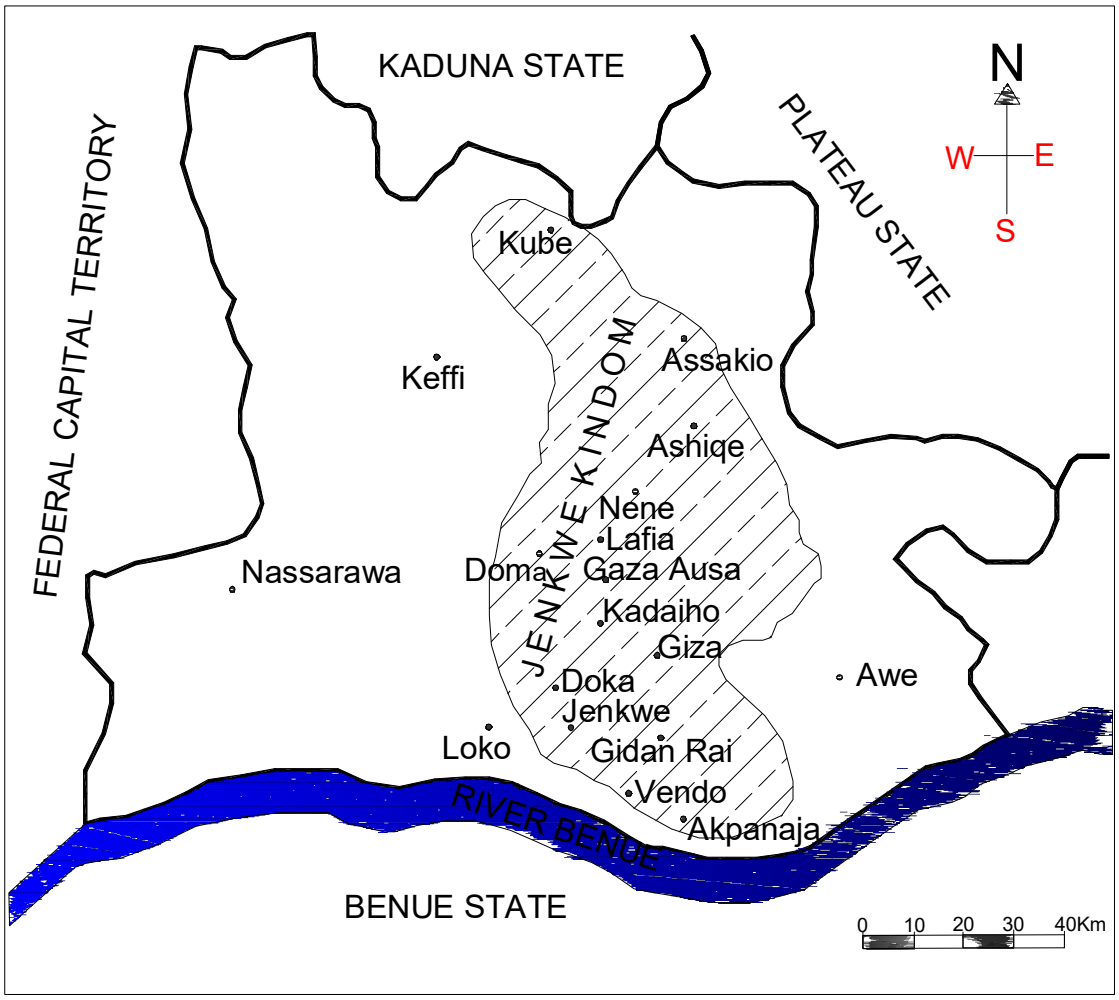

Figure 1.1. Map of Jenkwe Kingdom that include research areas of Ashige, Assakio and Nene.

Figure 1.1 shows the map of Jenkwe Kingdom which is also known as Migili Kingdom. It captures the study areas of this research; namely Assakio, Ashige and Nene. They are all presently in Lafia Local Government of Nasarawa State.

Economically, the Migili engage in fishing, made possible by the availability of rivers, such as River Ashige, River Kiriye-Goli and River Nene. This provides ready protein for them as well as livelihood. It is one of the most thriving occupations for men. The fishing technique involves damming a stream and then bailing out the water from the resulting pool. Nowadays, dried and fresh fish are transported from the location to different parts of Nigeria on weekly basis to local markets in Makurdi, Abuja, Jos, Lokoja and other major cities in North Central Nigeria. The farming community also exists in addition.

Millet is one of the preferred cultivated grains in many Migili communities, and this is because it is used to brew *mudú,* the popular local beer. This beer is considered among the people as better than the one brewed from guinea corn. The Migili consume most of their grains in the form of beer. Yam is also a major subsistence prodúce and the major cash crop exchanged for money. Maize is another popular grain that is planted from March to April, and then harvested together with the millet by August.

The political administration of traditional Migili society is segmentary in its arrangement. This consists of approximately 14) patrilineage descent groups (*Inni*) within the society. The segmentary lineages are classified as clans in which each group has a district name. Most often, each clan is identified by a distinct food taboo (*Isor*), facial marks, associated settlements, and in some instances, membership and property within a descent is transmitted patrilineally. For most Migilis, the belief that they all descended from a common ancestor is insignificant. Descent groups are either exogamous or endogamous. Each town or village is constituted by (almost entirely) same members of a particular group. Outsiders are accepted by virtue of the fact that their maternal parents share in the origin of the host group. Descent groups are not usually political units, except in the case of a settlement fashioned from an older one.

Most Migili are adherents of Christian religion but the traditional beliefs, that include (*rúblí-îsála)* is still foundedamong the older generation. The Migili high god is called *Obi*, and is considered to be synonymous with Jehovah in Christian religion. A major deity in Migili society is *Osi* and it is closely associated with justice and truth. The deity *Òsì* normally

comes to play in a ceremony where ritual ordeal performance is required of a person to identify truthfulness. The ordeal involves washing one's face with a special medicinal preparation. Many traditional Migili rituals and celebrations involve masked and costumed impersonation of the gods (Igli, 1982). In spite of the advent of Christian religion in many Migili communities, elderly men still meet deep in the forest at special sacred places to perform religious rituals on behalf of the community. This is usually marked with mudú, the locally-brewed beer. Elders also actively participate in preparing masquerade for special ceremonies such as festivals, funerals, coronation and so on.

According to Igli (1982), Migili community has been careful to preserve a small section of their forest for the gods, in order to sustain the performance of traditional religious rituals and other ceremonies of special festive seasons. The reason for the preservation is not only for performance of rituals and memories, but to also to sustain their cultural heritage. From oral traditions, none of the gods in Migili culture has a special relationship with any particular descent group. Hence, there are no marked differences in religious beliefs and rituals of the people across the different clans (Igube 2004). Celebrations of the gods always involve offering quantities of *mudú* and food for public consumption. The celebration of specific festival, for a god, is always prefixed to the term *mudú"* Traditionally, the food and locally-brewed drinks are offered to the gods and, later, taken to sacred groves in the forest where elders drink them. *Ódú* is another god celebrated. It is greatly feared in the time of war and disaster. The belief is that the one who touches *Odú's* symbol (a sort of flag made of bamboo and threads taken from the clothing of corpses) is invulnerable in battle.

1.6 Scope of the study

The central focus of this study is children of less than five years old, their parents, elderly men and women and traditional medicine men. Attention was focused more on children who were made to undergo body marking at the time of this research as well as those who already had body marking. The research is an exploration into body marking as a form of therapeutic measure against childhood diseases. The exploration was to investigate the practice of medical body marking on children among the Migili-Koro of Nasarawa State, with a view to determined local meanings and cultural knowledge it generates. In this

regard, attention was to examined prevailing knowledge of the people on body marking, parents' health seeking behaviour, their cultural beliefs and the influence of such beliefs on the construction of childhood diseases. Also, we hope to ascertain the symptoms and causes of childhood diseases as well as how parents seek health for their children through interpretations and meanings attached to symbols, herbal compositions, incantations, and physical processes of healing children.

The study covers only three Migili communities, namely Ashige, Assakio and Nene towns, all in Lafia Local Government Area. These locations were selected on purpose. For instance, Ashige was chosen because it is one of the largest Migili settlements in Jenkwe Kingdom. Assakio was chosen as the spiritual/religious centre in Jenkwe Kingdom and Nene was chosen because it is believed to be the first city founded by the Migili when they migrated from the ancient Kororafa Kingdom and settled in the present-day Lafia region. The three communities are assumed in this research to represent the entire Migili society, since, to a great extent, the belief system is fairly common to all.

1.7 Significance of the study

The study investigated medical body marking, which is a significant aspect of the indigenous health care practice of the Migili people in Nasarawa State. Existing studies on body marking have focused on the patterns of utilisation for preventive and curative healing processes both in adult and children. It is worthy to note here that, much attention have not been devoted to analysing the symbolism involved in medical body marking on children, and the factors that have sustained the practice in some African societies in spite of the popularity of modern medical system. More so, it is pertinent to state here that little or no scholarly work have been done on medical body marking in Migili society.

This study, therefore, investigates the practice of medical body marking on children among the Migili-Koro in Nasarawa State, with the aim of determining local knowledge and meanings it generates. This is because earlier studies merely mentioned this with no in-depth study of personal and collective approaches through which people attend to childhood diseases in Migili society. It is equally significant to affirm that this work considered broad issues on child health care, such as convulsion, pneumonia, polio and splenomegaly. These

categories of childhood diseases have not been extensively documented in Nigerian anthropological literature on health.

CHAPTER TWO
LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Literature Review

The chapter first deals with review of relevant literature and conceptual issues. The review is presented under the following sub-headings: the art of body marking on children in African cultures; childhood diseases and their treatments; traditional therapeutics and the management of childhood diseases as well as Migili cultural group.

2.2 The art of bodymarking on children in African cultures

Available literature on the art of body marking on children in Africa indicates that it is mostly linked with preventive and curative healing processes (Tabona, 2007; Salami and Irekpita, 2011; Kayombo, 2013; Uzobo, Olomu and Ayinmoro, 2014). It is an aspect of people's health-care practices common in many non-Western societies, including Nigeria. According to Ayeni (2014), it is one which involves making incisions or scarifications associated with healing infants and children who are afflicted with one form of diseases or the other. It also involves the performance of certain invasive cuts on children. Salami and Irekpita (2011) reported that the Esan cultural group in Nigeria has long sustained the art of making incisions on children because the practice, according to them, is believed to be the most effective remedy for abdominal swelling resulting from splenic enlargement. In a similar vein, Kayombo (2013) identified abdominal incisions among the Wazigua in Morogoro Region of Tanzania as one of the traditional methods for treating different childhood diseases like convulsion and pneumonia. For Kayombo (2013), the practice is deeply ingrained in the belief system of the people that construct it as a mode of therapeutic intervention for sick children.

On their part, Omokhoa and Iyeikhian (2011:134) reported that abdominal scarifications, another form of making incisions on the body, consist of skin incisions over an enlarged spleen in a child who has fever. This practice has been identified among the Benin of Edo State in Southern Nigeria, where a higher percentage of children had abdominal scarifications (Wagbatsoma *et al.* 2007). In fact, Ibadin, *et al.* (2008) noted that the practice of abdominal incisions in treating childhood malaria is a widespread custom among nursing mothers in Esan land of Edo State,

Nigeria. The argument for the persistence in all the cited instances indicate that body marking is believed to be very effective in curing certain sicknesses in children.

Studies have shown that, in many societies, the easiest means to remove the stigma of childhood diseases associated with an evil hand as causative agent is to make incisions on the child (Salami and Irekpita, 2011). This attitude and belief stems from the general conviction that the indigenous health knowledge approach in solving health problems is more effective than the modern health-care system. However, Jarret, Fatunde, Osinusi and Lagunju (2012) observed that among the Yoruba in Nigeria, that body marking on children has become less popular because of the influence of modernisation and Western education. Accordingly, body marking on children is limited to mainly *tribal* identification rather than therapeutic purposes (Ibadin, *et al.* 2008). The marks made are either for lineage or clan identification or, in some instances, for aesthetic self-awareness and personal sophistication. But in Esan society in Edo State, abdominal incisions continue to be made on children for therapeutic purpose of treating splenomegaly of various causes. The incisions made on sick children in this society appear to be gaining popularity because of the perceived therapeutic value (Salami and Irekpita, 2011:1) and for the purpose of protecting the children from different diseases often caused by the handiwork of evil forces like witches and sorcerers within the society.

Based on the foregoing, the practice in many societies is more health inclined than ceremonial. Similarly, Kayombo (2013) remarked that among the Karanga of Tanzania, body marking as a therapeutic method helps to cure headache both in children and adult. The marks made on the forehead or the side of the head is believed to be an outlet for the illness. The parents and guardians in Karanga society use this indigenous health provision to protect their children, making various incisions on the forehead, at middle of the chest, on the right and left of abdomen and the toes. With these, it is believed that the malevolent agents like witches and sorcerers cannot penetrate the charms therein to harm innocent infants and children (Kayombo, 2013) because the incisions are smeared with herbal remedies to close invasion of such malevolent agents (Langwick, 2004; Geckil 2009).

One form of body marking made on children in several parts of the African continent is the eyebrow incision. This has been reported by scholars, and the preposition is that mothers embrace the practice in rural Ethiopia, for instance, because it is considered effective in treating eye-related ailments in children and adults. Any attempt to eradicate it, therefore, would be against their cultural beliefs (Gebrekirstos, *et al.* 2004). However, the report also suggests that eye-brow incisions on children in Ethiopia seem to be on the decrease, due to fear of HIV/AIDS transmission on the one hand and greater awareness of mothers towards modern medicine to treat eye infection on the other hand.

Supernatural threat to a child's survival also influences body marking on children who are believed to belong to the spirit world. The art of body marking on children in some African cultures is influenced by the people's quest for the spiritual well-being of a child. Jegede (2002) gave an insight into how a mother took her daughter to a "*babalawo*" who diagnosed the child as ''*emere''* (that is, a spirit child that always comes and goes). According to him, the "*babalawo*" prescribed that bodily marks (incisions) should be made on the child and that appropriate medicines should also be rubbed on the child's body, to prevent her from seeing her spiritual peers. Similarly, Ellis (1894) reported that, in Yoruba culture an ''*Abiku''* child (a born–to-die child) whose mother had taken all precautionary measures without any success would endeavour to drive out the ''*Abiku''* by making small incisions on the body of the child, and rubbing therein green pepper or spices. It is believed that this action will cause pain to the ''*Abiku''* and make the spirit depart in earnest from the child. Ellis (1894) further maintained that, though the poor child may scream in pain, the mother however hardens her heart in the belief that the "*Abiku"* inflicts more suffering when pitied. In making the incisions, the diviner is symbolically driving out evil spirits from the child and the price the family has to pay is to be maximally involved in driving away the spirits. Ayeni (2014) also attested:

> Among the Yoruba, herbal doctors, priest of the god of herbalism Osanyin and body Artists, administer large number of medicines via incisions on the body……(shout) vertical marks under the eyes "*gbere oju*" of some children signify that medicines have been inserted to prevent the child from trembling, a condition believed to be caused seeking spirits (Ayeni 2014:32).

Sometimes, as a body artist explains, a mother or parent is expected to prepare a medicine and

bring it to the "*Oloola*" (circumciser), who will then put it in the cicatrices that he makes on the child and, in this way, it prevents the child from dying (Ayeni, 2014:32). The practice appears not to be popular any longer because of the rising influence of education and urbanisation, coupled with the advent of Christian values which interprets the practice as fetish. Besides, the practice is gradually fading away among educated mothers in parts of Southern Nigeria, due to exposure to modern medical knowledge that have helped to explain that frequent death of infants and children could be linked with sickle-cell anaemia (Makinde, 2012). Basically, the reason for the continuity of body marking in some cultures is due to the strong attachment people have to their belief systems.

2.3 Childhood diseases and their treatments

Researchers have acknowledged that children below five years are more vulnerable to different diseases due to the tender nature of their bodies. They are most likely to fall victims to several life-threatening ailments (Adedoyin and Fagbule, 1992; Tabona, 2007), which several factors may occasion. For instance, Olawuyi *et al.* (2004) reported that Nigeria records about 300,000 diarrhoea-related deaths annually among children aged five years and below, and this may be associated with demographic considerations such as poverty and poor nutritional habits.

Olawuyi *et al.* (2004) further observed that, although malnourished and well-nourished children have equal numbers of diarrhoea episodes, they are more severe or prolonged in the malnourished children. One possible explanation for the severity in malnourished children is that infections in the proportionally-larger intestinal surface of infants and children lead to passage of larger quantities of fluid. Evidence from different regions of the world indicates that children under five years of age suffer acute and persistent episodes of diarrhoea (Saba, 2012). Studies from sub-Saharan African countries like Nigeria, Senegal and Ethiopia highlight a complex interaction between diarrhoea and malnutrition and they suggest that this complexity can impair physiological development of the child and the height gained (Ayele, *et al.,* 2014; Yilgwan and Okolo, 2012; Saba, 2012). Death rate from diarrhoea in developing countries, particularly in sub-Saharan Africa, has continued to remain high. The statistics is consistently higher when compared with those in Latin America (Yilgwan and Okolo, 2012), a development linked to the lower economic status of many of the nursing mothers, most of who live in unhygienic

environment and are ignorant of the causative factors of diarrhoea.

There is the tendency for incidence of diarrhoea to be on the rise or be pronounced in 7-12 month-old infants, or even much higher among weaned children than exclusively-breast-fed children. The likely cause of this problem in many African societies is attributed to ignorance (Olawuyi, *et al.,* 2004) alongside unhygienic practices in food preparation for infants and children. Studies by Fayehun and Omololu (2009:18) agreed that virtually all cultural groups in Nigeria perceive contaminated or dirty water as one of the causes of childhood diarrhoea whereas other studies have evaluated the role of socio-economic and behavioural factors in the development and persistence of childhood diseases, including diarrhoea in some parts of Africa. Saba (2012) observed thus:

> Moreover, some visible risk determinants in slum areas such as the type of kitchen, dirty feeding bottles, disposal of household garbage, unhygienic latrines, eating from floor and food from vendor, use of non-purified water and poor storage of drinking water are increased risk of diarrhea. In addition, a significant association between effective hand washing practices and the incidence of diarrhea in children (Saba, 2012:22).

Improved public and child-health programmes come through massive investments in health education techniques that the people can relate to, understand and use to ameliorate ill-health situations.

Among the few studies exploring the influence of socio-economic and behavioural factors is that of Olawuyi *et al.* (2004) who observed that diarrhoea in children is closely associated with poor family background in many sub-Saharan African countries (Olawuyi *et al.* 2004; Yilgwan and Okolo, 2012). Socio-economic factors and cultural beliefs have also been associated with incidence of childhood diarrhoea in some parts of Nigeria. For instance, Fayehun and Omololu (2009) observed in their study that Hausa-Fulani mothers believe that, apart from contaminated water, food and unripe fruits are causative factors, hence the practice of keeping bathing sponge meant for a child near a well, could bring a curse upon the child or entire household. The cultural interpretation of this, is that, the bathing sponge should not be displayed in the public space where evil eyes could cast a spell on it, and there may be incidence of childhood diseases in form of diarrhoea. Similarly, they discovered in their study that, among the Tiv in North Central

Nigeria, incidence of childhood diarrhoea are attributed to casting of spell on children, which works out as manifestation of good and bad diarrhoea. The implication of this is that, in Tiv culture, diarrhoea is of two types. The good one is when a child is teething while the bad one is when the child begins to stool uncontrollably for no just reason. The latter most often results in weakness of the body. In actual fact, what really constitutes childhood diarrhoea is the inability of parents to immunise children at birth.

Moreover, malaria constitutes one of the endemic diseases that have threatened the survival of many African children. Data from public hospitals indicate that the morbidity arising from malaria is higher than HIV/AIDs, and that the most vulnerable groups are children under the age of five years (Federal Ministry of Health, 2005). Globally, 85-90 percent of malaria fatalities occur in sub-Saharan Africa, including Nigeria (Tinuola and Abubakar, 2011); and there has been a complex relationship between cultural beliefs and higher prevalence of malaria in the worldviews of many rural communities in Africa. For example, researchers and health policy implementers have consistently reacted to these problems (Ajala, 2001; Jinadu, 2003). However, among the Yoruba of Nigeria, the knowledge of child health-care system is not obscured, hence its practices are not new. In this culture, the problems are explained through natural and preternatural means. The belief in traditional practice is that diseases are sometimes caused as a result of lack of discretion of society upon which god(s) inflict a punishment. So, health solution is, first and foremost, to appease the gods through libations and related rituals (Alhassan, 2002:3). The studies have revealed that treatment of malaria-related illnesses in children is usually influenced by the cultural inclinations of those who decide on their cure (Saba, 1996; Salami and Irekpita, 2011). For example, in some rural communities, symptoms of high body temperature, feverish condition is interpreted from cultural perspective, that is, the people believe it has some connection with manipulation of evil hands.

Another disease that poses threat to the well-being of infant and children in many African societies is measles. Among the Karanga group, the naturalistic explanation for childhood disease such as measles is not common. For the Karanga, when a child suffers from measles in the early stage of life, the most probable cause is witchcraft (Tabona, 2007). In this light, it is pertinent to recall the observation of Chavunduka (1978) that the Karanga people go to their

traditional oracle or shrines to obtain information or consult the gods when they are faced with such life-threatening illnesses or diseases. For them, illnesses of any sort not only threaten, but can even destroy, the child. The incidence of measles, as a form of disease, comes usually with the moral consequences of parent's belief, and of behaviour in society (Chavunduka, 1978; Tabona, 2007). As the authors even suggest, marital infidelity, especially on the part of mothers, could bring about certain life-threatening illnesses such as measles on children. Tabona (2007) also observed that the practice in Karanga society is to ensure that a child infected with measles is prevented from sleeping in the same room with a promiscuous person, as bodily contact with the person is dangerous. The moral issues might have contributed to the strong belief in the supernatural, and the adoption of traditional therapeutic techniques as a step towards the ultimate restoration of health in a ritualistic fashion. The general response in health-crisis situation in many African societies is to carry out certain therapeutic processes that would necessarily entail confession of crimes committed by the parents as a step towards the herbal treatment.

One other serious childhood disease which haunts children in Africa, in particular, is convulsion. Tabona (2007) described this disease as one that affects children who are easily frightened and are very nervous. The behavioural angle promotes how cultures interpret convulsion. Kayombo (2013) has identified convulsion as one of the commonest childhood ailments in Africa. He captured the nature and the threat of convulsion in children from the narrative of a traditional healer:

> Child convulsion involves weakling of the child caused by evil eyes (witches). This is because most infants and children are vulnerable to convulsion and other childhood related diseases. The ailment afflict infants and children due to their delicate bodies, subjected to be penetrated by charms brought by witches and sorcerers. Thus, when a child experiences convulsion, conventional medicine is considered as an ineffective form of therapy (Kayombo, 2003:20).

Kayombo (2003) argued that convulsion, also known as *degedege* by the Karanga, is a health condition associated with malaria infection in children, since malaria symptom consists of high body temperature. However, he failed to explain the symptom(s) of child convulsion in his study. Rather, he focused on the preventive measures of convulsion in children within the Karanga society, an approach he hinted may have to deal with the strong beliefs of people in conventional

ways of illnesses and treatments, particularly those that work for them, but could also fail in some instances.

In a related vein, Shoko (1994) writing on convulsion in children, contends that it is connected with witchcraft. According to Shoko the general belief in Karanga society is that children naturally are victims of witchcraft. Shoko (1994) further stated that the belief in Tanzania is that there is prevalence of convulsion in the countryside as well as in the cities. However, Tabona (2007) argued that such belief is unfounded because in some instances, the exposure of infants to breeze and drinking of cold water were seemingly responsible for both febrile convulsion and pneumonia. Often, and rather unfortunately too, children are not taken to the hospital until they are unable to breathe properly (Tabona 2007). It is not unlikely; therefore, that some of the children would have been ill for weeks before the decision is taken to rush them to the hospital by parents/family members. And when they eventually do so, the import of the symptoms could be trivialised since they have limited knowledge of it.

Another illness associated with children is mumps. This disease, according to Tabona (2007), is a condition in which the region behind the ear and neck swells:

> Most often treatment of children with mumps involves meatie cub. The cub is extracted from maize and tied around the neck of the patients. This is believed to drive away the disease and to protect the child. Besides, it is believed, that the cub is spiritually endowed by benevolent spirit who act throughout the objects to conquer the illness (Tabona, 2007:10)

The explanation appears to be more inclined to spiritual causality, most probably because the general belief in many African societies is that there no medical cure for mumps. They think it heals naturally without any special medication even in the hospital. In a similar vein, Tabona (2007) identified flu as a common disease among Karanga children. The cause is most often linked to exposure of children to cold environment. According to him, the mode of treatment is more naturalistic than personalistic. This is because flu is considered mild when compared to other life-threatening childhood diseases. Apart from the personalistic view of children's vulnerability to some life-threatening diseases, it has been observed that behavioural attitude of mothers also contribute to incidence of child's flu ill-health. Just as Kayambo (2013) pointed out,

when a nursing mother (in Wazigua society) is involved in sex, it could result in a child falling ill because the milk of the nursing mother could be contaminated, and the breastfeeding child would become feeble, a sign that the parents had breached the community norms of rearing the child. In many traditional societies, when mothers violate the norms of abstinence during the period of breastfeeding, there are special herbal remedies administered to mothers and children (Kayombo, 2013).

It is believed that many childhood ailments in African societies are common within certain age bracket. The median annual incidence of diseases such as diarrhoea, measles and malaria peak in infants in 6-12 months old and decreases progressively thereafter (Davidson et al., 1996). In a related development, the progressive decrease could be attributed to the gradual development and maturity of children (Salami and Irekpita, 2011). The children perhaps develop some levels of independence and immunity as they attain maturity. The level of independence comes in form of crawling and walking around the immediate surroundings without parental support. In addition, as children develop in age, their immunity to certain diseases grows stronger. From this observation, it can be argued that physical and cultural construction of childhood diseases determine not just the characterisation of illness and the mode of treatment, but also the management in many African societies. By and large, prevailing socio-economic factors like education and economic status influence incidence, trends and prevalence of childhood diseases in many parts of Africa.

2.4 Traditional therapeutics and the management of childhood diseases

Traditional health practitioners use varieties of treatments, ranging from *magic* to biomedical methods such as fasting and dieting, herbal therapies, hydro-therapy, massaging and other surgical procedures. The mode of administration of herbal treatments on different parts of the body in children varies from oral administration and making incisions to bathing with herbal solutions among others. In some cultures cough, stomach ache and abscess are cured via bleeding and cupping, after which herbal ointment is applied with follow-up herbal drugs (Tabona, 2007). Among many groups in sub-Saharan Africa, bloodletting even in children is a form of healing that is widespread especially in rural areas (Hrdy, 1987).

While describing the traditional therapy on children, Hrdy (1987) noted that among the Lese in

Eastern Africa the people are very conservative, practising blood-letting on average of five times yearly. The practice is principally of rural setting, but continues to some extent in urban areas. It is necessary to emphasise again that incidence and persistence of childhood diseases (CHDs) are attributed to evil machinations of malevolent forces like witches, sorcerers and ancestors that apparently bear malice against children, their parents and other relatives. This is true of many situations of ill-health, whether in the rural or urban areas; because the same belief persists Sometimes, the wrath is believed to emanate from the ancestors, and deities, especially when taboos are broken (Jegede, 2002). Since diseases have spiritual causality, they must also have spiritual solutions. They could be cured with Yoruba children or adult wearing amulet (*onde*), scarification (*Igbere*), or the use of concoctions. The use of charms is also available. The patronage of this method of health delivery has not abated with modernisation of health delivery, and expectedly so, as Jegede (2002) posited:

> The "*Ayanmo*" mythology in Yoruba culture plays a significant role in the explanation of health conditions. It is a pathway to prevention and cure of childhood diseases that usually favour the patronage of traditional healing processes. The attitude of the people is that, utilization of the hospital comes only when traditional methods have failed (Jegede, 2002:322).

Though studies have shown that traditional therapeutic process is an integral part of the health-care system of many African societies (Tabona, 2007; Salami & Irekpita, 2011; Kayombo, 2013), available evidence suggests traditional medicine is given to 40 percent of children with convulsion, before they are admitted at the University College Hospital, Ibadan (Jarett *et al.,* 2002). The medicine administered on children often includes herbal preparations, marks made on the body, topical applications to the eyes and burns on the feet and buttocks. The application of some of these remedies on children would, in the view of many Westerntrained medical practitioners, compound the health conditions of children. But, traditional healers would object to such assumptions as biased, parochial and disparaging the value of traditional methods of treatment. What is to be taken into account in the dispensation of traditional medicine is that personalistic diseases require culture-bound approach. Illnesses must be understood within a cultural context, which would in turn shape the form of therapy (Tabona, 2007). Personalistic forces like ancestors, witches, and sorcerers may be major causes of serious illnesses that affect children (Jegede, 1998; Fawole, *et al.,* 2008; Hassan, 2013), a protective measure that takes

cognisance of cultural fact, would rationally link remedy with the spiritual realm.

For instance, when a dreaded disease afflicts a child, parents in Karanga society seek for protective medicine from the most powerful traditional healer. The general belief in Karanga culture is that convulsion in children seems not to have a permanent cure; however, a powdery substance (*Mbanda*) derived from a weed, which is burnt to drive away the evil spirits, can be applied to cure the child crying incessantly (Tabona, 2007). The ashes are rubbed on the cuts; the smell of the burnt herb is believed to be repugnant to the evil spirits frightening the child.

In most traditional societies, the generic properties of herbs for curing illnesses are well-recognised. Each herb performs specific function in the treatment of disease. Among the Karanga of Tanzania, Tabona (2007) reported that an herb used for the treatment of measles is called ''*hazvier*'', which means *unrestricted*. The interpretation, according to Tabona, is that, in Karanga society, herbs destroy all problems, without restriction. Hence, herb is the veritable instrument that brings about definite result and, if not available, the disadvantaged community will remain disadvantaged. Since the desired healing cannot take place without herbs, they are viewed in the community as being lively to humanity. Though Tabona (2007) failed to explain how these herbs are used and what impact they have on infants and children, he hinted that the regular use of these remedies on children are often discouraged in many parts of Africa by missionaries, colonial officials, and their agencies who interpret traditional curative methods as fetish and pagan (Reynolds, 2008; Kayombo, 2013). It has been observed that traditional method of protecting a child against health problems focuses on illnesses the etiologies of which are believed to be from religio-cultural world, which include witches, sorcerers, and other cosmic agents, like gods and ancestors (Jegede, 2002; Kayombo, 2003).

Child convulsion is just one of the commonest health problems associated with the foregoing. Some curative methods for child convulsion among the Wazigua of Tanzania may consist :

> ... of herbal plants, leaves, and green plants. They are crushed in mortar with pestle and then soaked in water for one hour and administered to the child. The dose for the infant is tea spoonful, whereas for children is a food spoonful (Kayombo, 2013:13).

Some African communities may adopt quite a different approach in treating convulsion in infants and children. But the most common forms of protection include wearing amulets, taking herbal baths, drinking dissolved solutions from animal body parts as well as administering marks smeared with herbs. In conventional medicine, the focus would be on vaccinations to kill diseases and improve nutrition (Balikci, 2006), but this is not the situation with traditional medicine, where people use remedies, like amulet for protecting children both from naturalistic and personalistic factors. We have called attention to the use of amulet as a form of protection earlier in this review. It can be worn round the neck, waist and wrist or arms for the protection of these sections of the body as well as the entire body itself. The amulet has to be made by an expert in traditional medicine and empowered with litany of incantations to be effective (Kayombo, 2013). The aim is to protect the child from malevolent forces that may want to torment.

This protective approach of healing has deep historical background. For instance, in ancient Egypt, the general belief is that malevolent forces take the form of poisonous snakes, scorpions, floods or almost any natural disaster and tangible forces (Saba, 1996; Beser *et al.,* 2010; Kayombo, 2013). As a measure to secure and protect themselves and their children against these forces, ancient Egyptians wore amulets and charms around their necks, ankles, waists, or anywhere else on their bodies (Kayombo, 2013). Geckil *et al.* (2009) observed that, in some cultures, incidence of childhood diseases is linked to specific periods and times in the month or the year in their historical consciousness. Researchers like (Varner, 2008; Spark-du *et al,* 2008) observed that the moon holds a mystical place in the history of human culture, especially as it pertains to health and well-being. We know, for instance, that herbal remedies for child convulsion are taken in the first few days of the new moon and waning moon (Kayombo, 2013). The rationale for the association of child convulsion remedy with the position of the moon is yet unknown, and there is little or no information to explain the effect of the position of the moon on the treatment of child convulsion (Reynolds, 2008). More studies are, therefore, required to ascertain whether or not any correlation of the position of the moon with health of humans exists, especially on children, whether such is positive or negative.

The content of the amulet can include herbs and spoken words as well as paper handwritten with

Ayat (Quranic verses) in predominantly Islamic communities (Anta, et al., 1995). In South Africa, it is the bracelet or necklace (Spark-du, *et al.*, 2008; Kayombo, 2013). Their spiritual powers provide some form of protection in homes and families and in some situations that are negatively impacting on people's personal belongings (Hassan, 2013). The medicine men are called upon to make *black powder* through incantations and manipulation of different objects. Remarking in this direction, Hassan (2013) stated

> It is made to work when incisions are made on different parts of the body on a sick child. In the cause of making the incisions, blood gushes out, and then powder substance is rubbed into the wounds inoculating the patient and leaving indelible marks on the skin, which are supported with amulet as an antidote against evil forces (Hassan, 2013:239).

This practice is integrated for effects with the belief in the Supreme Being and other smaller mediatory supernatural beings in the cosmological realm of many African societies.

As part of effective therapy for children afflicted with personalistic ailments in the community, rituals are performed and the purpose is for spiritual harmony and safety. Remedies may involve drinking herbs or bloodletting (Ellis, 1894). In Bagobo society, children are bathed regularly to keep them away from disease-causing germs and viruses (Gascon, 2011). Therapeutic methods for overcoming childhood diseases may also require elders, who are expected to be knowledgeable in finding cure as their long-standing experiences in managing such diseases are vital. The elders have a traditional responsibility of mediating between the sick person and supernatural forces in the land. Community priests come from the elders, and other specialised agents who appease the forces/spirits of healing and can remove any impending disaster in the family, village or the entire community. The information regarding the efficacy of herbal plants usually emanates from testimonies of elders who have tried and proven such herbal plants and their therapeutic wonders (Gascon, 2011). In actual fact, the curative applications of herbal remedies are usually handed down from generation to generation.

Therapeutic approach relies on traditional healers' familiarity with supernatural forces. This is combined with their personal and professional stake in healing and rituals (Kayombo, 2003). The healer is more likely to attribute an illness or misfortune to preternatural or supernatural causes

rather than an ordinary person (Simpson, 1980). As Simpson observed, in Yoruba society, in respect of a child experiencing teething pain, a traditional medicine man grinds the lower jaw of a crocodile family into a powder and adds mixture of powder leaves, and then tie the charm made of these mixtures round the neck of the child so as to ensure effective healing of the sick child.

What we have done in this review is to examine available literature on traditional therapeutic methods of managing childhood diseases. The point is that children in traditional societies undergo healing processes through oral herbal administration, hydro-therapy and body marking, which come in form of incisions/scarifications. A major approach in the management of childhood diseases involves magical and ritual performance on patients, which are designed to influence personalistic and supernatural forces like witches, sorcerers, ancestors and deities. In some other instances, social actions or behaviour of individuals within extended family have been considered as sources of illnesses. And in some instances too, children's illnesses are linked to bacteria parasites or unhygienic environment, hence bio-medical approach is adopted.

2.5 The Migili-Koro Cultural Group in Nasarawa State

According to Igube (2005), the name "*Migili*" simply means "people" in their dialect and this came into existence around the early 20thcentury, when the Nene people (in Lafia region) rejected being called "Koro" because the Hausa interpretation of the word (Koro) meant "a people driven away" or "weak people". This self-differentiating identity of the Migili from the larger Koro group has been acknowledged by scholars even in recent times. For example, Filaba (2014:15) pointed out that the Koro are not really a homogenous group, but a name imposed on over ten distinct language/cultural groups who were unsettled. The argument against the theory of a common origin of the Koro is connected with the assumption that they are widely diffused and divergent in language and culture (Gunn and Conant, 1960), although another school of thought believes that the Migili and other Koro groups share a common origin. This is derived from the notion that they are part of the larger Koro group that migrated from the ancient Kororafa Kingdom (Meek, 1931). Corroborating this position, some scholars (Igube, 2005; Agwadu and Agwadu, 2012) argued that the Migili were one of the Koro groups that inhabited the ancient Kororofa Empire before their migration to the present-day Lafia region

The Koro in Lafia region of Nasarawa State are popularly known as Migili; a single Migili person is called Jijili and the language is known as Ligili (Ogli, 1982; Igube 2004). Some of the contemporary elite hold that Migili is a different cultural group distinct from the mother Koro cultural group. However, the more elderly population, of the Migili cultural group, who speak the Lijili language, maintained that the name, Migili, which simply means *people*, was adopted in the early 1970s in rejection of people's continued linkage of Koro with dirt. This explains the reason most modern scholars have accepted in recent years the notion that Lijili language is a divergence of the original Koro language (Agwadu and Agwadu, 2012). Today, Migili as a cultural group has a writing system, and it is considered as a full-fledged language. And this is purely out of its political relevance in present-day Nasarawa State. Most Migilis also speak the Hausa language with certain degree of fluency as a second language. Joseph Greenberg, an American Anthropologist, had classified the Koro language under the Niger Congo group of languages. However, Igube (2005) argued that it is part of a member of the Bantu group of languages. Most Nigerian languages are classified under Kwa sub-group, as it is with the Lijili language.

On the historical migration of the Migili cultural group from the ancient Kororofa Empire, Ogli (1982:2) stated that all Migili accounts trace the migration of the people from the ancient Kororofa Empire, from which they are said to have taken their name of Koro. The Kororafa Empire had flourished around the 13th century A.D, which was believed to be a constellation of multi-ethnic entities (Igube, 1976). Scholars like (Meek, 1931; Hassan and Naibi, 1969; Igube, 2004) admitted that conflict between Koro and Junkun resulted in the migration of the Migili to the present location where they now live. Ogli (1982) pointed out that the Migili group moved Northward from Wukari until they reached the Benue River. It was from then they dispersed and founded many settlements. Studies indicate that they must have founded basically fourteen settlements, with its capital at Chalago (Igube, 2005; Smah 2011). Similarly, recent historical research has revealed that Migili people who now live in large towns and villages around Lafia, Obi, Doma and Awe Local Government Areas have traced their genealogy to Chalago (Igube, 2004; Filaba, 2014), although, at present, Chalago is only a small town being inhabited by the Migili and Alago cultural groups. The insignificant status of Chalago town presently could be traced to the period of conquest of Jenkwe Kingdom by the Bauchi Emirate.

Scholars have written on the political history of the Migili group even in recent times, for instance Filaba (2014), observed that a certain man called Danama was the first Koro ruler who was called *Zhe* Migili under the Bayero that gave him a flag as symbol of authority. Similarly, Ogli (1982) observed that the political and social arrangement in Migili society centres on the segmentary lineage group, which is also recognised as clan. Several studies have been done on the Economic Organisation of the Migili society. Scholars like Meek (1931), Ogli (1982), and Igube (1976, 2004, 2005) all agree that Migili are one of the greatest farmers in the North Central Region of Nigeria. Igube (2005:4) pointed out that the Migili live in very fertile region where food is grown in abundance and the soil is richly-endowed with nutrients for higher crop yields. They are well-known for cultivation of yam, cassava, maize, guinea corn and other staple foods. Guinea corn is one of the unique agricultural produce in Migili society. According to Ogli (1982), the Migili are well-known for brewing local beer made from guinea corn. Apart from this local beer, the guinea corn serves as one of the readily-made delicacies in most households. Furthermore, Andah (1990) and Filaba (2014) established that in pre-colonial period, they were good at weaving, leather work, sewing, iron smelting and they produced bows, poisoned barbed arrows, hatchets, spears and swords. They were also identified as great hunters.

The Migili, like other Nigeria cultural groups, have unique traditional beliefs relating to the Supreme Being, deities, ancestors, spirits, death and life after death. Several studies have been done on the traditional beliefs of the Migili people (Meek, 1925; 1931; Igube, 1988). For instance, Igube (1988) pointed out that the Migili by tradition had priestly castes that were responsible for the supernatural powers and awesome military strength of the people, which influenced their belief in deities and supernatural forces. This could explain the reason some persons develop special talents in carving masks and statues that are expressed in the form of gods and spirit pantheon in the society. The Migili as a people have great belief in the supernatural beings that operate in the society; and they are still worshiped in contemporary times, as they are constantly appeased with sacrifices and ritual performances (Ogli, 1982; Igube, 2004). A very prominent aspect of Migili belief is the worship of ancestors. Scholars like Igube (2005) alongside Agwadu and Agwadu (2012) have pointed out that ancestral worship is a predominant feature of the Migili traditional belief. There is a strong conviction among the

people that an aged man takes his spiritual power with him to the next world after his death and with this he automatically becomes a mediator between the living and the spiritual forces that control the world.

Generally, studies on Migili indigenous health system, as it relates to body marking on children are scanty. Past works on body marking have focused on adults and specifically addressed identification and bodily adornments. Scholars like Igube (1976) and Ogli (1982) stress that in the past, administering *tribal marks* was a distinctive feature among the Migili (Koro) of Lafia region. The common practice was seeing young men and women wear distinct *tribal marks* and tattoos on their necks, backs, feet and stomachs. Today, administering such marks is no more fashionable and popular especially among the younger people. Another aspect of Migili indigenous health system that has been documented is their use of herbal remedies for the treatment of different diseases, sicknesses and other kinds of ailments. For example, Igube (2005:32) admitted that the Migili have extensive knowledge of herbal medicines which they administer on their patients to cure all kinds of diseases as well as heal broken bones, madness and different types of ill-health. This knowledge, as acknowledged by Igube (2005), is handed over to succeeding generations by the forefathers and traditional healers. So enduring is this heritage that neighbouring cultural groups flock to Migili towns and villages to seek healing even for their children.

2.6 Theoretical Framework

The research adopts two major theories: the Culture Bound and the Symbolic interactionism theories.

2.6.1 Culture Bound Theory of diseases

Lambo (1955; 1962) pioneered works on the culture bound theory of diseases in non-Western societies Lambo (1955) postulated that health and disease in many non-Western societies are greatly influenced by culture. The culture bound theory of diseases views the etiology of diseases as rooted in socio-cultural factors other than the belief that illnesses in humans could be explained in terms of bio-medical causative factors. The theory attempts to analyse the etiology of disease from the perspective of socio-cultural factors like cosmology, myths, values, rather than bio-medical causative factors. In other words, traditional non-Western societies have different interpretations given to health and diseases in different cultures, prompted by the emergence of sub-specialties like Transcultural Psychiatry (Kiev, 1972; Lau and Stokes, 1974 in Erinosho, 2012) and Medical Anthropology.

