

Cultural Commingling: The Impact of Western Medical Conceptions on Igbo Cultural Understandings of Disease

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“Efi nwelu odudu na egbu ijiji o nachu kwa maka nke enwere odudu”.

A tailed cow flicks its tail to kill and chase away flies from himself as well as his tailless fellow cow.

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PREFACE

This project represents a culmination of my two-pronged academic studies at Duke University: the first is a major in International Comparative Studies (ICS) with a concentration in Africa; the second is the completion of a pre-medical program. During the summer of my junior year, I knew I had to complete some research in order to be competitive as a medical school candidate. To accomplish this, most of my peers chose to complete basic lab science research with one of Duke's many impressive professors. However, I decided to mobilize what I had learned through my ICS major and pursue a more social sciences-based research project. While searching for opportunities, I discovered a professor with an established Duke-sponsored program, who invited students to accompany him to Togo and complete diverse individual research projects. Knowing that I am a native-born Igbo, he informed me of the significant Igbo population that resides in Togo's capital city, Lomé. This, of course, sparked my interest and helped cement my decision to study the Igbo ethnic group as they live in an immigrant environment in Lomé. All of these factors make this research very personal to me. I was excited at the prospect of gathering and relaying information about a group of people whose lifestyles choices and health understandings are not well represented in the fields of science and research. I tasked myself to be an output for their voice, connecting them to academia. With those goals in mind, my fellow Duke students and I left the United States en route to Togo.

INTRODUCTION

“The issues of Western influence and its effects have long been analyzed and debated by scholars . As sometimes happens, the solution that emerges is syncretism, not the demise of tradition, but rather the blending of the old and the new...a complex interplay between new ideologies and more traditional concepts of disease.”¹ –Jason Harris

Mimi’s Story

Upon my arrival to Togo, I was housed with an adoptive Togolese family. The family was populous and occupied the entire compound. This compound consisted of a three bedroom house, a large yard centered by a well, in addition to four separate auxiliary rooms, that were across the yard. Though I directly lived with the first son’s wife in the main house, the rest of the family, who occupied the additional rooms, also considered me a part of their household. I was quickly taken under the wing of one of the cousins, a twenty nine year old girl named Mirielle, better known as Mimi. As the daughter of the eldest sister, she proved to be a good friend as well as a helpful resource. One of the many benefits of being matched with this family was the variety in occupations present in the compound, including *une couturier* (seamstress), *un électricien*, and *une boulangère-pâtissière* (baker). Mimi, herself, was a *coiffeuse*, or hair dresser. The second week of my visit I entered her shop, which is attached to the compound, to get my hair braided, but ended up getting a lot more than a new hairdo.

¹ Jason Harris. “Someone Is Making You Sick” Healthcare in Maya Guatemala, ed. John P. Hawkins (University of Oklahoma: 2007) p. 27

As she began to braid my hair, she asked me to describe my research. Using a short speech I had memorized in anticipation of this question because I initially lacked confidence in my impromptu French speaking abilities, I informed her that I would be looking at nutrition and sickness in Igbo women living here in Lomé. A little time passed in silence after I had finished my response and I started to wonder if I had failed to communicate a clear point. The silence was then broken by her pensive words “Une fois, j’étais tellement malade” (I was very sick once). I was intrigued by the intimacy of her statement and urged her to expand on her story.

“It happened during my apprenticeship about three years ago. I couldn’t get my baccalauréat (*bac*)² but I could do hair. I was accepted to apprentice under a woman named Gloria who lived on the other side of *Be*.³ Her husband worked with one of my uncles and I was excited to start my apprenticeship. Gloria’s husband, a wealthy man, owned several hair salons throughout Lomé. To keep her busy, he allowed his wife, Gloria, to manage the shops and the apprentices. For the first six months of the apprenticeship I was the shampoo girl, meaning I shampooed the customers as needed as well as performed some other local clean-up duties. A few more months passed by and I saw that other apprentices who had been around for an equal or shorter amount of time were getting promoted, allowed to do other styles of hair, the part that made the most amount of money. A year passed and I was still a shampoo girl and it was then that I knew that Gloria had something against me. Out of frustration, I began to fill in for some of my colleagues doing the styling or helping in the braiding, on the days that Gloria was at her other shops. The clients were extremely pleased with my work, with many requesting me each time they arrived for their weekly or bi-monthly appointments. My boss’s distaste for me only

² In Togo, only about 12% of the country get their *bac*, equivalence of a US high school diploma, while the rest of the country pursue various vocational studies and/or a trade. Many trades require an apprenticeship, a period of 2-4 years where the individual works under a master in that trade, eventually graduating to masters level themselves.

³ The neighborhood in which we lived, one of many neighborhoods in Lomé proper.

increased as the demand for my services mushroomed. After about six months I had a loyal set of customers, an awkward situation for an apprentice. When I thought that my boss's dislike for me couldn't get any worse, I fell incredibly ill. I was extremely fatigued and had difficulty keeping food down. Apprentice friends of mine confirmed my suspicions that my boss had gone to see the witch doctor, and put a curse on me. My illness lasted almost a month during the majority of which I was bedridden. One Sunday morning, I finally had the energy to make it to my church, L'Eglise Catholique Maria Auxliadora. That Sunday, the priest professed about God's power as the only true power. After confessions and a discussion with the priest, I went home feeling refreshed. About two days later, I was feeling better than ever. I knew that I had the power of God in me and that I could no longer be affected by Gloria's wicked ways. To my boss's disappointment, I returned to finish my apprenticeship. The curse must have backfired on her because a week from my return, she herself fell sick. I don't know all the details but I do know that she wasn't able to make it to the shop much anymore and that provided me with increased freedom over my activities. I left the apprenticeship with a large client base and now I have my own shop where they all come. God's grace saved me, and his spite challenged her. He gave me the skills and resources to be successful at my endeavors. Now sickness cannot control me and I have not been sick ever since."

Upon hearing Mimi's story, I went into some deep thinking. The conviction with which she knew what caused her sickness and how she was healed was incredibly surprising and at the same time refreshing. My disbelief in her conclusions made me cognizant of my biases or tendency to see Western science as the only option for disease explanation. While she recounted her story, I was, unconsciously, diagnosing her according to her symptoms concluding that she likely suffered a bout of mononucleosis, more commonly known as mono, and that she was

misguided about the causal relationships between illness and science. Later that evening while debriefing with my advisor, some questions came up that showed the holes in my haphazard assumptions. How had the timing of the illness worked out so perfectly? How did she suddenly get better, without taking any Western medication prescribed for mono symptoms⁴? Why did the boss fall sick within days? It got me thinking about how Africans, specifically Igbo people, think about disease. I became extremely interested in the role of biomedicine versus the role of divine intervention or other types of medical understandings among Igbo people. I decided it would be my duty to uncover what Igbo people believe about disease and give these beliefs the credence they may deserve.

The Literature on Etiology in Sub-Saharan Africa

Cultural understanding of disease can be wavering, dually affected by cultural history and foreign influence. The effects of such influences are frequently analyzed and debated by native and non-native scholars.⁵ These scholars look to see what changes, if any, have occurred in societies that have adequately survived and functioned well for hundreds of years. Many of these scholars claim that change is a natural result of time and an external presence, but the degree to which the society changes varies from area to area and culture to culture.⁶ This holds true throughout the continent of Africa where some communities have had minimal changes as a result of Western influence while others greatly altered cultural values and community operations. In these alterations, some beliefs and practices within a community, e.g. government,

⁴ Mononucleosis is a virus that does not have a cure, but its symptoms can be managed.

⁵ Jason Harris. "Someone Is Making You Sick" Healthcare in Maya Guatemala, ed. John P. Hawkins (University of Oklahoma: 2007) p. 27

⁶ Ibid, p.28

maintain strength and prevalence while others, e.g. diet, wane.⁷ In the case of Igbo people, beliefs regarding certain aspects of culture and health, such as infertility, remain indigenously rooted while other beliefs, such as those about diabetes, have been morphed by Western knowledge. Other ideologies about disease, for example in the case of high blood pressure, evolved to include relatively equal portions of both indigenous and foreign influences. These mindsets about disease are possible because Igbo culture is both adaptable and insular as a result of its cultural framework and foreign impact. Scholar Lori Leonard says “Few ethnographers have explicitly analyzed or reported the ways to which their informants define problems.”⁸ This is especially the case for Igbo people of Nigeria. Scholarly research into Igbo cultural history has lagged in comparison to other communities of the same magnitude. As a result, there is limited research available for use during the writing of this thesis. The lack of information is one of the main reasons why this thesis is necessary for today’s academic community.

Methodology

The data for this thesis was gathered through semi-formal interviews and participant observations. I interviewed approximately forty women, most of whom were introduced to me by one of my two contacts. I met Uchenna Ogonna, my first contact, at the church I attended, Praise Chapel International, a church that was frequented by Togolese and Nigerians alike. Uchenna escorted me to the homes of individuals he thought might prove helpful to my study. These home interviews provided a degree of privacy and frequently generated more thoughtful answers. Because of Uchenna’s extended network, I was able to interview women of various

⁷ Tola Olu Pearce . She Will Not Be Listened to in Public: Perceptions among the Yoruba of infertility and childlessness in Women.. Reproductive Health matters. Vol.7 , No. 13. Living without Children (May, 1999) pp.73

⁸ Lori Lenard. *Problemizing Infertility: Scientific Accounts and Chadian Women's Narratives*, ed. Marcia C. Inhorn and Frank Van Balen (City : Publisher ,Year) **200**.

demographic groups in order to achieve a wide range of responses, which helped me to identify patterns based on the women's answers. Uchenna was equally critical as a translator for elderly Igbos who speak a specialized local dialect that is difficult for me understand. Being from Abia State, the home state of most of my interviewees, it was easier for him to understand complex or antiquated words and phrases. The second contact, who was introduced to me by a dear Togolese friend of my professor, was Aikiki Onuwa.⁹ Aikiki was my guide in the market, walking me from stall to stall, which eased my introductions to the women that he knew from working with them in the past.¹⁰ Market interviews ensured that I had a diverse set of interviewees enough to assume a semi-representative sample of women.

All interviewees in this project were women, a decision that was made prior to my arrival in Lomé. This resulted from the original ideas for my research project, which was centered on nutrition, an arena that in Igbo culture is almost entirely dominated and affected by women. I decided to continue on the same trajectory even after the thesis had morphed because of the key roles women play in society. Igbo women, as they center their lives on the community, can be heralded as gate keepers of culture. By focusing solely on women, I could more accurately trace community value and cultural progression.

Over the course of two months, these interviews morphed from nutrition based to etiological beliefs based as a result of intriguing responses and developments in my research. At the beginning of my interviews, I attempted to ascertain what health issues these women believed were the most problematic in the Igbo community. The rest of the interview was

⁹ One can notice that most of my connections were men. This proved efficient because most women were either working (as market) or with their families where as some men had the freedom of unstructured employment. It was also helpful that they had their own vehicles that acted as transportation from site to site and they afforded me protection when I had to interview after dark and sometime later into the night.

¹⁰ Hezjiranaway, also known as the second-hand market, is dominated by Igbo's. Referred to by the Togolese as Marché des Igbo.

focused upon those illnesses, which almost always included a combination of diabetes, infertility and high blood pressure. The questions addressed causation, symptoms, and cure factors that I later used for comparisons.

An important aspect of the project was that of language. Being a native Igbo speaker, most of my interviews occurred in a combination of English and Igbo, based on the interviewee's preference. In this paper, I have translated all the interviews. Often translations from Igbo to English are inadequate or imprecise because ideas are misrepresented due to limited vocabulary, but care was taken to limit issues with mistranslation. As for the minimal amount of Ewe¹¹ interviews that were obtained to provide a base comparison, I relied on the expertise of a Togolese friend to act as a translator (into French), since I had almost no Ewe language training.

For the length of this paper, I refer to my interviewees by name. These names have been altered for the sake of their privacy. I also refer to the women by their title of marriage, if they possess one. Igbo culture dictates that a married woman (unless she opposes) is always prefixed with Mrs. in order to acknowledge and rejoice in her accomplishment of marriage and, often, of motherhood. I understand the sociological implications of including a title for women in modern gender neutral writing but in order to capture the cultural essence of the community at hand I decided to forgo these standards.

In this paper, I refer to Igbo medicine as indigenous and traditional and Western medicine as biomedical. I recognize that there are great nuances with using this terminology and I attempt to complicate those terms in this thesis. However, in order to succinctly address the divisions between Western medical culture and Igbo medical culture, these terms will consistently be used throughout this work.

¹¹ Ewe's are an ethnic group native to Togo that constitute the majority Togolese people that live in Lomé.

Igbos Introduced

Every people have its own language, its own art, its own way of building, planting, celebrating and eating, and its own way of looking at world and interpreting reality. Every people have its own philosophy of life, its own manner of showing belief in superior powers and respecting them.... Every people have its peculiar customs and traditions.... In short, everyday people have its' own culture. Igbo people are no exception.¹² –F.A Arinze

In this thesis, I will argue that Igbo people, who have had a challenging history as a colonized people, but especially as a minority in their home country of Nigeria, are an ethnic group that incorporates Western knowledge to various extents with indigenous understandings to create a synthesis of culture, values and beliefs.