This is due to the fact that the prevailing notion of disease in many non-Western societies clearly contrasts with the dominant perception of such in Western Industrialised societies. From the point of view of the culture-bound theory, culture is rooted in belief systems which, in turn, underlie the perception and interpretation of diseases in such societies. For instance, Peoples and Bailey (2000) argued that different cultures have different ideas about symptoms and causes of diseases, how to treat illnesses, the abilities of traditional healers and doctors, and the importance of community involvement in the healing process.

Culture bound theory examines cultural construction of diseases and their treatment (Scupin and DeCorse, 2008). In non-Western societies the cosmologies of the people reflect the powers of the supernatural and personalistic forces to cause illnesses in vulnerable persons such as children. This may not be the situation in Western industrialised societies where medical practitioners diagnose illnesses using scientific method. The generally accepted belief in such societies is that illnesses are caused by viruses, bacteria or other environmental agents. The reality on ground, though, is that different cultural groups

recognise different illnesses, symptoms and causes, and have developed different health-care models and treatment strategies. Therefore, concept of disease varies across human cultures and so is the nature and incidents of diseases. Culture, to a great extent, form the basis of interpreting, diagnosing and treating diseases differently (Baer, Singer, and Susser, 2003).

From the foregoing, notions of sick and healthy bodies are cultural construct that varies in time and space across human cultures (Martin, 1992). Cross-cultural research shows that perceptions of good and bad health conditions, regarding threats and prospects, are culturally constructed (Kottak, 2008). Patients in traditional societies conceptualise diseases from magico-religious framework. Therefore, Erinosho (2012) could posit that there is obsession with magico-religious factors in the etiology of diseases among different cultural groups in Nigeria. According to him, this perspective plays a profoundly critical role in how illness is perceived, evaluated and acted upon.

The general belief in African societies and other non-Western societies is that incidence of diseases can be attributed to influence of malevolent agents such as witches, sorcerers and other evil forces. In this regard, the prevailing cultural beliefs help to explain why people should have some level of confidence in the skills and healing abilities of traditional health practitioners, rather than those of cosmopolitan Western-styled health-care practitioners. Studies have shown that even with the availability of modern medical systems, Africans still express confidence in the efficacies of their magico-traditional healers (Lambo, 1955; 1962; Odebiyi, 1984; Jegede 2002; Ajala 2004).

The general attitude among Migili parents is based on the premise that cultural beliefs are very much an integral part of their daily lives. They shape how they perceive and construct certain childhood diseases such as convulsion, polio, and pneumonia that are considered *not ordinary*. Thus, the major focus of this study is to appreciate the fact that cultural and superstitious beliefs very much influence parents' understanding of symptoms and causes of childhood diseases and how they seek health. Challenges such as child malnutrition, inadequate clothing of children, and exposure of children to extreme cold and hot weather

conditions, extreme poverty of parents, and ignorance of parents on Child Health Care (CHC), coupled with non-functional modern health-care facilities, notwithstanding.

2.6.2 The Symbolic Interactionism Theory

Symbolic interactionism is a theory developed in the University of Chicago, in the first few decades of the 20th century. It first achieved prominence when the Chicago School came to dominate early American sociology. George Herbert Mead (1927) was one of the founders of the sociological tradition, which came to be known after his death as Symbolic Interactionism. The term was coined by Herbert Blumer in 1937. He emphasised that the nature of the theory could be summarised in the following manner: that the symbolic quality of social interaction centres on the meaning that individuals give to people and things (Doob, 2000:124). Meanings do not just exist in the social world; they are derived from people's judgments in the course of their daily experience. This judgement has to do with the regular interactions people have with one another. As individuals interpret their experiences, they give meanings to events and objects. But irrespective of whether meanings change or remain, symbols affect people's behaviour. Blumer (1969) noted that one of the basic elements in symbolic interactionism is the nature of the objects that people interact with. According to him, these objects are of three folds: physical objects including like trees; social objects such as parents and kin-groups; and abstract objects such as ideas or cosmology (philosophical principles). People's conception of the significant objects within their environment can differ vastly and are shaped by the interpretations they give in the course of interaction with others (Doob, 2000).

Every contemporary human groups have the innate ability to create and use symbols in the course of their daily interactions. Symbolic thought is unique and crucial to humans and to cultural learning…. a symbol is something verbal or nonverbal, within a particular language or culture that comes to stand for something (Kottak,2008: 282). A major theme in Symbolic Interactionism approach is derived from George Simmel's works which look within the symbols, processes, and interactions to determine the underlying patterns or forms of social life. Similarly, the evolution and popularity of the theory was heavily influenced by pragmatism and philosophical writings of George Herbert Mead (Scott and Marshall, 2003). Mead's interactionism orientation emphasised the following: analysis of human experience located firmly within the society; importance of language, symbols, and communication in human group life; ways in which our words and gestures bring forth responses in others

through a process of role-taking; reflective and reflexive nature of the self; and the centrality of human actions in symbolic formations.

Symbolic Interaction theory relates to the study or understanding of human culture through the meaning of symbols, values and beliefs of a society (Scupin and DeCorse, 2008). Anthropologists in their quest to fully understand symbols in human cultures have argued that human behaviour cannot be explained through the use of scientific method alone. A major interest of the symbolic interaction theory is that human beings are distinctly symbol-creating and manipulating animals. It is through symbols that they, out of all the animals, are capable of producing culture and transmitting a complex history. Interactionists are always concerned to study the ways in which people give meaning to their bodies, their feelings, their selves, their biographies, their situations, and indeed to the wider social worlds in which their lives exist.

Interactionists are more interested in the ways in which meaning is always emergent, fluid, ambiguous, and contextually-bound (Scott and Marshall, 2003). Symbolic Interactionists are interested in the ways people interpret their social world and the meanings they ascribe to it (Giddens; Duneier and Appelbaum, 2003:551). Therefore, symbolic behaviour in humans has much to do with how man communicates with fellow humans through, for instance, articulate speech, use of amulets, confession of sins, observing codes of etiquette, explanation of dreams and classification of relatives in designated categories (White, 2004:34). The weakness of the symbolic interactionism approach in this, or any other study, rests on its exclusive focus on cultural symbols at the expense of other variables that may influence perception of childhood diseases and healing in the study area. In other words, its application may still neglect some specific health conditions and processes that could improve child health care in the study area.

One of the central focuses of this study is to understand the role of symbols that come in numbers and patterns of marks given to children, the symbolic movement of the hand and language communication (incantations/prayers) made by traditional healers. Others are the symbolic roles/functions of herbs, grasses, water, ointment, clay pot, black thread, cowries,

bamboo stick, shea butter among other healing properties. The symbolic interactionism approach thus provides a better understanding of the entire processes of administering body marking and other aspects of healing the sick child in the study area. It is worthy to note that both social and medical anthropologists have adopted Symbolic Interactionism perspective in their quest to explain the social reality and cultural world view of different human societies (Mead, 1927; Peoples and Bailey, 2000; Scupin and DeCorse 2008).

CHAPTER THREE

METHODOLOGY AND RESEARCH DESIGN

3.1 Introduction

In this section, a detailed explanation is provided for the methods used in collecting data for the research. Topics treated include study population, research design, methods of data collection and method of data analysis. The research design is explorative investigation on the origin, nature and significance of body marking as a method for managing childhood diseases among the Migili in Nasarawa State. The approach required integrating observational and participatory observation methods, in-depth interview, key informant, focus group discussion (FGD) as well as survey instrument. These methodological approaches provided a systematic collection of data, factual and as accurate as possible. They provided information on knowledge, patterns and symbolism of body marking on Migili-Koro children. They equally provided insights into body marking and how it influenced construction of childhood diseases in Migili-Koro society

3.2 Study population

The study population consisted of children that are less than five years of age, their mothers, fathers, some elderly men and women, traditional healers/surgeons, the traditional heads in the three communities of (Assakio, Ashige and Nene), and the paramount ruler of Jenkwe Kingdom, which covers the entire Migili cultural group. The study population covered three Migili (Koro) communities comprising Assakio, Ashige and Nene, all in Lafia Local Government Area of Nasarawa State. These locations were selected purposively because they represent other Migili-Koro communities on the basis of shared historical circumstances of origin, migration, settlement, as well as social consciousness of the environment and situational challenges.

The sample size of children less than five years, their mothers and fathers on the basis of a particular household was taken by means of systematic random sampling technique. Every household was given the chance to be selected. The elderly men and

women and traditional healers were selected through probability purposive sampling technique. This approach enabled the researcher to have a fair representation of different categories of persons in the communities that could be knowledgeable about body marking and childhood diseases. Lastly, relevant information was gathered from traditional heads of the three communities and the paramount ruler of Jenkwe kingdom, as key informants.

3.3 Research design

The study adopted a thematic qualitative descriptive method, due to its forms: it is a descriptive investigation on medical body marking and the management of childhood diseases among the Migili-Koro of Nasarawa State. However, the design also adopted quantitative survey method for selecting respondents (under-five children); using simple statistical analysis techniques. Other methods used are participant observation, in-depth interview (IDI), Key Informant Interview (KII) and Focus Group Discussion (FGD). These approaches provided systematic description of events and situations through verbal sources illuminating on origin of body marking, processes of acquiring body marking, categories of persons knowledgeable about body marking, patterns of body marking, processes followed before body marking were administered on children and trends of body marking in Migili society. It also delved into issues like parents's understanding of sypmtoms and causes of childhood diseases and their health seeking behaviour. And lastly examined the health implications of body marking on children.

3.4 Sample size determination

To achieve the desired sampled size for the quantitative method used; (that is, the survey instrument) it required the researcher to select a particular segment of the studied population that adequately represented the entire population. In this regard, the researcher adopted appropriate sampling techniques. The necessity for this approach was the difficulties associated with collecting data from the entire population studied. According to the National Population Census (2006), Lafia Local Government Area had population of 330,712. This comprises 161,314 males and 169,398 females, and under-five (0-4years) population of 56,221. Therefore, to determine the sample size of under-five children (0-4years) who were

the target population for this study, Yamane's (1973) formula for sample size determination was used as shown below:

$$n = \frac{N}{1 + N(e)^2}$$

Where

n= required sample size

N = Total population of under-five children in Lafia Local Government of Nasarawa State 56,221 (NPC, 2006).

e = Margin of error allowed 5%

$$n = \frac{56,221}{1+56,221\ (0.05)^2}$$

$$n = \frac{56,221}{141.5525}$$

n = 397

Adjusting the sample size for 10% non-response rate

$$n_f = \frac{n}{1\text{-}NR}$$

$$n_f = \frac{397}{1\text{-}10\%}$$

n_f = 441

3.5 Sampling technique

The study adopted the cluster sampling technique. This sampling technique was considered appropriate for the study population due to absence of a comprehensive sampling frame. It was considered useful due to the rural outlook of the study locations. This was because there were no clearly-defined streets/roads and no identifiable house numbering. As a result, each of the study locations were divided into clusters. Then, within each cluster, a systematic sampling technique was adopted that helped us to select each household covered by the study. This involved the process of selecting the first household, and then followed by every sixth household in a cluster until the required number of sample size was collected. Then, within each household, where two or more children under-five years old resided, one of them was randomly selected. Through this process, only one eligible under-five child from the sampled household was selected.

3.6 Data collection methods

The procedure for collecting data for this study consisted of primary and secondary sources. The research work involved utilisation of both qualitative and quantitative techniques of data collection that included participant observation, in-depth Interview (IDI), key informant interview (KII), focus group discussion (FGD), and the survey instrument. Secondary sources included textbooks, journals, newpapers, and internet materials that realtes to body marking and childhood diseases.

3.6.1 Participant observation

In the course of carrying out the study the participant observation method was utilised. This enabled us to collect data on actions and interactional patterns within the Migili (Koro) society. In applying the method, the researcher actively participated in the daily activities of the society. During period of emergencies, when children experienced ill-health, with due consent given, the researcher participated in providing some form of assistance to parents, family members and traditional healers. For instance, when body marks were administered on children, the researcher observed specific rituals (incantation, prayers, bloodletting, application of herbal solutions and other ceremonial acts involved). In the course of the foregoing, efforts were made to record much of what happened. Personal observation was recorded in field notebook, diary and on electronic tape.

3.6.2 In-depth interview (IDI)

The In-depth Interview (IDI) was conducted on ten (10) traditional healers who were purposively selected from the three study locations. The healers were distributed in the following order: Ashige (four), Assakio (three) and Nene (three). Ashige had four because there were more healers identified in the community. They were mainly from the malefolk in the society because the practice of carrying out body marking on children is exclusively for them. Besides, it accommodates mainly those who are ardent traditional religion practitioners. We observed that few healers acknowledged their conversion to Christianity, and therefore could stress the role of Christian faith and prayers in the process of carrying out body marking on their patients. The traditional healers were knowledgeable in the diagnosis and management of childhood illnesses. The in-depth interview, as a technique of

data collection, explored the origin of body marking, processes for acquiring body marking, categories of persons knowledgeable about body marking, level of knowledge people have on body marking, patterns of body marking, processes followed before body marking were administered on children, and declining patronage of body marking in Migili society. It further explored prevailing cultural beliefs of the people and how this influenced the construction of childhood diseases in the society.

3.6.3 Key informant interview (KII)

The researcher identified individuals who were well-informed and knowledgeable in the research interest. These included the paramount ruler of Jenkwe Kingdom (Zhe Migili), the traditional heads of the three communities (Assakio, Ashige and Nene), and the elderly men and women who were familiar with the indigenous healthcare practices relating to body marking and the management of childhood diseases in Migili society. A total number of sixteen (16) key informants were interviewed through the key informant interview technique. This was achieved through the snowball technique of identifying informants, and they consisted of eight men and eight women that are elderly. This was made possible through the assistance of a research assistant, who is an indigene of one of the studied communities; his effort helped us to identify healers and elderly men and women (key informants) in the three studied communities. The elderly men and women were known to play the role of referrals in times of emergencies when children experienced ill-health in the communities. In this context, their wealth of knowledge and expertise on child health care (CHC) in the community was explored for symbolism, meanings and effectiveness of rituals. The age range of elderly men and women covered in this study were between the age brackets of 55-75 years.

3.6.4 Focus group discussions (FGDs)

Focus group discussions (FGDs) were used to collect required data for this study. This involved a group discussion of persons from similar social background and experiences. The focus group discussion sessions discussed topics drawn from the objectives of this study. The participants were selected purposively on the basis of gender. The focus group discussions consisted of twelve (12) sessions, one female session in each of the study

locations and three male sessions in each location. The reason for only three female groups was informed by the population of females that made themselves available in the focus group discussion were fewer when compared to the men population. Beside, most of the females displayed shyness to participate openly in a focus group discussion. The focus group discussions were held early in the morning on Saturdays between 7.30 a. m. and 10.00 a.m. and in the evening on Fridays and Sundays between 5.00 p.m. and 6.30 p.m.

The focus group discussions (FGDs) engaged young fathers and mothers of under-five children in the three study locations of Ashige, Assakio and Nene towns. The reason for their inclusion in the FGDs was to give them the opportunity to engage in open discussion sessions on issues that concerned their children's health care. The FGD helped to generate rich data in order to achieve the study objectives. This was because it allowed the freedom for group discussions to actively contribute to topical issues highlighted in the objectives of the study. Participants in each (FGD) were not less than eight (8), and more than 10. And they were selected through purposive sampling technique, in a manner that made the sample representative in the mode of problem-solving. A study guide was designed for each discussion group and the discussions were conducted at a time convenient for the participants and in very conducive atmosphere. The discussions were recorded on electronic tape recorder, but salient information was written in personal field notebook.

3.6.5 Questionnaire

The questionnaire in this study served as complementary instrument for primary data collection. It formed the basis for gathering quantitative data. Closed-ended and open-ended questions were designed in the questionnaires to elicit statistical data. The aim was to ensure a wider representativeness and validity of information collected. The questionnaire was divided into four major sections, viz. background characteristics; parents' knowledge on body marking; cultural construction of childhood diseases; and implications of body marking on the health of Migili children. A total of 441 copies of the questionnaire were given to the respondents (parents of children) during the fieldwork. However, a total of 399 copies were ultimately completed and returned by respondents and 28 copies of the

questionnaire were not properly completed by respondents, while 14 copies were not returned to the researcher for reason that they were misplaced.

3.6.6 Secondary data

Secondary data were collected by the researcher from different sources. The secondary data for this study included information collected from relevant textbooks, journals, newspapers, monograph, thesis, internet sources and other published works on body marking and childhood diseases.

3.7 Method of data analysis

The data analysis made used of both qualitative and quantitative data. Thematic data analysis approach was utilised for the qualitative data; through thematic analysis we were able to identified, analysed and reported major themes. Prior to the actual data analysis, preliminary analysis was carried out during daily checks of data to verify all conflicting views; these involved memos, descriptive and reflexive notes to the researcher kept as important points in the observation and interviews needed to be revisited. Since most of the qualitative data were collected in the local Migili language, the researcher first undertook thorough transcription (conversion of recorded speech to text) by putting verbatim what we heard from the audio recorder in hand written form on a notebook which was later typed and printed on paper for easy iterative reading.

One of the research assistant did the translation; the transcriber first translated the voice records from the local Migili Language to English Language, before transcription (that involved actual handwritten) of the speech to text. The process involved listening to the audio-tape, transcribing and noting the occurrences of concepts, local exegesis offered, and relationship existing between negative and positive ideas as well as trends and significance put on ideas. It involved setting the research objectives in different columns of an exercise book, and categorising as well as sorting the information collected into them, based on supporting and non-supporting evidence. The data arranged were presented in the analysis done in this work as narratives and vignettes both in the first person and the collective accounts. In a way, verbal and non-verbal texts were analysed for hidden sub-texts, in an

effort to present and represent the realities and symbolism of medical body marking on Migili children. For the quantitative data, the questionnaires served as the main instrument in gathering the data and was analysed using descriptive statistics such as simple percentages and frequency distribution tables. The statistical tables provide on-the-spot summary of the findings of the study.

3.8 Ethical consideration and reflection on social positioning as a researcher

A major significance of contemporary social and behavioural research basically involves human beings and has ethical implications. Ethical approval was sought from University College Hospital/University of Ibadan (UCH/UI) Ethical Review Board. And after the researcher painstakingly undertook required aptitude tests through the Internet, it was approved by the Ethical Review Board. The researcher took care of informed consent, anonymity, debriefing, assurance of confidentiality and safety from harm.

3.8.1 Consent

In the course of undertaking the research, consent was sought from community leaders, traditional healers, parents and other informants before pictures were taken and tape recordings done. Consent was equally sought before each interview session was conducted (In-depth Interview, Key Informant Interview and Focus Group Discussions).

3.8.2 Right of retraction

Right of retraction was respected in this research. Statements/comments and pictures unapproved by community leaders,traditional healers and parents were deleted from records.

3.8.3 Ethical consideration for community

Ethical consideration to research was equally respected. Pictures of community were not randomly taken, as regards healing processes, economic, religious social activities. The researcher entered the community each time with care, humility and respect for the culture of the communities, and more importantly that he is not a Migili indigene.

3.8.4 Right of debriefing

Right of debriefing was declared to community leaders, traditional healers, parents of children and other informants. Questions asked by the researcher were clarified and approval sought before documentation.

3.8.5 Right of anonymity and confidentiality

Right of anonymity and confidentiality was protected as the researcher did not take pictures showing identity of healers and patients (children) without their due consent and from parents as well.

CHAPTER FOUR

ETHNOGRAPHY OF THE *MÌGILI*-KÓRÒOF NASARAWA STATE, NIGERIA

4.1 Location and geography of Migili in Nasarawa State

The Migili occupy a vast expanse of land within the old Lafia Division of Nasarawa State in north central Nigeria. They make up Jenkwe Kingdom, which incorporates most of the land that stretched from the northern banks of River Benue northwards to Mada hills. The population of the group cuts across parts of present-day Obi, Doma, Keana, Lafia and Awe local government areas of Nasarawa State. Their closest neighbours are the Alago, Gwandara, Eggon and Kamberi. Their environment is associated with heavy forest, especially around the Lafia and Awe areas. It is also blessed with light bush and savannah vegetation. The geographical location of the Migili, also known as the southern part of Koro homelands down to River Benue, is richly blessed with economic trees, especially heavy woods, such as mahoganies, palm oil trees, ebony, iroko, shea butter and locust bean trees which flourish in great numbers all through the central regions of Nigeria.

Historical evidence has shown that the Migili, who great farmers, fishermen and hunters are have always preferred dwelling in the savannah, which allows free movement of people and goods as well as extensive farming activities. From early historical evidence, the savannah region favoured more dense population than other parts of Nigeria (Igube, 1976). The Migili live in very fertile region where food is grown in abundance and the soils are very fertile for high crop production.

4.2 Historical origin and settlement pattern of Migili in Nasarawa State

This study discovered that, in an effort to fully understand the ethnography of the Migili group, their historical origin needed to be ascertained. The general history of the Migili group, who are an extraction of the larger Koro group, maintained that Koro and Jukun were brothers, Koro was the elder brother and Jukun was the younger and both had established large cities south of River Benue. Koro and Jukun were part of the remnants of the ancient Kororafa Kingdom that existed in North-eastern Nigeria, side by side with the Kanem Bornu Empire.

The Koro claim that they migrated from Bornu and Lake Chad region through a passage between the Lake Chad and Mandara mountains from where they dispersed and migrated in groups to the southern bank of River Benue. It was from Kororofa that the Migili migrated *en mass* to the present Lafia region. Local historical sources showed that they migrated from the Kororafa Kingdom around 1132 AD. The Migili, who are also called Koro in Lafia, had established a kingdom called Nene between 12th and 15th centuries. Oral historical source revealed that the city of Nene was founded about 1770. The Migili, who were believed to be the earliest group to have inhabited most of Lafia, Awe and Doma regions, are still found in large numbers.

Their towns and cities are usually fortified by very high mud walls with deep wide ditch outside the walls. Their settlement pattern is usually based on homestead, revolving around lineage affiliation. The larger settlement in Migili society is the town while the clan reflects the wider kinship affiliation. Local history relates that 13 clans, which make up the present Migili society that were led by Azige Ogu on crossing River Benue at Akwanaja, settled there for sometime before a general survey of the land was carried out to locate the most suitable sites for final settlements. Prominent among these clans are Muzro (which is the present Doma town) Mukolo/Mugo clan (present Jenkwe and Gidan Rai), Mupano (present Shiga town), Mubri (present Gidinye, near Agyaragu town), Agyale clan (part of present Obi town), Muguni clan (Nene town in present Lafia), Musha clan (Gidan Ausa), Muzwa (present Giza town), Damiti clan, Mukoonoo clan, and Geen clan.

4.3 Religion and belief system of Migili in Nasarawa State

Our findings revealed that most Migili are Christians, fewer identify with the Islamic religion. The reason for this trend, according to Igube (2004), is closely connected with the hostilities the Migili experienced from the Hausa-Fulani jihadist in the early 20th century. Igli (1982) opined that, unlike Christianity, Islam as a religion, did not have much impact on Migili society due to its devastating role in dislodging the Migili from their ancient cities such as Chalago and Nene (Lafia). The jihadists were unlike the Christian missionaries, who were more persuasive and friendly in seeking new converts. The Roman Catholic Church was one of the earliest of the Christian Missions that had an in-road into Migili society.

Other Christian missions were Evangelical Church of West Africa (ECWA) and Evangelical Reformed Church of Christ (ERCC). The Pentecostal missions are recent and not widespread in Migili towns and villages. Noticeable among them are Winners' Chapel, The Redeemed Christian Church of God (RCCG) and Assemblies of God Church.

It is instructive to note that the society and its people still display affection for tradition in their religious beliefs and practices. They share belief in the supernatural and spiritual beings operating as spirits, deities, gods and ancestors. This is reflected in the way they worship and appease them with constant sacrifices and ceremonies. We observed the existence of shrines located in special places, such as the front of some houses. This was well-noticed in Ashige and Assakio. We also observed in Ashige a short palm tree that had red cloth with cowries shell tied at the middle. Evidence of locally-brewed beer poured at the foot of the palm tree was observed. It was considered a sacred tree in Plate 4.1,Page 48 is a sacred (grove) in one of the communities studied. It is a sacred place set aside by the community to honour their ancestors/gods. The grove is a dedicated for religious ceremonies and entry is prohibited. At special occasions like the celebration of New Yam Festival, revered traditional authorities perform certain ceremonies inside the grove.The researcher observed a very thick sacred forest (grove) in Assakio. When asked about its significance from a young informant, the reply was:

> Ah, this is a very thick forest the traditional priest annually goes into with other elders to perform certain rituals to appease the gods/spirits! People are not allowed to move into this thick forest (groove) to do anything. It is believed that the guardian spirits of the town reside inside the thick forest. It is a sign of respect to the gods/spirits for ordinary people not to enter this forest (Personal Communication October, 2015).

Ethnographic findings revealed that some traditional healers are still adherents of traditional beliefs, even though some had converted to Christianity. In addition, in one of the traditional healer's house we visited and interview was conducted, we noticed three tombs in the courtyard of the house. One was the tomb of his great-grand father, while the remaining two were those of his father and mother as shown in Plate 4.2, page 49. When asked why they were buried in the courtyard, the healer remarked, "We believed that our

ancestors still live with us, and they protect and sustain us and our children". The practice of burying dead parents in the courtyard is linked to power to invoke the spirits of ancestors/ancestresses, and offer sacrifices in form of foods and drinks, as a means of appeasing and showing them great respect. Another aspect of traditional religious practice identified in Migili society was the practice of magic and medicine. We observed that, in the sitting room of the traditional head of one of the towns, on the lintel of the sitting room and ceiling of the throne, were assorted amulets hung conspicuously.

Plate 4.1.Sacred grove (*ágúmu*) in Assakio community in Migili society.
(Source: Fieldwork, October, 2015).

Plate 4.2.Tombs of parents in the courtyard of a household in Assakio community. (Source: Fieldwork, November, 2015).

4.4 Values and taboos of Migili in Nasarawa State

The Migili as a cultural group have unique values that distinguish them from other groups within the north-central region of Nigeria. These values were handed down by their ancestors and are preserved by the present generation. Some of the outstanding values of the people are communalism, humility, bravery, hard work, honesty and respect for the elderly. We observed communal efforts in harvesting crops, building/constructing houses, and constructing and rehabilitating roads. We also observed that the average Migili man or woman, even the elderly, work hard on the farm. They actually pride themselves in producing food crops sufficient for the household and economic purposes. A sign of humility and respect of authority is that when a Migili man meets his superior or elder on the road, he kneels down and greets. When an elderly is walking along the road, the young men riding a bicycle comes down to kneel and greet before proceeding.

At several instances, we observed that if an elderly man or woman is carrying a load either from the farm or to the market, the young ones offer a helping hand by carrying the load to the door step of the elder's house. Similarly, taboos and superstitions help to ensure compliance with societal norms. The most common taboos deal with adultery and stealing of agricultural produce such as yam, maize, groundnut and guinea corn. Oral tradition of some of the clans/villages in addition have taboos associated with certain animals, like the leopard and monkey, which are totemic animals considered sacred and should not be killed, eaten or even touched by the descendants of the clans/villages.

4.5 Economic organisation of Migili in Nasarawa State

The greatest occupation of the Migili people revolves around farming. Nature has blessed them with fertile soil, on which food crops can be produced in abundance. They have found an ideal home on a vast fertile plain and have utilised the soil very efficiently to produce annually a large variety of food crops such as millet, guinea corn, beans and yam. Both men and women are hardworking and cherish the traditional occupation handed to them by the ancestors. As early as 6.0 a.m., the average Migili man or woman has gone to the farm and only returns around 5.00 p.m. The only resting day for them is Sunday.

Plate 4.3. Yam (*ńtrin*)market (*mízɛn*) in Ashige community. (Source: Fieldwork October, 2015).

On Saturday, farming activities usually terminate by 2.00 p.m. to enable them participate in other socio-cultural activities such as wedding and family meetings like settlement of disputes.

In the event of death of a member of the immediate family, lineage, or distance relatives, farming and other regular tasks are suspended. The Migili are major producers of yams within the old Lafia Division. At the period of harvest, in September-November, hundreds and thousands of tons of yams are transported from notable towns in Jenkwe Kingdom like Ashige, Kunza, Duglu and Agyaragu to the southern parts of Nigeria, especially south-eastern Nigeria. Plate 4.3 on page 51 shows yam sellers displaying their goods at Ashige market. They also produce great quantities of guinea corn, maize, groundnut, millet, beans, cassava, fruits and vegetable. They are also well-known for their local beer popularly called *burukuti*, brewed from guinea corn. There are many local beer joints in the studied communities, as illustrated on Plate 4.4 on page 53; 4.5 on page 54; Plate 4.6 on page 55 and Plate 4.7 on page 56. The local beer joints operate especially in the evening hours. Noticeable feature of the location of local beer joint are white basin and large rubber containers. In addition, we observed huge yam barns in homesteads and the drying of large quantities of guinea corn, maize and groundnuts on roof tops and verandas. Hunting and fishing are still carried out by the elderly men, especially during dry season when farming activities is at its lowest ebb. The rearing of domestic animals such as goat, guinea fowl, pig, and duck is part of the economic activities of the Migili people.

Plate 4.4. Women in a typical *burukutu* (local beer) joint in Assakio community. (Source: Fieldwork, November 2015).

P**late 4.5**. Woman selling *burukutu* (local beer) to male customers in Assakio community. (Source: Fieldwork, November 2015).

Plate 4.6. Men sitting in a *burukutu* (local beer) joint, drinking and discussing in Ashige community. (Source: Fieldwork, Novembe, 2015).

Plate 4.7: Men sitting in a traditional makeshift shelter in a *burukutu* (local beer) joint, drinking and discussing in Nene community. (Source: Fieldwork, December 2015).

4.6 Political organization of Migili in Nasarawa State

The political structure of the Migili is anchored on the paramount ruler, known as *Zhe* Migili, a first-class traditional ruler. The *Zhe* Migili is the spiritual head of the Migili cultural group. His political status and authority are derived from the general belief of the people that the *Zhe* is the direct representative of the gods/ancestors. The right to kingship is rotated among the clans of Musha, Mushro and Gindinye. However, the 2005 government gazette gave equal opportunity for other clans to contest for the title of *Zhe* Migili (Agwadu and Agwadu, 2012). The present *Zhe* Migili is from Musha clan. The patriarchal politics does not give due recognition to women as such. There are also Chiefdoms within the Migili society comprising Musha, Duglu and Gidinye Chiefdoms. The creation of these in recent years was to play the important role of reuniting the various towns and villages in Jenke kingdom into a centralised entity.

The administration of Jenkwe Kingdom was highly centralised, although the king delegated responsibilities to the various chiefs, village heads and other political authorities recognised within the kingdom. The constituted authorities and leaders within the society are, thus, the village heads, lineage heads, Age-grade associations and cultural associations. During annual cultural festivals, all Jenkwe chiefs and community heads are summoned to settle disputes and resolve urgent matters affecting the kingdom in the palace of the *Zhe* Migili. Similarly, at annual ceremonies/festivals, chiefs, village heads and their subjects reaffirm their loyalty to the *Zhe* Migili. So united are the people that the Migili society has a common political voice in Nigerian politics. Once a decision is taken to support a given political party or candidate, no one is expected to violate the agreement.

4.7 Kinship, marriage and family among Migili in Nasarawa State

Kinhip is reflected in the pattern of residence, which is based on segmentary lineage. The rule of descent is patrilineal, that is, it is through the father's lineage an individual is recognised in Migili society. The male child is the most visible point of reference and is directly linked to rights to inheritance, political title holding and religious authority amongst others. Settlement is patrilocal, for after marriage is contracted, the couple are expected to reside in the husband's patrilineal home. The most common form of marriage among the

Migili, in the pre-colonial period, was betrothal marriage. In this kind of marriage, there is the formal introduction of the groom to the bride's parents, and payment of the bride price is made as soon as the young bride experiences her first menstrual circle.

Today, however, in almost all Migili communities, the girls are free to choose whoever they wish to marry. Christian weddings have become more fashionable and acceptable to the younger generation of people. Marriage is considered a lifelong agreement between a man and a woman. Divorce is not permitted. Even when divorce occurs, the husband is encouraged to accept the wife back to his house anytime she returns to him, because she is regarded as his legal wife. The most common form of marriage in Migili society is the polygynous marriage. This allows a man to marry more than one wife at a time. The traditional economy of the Migili favours a large family size that consists of many wives and their children.

We observed several households in the studied areas, and found them to be polygynous male-headed family units, where wives and their children lived in large compounds. There is strong indication that Migili practise unilineal patrilocal rule of residence. The Migili society recognises and practices levirate marriage, which allows a younger brother to inherit the wife of his deceased elder brother. The levirate marriage is consummated after the funeral rites of the deceased brother have been completed. These rites involve rituals performed in the family house. There is no payment of bride price in any form. The younger brother takes full responsibilities of the care and support of the wife and children inherited from the deceased elder brother. This custom is still practised in the rural community by those who lack Western education and are inclined to traditional beliefs.

4.8 Inter-group relations between Migili and other cultural groups in Nasarawa State

In the course of research, we could detect some form of complex inter-group relations between the Migili and their neighbours. These include, but are not limited to, friendly and hospitable relations, settlement pattern, economic and political relations and management of conflicts. Since pre-colonial period, the powerful rulers of Migili had maintained a friendly and hospitable relationship with neighbours and received new migrants who came to settle

in their domain. They had very cordial relationship with the Alago people of Keana and Doma, who were believed to be their closest kinsmen in the Kororafa Empire.

Similarly, the Gwandara of Shabu and Kwandere are close neighbours, who have coexisted peacefully with the Migilis for many centuries. The Migilis are generous and hospitable people. They always welcome visitors who come peacefully and choose to settle among them. One of such groups that the Migili welcomed with opened arms was the Kanuri, also known as Kamberi. Local history states that, even though the Migili were the first settlers in the Lafia region, they maintained a legacy of friendship with the Kamberi group (who were migrants from Bornu Empire). They accepted them peacefully in Nene (Lafia). The Migili, after their migration from Kororofa kingdom to north central Nigeria, established and settled in many towns and cities side by side with the Alago their neighbours, namely the Keana, Arage, Doma, Assakio, Agyaragu, and Chalago among others.

Plate 4.8: A building in Assakio community, burnt as a result of the 2013 Migili/Eggon communal conflict. (Source: Fieldwork November, 2015).

The Migili and their neighbours (which include the Alago, Gwandara and Eggon) engage in economic relations by farming in the same territory. They equally actively engage in trading agricultural produce such as yam, millet, maize and groundnut with their neighbours. For example, the Agyaragu yam market is a major economic melting pot for the Migili and their neighbours. The Migili and Alago, up to this generation, maintain excellent relationships. Local history reveals that after the fall of the Kororafa Empire, the Migili carried most of their deities and divination to their present settlement and shared some of them with their Alago neighbours. This gives the reason *Odú,* one of the divinities of the Migili, is today adopted by the Alago of Doma and the Gwandara of Giza. Furthermore, other Migili deities such as *Awsho*, *Kalasho*, *Avabe*, *Anako*, *Okpili*, *Ashama* and *Maleku* have been adopted by their neighbours, especially Gwandara, Alago, Afo, Gwari, Gade and Eggon.

In another vein, at independence when elective politics was introduced in the old Lafia Division, the Migili teamed up with other suppressed and marginalised cultural groups to vote against the aristocrats of the Northern People's Congress (NPC). The political understanding between the Migili and their Alago and Gwandara neighbours has continued to the present democratic dispensation because of the historical, cultural and religious affinity they have and share with their neighbours. However, in spite of the foregoing relationships between the Migili and their neighbours, there are instances of communal conflict and hostilities in the recent past. The Migilis have had some form of bitter experiences with some of their neighbours. These include the Kamberi, who had used the Fulani herdsmen, as their close kinsmen to unleash havoc on Migili houses and farmlands in the last few years. Furthermore, findings from ethnographic data reveal that between 2012 and 2013, the Migili had protracted land disputes with the Eggon and Gwandara which resulted in loss of lives and properties. Plate 4.8 on page 60 shows the house of the traditional head of Assakio burnt as a result of conflict with the Eggons.

4.9 Indigenous health-care system of Migili in Nasarawa State

There is an elaborate indigenous health-care system handed down by the forebears from time immemorial. So successful is it that people from neighbouring cultural groups, like the Alago, Eggon, Mada and Afo flock to Migili communities to seek healing for various kinds

of diseases that affect both children and adults. At present, the society boasts of well-endowed and skilful traditional healers that cut across the old and younger generations. There are herbalists endowed with knowledge of the use of herbs, roots and other medicinal sources for the treatment of different diseases, sicknesses and all kinds of health problems. Some of them also specialise in the knowledge of administering body marking on children, to cure ailments like convulsion, polio, pneumonia and splenomegaly.

Similarly, traditional healers administer marking on adult-related illnesses such as dislocation, chest pain and backache. While diviners are health-care givers who specialise in managing and treating convulsion and few cases of paralysis in children. There are also bone-setters who handle cases of bone fraction and dislocation. Other traditional health practitioners, also manage mental health problem. The herbalists and bone-setters operate as members of guilds and associations. These healers operate as members of a revered cult, especially those who are diviners. The knowledge of herbs is inherited from elderly parents, grand-parents and even through dreams. In recent years, young practitioners do also acquire knowledge and skills of healing through apprenticeship under older and experienced practitioners.

CHAPTER FIVE

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

5.1 Demographic characteristics of sampled children population

As indicated in the immediate-previous chapter, this study adopts the quantitative survey instrument as a means of complementing its principal ethnographic qualitative research method. The aim is to give a wider scope to data gathering and analysis. Findings from this study were based on a sample size of 399 children under five years old covered by the study population. The data collected from the survey instrument were analysed, and presented in frequency tables.

Table 5.1. Socio-demographic characteristics of sampled children population

S/N	Variables	Options	Frequency	Percentages
1	Sex			
		Male	197	49.0
		Female	202	51.0
		Total	399	100.0
2	Age child was given body marks			
		Less than One year	36	9.0
		One year	132	33.0
		Two years	157	39.0
		Three years	58	15.0
		Four years	16	4.0
		Total	399	100.0
3	Location of child			
		Ashige	169	42.0
		Assakio	151	38.0
		Nene	79	20.0
		Total	399	100.0
4	Nature of disease child had when body marking was given			
		Convulsion	44	11.0
		Pneumonia	97	24.0
		Polio	08	2.0
		Splenomegaly	250	63.0
		Total	399	100.0

The findings indicate that 399 children were sampled from the three communities; 197 children (49.0%) of the sample size are males while 202 children (51.0%) were females. There were more female children captured in the survey instrument. On the age that child was given body marking, the table shows that from a total of 399 children sampled, 36 of them (9.0%) were less than one year; 132 children (33.0%) were one year while 157 (39.0%) were two years. Also, 58 children (15.0%) were three years old, and 16 children (4.0%) are four years old. From the foregoing, a greater percentage of sampled children fall between the ages of one and two years (72.0%) were given body marking. The reason for this high figure is closely connected with the fact that children within the age range of 1-2 years are more vulnerable to common illnesses. Another likely reason can be attributed to the weaning of the children from their mothers. The intervention at this stage is assumed by Migilis to drastically protect the child from common illnesses.

Furthermore, 169 children (42%) were surveyed in Ashige town while 151 (38%) were surveyed in Assakio town, and 79 (20%) from Nene town were covered by the survey instrument. The nature of the disease a child had when body marking was given as revealed in the survey instrument was 44 (11.0%) for convulsion. Also, 97 children (24.0%) had pneumonia while only 08 (2.0%) had polio. A total of 250 children (63.0 %) were given marks for splenomegaly, an indication that a greater percentage of children were given marks for splenomegaly. The wide spread of this disease among children in Migili society is attributed to the behavioural attitude of mothers who regularly breastfeed their children in the heat of the scorching sun. From ethnographic findings, mothers think that when their breast milk is exposed to the sun, children have the tendency to develop spleen disorder. Another prevailing belief discovered from this study is that when mother lye down to breastfeed baby, it results in enlargement of the spleen. According to some parents, the best cure for a spleen disorder in a child is to give marks on the lower abdomen region so as to bring out bad blood and water. But our observations among many children in the study communities revealed their malnourished status, which could likely be the reason for them to be vulnerable to common childhood disease such as splenomegaly.

5.2 Prevailing knowledge people have of body marking in Mìgili-Kórò society

For us to fully understand the prevailing knowledge people have of body marking in Migili society, the study delves into the following prominent themes: Origin of body marking, processes of acquiring body marking knowledge and skills, categories of persons who have knowledge on body marking on children, level of knowledge people have of body marking, patterns of body marking identified, processes followed before body marking is administered on children, and declining patronage: the effect of beliefs and attitudes on body marking practice in Migili society.

5.2.1 Origin of Body Marking in Mìgili-Kórò Society

From our ethnographic findings, virtually all those interviewed could not state when exactly body marking started in Migili society. It is believed by some that the Migili people started practising body marking from the era of the historic Kororafa Empire. It is believed that the knowledge was handed down to them by their forebears through generations. This is to justify the continuous acceptance of the practice among the people. The present generation of Migili only grew up to realise body marking as a form of indigenous health-care practice designed to meet the health challenges of the society. Nkosi Ajeh, the Secretary of Ashige Community Association, threw more light on the issue:

> We grew up to know the practice from our parents and we were initiated into it. So, I cannot tell the exact time that the practice started. But, basically, it has been with us since time immemorial, and it is hereditary, that is, it runs in family lineage that carries out the practice (Nkosi Ajeh, Personal Communication, October, 2015).

The above narrative was equally corroborated by the survey instrument data as relayed from the Figure 5.2 below

Table 5.2. Opinion of parent on the sources of knowledge on body marking

Option	Frequency	Percentage
Parent	175	44.0
Grand-parent	132	33.0
Relation	29	7.0
Traditional healer	18	5.0

Spouse	45	11.0
Total	399	100

Table 5.2, shows that 175 (44.0%) of parents admit their source of knowlwdge on body is from parents, 132 (33.0%) indicate their grand-parents provided the knowledge. And, 29 (7.0%) of parents reveal that relations provided the knowledge, and 18 (5.0%) indicate that they derived their knowledge on body marking from traditional healers. Similarly, 45 (11.0%) of parents admit that their source of knowledge on body marking is ther spouse. Our survey finding reveals a greater number 307 (77%) of respondents derive their knowledge of body marking from either parents or grand-parents. The foregoing is an indication that socialisation by parents and grand-parents in Migili society plays significant role in sustaining body marking practice in the study area. And ethnographic findings reveal that this phenomenon is still very strong even in this modern time.

Body marking in Migili society must have started because of the need for cultural identification of the people, especially a migrant society, which needs to protect itself as a community and treatment of certain ailments. In this regard, the giving of facial marks consists of one vertical line on both cheeks and three straight lines by the side of the mouth. For the women, identification marks were given on the stomach and on the back for the purposes of betrothal. This explains why, while a woman is at a tender age, the prospective suitor pays a token sum of money that is used to give the beautification marks on the abdomen and on the back. The marks serve as symbol of consummating the union between the suitor and the betrothed wife. Findings from ethnographic data reveal that marks for cultural identification and treatment of ailments were not of Migili origin, but were copied from the Tiv people who introduced it into Migili society. As narrated by Samiya Danzhe, a 75-yearold-healer:

Zhéla túlò naba ná ni zhé Amíshí.
Cenè kɔn à nɔ mínyɛ ble ńsɔ íwé.
kɔn zhéla à shó ǹgàn kɔn a zɔrɔ nɛ.
kɔn bā yàkaa kɔn a kló rúgɔn ádzáravé wá.
kɔn à shó zhe Amíshí kútsà kà dɔ kúva kɔn.
kpóò zhé ne gbíi. Kpóò, bà dro mùgàa ne.