Igbo people are an ethnic group that reside mostly in southeast Nigeria. Igbo people, like most West African populations, have a tense history with foreigners as a result of aggressive colonialism, devastating slavery and a vigorous struggle for independence from colonial rule. Portugal provided the first arrivals and settlers in what is now Nigeria or Igboland, followed by the British during the European scramble for Africa.¹³ From the end of the 15th century to mid-19th century, Igbo people and their neighbors were used as manpower for slavery.¹⁴ The Igbos' perceived strength, work ethic and close proximity to the Atlantic ocean made them especially

¹² F.A. Arinze, Christianity and Igbo culture, *Igbo Language and Culture*, ed. F.C. Ogbalu/E/N/ Emenanjo, Ibadan: Oxford University Press 1982, Vol 2, 181

¹³ Chukwuma J. Obiagwu, *Adventures of Ojemba; the chronicles of Igbo people*. Hamilton books. Lanham. 2008.

¹⁴ Orji, Matthew O. *The History & Culture of the Igbo people: Before the Advent of the White Man*. Nkpor. Jet Publishers 1999. Pg. 108

susceptible to be kidnapped for the trade.¹⁵ It is theorized that eighty percent of the slaves captured and shipped to Britain originated from the Bight of Biafra.¹⁶ The Atlantic slave trade efficiently undermined political and cultural systems that had been the way of Igbo people for centuries, maliciously tearing apart lineages and sending kidnapped Africans to the West Indies, the Americas and the United Kingdom.¹⁷

The British used Igbo people as a tool for territorial growth.¹⁸ Their systems of indirect rule overturned the centuries-standing democracy of Igbo culture, replacing local leaders with chieftaincies, challenging Igbo leadership and organization.¹⁹ In order to gain back some power and authority, many Igbo people decided to work alongside the British. Igbos comprised of the majority of the public work force throughout the Nigerian protectorate and their children populated the British school systems.²⁰ Consequentially, Igbo people became “highly educated in British values, culture and religion” while their indigenous doctrines were thrown “overboard”.²¹ The Igbo’s success as “puppets” of British rule, a term used by neighboring ethnic groups, meant to insinuate that the Igbo’s have no sovereignty. This dissatisfaction with the Igbo way provided a basis for animosity between the Igbo people and other Nigerian ethnicities. Igbos eventually realized that they would never achieve equality with the British.

¹⁵ Chima J.Korieh, African Ethnicity as Mirage? Historicizing the Essence of the Igbo in Africa and the Atlantic Diaspora, *Dialectical Anthropology* (2006) Vol. 30, pp. 104

¹⁶ Orji, Matthew O. *The History & Culture of the Igbo people: Before the Advent of the White Man*. Nkpor. Jet Publishers 1999. Pg. 108 - Bight of Biafra is the stretch of water and land that intersects with southeastern Nigeria (home to Igbo’s) as well as Gabon, Cameroon and Sao Tome and Principe. Chima J.Korieh, African Ethnicity as Mirage? Historicizing the Essence of the Igbo in Africa and the Atlantic Diaspora, *Dialectical Anthropology* (2006) Vol. 30, pp. 92

¹⁷ Ibid., p.87

¹⁸ Ibid., p.87

¹⁹ Orji, John N. *Political Organization in Nigeria since the Late Stone Age: A History of the Igbo people*. New York: Palgrave Macmillan, 2011

²⁰ Obiagwu, Chukwuma J. *Adventures of Ojemba; the chronicles of Igbo people*. Hamilton books. Lanham. 2008. 82-83

²¹ Ibid., 82

When moves toward national independence began in the mid 1950's, the British emphasized the tensions between the ethnic groups, with hopes that it would stop them from uniting toward independence. They were temporarily successful but by the end of the decade, Nigeria was granted independence in 1960. Shortly thereafter, the hateful sentiments that were present between the groups went on to result in a civil war.

In the 1960's, with a newly independent Nigeria, cross-ethnic understanding had to be searched for among Nigerian ethnicities. Residual and newly formed tensions between Igbo Christians and Hausa/Fulani Muslims²² ended up resulting in violence. For various political misunderstandings and disagreements, more than 100,000 Igbo people were massacred in cold blood.²³ Hausa mobs cut off the breasts of all known Igbo women in northern Nigeria (Hausa territory) and killed any men they were with. This genocide, led to Igboland's desire to secede, marking the beginning of the war in 1967. Nigeria, in retaliation, instilled blockades and bans that would starve residents of the newly recognized Biafra state.²⁴ The war lasted for four years and ended due to hunger and starvation of the Biafran people.²⁵ Millions of Igbo people died, many more lost property and jobs. Over one million civilians died in the ensuing famine.²⁶ Until this day the Igbos struggle to return to their originally thriving state, having been marginalized by

²² Most of Northern Nigeria constitutes of Muslims while the south is a mix of Christianity and indigenous religions.

²³ Obiagwu, Chukwuma J. *Adventures of Ojemba; the chronicles of Igbo people*. Hamilton books. Lanham. 2008. 87

²⁴ Ibid., 88. Biafra was recognized as a country in 1969 by the government and people of Gabon, Cote d'Ivoire, Tanzania, Zambia, and Haiti.

²⁵ Ibid., 88.

²⁶ Donald G. McNeil Jr. Nigeria: Those Born During Biafra Famine Are susceptible to Obesity. The New York Times. Nov. 1 2010

every group that lives in Nigeria, present and past. “He who is surrounded by enemies must always be on guard. Biafrans do not sleep.”²⁷

Each aspect of contemporary Igbo history, especially the Biafran war, directly worked to shape Igbo culture and philosophy especially the aspects of adaptation and insularity.

One of the key components to Igbo culture as a result of that described above is the Igbo’s ability to adapt. The first example can be seen during the time of slavery. Igbo people, having had their lineages broken and disrupted, resolved to discover another method that could allow the maintenance of economic and social understandings that had been present for a long time. Igbo expanded the *umunna*²⁸ to what is now known as the extended family.²⁹ Children of missing parents would be distributed among relatives and raised, in most cases as an almost equal part of the family.³⁰ A second example of this adaptability was the Igbo’s ability to quickly learn the language and customs of the colonizers in order to garner success within the oppressive colonial system. By the late nineteenth century, amid colonization, Igbo men became leaders in many sectors, controlling the majority of industries. Many middle- or upper- class Igbo children were able to speak English fluently by the time they were teenagers. This immersion in education made Igbo prosperous, a characteristic that would only mushroom the tension between Igbo people and Hausa and Yoruba ethnic groups, the two largest ethnic groups in the country. Members of these majority ethnic groups saw the Igbo people as selling out. On the contrary, the Igbo saw themselves as determined with instinctive entrepreneurial skills that allowed them to be

²⁷ Obiagwu, Chukwuma J. *Adventures of Ojemba; the chronicles of Igbo people*. Hamilton books. Lanham. 2008., 90

²⁸ Ummunna – an extended family

²⁹ Ndukaihe, Vernantius Emeka. *Achievement as value in the Igbo/African Identity: The Ethics*. Duetsche Nationalbibliothek. Berlin 2006 pp.166-170

³⁰ They would many times become house boys or house girls, living with the family, attending schools with the children and in exchange they would help out in the kitchen or in the yard. This system is unique to African societies and is rarely seen in western contexts.

court clerks, messengers, and interpreters as well as hold positions in the colonial administration. Igbo people adapted to the inherently negative situation of colonialism and decided that if they had no other option, they would thrive. A third and most enlightened example of adaptation is the Igbo communities' ability to rejoin Nigeria after the poverty and suffering of the Biafran war, and ultimately attain a higher degree of proverbial success than many other ethnic group in Nigeria.³¹ Matthew Orji summarizes this point with his introduction of a popular Igbo proverb that translates "The Igbo man can grow fat where others starve as long as there is fertile soil under his feet."³² Oriji's proverb adequately indicates the dire situation that Igbos were left in during and after the war, nevertheless they were able to recover. Igbo people who were forced to migrate learned that mastering the language could lead to success both economically and personally.³³ Living in these foreign communities Igbos acquired innumerable languages and skill sets, necessary for survival. According to Orji, "The Igbo man has an indomitable spirit to survive and succeed in life despite the worst handicap to which he is bedeviled."³⁴

At the same time that Igbo people were forced to adapt and in that adaptation achieve success, Igbo people chose to become increasingly insular. As a minority in both their native and diasporic contexts, Igbo people are constantly surrounded by larger, separate cultural values that threaten their own. With pride they seek to, in any condition, preserve their culture to their

³¹ Obiagwu Obiagwu, Chukwuma J. *Adventures of Ojemba; the chronicles of Igbo people*. Hamilton books. Lanham. 2008.

³² Matthew O. Orji, *The History & Culture of the Igbo people: Before the Advent of the White Man*. Nkpor. Jet Publishers 1999. 4

³³ It is widely accepted in Igbo culture as well as throughout Nigeria that Igbo's incorporated English years before many other ethnicities in Nigeria and because of the central location of Nigeria, Igbo's had the opportunity to learn English (or other colonial language) before many African societies. To the non-Igbo, the Igbo man is that regards is perceived as a sellout, succumbing to the language of evil. To the Igbo man, the others were unwise to not learn the language and benefit from the power and protection it provided from the white man.

³⁴ Matthew O. Orji, *The History & Culture of the Igbo people: Before the Advent of the White Man*. Nkpor. Jet Publishers 1999. 4

children and to propagate “Igboness” through generations, as they have frequently been denied the right to carry on their cultural practices and values. During colonialism, when children were required to learn English in their missionary schools, English was almost completely banned from homes. Children could speak and practice English as much as they wanted with their peers but when they returned home, they would revert back to speaking their native language. This distinction continues even until today, where Igbo’s speak English with other Nigerians but in the presence of only Igbo’s, instinctively speak almost solely Igbo. Igbo children who are raised outside of Igboland (but in Nigeria or close-by West African countries live a very similar lifestyle to those raised in Igboland in all aspects including diet, religious practices, relations, and language availability. An Igbo individual without a fully developed understanding of Igbo cultural values and beliefs, e.g. elder system of authority, is considered shameful. These children grow up with a similar, if not greater, desire to connect back with their culture. This is most visible in the relationship dynamics of the Igbo young and the elderly, and the constant transmission of wisdom and knowledge from those who are older to those who are younger, that has been the standard since the origins of the Igbo people. This system of an elder-run community was significantly demolished during colonialism. Decades later Igbos, in response to independence and a loss in the war, strived to retrieve any erased cultural values resulting in a tighter and stronger community. In summary, Igbo people have both the distinct ability to adapt as they see fit, but still try to maintain the core aspects of their culture within themselves.

Igbos in Togo³⁵

It is important to recognize that though this project occurs within the limits of Lomé, Togo, the data and conclusions it provides are not entirely exclusive to the Togolese community

³⁵ Uchenna Ogbonna, Interview July 15th, 2011

or even an immigrant community. The location was a matter of serendipity (and the generosity of Duke University) and the information can seemingly be applied to Igbo communities both native and in diaspora who are exposed to Western ideas. Unlike previously assumed, the data suggests that there are not specific differences in etiology of these diseases that changes based on length of time spent as an immigrant that cannot also be attributed to another cause such as age, or class. This is most likely a direct effect of the insularity of Igbo's in Togo and the similarity of culture between the two.

That being said, below is a short background of the Igbos in Togo. Living alongside native Ewes and Kabiyes³⁶, Igbo people are one of many groups that have established a significant settlement in Lomé, the capital and urban city center of Togo. Made possible and convenient through historical trade routes as well as by various economic sanctions specifically ECOWAS³⁷, Igbo people from Nigeria began to migrate to Togo beginning in the late 1960s. The greater part of Igbo people arrived in one of two distinct periods: the late-1960s to early-1970s during and after the Biafran war as well as the early 1990's. These two periods were marked by suffering in Nigeria, especially for Igbo people, with the devastating loss and poverty of the Biafran war and the political instability and deficiencies of a declining economy. Concurrently, Togo's economy began to grow and increasing periods of political stability took hold, creating a welcoming environment for entrepreneurs looking to prosper from the national growth. Many Igbo people living in Togo today participate in the Okrika or secondhand clothing

³⁶ Kabiyes are another ethnic group native to Togo

³⁷ Connects Ivory Coast, Ghana, Togo, Benin, Nigeria and Cameroon (listed from West to east) in a route that allows for movement in terms of trade and migration since before the arrival of Europeans.

market³⁸. Igbo people, even now, continue to emigrate out of Nigeria, heading to locations such as the United Kingdom, the United States, China, Ghana, and Togo.

Effects on Medical Understandings

Since the begin of colonialism, around the world, including Southeast Asia, sub- Saharan Africa and the Middle East, people of different cultures have adamantly fought changes that can irreversibly alter cultural identities. Sub-Saharan African societies, specifically, have been victims of aggressive Western indoctrination. Colonialism changed the entire face of societies that it touched. A domain in which these effects can be readily observed is in that of medicine. Western medicine (biomedicine) and indigenous medicine (culturally and socially specific medicinal practices) have been in contest for centuries.³⁹ Western biomedical knowledge has long challenged the ideas and medical understandings of non-Western societies. Each society has its own distinct reaction to these struggles, with many African societies taking an all or nothing approach. Some societies embraced the ideas and conceptions of the West, effectively sidelining indigenous values and ideals in the exchange. Other communities, in order to shield themselves from outside influences, refused all permeation of biomedical knowledge and continue to operate according to their native medical traditions though this is progressively rarer. Very few cultures

³⁸ The second hand market or *Okrika*, as it is known in Nigeria, was banned in order to protect the African textile industry. When used clothes are sold in Nigeria, typically from donations of charities in America who then sell it to vendors, they are sold at a fraction of the cost. This cost is too low to be challenged by domestic Nigerian clothing producers who are then forced to lay off individuals or close their doors. As a result the Nigerian government banned the selling of secondhand, and the market moved to nearby Togo who has no such laws against the industry.

³⁹ Isiugo-Abanihe, Uche C. "The Socio-Cultutral Context of High Fertility among Igbo Women" *Internatinal Sociaology* 9 (1994) DOI: 10.1177/026858094009002008

have been able to adapt some of the beliefs, habits and measures of foreigners as well as maintain the systems of their own culture in a collaborative fashion.⁴⁰

Igbo people have progressively blended the indigenous and Western medical perspectives to achieve a complex and detailed understanding of disease. This paper is concerned with the relationship between biomedical beliefs and cultural medical knowledge, examining the effect of the former on the latter. Scholar Azuka Dike says “where new structure is a combination of the traditional values and Western values...we have a case of adaptation of borrowed objects to traditional functions or a blending of the two.”⁴¹ Igbo people are able to adapt borrowed Western knowledge of biomedicine and weave these ideas with indigenous medical understandings to create a blend of two mindsets. This adaptation is well noticed in the etiology, or causation, of disease. Disease causation can be approached from multiple perspectives. In modern biomedicine, origins and cause of illness are typically physical and explicable through Western scientific principles, a major feature of medical diagnosis in modern health systems.⁴² In Igbo indigenous medicine, illnesses have a broader set of components and explanations that include physical as well as spiritual causations. In this paper, I distinguish the causation as physical or non-physical as well as biomedical or non-biomedical. Though this works for most causations, there are some which overlap and have more nuances that are explained in detail as they arise.

To understand the Igbo people’s capacity for adaptation and insularity, I will examine the following medical conditions and their causes as presented to me by the Igbo women in Togo. The first disease is diabetes, a disease that suggests the prevalence of Western understandings.

⁴⁰ Jamaine Abidogun, Western education’s Impact on Northern Igbo Gender Roles in Nsukka, Nigeria, *AfricaToday*, pg.31

⁴¹ Azuka A. Dike, *The Resilience of Igbo Culture: A Case Study of Awka Town*, Enugu. Fourth Dimension Publishers 1985, viii

⁴² (?)Falola. Toyin. and Heaton, Matthew. *Traditional and Modern Health systems in Nigeria*, (Trentony: Africa World Press, 2006) 1-86

The second disease is infertility, a disease that implies the pervasiveness of indigenous understandings. The third and last is high blood pressure, a particularly multifaceted disease that illustrates my point that Western and indigenous belief can peacefully coexist. Each of these three diseases are perceived with a different and distinct level of understanding in regards to causation and treatment with each illness possessing biological, psychological, sociological and cultural dimensions.⁴³ After colonial intervention and Western integration, the definitions and understandings of these diseases, particularly high blood pressure, transformed in interesting ways that suggest the coexistence of diverse ideas in a single space that may also define something distinctive to Igbo.

Why these diseases?

The diseases analyzed in this paper were derived from the women's opinions on illnesses they felt most affected Igboland.⁴⁴ Responses included but were not limited to high blood pressure, infertility/barrenness, diabetes, malaria, stomach flu, fever and stroke. The first four constituted the majority of answers, and seeing that three were non-communicable diseases, a territory often unexplored in sub-Saharan communities, I decided to focus primarily on those responses. Though there is limited research in each of these diseases pre-20th century, the minimal amount of research uses congruent societies and educated ethnological assumptions to conclude that diabetes⁴⁵, high blood pressure and infertility were present in Igboland pre-advent of Europeans, and not uniquely Western.

⁴³ Ibid., 85

⁴⁴ 'Sociologists recognize the differences of terminology between illness (subjective), disease (objective) and sickness (behavioral).' For the sake of simplification, these three terms will be used interchangeably for the duration for this paper. Ian Robertson (TITLE) *Sociology* Vol. 3 pp. 439. (FINISH)

⁴⁵ The diabetes under discussion is diabetes II, or adult-onset diabetes. Diabetes I and gestational diabetes do exist in Nigeria, but the majority of diabetes that has been identified in Nigeria is Diabetes II.

In Matrimony

As will become clear in the following chapters, I introduced these three disease and the positions they take using the metaphor of marriage. Marriage in Igbo culture consists of three distinct phases: introduction/dating, engagement/wedding, and life post facto.⁴⁶ Each phase of marriage can be equated to the three diseases that we will be discussing throughout the journey of this paper. Diabetes is equated with the introduction of couples while infertility goes hand in hand with the wedding component. High blood pressure concludes the story with a presentation compatible with life after marriage. Modern African Marriages are both new and embedded in longstanding social and cultural systems.⁴⁷ They have been impacted by Western ideals and religious intimidation. Igbo people reacted to these external pressures to different capacities for each stage of the marriage, creating a permanent hybrid that represent the Igbo culture malleability and durably. In this same power, Igbo people has altered or fiercely maintained beliefs about disease etiology, especially in regards to diabetes, infertility and high blood pressure.

⁴⁶ Dike, Azuka A. *The Resilience of Igbo Culture: A Case Study of Awka Town*. Enugu: Fourth Dimension Publishers, 1985, 141- 153

⁴⁷ Dike, Azuka A. *The Resilience of Igbo Culture: A Case Study of Awka Town*. Enugu: Fourth Dimension Publishers, 1985, 141- 153

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(Diabetes: Biomedical Breach)

He walked out of the boys' dormitory with his friend, Chigozie, both of them laughing hard. I ran to catch up with him, stopping a few steps before I reached them and changing my pace to a walk so it would seem that I just casually ran into them. "Good afternoon Nonso. Chigozie, Kedu (how are you)?" We walked together talking much about nothing until reaching the Law faculty, Nonso entered a building, and we all parted ways. That was a week before I finally got the courage to ask him out. Our first date was at Yori Cinema's and we saw G.I. Joe 2. I was so nervous the entire time, but this was his kind of movie so he seemed to enjoy it very much. After that we continued to date for about two more weeks until he then became my boyfriend. Beyond then it seems like time just flew past us. Nine months later he was getting ready to graduate while I still had two more years left until the end of my medical studies. After graduating he would be heading off to do his youth service⁴⁸, in which they can assign him to any city in Nigeria. The only stipulation that would allow him to stay here with me was marriage. The month before he graduated he proposed to me and, of course, I said yes, excited for the life that would now be ours together, me and the man I love. Who knew that the braniac village man⁴⁹ from Amofia⁵⁰ that I ran into just one day, would become the man that me, daughter of Eze Nibo⁵¹, would spend the rest of my life with.⁵²

⁴⁸ A one-year requirement of all college graduates to serve the country in a professional capacity, similar to an internship.

⁴⁹ In this case, village is used to denote a lower class from the eyes of an upper class urbanite.

⁵⁰ Famous village in Aba state

⁵¹ Eze Nibo is the most highly ranked individual of Nibo, a town in Anambra State,

⁵² This story is a fictional representative of common dating scenarios for young Igbo's. It can be regarded as a personal observation as a participant of the society

To begin, the dating scenario that was recounted above is reminiscent of a Hollywood romance, a prominent image of relationships in the West. Their ideas have become very representative of how many educated, as well as non-educated, Igbos have begun to approach relationships in recent history. These practices in dating directly contradict the rituals of courtship that were an important part of Igbo relationships. Traditionally in Igbo societies, a groom who is of age and ready to get married announces to his family and friends that he is in search of a wife, prompting these friends and family begin a search for potential mates. Over the next months, multiple options are provided for him. If he particularly likes any of the options, he chooses to begin the process of courting that girl. He is accompanied by his brothers and his father and/or uncle to pay the girl's home a visit and relay the message that they have come in search of the girl's hand in marriage. If the parents of the girl are impressed with the offer, then formal courtship begins, in which the families begin to learn more about each other and perform all the required rituals in hopes of becoming united. This was largely the way marriages were instituted in the past. Presently, instead of community based unions, Igbo people have begun to conceptualize marriage choices in more individualistic terms.⁵³ Scholar Winny Koster-Oyekan states "Traditionally, a marriage was a family affair. Nowadays a man and a woman choose their partners for marriage."⁵⁴ Free will in meeting and deciding one's partner, as illustrated in the chapter opening, has been introduced by Western beliefs and practices, revamping Igbo cultural methods. In a similar capacity, Western beliefs have almost entirely overhauled indigenous ideas in regards to diabetes and its etiology. Upon further analysis of diabetes causation, one can see

⁵³ Daniel Jordan Smith, Romance, Parenthood, and Gender in a Modern African Society, *Ethnology*, Vol. 40 no.2 p.130

⁵⁴ Korieh, Chima J. "African Ethnicity as Mirage? Historicizing the Essence of the Igbo in Africa and the Atlantic Diaspora" *Dialectical Anthropology* 30, (2006): 14

the biomedical mindset as the ruling majority, a mindset introduced to Igbo society through educated and wealthy Igbo people.

Diabetes mellitus, or diabetes, is a chronic metabolic disease characterized by hyperglycemia resulting from defective insulin secretion, insulin action or both.⁵⁵ In layman's terms, diabetes is a disease of increased blood sugar, upsetting the insulin/blood sugar balance crucial to the health of the body. Diabetes is universal, present in both first world and underdeveloped countries. Diabetes in various African countries was primarily explored by Western scholars and scientists in the early- twentieth century, though its incidence long predates that time.⁵⁶ Missionary to Uganda, Albert Cook, stated in one of his 1901 reports that "diabetes [in Africa] is rather uncommon and very fatal".⁵⁷ Similar reports and statements about diabetes around that time can be seen throughout the continent. Over the next fifty to sixty years, most scholars, including epidemiologists and public health officials continued to regard diabetes as rare in Sub-Saharan Africa.⁵⁸ Instead they focused on the sub-Saharan burden of HIV/AIDS and malaria, two of the highest killers in underdeveloped African countries.⁵⁹ It is only in the past few decades that research had been undertaken in sub-Saharan countries, having been that the already limited Africa health research was dominated by infectious disease, diseases that directly affected foreigners. Thoroughly analyzing the data, researchers discovered a significantly higher prevalence of diabetes than previously calculated in the communities of West and Eastern Africa. Some sub-Saharan countries came out with rates as high as six percent. Though this is

⁵⁵ Jean-Claude Mbanya and Kaushik Ramiya, *Diabetes Mellitus*, ed. Dean T. Jamison et al (Washington: The International Bank for Reconstruction and Development, 2006) 270

⁵⁶ Obiagwu, Chukwuma J. *Adventures of Ojamba; the chronicles of Igbo people*. Hamilton books. Lanham. 2008.

⁵⁷ Jean-Claude Mbanya and Kaushik Ramiya, *Diabetes Mellitus*, ed. Dean T. Jamison et al (Washington: The International Bank for Reconstruction and Development, 2006) 267

⁵⁸ *Ibid.*, 267

⁵⁹ Fitness & Wellness Buisness Week, Diabetes; Africa's Silent epidemic, News Rx Atlanta 2011

incomparable to Western counterparts (The United States has a staggering twenty-six percent diabetes rate). These new values most likely indicate the prolonged presence of diabetes in many of these communities, negating the results of previous studies. Nigeria, in particular, averages about a 3.1% diabetes prevalence rate.⁶⁰ Though there is no research that has identified what percent of that number constitute Igbos we can safely assume that they are somewhat implicated in that number. It has been predicted that by 2020, non-communicable disease including hypertension and diabetes will outstrip communicable diseases as a cause of death.⁶¹ Scholars estimate that the increase in diabetes is and will be due to demographic changes, a greater divide between the upper- and lower-classes, increasing urbanization and associated changes in risk factor levels.⁶² This migration from rural to urban living is inevitably associated with a lifestyle shift. Many Igbo people who were previously living in relatively healthy village lifestyles with limited access to foreign products and ideas are now shifting to an urban scenario that consists of increased food quantities and reduced food quality, low levels of exercise (highly unlike the intense activity level necessary for village life), as well as increased tobacco and alcohol availability.⁶³ Prevalence and severity of diabetes is higher in cities as a result of an association between urbanization and effects of westernization (e.g. increased life span, reduction in infectious disease, etc).⁶⁴ The importance of understanding non-communicable diseases can hardly be stressed enough and it will take a reevaluation of the Western biomedical theory to completely understand diseases, such as diabetes, in this foreign context.