This translates as:
Our traditional leader in those days went to pay the traditional leader of the Tiv a visit. On his arrival to the palace, he saw some people with body marks. So, our leader inquired what problem it must have solved. He was told that it cured childhood illness like splenomegaly. He, then, begged the host if he could be given a portion of the medicine and the traditional authority to cure the illness, and the Tiv leader obliged. There and then, the initiation was negotiated (Samiya Danzhe, Personal Communication, February, 2017).

Another oral tradition explained that a Tiv hunter on hunting expedition had dwelt in Migili land and introduced facial marks to the Migili people. The Migili people could have persuaded the Tiv man to give them the same marks he had. Further findings from our observation reveal that facial marks seen on faces of men and women who are above 60 years are similar to those of the Tiv people. At the time body marking was introduced into Migili society by the Tiv, the marking were solely for aesthetic purpose, that is, for beautification and identification. With time, facial marks became popular among the Migili people, and the general belief was that anyone who did not have the marks would be captured or stolen by the Hausa/Fulani. According to Igube (2005), the giving of marks was made popular due to the fact that

> The giving of facial marks was a distinguishing feature among the Migili of Lafia. During the pre-colonial times facial marks were given as a way of distinguishing the Migili from their neighbours, especially in ancient wars (Igube, 2005:2).

Findings from our observation show that, among the present generation of Migili, it is very rare to identify young men and women with facial marks, apart from those for curative purposes. Further ethnographic findings reveal that body marking for splenomegaly, popularly known as *sépa*in Lijili language, is one of the most common forms of body marking. Generally, facial marking is becoming less popular due to the impact of Christianity religious doctrines and Western values on the people.

It is noteworthy to state here that the exact period body marking started in Migili society seems unknown to the people, even the elderly. For example, this is the account of Cheni Leku, a 60-year-old female key informant from Assakio town:

Kónyííkpùnyo mêŋ n ri kɔn n ní ǹgànɛ ná.

N pen ípéré kɔn a fára ne ma.

A fára tùnú túlò wá.

Ba yàka la kɔn múcó la zɔrɔ ná.

This translates as
As old as I am, I grew up and met the practice. I don't know when and how it actually started. It started since time immemorial. We were told that our fore-fathers practiced it (Cheni Leku, Personal Communication, October, 2015).

There are various accounts of how body marking, especially the one for curative purposes, began in Migili society. According to Oyele Gbotu, a 55-year-old traditional healer from Assakio town recalled the origin of body marking:

Kútu áìwé túntúńna ádzáravé háda ńsɔn

Kíshísha kɔn múcɔ ka yàka la nɛ wá. Bá yàka la

kɔn írà lo dɔn ìpere nɛ kɔn baà ma ǹtrín lo cwé

kùcɔ á mbɔn. Nnɛ, mínyɛ lee bàn ma átrá gbo ǹgane ná.

Ntrín íkósóklɔ bàn ma nì. Nyen kɔn a gbo átra mbɔn ne ká ná

cí ńtrín nɛ ká gɔɔ bɛ̀, ìnɔn ní nì kúkplà kán klɔ rúgɔn sépa nɛ ná.

Wee, ba cwe ńtrín nɛ kɔn bà tan bɔ. Ba ywara múdàn bɔ. Kɔn

ba lò ńkɔn kɔn n kpíjà sépa. Nyɛ nɛ an ma si mínyɛ íjɛ mútá.

This translates as
The origin of body marking, especially on children is linked to a story that was told by our forefathers. We were told that there existed a game, whereby the root from a particular plant would be placed on a heap and many people would be expected to throw arrow at them. So, the last tuber that has not been arrowed would be buried and the person that threw the arrow in the sand and removes the tuber gets the authority and power to heal sickness such as splenomegaly. Usually, the tuber is cooked and eaten; it is also dried and grounded into powdery form to be spread on the marked region. Take note that the person that becomes the automatic healer after shooting the arrow on the tuber/root would wave it round his head for up to seven times (Oyele Gbotu, Personal Communication, October, 2015).

The above narration highlights the prowess of men in the past. It also indicates that acquiring knowledge and skill as relates to healing the sick necessitates display of strength, determination and accuracy. From our findings, the connection of the above game to the art of healing indicates the prowess of a person to treat diseases. The root, according to our finding, was most likely the root of a plant. And the significance is in waving the tuber round the head of the eventual winner of the game, which signifies that the head is strategic to the very existence of the individual and on it rests the ultimate authority to treat diseases. And most importantly, the head is the cradle of inspiration for the healer. In addition, in the world view of the Migili people, waving the tuber round the head of the individual seven times confirms the eventual initiation of the winner of the game into the profession of healing. Seven numerically signals perfection of the initiation and indicates that the healer will achieve success.

Another version statesthat, in the past, diseases were rampant among the Migili people, and the sick were only treated via drinking bolied herbs although the potency of the boiled herbs was less effective and, in some instances, diseases reoccurred after the herbal remedies had been administered on patients. What this means is that oral administration of herbs, as a method of treating children's illnesses, was considered less potent in the past. So, it became imperative to device more effective methods of treating sick children. This, then, necessitated the giving of marks to the sick in Migili society. Our findings reveal this and prove it to be more effective than oral administration of herbal remedies. Therefore, the people thought of solving their health problems in this way. They came up with the idea of body marking as a form of traditional and spiritual methods for treating certain dieases. The survey instrument also sought the opinion of parents on major reasons for the continued utilisation of medical body marks on children in Migili society.

Table 5.3. Opinion of parent on major reason for utilizing body marking on children

Option	Frequency	Percentage
To heal child from common illnesses	287	72.0
To heal child from mysterious illness	60	15.0
To protect the child from evil forces	43	11.0
To fulfil the custom of Migili society	09	2.0
Total	399	100

Table 5.3, indicate that 287 of respondents (72.0.7%) admit that a major reason for administering body marking on children is to heal common childhood diseases. Also, 60 respondents (15.0%) indicate that body marking were administered on children to heal them from mysterious illness. In addition, 43 respondents (11.0%) express the opinion that body marking were administered to protect the child from evil forces, and just 9 respondents (2.0%) indicate that body marking were administered on children to fulfil the custom of the Migili society. Table 5.3 above, greater number of respondents indicate that body marking is administered on children mainly for the purpose of healing common childhood diseases especially splenomegal**y**.

Further ethnographic findings reveal that women used to breastfeed their babies in a lying position. And this manifested in certain symptoms like vomiting, high temperature, hardness of the stomach region resulting in splenomegaly as a form of illness that afflicts children. The traditional healers initially prepared herbs that were administered orally on patients. However, this could not give lasting cure to children because it was considered ineffective. Then, there was a revelation to a certain man named Dagbonyo to start giving marks on children, and then apply a powdery substance on the part of the body where marks are been made. This was tested and it turned out to be effective and thus led to the popularity of giving marks to children, especially for splenomegaly which has been practiced till this generation. The aspect of revelation in the story denotes that giving marks is linked to divine

source. The explanation for this is that certain individuals were given supernatural powers in the past. Samiya Danzhe, a 75-year old traditional healer from Nene village attested thus: *íklɔ rùgɔn nɛ fara ńsɔn nyelo kɔn ba rɔ kɔn.*

Dagbonyo nɛ wa. Kíshísha yàka la kɔn báa yàka.

Dagbonyo ǹ kìlɛ̀lɛ̀ wá. Bá yáka kà sere ńkɔn áaci

blênìwé ísála. Kpóò à klɔ rúgɔn lɛɛ.

Tùnú nɛ kɛ kɔn a náa rítrê nɛ.

This translates as

> The practice was linked with the life experience of a particular man, named Dagbonyo. According to oral tradition, body marking was revealed to Dagbonyo in a dream. He, Dagbonyo was given the authority to start giving marks and apply certain herbal ingredients to parts of the body where marks were given. This revelation helped to cure certain illnesses and ever since the practice of body marking has been with the Migili, and has continued till this generation (Samiya Danzhe, Personal Communication, November, 2015).

But Zhegoro Iperesi, a 50-year-old traditional healer from Ashige, gave his own account of the origin of the practice:

> My maternal great-grand father who lived here many years ago was believed to be one of the first healers that started body marking practice here. I am even named after him (Zhegoro Iperesi, Personal Communication, October, 2015).

Many people in Migili society cannot tell exactly the personality that originated body marking as a form of indigenous health practice. The common assumption is that a particular person must have started or brought the knowledge to the community. The real personality, who discovered the knowledge of giving marks for identification and aesthetic purpose, as well as the cure for children's illnesses, appears buried in obscurity. Consequently, the origin is ascribed to different individuals. He could even be an outsider, according to Zhe Migili, Ayuba Agwadu Audu, the paramount ruler of Migili Kingdom:

> The marks for body beautification, to the best of my knowledge were introduced into Migili society by the Tiv. But marks for the treatment of splenomegaly (enlarge spleen) in children, our fore-fathers told us that a certain Migili man went out of town for a long time, then later came back

> home to practice it (Ayuba Agwadu Audu, Personal Communication, October, 2015).

The above finding has some measure of authenticity because the marks given for identification among the Migili has close resemblance with the marks the Tiv have. Our sources could not give much reliable evidence for when and where body marking actually originated, so according to Iperesi Leku, the traditional head of Ashige:

> We were told that body marking started with a man called Gudu Okwe. As we were told, this man received revelation in a dream to start it, to treat illnesses like splenomegaly that was prevalent among children Body marking became popular due to the ineffective oral administration of herbs on sick children (Iperesi Leku, Personal Communication, October, 2015).

This calls for determining the nature of the dream had by Gudu Okwe. Since we could not get a response to our inquiry, the narrative may just be a myth that revolves around how the practice of body marking started among the people.

5.2.2 Processes for acquiring knowledge of Body Marking in Mìgili-Kórò society

The processes for acquiring body marking knowledge in Migili society are three-fold. Firstly, it could be acquired through inheritance; that is, passed directly from father to a son. This implies that, within a family or lineage, a son can automatically inherit the power, authority, knowledge and skills from his father or grandfather. By this, acquiring body marking knowledge is hereditary and therefore connected to a particular family or lineage. Acquisition of knowledge on body marking comes with a father transferring the power, authority and skills to the son. Most often, it is a male child who is customarily permitted to inherit it from his father. In the olden days, most traditional healers acquired the knowledge directly from their fathers. Hence, the acquisition seems to be basically hereditary.

In each village, a particular family has an exclusive privilege of the knowledge and skills of body marking practice. This means that the actual knowledge of putting it into practice could vary from one family or lineage to another. In any case, not all families have the knowledge. In fact, some people in a practising family or lineage may not even be interested. As asserted by Oyele Gbotu, a traditional healer from Assakio, “It is not

mandatorily linked to a lineage, but most often than not you see that it is the children of the healers that take after their parents when they are no more". Therefore, anyone could learn and practice it. For instance, Zhegoro Iperesi, a 50-year-old traditional healer from Ashige town remarked:

> I knew about the tradition through my father. My father learnt it from my maternal great-grand father who happens to be the first person to have started the practice in this village. My father in turn called me and advised that I practice it so that I could save lives when he is no more. So, I can say I inherited it. My father is still alive today, and still practices it (Zhegoro Iperesi, Personal Communication, October, 2015).

It is pertinent to further state that those who acquired the knowledge through inheritance, that is, directly from father to son, were often initiated into the practice of body marking at a very tender age. The father, usually, gives early initiation and training to the son. This is done in a shrine where water, already filled with certain materials which have been prayed over, is administered by drinking and sprinkling on the body seven times by the father.

This implies that inheritance involves some form of initiation ceremony or ritual for the son. The symbolic meaning of the father sprinkling the son is to ensure that the son receives full impartation of the gift of healing the sick. Nyepeogasi Gbado, a 65-year-old traditional healer from Assakio, expatiated on the issue of inheritance:

> *Ndà nyɛn ká só kúva mùgàn nɛàn yiwɔ na*
> *Nàlí ká ná yàka áwa íklɔ rúgɔn. Ndà kɔn àn bɛ jɔɔ*
> *Kúkun ká ma áva kɔn ko nìnù ńsɔn áklodzi kwɛɛ.*
> *Kon à sho kìtsà. Nkɔn a ma kúva kɔn ro bɔ,*
> *Dzá kɔn à kplɔ nyí klɔ rúgɔn nɛ kɛ ná.*
>
> This translates as:
> One's father or healer will take the interested fellow to the forest to show him the herbs required for healing. After this, the father or healer comes home and asks the interested son to kneel down. The father or healer places the interested person's hand on a pot with a token sum of money like a coin and makes incantations. Once the healer removes the hand of the interested person from the pot, he becomes an authority and can heal

sick patients (Nyepeogasi Gbado, Personal Communication, October, 2015).

Taking the interested person to the forest is to show him the plants or leaves needed for healing the sick, and placing the hand of the new healer on a pot as incantation is recited, signifies the transfer of spiritual powers of healing. Placing the hand of the young healer on a pot indicates that he has full professional prowess to accomplish the art of healing patients. The use of the coin also signifies that the new healer will always have his means of livelihood. The reciting of incantations helps to consolidate the initiation rituals. Besides acquiring the knowledge of body marking through inheritance, a son who so desires and picks special interest in body making practice only needs to be closer to the father during his father's life time and watch him. The implication of this is that, by being closer to the father, the son is interested and could by this be privileged to receive the special secrets and skills of effectively carrying out body marking on patients. However, the father will do so only for specific reasons known to him.

Secondly, acquiring body marking knowledge is, at the moment, no longer a *closed* family affair or a cultic privilege. Rather, it has become open to all those who show special interest in the art. The interested person goes through a period of apprenticeship training with an experienced healer. The period the apprentice spends depends on how often he makes himself available for training. It could be short or long, but he must carefully observe what the healer is does, note and assimilate what the healer tells him as well as be willing to undertake the practice according to the instructions given. There is always a price to pay, as asserted by Nyepeogasi Gbado, a 65-year-old healer:

Ɔn ma nyéne ná nàlí kà ná níáwa gɛgɛn.
Ńkɔn yií zà kɔn ɔ bɛ dɔ kúva kɔn. ɔn yíya
gɔ kó wànà kɔ jɔɔ kà mɛrɛ. Nyɛ kɔn dɔ kúva
nɛàn písɛágálò yàna bɔ.

This translates as:
You have to make the interested person to observe. You take him to the forest to see the needed herbs. When you are back, you initiate him into it,

> catch an animal like a lizard and make him experiment on it, by making incisions on the stomach. A little token will be given by the trainee. (Nyepeogasi Gbado, Personal Communication, November, 2015).

According to Nyepeogasi Gbado, lizard is used as a specimen for the trainee to come to terms with the spilling of blood. With this experiment, he is expected to develop courage anytime he gives marks on patients. The significance of using an animal in form of a lizard is to, actually, demonstrate the processes involved in giving marks on a sick patient. Besides, it gives the young healer knowledge on how blood flows in living creatures. This mode of acquiring knowledge on body marking in Migili society was corroborated by Zhegoro Iperesi, a traditional healer, who stated that, "for me I acquired it through constant observation and practise under a more experienced healer".

Thirdly, a person can acquire body marking knowledge through divine revelation in form of dream or trance. In years back when traditional religious beliefs and practices were dominant among the people, acquiring body marking knowledge was through special divine revelation from ancestors/gods by means of dream/trance. In recent years, this mode of acquiring knowledge on body marking seems to have reduced in Migili society. The reason may not be unconnected with people's conversion to Christianity which discourages traditional beliefs and practices, especially among the younger generation. Presently, the younger generation now considers such revelation as heathenish or impious. To further buttress this point, Dagya Ozige, a traditional healer of forty-five (45) years, from Assakio town asserts:

> It is learnt and some get the revelation to practise it through dreams. But here, and in surrounding villages, we do not have healers who acquire their knowledge and skills through dreams. They (traditional healers) of such categories are very few. (Dagya Ozige, Personal Communication, November, 2015).

Of course, social change has seriously impacted on the knowledge, skills and practise of body marking. This means that persons within a family or lineage who hitherto automatically inherited body marking knowledge and skills can now learn and acquire it. The young interested healer, as an apprehentice, has to follow the experienced healer to the

forest, so that the latter can show him the plants, leaves, grasses and other things to do. The apprentice observes whatever the healer is doing, how the plants, leaves and grasses are gotten and prepared alongside how and when marks are administered on patients. He (the young apprentice healer) also learns the rituals involved such as incantations and prayers from the older and experienced healer and then acquires the knowledge and skills as well as the authority to heal patients.

5.2.3 Categories of persons who have knowledge of body marking in Mìgili-Kórò society

The practice of body marking in Migili society is exclusively the right of male folks. It is gender-specific. The widely-accepted tradition is that only men have the exclusive privilege to practise the art of body marking. And, more importantly, of the men folks are the very few persons that have the knowledge and skills to administer the marks, since time immemorial. According to Yepko Gbado, a male key informant, men, rather than women, are presumably endowed to better understand the skills, which require being "strong hearted, and determined because he is going to deal with blood and pain". This is also corroborated by Masa Obu, a 62-year-old female key informant, from Ashige:

> *Ńkɔn pɔɔ kútu âgàn na, ɔn yíya zɔrɔ ma.*
> *Ńkɔn zaà nàyɛ kpɔɔn na, ɔn yiya zɔrɔ ma. Mínyɛ*
> *blê yíya ní ba ńwɔn áadzá ma. A za kónyɛ zɔrɔ na.*
>
> This translates as:
> If you are not skillful, you cannot do it. Also, if you are not strong hearted or determined you cannot do it. Some people cannot, even withstand the baby's continuous crying. Therefore, it is not so meant for everybody. (Masa Obu, Personal Communication, November, 2015).

Although some women might have knowledge of how to prepare herbal remedies for common childhood illnesses like jaundice, malaria, mumps, and even convulsion, what is expected of them is that they administer the herbal ingredients orally. Notably, doing the actual marking of the child deals with spilling blood, handling pain, and sometimes

becoming engage in struggles with patients. In this wise, Cheni Benjamin, a 66-year-old female key informant from Assakio asserts:

> *N pɛ nyí kɔn bɔ amá npɛn kútú zɔrɔ ma.*
>
> *mínyɛ rán zɔrɔ ba cɛnɛ ma. Sédé ba bɛ rúplɛ bɔ*
>
> *N pɛ nyí kɔn bɔ amá npɛn kútú zɔrɔ ma.*
>
> *mínyɛ rán zɔrɔ ba cɛnɛ ma. Sédé ba bɛ rúplɛ bɔ*
>
> This translates as:
> I know about body marking, but do not have the knowledge and skills of doing it. Women majorly in this community do not practice it. Women here can circumcise children, but cannot administer body marking and associated rituals on children (Cheni Benjamin, Personal Communication, November, 2015).

Women are involved in the circumcision of newborn babies, but tradition excludes them in body marking practice. Although the exclusion of women from the practice of body marking is still shrouded in secrecy. Our ethnographic findings reveal that, women have the privilege to circumcise new born babies. They play the role of midwives; that is, traditional birth attendants (TBAs). They also have the singular privilege of nursing newborn babies, which requires them to bath the new born babies. Child circumcision, as a custom, does not require performance of elaborate rituals in form of reciting incantations or elaborate prayers. A 62-year-old female key informant from Nene town opined that "I am a woman, but women do not practice body marking here. It is practice solely by men". Only the traditional healers have the authority, power and skills to carry out body marking on children and they are mostly males. Male hegemonic rule thus demands that they, invariably, see the profession as preserve of men. Samiya Danzhe, a 75-year-old healer, corroborated this position:

> *Mínyɛ vele báá sála íwéńsɔíbɛ rúplɛ ná cɛ nyí kɔn ba*
>
> *dɔ mínyɛ vɛ́lɛ ńtson ná. Amíshí ba yàka cɔɔ la kɔn*
>
> *mínyinyrán ka zɔrɔ múdu kɔn na. sédé bán yíya bɛ rúplɛ bɔ.*
>
> This translates as:
> Men are confined to both body marking and circumcision, while women are restricted from the giving of body marks. This has been attributed to the fact that men were first initiated. Besides, the Tiv people told our

fathers that spirituality and magic is heavily involved in body marking. As a result, women are forbidden from being largely involved. But, circumcision is something that is common (does not involve the spirits). In addition, circumcision was not borrowed from any culture, there is just no special thing attached to it (Samiya Danzhe, Personal Communication, February, 2017).

Plate 5.1. A traditional healer from one of the Mìgili-Kóròcommunities.
(Source: Fieldwork,October 2015).

Ethnographic data captures a picture of an experienced and elderly healer from one of the community studied. For example, a careful observation of Plate 5.1 on page 83 shows that the healer has some protective charms tied round his arms, and there are also some rings on his fingers. This may explain what the men mean by authority and power. Women may have authority but they do not have power.

5.2.4 Level of knowledge people have on body marking in Mìgili-Kórò society

It is significant to mention here that knowledge of body marking on children is closely linked with deep understanding of traditional religious beliefs and practices. The implication is that the practitioners derive their knowledge from traditional religious beliefs and experiences. The knowledge is usually transferred from an older and experienced practitioner to a younger apprentice. Only those who have been selected have the required endowment of wisdom qualify for initiation ceremonies, which they can receive from their fathers, grandfathers and experienced practitioners.

The initiation involves performance of rituals coupled in some cases with intense prayers or incantations. The new practitioner is taken to the forest, then isolated to avoid distraction, and taught the different pertinent trees and/or leaves for preparing herbs. He learns how to administer marks, among other requirements, on patients. The knowledge, as we earlier hinted, comes from the ancestors as affirmed by Mamo Akosi, a 65-year-old traditional healer:

> Ípɛ mɛíwe ísala háda ńsɔn múcɔ la wa. mínyɛ
> lɛɛ nzanɛ gbii kɔn ma. Nyèé wa cenyín kɔn a dɔn ágá
> mùga wá. La krɔ ǹkpin á mùcɔ la wá.
> This translates as:
> The level of knowledge I have about body marking is closely linked with traditional religion. Well, many people who do not like this practice feel it

> is fetish and has something to do with traditional beliefs. This is true, because none of the incantations we make is connected to any religion other than the traditional religion. Our ancestors did this many years, we copied from them, and today many people come from different areas to be marked for curative purposes (Mamo Akosi, Personal Communication, November, 2015).

Whosoever acquires the knowledge and skills of giving body marks, must belong to a particular cult. This stipulation for qualification is acknowledged in other African societies:

> Among the Azande of Sudan, a young person after completing training as an herbalist is admitted to the society of his colleagues. As a statutory requirement, he is compelled to join Association of medicine people (Encyclopaedia, 2017:7).

From the foregoing, a prerequisite for a practicing healer is to identify himself with an association of practitioners. The membership ensures that ethical codes are obeyed by members. In reality, there is no established formal cult group that regulates the practice of giving body marks in Migili society. However, the practitioners know themselves, and adopt similar approaches unknown to the generality of the people in managing the health of their patients. There are certain secrets known to practitioners that are unknown to non-practitioners. This explains that certain secrecy is associated with body marking practice; the characteristics of these are pointed out by Samiya Danzhe, a traditional healer:

> *Cɛnɛ a dɔn ágán mùgà wácɛ nyín kɔ mínyɛ kwɛɛ*
>
> *ba pɛ kúcɔ kɔn na. Ba dɔ mínyɛ kúva kɔn wa.*
>
> *Nkɔ ba kpi ba, ba bɛ dɔn mínye kìlɛlɛ wá.*
>
> This translates as:
> I feel that in this village it is more or less associated with religious cult. The reason is because, in those days, only two people in the community would know where the trees or plants are found, and would have to go into the forest to look for them. Besides, acquiring the knowledge was largely as a result of initiation. It is only these two people that would have the knowledge, and they would not tell anybody about the herbs. But when both of them die, they will come in a dream to another selected two people to reveal the trees or plants to them (Samiya Danzhe, Personal Communication, November, 2015).

This position is further strengthened by the belief that the spirits of the land reveal their secret of healing to selected persons. These spirits do not interact with ordinary people, except the traditional healers who have acquired the authority, powers and skills of body marking; and of course, there are specific categories of spirits that control each healer. The nature and location of each spirit depends on the village, town or even clan as reflected by Mamo Akosi, a traditional healer from Nene town:

> *Cɛnɛázúnu áalí bá klɔ rúgɔn íwé na.*
> *La dɔn ǹ gbɔmɔ, Ńkpɔnnkpɔn ńsɔn dándána.*
> *Ázúnu nɛ drɛ naci wá. Nɛɛ, ba áci ne nàza*
> *Àázùnu ne wá.*
> This translates as:
> In this community, the categories of spirits associated with body marking are forest spirits. We have *Gbomo*, *NkponNkpon* and *Dandana*. These spirits are in the trees. So, they are believed to live inside the trees. Also the trees are named after the spirits. Note that, Gbomo is first cut as herb from the East and then the West, before you remove the herbs. These spirits control the healer mostly in the night, and inside the house (Mamo Akosi, Personal Communication, November, 2015).

It is for the spirits to determine who can be welcome into their group. While each spirit may suggest different areas of specialisation, they can also represent different cults of knowledge and practice. Knowledge and boundaries are established, in our view, to mark out specific identities and protect boundary. For as many names of trees as can be used for identity creation, there are knowledge, recruitment strategies and operative codes which justify the isolation emphasised. Here, besides Gbomo, *Nkpon Nkpon* and *Dandana,* there are *Chumba*, *Ifle* and *Kudro*representing different ritual performances. According to Zhegoro Iperesi, a fifty (50) years old traditional healer from Ashige, the nature of the latter spirits is:

> Chumba always breaks, that is, helps to break the hardness of enlarged spleen, *and kudro* helps to stop the child from vomiting, while *Ifle* is to cool down the body temperature (Zhegoro Iperesi Personal Communication, November, 2015).

What we heard from Oyele Gbotu, a 55-year-old traditional healer from Assakio town, affirms the idea of supplication and boundary maintenance indicating cultic identities, "Two categories of spirits are associated with body marking, these are forest and land

spirits". He believes the spirits live in the trees, but they cannot be seen physically. He obviously does not belong to the same group as the man from Nene. Those who practise in Nene are also familiar with three spirits, which could be identified with different trees, placed in a block of three. For instance, some associate the spirits with trees like *Gumaya*, *Kukpen* and *Mugon*.

The spirits enter and control the healer at specific time of the day. This happens most often when the healer is alone in his closet (apartment) or in the forest. And it comes in form of dream or trance to encourage the healer to continue the work of healing and saving lives. Where there is need for amendment, adjustment or innovation in healing patients, the spirit will direct the healer. The spirit also controls the healer, and this happens sometimes when he is reciting incantations. Most often, the style of incantations/chanting comes through inspiration of the spirit. The spirit possesses the healer and leads him to recites incantations that enable him to heal his patient. The making of incantations is to accelerate the healing process. According to Mamo Akosi, a traditional healer:

> *Ńkɔn kúzùnù bɛ kìlɛlɛ, a bɛ*
>
> *Tana nyɛ́ mùgan áwa ká klɔ rúgɔn*
>
> *nɛ. kpóò ɔ cɛ da.*
>
> This translates as:
> When the spirit appears in dreams, it tells you (the healer) all the plants, leaves/grasses needed to be used, and the procedures expected to be followed so as to ensure a successful healing. But, you (the healer) will not see anything once you wake up. (Mamo Akosi Personal Communication, November, 2015).

The experience of another healer, Akamuge Akule, 45 years old, is that:

> For my own, the spirit could control me at any time of the day. It can happen anywhere provided I am focused and have a particular mission at heart, and at a particular time (Akamuge Akule, Personal Communication, November, 2015).

The spirit appears in dream, and the ancestor appears either in the same way or physically in a family or lineage. They come to reveal certain knowledge of healing the sick.

The manner and circumstances in which the spirits control the healer is vary according to the community or clan of the healer.

The healing ritual starts with going into the forest to collect necessary plants, leaves and grasses, then followed by pounding them. When treating the patient, the healer observes and palpates the parts of the patient's body where marks need to be administered. It is significant to stress here that when healing is being carried out, it is the voice of the spirit the healer hears and then speaks out as he recites the incantations. With this, the healer is operating within the spiritual realm, and could assist in successful delivery of the task. Not all healers could accept the spirit postulation. There are those who believe that supernatural powers exist, but their power is not binding on them. Incantations as an essential aspect of healing, therefore, becomes necessary as Oyele Gbotu, a traditional healer avers:

> *La dɔ nyee kɔn agan kɔn múcɔ*
> *la zɔrɔ nɛ dɔ ńyee wa. A na*
> *kùtúmá dɔn ba. La múdàn rɔ ba kɔn*
> *bà bɛ tɔ la lùgbà. La tséne ka lɛɛ*
> *nyín kɔn múcɔ laa zɔrɔ múdàn ne wá.*
>
> This translates as:
> We believe that what our ancestors did was real. It worked for them, so we equally call on them to help us cure our patients. We seek their help in the healing process. The importance of making incantation is that, we do that because our ancestors did same. So, if you (as a healer) make marks on a child and does not get healed, maybe you did not make the correct incantations properly. People may take it that you have abandoned your ancestors or do not believe in them. (Oyele Gbotu, Personal Communication, November, 2015).

What is known or has been done is real and can be tested. The unknown is dangerous, for it can prove to be weak in delivering expectations. In this manner, knowledge of the act becomes fossilised into traditional thought system as contextually having or lacking power of applicability. It can be trusted because it is assumed to be reliable and valid. Dagya Ozige, a traditional healer, relates the Migili worldview on this:

> *La tséne ka lɛɛ nyí kɔ la dɔńyee*
> *dɔ múcɔ la ne wá. La rɔ ba bɛ kená.*

This translates as:
The symbolic meaning of making incantations, rest on the belief that there is power in the spoken words. And most significantly we believe in the power of the gods of our ancestors. So, we invoke them to come to our aid (Dagya Ozige, Personal Communication November, 2015).

Finally, land spirits are also associated with body marking practice. According to Osidubo Izorosi, a 50-year-old traditional healer:

> The art of body marking in this community is mostly associated with land spirits. The spirits sometimes demand sacrifice of fowl, but definitely not human blood. The spirit controls me at noon, when the sun is tense. And this happens only to this lineage and it usually takes place in the forest (Osidubo Izorosi, Personal Communication, November, 2015).

From the above quote, we have a sense of land that can be associated with the environment, vegetation or temperature, residence, and consumption. There are, therefore, environmental spirits in the communities meant to control situational occurrences in an ecological frame.

5.2.5 Patterns of body marking identified in Mìgili-Kórò society

There are varieties of body marks administered to persons in Migili society. The facial marks are for identity and personal beautification, and were fashionable and popular among the people some decades ago. Basically, the ones made on women's abdomen and back are purely for betrothal and beautification purposes. Some marks on people's faces are for treatment of sicknesses. This explains that some persons, during their childhood, were given marks to treat one form of illness or the other. The word for mark in Lijili language is *isala*, while the word for body is *rubli*. Generally, body marking is known or called *rubli isala*. Marks given for beautification and identification of the body are known as *iwe*or*isala gbudu*. The word g*budu* is derived from the name of a man who was believed to have introduced marks given on the face and back of individuals in Migili society. The marking given to children are mainly for curative purposes. Detailed classifications of major patterns of body marks common in Migili society are illustrated in Table 5.15.

Table 5.4. Patterns of body marking common in Mìgili-Kóròsociety

S/N	Name in Migili	Name in English	Translation	Patterns
1	*Iwe* rúgɔ-áwo	Pneumonia marks	*Marks given for the treatment of pneumonia*	*Usually four to six vertical lines and three horizontal lines given on the chest.*
2	*Iwe Sépa*	Splenomegaly marks	*Marks given for the treatment of* splenomegaly	*Usually ten to twelve vertical lines and seven horizontal lines given on the left region of the abdomen.*
3	*Iwe* rúgɔ-átrɛ̀	Polio marks	*Marks given for the treatment of* polio	*Three vertical lines marked on both knees.*
4	*Iwe sunsu*	Convulsio~~n marks~~	*Marks given for the treatment of* convulsio~~n~~	*One vertical line given on the forehead and one each on both cheeks or sides of the face.*
5	*Iwe Ikasonkpi*	Dislocation marks	*Marks given for the treatment of* dislocation	*Usually three vertical lines or six vertical lines when it is severe on the affected region either ankle or waist.*
6	*Iwe gbudu*	Facial/Beautification marks	*Marks given for the identity/beautification of the face and other parts of the body*	*One vertical line given on both cheeks and three horizontal lines given on the side of mouth, and three horizontal lines given on women's navel.*
7	*Iwe Kurfi*	Chest pain marks	*Marks given for the treatment of* chest pain	*Three vertical lines given on the chest.*

8	*Iwe ime*	Back ache marks	*Marks given for the treatment of* backache	*Just one vertical line is given on the lower region of the back.*

As revealed in Table 5.4, page 90, the *iwe* rúgɔ-áwo marks are given for the treatment of pneumonia; the *iwe sépa* marks are given for the treatment of splenomegaly (spleen disorder) in children. The *iwe sunsu* marks are given for treatment of child convulsion while *iwe* rúgɔ-átrɛ̀ marks are for the treatment of polio or paralysis in children. Ethnographic data revealed a greater number of traditional healers in Migili society specialised in both *splenomegaly (iwe sépa)* and pneumonia (*iwe* rúgɔ-áwo). A few healers specialised in polio and convulsion. They are few due to the fact that these illnesses (convulsion and polio) do not occur frequently in children. They are more frequently linked with malevolent/mystical agents like witches, sorcerers and other evil forces, which require deep level of spirituality to handle. The position of Samiya Danzhe, a 75-year-oldhealer from Nene is that:

> *Iklɔ sunsu ńsɔ kítrɛ dɔn*
>
> *Ńná mìnyɛ mùgàn wátúntú mínyɛ kɔn*
>
> *Ba koba ási na. cɛ nyí kɔ ba hada ńsɔ*
>
> *Ázúnù lɛɛ wa.*
>
> This translates as:
> Convulsion and polio treatments are for those who are deeply rooted in traditional beliefs and practices, most especially the non-Christians. The reason for this distinction is that treatment of polio and convulsion require a higher level of seeking the assistance of supernatural powers. (Samiya Danzhe, Personal Communication, February, 2017).

From this narrative, the categories of healers that can treat polio and convulsion have dualist statuses; they play the role of herbalist (*cɛ́ɛ̀nwa*) and diviner. As herbalists, they have been initiated into having the knowledge of collecting plants and leaves to treat patients. On the other hand, as diviners, they have deeper spiritual powers that sometimes enable them to commune with supernatural forces. It is worthy to state here that in Migili society, traditional health-care delivery approach provides for two major categories of health professionals; namely the herbalist and the diviner. The herbalists are more common than the diviners and most herbalists acquire their knowledge and skills through apprenticeship while others inherit from their fathers or grandfathers. The herbalist, as a health-care

practitioner, is knowledgeable in identifying and making herbal medicines for the treatment of various diseases. The herbalist necessarily performs rituals in form of incantations and prayers so as to ensure effective healing for his patient. On the other hand, the diviner is a traditional healer who has a deeper mystical knowledge about healing the sick. Most often, the diviner has knowledge of the use of herbs, roots and other healing properties. The diviner is known as *Insha* in Lijili language. He is consulted in situation where the patient's health condition becomes very critical and mysterious. The mode of inquiry by the diviner involves elaborate use of divination instrument and going into trance to ascertain the real cause of the illness or misfortune.

Further revealed in Table 5.15, page 90, is that the number of marks given for each ailment varies. For convulsion, it is usually one mark given on the forehead and one mark on each cheek although one mark each can be given on the side of the face. For splenomegaly, the number of marks ranges between 10 and 12 horizontal lines and seven vertical lines. They are given on the lower abdomen region. According to Osidubo Izorosi, a traditional healer< "What I know very well is the marks for the splenomegaly (*sépa)* because I am a specialist in it. Here, in this town, we are mostly familiar with the splenomegaly".

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The marking given for polio is three, made on both sides of the knees. The rationality offered by Zhegoro Iperesi, a 50-year-old traditional healer from Ashige, is that:

> The one for polio is such that, if a child has it and the illness is actually from God, the hospital can cure it. But, if it is caused by bad people or unseen spirits, once you give such a child an injection the child automatically will become paralyzed and may never walk again. So, parents are advised to bring such cases to be effectively handled by the traditional healer, most often a diviner. (Zhegoro Iperesi, Personal Communication, November, 2015).

The implication of the foregoing is that polio, as an illness that afflicts children, has both natural and preter-natural causes. The one considered natural is the one from God, while the preter-natural one is believed to be caused by malevolent agents like witches, sorcerers and unseen spirits. Apart from giving marks on both sides of the knees, the healer carefully massages the waist, knees and limbs of the child. This helps to accelerate healing

for the patient. He (the healer) equally makes use of local ointments (like shea butter and alligator pepper) that help to improve healing of the limbs and joints. As well, marks for pneumonia are between four to six vertical lines by three horizontal lines on the chest region, and they may be administered either above or below the breast region

It is instructive to state here that, till the present generation, some adults who experienced ailments such as dislocation, chest pain and backache are given marking on specific parts of the body. For example, marking for dislocation in Lijili language is called *iwe ikasonkpi*. The pattern usually consists of three vertical lines or six vertical lines, when it is considered very severe on the affected region, either on the ankle or waist. After the marks are given, local medicine is applied on the spot where the marking is given and followed with silent prayers by the healer. The purpose for administering the marks is to bring out the bad or impure blood from the part of the body where dislocation has occurred. Ethnographic findings have revealed that waist dislocation is a common ailment among adults. The ailment is closely linked to the strenuous tasks undertaken by adults; these are farm cultivating, wood cutting, sheaving of grains, craft making and weaving among others although some elderly persons argue that bodily dislocation could sometimes be attributed to evil doers (witches and sorcerers) in the community.

Another pattern of body marking identified among adults in Migili society is for chest pain, called *iwe kurfi*. It consists of three vertical lines given on the chest region. This pattern of marking is different from the marking for pneumonia in children. It is given to adults when they experience persistent pain in the chest. After the marks are administered, local medicine is applied on the spot and this is followed with silent prayers for the patient. This is how a female key informant from ethnographic remarked on this pattern of marking in Migili society:

> As you can see (showing the researcher her chest because she did not wore a top blouse as result of the hot weather), I was given three marks under my breast for the cure of chest pain. This was when I was around thirty years (Maza Obu, Personal Communication, November, 2015).

Furthermore, ethnographic findings have revealed that marking for the treatment of backache in adults is common in Migili society. It is called *iwe ime*in Lijili language. The marking for the treatment of backache is given to adults who persistently complain or experience severe ache on the back part of the body. The pattern consists of just one vertical line given on the lower part of the back. As required, local medicine is applied on the spot where the mark is given, then followed with silent prayers as a way of eliminating the pain from the body.

As earlier stated, facial/beautification marking in the past years was very common in Migili society. It is called *iwe gbudu* and, as previously stated, g*budu* is the name of a man who was believed to have introduced the art of body marking into Migili society. The pattern for facial/beautification marking consists of one vertical line given on both cheeks and three horizontal lines given on the sides of the mouth. For women, apart from the facial marking, three horizontal lines are given on the abdomen round the navel as a symbol of betrothal. Evidence from our ethnographic finding reveals this, as a female key informant avers:

> Marks for identification and beautification were common in the olden days. We as young would be wives were given special marking on the navel as a symbol of betrothal to our suitors. And special token was paid as a symbol of commitment to the marital union (Kpana Mamo, Personal Communication, November, 2015).

However, as result of modernisation and Christianity, this cultural practice of giving marks for identity, aesthetic/beautification and even marital purposes have tremendously declined in significance. Ethnographic findings reveal that only elderly men and women now bear marks for cultural identity, beautification and marital value.

5.2.6 Processes for administering body marking on children

The ethnographic discussion is that, before embarking on the journey to the forest, the healer has to commune with supernatural beings by uttering certain incantations. The content and number of the incantations vary from healer to healer. From several ethnographic sources,

we have gathered that it is common for the healer to reciting incantations before getting herbs in the forest. A typical incantation goes thus:

Osi wo yiwo la be rubon na,
Osi wo yiwo la be rubon na,
Osi wo yiwo la be rubon na,
Minye kupo zun ba don kuva wow a.
N be kuco me na.
Wo Osi don la na.
N da kuwa nne ke.
Nkon Nma don minye bo.
Kon o ton lugba.
Nyi kon nye ne a no
Kukpla nson minye.
This translates as:
God of our ancestors, you brought us to this world, .
God of our ancestors, you brought us to this world,
God of our ancestors, you brought us to this world,
All people are created by you and are under your authority.
I am not doing this on my own, but all powers come from you.
It is you that gave us this.
Whenever I administer these herbs to people let it work.
Help me whenever I bring such cry,
So, that the sick ones shall be strong among other humans
(Mala Kyari, Personal Communication, November, 2015).

It is a supplication to a superior power identified as God. It is notable that the healer addresses the supernatural being three times. The belief is that calling on the supernatural three times invokes His power. The belief of the healer is not in the herbs, but in the spiritual force which makes things happen. However, the first step in the process is collecting the right herbs. Thereafter, the healer returns to his clinic (as shown on Plate 5.2, on page 96) to prepare them to *drug* by grounding into powdery form. The powder is applied to the place where marks have been made on a patient who has any of the illnesses already highlighted. Ingredients of making the drug are leaves obtained from *revealed* trees, grasses, water, and pot for boiling the herbs. The herbs are ground into powdery forms; and cup is used to store the water, which is used to clean the identified part of the body on which marks would be administered. In the course of the treatment, the water is used to wash the affected region for purpose of hygiene. The cup is forbidden from being used by anyone else in the family to avoid pollution. The cup is to hold the water that will be used to wash the part of the body

that would be marked. In the past, a small knife was used for giving marks on the body; but razor is now the major instrument used for marking today due to modernisation and fear of spreading blood-borne diseases.

Plate 5.2. Inside a traditional healer's clinic in Assakio community.
(Source: Fieldwork, October 2015).