⁶⁰ G.V. Gill et al., A sub-Saharan African perspective of diabetes, *Diabetologia* 52, (2009) 10

⁶¹ Abubakari, A. R. and Bhopal, R.S. "Systematic review on the prevalence of diabetes, overweight/obesity and physical inactivity in Ghanaians and Nigerians" *Journal of the Royal Institute of Public Health* 122, (2008): 173-182

⁶² Jean-Claude Mbanya and Kaushik Ramaiya, *Diabetes Mellitus*, ed. Dean T. Jamison et al (Washington: The International Bank for Reconstruction and Development, 2006) 267

⁶³ G.V. Gill et al., A sub-Saharan African perspective of diabetes, *Diabetologia* 52, (2009) 8

⁶⁴ Jean-Claude Mbanya and Kaushik Ramaiya, *Diabetes Mellitus*, ed. Dean T. Jamison et al (Washington: The International Bank for Reconstruction and Development, 2006) 272

Diabetes is a problem for Igbo people, a disease that has been present for many years but only recently studied in this population. To the Igbo person, diabetes is known as *onyia mma milli* (*urine disease*) or literally, water-retention sickness. This disease was often recognized by the gathering of ants around the affected individual's urine, a sign that there was an excess of sugar that went unprocessed by the kidney due to an uneven amount of insulin in one's system. Other indigenous symptomology included blindness and increasing body weight. All these signs align with biomedicine in its description of diabetes confirming the presence of diabetes before the advent of Europeans and Western culture.⁶⁵

For decades, Western scholars argued that foreign ideology permeation into indigenous cultures through education has been a source of great health improvement in those communities. Physician and public health scholar Geoffrey Gill notes that "the education- health relationship is well documented", implying that it is a well-supported theory that higher levels of 'Western introduced' education equals progressively changing attitudes about disease.⁶⁶ It seems that for diabetes in the Igbo community, these presumptions hold true. Ideology surrounding diabetes has definitely taken a Western bend, distanced from indigenous understandings. Those who are university-educated appear to be the point of origination of these ideas that are Western and biomedical in nature. Overall, beliefs concerning causation of diabetes in the Igbo community demonstrate the domination of biomedical ideology over indigenous medical understandings. Among the three categories of age, wealth and education, the most interesting differences and/or similarities are visible when looking at the effects of class (wealth and education) on the

⁶⁵ Diabetics are at increased risk for diabetic retinopathy, the disintegration of one's retina. - Uncontrolled chronic hyperglycemia results in long-term damage, particular dysfunction, and failure of the eyes, blood vessels, nerves and kidneys. -- Hult, Matrin et al. "Hypertension, Diabetes and Overweight: Looming Legacies of Biafran Famine' *PLoS One* 5, no. 2 (2010) DOI: 10.1371/journal.pone.0013582

⁶⁶ G.V. Gill et al., A sub-Saharan African perspective of diabetes, *Diabetologia* 52, (2009) 8

individual's response to my interview questions. Beliefs about diabetes have been shaped by those with increased wealth and higher levels of education. Knowledge as related to diabetes is passed down through a system of class, with those who are able to obtain a higher level of education dominating the ideology about the causation of diabetes.

The causes that were most common among the women's responses seem to have a biomedical aspect in common. This conclusion is directly observed from the interviews of the women, a few of which are written below. They then go on to share their knowledge with those of lesser education or lesser wealth through peer-based interactions at school, work, church, and so on.

Illustrating a dominant belief among the Igbo women were Mrs. Chika Adanna and Lolo⁶⁷ Ifechi Ugochukwu. These two women are members of the church I attended during my stay in Togo, an international church with many immigrant Nigerians. Lolo Ugochukwu lived approximately four minutes from the church in a three story building that housed her husband and two daughters, her brother-in-law's family, two maids and one houseboy. It did not take much understanding for me to realize that this was a wealthy family, who had exemplified upper class living and experiences throughout their lives. The interview, conducted in their home, took a form of a dialogue between the two women. Together they elucidated a biomedical physical causation of diabetes, dietary habits.

Me: Why do you think diabetes is so rampant?

⁶⁷ Lolo is a prefix (similar to Mrs.) that is given to wives of chiefs

Lolo Ugochukwu: On the subject of diabetes, they eat much carbohydrates. *Gari*. *Akpu*⁶⁸. *Yam*. All those things contain sugar. That is why we have much diabetes now, if I may say so.

Mrs. Chika Adanna: Let me ask you a question (she says to Lolo) didn't they used to eat *akpu* and *gari* back then?

Lolo Ugochukwu: No, we ate much leaves and fruits. You know now, Africans believe that if they eat until full, after they eat their *gari*, they won't saw lets use fruit to digest the thing, but instead after eating that *gari* that contains sugar, you will see one person, that will take coke, that big one, saying he wants to be completely full. He doesn't care to know the contents, what he believes is to eat until fullness. Maybe even in that food, he will look for another carbohydrate. The soup that it is eaten with, there is no quality, at least to counteract the sugar. They don't want anything to eat that is light, doesn't fit with philosophy of being full. Especially those in the village...and also it is in the blood.⁶⁹

In their response, these women address most of the commonly accepted causes of diabetes in the Igbo community. To begin with, they attack the issue of diet and dietary habits. Excessive intake of carbohydrates, which breaks down in the body as sugar is a leading cause of diabetes. This understanding is a product of Western education. Biomedicine dictates that diabetes results from a glucose (sugar) and insulin imbalance in which an excess of sugar creates a problem for processing of insulin. Lolo Ugochukwu identifies the problematic sources of the carbohydrates

⁶⁸ *Gari* and *Akpu* are different versions of dried cassava, with a mostly carbohydrate make up, approximately 78g per 1 cup of flour.

⁶⁹ IW. Personal Interview, 1st February, 2011.

that include standard Igbo meal components, *Gari, Akpu and Yam*⁷⁰. These starches, along with rice, are the main components of over seventy percent of Igbo meals. In reply to Lolo Ugochukwu, Mrs. Adanna, as a vernacular scientist, sought to determine why if diabetes was so simply caused was it not as prevalent during the time of their ancestors. The question she posed attempted to separate *ndi mbu* (our forefathers) from Igbos of today. Alternatively put, Mrs. Adanna was challenging Lolo Ugochukwu to differentiate indigenous pre-colonial and colonial Igbos from current-day Igbos whom have been influenced by outside cultures and societies. Lolo Ugochukwu's answer to that challenge was apt; Igbo people, as farmers, ate an increased amount of leaves and fruits and had different practices of eating that were less gluttonous. During their interview, I suspected that these women had a high level of education. This was confirmed when they revealed they had both done there 1st level (undergrad) or masters at prominent universities in Europe. The analysis above by Lolo Ugochukwu and Mrs. Adanna match that which has permeated indigenous medical beliefs about causation, which will be expanded on later, and replaced them. The ideas of diet as the cause of diabetes is so well adapted that many responders replied with a response of sugar though they were unable to thoroughly expand on the biomedicine behind the sugar or address connecting dietary habits. Many of these women who were less wealthy and/or less educated continued to regulate the known biomedical response without a complete or through understanding.

Mrs. Nneka Okeke, one of the few Anambra State Igbos who I interviewed,⁷¹ expanded on the issues presented above. Mrs. Okeke's interview was likewise done at the market, during one of my market interview days. Mrs. Okeke was very well spoken, in both English and Igbo

⁷⁰ Yam, as an Igbo crop, is quintessential in Igbo cuisine, used along with its derivatives in many dishes especially during harvest seasons.

⁷¹ Most women were from Abia State. I, like Ms. Okeke, am from Anambra, and during our conversation discovered we were from the same hometown, though she has been in Togo since before I was born.

continuously switching between the two as is done by many learned Igbo people. When I asked about her business, a manner of ascertaining her class or wealth, she regrettably informed me that business is not working out for her here at all and that she was considering returning to her parents' home in Nigeria. When asked about diabetes this was her response:

Diabetes is a result of bad habits. If you take too much carbohydrate, too much sugar, like overripe banana and tea that's too sugary every day, you can get it. If you do things like smoke or intake drugs, you can get it. You need to stop doing all those things, and it won't be too bad for you.

Being educated but not wealthy, Ms. Okeke still provided a biomedical physical response citing poor habits as a cause for diabetes. She mentions poor diet that includes an excess of sugar or sugary substances, as well as an excess of tobacco (and other drugs) as separate causes which when accounted for together create the conditions for inviting diabetes. In addition to the responses above, several other women also included exercise or the lack of it as another disease-forming habit, encouraging women to exercise more, like was done in the past. By addressing lifestyle, she presents a holistic biomedical view of diabetes etiology. Ms. Okeke's opinion supports that many Igbos have adopted a biomedical set of understandings in regards to the causation of diabetes, and as hinted by Ms. Okeke, Igbos have knowledge of preventative measures against diabetes as well.

In the biomedical definitions of diabetes, there is another cause that controls its significant share of disease etiology, one that was addressed briefly by Lolo Ugochukwu. This idea is that of heredity. This brings us to Mrs. Ifeoma Obidiegwu. Mrs. Obidiegwu, a mother of three is a graduate of University of Lagos, one of the best universities in Nigeria. She lives in a modest home, close by to that of my host family. She was a stay-at-home mother, while her

husband ran a business. When asked about her background, she explained that she was not a product of wealth. Growing up in the village, Mrs. Obediegwu was blessed with school smarts so when given the opportunity, she excelled in all her courses, providing her with the skills to seek a sponsor. With the sponsor's help she finished secondary school, and university with a degree in English literature. Mrs. Obidiegwu was one of many respondents who addressed the issue of heredity in the etiology of disease. She said "For some people, it's heritage, right from the family." She went on to explain that in her younger sister's husbands family, they had a history of diabetes, and that it had been the killer of many of the men in her family since the time of her great grandfather. Her biomedical response that involved a physical causation is a product of a combination of being surrounded by those of an educated class and possessing a university education, but also simply from being around others of the upper-classes too. Etiology of diabetes as a disease is now viewed from a biomedical physical perspective by westerners and Igbos alike. Igbos now understand diabetes as caused by diet and poor nutritional habits instead of solely stress or divine intervention. This transition of indigenous beliefs makes commentary of Igbo culture and its high level of adaptability. Igbo history, with its marginalization and struggle has created this need to succeed in spite of societal conditions. As a result there has been an increased amount of Igbo men and women who complete a university education whether in Nigeria or abroad, in order to be better placed for life success. During this period of education, many of them were rooted in Western ideas, cross disciplines, ideas that sometimes replace comparative beliefs from Igbo culture, with biomedical etiology of diabetes.

The above examples demonstrated that the majority of medical understandings surrounding diabetes among Igbo people are based on introduced biomedical definitions that were transmitted through education. Though this is likely true for most Igbos there are

exceptions in understandings that both support and refute that hypothesis. Some of these contrasts are due to incomplete penetration of Western biomedical concepts while others can be seen as simply exception to culture which is present in many societies. Below are some of these contrasting opinions to introduce the role of indigenous medical beliefs.

Our first story comes from Mrs. Chioma Ibekwe. Mrs. Ibekwe proposes an interesting contradiction in that her story seems to oppose the illustrations above. Mrs. Ibekwe presented an interesting and complicated interview. I held Mrs. Ibekwe's interview in her home, close to the *Adidogome* neighborhood. Her community consisted of several floor homes, or incredibly large one floor houses. Each of these houses gathered up its own share of land leaving lots of space in between them. Any visitor could clearly see that this neighborhood was inhabited by upper-class individuals. I entered her home, exquisitely decorated with European art, and I was impressed by the state of the house. Mrs. Ibekwe answered the door in her pajamas, and led me to the living room to conduct the interview. It is important to note that this was not the only well-decorated home that I had been to, already having been to this neighborhood for other interviews, but Mrs. Ibekwe's response stood out from those of her peers from this area. Mrs. Ibekwe seemed to lack information about many of the questions I asked her. I then decided to only ask her questions on diseases that she told me of, in order to limit her mounting embarrassment at her inability to answer my questions. When it came to diabetes her response demonstrated an indigenous understanding with a non-biomedical non-physical causation.

I would say overthinking. Maybe you have problem that is overburdening, and you don't know how to handle it. For example, let me take my family. I was two years old when my father died. Due to no one looking in after me, and no one helping my mother out, the burden was too much. She didn't know what to do.

What do you do with seven children? No one came to help the family or children. As a result, some of us children got sick. At that time due to what she was thinking, she started to get sick all the time and developed diabetes and hypertension. So her thinking a lot, her heavy burdens caused the diabetes.⁷²

Mrs. Ibekwe, being seemingly rich and well educated, gave an answer that would have been appropriate for those with minimal education or whom have been secluded from urban information transfer over the past decades. Confused I consulted the contact who had introduced us to find out why her answers were so distant from the trend. He told me that she married her husband only a year and a half ago and he moved her out here. Before that she was a village woman.⁷³ As is done by some successful Igbo men in diaspora, when it is time for them to get married they go choose a village girl, who is not out for their money nor smarter than they are, to be their wife and the mother of their children. In Mrs. Ibekwe's case, though it may seem from her surroundings that she was part of the wealthy and university educated who had a certain perception, she was in reality part of the poor and consequently had a differing set of responses, for questions relating to diabetes.

Though diabetes etiology among most of the women I spoke with tended to be of Western biomedical origin, there are some individuals, most of whom are far removed from the propagators of Western biomedical information as well as a few who are near, that still hold an indigenous set of medical beliefs surrounding diabetes. One such example is Mrs. Nkieruka Udabah. Mrs. Udabah's name and credentials preceded her. As the managing director at Herzirananaway market, she was the Madame in charge of many of my respondents. To many Lomé merchants, she is the individual who controls whether or not you had a stall, in essence

⁷² VN80046, July 8th 2011

⁷³ My use of village refers to no particular village but the instead implies that someone has village tendencies because they most likely only finished primary school.

whether you earned a living, making her a very powerful woman in the Igbo community. I only had the opportunity to make her acquaintance through one of my contacts with whom she was on intimate terms with because he was in the process of courting her daughter. Due to Mrs. Udabah's high level of education and her worldliness, I assumed that I would be able to predict some of her responses, but I was surprised when she responded in this manner:

Diabetes is one of those things. It is hard to describe but it can be dangerous. I know some people who had it and are now with their dead family. This diabetes can be caused by stress that happens when someone curses you. They are cursing you because you succeeded but then you start to have a very hard life, and pray to the Lord that justice be seen. They are jealous. They just want to see you fail.⁷⁴

Mrs. Udabah's response that diabetes is caused by a curse that inflicts stress classifies as a non-biomedical physical attribution to the cause of diabetes. Someone's distaste for your livelihood results in you acquiring diabetes. This outlier can be an example of the system of medical understanding prior to Western influence, but its rareness demonstrates the magnitude of influence that foreign medicine has had in the Igbo system.