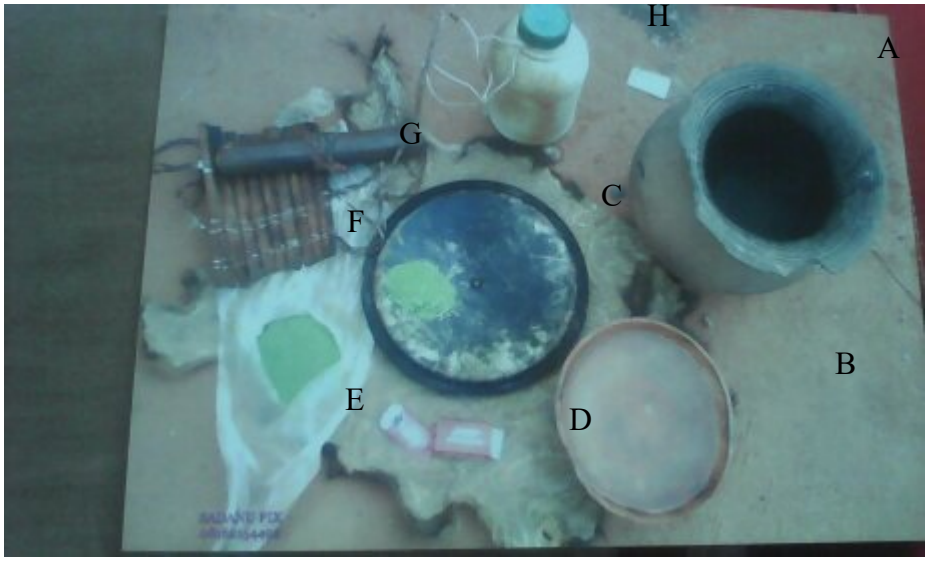


Plate 5.3. Materials used by healer for treatment of body marking on patients: Clay pot, ground herbs, calabash, *akpala* and razor.
(Source: Fieldwork, November 2015).

Plate 5.3 on page 97 is the picture of some medicinal ingredients and other materials used by a healer. Clockwise, (A) is a clay pot used to boil herbs; (B) is the calabash that contains ashes; (C) is the bowl containing ground herbs; (D) is razor; (E) are some ground leaves. (F) is a matwoven from bamboo, use for casting the leg of a child being treated for polio. G) is a broken hoe called *okpala,* used for therapeutic healing for a child suffering from polio illness, and (H) is a rubber container used to store shea butter, as ointment for healing the limb of a child.

The following account by Dagya Ozige who is a 45-year-old traditional healer, from Assakio explains the treatment of splenomegaly in children:

> We go to the forest to get the needed herbs called *Ivo gbaro* and *kukpe* which will be boiled and taken after the child receive the marks. The marks are on the side of the abdomen for splenomegaly. After incisions are made, I scratch the back of the pot, the black powder from the back of the pot and then spray it on the marked region. The black powder from the pot also helps to heal the wound. Note should be taken that I have to drink the prepared boiled medicine first before giving to the sick child. (Dagya Ozige, Personal Communication, November, 2015).

The traditional healer admitted that the black powder scrapped from the back of the pot also helps in healing the wound made on the patient. Although Mala Kyari, a fifty (50) years old traditional healer from Ashige who specializes in the treatment of splenomegaly in children fails to mention the "black powder", he points out that:

> The leaves and herbs need to be dried and pounded into powdery form. If a sick child is brought, we check to ascertain if it is truly splenomegaly or any other illness that requires marking. If it is confirmed, we wash the affected part with water and then we give the marks. After this, the powdery medicine is sprinkled on the marked region of the patient body, while some powdery herbal substance, will be given to the child to drink. The powdery herbs could be added to any liquid food or beverage.
> (Mala Kyari, Personal Communication, November, 2015).

Each case is treated on its merits and, as we have earlier hinted, each *cult* has its own developed approach to healing. Each healer, notwithstanding, must have in-depth knowledge of the composition of medicinal resources effective for each illness he intends to manage. That is, he should know the particular grasses, leaves, roots and other liquids like water or honey that cure a particular illness. He needs to know the exact time of the day to do the healing. He, of course, has an understanding of the symbolism put together for the healing, like movement of the hand and spraying of the herbs on the patient. Notably, however, their understanding may not be completely revealed to the uninitiated:

> After initiation, much spiritual knowledge comes to the healer. But, this is not meant to be revealed to anyone other than a co-healer (Oyele Gbotu, Personal Communication with sixty-five years old healer, February, 2017).

According to Samiya Danzhe, a 75- year-old healer from Nene:

Múgan kɔn n zɔrɔ ne dɔn chumba,

íflɛ, ńsɔn kúdrɔ. Lɛlɛ, ńsɔn rézan dɔ

múdàn bɔ. N shɔ kútsa kɔn

bà bɛ dɔn kìlɛlɛ.

This translates as:
The herbal remedies I use are gotten from three trees, *chumba*, *ifle* and *kudro*. Apart from these herbs, water and razor blade are essential items for giving the marks on the patient. As for the process, I always make incantations in form of prayers. So, usually I would have a dream in which I would be told everything that I have to do. And I always do the markings early in the morning, when the moon, the sun and other heavenly bodies are hidden. (Samiya Danzhe, Personal Communication, November, 2015).

What is being suggested here is that body marking in Migili society requires some rules. The marks are neither given haphazardly nor determined by individual whims; rather, there is a definite pattern to follow. The giving of the marks starts always from left to right and from bottom to the top. The reason for this is to avoid blood flowing downward to cover the to-be-marked region; that is, the yet-to-be-marked part of the body. Findings from Baka Ozhe, a 40-year-old traditional healer reveal the simplest process of body marking in Migili society:

> I get herbs or leaves from the forest; say some incantations then administer the marks using razor blade. After the marks are given, I apply some of the powdery medicine on the marked area, while some will be boiled and given to the patient to drink. (Baka Ozhe, Personal Communication, December, 2015).

This process was equally stressed by a male FGD participant who claimed to be familiar with the processess of giving marks:

> A healer is expected to wash the patient body where marks are to be given with water, take a new razor blade and give the marks. After this, the powdery medicine is applied to the part of the body where marks have been given. The healer also makes incantations before, during and after making the marks on the patient. (Personal discussions with male FGD participant, December, 2015).

In a related vein, Osidubo Izorosi, a traditional healer, declares:

> Once you are a practitioner, you always have to get the required herbs ready. The herbs or leaves we use here for splenomegaly are *Chumba*, *kudro* and *Ifle* leaves. We make the incisions and then spray the powder made from these tree leaves and pound together. Some leaves are boiled and given the patient to drink. (Osidubo Izorosi, Personal Communication, November, 2015).

In the treatment of convulsion, ground herbs and other items like blade, water, for the giving of the marks on the patient would be made available. Where the convulsion is not too severe, only powdery substance would be applied on the child's nose. And once the child sneezes, he gets revived. But if the patient does not sneeze, it means that the health condition of the child is very critical. With polio, when the child is brought to the healer, the healer examines carefully the spinal cord region as well as the limbs of the child to ascertain the condition. If the limbs appear to be somehow strong, simple therapy will be carried out for few days. However, where it is observed that the condition seems critical, and is considered to be an attack from evil forces, marks are made on the knees of both legs. Most often, marks are administered on the unaffected leg so that attack does not move to the other leg. Also, an instrument in form of bamboo tied with rope being used to massage the legs for a period of seven days. Local ointment like shea butter is used to massage the limbs to improve the strength of the legs. In extreme cases, a black rope is tied round the waist of the

patient. The aim is to protect the child against any further attack of polio. In some situations, women are called upon to assist in healing children with polio-related illness. According to Oyele Gbotu, a traditional healer:

> *Nwan kìtrɛ mɛ zɔrɔ muna.*
> *Mínyinyrán bá zɔrɔ lùkpò ná. Ba*
> *tro àci blɛǹpɛrisa kɔn bas ho*
> *kútsà kɔn ba ma dɔn nyɛrùgɔn.*
> This translate as:
> For the one that relates to the limbs (polio) I do not give marks. The women are more familiar with it than men. At dawn they (women) boil a certain herbs and massage the joints of the child and God willing the child walks. (Oyele Gbotu, Personal Communication, December, 2015).

5.2.7 Declining patronage: effect of change in belief and attitude on body marking practice in Mìgili-Kórò society

From ethnographic findings, some elderly and middle-aged parents admit that they were given marks at childhood to cure one form of ailment or the other, and this motivated them to transmit such belief in the efficacy of body marking practice on their children. A few of them even showed us the specific part of the body the marks were given. We observed that most traditional healers who undertake body marking on children fall below sixty (60) years. The reason for this is that the older and experienced practitioners are dying and younger persons are replacing them. The young people have developed interest in traditional healing practice due to the fact that it provides a means of livelihood for them. This explains the increase in the number of young persons involved in body marking practice. It appears the financial benefit must have encouraged these younger traditional healers although some younger healers expressed the opinion that the practice was inherited from their fathers/grandfathers due to their desire to save lives.

Generally, there is some level of acceptance of body marking, especially among parents, in the rural communities. The attitude among the people can be considered from two angles. Firstly, body marking, to some extent, is still an integral part of the health-care practice the people are used to. It is an age-long indigenous health-care practice of the people and the traditional healers have continuously held on to it. The younger generation,

therefore, sees it as an aspect of the enduring cultural heritage of the Migili that should be preserved. For them, body marking is one of the indigenous health practices that have been preserved and still useful in saving lives of children in Migili communities and other neighbouring cultural groups that patronise it. Hence, it is both an indigenous health system and cultural heritage. Secondly, the re-occurrence of certain childhood diseases such as convulsion, splenomegaly, and pneumonia, that have not been effectively treated in spite of the presence of primary health-care clinics, in and around the study communities, has contributed a great deal to the continuous patronage and relevance of body marking practice in Migili society. Yepko Gbado, a male key informant, captures it thus:

> Our traditional health practices have been with us since time immemorial. So people will continue to embrace or accept it. I cannot say it is dying because it is not actively practiced like before. But, to some extent, it is still done, especially if the illness is associated with evil forces. We believe evil forces often cause sicknesses on children anyhow these days. So, it makes people to continue patronizing it since hospital treatment cannot be effective (Yepko Gbado, Personal Communication, October, 2015).

Ethnographic findings reveal that, in spite of presence of primary health centres in Ashige and Assakio communities, however, health personnel and facilities are poor as well as inadequate. On the other hand, Nene community even lacks a standard primary health clinic. Plate 5.4, on page 103 shows signpost of Assakio primary health centre and the entrance to the primary health-care centre. This scenario is similar to the finding by Alabi (2017) who admits that:

> Residents of Maigiginya village in Kaduna State have been forced to patronize traditional doctors, since the modern health facility in the area does not serve the purpose for which it was built (Alaba 2017:27).

Plate 5.4. Above is Signpost ofprimary health-care centre in *Assakio* and below is the entrance to the centre.
(Source: Fieldwork, May 2016).

Similarly, Illah Obadiah, a male key informant, gave insight into the acceptability of body marking:

> They (our people) still consider it relevant, as much. Once an illness is suspected not to come from a natural source, they (parents) will consult the traditional channel for cure. So, people still embrace it to some extent (Illah Obadiah, Personal Communication, November, 2015).

In addition, the popularity and acceptance of body marking in Migili society is also due to the openness of the practice to anyone who shows special interest. In recent years, the practice has become open to any interested person who is ready to undertake apprenticeship training. In this regard, the younger ones are showing willingness for it. The reason for this development is partly due to the fact that the token paid by patients or parents of children generates income for the healer. The amount of money collected by each healer depends on the illness treated. For example, treatment for splenomegaly and pneumonia cost as much as One thousand naira (N1, 000.00), while polio and convulsion cost Three thousand naira (N3, 000.00). It could even be 2,000.00 naira, depending on how the patient or parents bargain with the healer. Polio and convulsion cost more because they require more effort and time to treat.

Table 5.5. Opinion of parent on the level of acceptance of body marking

Option	**Frequency**	**Percentage**
It is accepted by most parents	281	70.0
It is accepted by few parents	82	21.0
Parents are indifferent in accepting it	36	9.0
Total	399	100

Table 5.5 shows 281 (70.0%), indicating that most parents accepted body marking on children; 82 (21.0%) represent that few parents accepted body marking on children while 36 (9.0%) represent that parents are indifferent to accepting body marking on children. From the foregoing, it can be argued that the level of acceptance of body marking among parents is very high from the survey data. This attests to the fact that a greater number of parents, 363 representing (91.0%) in the study area accept body marking for the management of one category of childhood diseases or the other.

On the other hand, lack of popularity of the practice has been linked to the advancement in medical sciences and the advent of modern hospital in Migili communities. For Nkosi Ajeh, a male key informant:

> Body marking is no longer as popular as it used to be in the olden days. This is because in the past, people had no awareness of the causes of some of the illnesses and knew no ways of preventing them. But now, they have knowledge on the causes of some of these illnesses. So, this has made it relatively unpopular. (Nkosi Ajeh, Personal Communication, November, 2015).

Following the same train of thought, Yekpo Gbado, a male key informant noted that:

> Our parents in those days never had or knew about modern medical system. So, they resorted to giving of marks for cure of certain ailments. But as a result of advancements in health care delivery, body marking practice has become unpopular among the younger generation (Yekpo Gbado, Personal Communication, November, 2015).

Also, acceptance of Christian religious beliefs and practices among some parents has somehow discouraged patronage of body marking on children. For some Pentecostal Christian parents, body marking on children is considered impious and heathenish. They patronise it reluctantly when the Western scientific method of treatment fails or is ineffective. For Amos Abuku, a male Christian key informant from a Pentecostal denomination, the point is:

> Body marking is not as popular as it used to be in the past, but people know about it. Though, Christianity has made them to regard it as fetish or evil. However, in critical health conditions, they fall back to it when other means cannot cure their children illness (Amos Abuku Personal Communication, November, 2015).

Few of the educated people are interested in having body marking on their children, primarily because the majority consider it an uncivilised form of medical practice in contemporary times. Those who cherish tradition still do, and see it as a sign to communality and identity.

Furthermore, the fear and pain experienced when people undergo body marking has been a major factor of discouragement also, especially among young people. Osidubo Izorosi, a traditional healer, notes:

> *Awá bɛ mínyɛ lɛ wa. mínyɛ lɛɛ naba*
> *Nàsìmítì na. Máńkɔn á klɔ na, kɔn*
> *Bà ma bɛ.*
>
> This translate as:
>
> Fear usually discourages many people from doing it. People now go for hospital medication, but come back sometimes if it cannot solve their health problem. The attitude of many people is mixed. This is because some like it while others do not. But most do not like it any more (Osidubo Izorosi Personal Communication, December, 2015).

On the other hand, findings from ethnographic data reveal some level of acceptance and popularity of body marking practice in Migili society. For example, a male participant at an FGD session asserts:

> Perhaps not all aspects of traditional healing are bad; and fear may not be a strong deterrent, afterall: It is still a recognize and culturally accepted practice among our people. Even as we speak, people still practice it, especially for curative purposes on children. For bodily decoration and identification, it is dying out. Though, not many people practice it (body marking) these days; some persons still have not totally embraced the modern ways of treating certain illnesses, because they are still rigid to the traditional methods of treatment (Personal discussions with male FGD participant December 2015).

It would appear that how people perceive their body, how they look, and how they think others would look at them, play critical role in the acceptance of body marking. This is unexpected where society makes a conscious difference between body as aesthetics and body as medical site. The fact that the latter, through surgery, can leave marks on the body, means it can affect perception of beauty.

Parents admit that illnesses like jaundice and malaria do not necessarily require the administering of body marks although some kind of traditional self-medication are given in the early stage when traditional self-medication is done.. Parents also admit that they often

take their children to the primary health clinic in the neighbourhood as alternative to traditional methods of health practices. The emerging trend that we have observed among Pentecostal Christians is that those in the category of persons named Christians or educated consider the practice of body marking on children as impious and heathen practice. They prefer starting with self-medication and later taking the child to the local chemist/clinic for proper medication. Only when these approaches fail do they patronise the traditional method.

There is substantial evidence of treatment of different categories of childhood illnesses that have been successfully managed and cured by traditional healers in the study communities. These include several cases of convulsion; enlarged spleen disorder (splenomegaly), polio, and pneumonia. As affirmed by Ayele Sam, a male key informant, body marking "given to my child was permanently used to cure his convulsion". He goes further:

> From experience, cases of convulsion in children are not managed through modern medical practice. This is because we believe the causative factor is most often spiritual than natural or biological. The traditional method of managing child convulsion is very effective and reliable. We can attest to many instances in which many of our children have gotten lasting cure with the traditional method (Ayele Sam, Personal Communication, November, 2015).

Similarly, another parent from the FGD session corroborates the efficacy of traditional approach in managing splenomegaly in his child:

> From time immemorial, the giving of marks, especially for children who suffer from splenomegaly and other illnesses have been acknowledged as an effective healing method. The marks given on the affected region helps to deal with the sickness. For example, if it is not marked, the splenomegaly will grow and probably eat up the intestine of the child, and may lead to death. So, the marks given allow the bad blood to come out and heal the child. The internal wounds are also destroyed with the herbal medicine applied (Personal discussions with male FGD participant, December, 2015).

5.3 Parents understanding of symptoms on childhood diseases

There are certain symptoms that parents consider necessary to ascertain the causes of their children's illnesses. How much of these symptoms they know depends on their past experiences with children and the frequency of interaction with healers. Mothers are in a better position to understand the health condition of their children because they are in frequent contact with them, as the fathers are always out of the home. The mother watches for the development of symptoms until when it is unbearable and she reports the matter to the father or the father notices it and takes necessary action. This explains why the mother is always the first to administer first aid, in Migili society; though she is likely to start with either modern drugs or herbal medicine.

Table 5.6. Opinion of parent on how to identify symptoms of a childhood disease

Option	Frequency	Percentage
Personal observation	124	31.0
Past experience of an ailment	102	25.5
Relying on observation from elders	94	23.5
Consulting a traditional healer	79	20.0
Total	399	100

Table 5.6 shows that 124 (31.0%) of the parents identify symptoms of a child's illness by personal observation while 102 (25.5%) do from past experience. Also, 94 (23.5%) of the parents identify symptoms of child's illness by relying on observation from elders and 79 (20.0%) do by consulting a traditional healer. From Table 5.8 above, more parents identify symptoms of child's illness through personal observation.

In the course of our research, Nkosi Ajeh, the Secretary of Ashige Community Association, explains his knowledge of symptom of splenomegaly in children:

> It involves vomiting and high body temperature. The child's body looks pale, and seems as though there is insufficient blood in the body of the child (Nkosi Ajeh, Personal Communication December 2015).

Yepko Gbado, a male key informant, from Assakio speaks on the same subject:

> The major symptoms of Splenomegaly are body hotness, vomiting and excreting watery faeces that appear to be greenish. The physical symptom is that the side of the lower abdomen will be thick as though something solid has been deposited inside the stomach of the child. There is also loss of appetite on the part of the child (Yepko Gbado, Personal Communication November, 2015).

Kpana Mamo, a 62-year-old female key informant from Nene community, adds her own idea of symptoms of splenomegaly:

> *A bɛńsɔn ádzí shán ká gɔ ási dzá kplɔ*
>
> *súsɔnɔ. kɔn dzá kpɛlɛ gɔ ḿbɛn kporo,*
>
> *kɔn à zhanwɔ kpókpó.*
>
> This translates as:
> Comes with dysentery, and the child regularly excretes stool that is neither yellow nor reddish but looks greenish. The eye that is, pupil of the child sometimes will turn yellowish and urine can even turn very yellowish. Whenever the child sucks mother's breast milk, he/she vomits; and when the side of the lower abdomen is touched the child screams with pain. These are all symptoms or signs of enlarge spleen (splenomegaly) in a child (Kpana Mamo, Personal Communication, December 2015).

Not all parents would agree with the above observations, and their reservations would be based on the fact that a child who experiences these symptoms may not necessarily be infected with splenomegaly although evidence of swollen lower abdomen is generally believed to be a major symptom of enlarge spleen in children.

As previously disclosed, most parents in Migili society share the belief that convulsion is an illness caused by an evil bird, most often the owl. The common symptoms of convulsion identified by the parents include hotness of the body, change in the colour of the eyes of the child, irregular passing of faeces, persistent shivering of the child, severe hotness of the head, stiffness of the neck, and outpouring of saliva from the month. A female FGD participant states that, "convulsion in children usually comes with the screaming of the child, then followed by jerking, and the eyes immediately turns whitish". Also, Yayamani Wuni, a female key informant admits that, "for convulsion symptoms there is motionless body, a very high body temperature and loss of appetite over long hours". Symptoms of

convulsion in children usually make parents seriouslyworried because social and marital misbehaviour is suspected in either the husband or wife.

Polio is believed to be connected to manipulation of evil forces in Migili society. It is believed that a promising child can be afflicted with the disease. Although the disease is not common among children, according to a male FGD participant, "the symptoms for a child that is afflicted with polio is normally weakness or paralysis of the legs, as well as swollen legs". Pneumonia is seen by some parents as an illness caused by exposure to cold. Though some persons, especially traditional healers, consider pneumonia as being cause by spiritual forces, some parents stated that it is detected by difficulty in breathing. The chest region of the child may move abnormally; that is, much faster up and down. The heart pumps very fast too. In addition, the child cries whenever he is carried around the ribs, and this makes him/her to scream. Some mothers noted that, when a child has pneumonia, he feels pain when touched on the chest. A female FGD participant discloses symptoms of pneumonia in her child:

> There is hardness of the chest region. The child experiences chest pain, shows discomfort, and has difficulty in breathing. It is often accompanied by lack of appetite and feverish condition (Personal discussion with female FGD participant, December, 2015).

Diarrhoea in the Migili worldview comes in two forms. The first is considered natural diarrhoea; the other is linked with evil forces. The unnatural or spiritual diarrhoea is the consequence of immoral action done by the parents. Hence, the sickness is most often seen as an evil affliction. In the view of the people, natural diarrhoea can be cured with local medicine as well as Western medical treatment. But the spiritually-induced diarrhoea cannot be cured in the hospital. To cure it, the family must probe to discover the family member who has committed the unpardonable act that brought about the sickness and award sanctions. This may involve the intervention of the diviner, *gbóìshán*, and the performance of certain ritual prescribed by the *gbóìshán;* the ritual which is called *ícwéìpànà* which literally means "healing the child through cleansing". The symptoms of diarrhoea in children, according to most Migili parents, include hotness of the body, persistent crying of the child, frequent stooling of watery substance as well as lack of appetite. Mumps come

with swollen jaws in children, and this called *makumaku* in Lijili language. The symptoms consist of hotness of the body, swollen cheek and jaw. The disease in children is usually treated with the excreta of an insect called *ablakpa* in Lijili language. The excreta is sandy in nature and has to be disolved in water before being rubbed on the swollen spot. What Iperesi Leku, the traditional head of Ashige, knows about mumps is that:

> Medical doctor cannot cure this illness, mumps. Except through the traditional method. For *makumaku* marking is not required on a child for curative purpose (Iperesi Leku, Personal Communication November, 2015).

Jaundice, also known as *rugunwala,* is known through symptoms which include yellowish urine, the eyes of the child also appear yellowish; the child will be restless too. It is also associated with high body temperature in the child. Measles does not require any form of body marking. The major symptoms identified by parents are rashes on the body, high body temperature and loss of appetite by children. For most children, the illness causes them to be restless, especially in the night. Illah Obadiah, a male key informant, notes that, "persistent sneezing, frequent crying and inability of the child to sleep are major symptoms of measles".

Critical to the understanding of the symptom of childhood illnesses are the elderly persons in the community. They are usually consulted by parents to ascertain symptoms. The elderly persons, based on past experiences, can look at the child carefully and easily detect the cause and offer remedy. However, in extreme or critical situations, the *gbóìshán,* as adiviner, is considered the most qualified and knowledgeable person to diagnose a child's illness. For the *gbóìshán*to identify the symptoms, he performs certain rituals; for instance, the divination of throwing up cowries and a rope of red cloth on the ground. If all the cowries face upwards after they have been thrown, the problem has no connection with evil forces. But, should some or even one face down, evil forces are connected with the illness. Previous experiences of the *gbóìshán*enable him to cross-examine the parent critically, and evoke responses useful to the healing. For example, the *gbóìshán*would ask the parents if they have violated any taboo/norm or even seen a masquerade in their dreams. What is

disclosed is, then, interpreted. Equally important is the fact that not all interventions are based on dreams.

Table 5.7. Opinion of parent whether symptoms of childhood disease influence health seeking behaviour

Opinion	Frequency	Percentage
Yes	328	82.0
No	71	18.0
Total	399	100

Table 5.7 shows that 328 (82.0%) of the parents of sampled children gave positive opinion on how their understanding of the symptoms of childhood diseases influences health-seeking behaviour. Only 71 (18.0%) of parents negatively denoted how their understanding of symptoms of childhood diseases influence health-seeking behaviour. Table 5.10 indicates that parent's familiarity with symptoms of a child's illness provides a direction for health seeking behaviour.

5.3.1 Parents understanding on causes of childhood diseases

In Migili society, several factors have been linked to causes of childhood diseases. Among these are biological or environmental, social or behavioural and mystical or supernatural factors. Firstly, in Migili society, explanations are located in biological causes of childhood diseases. Some parents share the opinion that childhood diseases are caused when flies perch on human faeces, decomposed animals, and other waste materials around the environment and then such flies come in contact with food and drinking water consumed by children. This suggests that unhygienic environment can be responsible for childhood illnesses. Since most frequently, children eat their food in the open and drink contaminated water, they are prone to get infected with water-borne diseases such as diarrhoea and dysentery. This is aptly expressed by Illah Obadiah, a key informant, "food can cause illnesses in children especially when uncovered and had been touched by flies. In addition, exposing and laying children on cold bare floor in a room can also lead to children contracting childhood illnesses like pneumonia".

Furthermore, the attitude of some mothers has been implicated in the prevalence of certain childhood diseases. For example, the action or behaviour of a married woman can cause her child to experience one form of illness or the other, and convulsion is the most common in this context. Yayamani Wuni, a female key informant reflects the Migili mindset on this.

Nkɔn nyránîtsí lùbála zɔrɔ ígbáàvɛlɛ,

A yíya bɛ rùgɔn dɔn dzá bɔ. Túntú sunsu.

This translates as:
When a married woman involves herself in extra-marital affairs, it can cause a child to experience one form of illness or the other. And the most common of these illnesses include convulsion. (Yayamani Wuni, Personal Communication, November, 2015).

Similarly, ethnographic findings reveal that behavioural attitude of mothers could result in the prevalence of childhood illness like splenomegaly. For instance, it is a common belief that children develop splenomegaly when the mother frequently breastfeeds in lying posture. However, this assertion is disproved by Samiya Danzhe, a traditional healer, who submits that:

Adzá cɛnɛ rúgɔn nɛ cɛn kɔn ba

sɔn ḿbɛn nɛ wá.

This translates as:
Personally, children get splenomegaly due to the sucking of a mother's breast milk that has become soured. This is because when the mother stays under the sun for too long the temperature of the breast milk gets hot. And this often increases the swollen of a child lower abdomen (Samiya Danzhe, Personal Communication November, 2015).

Dagya Ozige, another traditional healer, disputes that position:

Mɛ gbɛn kɔn ḿbɛn jɛ dzá cɛnɛ

Sépa ma. mɛ ní kɔn ázúnù wa.

This translates as:
I do not believe that breast feeding a child side-ward can cause splenomegaly. To me, I believe it is the spirits that cause it. They attack

the child in a particular spot and suck up the blood. So, if the child is not cut, they keep sucking his/her blood and make him/her emanciate. In chronic cases the child dies (Dagya Ozige, Personal Communication, October 2015).

Some parents who lack formal education attribute certain childhood diseases mystical causes. For such parents, illnesses like convulsion and polio could be ascribed to malevolent forces. For example, it is believed that evil persons may pour out charms on the road to harm mothers. These charms harm the innocent children instead of the mothers. Evil spirits cause or afflict children with different types of illnesses. Most Migili parents attribute child convulsion to the manipulation of a certain mysterious black evil bird. The belief about this evil bird is widespread among Migili parents. Maza Obu, a female key informant from Ashige town, narrates her personal experience:

dzárùnɔ dzidzi lo bɛ da kútrɔ kùcɔ

kùgbàn kɔn dzá cɛnɛ sunsu. Mínyɛ lɛɛ

ba pɛ nyí dzárùnɔ nɛ bɔ.

This translates as:
I had my experience when a certain black evil bird came and danced round the top of my house three times. After this, I saw my child experienced convulsion. Everyone in this community knows about the evil bird that causes this sickness. It does not have to perch on a roof top for a long time. It simply dances in the air around the house and leaves. Once people see it, they get so worried about upcoming evil. For us convulsion in children is not an ordinary ailment (Maza Obu, Personal Communication November, 2015).

In a similar vein, Masi Ogli, a female key informant, shares her view of this bird:

Dzárùnɔ dzidzi nɔ bɛ rùgɔn ádzáravé

na. sédé rúgɔn áawo, áwo dɔn bɛ mùnɔ

This translates as:
Convulsion in children is also associated to a mysterious black evil bird which hovers around one's house with frequent shouts. So, if ones child is lying outside and crying it is believe that, the evil bird takes away the spirit of the child and makes the child to convulse. For pneumonia, most often the natural cause is when children are exposed to very cold

> environment. In situations whereby children are allowed to lie on the cold floor. Although, we still believe a very severe pneumonia in children could be as a result of evil breeze (Masi Ogli, Personal Communication, November, 2015).

Various ethnographic findings reveal that the mysterious black evil bird in Migili society is closely associated with evil occurrences. As such, whenever it flies around the roof of a house members get scared and do their best possible to drive it away. Another common belief among Migili parents is that when a woman, especially a pregnant woman, walks around at night, there is the tendency that an evil spirit may enter her womb and afflict the child with a strange illness. Consequently, when the child is born it may not walk when it is time for him to do so. This is a major explanation for polio disease in some children.

Furthermore, there is the widely held belief among parents in Migili society that, evil people are everywhere. They can secretly drop some charms in a neighbour's house. This most likely contributes to children falling sick. In fact, the wind, especially the whirl-wind is considered a harbouring preternatural force. It is considered a tool of the wicked people in the society. Whenever whirl-wind blows, parents take their children into the house as a means for protection from harm. Parents in Migili society have diverse perceptions of the causes of childhood diseases; but each view depends on the nature, duration and severity of a child's illness. Most parents rely on the advice of elders and, ultimately, the diviner (*gbóìshán)* especially for illnesses like measles, convulsion, pneumonia and polio. The diviner helps parents to detect the real cause of a child's illness and some parents express the view that splenomegaly and pneumonia in children could be caused by spirits. Data from the survey instrument further expantiate on the causes of childhood diseases in the studied communities as enunciated below:

Table 5.8. Opinion of parent on the causes of childhood diseases

Option	Frequency	Percentage
Stealing	42	11.0
Marital infidelity	57	14.0
Violation of taboo	70	17.5
Superstitious belief	72	18.0
Psychic evil intention of relation	114	28.5
Unhygienic environment	44	11.0
Total	399	100

Considering Table 5.8,42 respondents (11.0%) indicate that stealing by parents could be a major reason for a child to fall sick, while 57 (14.0%) blame it on marital infidelity. Also, 70 (17.5%) admit that violation of taboo could cause a child to fall sick and 72 (18.0%) declare that superstitious belief could cause illness in a child. In addition, 114 (28.5%) of the respondents reveal that psychic evil intention of relations could cause a child to experience illness in children. Similarly, 44 (11.0%) of the respondents reveal that unhygienic environment could make a child to fall sick. Table 5.9, above clearly indicates that cultural factors such as stealing, marital infidelity, violation of taboo, superstitious belief and psychic evil intention of relations play significant role in parents' understanding with regard to causes of childhood diseases in Migili society. Indeed, finding from survey instrument reveal that biological factor like unhygienic environment is consider as an insignificant factor that shape parents' understanding on the causes of childhood diseases in the study communities. This can be attributed to widespread illiteracy and lack of public health education among parents.

5.4 Health--seeking behaviour of parents

The health-seeking behaviour of Migili parents depends on the health condition of the child, and most importantly, the nature of the symptoms observed. Often symptoms identified help parents to seek treatment for the sick child. For ordinary ailments like cough, cold, and fever, self-medication is usually undertaken on the child. However, from ethnographic findings, some parents admit that, once symptoms of earlier-mentioned illnesses are noticed, they either make use of local herbs or consult a local chemist, or ultimately visit the primary

health clinic. Where treatment at this stage seems not to be yielding the desired result, a traditional healer (specifically diviner) would be consulted.

Table 5.9. Opinion of parent on the major factor that determine health-seeking behaviour

Option	Frequency	Percentage
Familiarity with the illness	88	22.0
Severity of the health condition of child	174	44.0
Mysterious nature of the illness	137	34.0
Total	399	100

Table 5.9 shows that 88 (22.0%) of parents express the view that familiarity with illness determines their health-seeking behaviour while severity of the health condition of the child determines health-seeking behaviour for 174 parents (44.0%). Additionally, for 137 parents (34.0%), the mysterious nature of the illness determines health-seeking behaviour. From Table 5.13, the health-seeking behaviour of most parents in Migili society is influence by the severity of the health condition of the child. This data equally corroborate our ethnographic findings which reveal that severity of illness of a child influences health-seeking behaviour of parents.

Figure 2, page 117, is a chart of health-seeking behaviour of parents in Migili society. It indicates that the health-seeking behaviour of parents starts with self-medication. However, where the ailment persists after some days, parents consult a local chemist or even visit the primary health clinic towards obtaining better treatment. However, where the ailment appears problematic and deteriorates, parents either consult an herbalist or diviner.

Table 5.10. Opinion of parent on first line approach in health-seeking behaviour

Option	Frequency	Percentage
Self-medication	107	27.0
Local Chemist	87	22.0
Primary health clinic	75	19.0
Herbalist	73	18.0
Diviner	57	14.0
Total	399	100

Table 5.10 shows that 107 (27.0%) of parents admit that consulting the local chemist is their first line of approach in health-seeking behaviour while 87 (22.0%) do not make the local chemist their first line of approach in health-seeking behaviour. Furthermore, 75 (19.0%) of parents agree that the primary health-care clinic is their first line approach in health-seeking behaviour, 73 (18.0%) denote herbalist as the first line, and 57 (14.0%) designate the diviner as their first line approach in health-seeking behaviour. From Table 5.12, a greater number of parents make use of self-medication when ailment starts in a child.

This depends on how parents and other relations, especially elderly members of the family, perceive and interpret the cause of the ailment. In this regard, it is considered that parents are compelled to consult the diviner for only very serious health condition. When the diviner (*gbóìshán*) is consulted, he will ascertain the cause of the illness through the use of certain instruments. The step adopted by a female FGD participant is narrated herein:

> As a parent, when my child is sick, it is the symptoms that I notice that will help me to know the kind of treatment I should give to the child. As a mother, the mildness of the symptoms determines if I will give self-medication or I will take the child to the chemist. For instance, when I observe high body temperature, loss of appetite and vomiting for more than four days without any improvement, then, I know the child requires urgent and better treatment, may be from the clinic. It is only when the symptoms persist or get worse after clinic treatment that I will seek help from the traditional healer (Personal discussion with female FGD participant, December, 2015).

The above approach reflects the position of a school teacher in one of the communities, and that of a female FGD participant, with senior school certificate background, who owns a grocery shop:

> When the health status of my child appears to be mild, I will give self-medication. However, if it didn't improve I will seek for hospital treatment. But when treatment from the hospital seems to be failing, I have no option but to seek help from traditional healer. This approach is usually done with the hope that the child will receive permanent cure for the lament (Personal discussion with female FGD participant, December, 2015).

She is like the earlier reported participant with formal education but, then, has greater preference for traditional healing. That is why going to the traditional healer is the second and not the last step in the health-seeking process. When sickness persists, parents look for alternative methods of treatment. It is important to state here that, from our findings, the body language of parents shows that they do not feel happy to see their children fall ill at all. They feel sad whenever symptoms start manifesting in a sick child; they appear to behave strangely and, being agitated and worried, seek assistance from elderly members of the family. This attitude may not be peculiar to Migili society:

> The idea of health and healing is a family affair and is deeply rooted in the traditional African setting. An extended family or kin forms a group in the action process towards health (Rinne, 2001:49).

The significant role of extended family members in the process of healing the sick in many African societies cannot be overemphasised. They, especially elderly women, are very knowledgeable in the treatment of common childhood diseases; therefore, they are reckoned with in times of health crisis for children. In many instances, they are the first referral point when the parent of the child is helpless and cannot effectively manage the ailment. In the society, these elderly women are acknowledged for wisdom, experience and skills in managing and solving health-related problems in children.

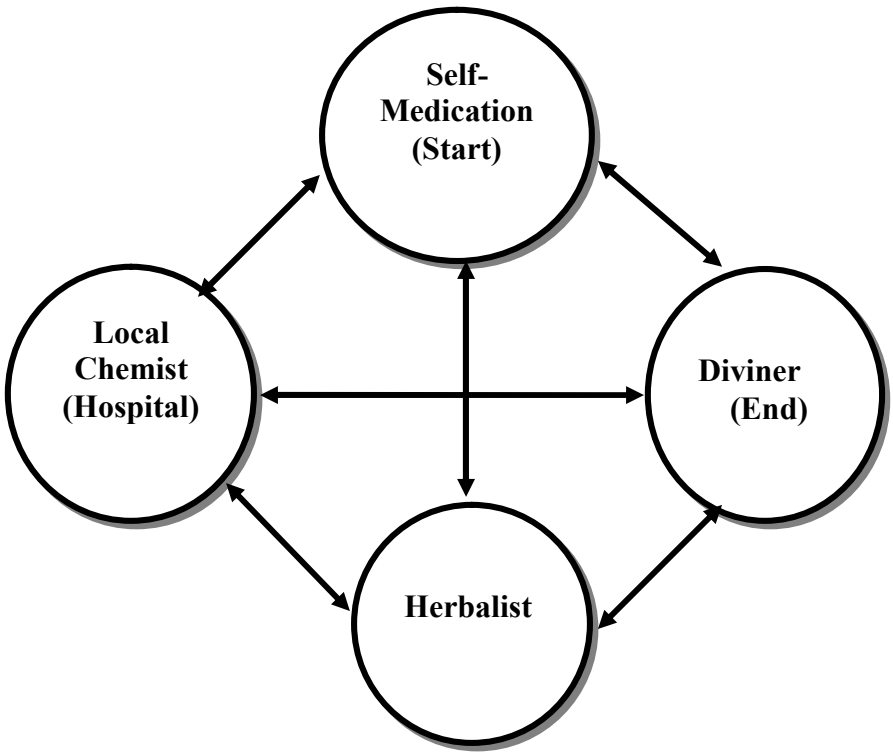
Table 5.11. Opinion of parent on how understanding of causes of childhood disease influence health-seeking behaviour

Opinion	Frequency	Percentage
Yes	312	78.0
No	87	22.0
Total	399	100

Table 5.11 shows that 312 (78.0%) of parents of sampled children asserted that their understanding of causes of childhood diseases influences health-seeking behaviour. Also, 87 (22.0%) gave negative opinion on how their understanding of causes of childhood diseases influence health-seeking behaviour. Findings from Table 5.11 indicate that parents' better

understanding of their children's illness, to a great extent, influences and shapes health-seeking behaviour.

Figure 2.Chart ofhealth-seeking behaviour of parent in Mìgili-Kórò society



It has been stressed by Van der Geest (1988) and Pearce (1989) that pluralistic health-care system, such as the one among the Migili, is common in Africa. Accordingly, it is natural for parents in Migili society to take a series of action starting with a visit to a local chemist for quick remedy. However, rather than visit a chemist, some parents take the child to the primary health clinic where illnesses like fever, cough, and jaundice are often treated. In another situation, parents consult a traditional healer (either herbalist or diviner) for illnesses like convulsion, acute pneumonia, polio and acute splenomegaly. In most instances, the perception and interpretation of parents is that these illnesses have spiritual undertone. The herbalist (*céènwa*) or diviner in Migili society is considered the best health practitioner in the management and treatment of childhood illnesses, especially where the cause of the illness seems to be shrouded in mystery. Where the state of health of the child appears very precarious, the diviner fetches his spiritual equipment and chants required incantation to ascertain the cause of the illness when the child is presented for treatment. As illustrated in Plate 5.25 on page 162, a diviner uses sticks, combined with rope, cowries and red pieces of

cloth smeared with charms as a kind of instrument to explain the cause of the illness or misfortune. Other instruments used by the diviner are water in a calabash, water in white basin or mirror. The revelation of the diviner is considered a lasting solution to the illness most times in Migili society

Highlighting the type of first aid she will render, a female FGD participant discloses:

> In circumstance where my child's illness (of pneumonia) is very severe and the child cannot breathe well, I make use of hot balm a form of traditional "first aid" treatment administered on some other instance too, I use alligator pepper, chew it in my mouth and spray it on the ribs. (Personal discussion with female FGD participant, December, 2015).

Another female FGD participant states that "in an event of a child having pneumonia, we use shea butter oil to rub the ribs of the child and this usually brings some form of relief or healing for the child". In some instances, parents take the responsibility of carrying out personal therapy on their sick children, as in the case of a male FGD participant who admits:

> When my child has pneumonia, I personally undertook self medication for him. I had to fetch some fire, to get him warmth and massage the sides around the chest region gently. The massaging has to be done front and back (Personal discussion with male FGD participant, December, 2015).

Sometimes, worry, anxiety, confusion and even depression set in for some parents, and this influences direction of health-seeking behaviour. A female FGD participant recalls when her child was sick:

> As a parent, I was somehow familiar with certain symptoms of a child's illness. But, when I could not understand what really was wrong with my child, I had no option than to take the child to hospital, and when things did not improve I sought help from a traditional healer. Most often, once I notice strange symptoms in my child, I get worried and even nervous. I will start to think of many bad thoughts (Personal discussion with female FGD participant December, 2015).

Sometimes, the health-seeking behaviour of parents moves from self-medication to consulting a local chemist and then directly to either the clinic or the diviner for treatment due to anxiety and confusion. This is due to the nature and severity of the illness. However, it is not in all situations that parents follow the sequence depicted on the chart. As a female FGD participant intimates:

> From experience, in critical situation of convulsion episode in a child, this happened to be a major illness that demanded urgency and swiftness. As a mother my disposition was hopelessness, I even cried and felt that my child would die The most convenient and easiest life–saving option for my sick child was for me to urgently sought assistance of a diviner (Personal discussion with male FGD participant December, 2015).
>
> .

Basically, convulsion episode provides terrible sight of emotion and anxiety for mothers. They (mothers) cannot hide their worries about the survival of the child. It disturbs them considerably, making them to cry and pray until the sick child is revived.

Plate 5.5.Diviner with his divination instrument trying to ascertain the cause of a (child) patient's ailment. (Source: Fieldwork, February 2017).

5.5 Cultural beliefs and construction of childhood diseases in Mìgili-Kórò society

The study in a bid to generate wider opinion on how cultural belief of the Migili society influenced childhood diseases data from the survey instrument was analysed. Table 5.5 below provides opinion of parents.

Table 5.12. Opinion of parents on how cultural beliefs influence construction of childhood diseases

Opinion	Frequency	Percentage
Yes	328	82.0
No	71	18.0
Total	399	100

Table 5.12 shows that 328 parents (82.0%) are of the opinion that cultural beliefs influence construction of childhood diseases whereas 71 (18.0%) do not believe that cultural beliefs so. Accordingly, most parents in Migili society are of the opinion that cultural beliefs still play significant role in the construction of childhood diseases. This data is corroborated with our ethnographic findings which reveal that parents' cultural beliefs influence and shape the construction of childhood diseases.

For most Migili people, religious beliefs pervade their world view. The religious beliefs form an integral part of their growing up, consciousness and, therefore, it is an underlying feature in the socialisation process of the young ones. Later as adults, they accept that there is a link between the spiritual world and causes of certain illnesses. As observed by Peoples and Bailey (2000), many beliefs and rituals of various societies are concerned with explaining, preventing, and curing disease. Most often, such beliefs are geographically localised. That is, each clan has its specific beliefs. There is a widely-held belief that evil forces can afflict a child with any ailment, as Mache Zheba, the traditional head of Nene village asserts:

La dɔńyee kɔn áná dɔn ńna á
Ázùnù wa. Mùkpókìna du rúmú kɔn
ba za íse pla wa. A dɔrɔ kɔn
ba za ǹwala ma. Cɛ nyín kɔn azúnù
dzídzí ba íya ma rúgɔn dɔn ádzá ba bo nɛ.

This translates as:

> We believe that farms are owned by the spirits and they (spirits) visit the farms occasionally. A farmer is always advised to come back home at noon because it is believed that they (spirit) visit the farms at noon. You can go back after the sun must have gone down a little. In the night too, if one is unlucky, he/she may come across an evil spirit and ones child could fall sick (Mache Zheba, Personal Communication, November, 2015).

It is also widely believed that this could lead to a child falling sick. This explains that the spirits of the dead are everywhere. For instance, the elderly people believe the air is populated by certain unseen spirits. They also believe that whirlwind or *wind devil,* as it is denoted by them*,* is not ordinary; it could be manipulated or generated by human beings who have mystic or evil powers. In addition, evil spirits could attack a person in dream, through bodily contact in social gatherings, and some other ways like the use of personal belongings such as comb, slippers, shoes, clothes. What makes it plausible to the Migili mind is described by Iperesi Leku, a traditional leader of Ashige:

> There are evil forces among us, which cause childhood illnesses. They (evil agents) know children that have brighter stars. Who may turn out to be great men and women in the future. So, they would do what will cause their early downfall. They could do this by secretly or magically cutting a piece of cloth of the child or the sand spot on which the child's feet have touched to make evil things. If a supernatural power is not consulted for healing and protection the child may die (Iperesi Leku, Personal Communication, November, 2015).

In a similar vein, Maza Obu, a female key informant submits:

> *mínyɛ la dɔáyee kɔn ázúnú*
>
> *dɔn bɔ kɔn ba dɔn bɛ*
>
> *rùgɔn nɛ ná.*
>
> This translates as:
> There is the prevalence of strong belief that evil forces exist in our society. If not, how can a child be in the hands of the mother and the spirit wouldnot attack the mother, but the child. It means, spirits desire something in children. Perhaps to spoil their future and fortunes (Maza Obu, Personal Communication, November 2015).

Sicknesses are afflictions engendered by manipulation of malevolent forces. They simply infuse impurities into the blood of victims through nightmares, dreams (of victims

being fed) or in bodily swellings arising from picking the soil on which a victim has stepped, then turning the soil into unseen object which punctuates the body and contaminates it. According to Peoples and Bailey (2000),

> as
> People think that illnesses or other misfortunes are caused by the action of some evil humans who often use special supernatural powers against the afflicted person. Belief that certain people, called sorcerers and witches, have powers to harm others by mystical means is enormously widespread among humanity. Sometimes witches and sorcerers are thought to strike randomly and maliciously against people who are innocent of any wrongdoing. More commonly, they direct their evil magic or thought toward those against whom they have a grudge (Peoples and Bailey, 2000:227).

Table 5.13. Opinion of parents on categories of evil forces that can cause illness in children

Option	Frequency	Percentage
Witches	166	42.0
Sorcerer	132	33.0
Ancestral spirit	58	14.5
Unseen spirit	43	10.5
Total	399	100

In Table 5.13,166 (42.0%) of the parents perceive witches as an evil force that can cause illness in children while 132 (33.0%) perceive sorcerers as an evil force that can cause illness in children. On the other hand, 58 (14.5%) of parents perceive ancestral spirit as an evil force that can cause illness in children while 43 (10.5%) of the parents perceive unseen spirit as an evil force that can cause illness in children. From Table 5.7 above, there is clear indication that in Migili society, belief in the existence and powers of witches and sorcerers are still wide spread and prevalent despite modernity and Western civilisation.

The healer, after all, has power to gain entry into the body and locate hidden things inside it, just as a night is to the invisible eyes, or a dream is to a sleep; the body has a revelatory power of the good and the bad. The soil, mouth, food, body, and cloth are mere contact points with the good and the bad just as dream is. The contagious effect and the changes it brings, gives or take away something from the body, Rasi Zhekaba, a 65-year-old female key informant, opines:

Npɛ bo. Ce nyíkɔn mínyinyrán lɛɛ bà
lɛlɛ ná. kɔn ázúnù bɛ ma ádzá ba.
Kâ kplɔɔ ádzá rúgɔn ná.

This translates as:
I know this because from experience many mothers have dreamt that an evil man came and carried one of their children away. And when the mother tried to catch up with the man to collect back the child the man disappeared. And most often than not, the child taken away in the dream falls sick or dies in reality. (Rasi Zhekaba, Personal Communication, October 2015).

Evil forces are very much active in causing misfortune and sicknesses in children. The foregoing was substantiated from the survey instrument below.

Table 5.14. Opinion of parent whether child illness can be attributed to evil forces

Opinion	**Frequency**	**Percentage**
Yes	358	90.0
No	41	10.0
Total	399	100

Table 5.14 shows that 358parents (90.0%) indicated that a child's illness can be attributed to evil forces while 41 (10.0%) attribute it to evil forces. Finding from Table 5.6 above table indicates that most parents representing 358 (90.0%) in Migili society still attribute cause of illness in children to evil forces. In an in-depth interview with Osidubo Izorosi, a traditional healer, we got more insight into how evil attacks may occur:

Nkɔn nyɛ sóo ìwɔ na, àn yíya

bɛ ma ágándzídzí yànaà bɔ.

kɔn dza wɔɔ bɛ ma dà.

This translates as:
If anybody hates you, he/she can keep something evil in or around your household that you or your child may step on and be afflicted. It is a fact that there are unseen evil forces or spirits that exist and can attack people with strange ailments. (Osidubo Izorosi, Personal Communication, October, 2015).

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The people's belief in revelation through dreams is widespread, as Nyepesi Izorosi, the traditional head of Assakio, reports:

> I believe so much in the reality of dreams. Sometimes, one would sleep and dream that some strange beings or a familiar person that has died visits the dreamer to fight him/her or give him food to eat. Such dreams could manifest in strange illness for a child or even an adult. (Nyepesi Izorosi, Personal Communication, October 2015).

Furthermore, in Migili society, lack of morals could affect bodily health system of persons. For instance, when one steals from a relative or neighbour, or even become indebted to someone and cannot pay back such indebtedness, it is believed that such could evoke a curse from the creditor. The curse invariably could result in sickness for the individuals or their children and can destroy their future. The development can become a generational curse if the ancestors/gods are appeased. And it may continue to destroy the family, as Ayege Sam, a male key informant attests:

Nyídzîá mùcɔ yíya bɛ rùgɔn

bɔ karsì kùrkpòńsɔn ákpákyrɔ.

Ákpánɔsfúnu rùblídzá.

> This translates as:
> There is a widely held belief among our people that certain childhood disease associated with immoral action of parents. For instance, a child could incur the wrath hanging on his/her parents. And the disease commonly linked with this belief is mainly measles called *kurkpo* in Lijili language. When this illness attacks a child, it is believe to be an affliction from the enemy. Another one is called *akpakuro*, which is similar to measles, but not exactly the same as measles. The symptom is usually boils all over the child's body (Ayege Sam, Personal Communication, November, 2015).

Also, there is an illness that paralyses a child's legs in form of polio; it is called *Ikpiti* in lijili language. It is believed that evil forces are responsible for it. Some parents believe that if the *Ikpiti* cannot afflict the parents, it would surely afflict the child or any close relation. *Ikpiti* is assumed to be caused when one steals or sleeps with another man's wife. The enemy uses it as a weapon to attack a person or relation, and most often children are the easiest target.

Similarly, marital infidelity especially for a wife can result in a child's ill-health. In the event of a woman attending burial ceremony in neighbouring village and sleeping over

for all-night wake-keep as custom demands, there are instances, where young women engage in extra-marital affair with other men. In such situation, where the woman refuses to confess, there is strong likelihood that her child would experience strange illness and could die. But if she confesses, the child would be taken to the diviner for ritual performance and the imminent misfortune averted. The culture strongly frowns at a woman having extra-marital affair. The wife's infidelity could lead to misfortune or illness such as high fever and even convulsion for her child. Where the mother of the child refuses to confess her illicit act, the child could eventually die. As a male FGD participant reveals this:

> Cultural belief about women infidelity in marriage is that it brings illness on children. The woman in question must confess and the gods must be appeased before the child can be healed (Personal discussions with male FGD participant December, 2015).

Another male FGD participant supports the view:

> What is considered soft or mild in a particular culture may be bad in another culture. But in Migili culture marital infidelity is a taboo; it is a stigma on the children of a woman who violates the norms. It could cost the children loss of chieftaincy title (Personal discussions with male FGD participant December, 2015).

There may be more penalties, especially if the woman continuously keeps her adultery secret. There is the possibility that it could make her child to convulse or ultimately die. The only remedy left for such a woman is to confess her mischief to the elders.

Also, when married couples quarrel and refuse to settle their misunderstanding, but go ahead to sleep in the night, they are likely to have bad dreams, which is called *Ije* in Lijili language. The *Ije* literally means witchcraft or wizardry. Where couples are unable to settle their quarrel the following morning before the sun rises, they are expected to consult a diviner for ritual purification. Otherwise, one of their children will fall sick or even die. In addition, breaking of taboo by an individual could make a child to fall ill. For example, it is forbidden for a woman to look out through the window to see a masquerade. When happens woman defies this, one of the woman's children will have fever and experience convulsion.

Similarly, Migili parents who see a masquerade in dream carrying their child would experience bad omen. When the parent wakes up, it is interpreted as *not ordinary* dream,

especially when one of the children suddenly falls ill. When parents have such a dream, they have to inform the elders and immediately seek the assistance of the diviner for solution. The way out is to consult the oracle and perform necessary rituals to avert unforeseen calamities. What can also result in a child's sickness is for people to cultivate crops or carry out social activities on *sacred spaces* which are forbidden for public use. To violate this rule results in a child's falling sick. A male FGD participant states:

> There was a case of a man who encroached on a land meant for the ancestors. This land is where sacrifices are made to the gods. And this resulted in his child being infected with strange ailment (Personal discussions with male FGD participant January, 2016).

When the foregoing situation occurs, the only remedy to avert the strange illness is for parents to appease the gods with sacrificial animals like a cock. Equally important, children were often, and are still, taken to a diviner to ascertain the cause of illness and get cured.

In addition, there is a widely held superstitious belief that is usually associated to a mysterious black evil bird. It is believed that the evil bird torments and causes children to experience convulsion whenever it comes and perches on the roof of the house and hoots continually. A male FGD participant narrates this popular superstitious belief to us:

> When a mysterious black bird comes to perch on the roof of a house and cries continually and coincidently a child cries too at the same time, it is mystically believed in Migili society that the bird carries the voice of the child as well as his/her spirit and makes the child to experience convulsion. So, whenever people hear and see such evil bird crying close to the house, they look for a stone to chase away the bird (Personal discussions with male FGD participant, December, 2015).

In such scenario, a parent takes the convulsing child immediately to a traditional healer, preferably a diviner who specialises in the treatment of convulsion. The healer starts performing certain rituals with celerity. He goes into deep spiritual meditation, followed by incantations and oral administration of certain herbs to the sick child. If the attack is considered to be severe, and the child's condition remains critical, marks are administered on the child. Another approach to treating convulsion in a child is for the healer to tie black rope with a cowrie, recite incantations on it, and then ties it round the neck of the child

attacked by the evil bird. As illustrated in Plate 5.6, on page 127, the healer gets a black thread, cuts it to a sizeable length and fixes the black thread into a white cowrie. Usually, a local medicine is rubbed on the black thread and white cowrie after which some prayers are said on it before being tied on the child. The belief is that when the mysterious evil black bird sees the black rope and cowrie on the child's neck, it will retreat and not attack the child with convulsion. The child is, thus, guaranteed safety from future attacks by the evil bird.

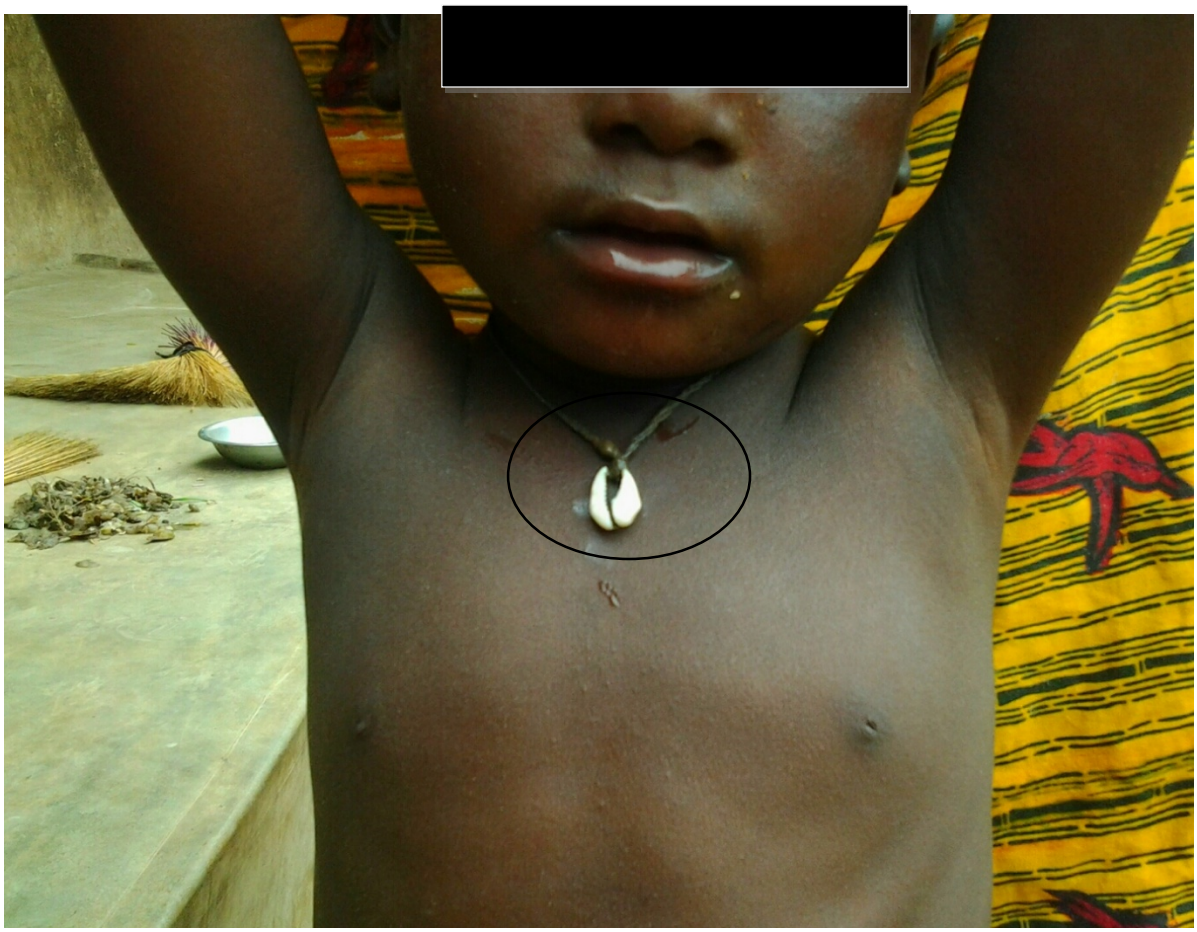

Plate 5.6. A boy wearing an amulet made of black thread and white cowrie (treated with local medicine) tied round the neck. (Source: Fieldwork May, 2016).

The amulet is expected to protect the child from recurrent attacks of convulsion. It is a protective symbol believed by parents as a kind of safeguard against the evil agent (the mysterious evil bird) that causes convulsion in children.

Lastly, the evil intention of relations or neighbours can cause illness in children. This has to do with the general attitude and behaviour in form of anger, jealousy and envy asssobiated with relations and neighbours. In some instances, close relations or neighbours may not wish other people's children well; such people are considered wicked. The wicked or mischievous persons could drop invisible objects on the ground, or at the entrance of a house, so innocent children unwittingly step on. The innocent victim gets afflicted with one form of illness or the other. This situation was corroborated by Lavo Audu, a female key informant:

> *Nkɔn ba ma múgan yana mìjɛn, dza*
> *Yíya bɛ dà bɔ. Ká bɛ rùgɔn dɔ bɔ.*
> *Rúgɔn lɛɛ za kpoo na kuma*
> *Kó ásìmítì klɔɔáblɛ ma.*
> This translates as:
> Concoction can be placed on the road and once a child or parent crosses it, it would result in illness or misfortune. For most Migili people, childhood illnesses are not just ordinary; rather they come from evil hands that afflict them. Any illness that afflicts a child, and defies self medication or hospital treatment, must be as a result of evil forces attack (Lavo Audu, Personal Communication, November, 2015).

Table 5.15. Local names of childhood diseases in Mìgili-Kóròsociety

S/N	Names of Common Childhood Diseases in English Language	Names of Common Childhood Diseases in Ligili Language
1.	Measles	*Krukpo*
2.	Convulsion	*Sunsu*
3.	Pneumonia	*Rúgɔ-áwo*
4.	Fever	*Apini*
5.	Polio	Rúgɔ-átrɛ̀
6.	Cough	*Akpotro*
7.	Splenomegaly	*Sépa*
8.	Diarhorea	*Atini*
9.	Malaria	*Rugo-iye*
10.	Kwashiorkor	*Ifunu-lukpe*
11.	Cold	Áwo
12.	Chicken pox	*Akpakro*
13.	Jaundice	*Rugo-wala*
14	Mumps	*Makumaku*

5.5.1 Categories of childhood diseases and processes for treatment in Mìgili-Kórò society

As indicated in Table 5.15, on page 132, convulsion is one of the common childhood diseases identified in Migili society,which requiresthe giving of body marking. It is known as *sunsu* in Lijili language. When the child under attack cries continuously, jerks and finally convulses. As “first aid” for less serious convulsion, a particular leaf called *Rinano*, a kind of vegetable plant, is cut from the bush and squeezed for the liquid to be administered into his nostrils and eyes. The leaf is also rubbed on the child’s body. Should the convulsion appear severe or become frequent, the child is taken to a traditional healer where marks are administered. A mild or first-time convulsion in a child does not necessarily require body marking. In the case of convulsion in children, three vertical marks are administered, one each on the forehead and cheek or side of the head, and followed with the healer symbolically waving his palm seven times round the head of the patient as a way of driving out the disease.

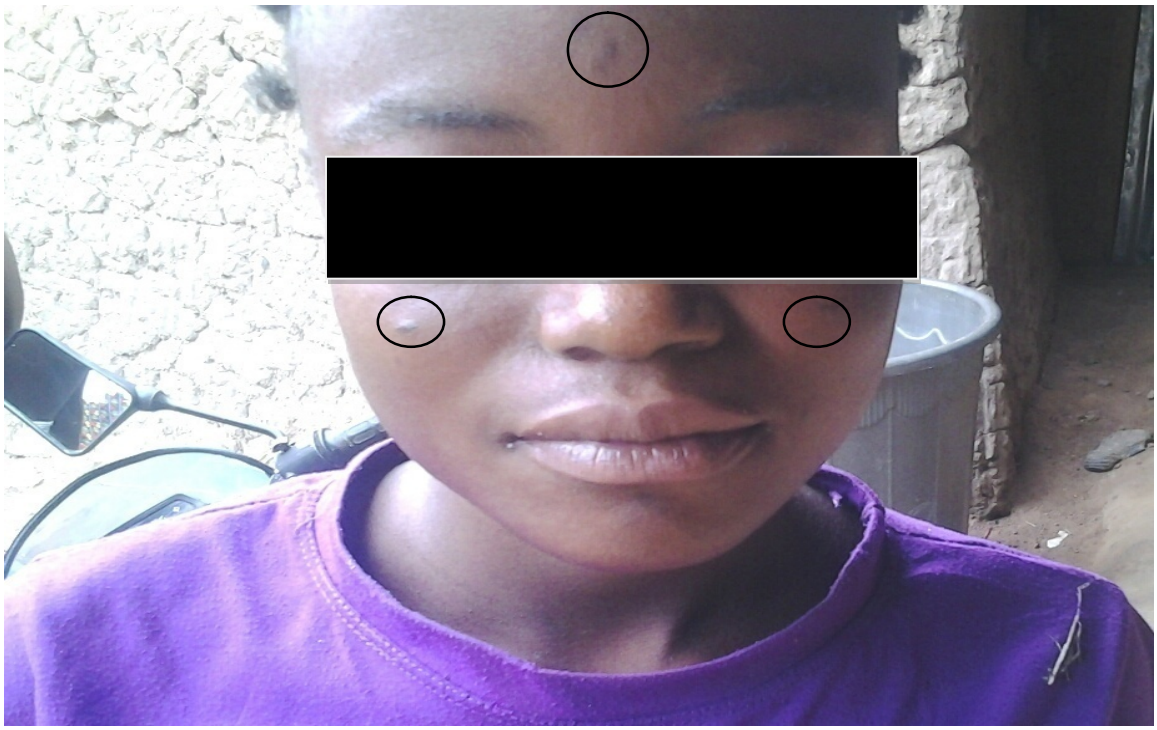

Plate 5.7. A girl of four years bearing vertical marking for convulsion (on the forehead and cheek. (Source: Fieldwork November, 2015).

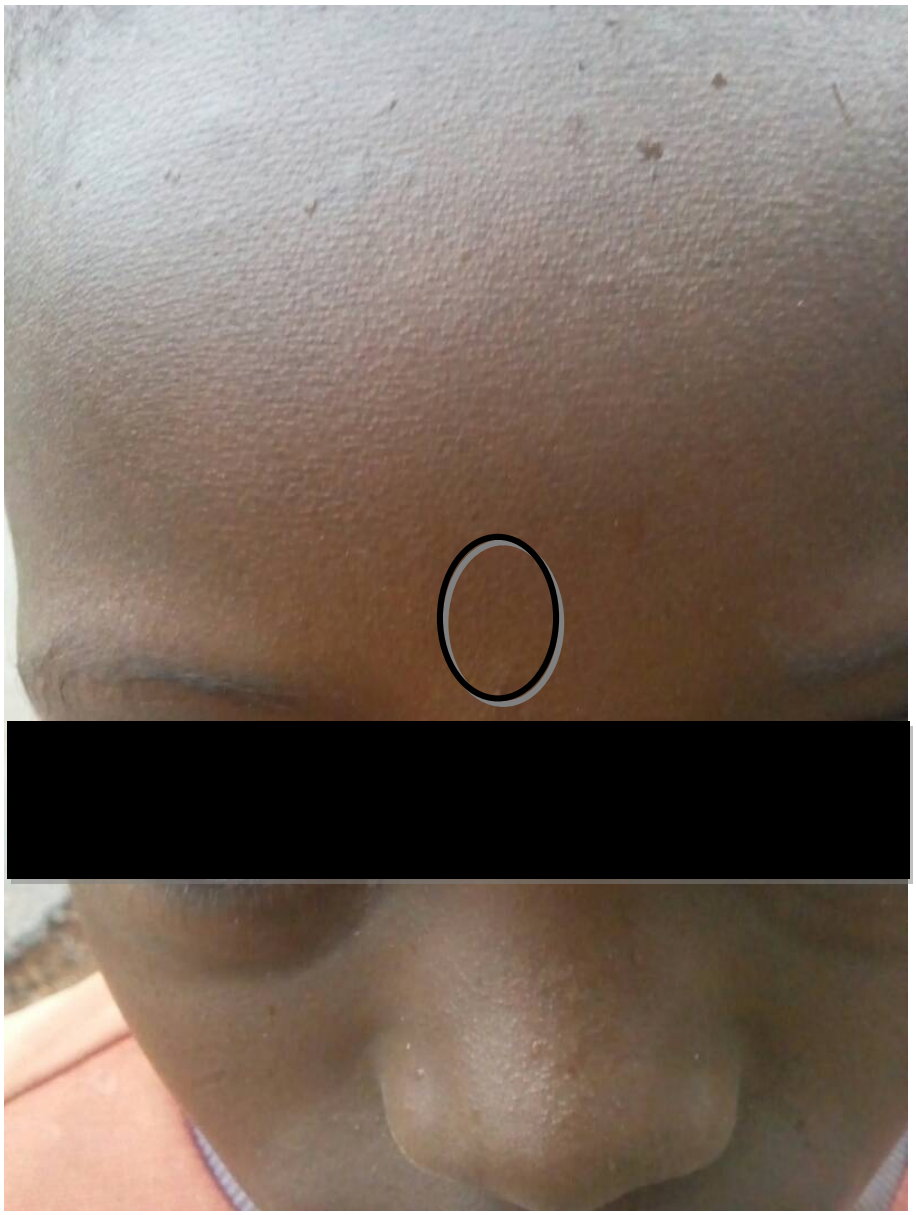

Plate 5.8. A boy of four years, bearing one vertical mark for convulsion on the forehead. (Source: Fieldwork November, 2015).

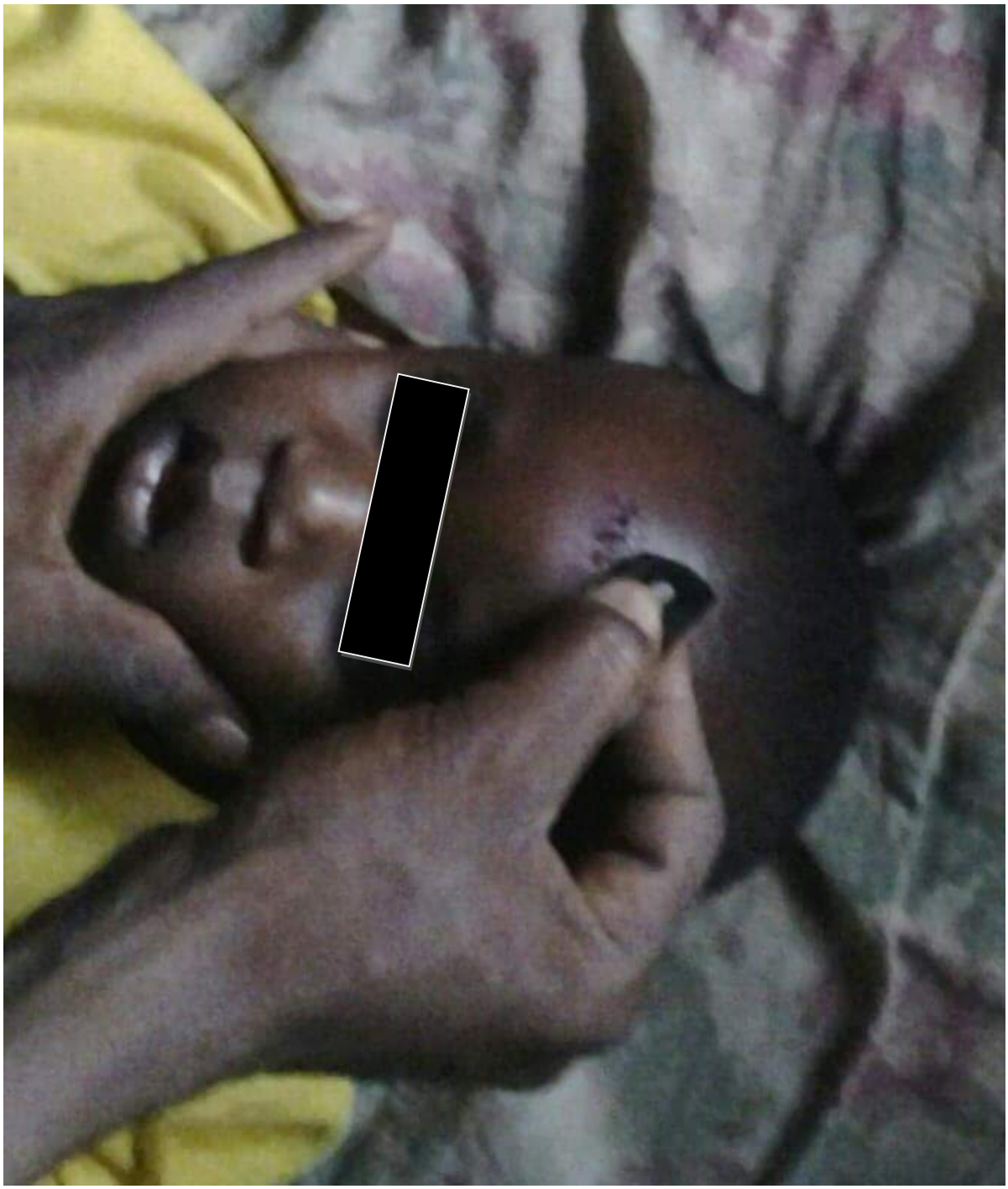

Plate 5.9. A boy of less than two years being markedon the forehead for convulsion. (Source: Fieldwork, February 2016).

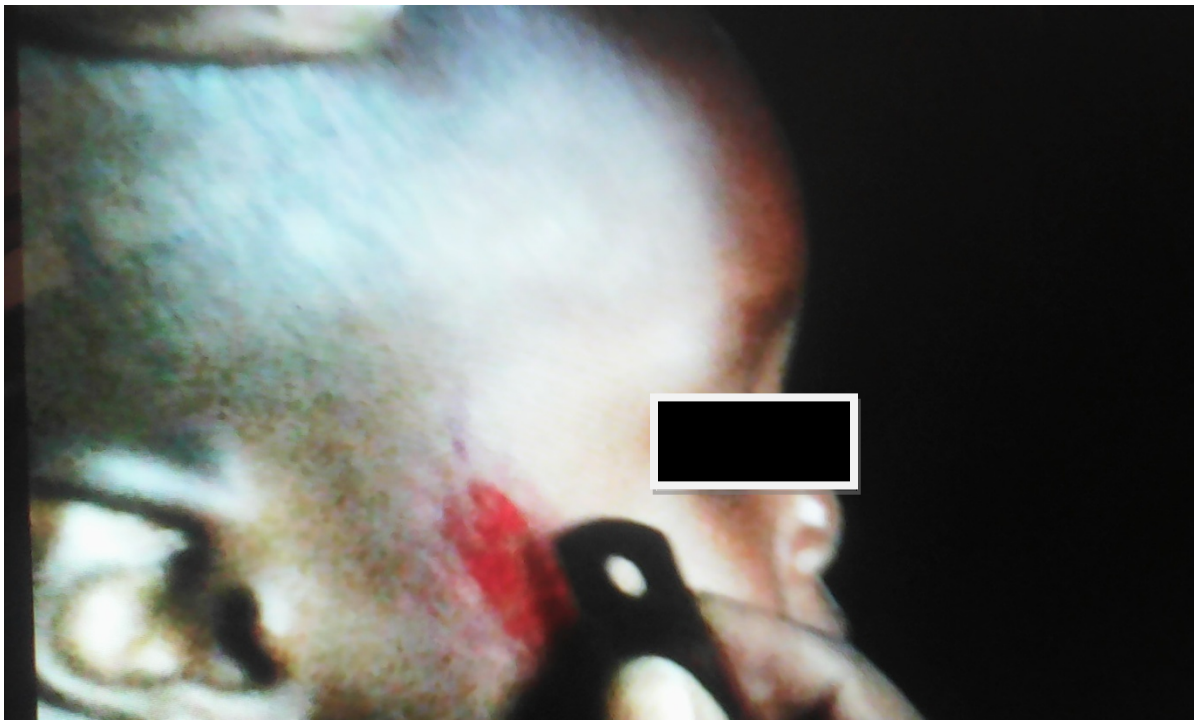

Plate 5.10. A two-year-old boy being markedon the side of his cheek for convulsion. (Source: Fieldwork February, 2016).

Plate 5.7 on page 134 shows a four-year-old girl marked for convulsion and Plate 5.8 on page 135 shows a three-year-old boy marked on the forehead for convulsion. Similarly, Plate 5.9 on page 136 shows a healer giving marks on the forehead of a boy less than two years old for the treatment of convulsion. Plate 5.10, on page 137, is a boy of two years old being marked on the side of the cheek for the treatment of convulsion. The picture in Plate 5.8 on page 135 is quite different from Plate 5.9.0n page 136. The marks for convulsion can be given either on the forehead or the side of the cheek, as long as it fulfils the purpose of allowing the medicine to penetrate into the body of the patient as a way of driving out evil spirits.

Timing is essential to the healer in determining if convulsion in a child is mild or severe. The oral administration of the liquid from the *Rinano*vegetable plant is timed. That is, a period of about 30 minutes is given for the patient to gain consciousness. After the expiration of this time and the child is not revived, the healer deems the development serious and is inclined to take another step of giving marks on the child. There is no standard time stipulated for healing. It depends on the experience of the healer, and providence. In one ethnographic setting, a convulsing child was taken to a healer, herbs were administered for revival, and the following incantation was uttered:

Osílà don ke dzà nɛ
Ńyí là nà.
Là dó koó doń wó wà
Yánà dzà nɛ kà rí!

It translates as:
God of our ancestors,
We are trying to revive this child not for evil purpose
and not with our authority.
We want him/her to be well
So that he/she can serve you.
Make this child to wake up!
(Personal Communication from Samiya Danzhe, a traditional healer, May, 2016).

It is instructive to state here that the healer thinks God is the One who heals. He equally admits helplessness in delivering the patient, ascribing the healing power to three factors: God, gods, and ancestors. The healer is only a messenger and the means to an end, a mere instrument as it were.

In another scenario, a mother presented her convulsing child to a clinic. The wailing mother was in company of a few other women who were in pensive mood. The child was motionless and the eyes appeared whitish. This indicates severe convulsion, which had put him in a state of coma. The healer took the child from the mother and quickly intensified his incantations/prayers to the ancestors:

Ńgà kón múcɔ la Zòrɔ nɛ kɛ̀
Ńgà kón la zòro nɛ kɛ̀.
Inayi tulo kon yi ni nya kon la zoro ne.
I da de!
Ida mudú kon la ya ka yi ne,
Kon yi da den.
Mukpona wa yi gise kina.
Nyelo na je mbo
Nyelo kpele cwe moon boo.
Nyela koo den nyelo koo den
Zak on levu be
Nata kici ka tana kon
Aa kloo mbo, ko nye na ta kon
Ko nye na lukpo kon
Iri kon I maabli yi
Ko nye ri akan be didre na
I ma aabli yi!

This translates as:
With special signs and gesticulation, the translation goes thus,
This is what our fore-fathers did.
This is what we are doing.
You saw what we used to do (referring to the fore-fathers)
You say like this!
Say and do exactly how we told you, say and do exactly.
We are labourers/farmers, share the piece of land.
Someone should share it (with a big lump of sand),
Another one should follow the demarcations
Someone should follow like this,
Someone like that.
The chief farmer comes to the shade and says, it is finished!
Everyone should choose his portion (of the divided land).
Everyone should go to his portion
Help one another when you finish cultivating your own.
None should come and rest (after finishing)
Help one another! (Personal Communication from Oyele Gbotu, a traditional healer, May, 2016).

As incantations were being chanted, marks were given and the child woke up instantly. It is clear indication that the healing power rests with the ancestor. However, a synergy is presumed to exist between the healer and the ancestor in the role play that brings healing: Chief Farmer (the ancestor) comes to the shade; everyone (the healer inclusive) has the portion (role). Both must address their varied concerns, but at the same time, they must help each other.

A look at Table 5.15 on page 132, also, indicates that splenomegaly is a category of childhood diseases in Migili society that requires body marking. It is known as *sepa* in Lijili language. It is not in every suspected case of splenomegaly that a traditional healer recommends body marking. The body must be perceived to be strong for marking, and then, the healer will give the parents some powdery substance to be administered orally to the child. The essence of administering powdery substance orally is to enable the affected spot to be ready for marking in time. When the child is brought for marking, it is not compulsory that both parents must be present. Notably, many a time, only the mother brings the child; in some instances, the father is present. This is because some mothers would rather prefer the fathers to bring the sick child, for reason that, such child may not endure the excruciating pain and the father can calm him down or hold him firmly. When the child is brought again after the diagnosis of the problem, the healer palpates the lower abdomen region, hits it with a soft object like slippers, and observes. If the affected spot rises and goes down again, the body is perceived at this stage as being ready for marking.

As early as 6.00 a.m., before the rising of the sun, the parents present the child for marking, and then the healer prays to the ancestors/gods as follows:

òsì, rúgɔ go nyɛ ná
La dú bènyɛnnɛ kón
rúgɔ go ne wa
La dòn ka don wɔòsì wá
La kɛ̀ dòn don ríblí laá na
Nyi kón nyenne a no
Ntro nson miye nɛ wa.

This translates as:
God, it is sickness that has attacked this fellow.

We want to help this patient.
We want to save him/her life for you.
We are not helping/saving him/her for our sake.
We just want this suffering fellow to be alive among people as you would wish (Personal Communication from Osidubo Izorosi, a traditional healer, December, 2016).

After the incantation, as shown in Plate 5.11 on page 142, the healer gives the marks, starting from bottom to the top and from left to right. The reason for this approach is, as we earlier stated, to avoid the blood from covering the place that has been marked. Thereafter, the healer goes on to sprinkle the prepared ground leaves (herbs) on the marked region of the abdomen as shown in Plate 5.12 on page 143. This process involves a delicate and risky approach, because starting with the manner cutter is handled, there is strong likelihood of inflicting injury on the child or the healer. We observed that the child screams and struggles to avoid being given the marks. It is worthy to note that the healer gives the marking without the use of protective device in form of hand gloves and absence of steriliser and anaesthetics. From the point of view of modern health-care practice, this could facilitate the transmission of blood-borne diseases like Hepatitis B, and HIV/AIDS. On a particular occasion, a child received minor cut on the hand from the razor the healer used to administer the marks. Worthy of note here is that wounds made from the marks are usually exposed, without due professional medical care of covering it. And this makes it prone to infectious diseases when the child plays around.

In Plate 5.13, on page 144 the healer takes some seconds using his hand to palpate the abdomen of the child where the herbs has been sprinkled. This allows the herbs to penetrate into the body where marks have been administered. The aim is to ensure that the herbal medicine penetrate deep inside the blood stream of the child in order to accelerate the healing process. In Plate 5.14, on page 145, as part of the healing process, the healer ritually waves his palm seven times on the abdomen of the patient as a form of symbolic act that the illness is being sent out. This is followed with muttering of incantations by the healer.

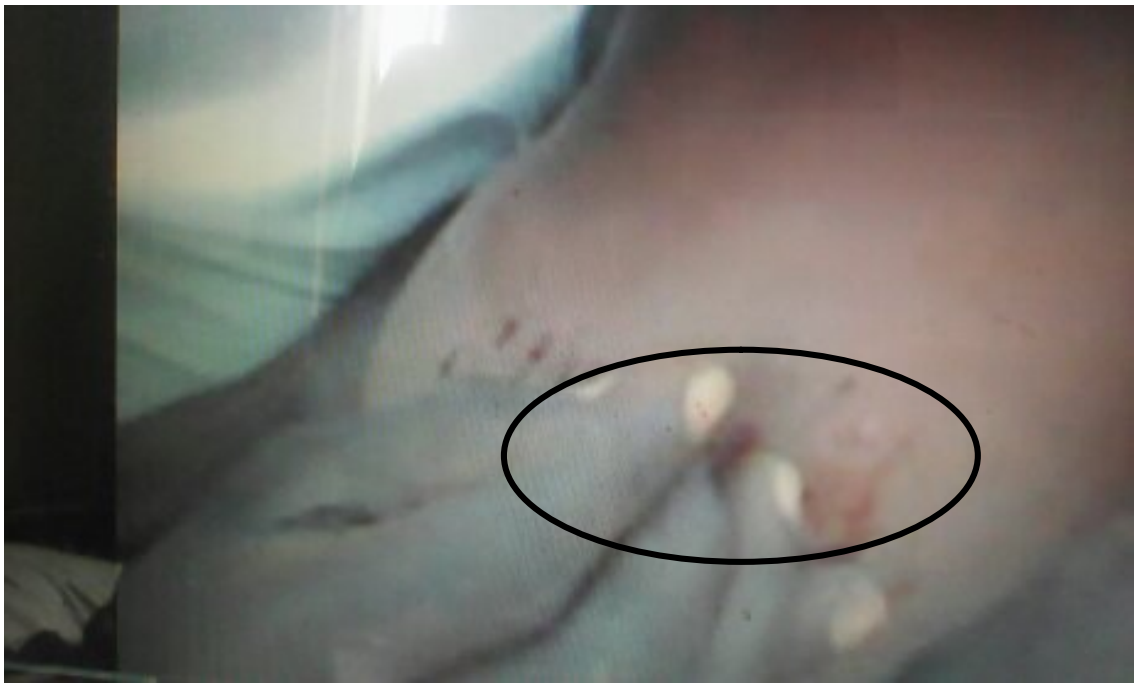

Plate 5.11. Healer in Nene community administering marks on the left lower abdomen of a year-old girl for Splenomegaly. (Source: Fieldwork February, 2016).

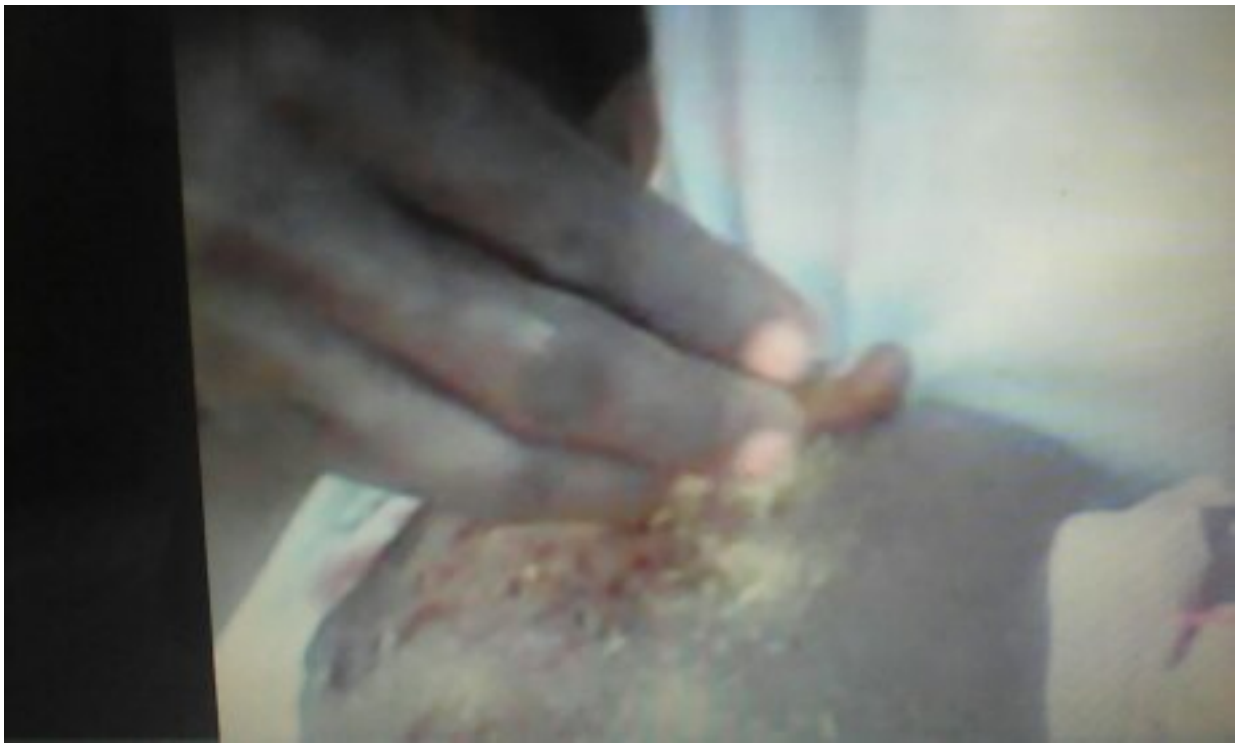

Plate 5.12.A healer spraying ground herb on the abdomen of a year-old child after marks had been administered for the treatment of splenomegaly. (Source: Fieldwork February, 2016).