On my way out of church one Sunday, I collided with an open faced olive oil, avocado and onion sandwich. My dress became saturated with the sandwich toppings and I was very upset. The young boy at fault, stood in front of me speechless, scared and sad. His mother, traveling right behind him, came up to me and attempted to help me clean the dress, offering that I come home with them to eat lunch so she can help me wash off the stain and return everything back to new. The mother, Mrs. Adaora Chukwurah, ended up being a close family friend of one of my contacts, Uchenna and together he and I joined her for lunch at her home. Her house was a

⁷⁴ VN80323, June 23 2011

modest one bedroom home that housed herself, her husband and her three children. After lunch, I was presented with the opportunity to continue my research, and interviewed her as she cleaned up her kitchen outdoors while the men sat inside talking. It was clear from her living situation that their family had little money while her grasp on the English language suggested that she had minimal secondary school training. On the subject of diabetes, she provided a summarizing biomedical response with physical components:

For some people [diabetes] comes from family, heritage. For others, it can depend on the foods that they take. All the starchy foods like yam and gari can develop the problem because we take them too much. Instead of rice, in the morning, *akpu* in the afternoon and *gari* in the night, which is unadvisable, you try and eat our other foods that are healthy like beans.⁷⁵

Mrs. Chukwurah presents a well-rounded perspective to the responses. Not only did she point out the negative foods that can contribute to diabetes, she suggested healthier alternatives. Her background is very different from those who seem to be the disseminators of the information, but her opinions seem to perfectly align. Mrs. Chukwurah is neither wealthy nor university educated, but instead unemployed, living in a small home with a large family. Even though that is the case, her biomedical physical response addresses diet, heritage and habits. She touches on most of the etiology frequently cited by physicians in biomedicine.⁷⁶ To further understand the connections between knowledge, beliefs and background, I asked her where she learned this information. She replied that she wasn't quite sure, but believed that she had picked it up over the years, from her friends. It is more than likely that these friends or their friends were members of the higher class with the university education in which the knowledge was passed along. The presence of this

⁷⁵ VN800023 – Spoken in Igbo, translated to English.

⁷⁶ Excluding lack of exercise

information in Mrs. Chukwurah as well as others like her highlights the transmission of information and the true lengths in which Western biomedical information has traveled.

In conclusion, it seems that diabetes presents a case in which Western biomedical understandings have toppled indigenous medical understandings of disease. Diabetes is no longer understood as a disease caused by relational misunderstandings or divine consequences, but the ramification of poor dietary choices, especially pertaining to sugar intake, as well as to the effects of heredity. Though these foreign ideas began in wealthy and/or educated individuals who were exposed to Western culture, it has rippled through the community to at least become the dominant way in which the disease is understood.

Trying to comprehend the mindset of etiology for diabetes results in a twofold benefit including a deeper understanding of diabetes. Medical anthropologist Linda Hunt recognizes that “significant differences exist between patient and provider perspectives, reflecting their different educational, ethnic and socioeconomic backgrounds.”⁷⁷ One is a deeper understanding about how similar diseases are processed, the other being more efficient methods that can be used to reduce the potential impact and growth of this illness. Dealing with illness needs a realization of source and a connection of source to treatment. A biomedical understanding of source leans better towards a biomedical basis for cure and prevention. If Igbo people understand diabetes to be caused by dietary choices, then campaigns for culturally applicable dietary alterations will prove most effective. Nutritional alternatives for the key foods at hand or decreased proportion sizes will also be valuable solutions. It is also interesting to note that though the prevalence of diabetes increases with age, knowledge of diabetes, unlike infertility (detailed in the next chapter) is not directly tied to age but instead to class. Knowing that the information directly

⁷⁷ Linda M. Hunt and Nedal H. Arar, "An Analytical Framework for Contrasting Patient and Provider Views of the Process of Chronic Disease Management," *Medical Anthropology Quarterly*, New Series, 15, No.3 (2001): 348

related to diabetes transmits from the wealthy to the poor, the university-educated to the non-university-educated, it would presumably be effective to transmit cure or prevention information in that same manner. This can even decrease the amount of health expenditures⁷⁸, eliminating extraneous health initiatives and focusing on those that are more likely to be efficacious.

⁷⁸ Jean-Claude Mbanya and Kaushik Ramiya, *Diabetes Mellitus*, ed. Dean T. Jamison et al (Washington: The International Bank for Reconstruction and Development, 2006) p.281

2

(Infertility : Indigenously Indoctrination)

2

It's finally time. You walk out for the second time into the crowd of family and friends sitting outside. With your ashoebi in a line behind you, you dance out into the crowd in search of the specific table. You find the oldest man, who is surrounded by other elders, and important men and women in the society. Having approached the table you kneel down. They ask you if you understand what you are getting yourself into and when you reply yes, they ask you to rise and search for the man that you want to make the commitment with you. Your fiancé is sitting among his friends somewhere in the crowd and you make a big show of searching for him. When you spot him, you let them know exactly which one you have in mind with some elaborate and specific description. An elderly woman in your family, usually a grandmother or oldest aunt, then brings him to you and ascertains if this is who you are referring to. When you say yes, all the elders come together and pray over both of you, as you both kneel down in front of the community. They pray that your marriage is blessed with love, wisdom and fruit. They ask you and him to swear to forever as is the custom for Igbos. When you stand up from that prayer, you are at that point, a wife, your husband's wife. Congratulations and excitement commence as well as a certainty that this matrimony has been approved and blessed by the elders of the society and will therefore be successful.

The *igba nkwu* (traditional marriage) ceremony above captures the fundamental idea of a marriage as a family process rather than an agreement between two individuals. The blessings of the elders along with their advice and celebration make an Igbo wedding a quintessential part of culture and life. The rites, rituals, attitudes, and beliefs of Igbo culture are held by the aged and respected by the youth, who will mature and take their position as the philosophers in society and the teachers of children. The centrality of seniority in Igbo weddings is also revealed in beliefs surrounding the etiology of infertility. These beliefs are propagated down from elders to the youth, symbolizing a difference in age and life experience and representing indigenous medical understandings. Seniority has long since provided the basis for information transmission. This is true for many of Igbo cultural values and practices including medical knowledge.

Infertility, or the failure to achieve a successful pregnancy after two years of non-protected regular intercourse, is a pressing issue in the Igbo community both locally and in the diaspora. Infertility, specifically the etiology of the disease, demonstrates the Igbo cultural perseverance in the rivalry between indigenous and biomedical understandings of health. Igboland is a society in flux, but it has strong cultural traditions which have survived hundreds of years even with Western influence and structural changes. The way in which Igbo people understand infertility causation follows an Igbo baseline of knowledge, a framework in which wisdom, including that surrounding disease is passed down to youth through a system organized through age and seniority, e.g. parents to children, elders to youth. This pattern of learning contrasts with what we saw in the previous chapter on diabetes, and the domination of biomedical interpretations. Instead of knowledge facilitated by Western education and wealth, as is the case of diabetes, infertility follows a more indigenous trajectory that aligns with Igbo

methodology, learning by living. Examining how Igbo women see infertility prepares us to comprehend their views on high blood pressure, a disease that instead of highlighting either the Western or indigenous components demonstrates a blending of the two dimensions, a unity between indigenous and biomedical understandings.

Ethnologist Frank Van Balen suggests that, “African men and women use a number of different models to interpret and explain fertility problems. Social, spiritual and relational disruptions, in addition to physical ones are cited as causes.” These models apply to Igbo men and women, though some of these causes are notably more attributed than others for infertility in Igboland. Unlike the previously analyzed differences in the etiology of diabetes that can be traced through class, the etiology of infertility is best understood by examining age and experience. Though scholars frequently associate increases in overall knowledge with higher levels of Western education, infertility in Igboland suggests instead that etiological knowledge related to infertility is correlated with experience. Those who are elders of the community are better versed in the cultural understandings of the disease. They form the beginning of a factory line, passing on information to the youth who as they mature do the same for subsequent generations by use of stories and dialogues. This is evidenced by the relevant differences in opinions only visible among different age groups and insignificant across varying levels of Western education. Most interviewees, having reached the stages of life where they have already acquired this information relayed non-biomedical responses when questioned. There were a few exceptions, all which correlated with very young women.

Though the study of infertility in sub-Saharan African countries by Western scientists and scholars only began in the past few decades, the inability to have children for African men and women, including the Igbo people, is not a recent occurrence. From the beginnings of European

inhabitation in sub-Saharan Africa, infertility as a public health problem was seldom addressed. It is only in the 1970's that studies reveal that infertility was a problem throughout the colonial period. In the global scope, the countries of sub-Saharan Africa were seen as places of "hyperfertility." Women in this area had a higher birth rate and a larger number of children per woman as compared to European women. This perceived high fertility during the 19th century was beneficial to Europeans because it produced more viable subjects to be exported and sold. Scholar Lori Leonard writes that all attempts to make "head counts" during the colonial period produced data that was "irregular and unreliable as to be virtually unusable". Population growth counts that could have possibly demonstrated increasing infertility were not a priority for westerners. Meanwhile, the local Africans were aware of infertility in their communities and its short and long term consequences of social separation and lineage. Population and fertility have long been public concerns in African states, including pre-colonial, colonial and post colonial polities. Regardless of African concerns, infertility as a community problem continued to remain invisible to the Western eye. In Nigeria, the difficulty of conceiving of infertility as a public health concern was made more challenging by the fluctuation in the population due to death and migration that occurred during the time of Nigerian Independence (1960s) and after the Biafran war (1970s). It is only in the past half century that Western scientific and biomedical research has taken a noticeable interest in sub-Saharan reproductive issues, beginning with the discovery of the 'infertility belt' in central Africa (1995), which led to a realization that the social context of reproduction in Africa is different and much more complex than previously understood. This is true because the importance of children and family in many African communities is of a greater weight than in Western societies, where there might be other options to childbirth or a high number of children. Infertility rates in West African societies are lower than those in central

Africa but certainly not nonexistent. As so, problems of infertility have the potential to create tensions and disarray in these societies when coupled with the central cultural importance of children as a means of likelihood of survival of the culture.

As Lori Leonard highlighted, “standard Western definitions of infertility are cultural constructions that may not be applicable in non-Western settings, where women's self defined fertility problems are of much greater scope that standard definitions of infertility would suggest.’ In other words, Western definitions do not take into account the cultural and economic significance of family and children of many African communities, For example, women who are unable to bear their second, third and/or fourth child accurately identifies herself as infertile. As a result standard demographic studies of infertility in Africa [including Igboland] regularly miss many instances of indigenously defined problematic fertility in the lives of African women. Infertility is principally a significant issue for Igbo people because it is directly connected to the core of Igbo culture and philosophy. Children in the Igbo community are both a cultural and economic legacy, the vehicle through which knowledge and property are transferred through generations. Scholar Uche Isugo-Abanihe concludes that Igbo’s have a historically high rate of fertility “due to a strong adherence to cultural beliefs and norms which view children as the source of preserving and extending the lineage and which bestows a sense of fulfillment and esteem on parents of a large family.” Consequently, a daughter’s reproductive impairment can destroy the status and even future prosperity of the entire kin group. To demonstrate the importance of fertility in the community, one of my interviewees provided me with a portion of Igbo history that was likely told to her by her elders in story when she was young. According to Mrs. Ifegbuna, in the past, Igbo women strove to birth nine children. If they reached this mark, the community would *goli ya ofo* or celebrate the woman’s accomplishments through song, food

and festivities. Many Igbo girls grow up recognizing that their ultimate purpose was to become a mother; and at the same time, men learned a similar idea about fatherhood. From this perspective, children are a celebrated blessing in almost any context and the inability to conceive denies the couple the chance at a complete participation in Igbo culture.

To further understand the etiological philosophies of Igbo women in regards to infertility, it is best to refer to their personal stories. In Lomé, two-thirds of the women that I interviewed mentioned infertility or barrenness as a significant issues facing Igbos. Below are the different perspectives I encountered. The first few stories that reveal a non-biomedical response represent the majority of the responses while the last few stories that evoke biomedical reasoning, represent only a small minority. Most beliefs regarding infertility can be categorized as non-biomedical non-physical, save for a few exceptions, and these beliefs are transmitted through experience as indicated above.