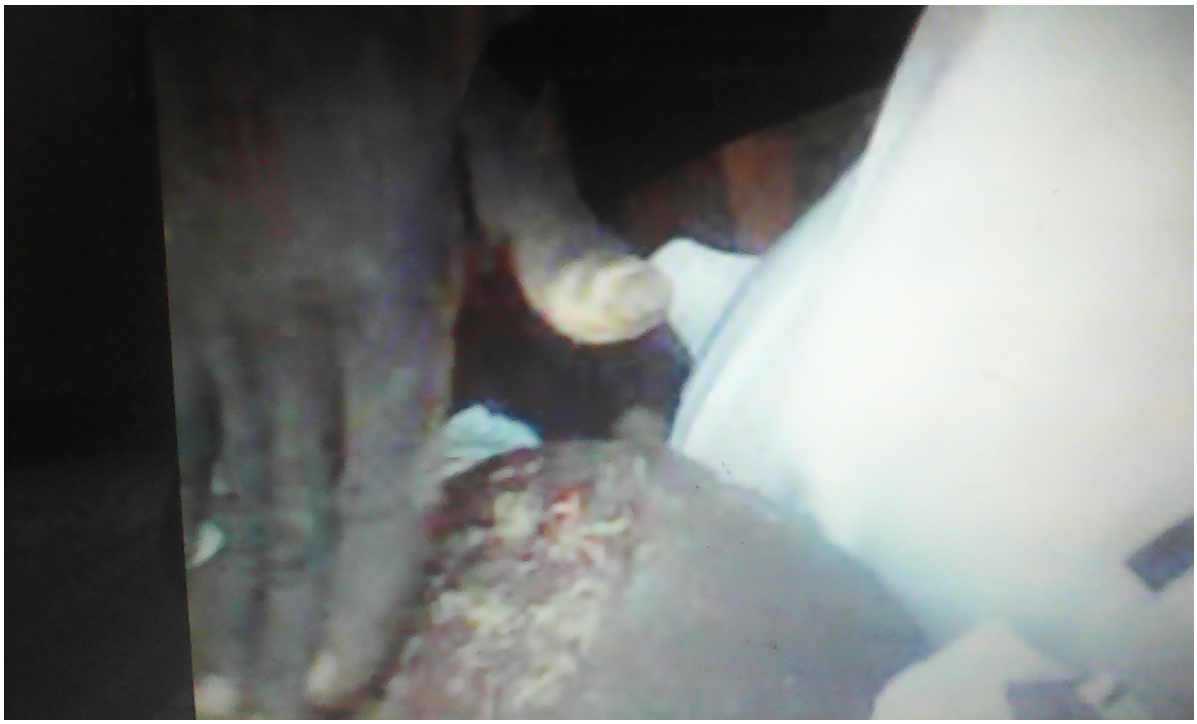

Plate 5.13. Healer massaging sprayed herbs on a year-old child after marking was administered for treatment of splenomegaly. (Source: Fieldwork February, 2016).

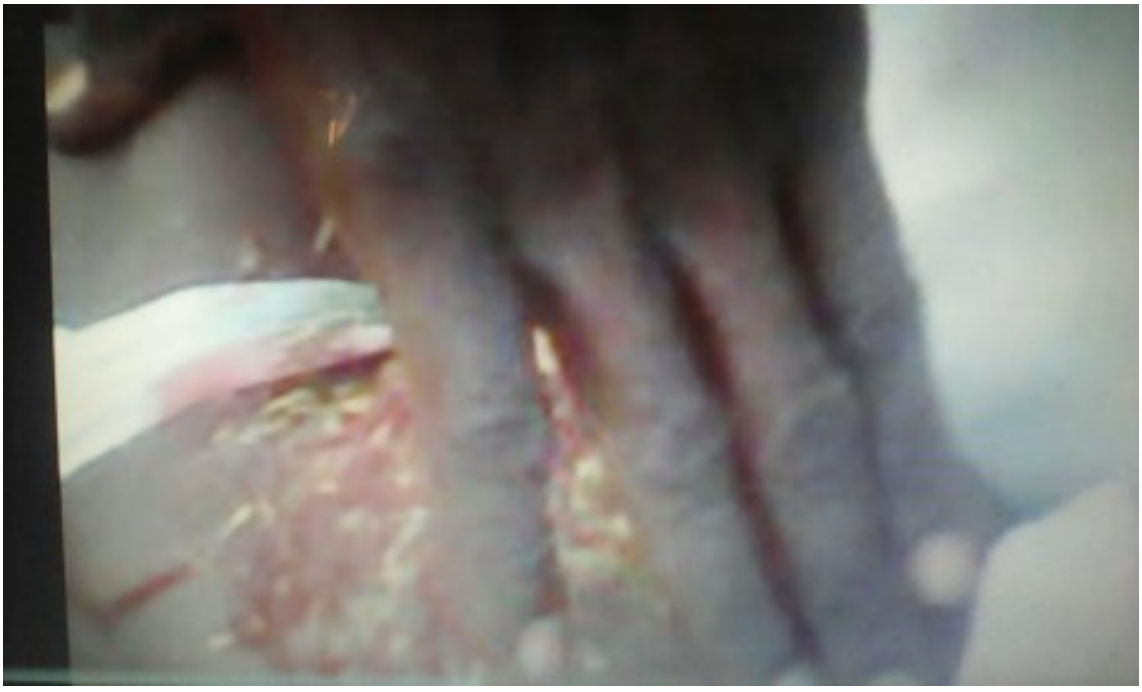

Plate 5.14. Healer performing ritual on a year-old child to symbolicallyindicate driving out the sickness of splenomegaly. (Source: Fieldwork February, 2016).

Thereafter, he takes a small quantity of the powdery substance and licks it to assure observers that the herbal powder is not harmful to the child. Next, he gives the father of the child some quantity of the herbal powder in nylon with instruction that only small quantity of the substance should be mixed with local beverage or warm water and given to the child morning and evening for seven days. The instruction goes with a caution that the child should not bath until the following day, so as to allow the wound to dry up. According to Nyepeogasi Gbado, a traditional healer, the advice can go thus:

> *Múcɔ yana ńkɔn mùgan cɛn ńzɛn àn*
> *kpɛ kún boo. kɔn bà shɔ zarɔ. La yàka*
> *ba kɔn ba zɔrɔ gàn kɔn laa yàka ba nɛ*
> *kpɔɔn wá ní kà kpɛlɛ bɛ na.*
>
> This translates as:
> The parents get the powdery herbs as reserve in case blood gushes out again. They are to spray the powder on the region and the blood will stop. Sometimes, we give those herbs to be boiled and drank.We advice that they adhere strictly to whatever we tell them to do. For, anything contrary to our advice may result in re-occurrence of the illness (Nyepeogasi Gbado, Personal Communication December, 2016).

Plate 5.15, on page 148 shows a two-year-old boy with a marked abdomen treated for splenomegaly. Plate 5.16 on page 149 also shows a three-year-old boy with marked abdomen treated for splenomegaly. On the other hand Plate 5.17 on page 150 shows a boy of less than five years, bearing marks treated for splenomegaly; standing with him are his siblings in the corridor of their house. We observed that the marks given to the boy in Plate 5.17 on page 150 for the treatment of splenomegaly are very elaborate and more in quantum than other earlier cases illustrated in this study. It is significant to state that the marks given to the boy in Plate 5.17 was administered by a more elderly and experienced healer. From ethnographic findings, we observe that older and more experienced healers give accurate and more elaborate marking than the younger healers. This is because marking given by inexperienced younger healers are sometimes inaccurate and incomplete, as we further observed. The pattern of the marking given for the treatment of splenomegaly ranges from 10 to 12 vertical lines and seven horizontal lines measuring between 0.5 cm and 0.7 cm. The seven horizontal lines stand for perfection of healing although we discovered from our

observation that the vertical lines were not consistent. On Plates 5.15 and 5.16, the children seemed to be malnourished, an indication that they may be suffering from kwashiorkor or other childhood-related illnesses.

Plate 5.15. A three year old boy, bearing fresh marks for treatment of splenomegaly. (Source: Fieldwork February, 2016).

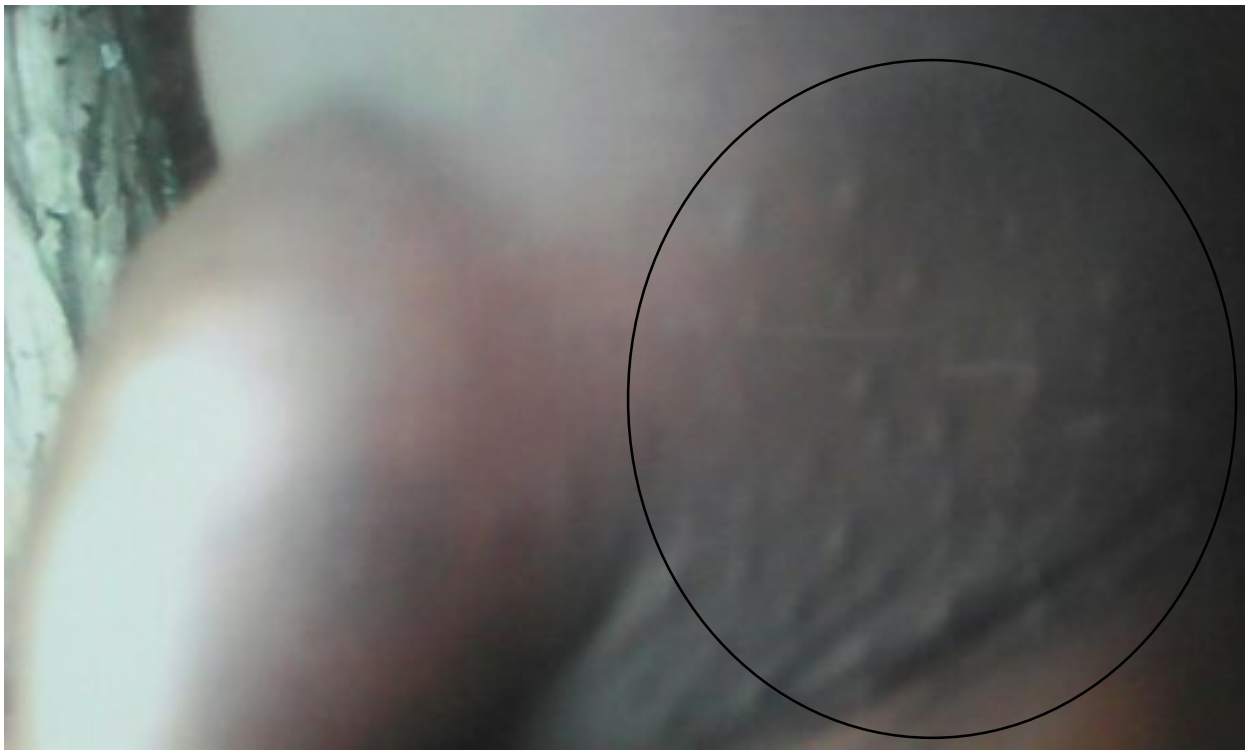

Plate 5.16. A two-year-old boy bearing marks for splenomegaly. (Source: Fieldwork March, 2016).

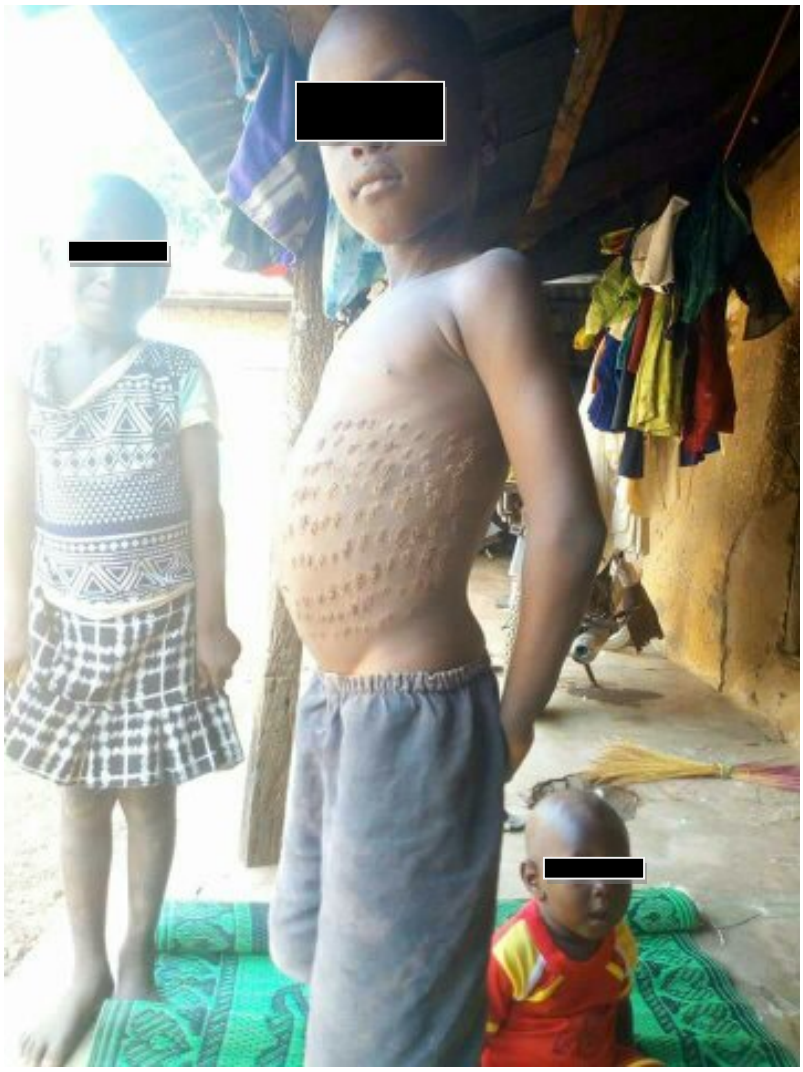

Plate 5.17. A boy less than five years old bearing marks for splenomegaly and standing close to his younger siblings. (Source: Fieldwork March, 2016).

As indicated in Table 5.15, on page 132, polio is another type of childhood diseases that require body marking in Migili society. It is known as *rúgɔ-átrɛ̀* in Lijili language. The age range of children afflicted by this disease is between one and two years. At this period, in the physical development of the child, he should be able to crawl and later walk around the house or compound. More often, it is a pride that the child starts to crawl and later walk between six months and one year. Where this is not occurring, anxiety is generated and parents begin to observe for symptoms of illness. Once the symptoms are noticed, the child is taken to a traditional healer who specialises in the treatment of paralysis or polio. In the healer's clinic, the child's development is observed carefully. Some of the instruments used are broken handle of a hoe called *Lúfɔ* in Lijili language, ointment made from shea butter, sliced bamboo sticks called *ákpálà* in the Lijili language, water and rope.

At the initial period of healing, the healer warms the broken handle of the hoe and uses it to massage the nerves and knees of the child as indicated in Plate 5.19, on page 154 after the ointment has been rubbed on the child's knees. The *ákpálà* is tied round the child's knees. The process is repeated in the morning and evening, until it expels the polio in the child. We observed that marks are administered on both knees of the child even before the massaging processes take place. Three marks are given on both legs, so that the evil spirit tormenting one particular leg would not move to the other untreated leg. A very serious paralysis may take up to a month to heal, but less serious cases take less than a month. The healer, when massaging the legs, chants relevant incantations:

Yìn ná yi mú zɔn
Kón yín nayi na nkpin
I na li lube, kon yin ci
Lúbɛ nɛ kón zhe muzho
A je agbele kon cì kúbɛ́
Don azhoo keli ko nyelo
Na dzi kwon a.
Nye ka dzi kulo,
Gbɛlɛ́ àn dzóò dɔ ígbèrɛ.
Gbɛlɛ́ zhe kupo ka yiwo
Yi nayi ne an ma igbere be don,
Zhemuzho kon zhemuzho,
A be don azhoo.

This translates as:
You travelled to another place to showcase your talent.
In the village square of the foreign land.
The youth healer would ask his subordinates,
to make an announcement to the youths:
Let none of you fight or cause misunderstanding here.
Anyone that goes against this will pay a fine.
The assistant of the chief that followed you,
Together with the youth leader will share the fine amongst others,
While the culprit will watch them enjoy.
So, do not attempt anything evil!
(Personal Communication from Mala Kyari, a traditional healer, November, 2016).

It is worthy to note from the above incantations that the gift of healing in Migili society is considered a rare talent. And such talent cannot be hidden and it extends to even outsiders. The young healer is expected to learn the skills of healing diligently and make it available in the public space. Also, it is instructive that the gift of healing the sick in the community is not meant to be used to create hostility and, where such occurs, offenders are sanctioned.

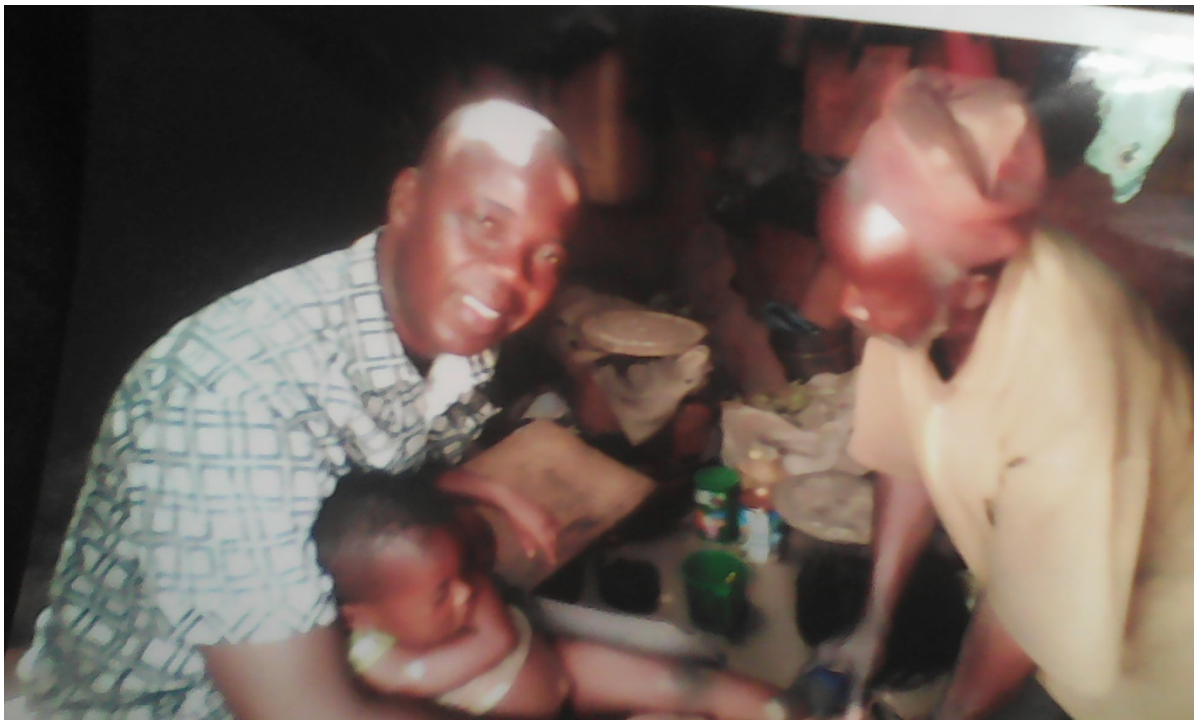

Plate 5.18.The researcher assisting as healer treats a polio patient by massaging the limbs. (Source: Fieldwork May, 2016)

The evil spirit is sent back to the world beyond; that is, the world of the imaginary where it can function properly. Some of the wordings of the incantations may indicate the sins of the child's parents which the child should not commit. Another incantation for remedy goes thus:

Ósí, wɔ bɛ n dzá nɛ itsne na.
Dzá nɛ, kan bɛ ma na.
Kan bɛ ma ritree a a,
Co kón nson mru kón na.
A no nye iswe nkwale.
A no nye izoro nblan don muco kón,
I ife ka nye muno nɛ,
A cɛnɛ́ nna kón ma dan,
Ka no mpani don múcɔkón múdon.

This translates as:
God of our ancestors,
You brought this child into this world.
Do not come and take him/her away from the parents.
Let him/her grow to be mature.
Let him/her grow to labour for the parents,
The sufferings of the parents even during the pregnancy should not be in vain.
The child should grow to become responsible and have his/her own children too.
The incantation is directed to the child's ancestors whose concern must be to protect the lineage from harms and thereby preserve it for several generations. As long as the child lives, the ancestors live through the child as their "ambassadors" on earth.
(Personalcommunication with Samiya Danzhe, a traditional healer, November, 2016). .

The significance of this kind of incantations is that it portrays the faith the healer has in the ancestor. The content of the incantations/prayers refers to pregnancy not being in vain, and those children, being responsible for lineage survival; the ancestors having role to play as lineage ambassadors in the world beyond. The implication of this is that harm to one is harm to all.

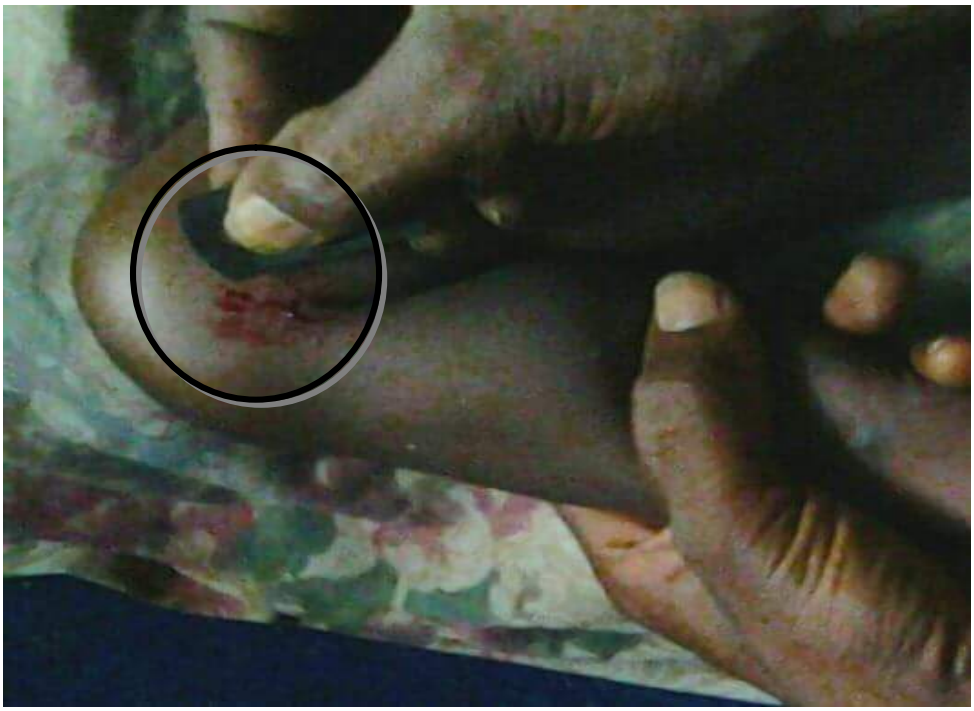

Plate 5.19. Healer in Ashige town administering markings on boy less than two years old for treatment of polio. (Source: Fieldwork February, 2016).

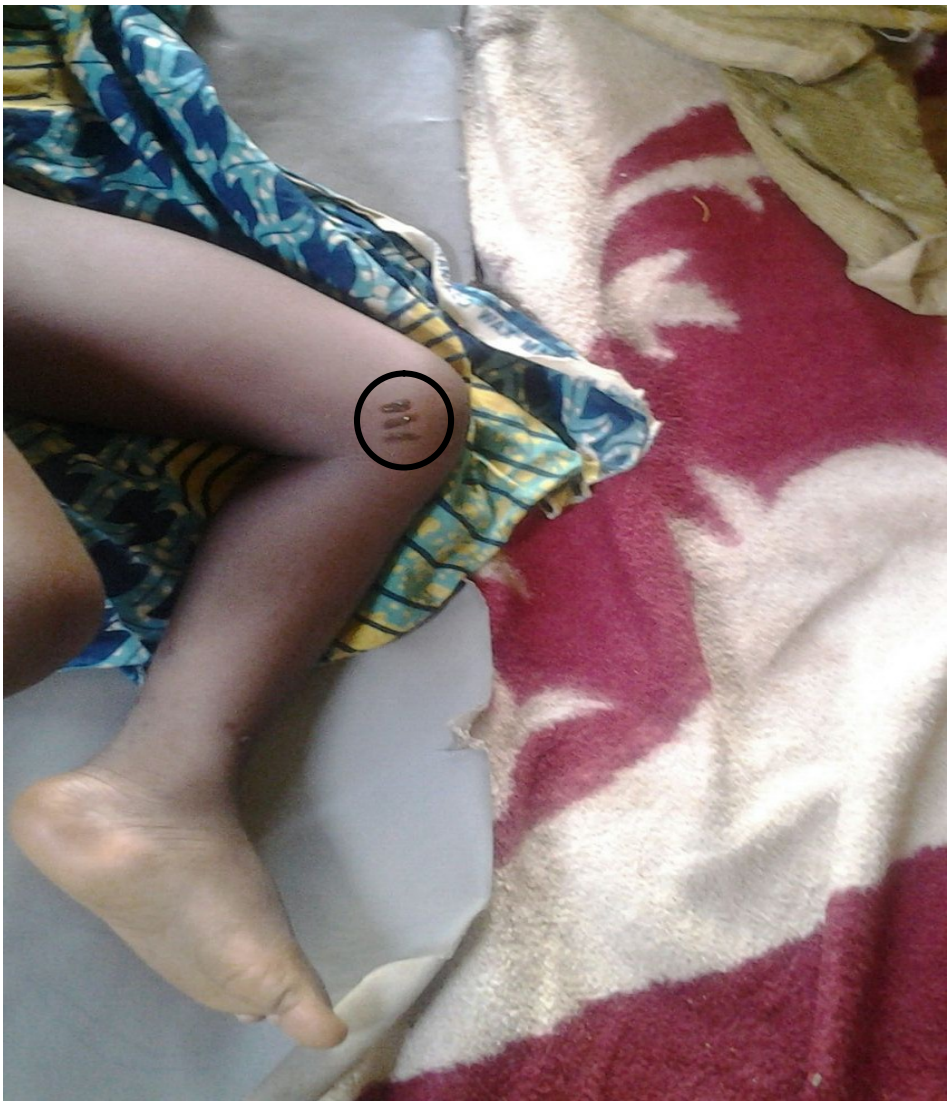

Plate 5.20. A two-year-old boy administered marks for treatment of polio. (Source: Fieldwork March, 2016).

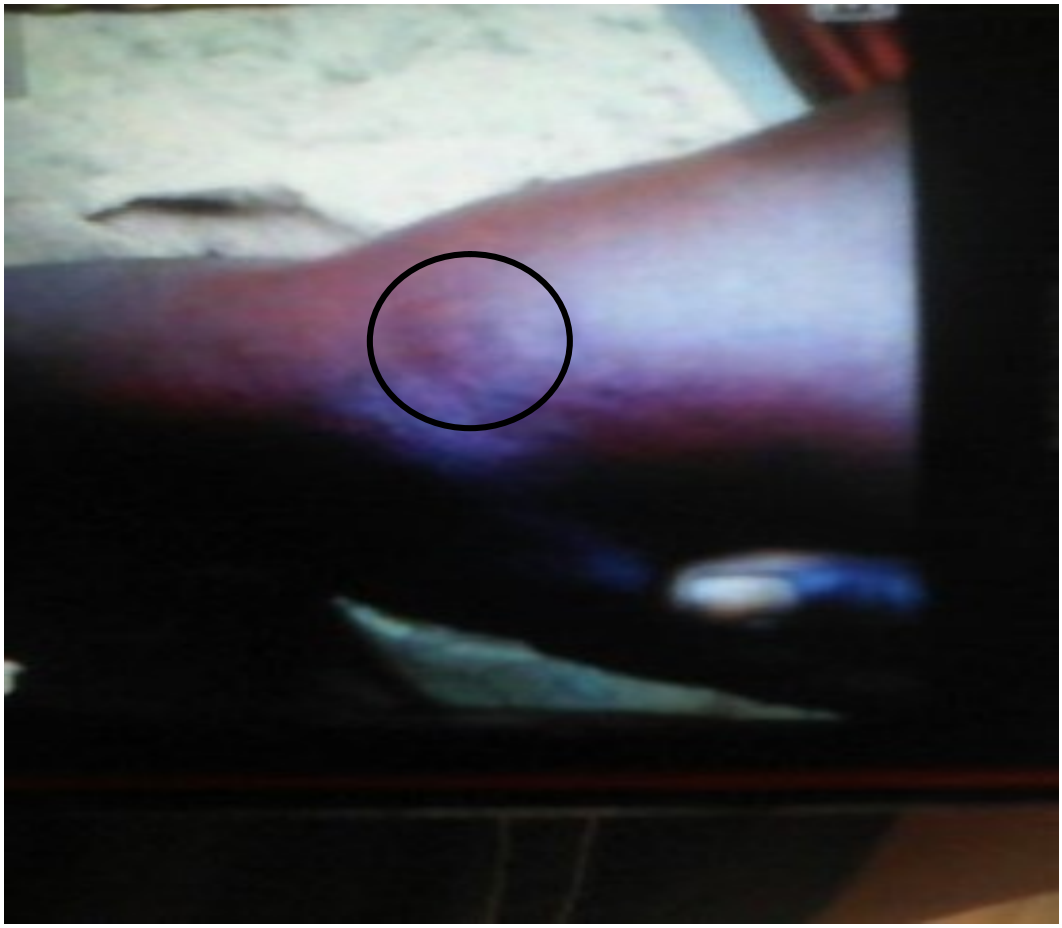

Plate 5.21. A four-year-old boy bearing three marks on the side of his knee for treatment of polio. (Source: Fieldwork February, 2016).

Plate 5.19, on page 155, shows another healer administering marks for polio on a child. The marks administered for the treatment of polio are three vertical lines of 0.5 cm. The marks are administered on the side of the knees. The number three is symbolic in the treatment of polio because three, as a number in Migili culture, signifies stability in the treatment of a polio patient. After the marks are administered on the knee, the healer recites incantations and smears the marks with herbal medicine. Plates 5.20 on page, and 5.21, on pages 156 and 157, respectively are pictures of children given marks for polio disease. The picture in Plate 5.20 shows a two-year-old boy with three marks administered on one of his knees. When three marks are administered, the condition of the patient is severed. Plate 5.21 shows a four-year-old boy that was given three marks for treatment of polio. His polio had been successfully treated when this picture was taken in the course of this study.

We observed that the foot of the boy (patient) on Plate 5.20 appear swollen. This could be attributed to the fact that the foot was feeble and weak. This is because the leg was considered *not active* and blood was not flowing freely. In not-too-serious cases of polio, mothers and aged women could carry out first aid treatment on children whose limbs are too to walk. When they observe that a child fails to crawl or walk at the expected period of growth, they get leaves from the forest, boil them in water and then use the herbs to massage the waist, knees, and the feet of the child. This process supposedly brings expected result for the child.

Table 5.15, on page 132, also indicates pneumonia as one of the childhood diseaseswhich require the giving of body marks. It is popularly called *rúgɔ-áwo* in Lijili language. It is a common ailment in the community, especially during harmattan and raining seasons. We observed that not all cases of pneumonia in children require marking on the body. If observed by the healer to be mild, the patient can be treated with ointment and hot herbal medicine. But when it is considered severe, the healer is compelled to recite incantation/prayer to the gods, basically the ancestors:

Nkón n da ámlà je múcɔ,
A la na dzá kan dzina.
Ama nkón a za ámlà na
Ka dón nyeé kútun kón yii

Yaka la nɛ wa,
Yi tón lugba kón dzá nɛ nɔ ntrɔ.

This translates as:
If I am lying against my fore-fathers,
Let this child not be healed.
But, if it is true according to what you taught us,
Help me, let this child be healed and be strong and healthy again
(Personal Communication from Akamuge Akule, a traditional healer, January2015).

After the incantations/prayers are said, the healer puts water in a cup and then takes some of the water to wash the chest where the marks are to be administered. He, the healer, quietly offers a prayer and begins to give the marks. This is followed with the healer symbolically waving his palm seven times as a way of sending out the ailment from the patient. The marking causes the child to scream and struggle to free himself from pain. In one case recorded when the child was administered marks, the researcher in company of the parents of the child gave support to enable the healer to hold him. We uttered expressions of sympathy as the child was consoled by all present. The assistance we offer red was in form of holding the hands and legs of the child by the researcher and parents, as the healer gave the marks, beginning from lower part of the body to the upper portion.

As shown in Plate 5.22, page 161, marks were administered in the chest region of a four-year-old boy starting from the lower to the upper region, and from the left side (of the healer, right of the patient) to the right side (of the healer, left of the patient). Also, Plate 5.23 onpage 162, shows a-three-year old boy who was administered marks for pneumonia. Similarly, Plate 5.24 on page 163 shows marks for pneumonia administered on a girl of four years. The marks administered on the boy in Plate 5.23 page 162, is more than a month and the wound had been healed. On the other hand, Plate 5.24, on page 163, shows a girl with marks administered for pneumonia that had been completely healed. However, careful observation of Plate 5.25 on page 164 reveals that the marks are not as accurate as the earlier ones in Plate 5.22 and Plate 5.23. The number of marks, given (for the boy and girl in Plates 5.22 and 5.23 on pages 160 and 161) vertically, ranges between four and six. It is noteworthy that, horizontally, it is three. And the number three in Migili culture symbolises stability in the healing process.

The number of marks for pneumonia ranges from four to six in three vertical lines. In the course of .treating a child with pneumonia, the healer may use a magical rope to perform a kind of therapy. He ties the rope around the rib or chest of the patient, then pulling it forward (towards the healer) with his hand seven times to symbolically draw away the disease from the child. The rope is said to have spiritual powers of its own. Regarding that, Akamuge Akule, a traditional healer, comments:

> *Kílí nɛ dɔ nàzùnù lɛ wa. Ba ma gɛnɛ*
>
> *kúcɔíjɛ sóon. kɔn ba ma da cɛn kɔn bàn*
>
> *sala nɛ.*
>
> This translates as:
> The rope has spiritual powers that pull the illness out. The rope is being hovered over fire to touch the chest region of the child where he/she has been given marks. After this, the fire is quenched with cold water. This is significant because it is believed that the sickness that is aching the child will now disappear (Akamuge Akule, Personal Communication, January 2016).

Pneumonia is believed to be caused by evil spirits and, because of this, the assistance of the ancestors is required to heal the sicknesses. On the day of treatment, the healer does not communicate with anybody before embarking on the actual treatment. The belief is that, should he speak with anyone before treatment is administered, the treatment may not be efficacious on the patient. This idea applies also to ailments like convulsion, splenomegaly and polio.

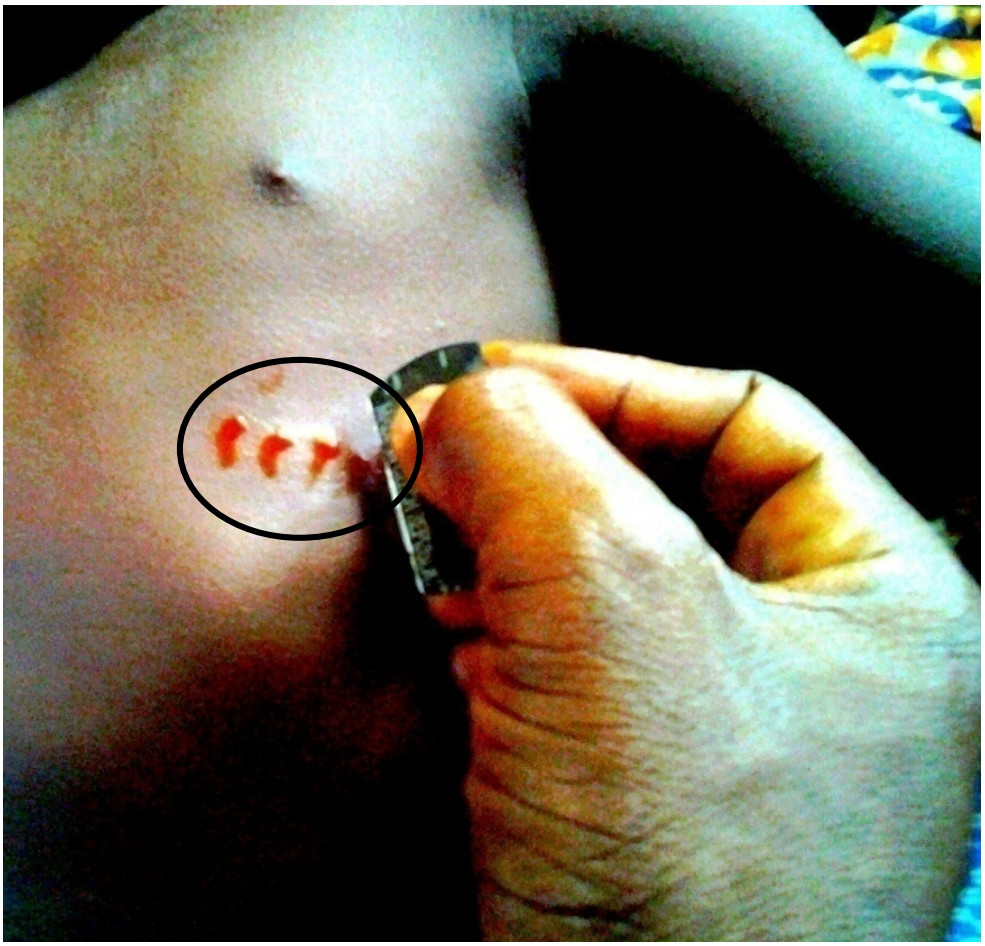

Plate 5.22. Healer administering marks on a three-year-old boy for treatment of pneumonia. (Source: Fieldwork, January 2016).

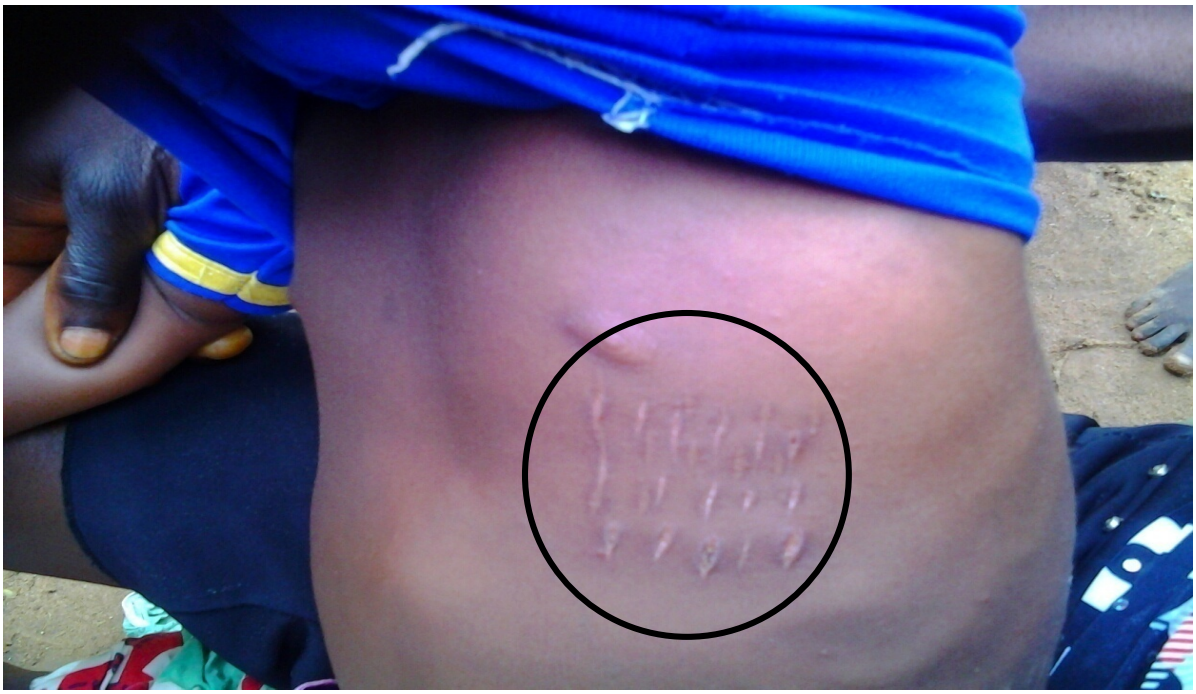

Plate 5.23. A four-year-old boy bearing marks for the treatment of pneumonia. (Source: Fieldwork, January 2016).

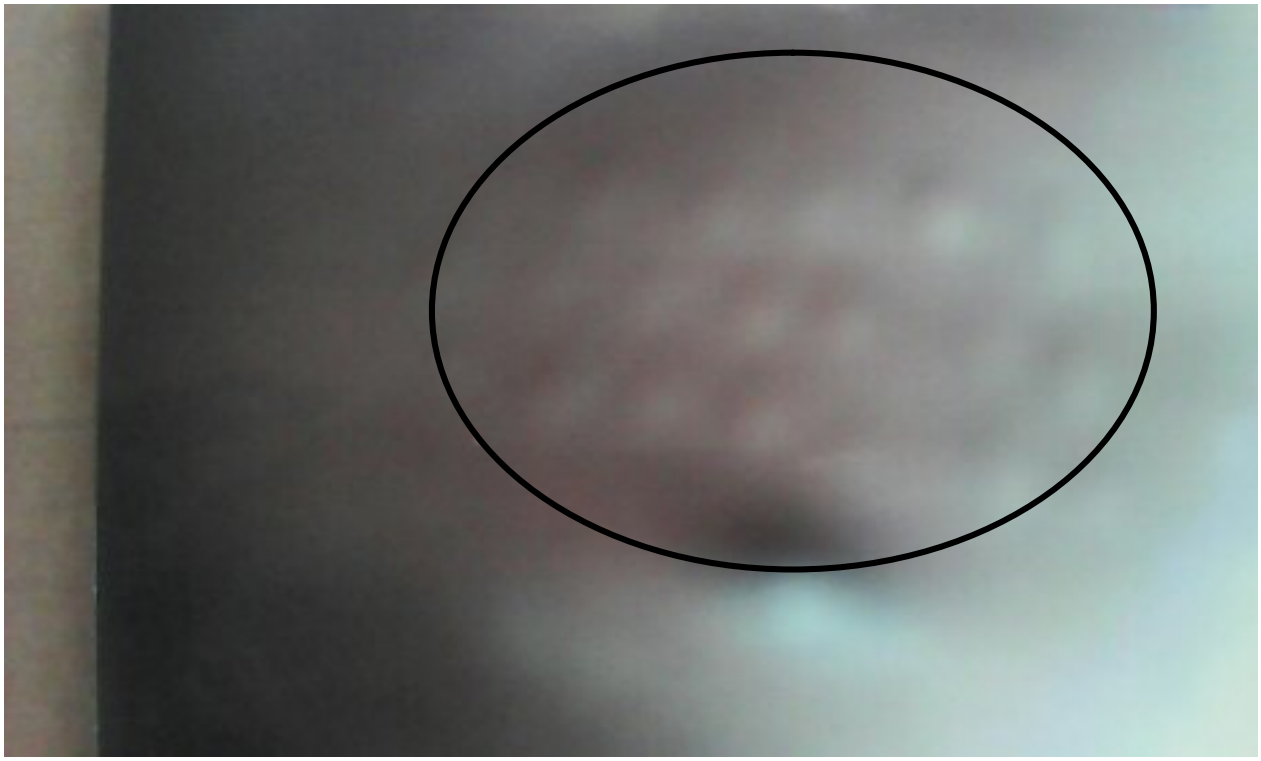

Plate 5.24. A four-year-old girl bearing marks for the treatment of pneumonia. (Source: Fieldwork, January 2016).

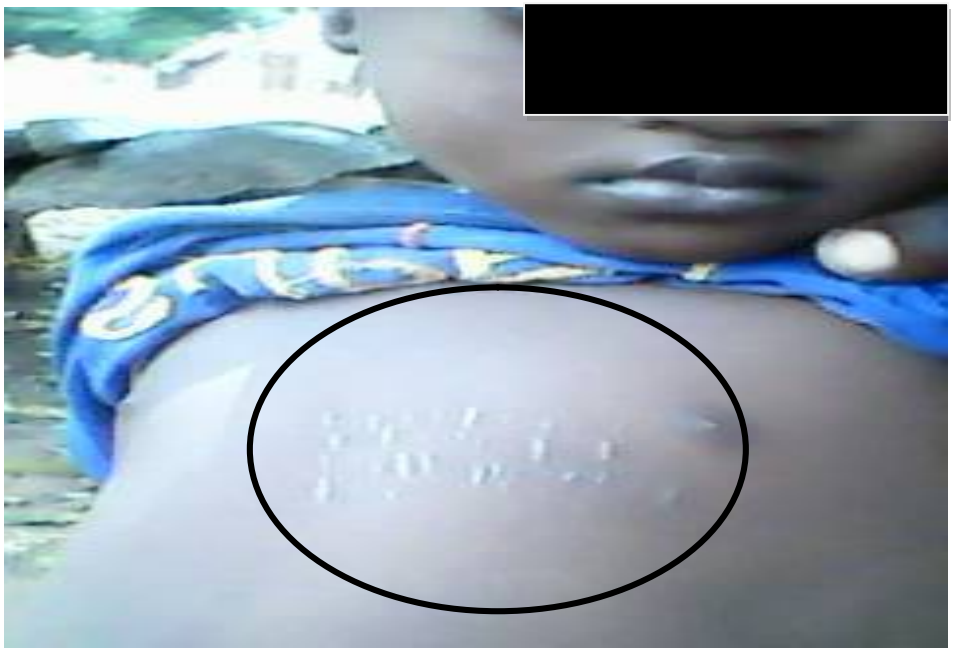

Plate 5.25. A three-year-old girl bearing marks for the treatment of pneumonia.(Source: fieldwork, January 2016)

5.5.2 The role of ancestors' in ritual performance of healing in Mìgili-Kórò society

Evident in the several incantations we have recorded and in the belief of the people is that there is need for the full blessing of the ancestors. This belief is well-noted in the health-care delivery system in the society. Indeed, ancestors (*múcɔ*)have a symbolic space, time and honour as the influential factor in perfecting healing in the health process. The presence of these spiritual forces around the healer greatly influences efficacy of the healing processes. According to Ngubane (1977), the traditional healer is a person of great respect in the African community. He is a medium in the communication with God. Consciously, the herbalist or diviner as healer acknowledges the unique role that supernatural forces like ancestors can, and do, play in making rituals successful.

It is germane to emphasise that the knowledge the healer acquires comes from the revelation of the ancestors or gods. The knowledge is transferred from one generation to another. According to Dagya Ozige, a 68-year-old healer from Assakio town:

Kílí nɛ dɔ nàzùnù lɛ wa. Ba ma gɛnɛ
kúcɔíjɛ sóon. kɔn ba ma da cɛn kɔn bàn
sala nɛ.
This translates as:
The spirits of our ancestors have always guided me on what to do. In fact, revelation of how to treat a future patient or victim is always given to me in dreams. The spirits reveal to me which kind of illness and which kind of marks I have to give(Dagya Ozige, Personal Communication November, 2015).

The healer's ultimate power of healing the sick rests with his ancestors. The entire knowledge and skills the healer has acquired is shrouded in religious ethos and values handed down by the ancestors. The ancestors constitute a source of revelations of nature and composition of the herbal remedies required to heal the sick. They inspire the healer to make originating fresh incantations/prayers.

Ancestors are acknowledged in the healing process when the healer invokes their spirits and recite the necessary incantations/prayers. Rinne (2001) agrees with this in the following assertion:

> Many diseases are seen as messages from the ancestors or the spiritual world. The Yoruba consider the connection between the healer and the ancestors as very strong and this, therefore, strengthens the experience the healers have with the ancestors in their everyday life, especially as it affects health care delivery (Rinne, 2001:24).

Often, the healer encounters the ancestors in his dreams and, in the course of performing ritual and treating the patient, the healer experiences signs that the ancestors are actively involved in the healing process. Some of the signs that indicate the ancestors assist in the healing process are that: sometime a strong wind will blow around the healing scene; the healer will hear a quiet voice communicating a message to him; or in certain instance, the patient would just abruptly wake up from his/her unconsciousness. This manifests when the patient calls the name of the father, mother or a close relation, with some feeling of anxiety.

5.6 Implications of body marking on the health of Mìgili-Kórò children

It is observable from our findings a major reason for giving marks on a sick child is to ensure that the medicine penetrates deep into the body very well to achieve long-lasting healing. Apart from allowing the medicine to infiltrate the veins of the patient very well, marking equally allows the bad blood to gush out. Also some traditional healers have stressed that giving marks permits the medicine to get into the veins of the patient and heal the *inner* sickness which is presumed to be mystically or spiritually induced. This is corroborated by a male FGD participant:

> It effectively deals with the sickness by curing the inner sickness. For example, if the lower abdomen of the child that has been diagnosed of splenomegaly is not marked, the enlarge spleen will grow and probably kill the child. So, the child is given marks so as to ensure that the bad blood comes out freely from the body and relieves the child of the

> sickness. And more importantly, the internal wounds are destroyed by the medicinal herbs that are applied to the wound (Personal discussion with male FGD participant December, 2015).

Findings from ethnographic data revealed that two major symbolic meanings are linked to the giving of marks on Migili children. Firstly, it helps to bring out impurities in form of bad blood from the body of the sick child. It is believed that, in the case of splenomegaly, it is the bad blood that makes the child's abdomen swollen and at the same time manifests vomiting, hotness of the body and lack of appetite in form of bad blood. Secondly, several ethnographic findings from healers reveal that marking the body of the child is believed to give some form of spiritual benefits, usually as a kind of protection. It is also believed to symbolically ensure severance of link between the sick child and the evil forces that torment the child. For instance, in perfecting the treatment of spleen disorder in a child, the healer symbolically moves his palm seven times away from the patient to indicate that the disease has been totally sent out of the child's body.

Also, it is a widely-believe in Migili society that marks given to a child who has convulsion confers permanent cure than the use of orthodox medication. Our findings reveal that both traditional healers and parents admit that the indigenous health-care practice of administering body marking on children for the treatment of convulsion and polio have proven more effective and enduring than modern medical method. The general belief among parents is that, as long as sicknesses and misfortune, are conceived and interpreted from the view point of religio-cultural or spiritual experiences, the indigenous approach requiring the giving of body marks will remain relevant in the treatment of childhood diseases. Finding from the quantitative data below corroborated the benefit of medical body marking on Migili children.

Table 5.16. Opinion of parent on whether body marking has actually saved the life of a child

Opinion	**Frequency**	**Percentage**
Yes	350	88.0
No	49	12.0
Total	399	100

Table 5.16 shows that 350 (88.0%) of respondents gave positive opinion that body marking has actually saved the life of a child while 49 (12.0%) gave negative opinion. Table 5.18, indicates a high percentage of parents affirming that body marking has saved the lives of children. Notably, this corroborates our ethnographic data wherein most parents expressed the belief that body marking as an indigenous healthcare system in the mamagement of childhood diseases, actually has saved the lives of children, especially from illnesses believed to have been caused by malevolent forces in the community.

On the other hand, the negative aspect of body marking on children has to do with the severity of injury received by patients. For example, Plate 5.26 on page 168 shows the injury sustained by a boy marked for splenomegaly. This is more severe and pronounced because of the multiply cuts given to the boy. It leaves *hypertrophic scars* in the region where marks were given. In another vein, ethnographic findings from some traditional healers have revealed that, from past experiences, some parents fail to adhere to specific instructions/prescriptions after marking was given on sick children. Zhegoro Iperesi, a 50-year-old traditional healer from Ashige, testifies thus:

> The challenge I had in the past was with some careless parents. Sometimes, they (parents) don't follow prescription or direction given to them, and the wound will not heal as fast as it could on the child. So, they (parents) have to come back again. And so, I give marks again on the already marked region. When this occurs, it enlarges the scar on the child's body and therefore resulted in hypertropic scars or keloids (Zhegoro Iperesi, Personal Communication October, 2015).

The direct implication of such parent' scepticism is that it makes the child's body susceptible to infectious diseases as he grows up. In this regard, a male participant in an FGD session, comments:

> The body marks could give someone a kind of cancer of the skin. I know a legendary singer (musician) from Kunza village in Migili, who had cancer of the skin seven years after having a road accident that affected the region incisions were made. The singer had an accident that resulted in bodily injuries and the region where incisions were made could not heal as expected. This later resulted in cancerous infection and eventual death of

> the singer (Personal discussion with male FGD participant, December, 2015).

In some instances, when marks are not properly administered, it could result in severe injury which hinders the desired healing. Nkosi Ajeh, the Secretary of Ashige Community Association, comments:

> For the marks that were given to my daughter at childhood, the first markings given by the medicine man were not properly given. Then, a second medicine man was consulted who also did not administer the marks very well, because he did it with fear. However, the third medicine man got it right. And because of the multiple marking done, the scars appeared to be more pronounced. This made her marks look slightly bigger and different from others. Such a case is not common. My daughter's marks appears to be bigger and wider. This to some extent negatively affected her growing up into womanhood. The sight of the scars made her to be uncomfortable with her body and around her peers when playing with them. And she was ridiculed in school by her classmates when her body was exposed (Nkosi Ajeh, Personal Communication November, 2015).

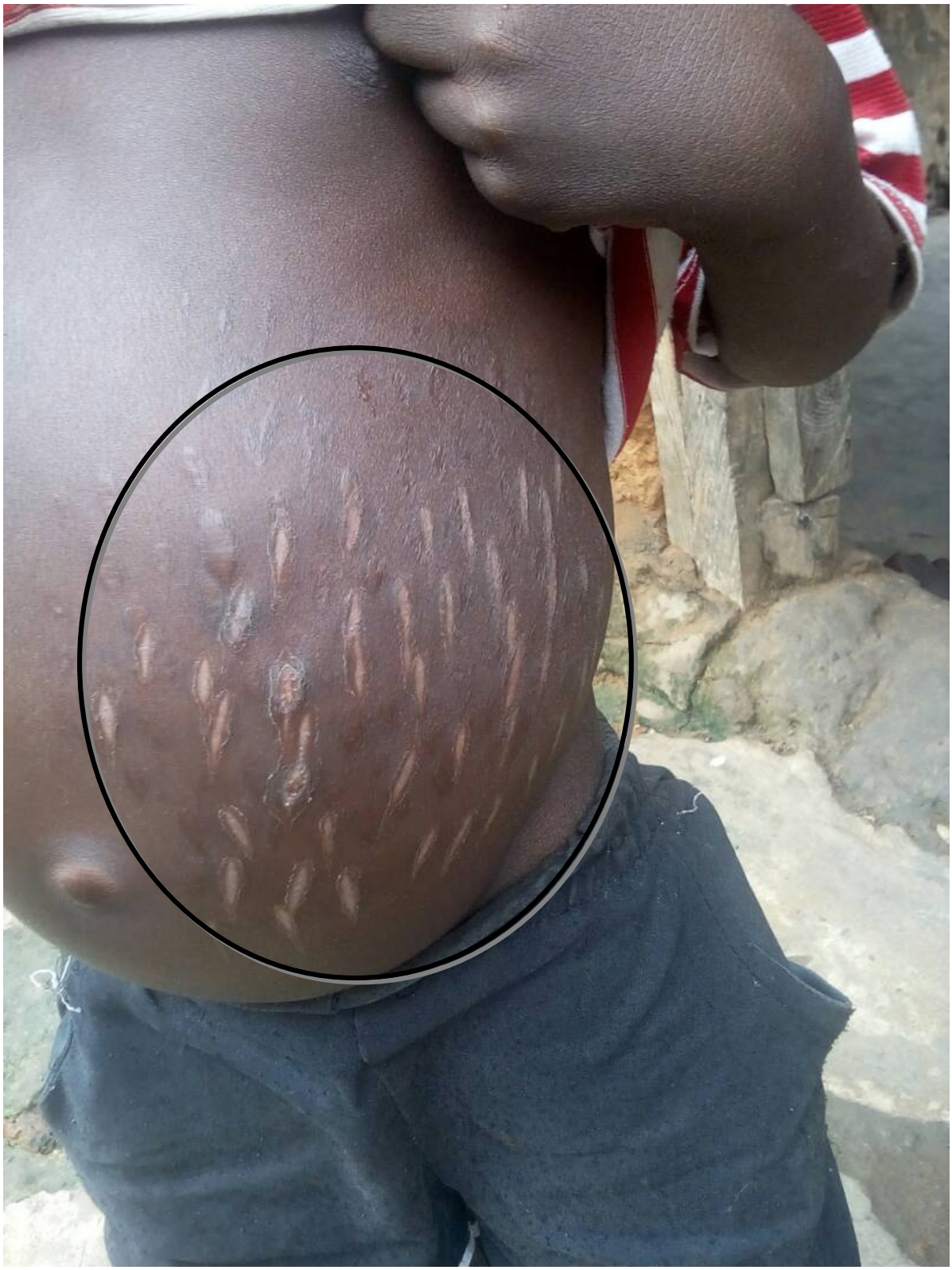

Plate 5.26.A four-year-old boy with scars on the left side of the abdomen for treatment of splenomegaly. (Source: Fieldwork February, 2016).

Another negative implication associated with giving of body marking is that children experience trauma. This is closely linked to the severe pain children experience when they undergo marking. Some parents admit that the memory of the pain experienced by children sometimes lingers for a long time. This leaves lasting effects on the child's disposition to pain even right into adolescence. The following is the recollection of a male FGD participant:

> As a parent, sometimes I feel the pain children usually go through after marks are given to them, especially the marks for splenomegaly. This is because the markings are much and the child experience longer period of pain and agony.. There is no doubt when the marks are finally administered it put the child in an excruciating and traumatic state. Sometimes, the marks administered create large wounds that usually take longer time to heal (Personal discussion with male FGD participant, December, 2015).

Similarly, another male FGD participant comments:

> It resulted in some form of discomfort for my child. Although, the discomfort was for a short time, but immediately after the marks were given on the child, few days later he was better (Personal discussion with male FGD participant, December, 2015).

More is captured in the contribution of a female FGD participant:

> The trauma children experience when marking are given is usually long lasting. And often times it create a kind of fearful feelings any time they see the sight of razor blade close to them (Personal discussion with female FGD participant, December, 2015).

Also, ethnographic findings reveal that the nature and extent of body marking practice on children is considered harmful against children in modern times. This is because of the processes of administering the marks, especially for splenomegaly and pneumonia which involve the giving of many invasive cuts on the body without administering anaesthetic on patient. This falls short of modern best practice in health-care delivery. Moreover, the non-use of modern protective devices like hand gloves in the course of administering the

marking by healers is considered not only crude but in negation of modern method of health-care practices.

As asserted by a male FGD participant;

> For me, I did not grow up in the village and I was not given either the *sepa* marks or any other marks for curing childhood illnesses. And in this modern time I consider the giving of body marking on children, as harmful traditional practice, especially marks for spleen disorder and pneumonia (Personal discussion with FGD participant, December, 2015).

In addition, ethnographic finding reveals that when marks are administered, sometimes the process involves delicate and risky approach whereby the instrument used (the blade) inflicts minor cut on either the healer or the patient. The scenario that plays out is that the process of administering marks results in the child screaming and struggling to avoid being cut with the sharp instrument (razor blade). From ethnographic findings, we observed in a particular incident that a child, in the course of being administered marking for splenomegaly by a healer, sustained a minor accidental cut as a result of screaming and struggling. Another health problem identified from the study is that, when marks were given for splenomegaly, the wounds were exposed. This is because traditional healers lack the professional medical expertise of covering fresh wounds, and this could make children susceptible to infectious diseases. The reason is that children, by their nature would play on the ground, after few days of being administered with marks. Also, ethnographic findings reveal that the inability of traditional healers to adhere to modern medical practice of wearing hand gloves in the course of administering marks on children poses serious health risk of contracting blood-borne diseases like tetanus, Hepatitis B, and the dreaded HIV. By this, the lives of sick children and even traditional healers are at risk.

Besides, some parents argued that the practice of body marking on their children has done more harm than good. As far as a male FGD participant is concerned, “the practice has not been scientifically proven to be efficacious”. Contrary to this, there is a new attitude among some Migilis, and this has increased the level of acceptance of body marking. This

new development is closely linked with the general belief that it protects children from kidnapping. To corroborate this new development, Illah Obadiah, a 65-year-old male key informant, comments:

Mínyɛ lɛ só kɔn ádzáavɛlɛ ba drɔ
Mùgan ná. yínnɛ, ba sála ba íwé,
kɔn bà ma múgán jɛ rùblí kà bɛ ba.

> This translates as:
> Some people want utmost protection for their children, especially the male ones. So, marking are administered and some charms are implanted inside the skin and it works very well for the child when he grows up. Such special marks can protect the child when he comes in contact even with ritualists or kidnappers (Illah Obadiah, Personal Communication, October 2015).

Moreover, the fact remains that some persons still believe that body marking is a lasting cure for certain childhood diseases.

CHAPTER SIX
SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

In this chapter, our aim is to provide a summary of this thesis and offer conclusion by enumerating the prominent issues that have emerged in the course of undertaking the research. We equally make necessary recommendations that would be of immense benefit in overcoming some of the inherent problems associated with body marking as an indigenous health-care practice in Migili society.

6.2 Summary

This research focuses on body marking as an indigenous health care system for managing childhood diseases among the Migili in Nasarawa State. The study spanned over a period of one year, the researcher plunging into ethnography and having opportunity to interact with traditional leaders, traditional healers, aged men and women, parents of children and some children on whom body marking was administered. We were able to observe processes involved in administering body marking on children. The thesis is organised into six chapters.

The first chapter provides the background to the study. It examines several definitions of body marking in human societies, the purposes cultures give for body marking practice, which range from aesthetic, family identification and spiritual protection to the curative. It highlights cultural beliefs as a major factor that influences cultures to prescribe body marking for children. The research statement of problem identifies the prevailing environmental challenges and world view on childhood related diseases in the study area. This provides the underlying reason for parents to continually utilise body marking as an approach for the management of childhood illnesses in spite of the emergence of modern health-care delivery system. The chapter also states the direction of the study through its stated research objectives, which explore the prevailing knowledge people have on body marking, prevailing cultural beliefs of the people and the influence on the construction of childhood diseases. It equally seeks to examine parents understanding of symptoms and causes of childhood diseases and their health-seeking behaviour and, finally, notes the

implications of body marking practice on children in Migili society. The scope of the study covers three Migili communities of Ashige, Assakio and Nene.

Chapter two highlights various extant studies relevant to this study under the following sub-themes: (a) the art of body marking on children in African cultures (b) childhood diseases and their treatments (c) traditional therapeutics and the management of childhood diseases and (d) Migili cultural group in Nasarawa State. Two theories were used as frameworks and employed as models for the study. The first theory, the Culture Bound theory of diseases, Lambo, 1955; 1962) argues that concepts of health and diseases in non-Western societies are greatly shaped by culture. The theory provides the basic explanation that cultural beliefs very much influence the construction of childhood diseases and health-seeking behaviour of parents in Migili society. The second theory is the Symbolic Interactionism theory of (Mead, 1927; Blumer, 1969). It was adopted as a tool to explain the role of symbols in the interactions that produce body marking on children. It helps to explain the significance of language in the communication of the healer in form of incantations/prayer to the ancestors/God and in the discussions with the parents of the children.

Chapter three focuses on the research methodology and explains the procedure used in gathering data. These include in-depth interview, key informant interview, participant observation, and focus group discussions. These were complemented with the administration of the questionnaire. The last method, being the quantitative instrument, was adopted to enable us generate data on the large number of children given body marking in the past and those administered body marking during the period of the research. The aim is to enable the researcher to have a wider coverage of the views on body marking. From the foregoing, 10 in-depth interviews were conducted with randomly-selected traditional healers. Key informants interviewed were 16 (eight elderly men and eight elderly women). In addition, 12 focus group discussions were held to seek the opinions of parents on the study objectives.

Chapter four provides detailed ethnography of the Migili cultural group. The major themes enumerated in the ethnography of the Migili cultural group include: location and geography; historical origin and settlement pattern; religion and belief system; values and taboos. Also highlighted are the economic organisation; political organisation, kinship,

marriage and family system as well as inter-group relations between them and their neighbours, andideas of the indigenous health-care system.

Chapter five is about data presentation, analysis and interpretation. Children below five years were sampled with the survey instrument. The sampled population comprises children who were administered body marking earlier and those administered during the period of the study. From the sampled population, the categories of diseases children had before and during body marking at the time of research were convulsion (44), polio (08), pneumonia (97) and splenomegaly (250). The study identified body marking as an indigenous health-care practice handed down to the present generation of Migili people by their forebears. The knowledge is acceptable and meaningful to them as a result of the usefulness of body marking in managing and overcoming current health challenges. Findings from this study reveal that body marking practice came by way of cultural diffusion from neighbouring groups like the Tiv, and by divine revelation to a few persons in the society. To better understand the knowledge and skills of the healers, the study examines the processes for acquiring body marking, as this has to do with inheritance, apprenticeship and divine revelation.

The thesis identifies categories of persons who have knowledge of body marking practice; these are the menfolk who have exclusive knowledge and skills on body marking practice. The reason advanced for this is that, at its inception as a cultural practice, only men were initiated into the art. This was because tradition favours the menfolk on the grounds that they have deeper spiritual understanding to acquire the knowledge, authority and skills. The level of knowledge required of the healer is that he should have deep understanding of traditional beliefs and practices; he must pass through the rigours of initiation, that would enable him to have vast knowledge of different leaves, plants and other essential herbal components for carrying out healing; he must be knowledgeable in how to prepare herbal remedies for each ailment. He needs to be skilful in administering the marks on the patient; have adequate knowledge of the processes of performing rituals which require him to know how and when to recourse to incantations and prayers. Above all, the healer needs to be conversant with the supernatural forces like the ancestors, gods and spirits, who he regards as formidable spiritual forces on which he can depend in providing perfect healing for patients.

In addition, the thesis provides the patterns of body marking common for each disease in Migili society. The common marks identified from this research are marks for convulsion, polio, pneumonia and splenomegaly (spleen disorder). They are mainly for curative and protective purposes. The number of marks given for these diseases varies, depending on the nature and severity of the cases. Other marks identified in this study are marks for dislocation, aesthetics or beautification as well as for chest pain and backache. A major finding of this thesis is knowledge of the processes the healer follows before marks are administered on the sick child. This requires the healer to make a journey to the forest, and collect the required herbal resources. In the course of collecting the leaves, plants and roots, the healer must commune with the supernatural forces via necessary incantations/prayers. This is then followed with the preparation of the herbal medicine at home.

The thesis further discovers that there is a declining patronage of body marking in Migili society, caused by new belief and attitude of the people. It was discovered that, while the older practitioners are dying, the younger generations are developing interest in the body marking practice. This trend is linked to the financial reward that comes with the practice. Basically, then, some level of acceptance of body marking practice still exists among some parents. This explains why some parents make use of body marking in the treatment of certain diseases believed to be influenced by personalistic or supernatural forces. On the whole, however, patronage of body marking in the management of childhood diseases has declined due to the advent of Christianity, Western education and availability of modern health-care system.

More significantly, the thesis argues that cultural beliefs influence construction of childhood diseases within the Migili society. In this light, it presents some of the cultural beliefs such as the manipulation of physical environment by neighbours or relations who place evil objects in and around targeted households; evil actions of malevolent/personalistic agents such as witches and sorcerers through dreams; the immoral actions/behaviour of parents who engage in acts of stealing or financial indebtedness as well as marital infidelity especially on the part of women. The thesis stresses that constant quarrel between spouses, widely held belief about mysterious black evil bird that causes a child to experience convulsion, alongside psychic evil intentions or actions of certain persons in form of

jealousy, envy and anger can result in childhood diseases. Similarly, the violation of taboos in situation where a woman looks through the window to see a masquerade, and the cultivation or use of sacred land meant for the gods for the purpose of farming, can result in the manifestation of strange disease in a child.

The thesis provides explanations on categories of childhood diseases and processes for treatment in Migili society. For example, in the case of convulsion in children, three vertical marks are given one each on the forehead and both cheeks and followed with the healer symbolically waving his palm seven times round the head of the patient as a way of driving out the disease. For splenomegaly, ten to twelve vertical marks are given on the left side of the abdomen, starting from bottom to up and from left to right; across seven horinzontal lines. This is followed with the healer symbolically waving his palm seven times as a way of sending out the ailment from the patient. While for pneumonia, four to six vertical marks are administered on the chest region; starting from bottom to up and from left to right across three horinzontal lines. Also, this is followed with similar ritual performance. On the other hand, polio requires the giving of three vertical marks on each knee of the sick child. This is followed with ritual performance of the healer waving off each knee seven times, as a way of driving out the disease. The symbolism of each pattern of marks reflects the world view of the people as regard sicknesses being caused either by malevolent agents/ancestors/gods.

The nature of the disease and health status of the child influences direction of health-seeking behaviour of parents. The health-seeking behaviour of parents incorporates some stages, namely: self-medication, consultation of the chemist/clinic, engagement with traditional herbalist and, lastly, the meeting with diviner. At the initial stage, if the illness is mild, parents try as much as possible to manage it through self-medication. But when symptoms and disease persist, parents seek assistance from more experienced family members. They could go further to seek help in the primary health clinic or traditional herbalist who carefully examines the child to determine the exact cause of the ailment. The last help comes from the diviner who is usually considered the last referral point. The diviner comes in when the ailment has deteriorated and the child is in a very critical condition. The role of the diviner is to detect the real cause of the child disease, especially where there is suspicion of evil manipulation by unseen personalistic or supernatural forces.

The thesis identified both positive and negative implications of body marking on children in Migili society. A significant reason for giving body marking is that, symbolically, it serves as a means of severing the link between the patient and the evil forces that afflicts the child with the illness. This explains the reason the healer symbolically move his palm seven times as a way of driving out the evil forces tormenting the sick child. On the other hand, the study reveals that medical body marking administered on some children have resulted in bodily injury and trauma. For some children, the memory that comes with the processes of administering the marks leaves an enduring attitudinal disposition to pain in the mind. .

6.3 Conclusion

The following conclusion are drawn from this study: parents in Migili society have continued to utilise medical body marking for managing childhood diseases, in spite of the advent of modern medical practice. This is an attestation to the ingenuity and creativity in the Migili-Koro perception and treatment of certain childhood diseases. The study provides insight into the psyche of parents who share the belief that not all diseases are caused naturally. To some parents, sickness, especially convulsion and polio, are spiritually influenced and, therefore, are afflictions engendered by manipulation of malevolent forces in the society. The generally held belief among parents is that, behavioural acts and supernatural forces influence incidence of certain childhood diseases. Although, illnesses can be as a result of biological/environmental factors, like mother breast feeding her child in the scorching sun, and consumption of contaminated water and unhygienic food by children. Similarly, some parents are of the view that cultural beliefs and practices associated with breaking of taboos, marital infidelity, evil actions of neighbours and the appearance of a mysterious black evil bird most often could cause childhood ailments like convulsion, pnuemonia or polio.

The foregoing provides ample reasons for parents' reliance on traditional healthcare approach, in the form of body marking, to manage childhood diseases like convulsion, polio, splenomegaly and pneumonia. The study concludes that cultural knowledge and meanings from medical body marking have been helpful to the Migili-Koro people in developing more syncretist approaches to manage childhood illnesses that have defied modern medical

treatment. Notwithstanding the popularity in the utilisation of body marking among parents in managing spiritually influenced childhood diseases, the practice has declined considerably. This has been attributed to the fact that some parents perceive it as impious or heathenish. In addition, the excruciating pain and trauma children experience when marks are administered, serve as discouragement for some parents. And some parents contended that medical body marking on children has no scientific backing and, therefore, is injurious to their physical development.

6.4 Recommendations

Body marking in the study communities still retains some level of relevance and acceptability, in spite of the advent of modern scientific medical practice. This is closely linked to the widely held belief among parents that certain childhood diseases are spiritually induced and, therefore, require spiritual approach in their treatment and management. In the light of the foregoing, the following recommendations are hereby canvassed:

i. This study proposes that body marking as an indigenous health-care practice in Migili society should be sustained and developed as an alternative health-care system for the treatment of childhood diseases that are considered to have defied modern medical practice.

ii. As a way to improve medical body marking as an indigenous health care system, so as to make it more effective and acceptable, traditional healers should be trained and integrated into the mainstream Western health care delivery system in Nasarawa State.

iii. This study tends to call for Botanists and Pharmacognocists to undertake in-depth research into the botanical constituents and medical components of varieties of leaves, grasses, and trees/plants used by traditional healers in the management and treatment of childhood diseases in Migili society. This will help to make the traditional healing practice more scientific and verifiable.

iv. To overcome the problem of the spread of blood-borne diseases, traditional healers should adopt modern medical method by wearing hand gloves, and sterilise their instruments in the course of undertaking the art of body marking.

This will protect them and their patients against the spread of blood-borne diseases such as tetanus, Hepatitis B, and the dreaded HIV virus.

v. As a measure of improving child health care in the study communities, mothers should inculcate better sanitation practices and education for their children.

vi. Relevant stakeholders like traditional rulers, community leaders and parents should be enlightened on proper health care of children, so as to prevent occurrence of preventable childhood diseases like splenomegaly, pneumonia and malaria.

vii. Access to health care should be made convenient and affordable both for children and mothers. By this, there is need for provision of quality health care at the primary level.

viii. As a matter of urgency, the Nasarawa State Government should build a primary health-care clinic in Nene town and furnish it with qualified health personnel and adequate facilities. This will greatly improve the health status of infants and children in the community.

ix. Health is linked to values, morality and ethical conducts that could serve to promote an ordered, peaceful society (pages 111-112). Thus, there is need to emphasise these in health-care delivery.

x. Our ethnographic findings might have revealed some misconceptions of types of sicknesses from the Western point of view and such misconceptions should be noted in the public space to be addressed by the appropriate authorities.

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APPENDIX I

Scientific studies on*Alnus glutinosa*, black alder which known as *Gumaya*/*Gbomo in Ligili language*. It is a species of tree in the family *Betulaceae*, native to most of Europe, southwest Asia and northern Africa.The bark of common alder has traditionally been used as an astringent, a cathartic, a hemostatic, a febrifuge, a tonic and as restorative (a substance able to restore normal health).A decoction of the bark has been used to treat swelling, inflammation and rheumatism, as an emetic, and to treat pharyngitis and sore throat (Sati *et al.,* 2011).It is helpful for pain relief, nerves soothing and recuperating strength especially for patients who have experienced paralysis. It is a common plant used by healers to treat polio in children. The leaves have also been used to reduce breast discomfort in nursing mothers and folk remedies advocate the use of the leaves against various forms of cancer.

Equally, studies on *Quercus nigra* also known as Kukpen or *Nkpon Nkpon*plant in Ligili language have been effective in addressing deficiency of blood in the body of patients. This is used for children who are afflicted with splenomegaly disease and experience deficiency in blood. Galls produced on the tree are strong astringent useful for the treatment of haemorrhages, chronic diarrhoea and dysentery as well (Pamplona-Roger 2002).The herb is administered on children so as to assist them to regain sufficiency in blood. It serves a blood purifier for the patient. A decoction of the stems has been used in the treatment of coughs. An infusion of the leaves and stems has been used as gargle in the treatment of sore throats. A decoction of the roots has been used to treat sicknesses associated with teething. The bark has been chewed and the juice swallowed in the treatment of whooping cough and "cold on the lungs". Healers in Migili society use this to treat pneumonia.

Ocimumgratissimum, African basil *rinano*, which the Yoruba in south-west Nigeria call *efirin* is a species of *Ocimum*. It is native to Africa, Madagascar, and south Asia. *Ocimum gratissimum* is a common culinary herb in West Africa and is used by some in the Caribbean. The extract of the leaves is documented to possess anti-diabetic properties and anti-hyperlipidemic effects (Natural Health on the Web, 2012). Basil leaf has long been believed to have a mood-enhancing effect on the body. It is regarded as a nerve tonic as it helps relieve the body from fatigue and enhance the mental capacity and memory. Basil can also be used to treat headache, cold, cough and running nose. Some studies have reported

that Basil has a natural component called *adaptogen* which serves as strong effect to reduce oxidative stress. The leaf is used in many African societies for the treatment of diabetes. It is pound on a mortar mixed with little quantity of water and administered on the nose and eyes of the child that experiences convulsion, especially for first time patient.

Scientific medicinal studies of *Quercus platustris*,also called Swamp Oak in English language and *Ifle*in Ligili languagehas been put to great use as herbal medicine for many centuries. As in the case of many herbal remedies, there is growing scientific interest in the abilities of swamp oak to treat a variety of illnesses (Joshi, 2000). Galls produced on the tree are strongly astringent and can be used in the treatment of chronic diarrhoea and dysentery. An infusion of the crushed inner bark has been used as a purgative, and to treat intestinal pains. Among the Migilis, this plant is used by traditional healers to treat splenomegaly (spleen disorder).

Scientifically, *Platanus hispanica*,known as Plane Tree in English language and *Chumba in Ligili language*, as decoction, is used to treat dysentery and can be used to heal wounds.The bark can be boiled in vinegar and then used in the treatment of diarrhoea, hernia and toothache.It is believedamong traditional healers in Migili society to be ahealing property that helps relieve hardness of the lower abdomen of patient with splenomegaly (spleen disorder).Evidence from scientific research on *Celtis laevigata*, **S**ugarberry,*Kudro*. Native Americans use it as medicine for food. It is also a good remedy to fight ageing and cancer (Moerman, 1998). It is equally widely-used in folk medicine due to its cytotoxic and antioxidant properties. A decoction of the bark has been used in the treatment of sore throat. It has equally been used with powdered shells, as a treatment for venereal diseases. Traditional healers in Migili use it as a remedy for vomiting in children infected withsplenomegaly (spleen disorder).

The Peruvian pepper, *Schinus molle*, is also known as American pepper or simply pepper tree, and known as *Dandana in Ligili language*. Historically, it is a native of Peruvian Andes.In traditional medicine, *Schinus molle* is used in treating variety of wounds and infections due to its antibacterial and antiseptic properties (Ferreroa, Alejandra, Cristina & Zanettia, 2007). It has also been used as an antidepressant and diuretic, and for toothache, rheumatism and menstrual disorder. Fresh green leaves in bunches are used shamanically in Mesoamerican traditional ceremonies for cleansings and blessings. Traditional healers in

Migili society use it to heal wounds on the body after marking is given to patients and it sometimes serves as a remedy for feverish condition.

Scientific studies of *flaxinus pennsylvanica*, the blue ash *Ipri,* show that it has a very long historical tradition of being used as medicine. There are *very* long historical traditions of using the ash as a medicinal herb. Its use as a medicinal herb was already knownby the Greek physician Hippocrates (460-377 B.C). Similarly, the medicinal use of Ash bark dates back to nearly 2,000 years ago, in view of the fact that its medicinal record was first found in China's earliest medical work-*The Divine Farmer's Material Medica.* The ash contains manysubstances known for their medicinal benefits. From the point of view of Western medicine, modern pharmacological studies have shown that it can inhibit pathogenic microorganisms, cancer, fight oxidation and protect nerves and blood vessels. The leaves, bark and young twigs contain *coumarins* (*fraxin*, *esculin*, and related substances) that inhibit the growth of bacteria and fungi. These properties could make the ash beneficial inthe treatment of wounds and sores, and to reduce swelling. The ash bark is used as a fever-reducing agent and substitute for quinine, which is derived from the quinine tree (*Cinchona pubescens*). The bark and leaves have been used traditionally as herbal remedy for diarrhoea. Traditional healers in Migili society use the *Ipri* to treat variety of ailments and sicknesses that afflict children, such as diarrhoea, feverish condition, healing of wounds and blood purifying. In Ligili language it is called Mugon. While the English called it Moose bark maple and the botanical name is *Acer Pensylvanicum*. It serves as a means for the treatment of stomach pain and cough in children.

In traditional medicine, honey *ruto*is one of the effective healing properties in managing various ailments. It contains both antiseptic and antibodies. Its medicinal properties have been widely acknowledged in different parts of the world both in ancient and modern times, in Europe, Asia, Australia and Africa. Modern science has acknowledged honey as a useful application in managing chronic wound. Clinical studies have also revealed that it is very effective in oral rehydration solution in children and infants with gastroenteritis. Honey has been found to shorten the duration of bacterial diarrhoea in infants and young children. Scientific research has revealed that honey reduces nightmare coughing and improves sleep quality in children with upper respiratory infection better than

cough medicine *dextromethorphan*. In contemporary world, it is used as food supplement in many households.

Also, the Shea butter*kukonyu*is an effective healing ingredient to restore weak nerves forpatients who experience paralysis or polio. It contains collagen and phenotic compounds of stearic, oleic, palmitic, linoleic and arachidic. The ointment is dissolved in a jar and the limbs and joints of the patients who experience ailments such as paralysis, backache, and waist pain are massaged with the preparation for effective relief.

Studies on *Aframomun danielli* (alligator pepper) also known as*wolo nva*in Ligijili language.The plant is abundantly found in Africa and is a West African spice.This pepper is a relative of grains of paradise obtained from the species *Aframomun Melegueta*.The herbaceous flowering plant grows perennially throughout the year and is found in swampy parts of West African coast. The seeds are normally seen or revealed only after the pod is opened. When new babies are born in Yoruba culture, they are given a small quantity as a taste of pepper.

Among many cultural groups in Nigeria, this spice is used during naming ceremonies and other religious and cultural events. Therefore, it is a ceremonial routine for welcoming baby into the world. It is used as a form of ritual performance in the treatment of convulsion in children and applied for the treatment of paralysis. In emergencies relating to child convulsion, alligator pepper is chewed and then sprinkled on the eyes of the child, as a means of revival. For polio treatment, it is chewed and then sprinkled on the waist and limbs of the patient. Generally, it is used for the treatment of malaria, wounds and prevents infection, protection against accidents when swallowed before embarking on travelling, to improve the state of drunkenness, and to improve digestion.