To understand one of the reigning opinions of the women I interviewed, I looked to Mrs. Chibueze Onyilofor. A fifty-year old mother of five, Mrs. Onyilofor and her husband moved to Togo about ten years ago, immediately after the birth of her last child. I interviewed her at her home, a welcome deviation from the bustling and loud market interviews that I had been conducting at mid-day. Her children had just left for bible study and her husband was away on business, leaving her with the house to herself and providing the circumstances for a longer, more in-depth interview. At the beginning of the interview I attempted to determine what illnesses she deemed particularly afflicted the Igbos. Her responses were barrenness, or the inability to bear children, stroke and high blood pressure. Addressing her primary disease I pointed out to her that she had her fair share of children whom I assume to be a handful, and that there were many children playing out in the yard, at least ten in a compound of only three

families. She said that though she was blessed with children, many people are not as lucky, specifically her husband's sister (who only has two children), her friend from church (who has yet to conceive, but is married) and her aunt on her husband's side (whose childbearing years had ended without bearing any children). When I asked her what she believes causes this problem she explained to me a relational causation of infertility:

Women have problems *itu ime* [getting pregnant] because they probably did something wrong in their past, whether they know it or not. If they angered someone, that person could be taking it out on them by going to *dibia* [or native doctor] and placing a curse on them. If they cursed someone before, this could be "*ife onye metelu*" ['what one has done or 'karma']. Maybe she wasn't truthful to her husband when she got married and had been sleeping around so now she has a problem that she cannot take away. *Ajommadu* [or bad person] always have problems later in their life.

Mrs. Onyiofor's etiological beliefs for infertility fall squarely under what I have cataloged as non-biomedical non-physical. The first issue she addresses is the wrongdoings of the infertile woman. She does not indicate specific sinful or unlawful acts but instead alludes to an umbrella of wrong choices. This response is very commonly seen by scholars who report that infertility is often attributed to immoral behavior or activities that anger ancestors, the deities or others in the community. Mrs. Onyiofor also addresses the figure of *dibia* or 'native doctor'. With the capability to inflict non-physical harm on others, individuals use *dibia* to cast curses on those who have done them wrong, curses that most often involve no physical contact with the individual in question. She ends her description condemning the decisions that bad people make at the source of all their travails. She introduces a system of internal justice for external mistakes,

as a source of illness, a concept known to many westerners as karma. This idea of karma is frequently used in Igbo culture as illustrated by the common Igbo proverb “*onye ogo nne mmadu na eme ka agowa nne ya.*” This proverb translates as, ‘he who curses another’s mother is inviting his own mother to be cursed.’ That proverb supports Mrs. Onyiliofor belief in a universal justice system, but also introduces mothers as a recipient for that justice. Having heard these indigenous beliefs, I wanted to figure out how she arrived at internal justice as a source of illness causation, hoping it would lead me to some sort of connection among different groups of women like I observed in diabetes. I asked her how she knew what she told me, to which she chuckled and responded that she was not really sure that “it was just something you know as you grow up.” Mrs. Onyiliofor is referring to the Igbo pattern of knowledge propagation from elder to youth which can come from parents, aunts and uncles, to children, nieces and nephews. I began to realize that for infertility, class does not explain variations in people’s responses.

The other majority opinion can best be understood in an interaction between two women. At Herzdiranaway, or the “Igbo market” as local Ewe’s refer to it, I stopped at a hair braiding stall in order to get my toenails painted. I chose my nail polish color then decided that this would be as good a time as any to gather more information for my research. There was only one other customer at this outdoor stall and she was getting Bob Marley braids from a woman I took to be the stall owner. I introduced myself and described my purpose in hopes of gaining permission to use their contributions as part of my project. The hair braider, twenty-eight year old Nkechi Umeh, was eager to participate while the customer whose name I never obtained took some time to warm up to the conversation. Soon enough, they both were answering questions I posed as well as many that I did not ask as they delved into a conversation between themselves.

Uche: What do you both think about women who have infertility problems?

What causes them these problems?

Mrs. Umeh: It is God who blesses women to have children.

Customer: Yes, many women think that because they are not having children right after they got married that there is a problem. One will have a child when God says it is time. Sometimes that time never happens for some women and they accept that God has other plans for them.

Mrs. Umeh: Exactly. Me myself, I thought I was never going to have children. I have been married to my husband for almost seven years and we only just now got pregnant. God decided it was my time.

(This is the first time that she is announcing her pregnancy to the customer and the customer, in utter surprise jumps up and asks her if it's certain. When Mrs. Umeh confirms that is three months pregnant, the client rejoices and walks around the store with her hands raised singing *Chineke idi nma, idi nma, Chinke idi nma, idi nma* or 'Lord you are good, you're good.')

These women identify infertility as a divine decision, vocalizing a non-biomedical non-physical causation. It is God's "grace and mercy" that affords couples the opportunity to bear children and create a family. This etiology arises from a powerful faith in a God displayed by many Igbos. Some might argue that believing in the Christian God as a source of illness is not inherently representative of Igbo culture because Christianity was introduced to the Igbos by colonization and is not their native religion, but rather a Western set of beliefs. Though it is true that Christianity was introduced to the Igbos in the 17th century by various European missionaries, it is false to assert the presence of those missionaries and the introduction of Christianity marks the

beginning of a belief in a higher power. The Igbo people have long been religious making it easier for them to adopt Christianity and make it one of the bedrocks of Igbo culture. Prior to Christianity, Igbo people worshipped *Chi* also known as *Chineke* and sometimes *Chukwu*. Each of these names represents the almighty presence that governed all of life. Beneath Chi, they also worshipped Ani (mother earth), and in some cases juju-gods. This belief in a higher God exemplifies a strongly held faith characteristic of Igbos. This higher God offers justice, and this justice for sins committed sometimes takes the form of illness, or infertility in this case.

Religious beliefs like the spiritual beliefs in the interview above are transmitted through families and communities rather than through formal educational institutions. Individual beliefs strengthen as they are increasingly exposed to these ideas of a higher power, making elderly individuals more informed than youth who are still finding their place in society. These beliefs are passed down through reflective stories, everyday proverbs and constant observation between the elderly and the youth. To confirm that claim I asked Mrs. Umeh how she learned these ideas to which she, like many other respondents answered “my mother taught her most things she knows, including how to raise children as well as understand and treat sickness”, a protocol that she planned to continue for her daughters.

The next example discusses stress and its connections to infertility, the third and final majority response for infertility causation. I will more fully discuss stress, and its various meanings and implications in the following high blood pressure chapter, but I want to introduce it here as it applies to infertility.

A third non-biomedical non-physical causation was presented by Mrs. Ijele Ogojiaku. Mrs. Ogojiaku was a close family friend of Uche Ogbonna, one of my contacts and close friends while in Togo. When Uchenna and I arrived at her home one evening several members of the

family rushed to greet me, excited to finally see the bride-to-be of their close friend. They seemed pleased with Uchenna's bridal choice with Mrs. Ogojiaku's adding "Eh heh, no be pikin. Ready for many young ones". Alas, when they were told that I was not the girl they were waiting for but just an American friend doing research, they were disappointed (as was I, having gotten caught up in the happy emotions). After a few minutes, things calmed down and we able to begin our interview.

Uche: You said earlier that barrenness is something that Igbo women struggle with. What do you think causes this? Why can't they have children?

Mrs. Ogojiaku: There are many things that can cause this problem. A lot of the time it can be *agwu isi* (worry/stress) regarding a pregnancy itself that causes one to be unable to bear children.

Uche: Can you give me an example?

Mrs. Ogojiaku: For example, when women marry, especially if they are not too young anymore, you are expected to be pregnant very soon, and give your husband children before your time is over. If not, your marriage might not work. My father married mother because his first wife could not give him a child after their first year of marriage. Eventually she had a son, but he died a few years ago.

Mrs. Ogojiaku's identifies *agwu isi* or 'worry/stress' as a non-biomedical non-physical cause for infertility. After acknowledging that there are many sources of infertility she goes on to explain stress as one of those important sources. Family and reproduction, as mentioned earlier in this chapter, is the center of Igbo culture. When this foundational aspect of culture is threatened, women who do not produce children develop acute stress which further inhibits their ability to

conceive. The consequences of being barren can include their husband taking a second wife, being released of their wifely duties or from the family and/or dislike and loss of respect from both her side and husband's side of the family. When couples fail to conceive (or have several children) they miss out on what is the quintessential Igbo experience, a family that offers its members, protection, companionship, security and socialization because the family values security and survival above the interest of the nuclear family or individuals. Fears of failure including inability to perpetuate the culture only succeed to increase the stress and propagate its effects. This redundant cycle begins when the girl is young and is taught that her primary purpose in life is to be a mother. These internal expectations are instilled in her by her parents, as well as aunts and uncles in the community. Mrs. Ogojiaku insightfully recognizes that the many traditional requirements could give rise to stress that could inhibit child bearing. Although Mrs. Ogojiaku is approaching her late sixties, and is a retired optometrist (indicating a high degree of education) her understanding of infertility is entirely rooted in Igbo culture and traditions, and she continues to propagate those traditions as seen by our interaction upon meeting. By exclaiming "Eh heh, no be pikin. Ready for many young ones" at our introduction she was insinuating that because I was not a small girl (having filled out in a womanly fashion) I was 'ripe' to be pregnant. Like many older members of the Igbo community she expects a newlywed couple to fall pregnant with swift timing, and consequently it is not difficult to imagine the anxiety in that expectation that could eventually lead to physiological complications via stress when couples are unable to fulfill expectation.

As seen in the above examples the older women relayed community held ideologies that infertility is caused by bad spirits, divine determination and stress. These non-biomedical non-physical responses are representative of how Igbo people understand infertility. These women

who represent the gamut of women including the young and old, the rich and poor as well as those who are or are not university educated convey information that they learned from their elders as well as pass it on when it is their responsibility. On the other hand, there were a few women whose ideals initially seemed to contradict these predominant responses or the categories in which they fell within.

One such woman is Chidera Nwokocha. Chidera is a twenty-three year old law student at the University of Lomé who lives with her parents and recently found a boyfriend. I was interested to see her perspective on the causation of disease, particularly because she was, comparatively, very young. Earlier that week, I had interviewed Chidera's mother, Mrs. Ifeoma Nwokocha. Mrs. Nwokocha is a very successful mother of four girls, and a prominent lawyer, frequently representing influential Nigerians in international contexts. Below are both responses as related to infertility.

Chidera Nwokocha: [Fibroids] Let it be that you have fibroids. Why do you continue to eat animal fat that only adds up, making the fibroid worse? Exercise and drink hot drink so you can burn the fat. The presence of all that fat is taking up space in your uterus that is for your baby, so don't do such things.

Mrs. Ifeoma Nwokocha : There are those who can easily fall pregnant, as soon as they try, they are pregnant. For others it's not so easy immediately, but with time, they will get pregnant. Some people, throughout their life time, will not give birth. That's just how it is. I would say that the problem was that of women or of men but of both of them. Sometimes it's a problem from the men's side and other times it is a problem from

the woman side. Other times, the problem is nobody's fault, but instead it is not Gods time yet for them to have a child. When it His time, then they will see a child.

Chidera was one of the few women who provided me with a biomedical physical causation response for infertility. When asked how she knew this information she proudly replied that her friend in medical school taught her some things. Chidera primarily addressed the issue of fibroids. She explains that the presence of these fibroids in a woman's uterus makes it difficult for a child to share the uterus, therefore encouraging infertility. This opinion can be contrasted with the opinions supplied by Chidera's mother. Mrs. Nwokocha suggests several sources of causation all which fall into the category of non-biomedical non-physical most of which have been previously addressed in this chapter. Mrs. Nwokocha's interview also expanded the list of non-biomedical causation by addressed shared husband and wife causation. This particular analysis can be seen as indigenous but not necessarily traditional. In the past, the inability to have children has fallen to the hands of the women in the relationship. After many generations in which Igbo men remarried (or added wives) and were still unable to produce children, ideas of male infertility took hold. This knowledge was not a product of biomedical information but instead cultural observations. At first glance, it seems that Chidera's beliefs in comparison to those of her mother illustrate the effects of higher education or other Western influences in Igbo understanding of culture. This assumption was dispelled when I learned that the most significant difference between Mrs. Nwokocha and her daughter is age and life experiences, not education. Both women are highly educated upper-class individuals. Chidera, unlike her mother, is still a child though, according to the societal values because she has yet to commence the stages in life that include marriage and child bearing. Anthropologist Tolu Pierce dictates "adulthood in Africa is not attained by mere maturity" meaning that Chidera becomes an adult as she gets married,

owns property and has children. As a result, there is much that she doesn't know because information has yet to pass down from mother to child, as is typical. I expect that as Chidera progresses in life, and has increased spousal/maternal dialogues with her mother and sisters, some of her opinions particularly those related to infertility will morph into a version more similar to her mother's. This mentality is contrary to a commonly held biomedical assumption that knowledge increases with education. If I had had the opportunity to interview Chidera's older sisters who had a similar upbringing, I predict that I would have discovered that they had more traditional viewpoints, having all gotten married and had children by this point. I admit that Chidera could possibly reject her mother's way of thinking or create her own syncretism in thought, but when it comes to infertility, it can be seen that most Igbo people opt for traditional understandings.

In summary, the etiology of infertility manifests through a system of experience and seniority resulting in non-biomedical non-physical causation responses reflective of Igbo cultural values. Individual infertility behavior takes place within the context of complex social organizations and under the influence of multiple social, cultural and ideological realities. Though infertility causation is indigenously dominated, this is not as stark a contrast with Western biomedical ideas as it may seem. Science surrounding infertility has become fluid as scientists find more and more possible biomedical causes. In the past few years, they have even begun to expand past conventional biomedicine, exploring other dimensions of health such as effects of stress and psychological conceptions. This non-biomedical non-physical causation of infertility has received increased attention in the Western biomedical community over the past few decades as Western science begins to understand the true complexities of illness. This

attention is sourced from non-West communities and philosophies that have a history of exploring these ideas.

This distinction in the way infertility is understood requires a diverse approach from biomedical treatment. Anthropologist Tolu Pearce invites communities to “challenge cultural constructions that impact the social position of both the infertile and women in general.”

Igbo philosophy, as related to infertility, seems to have escaped the Western intrusions that can be seen in other dimensions and diseases, and instead uses indigenous methods to sustain a locally generated values and beliefs.

3

(**High Blood Pressure: Cultural Coexistence**)

3

I never thought I'd like being married. Yes, I know that it's something that you have to do, and that as old as I am if I waited any longer people might start to wonder. But now, two years into it, I cannot imagine a better life. I love my wife. I get to have sex with her whenever I want. She sometimes drives me crazy though so I am glad she has her own room. Yes, her mother keeps pestering us about her grandchildren, always asking when she is going to come for omügwo. I think that she has even gone to dibia to ask him about my childlessness. Little does she know that her daughter is on birth control, so when we are ready to start having children, we will, on our own. Last week, we went to Egypt for a couple weeks to see a dear friend. Taking a vacation from my work, we rode camels and went shopping, where my wife bought things, probably, more than she can possibly use and definitely more than we can afford. Regardless, my aim in life is to please my family so if she's happy, then well everyone's happy, especially me.

In the story above, we see the mindset of a newlywed young man, who displays a joy and excitement typical of the early stages of marriage. This marriage encapsulates Igbo traditions, providing the wife with her own personal room into which the man is not allowed, as well as feeling the pressures of expected high reproductivity. At the same time, living beyond one's means through with fancy vacations to foreign locations as a couple, show distinct influence of foreign cultures. The above post-wedding period symbolizes current Igbo people copying Western standards into indigenous beliefs and practices to create a mishmash of a new system. Much of the marital relationship is negotiable and depends on both modern and traditional scripts. In a similar fashion, beliefs about high blood pressure reveal a mix of two worlds that Igbo people have managed to live in one.

Just like in the case of the young couple above, concepts about high blood pressure arise from both Western and indigenous Igbo beliefs. Contrary to the other two chapters covering diabetes and infertility, ideas about high blood pressure cannot be so easily grouped into categories of class (wealth and education) or age/seniority. This chapter will explore high blood

pressure etiology. The first causation factor of stress, there are two competing and interrelated definitions in contemporary Igbo society. Complicating this dynamic even further are other Western attributions to the etiology of high blood pressure such as diet and heredity, along with indigenous attributions such as spiritual curses and unknown forces. Modern Igbo culture, having developed an innate ability to adapt and succeed as a result of struggle, is able to incorporate new understandings into existing traditional structures.

For the sake of clarification, the biomedical definition of blood pressure is the force of blood against the walls of the artery as blood circulates through the body. Blood pressure characteristically rises and falls throughout the day and can cause health problems if it stays high for a long time. Increased pressure on the artery walls, or high blood pressure, increases one's risk for heart damage and stroke. It does this by hardening the arteries which leads to decreased blood and oxygen flow to the heart, subsequently causing chest pain, heart attack or even heart failure. By bursting or blocking the arteries that supply blood to the brain, it can cause a stroke. Consequently high blood pressure, or hypertension, is a major public health problem in populations worldwide with growing incidence in developing countries.

In Africa, as addressed in earlier chapters, health research and public health initiatives have historically been focused on infectious diseases. It is only in the past few decades that Westerners have begun to acknowledge the public health concerns related to cardiovascular disease. Epidemiologist Samuel T. Olatunbosun addresses this issue saying "as infection and malnutrition are being overcome in many developing countries, cardiovascular disease is emerging as an important cause of morbidity and mortality". According to the World Health Organization (WHO), the prevalence of raised blood pressure in a 2008 global health analysis was highest in Africa, where it was 46% for both sexes combined. These issues of high blood

pressure in sub-Saharan Africa most likely predates westernization of African communities, as assumed by studies of extremely rural and secluded communities, areas that have had minimal contact with Westerners. Researchers attribute the minimal research or care in many sub-Saharan communities to a non-existent screening process and limited access to care. This low level of attention to cardiovascular disease is a problem that needs to be ameliorated by increased research and initiatives.

Hypertension in the Igbo community is no exception. Igbo people living in both urban and rural areas of Nigeria experience a high rate of hypertension, a rate that also extends past Nigerian borders impacting Igbo in diaspora. To determine if Igbo's perceive high blood pressure as solely a Western concern or a product of Western contact, I asked several of the women if high blood pressure is a disease of *ndi beke* (white people). One responder Mrs. Nneoma Enyi, replied in a self-assured manner, that "Igbo people suffer from high blood pressure, whether in Togo, Nigeria or in the villages where they have only ever heard of white people". She concluded "High BP is for everybody. High BP is everywhere". This woman perceives high blood pressure to be an ethnically and geographically non-discriminatory disease. For those who provided an answer to the previous question, I followed up with a second one on why it seems that high blood pressure is so pervasive today in a way that it was not during the time of our grandfathers and forefathers. To this, Mrs. Enyi replied that *öbala mbanyi-elu* (high blood pressure) has always been present, even though we may have a different or more complete understanding of the illness today. An example of this different or more complete understanding is best seen in diabetes, and how Igbo's now know it as an insulin related disease that has a hereditary component where as those in the past recognized it as a sickness of the eyes and body, because extreme diabetes affects eyesight and leads to weight gain. Her answer supports the

statements of the scholars above who introduced the ideas of limited understanding and research being done in African communities. Though there is limited research and information about high blood pressure and its place in Igbo society in the past, Igbo people, like myself and Mrs. Enyi are able to sketch its effect through apocryphal stories and knowledge.

During my research, I discovered that Igbo women express many opinions about the etiology of high blood pressure. Moreover, Igbo women's opinions are not segregated according to standard demographic categories of age, wealth or education. Wealthy older educated women had the same responses as poor younger uneducated women. There were representations of both Western biomedical and indigenous medical influences in these women's opinions. For every response that seemed to display the dominance of foreign values there was a contrasting response that showed native beliefs. Below are the various responses that were given by these women including stress versus *oke echichie* (stressful thinking) and heredity & diet versus higher powers. These responses represent a range of participants and a wide gamut of etiological beliefs of Igbo women regarding high blood pressure.

Before I offer and analyze the women's responses, the first set dealing with stress and *oke echichie*, it is important to provide definitions for each term, as related to illness.

Stress is frequently not a useful term for scientists because it is such a highly subjective phenomenon that defies definition. A biological definition of stress is the departure from physiological homeostasis, considering the displacement itself or the work required to get back to equilibrium. This can also be described as a non-specific response of the body to any demand for change. In Western society, this can manifest itself as a result of local and personal dissatisfactions such as struggles at work to achieve promotion or job maintenance, argument or

separations in relationships or inadequacies in academic performance and the struggle to succeed. Some scientists refer to many such typically Western stressors as chronic.

Oke echichie, (too much thinking) or *agu isi* (worry) in some contexts can be considered the Igbo equivalent of the concept of stress. *Oke echichie*, literally translates to ‘hard or excessive thinking’ which means that the individual is so overwhelmed with whatever situation is at hand that their thoughts cannot escape the dimensions of that problem. In most examples of *oke echichie*, there presents a very extreme separation from physical, psychological or social homeostasis and distant path back to equilibrium e.g. death in a family, loss of a home or income, threat of harm (present or future). In biomedical parlance these one-time kinds of stressors are frequently referred to as acute.

With these two definitions in mind, we can see the difference between biomedical and indigenous medical presentations of ‘stress’. Igbo people, who negotiate both Western and Igbo societal understandings, experience the dual characterizations of stress and attribute High blood pressure causation to both Western-defined stress and Igbo-defined *oke echichie*.

Take the case of Mrs. Uzoamaka Anachie. A recently immigrated middle-aged woman, she moved to Togo for economic reasons. In Nigeria, she and her husband were struggling to stay financially afloat until her brother-in-law helped her husband become an importer for a second-hand clothing business, moving them to Togo. Our interview was in her home but her four children, noisily enjoying their time off of school, forced us outside to complete the interview. Mrs. Anachie, though eager to respond to my questions, seemed nervous yet assured at her responses to some of my questions. One could only assume that her nervousness resulted from a fear revealing too much during her interview, though she adamantly denied the presence of any disease in her family. At the same time, she had such strong and natural understandings

for the questions that she had confidence in her responses to me. Mrs. Anachie illustrates the first example of Western defined stress as a cause for high blood pressure amongst Igbo people.

Uche: Why do you believe that Igbo people are particularly afflicted with problems of high blood pressure?

Mrs. Anachie: Igbo women, in particular, have high blood pressure. We get this High BP through [stress]...Let me give you an example. Sometimes a woman will give birth [in Nigeria] and then to go Togo. Her life then becomes difficult because the woman will consistently be wondering how she will feed her children, and with what finances she might put a roof over their heads. Situations such as that will inflict Igbo women with high blood pressure.

Uche: If you had birthed your children here in Togo versus at home in Nigeria, would high BP continue to be a problem? Is high BP specific to Togo?

Mrs. Anachie: The reality is that if you stayed in Nigeria, it is less likely that you would suffer from high BP because your mother and father are present, and whatever you are able to make, you'll manage to get by. On the contrary, here in Togo, you are always thinking about rent, school bill or finding money for groceries.⁷⁹

Mrs. Anachie introduces stress, according to its biomedical non-physical definitions. According to her, certain life pressures in Togo and the presence or absences of family or support system can most definitely be a cause of stress to Igbo people. The pressures of finances, especially for women who handle the primary burden of childrearing, can also be a major cause for stress.

Consequently these individuals are prone to increased prevalence of high blood pressure.

Alongside those are also pressures of immigration and detachment from one's home. The

⁷⁹ VN800094, July 2nd 2011

centrality of the Igbo family makes immigration that much more drastic and stressful. Mrs. Anachie is very convinced that stress and high blood pressure have a causal relationship on elevated blood pressure, a relationship that is still being explored by the biomedical industry.

The mother of a friend that I had made since arriving in Togo provided another version of a Western biomedical view of the relationship between stress and high blood pressure. Mrs. Nneka Ofo is a vibrant woman who had been in Togo for over 25 years; she was married there and gave birth to all her children in Togo. She, like most other respondents, identified high blood pressure as one of the problems facing Igbo people. Without being prompted, she went on to explain the cause of high blood pressure in Igbo society, saying, “it is the problem of oke echichie that disturbs Igbo people due to excessive labor and stress.” Since Mrs. Ofo used both oke echichie and stress in the same sentence and context, I struggled to understand exactly what she meant so I encouraged her to provide me with an example of the word stress. The story that she ‘created’ resembled experiences lived by many Igbo mothers.

Imagine that your thirteen year old girl doesn't come home at a decent hour when you told her, and she should know better. Next thing you know it is late at night and she is still not home. What would you do? Wouldn't you worry? I do not know if someone has kidnapped her or if she is stuck in a cave somewhere. Yes, I'll call police quick quick and all her friends. What do you mean she didn't call me to tell me where she is? What you mean she hasn't come home yet? As soon as she comes home at night, I'll be angry. (Screaming) “I maro na oke echichie'm maka gi n'enyem high BP” or you didn't know that the worry you caused me [when you chose not to come back on time] was raising my blood pressure.

Mrs. Ofor's biomedical non-physical etiology for high blood pressure aligns with Western medical perceptions of stress and its influence on disease.

The contrasting perspectives about *oke echichie* received a similar amount of responses. One prime example comes from Mrs. Ijeoma Nwanna, who like Mrs. Anachie is a mother of four and a recent immigrant to Togo with a similar educational background. Mrs. Nwanna married her secondary school sweetheart who had already moved to Togo to join the secondhand clothes business. Rather than meet at home where quietness and or solitude would be standard, the interview was done at the market in the middle of the working day, to better accommodate her schedule. Alongside the sounds of the *ökpa* seller with his bells and the disputing sale in the opposite stall, Mrs. Nwanna provided very clear and precise responses. When questioned about the causation of high blood pressure, she offered several different methods that one could get the disease.

Uche: How do people get high BP?

Mrs. Nwanna: Sometimes their enemies inflict them, and other times, it is because of *agwu isi*.

Uche: What do you mean?

Mrs. Nwanna: For example, if someone important to them suddenly dies, that can cause high blood pressure. Hardship, stress, and things not turning out as they should, are the reasons that cause them to have a stroke of high blood pressure.

Agwu isi is used by Mrs. Nwanna to explain the etiology of high blood pressure. *Agwu isi*, literally translates to 'possessed head', implying that the person has gone mad with the volume and depth of thoughts in their mind. It means that the individual is overwhelmed and troubled by

a given extreme situation. This non-biomedical non-physical causation inherently describes negative and natural non-physical reaction to spiritual (and non-spiritual) problems that manifest itself through illness. Mrs. Nwanna's explanation using *agwu isi* or Igbo 'stress' demonstrates the indigenous medical components of high blood pressure. Mrs. Nwanna also addresses a non-biomedical spiritual cause of enemy infliction that will be explored towards the end of this chapter.