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APPENDIX II

IBADAN WORDLIST OF 400 BASIC ITEMS IN *MÌGILI-KÓRÒ*

(1.)	Head	kúcɔ́
(2.)	Hair (head)	ńswàná kùcɔ́
(3.)	Eye	kísí
(4.)	Ear	kúton
(5.)	Nose	kúwɔn
(6.)	Mouth	ŋ̀yin
(7.)	Tooth	kínyí
(8.)	Tongue	múnɛ
(9.)	Jaw	kúpan
(10.)	Chin	ńgbújá
(11.)	Beard	ímrù
(12.)	Neck	kúgbɛ
(13.)	Breast (female)	ḿbɛ́n
(14.)	Heart	kíyɛ́
(15.)	Belly (External)	lúkpɛ
(16.)	Stomach (internal)	lúkpɛ
(17.)	Navel	kútulúkpo
(18.)	Back	ímɛ
(19.)	Arm	kúva
(20.)	Hand	kúva
(21.)	Nail (finger or toe)	kúcâsolo
(22.)	Buttocks	áplámá îdzri
(23.)	Penis	rúplɛ́
(24.)	Vagina	ítùmà

(25.) Thigh kíjɛ

(26.) Leg kítrɛ

(27.) Knee kúlu

(28.) Body rúblí

(29.) Skin kítàárúblí

(30.) Bone kúkún

(31.) Blood ńzen

(32.) Saliva ńcɛn

(33.) Urine mblée

(34.) Feaces ádzi

(35.) Food ríje

(36.) Water ńkwalɛ

(37.) Soup/sauce/stew kízin

(38.) Meat múna

(39.) Fat ńdzɛn

(40.) Fish kúswé

(41.) Oil ńnɔ

(42.) Salt ŋ́sán

(43.) Wine/beer (gene) múdún

(44.) Palm múzɔn

(45.) Yam ńtrin

(46.) Cassava lógo

(47.) Guinea corn áglo

(48.) Millet ámú

(49.) Maize sìsɛlɛ

(50.) Beans ńzon

(51.) Pepper ńván

(52.) Okro ńkplɛ́ɛn

(53.) Plantainńtrúkpó

(54.) Bananańtrúkpó

(55.) Orangelómú

(56.) Groundnutàvli

(57.) Kola nutgóró

(58.) Tobaccońzɔn

(59.) Cottonrìlì kpìlì

(60.) Oil palmmúzɔn

(61.) Seed ísɔ

(62.) Grass` ásɔ̀

(63.) Tree kíci

(64.) Leaf awa

(65.) Bark (of tree) kúfrɔkìci

(66.) Root kúgúmú

(67.) Thorn ígan

(68.) Stick kíci kúkɔlɔ

(69.) Firewood ríci

(70.) Charcoal àkàńdré

(71.) Fire átrá

(72.) Smoke ńzɔn

(73.) Ashes ńson

(74.) Water pot ìnù àńkwálɛ

(75.) Cooking pot íńù áagáítán

(76.) Calabash ìńù

(77.) Grinding stone kícɛ

(78.) Mortar kùzwa

(79.) Knife mbán

(80.) Hoe kwárá

(81.) Axe ìfɔ

(82.) Matchet àdà

(83.) Spear (war) ɔkpà

(84.) Bow (weapon) àtrà

(85.) Arrow mùsɔn áatrá

(86.) Iron (metal) ígbán

(87.) Mat kígán

(88.) Basket gúgú

(89.) Bag gúfɛ̀

(90.) Rope kílí

(91.) Needle yémùla

(92.) Thread rílí

(93.) Cloth (material)ítrɔ

(94.) Robe/Gown/Smock (man's) ítrɔ

(95.) Hat/cap fɔ̀ro

(96.) Shoe átáàtrɛ̀

(97.) Money áklodzi

(98.) Doo (way) míjɛn

(99.) Wall (of house) kúpì

(100.) Room kùyo

(101.) House ítsi

(102.) Compound ŋ̀kpinîtsi

(103.) Town kúpɔkùkpò

(104.) Village kúpɔ

(105.) Well líìzhàn

(106.) Rubbish heap kúdúnù

(107.) Road míjɛn

(108.) Market mízɛn

(109.) Farm kíná

(110.) Bush ásò

(111.) River íseni

(112.) Sea íseni

(113.) Boat (canoe) jereji á ʼnkwálɛ

(114.) Stone kúpɛ́lɛ

(115.) Mountain rúgɔn

(116.) Ground rúbɔn

(117.) Earth (soil) ḿbɔn

(118.) Sand ḿbɔn

(119.) Dust kínrî

(120.) Mud ńtɔnɔkɔ

(121.) Wind kúmruu

(122.) Rain nɛ́rɛ́

(123.) Sunshine ísɛ́ńwalá

(124.) Sun ńwalá

(125.) Moon ȯtsan

(126.) Star kúzùgbé

(127.) Day ísá

(128.) Night ájí

(129.) Dawn ḿpɛ́rɛ́ìsà

(130.) Darkness míjín

(131.) Sleep shɔńla

(132.) Work nakùtùmá

(133.)	War	lúkɔ
(134.)	Fear	áwa
(135.)	Hunger	ínùma
(136.)	Thirst	kúwɔ
(137.)	Year	músɔn
(138.)	Rainy season	rúwɔn
(139.)	Dry season	lúwɔn
(140.)	Sun	ńwalá
(141.)	Story	kíshísha
(142.)	Word	òka
(143.)	Lie(s)	àmlà
(144.)	Thing	ágán
(145.)	Animal	ágáakɛ́
(146.)	Goat	ɔvɔn
(147.)	He-goat	dùmùvɔn
(148.)	Sheep	cɛ́mɛ́
(149.)	Cow (zebu)	òna
(150.)	Horse	ɔdɔn
(151.)	Donkey	zàncin
(152.)	Dog	òva
(153.)	Cat	músù
(154.)	Rat	òkpín
(155.)	Chicken (domestic fowl)	kúkpa
(156.)	Cock	kɔríìkɔ
(157.)	Duck	gwàgwá
(158.)	Egg	kúkpa
(159.)	Wing	áplan

(160.) Feather kíjì

(161.) Horn kùtúmá

(162.) Tail ízùmà

(163.) Leopard

(164.) Crocodile kámà

(165.) Elephant gbólu

(166.) Buffalo (bush cow)òkɛ

(167.) Monkey bɛ̀nɛ

(168.) Tortoise òklú

(169.) Snake múna

(170.) Lizard (common variety) wànà

(171.) Crab krìká

(172.) Toad (frog) ɔmlɔn

(173.) Snail koli

(174.) Housefly kídríi

(175.) Bee ísho

(176.) Mosquito íyè

(177.) Louse shámá

(178.) Bird dzárùnɔn

(179.) Vulture glumù

(180.) Kite kúwaiyé

(181.) Hawk ńyén

(182.) Guinea fowl òzon

(183.) Bat rúùzùn

(184.) Person nyɛ

(185.) Name áza

(186.) Man jìjili

(187.) Male nyɛvɛ̀lɛ̀

(188.) Husband shá

(189.) Woman nyɛrán

(190.) Female nyɛrán

(191.) Wife nyrán

(192.) Old person nyɛkúkɔn

(193.) Senior/older nyɛkpò

(194.) Father ǹda

(195.) Mother ǹma

(196.) Child dzá

(197.) Children adzá

(198.) Son dzáàvɛ̀lɛ̀

(199.) Daughter dzányiyrán

(200.) Brother (elder) (for man) lúkpò nyɛvɛ̀lɛ̀

(201.) Brother (younger) (for man) nyɛcɔ nyɛvɛ̀lɛ̀

(202.) Sister (elder) (for woman) nyɛkpò nyɛrán

(203.) Sister (younger) (for woman) nyɛcɔ nyɛrán

(204.) Mother's brother cìcán

(205.) In-law òlɔ

(206.) Guest (stranger) nyɛzɔn

(207.) Friend òyà

(208.) King zhɛ́

(209.) Hunter ògbɛ̀n

(210.) Thief òyi

(211.) Doctor (native) zɔrɔmùgàn

(212.) Witch nyíijɛ̀

(213.) Chief zhɛ́

(214.) Medicine (charm) múgán

(215.) Fetish (juju) múgán

(216.) Corpse múkɔn

(217.) God òsì

(218.) One lo

(219.) Two àbɛ̀ɛ

(220.) Three àcɛ́ɛ́

(221.) Four ànààrɔ

(222.) Five àsóon

(223.) Six mízín

(224.) Seven mútá

(225.) Eight rúnɔn

(226.) Nine zacɛ́

(227.) Ten zabɛ̀

(228.) Eleven zabɛ̀ plɔ lo

(229.) Twelve zabɛ̀plɔ bɛ̀

(230.) Thirteen zabɛ̀ plò cɛ́ɛ́

(231.) Fourteen zabɛ̀ plò nààrɔ

(232.) Fifteen zabɛ̀ plò sóon

(233.) Sixteen zabɛ̀ plò mízín

(234.) Seventeen zabɛ̀ plò mútá

(235.) Eighteen zabɛ̀ plò rúnɔn

(236.) Nineteen zabɛ̀ plò zacɛ́

(237.) Twenty zabɛ̀ bɛ̀ɛ

(238.) Twenty-one zabɛ̀ bɛ̀ɛ plɔ lo

(239.) Twenty-two zabɛ̀ bɛ̀ɛ plɔ lo

(240.) Thirty zabɛ̀ bɛ̀ɛ

(241.) Forty zabɛ̀ sààrɔ

(242.) Fifty zabɛ̀ sóon

(243.) Sixty zabɛ̀ mízín

(244.) Seventy zabɛ̀ mútá

(245.) Eighty zabɛ̀ rúnón

(246.) Ninety zabɛ̀ zacɛ́

(247.) Hundred rúno

(248.) Two hundred rúno bɛ̀ɛ

(249.) Four hundred rúno nààrɔ

(250.) Black mìtì

(251.) White vúvlú

(252.) Red súsɔnɔn

(253.) Big (great, large) kúkpò

(254.) Small kwɛ́ɛ̀

(255.) Long (of stick) drɔlɔ

(256.) Short (of stick) kpíì

(257.) Old (opp. New) gugrɔn

(258.) New sísá

(259.) Wet flɔɔ

(260.) Dry kúkɔlɔ

(261.) Hot (as fire) yɔɔ

(262.) Cold dìín

(263.) Right (side) ǹvalɛ̀

(264.) Left ḿpɛ̀nɛ̀

(265.) Good zwá

(266.) Bad dzíì

(267.) Sweet (tasty) sán

(268.) Heavy mlu

(269.) Full cíka

(270.) Strong kpɔɔn

(271.) Hard kɔlɔ

(272.) Eat tan

(273.) Drink swé

(274.) Swallow mlɔn

(275.) Bite nyánkínyín

(276.) Lick nère

(277.) Taste músán

(278.) Spit zwìncɛn

(279.) Vomit kporo

(280.) Urinate serembléè

(281.) Defecate kùmáadʒi

(282.) Give birth tsa

(283.) Die kpoò

(284.) Stand (up) zízín

(285.) Sit (down) dídrɛ

(286.) Kneel kúkun

(287.) Lie (down) shúshɔn

(288.) Sleep shúsɔn

(289.) Dream kílɛ́lɛ̀

(290.) Go náà

(291.) Come bɛ́

(292.) Return (intr) íkpɛ́lɛ

(293.) Arrive zà

(294.) Enter li

(295.) Climb swa

(296.) Descend ci

(297.) Fall gbúgla

(298.) Walk nyɛrína

(299.) Run dańsɔn

(300.) Jump yé

(301.) Fly yé

(302.) Pass (by) kɔɔ

(303.) Turn round (intr) kplɔ

(304.) Follow cwe

(305.) See ní

(306.) Hear wusɔ

(307.) Touch (with hand) da kúva

(308.) Know pɛ

(309.) Remember cuwɔ

(310.) Forget vukɔ

(311.) Think gbáglá

(312.) Learn mɛ̀rɛ

(313.) Laugh túrtɔ

(314.) Weep (cry) zhánwɔn

(315.) Sing sɛ́ kútrɔ

(316.) Dance da kútrɔ

(317.) Play (games) gbo írà

(318.) Fear saawá

(319.) Great (salute) íwánkùkpòò

(320.) Abuse tɔrɔ

(321.) Fight da kúlɔ

(322.) Call (summon) rɔ

(323.) Send (someone to do something) jɛ́ kùtúmá

(324.) Say (direct speech) drɔ

(325.) Ask (question) sho

(326.) Reply dɔ ámsan

(327.) Ask (request) sho

(328.) Refuse tɔò

(329.) Link háda

(330.) Want (desire) kwàna

(331.) Look for pisɛ

(332.) Loose (something) tasɔ

(333.) Get (obtain) cɛnɛ

(334.) Gather (thing) krɔkun

(335.) Steal yi

(336.) Take (one thing) ma

(337.) Carry (load) ma

(338.) Show (something) masi

(339.) Give dɔ

(340.) Sell lí

(341.) Choose bɛ́

(342.) Buy gbɛ

(343.) Pay (for something) dɔ áklodzi

(344.) Count tsene

(345.) Divide (share out) gìsɛ

(346.) Finish (intr) klɔɔ

(347.) Catch gɔ

(348.) Shoot tsì

(349.) Kill wɔ

(350.) Skin (flay) kítà

(351.) Cook trɔ

(352.) Fry kanɔn

(353.) Roast sɔnɔn

(354.) Pound (in mortar) zwe

(355.) Grind gbo

(356.) Pour zàrɔ

(357.) Throw gbo

(358.) Sweep krɔńkpin

(359.) Burn jí

(360.) Extinguish (tr) níátra

(361.) Plait (hair) sùle

(362.) Weave (cloth) nɔ ítrɔ

(363.) Spin (thread) nɔ rílí

(364.) Sew tún

(365.) Put on (clothes) jɛ́ ítrɔ

(366.) Take off (clothes) bɛ́ ítrɔ

(367.) Wash (things) gru ágán

(368.) Wash (body) drɔ

(369.) Wrinse (clothes) ywara

(370.) Pull bɛ́nɛ

(371.) Push túra

(372.) Beat (person) pa

(373.) Beat (drum) pa

(374.) Break (pot, calabash) sɛ́ ínù

(375.) Break (a stick) wrɔ

(376.) Tear (tr.) parɔ

(377.) Split sísɛ

(378.) Pierce tún

(379.) Hole kúzɔn

(380.) Dig sɛlɛ

(381.) Sow (seeds in holes) jɛ̀rɛ

(382.) Plant (tubers) jɛ̀rɛ

(383.) Bury nì

(384.) Build (house) zwe

(385.) Mould (pot) zwe

(386.) Carve (wood) símí

(387.) Make zɔrɔ

(388.) Hold (in hand) yuwɔ

(389.) Tie (rope) ló

(390.) Untie foro

(391.) Cover (a pot) ko

(392.) Open (door) gwàra

(393.) Close guso

(394.) (Be)rotten von

(395.) Stink mru

(396.) Swell (intr.)of boil funu

(397.) Blow (with mouth) tse

(398.) Blow (of wind) da kúmrúu

(399.) Surpass kà

(400.) Dwell drɛ

Other words not found in the Word List include,

(1.)	Herbalist	cɛ́ɛ̀nwa
(2.)	Diviner	gbóìshán
(3.)	Ancestor	múcɔ/múcɔ
(4.)	Convulsion	sunsu/(sometimes-kpíìkpíì)
(5.)	Groove	ágúmu
(6.)	Taboo	ágíìsɔn
(7.)	Polio	rúgɔ-átrɛ̀
(8.)	Pneumonia	rúgɔ-áwo
(9.)	Splenomegaly (spleen)	sépa

APPENDIX III

UNIVERSITY OF IBADAN

DEPARTMENT OF ARCHAEOLOGY ANDANTHROPOLOGY

IN-DEPTH INTERVIEW (IDI) GUIDE

The following questions are hereby formulated with the goal of allowing the informant to give detailed discussion of issues. The researcher may probe further into some other relevant themes that could help generate more relevant information.

1.) What can you tell us about body marking on Migili children?

2.) Do you have an idea when body marking practice began in Migili society?

3.) Can you tell us the story behind how body marking began in Migili society? Probe: Can you please elaborate?

4.) Is the origin connected with life experience of a person?

5.) What do you know about body marking?

6.) How did you know that the practice exists?

7.) What knowledge do you have about body marking on Migili children? Probe: Can you elaborate further?

8.) What is the process for acquiring knowledge about body marking?

9.) How is the knowledge transmitted in Migili society?

10.) What types of body marking exist in Migili society?

11.) What is the attitude of people in Migili society toward body marking?

12.) What is happening in Migili society on people's knowledge of body marking, especially on children? Probe: Are young people still interested in preserving the knowledge of body marking?

13.) Is the knowledge oexclusive to traditional healers?

14.) Who are the persons or group of persons that pass on body marking knowledge?

Probe: How is the knowledge passed?

15.) Is the knowledge linked with a particular lineage or class of people?

16.) Is the knowledge derived from religious experience?

17.) Is the knowledge associated with a religious cult?

18.) Is the practice of body markinglinked to traditional religion? Probe: How do you explain this?

19.) What category of spirit is associated with body marking in Migili society?

Probes: What is the nature of the spirit?Does the spirit control the healer?Is it a forest, water or land spirit? At what time of the day does the spirit enter the body?Where can it happen?

20.) Is the practice of body marking adduced to culture?Probe: why is it so in Migili society?

21.) Does it have anything to do with beliefs of the Migili society? How?

22.) Is body marking in Migili society associated with childhood illness?

23.) What types of childhood illnesses are treated with body marking?

24.) Are there specific marks for each illness? Probe: Can you give me some examples?

25.) What is the significance of these marks to the sick child? Probe: Can you please elaborate?

26.) Please, can you explain the processes and items used in healing a sick child?

27.) What role do herbal remedies like water, ashes/powder and ointment play? Probes: Can these actually have power to heal a sick child?Does it involve elaborate rituals?

28.) What is the symbolic meaning of making chants and incantation when curing a sick child? Probes: why is making chants important? Where do you derive your knowledge of incantation?

29.) In your own view, do supernatural beings exist? Probes: Do you think supernatural beings have a role to play in healing process? What actually is the role ofsupernatural beings when ritual performance is done?

30.) What is your view of evil forces in Migili society?Probes: Do they really exist? Do people have the same views with you?Can childhood illness be attributed to such evil forces?

31.) How do you know that evil forces can cause diseases in children?Probe: Do you have any past experience you can narrate to us?

32.) Have you ever been involved in the healing process of a child's illness? Probe: what was the cause of the illness and how was it effectively cured

KEY INFORMANT INTERVIEW (KII) GUIDE

The Key informant interview will take the form of semi-structured questions which have been formulated so as to enable the informant give detailed discussion of specific issues under study. The researcher will allow informant to give further explanations into some other relevant themes that could help generate more information.

1.) From your personal experience, can you please tell me about the practice of body markings in Migili society? Probe: Can you please elaborate?

2.) In your opinion, will you consider yourself as being knowledgeable about body markings? Probes: How?

3.) Will you say the knowledge of the practice is available to all community members of Migili? Probe: why do you think so?

4.) How did body marking begin in the Migili society?

5.) Is the tradition of body marking still popular among the younger generation? Probes: why is it so in Migili society?

6.) What should be done to uphold this tradition?

7.) Is it still an acceptable cultural belief in Migili society?

8.) What do you know about childhood diseases and their causes?

9.) Are these diseases/illnesses associated with cultural beliefs?

10.) Can you mention these diseases/illnesses and how they are identified and cured?

11.) What is your view of superstitious beliefs and childhood illnesses?

12.) Have you ever disregarded such superstitious beliefs?

13.) Is it true that superstitious beliefs influence incidence of childhood diseases/illnesses in Migili society?

Have superstitious beliefs helped in identifying childhood diseases/illnesses? Probe: why so?

14.) What do you consider to be the cause of a child illness in Migili society?

15.) How and who identify child (ren's) illness in Migili society?

16.) How are they identified? Are there specific symptoms for different diseases/illnesses?

17.) Do body marking have positive or negative effects on children as they grow up?
Probe: Do you think so?

FOCUS GROUP DISCUSSION GUIDE

The following themes shall be raised in question form while the members of the group are encouraged to discuss the issues. There will be probe reactions by the facilitator at various intervals. The researcher shall facilitate each group while an assistant will be responsible for note taking. The discussions shall also be recorded on tape.

The discussion will be guided by the following topics:

A: PARENTS' KNOWLEDGE ON BODY MARKING

1.) What do you know about body marking on Migili children? Probe: Can you elaborate?
2.) What is your knowledge and perception of body marking?
3.) Can you explain the reason(s) for its practice?
4.) Why is body marking important to children in Migili society?
5.) Who carries it out on whom?
6.) When is it done?
7.) Where is it done?
8.) How is it done?
9.) How does it affect little children?
10.) What is your view of body marking and curing of childhood diseases?
11.) What types of body marking exist in Migili society? Probe: Can you give me examples?
12.) Are there specific diseases that are cured by the marking? Probe: Please elaborate further.
13.) What value do body marking have on a child?
14.) Do you really believe in the effective cure of body marking on a sick child?
15.) Why this strong belief in Migili cultural group?

B: CULTURAL CONSTRUCTION OF PARENTS' ON CHILDHOOD DISEASES

16.) Can body marking be considered as a practice based on cultural belief? Probe: How do you mean?
17.) Why is this so in the Migili society?

18.) Can you please mention some other reason (s) for body marking practice other than cultural reasons?

19.) Is there any relationship between cultural beliefs and a child illness in Migili society? Probe: Why is it so for the Migili society?

20.) What is the Migili society view of spouse who violates marital norm of fidelity? Probe: Has it ever led to a child falling ill?

21.) How can a child illness be identified in Migili society?

22.) What are the procedures for seeking treatment/cure for a child illness?

23.) How can the symptom of a particular illness be identified?

24.) Is the symptom familiar to the parent?
Probe:What can a person do if symptoms appear strange?

25.) What is the reaction of parents when the symptom of a child's illness cannot be identified?

26.) Can other family members help identify the symptom of a child's illness?

27.) By which other means can the symptom be identified?

28.) What kind of symptomsdo parents look for in a child before seeking help from traditional healer? Probes: Must it be strange? Is it only a diviner that can confirm the symptom?

29.) At what point in time will a person seek the help of a traditional healer/diviner?

30.) Is there a specific health-seeking behaviour for a particular childhood disease?

C: IMPLICATIONS OF BODY MARKING ON THE HEALTH OF MIGILI CHILDREN

31.) Can you mention some outcomes either positive or negative that are linked with body marking in children? Probe: How did you feel about the pain children experience?

32.) Has it actually cured illnesses in Migili children? Probe: Please, give some instances?

33.) Has body markings ever resulted in scars, bodily discomfort in children?Probe: How did the scars or bodily discomfort come about?

34.) Has it resulted in untimely death of a child?

35.) Has there been a case of transmission of infectious disease in children?

36.) Have there been instances where children developed other forms of illnesses?

UNIVERSITY OF IBADAN
DEPARTMENT OF ARCHAEOLOGY AND ANTHROPOLOGY

Dear parent (s)
,

I am a postgraduate student of the Department of Archaeology and Anthropology, University of Ibadan, working on the topic **"Medical Body Marking (*Rúblí Isala) and the* Management of Childhood Diseases among the Migili-Koro in Nasarawa State, Nigeria"** You are approached in this community to help us answer the following questions on behalf of your child on the above topic. Please, bear with us and try to give us your maximum cooperation. Information you give is solely for the purpose of this research and shall be treated with utmost confidentiality.
Thank you and God bless.

Questionnaire Code:

A: DEMOGRAPHIC CHARACTERISTICS OF CHILDREN

1. Sex of child: (1) Male (2) Female.
2. At what age did your child receive body marking?.....
3. Name of village: ----------
4. What kind of illness did your child have when body marking was given? (1) Malaria (2) measles (3) Convulsion (4) Polio (5) Pneumonia (6) Headache (7) Splenomegaly

B: PARENTS' KNOWLEDGE ON BODY MARKING

5. Do you have knowledge of body marking? (1) Yes (2) No
6. If yes (5 above), what is the source of your knowledge of body marking? (1) parent (2) grandparent (3) kindred (4) spouse (5) divine revelation (6) others, please specify……..
7. Is body marking on children still in existence in the present generation? (1) Yes (2) No.
8. Is this the first time body marking will be given to your child? (1) Yes (2) No.
9. What is the acceptance level of body marking by Migili parents? (1) most parents accept it (2) few parents accept it (3) parents are indifferent to it.
10. What is the major reason for the giving of body marking on your child? (1) to heal the child of common illnesses (2) to heal the child of mysterious illnesses (3) to fulfil the custom of the Migili society.
11. Is body marking a widely-accepted practice in Migili society? (1) Yes (2) No.

C: CULTURAL CONSTRUCT OF PARENT ON CHILDHOOD DISEASES

12. Do cultural beliefs influence the construct of a child illness? (1) Yes (2) No.
13. If yes (12 above), in what circumstance? (1) when the illness comes so suddenly (2) when the illness becomes severe (3) when causes of illness can not be identified.
14. How do parents understand causes of a child illness? (1) stealing (2) marital infidelity (3) violation of taboo (4) superstitious beliefs (5) psychic evil intention of relation (6) unhygienic environment.
15. Can a child's illness be attributed to evil forces? (1) Yes (2) No.
16. Which category of evil force can cause illness in a child? (1) witches (2) sorcerers (3) ancestral spirit (4) unseen spirit.
17. Does cultural belief influence parent's health-seeking behaviour for a child's illness? (1) Yes (2) No.
18. If yes (17 above), what is the determining factor in seeking health for a sick child? (1) familiarity with the illness (2) mysterious nature of the illness (3) precarious condition of the child,
19. How do you identify symptoms of your child's illness? (1) personal observation (2)past experience of an ailment (3) relying on observation from elderly persons (4) consult the traditional healer.
20. Does the symptom influence your health-seeking behaviour? (1.) Yes (2.) No.
21. Does parent understanding of causes of childhood diseases influence health-seeking behaviour? (1) Yes (2) No.
22. If yes (21 above), what is your first-line approach to health-seeking behaviour? (1) self-medication (2) local chemist (3) use of primary health care clinic (4) herbalist (5) diviner.
23. What factor determines parents' health-seeking behaviour? (1) severity of the health condition (2) mysterious nature of the illness (3) familiarity with the illness.
24. Has body marking actually saved the life of your child? (1) Yes (2) No.

D: IMPLICATIONS OF BODY MARKING ON THE HEALTH OF MIGILI CHILDREN

25. In your opinion, do you consider body marking on children as a healthy practice? (1) Yes (2) No.
26. If yes (25 above), how healthy it is on a child? (1) healthy (2) very healthy (3) extremely healthy.
27. Is it an effective remedy for curing a child's illness? (1) Yes (2) No.
28. Has body marking actually saved the life of your child? (1) Yes (2) No.
29. Has it resulted in any form of bodily discomfort for your child? (1) Yes (2) No.
30. Can you identify any permanent scar on your child's body as a result of body markings? (1) Yes (2) No.

31. If yes (30 above), what part of the body? (1) abdomen (2) chest (3) leg (4) kneel (5) neck (6) head (7) Others, please, specify……
32. Has your child received any bodily injury as a result of body marking? (1) Yes (2) No.
33. If yes (32 above), how did your child receive the injury? (1) my inability to properly care for the child (2) poor handling of instrument by traditional healer/surgeon (3) use of unsterilised instrument (4) fragile nature of the child's body.
34. Has it in any way adversely affected the physical development of your child? (1) Yes (2) No.
35. If yes (34 above), in what aspect of his/her physical development? Please, specify…….
.
36. Has it in any way adversely effected your child's mental development? (1) Yes (2) No.
37. If yes (36 above), please, specify…….
38. Has body marking endangered the health of your child? (1) Yes (2) No.
39. If yes (38 above), has it resulted in loss of life? (1) Yes (2) No.

Thank you.

TRANSLATION IN MIGILI

NKPI IMERE AGAN kukpo rubon Ibadan
MMISELE IMERE AGAN ICO (ARCHAEOLOGY AND ANTHROPOLOGY)

Yi muco Adza,

me ndo mere agan nkpi imere agan ico wa, nkpi imere agan kukpo a Ibadan wa, ndo saro kon pe kutun kon ba do sala minye agan ribli nne nson rugon adzarave rubon Mjili, Kon ba don Nasarawa rubon Nigeria nne wa. la be napo nyi be sho yi nnyi minyi lijele adza. yi go aye nson la kon nyi gbi kon yaka la gan la sho nne minyi kon cene gan kon la don pise nne. la pise kon la tana nyi kon, lan zan ma agan ivivino nyi lo mayaka minye muna. Oko nyi osi ato nyi lugba.

A. KUTUN AGAN
1.nyevele te nyenraya:(1) Nyevele (2) nyenraya.

2.Aza kupofi----------

3. nkon za tun na bo je----------

4. kutun dza: (1) rugo sunsun (2) rugo aye (3) rugo iye (4) rugon Sépa.

B. GAN KON MUCO BA PE KUCO IWE ISALA NNE

5. Wo agan lo kuco iwe isala bo? (1) nwo (2) aya.

6. Nkon pe bo (6 zuzwe) ozoro lubon kon pe? (1). Muco (2) cuco (3) nyeye wo (4) bere wo (5) kilele (6) able, kon dro----------

7. Isala adza iwe, a lo nyerina rubon mijili bo?(1) nwo (2) iyi.

8. Dza wo adon muso so kon ba sala agan?----------

9. Ncoon kon ba sala dza wo agan Kufi nne ke? (1) nwo (2) iyi.

10. Mijili ba gbi nyi sala iwe bo? (1) ba gbe bo (2) minye kuko ka gbe na (3) adza ba gbe mada bo (4) minye agan ico ba je minye zoro na.

11. Bo je kon ba sala adza agan?(1) kon a ka adza (2) Ka klo adza rugo (3) Ka klo rugo dzi-dzi-dzi (4) minyi kon la zoro idre mijili nine.

8. Rugo wa si kon dza wo ago kon ba sala iwe?(1) rugo iye (2) kurukpo (3) kpikpi (4) rugo iwara alu (5) iwu (6) kuco isala(7) Sépa.

9. Minye shin wa ba sala kufi rubon mijili na?(1) nwo (2) iyi.
10.Nkon ado da wa (14 zuzwe) bo je kon adon da?(1) agan muco la wa (2) muga iklo rugo adzarave wa (3) mije izoro rugo adzarave wa ke ka na.

11.Bo do kutun kon ba don sala adza iwe?(1) ka klo rugo keke wa.(2) Ka jere aga dzidzi kon an swara dza nne wa.(3) kon la zoro idre muco la (4) Minyi kon la cuwo nnyi agan muco la.

C.KUTUN KON IDRE JE MUCO ZORO NSON RUGO ADZARAVE NNE
1.Idre je muco zoro nson rugo adza kutun kon ba don zoro nne na? (1) nwo (2)iyi

2.Nkon a don nwo wa (1 zuzwe) nza mije wosi?(1) ipere kon rugo nne be kpalanva nne (2) Ipere kon rugo nne a kalukpo nne.

3.Azunu dzidzi ba be rugo do adza bo?(1) nwo(2) iyi

4.Nko adon nwo wa (3 zuzwe) nza azunu aba isi? (1) Ije (2) azunu muco (3) azunu nkpo.

5.Anza agan ba isi ba do be rugo mada?(1) mubere(2) itre (3) minyekpikpi (4) nkon muco yi miyi (4) agan dzidzi kon muco/teh mere, zoro nye nne.

6. (5 zuzwe) gbo isha an be rubon risi na? (1) nwo (2) iyi.

7. Nkon adon two wa,(6 zuzwe) ban zoro lubon?(1) won sha gbotu (2) on do aklodzi (3) nyi ko lubala (4) ban dro nkwale ibetsi.

8. Idre a je muco saro kutun izoro rugo adza bo? (1) nwo(2) iyi.

9.Nkon adon da wa (8 zuzwe), ba saro rugo lubo? (1) kutun kon wo pe rugo nne (2) kutun mudzi rugo nne (3) kutun kon rugo ata dza nne.

10. O zoro lubo kon pe nza rugo nine? (1) navava wo (2) O pe nkpi muco (3)o na nkpi gbisha(4) kuco kon o nini nye an za rugo nine.

11. Kutun kon rugo zoro nne kon a jo saro miji muga Kong na? (1) nwo (2) iyi.

12 Nkon adon nwo wa, (11 zuzwe) bo jo saro mije muga?(1) kutun kon onini rugo nne zoro nne wa (2) kutun kon gbe kuco rugo nne wa (3) mudzi rugo dza nne wa (4) Able.

D. LUDZI ISALA KUFI ADZARAVE RUBON MIJILI

1. Wo nini kon isala iwe a don agan zuzwa?(1) nwo (2) iyi.

2.nkon adon nwo, (29 zuzwe) muzwa kon adon lubon?(1) mukplakpla (2) a nakutuma bo (3) kutuma kon gigene wa.

3. Adon mije iklo rugo kphohn na? (1) two (2) iyi.

4. Iwe sala nne a ke tro dza wo? (1) nwo (2) iyi.

5. Nko a don nwo wa (32 zuzwe) nza mije wusi----------

6. A zoro dza wo ibli nwolo? (1) nwo (2) iyi.

7. Kudene ibli nne a sho ribli dza wo body? (1) nwo (2) iyi.

8. Nkon a don nwo wa,(35 zuzwe) musele ribli wusi? (1) lukpe (2) aye (3) kutukpa (4) kulu . (5) Kugbe (6) kuco(7) able, dro----------

9. Dza wo a Zoro ibli ipere Kon ba don sala iwe nine?(1) nwo (2) iyi.

10. Nkon adon nwo wa, (37 zuzwe) azoro lubo kon a cene ibli nne? (1) kucon kon nma rila nne wa (2) nye kon sala iwe nne wa aza zoro nson tro kutuma rugba na na (3) itro kutuma no za sesere na na (4) kutun kon rugo nne a ka lukpo nne wa.

11. Kuco nne akplo ludzi don kutun Kon dza wo a ri nne? (1) nwo (2) iyi.

12.Nko adon nwo wa (39 zuzwe) mesele ribli kon wusi? odro na----------

13.A je dza wo bri na? (1) nwo (2) iyi.

14. Nkon a don nwo wa (41 zuzwe) odro na----------

15. Iwe isala nne a be ni bli don dza wo? (1) nwo (2) iyi.

16. Nkon a don nwo wa (43 zuzwe) dza wo akpo ipere kon ba don sala iwe nne?(1) nwo (2) iyi. oko

APPENDIX IV

PARENTAL INFORMED CONSENT FORM

IRB Research approval number:

This approval will elapse on:

TITLE OF THE RESEARCH: Medical Body marking (*Rúblí Isala)* and the Management of Childhood Diseases among the Migili-Koro in Nasarawa State, Nigeria.

Name and affiliation of researcher/applicant: This study is being conducted by Ambrose Woyengiemi Ogidi of Department of Archaeology and Anthropology, Faculty of Arts, University of Ibadan.

Sponsor of research: This study is self-sponsored.

Purpose of research: The purpose of this study is to examine the continuous relevance of body marking in the management of childhood diseases among the Migili-Koro in Nasarawa State.

Procedure of the research: A total of 441 participants will be recruited into the study. A purposive sampling research technique will be adopted to gather the required study population. Participants in this study will include the paramount ruler of Jenkwe kingdom, (Zhe Jenkwe), the community leaders of the three study locations; a large proportion of elderly men and women, recognised traditional health practitioners (surgeons) and parents of children under five years. Informants/participants will be obliged to set aside some time to supply the information required by the researcher.

Expected duration of research and of participants involved: Your child should not spend more than 3 hours during the field visit.

Risk(s): The study will not pose any risk to your child.

Cost to the participant(s): Time for your child's participation is the only requirement.

Benefit(s): The goal of this research is to suggest measures that will eradicate harmful cultural practices that affect your children in Migili society.

Confidentiality: All information collected in this study will be given code numbers and no name will be recorded. This cannot be linked to you in anyway and your name or any identifier will not be used in any publication or reports from this study. As part of our

responsibility to conduct this research properly, officials of WHO and UNICEF may have access to these records.

Voluntariness: Your child's participation in this research is entirely voluntary.

Statement of person obtaining parental informed consent: The goal of this research is to ascertain the nature, patterns and processes of body marking in the management of Childhood Diseases among Migili-Koro, in Nasarawa State. We hope to give useful recommendations from this study that will help stem health-related problems which have continued to affect your children in the study area.

I have fully explained this research to

…….. and

have given sufficient information, including what has to do with risks and benefits, to make an informed decision.

DATE:…….

SIGNATURE…….

NAME:……

…….

Statement of person giving consent: I have read the description of the research and have had it translated into the language I understand. I understand that my participation is voluntary. I am very familiar with the purpose, methods, risks and benefits of the research to the extent that I want to take part in it. I understand that I can decide to stop being part of this study at any time. I have received a copy of this parental consent form and additional information sheet to keep for myself.

DATE:……

SIGNATURE…….

NAME:……

……..

WITNESS' SIGNATURE (if applicable)……

WITNESS' NAME (if applicable)……..

Detailed contact information including contact address, telephone, e-mail and any other contact information of researcher (s), institutional HREC and Head of the institution:

This research has been approved by the Ethics Committee of the University of Ibadan and the Chairman of this Committee can be contacted at Biode Building, Room 210, 2nd Floor, and Institute for Advanced Medical Research and Training, College of Medicine, University of Ibadan, E-mail: uiuchirc@yahoo.com and uiuchec@gmail.com

In addition, if you have any question about your participation in this research, you can contact the principal investigator,

Name……
……

Department……Phone……
……..

Email……
……

PLEASE KEEP A COPY OF THE SIGNED INFORMED CONSENT.

TRANSLATION IN MIGILI

KUSRUKPE 'KA NKPI MUCO

IWE WAN KON ADOH MIJE KON BA NO KUSRUKPE NNE:
IMA, IPERE KON BAN NO KUSRUKPE NNE GBA NNE:

KUCO KA: Isala isu ribli nson rugo a dzarave Migili rubon Nasarawa, Lukpe Rubon Nigeria.

AZA NSON MINYE KON BAN CICI NSON NYE KON AN NO KUSRUKPE NNE: Nye kon an no kusrukpe nne ke nyelo kon ba ro kon Ambrose Woyengiemi Ogidi Nye kon Adon nson nkpi imere agan lo kon ba ro kon Archaeology nson Anthropology, Chen kon nkpi pegan arts adon bo nne, Nkpi imere agan kupkpo a rubon Ibadan.

NYE KON AN DO AKLODZI KUTUMA NNE: Nye kon an no kusrukpe nne non zunu aklodzi avuva kon na.

GAN KON AJE KON BA NO KUSRUKPE NNE: Ba no kusrukpe nne minyi kon ba nini teh adon zwa kon ba dre sala isu ribli karisin kon idre Migili gbi nne teh aza zwa na wa mada nson kutun kon an no do adzarave misele mukplakpla ribli nne.

KUTUN KON BAN NAKUTUMA NNE: kutun kon ban sho minye nnyi, kon ba kro Oka nkpi minye kon ba ma si, kon ba nini wan kon a don tro nne, no do kutun Kon ban ma kon ba zoro kusrukpe nne na. Minye kon ban no lukpe kutuma wan nne ke; Zhe Migili, Kon adon n Jenkwe nne, Azhe apo fifi ace Kon La zaro apo ba, Kon lan na kutuma ni ba nne; minye kuko minyevele nson minyenyran, muje kisi mukplakpla ribli aban kon ba pe ba kpohn nne nson muco aban kon adza ba no muso aso nne. Minye kon ba ma kuco ba do kon ba zoro nblan nne, ban yaka Nye kon an sho ba nnyi nne shin gan kon ba pe nne.

IPERE KON BAN ZORO KUTUMA NNE NSON MINYE KON BA DO KUCO NNE: Shi-Shi-Shi-shi ipere, ba don pise kon, minye kon ba do kuco nne, ba ma atsa mizi kon ba klo KUTUMA KUSRUKPE nne na. On ka ma ipere koh igba ace, ice kon on na kutuma nne na.

LUDZI: kutuma wa nne an zan be nludzi do nyen kon ama kuco kon, kon an na kutuma nne muna.

GAN KON NYEN KON, A DO KUCO KO AN BRO NNE: Nye Kon ado kuco nne an Zan bro aklodzi kon muna.

MUZWA KON: muzwa kutuma kusrukpe wa nne ke kutun kon an tolugba kon ba go shin idre ban Kon ban be ludzi don adzarave Migili nne goh wo nne.

AGAN IVIVONO: shin ka kon la gbe nkpi nyi nne, lan kro so wa. Oka, lukpe 'ka kusrukpe nne lan zan ma yaka minye lo, teh, la ma no kusrukpe lo wo muna. Iko kutuma la ke, kon la nini Kon kutuma kusrukpe wa nne a dzi zwazwa nne, kuco nne wa kon, ble igbakuco minye kon ba don jekisi mukplakpla ribli, lo kon ba ro ba kon WHO nne nson UNICEF ba nini gan kon la zoro lukpe kutuma kusrukpe wa nne bo na.

IDO KUCO: Ido kuco lukpe kutuma wa nne, ado wan blan wa.

OKA NYE KON KUSRUKPE WA NNE AN GBO KUVA KON NNE: kusrukpe wa nne adon minyi kon ba nini kutun kon, isa la isu ribli adzarave, wan kon adon idre Migili, kon ba don rubon Nasarawa na nne ado bo nne wa. La sesi bo kon shin agan aban kon la nini, kon an ben ludzi n mukplakpla ribli adzarave Migili nne, lan le yi kon yi pe bo.

Nka ma kutun kusrukpe nne yaka.....nson kutun ludzi kon, muzwa kon, wan kon an gbagbla Muno nne.

ISA.....IJEKUVA.....

..

AZA.....

OKA NYE KON KUSRUKPE NNE GBO KUVA KO, KON A TSENE ONE: nka tsene kusrukpe nne, mada, nka wuso kon ba tsene linye me nne, nka pe kuco kon. Npe kon, ido kuco me ado nblan wa. mada nka pe gan kon ba no` kusrukpe nne kuco kon nne, Mije kutun kon ban no nne, ludzi nson muzwa kon, konyi nne, meh gbi kon nma kuco me do, kon zoro. Me mada nka pe Kon ipere kon ndon npise Kon nle nne, kon nle gba na. Nka cene kusrukpe nne nson able mada, wan kon nma yana nkpi me nne.

ISA.....IJEKUVA.....

..

AZA.....

IJEKUVA NYESEDA(nkon ado bo).....

AZA NYESHEDA (nkon ado bo).....

Gan kon ba don pise nkpi nye kon an na kutuma ino kusrukpe nne ke ice nkon adre nne, iwe aga ida ka Kon, fax, e-mail nson aga ban kon nyen an cono Muno nne, nkpi mere 'gan nson nkpi kukpo an kpi imere agan Kon:

Kusrukpe wa nne, ado nigbi minye nkpi imere again kukpo Ka do rubon Ibadan nne wa, mada, nyeritre igba kuco wan kon ba doh mije kusrukpe nne, Nyeh an cono nkpi kupi lo kon ba ro kon Biode, kuyo iwe 210, itsi luco nwa abe, nkpi ipega wan ijekisi mukplakpla ribli nson isono minye, chen kon nkpi mere agan wa iga` gege do bo nne wa, nkpi imere agan, kon ado kupo kukpo rubon Ibadan nne wa;E-mail:

Lo kon a kpe gbe cwe muno nne ke, nkon o don nka isho, kon on sho lukpe kutuma nne, kpo, O sho nyeritre wan kon ado jesiki n kutuma kusrukpe wan nne,

AZA.....

Misele.....Iwe agan ida oka.....

Email.....

O ZORO NYI 'SI, KON MA KUWELE KUSRUKPE WAN NNE, WAN KON BAH JEKUVA MUNO NNE, YANA NKPI WO.

APPENDIX V

INSTITUTE FOR ADVANCED MEDICAL RESEARCH AND TRAINING (IAMRAT)
College of Medicine, University of Ibadan, Ibadan, Nigeria.

Director: **Prof. Catherine O. Falade,** *MBBS (Ib), M.Sc, FMCP, FWACP*
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e-mail: cfalade@comui.edu.ng lillyfunke@yahoo.com

UI/UCH EC Registration Number: **NHREC/05/01/2008a**

NOTICE OF FULL APPROVAL AFTER FULL COMMITTEE REVIEW

Re: Body markings and childhood diseases among the Migili (Koro) of Nasarawa State, Nigeria

UI/UCH Ethics Committee assigned number: UI/EC/15/0449

Name of Principal Investigator: **Ambrose W. Ogidi**

Address of Principal Investigator: Department of Archaeology & Anthropology, Faculty of Science, University of Ibadan, Ibadan

Date of receipt of valid application: 03/12/2015

Date of meeting when final determination on ethical approval was made: **17/03/2016**

This is to inform you that the research described in the submitted protocol, the consent forms, and other participant information materials have been reviewed and *given full approval by the UI/UCH Ethics Committee.*

This approval dates from **17/03/2016 to 16/03/2017.** If there is delay in starting the research, please inform the UI/UCH Ethics Committee so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. *All informed consent forms used in this study must carry the* UI/UCH EC *assigned number and duration of* UI/UCH EC *approval of the study.* It is expected that you submit your annual report as well as an annual request for the project renewal to the UI/UCH EC early in order to obtain renewal of your approval to avoid disruption of your research.

The National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the UI/UCH EC. *No changes are permitted in the research without prior approval by the* UI/UCH EC *except in circumstances outlined in the Code. The* UI/UCH EC *reserves the right to conduct compliance visit to your research site without previous notification.*

UI/UCH EC 17-MAR-2016 APPROVED COLLEGE OF MEDICINE, U.I.

Professor Catherine O. Falade
Director, IAMRAT
Chairperson, UI/UCH Ethics Committee
E-mail: uiuchec@gmail.com, uiuchirc@yahoo.com