A second example of non-biomedical nonphysical causation can be seen in Mrs. Chinenye Okeke's response. Mrs. Okeke's interview, like that of Mrs. Nwanna also occurred in the market, but in the shoes section. Not being in her home where I could more readily ascertain her wealth but instead in a stall that resembled all other stalls at the market, I was challenged to forge an assumption on financial status until her children stopped by her stall to ask for money to purchase sweets. Looking at her poorly dressed children in tattered clothing, it became clear that she was not well off. When I entered her stall, she was in a *heated* discussion with the woman in the adjacent stall about how business had not improved and her husband was never home, frequently traveling to do business but nothing had proven profitable and how since there was no one at home her sick children would spend the day with her in the market. After what I perceived as short period of venting of stressful life problems she concludes her conversation by saying to her associate "I am blessed and thank God everyday". Ten minutes later during her interview I prompt her to give me an example of what she meant by stress, which she used in her response about high blood pressure causation. I was expecting her to repeat some version of what I overheard, but instead she tells me about a friend of hers.

I know of my friend that had [high blood pressure] but he is better now. He developed the problem when he had a crash in his business. Some bad people

had cheated him out of his money and armed robbers burned down his office.

This shock caused him to get high BP but now, with the grace of God, and things are turning to his favor. For [Igbo people] ...stress is when something sudden happens unexpectedly. One can even receive shocking news of death and develop high BP.⁸⁰

The account of her friend's development of high blood pressure due to life events which were extreme and unexpected. Mrs. Okeke's response demonstrates a thorough understanding of Igbo culture and shows indigenous medical manifestations of *oke echichie* in disease. Her response exemplified the differences in the two systems, foreign and indigenous by the presence of a certain intensity in her story, which illustrates the circumstances surrounding an attack of high blood pressure.

As can be seen in all the examples above, etiology of high blood pressure has both biomedical Western and indigenous medical roots. These perspectives are equally present in all different members of the community regardless of age, wealth or education level. These responses provide support for the coexistence of both systems in one community. One important note is that due to the nuances of language influences and usage, the actual words that the women used to convey the message was not always indicative of what she meant. Igbo women, use *oke echichie* and stress somewhat interchangeably but definitely hold two different ideas about stress as introduced to them by their personal culture and by foreign influence. In that case, context in which the words are being used becomes just as important as the word that was chosen.

⁸⁰ VN80074, June 22nd, 2011

The last set of ‘opposing’ opinions that were given by the women emphasized reasoning, dietary, heredity and spiritual choices given below. Approximately the same number of women responded with each one of the three secondary causations, diet, heredity and spiritual inflictions.

Mrs. Chidinma Arachie, seventy-four year old native of Ariba presented a biomedical opinion when asked about the etiology of high blood pressure. Mrs. Arachie’s interview took place at a particularly peculiar location. She was one of two women whom I interviewed at the hospital that I volunteered at during my time in Togo. Hopital de Be, a local hospital was staffed by mainly Ewe and Kabiye men and women who spoke French in addition to native Togolese languages. Mrs. Arachie, being elderly when she immigrated to Togo, never had a chance to pick up the French language so I acted as a translator for her. After her patient consultation, I asked her if we could conduct an interview and she said she had nothing better to do. When asked the cause of high blood pressure, Mrs. Arachie mentions several of the causes already stated above but with the addition of a different component.

You know what it is? It is [*oke echichie* and heredity] but it is also salt. We don’t eat salt like the people of America do, and when you do then you start to have problems. But there is some salt, in our fish. But if you buy things fresh, you don’t have to worry so much. All those things in cans that are everywhere now, is giving people problems, I bet you.⁸¹

Mrs. Arachie presents an interesting opinion. Due to her age, one might assume that she would be minimally informed about foreign lifestyles and resulting Western biomedical causations. On the contrary, Mrs. Arachie was one of the first individuals to introduce the concept of sodium, the main component in salt, as a biomedical physical cause for high blood pressure. It is especially interesting how aligned with biomedical understandings of causation her response is,

⁸¹ VN800073, June 22, 2011

detailed with American comparisons. According to the Center for Disease Control (CDC), most of the “excess salt”, a trigger for increased blood pressure, comes from processed and restaurant foods, foods that make up the majority of a Western diet. Though processing of foods is steadily increasing in Nigeria including in Igboland, the prevalence is significantly distant from that of the United States. This begs the question of if salt is a significant component of high blood pressure in Igboland and if the knowledge is truly reflective of the community in which she lives.

Another biomedical physical manner of acquiring the disease that was presented to me by the women was heredity. Mrs. Chiamaka Nwoye, was 72 year old widow who lived with her son and daughter-in-law. Even with the slight difficulties in total understanding because of her antiquated Igbo, frequently used by the elderly of society, her belief of heredity as a cause of illness was clearly communicated. Mrs. Nwoye’s husband passed away as a result of a combination of illnesses one of which included high blood pressure.

This *öbala mgbanyi-elu* is caused by over-thinking things. It’s also partially hereditary. When it is in that person’s grand-family, you are more likely to suffer from it. I know that my husband’s mother had it, and I think someone else on his side. I tell my children to take special care of themselves, especially now they are grown because they want to avoid any of the problems that [her and her husband] have.

Heredity as cause for high blood pressure was most likely present in Igbo indigenous medical knowledge before the arrival of Europeans as illustrated by Ms. Nwoye’s medical understanding of the disease. Mrs. Nwoye, being elderly, addresses a critical aspect of Igbo culture, its conception of lineage. Igbo people have always believed that many qualities of an individual are a product of heredity including visible and invisible traits, a concept that affects union between

Igbo families. Western influence in the past century has expanded these ideas to include a direct explanation of the generational transmission through genes. This modification in understanding heredity served two purposes. *The first eliminated some indigenous assumptions such as the transmission of laziness or male children through genetics. The second strengthened previously held beliefs such as the transmission of physical attributes, e.g. strength or sickle cell disease through genetics.* Though it is less and less important as Igbo people move into the industrial age, heredity will remain a foundation of the propagation of Igbo culture.

The last causation that we will address is that of spiritual intervention provided to me by Mrs. Ogonna Pethos, a young Igbo woman. Married to a Togolese man I was introduced to her by a Togolese friend rather than my Igbo contacts. Mrs. Pethos seemed very cautious in her response to my questions, stating her fear that she would say the wrong thing. After being reassured that I only want her opinions, she opened up and proceeded to provide an exciting response.

I think that high blood pressure comes when someone doesn't want you to succeed. They go to *dibia n'agwo ogwu* and get them to curse you. That's why you should try and treat people like you want to be treated because you don't want anyone to do that to you. It could also simply come from jealousy, my auntie had someone do that to her because her business was getting better and her children had gotten into university.

This response addresses a non-biomedical non-physical causation for high blood pressure, provided to us by a seemingly unlikely young woman who due to her young age is expected to be more ingrained in Western culture. Mrs. Pethos, perceives an external curse by an outsider as the cause of hypertension that affects individuals at specific stages of the life. This curse can

occur is numerous different ways, including the use of magic, poisons or other indirect spiritual methods.

Another response that is neither biomedical nor indigenous but interesting nonetheless is the many responses of “I do not know” that I received. Though I also received this response during questions regarding diabetes and infertility, the grand number of individuals that responded with ‘unknown’ when asked about high blood pressure made that response particularly significant for this disease. Through various questions, I gathered that all women knew about the disease but these women were not able to pinpoint any causation and were content with their ignorance. A part of this ‘don’t know’ response provides commentary on Igbo culture and its effect on medical understandings. And Igbo proverb reads “*Onye malu ihe ma mgbe o mara*”, which translates to ‘a wise man knows when he does not know’. Igbo people are capable and willing to accept an unknown medical answer, in contrast with the Western biomedical field that constantly seeks to find answer and is rarely satisfied. It is important to note that these women are willing to utilize either indigenous or biomedical medicines to treat the high blood pressure while being eluded by its causation. They charge those who ‘do know’ with the task of knowledge and treatment, knowing that they have knowledge in other areas that they can offer.

In conclusion, high blood pressure represents the synthesis of indigenous and Western medicine in Igbo etiological understandings. Igbo women believe that high blood pressure is caused by a multitude of factors including both Western and indigenously defined stress, divine determination, excess salt, spiritual afflictions and heredity. They are also willing to accept a lack of etiological knowledge. Igbo people process high blood pressure with an intellectual diversity that is a result of their ability to adapt foreign cultures while maintain indigenous

values. The synthesis of both Western and indigenous dimensions of causation supersedes demographic divisions and assumptions. Wealth, age, or level of education did not present as a determinant factor in the woman's beliefs about high blood pressure causation.

Knowing that Igbo people consider many sources of information when thinking about disease makes it easier to input of Western ideas when dealing with diseases. Some aspects of Western medicine are proving beneficial for the Igbo community. For decades high blood pressure has only been attributed to diet and exercise. These causes, though significant in many Western environment are minimally applicable in Igboland because the salt content of most Igbo diets do not reach a level of concern, and the exercise level significantly exceeds most Western individuals. That being the case, what else can account for the increased levels of high blood pressure in the Igbo community? When faced with this question, one has to seriously consider the other known causations provided by the Igbo women in their interviews. It seems that Igbo people have accepted and understood the effects of stress on the body and as a cause of illness. Further research into the true instances and effects of the two different types of stress is highly warranted.

CONCLUSION

This paper identifies the diverse scope of Igbo etiology of disease, dually informed by the indigenous medical systems already in place at the time of colonization and by Western biomedical beliefs introduced after colonization. In particular, the diseases in question, diabetes, infertility and high blood pressure, identify and support that various aspects of Igbo culture as it presents itself here are simultaneously adaptable and insular. Each illness, especially high blood pressure, demonstrates how neocolonialism has placed Igbo people in a particular cultural conflict between exogenous knowledge (Western biomedical) and endogenous knowledge (indigenous medical).⁸² In this conflict, Igbo people strive for a hybrid cultural identity, which allows for the coexistence of local and foreign beliefs.

This conflict is born from the challenge of social and cultural intrusion wrought by colonization that has existed in Igboland since the sixteenth century. African scholar Jamaine Abidogun writes, “It is not small matter that Nigerian cultures and societies have been challenged internally and externally over several hundred years”.⁸³ Igbo people in particular have had a history that not only includes brutal slavery and tragic colonialism, but devastating losses during their struggle for independence to secede from Nigeria and form the Republic of Biafra. The Biafran war, as explained in the introduction, was a particularly difficult time to be an Igbo individual in Nigeria, seeing as Igbo people suffered extremely both physically and psychologically, enduring violence, starvation, and the loss of numerous family members, property and homeland.⁸⁴ The post Biafra era brought about two distinct cultural changes. The

⁸² Abidogun Jamaine. Western Education Impact on Northern Igbo gender Roles in Nnsuja Nigeria. *Africa TODAY* 29

⁸³ *Ibid.*, 31

⁸⁴ Biafra also has the physical effect of starvation during the famine which has created the situation in which those who lived during that period grow up to be more susceptible to obesity and attendant

loss and marginalization of the Igbos by the rest of the country served to further unite the Igbo people. This only increased the Igbo's desire to remain insular and raise the youth to be proud of their ancestors. At the same time, the loss of the war and downturn of the Igbo economy resulted in increased Igbo migration to other parts of Nigeria, as well as other African and non-African countries. This mass emigration reinstated the Igbo tendency to adapt to all locations and situations in order to survive. In summary, the Biafran loss made Igbo people increasingly resilient yet gave them greater flexibility. The history of struggle and triumph manifested itself in my interviews with various Igbo women, reflecting an idiosyncratically Igbo perception of the world around them. Ethnologist Daniel Smith's claims that "the variety of trends, alternative world views, conflicting philosophies, and pluralism of beliefs systems and disorientation in value scales through the successful introduction of foreign systems endanger Igboland and what it stands for."⁸⁵ We can see this ordeal in Igbo understanding of disease causation where Igbo people have to continually account for these differing systems (indigenous and Western) and come up with a conclusion or plan of action that redefines who they are as an Igbo person. Igbo people over time have learned to adapt and propagate Western (or other foreign) culture as it was previously needed for survival, as well as maintain a certain standard of traditionalism that can be passed down to future generations as the basis of their society. Even more impressive, Igbo people have been able to negotiate the two on a daily basis, sometimes invoking both understandings when discussing or agreeing upon a single matter.

In this study, the focus was placed on beliefs surrounding etiology. Though the interviews covered a few other aspects of health, namely nutrition and disease treatment, I was

maladies.⁸⁴ This increase only makes the diseases covered below that much more important in the face of an evolving and ever changing world. Donald G. McNeil,

⁸⁵ Ndukaihe, Vernantius Emeka. Achievement as value in the Igbo/African Identity: The Ethics. Duetsche Nationalbibliothek. Berlin 2006 p. 70

most interested in seeing how Igbo people think and how they formed their beliefs about disease. Etiology presents culture in a straightforward manner that is relatively simple to comprehend; it draws on understandings and beliefs that are not constrained by living conditions such as location, wealth, or education. This is not to insinuate that these living conditions do not affect beliefs and understandings, but simply that each individual regardless of their background or situation has the ability to voice an opinion, and call it their own. This does not hold true for treatment, in which factors such as wealth can limit or encourage one's understanding of disease treatment and ability to obtain care, e.g. richer people can choose between hospitals with pharmacies and other alternatives while those with limited finances have limited options. I would add, too, that etiological belief is often stronger than biomedical fact because belief is an internalized set of values, while fact is often not internalized. This etiological understanding has the ability to further cultural comprehension because it innately reflects the society of those who hold those views.

I will now draw conclusions for each of the diseases discussed in this thesis and the respective cultural components that were addressed. To begin, diabetes etiology represents one of a long list of areas in Igbo life and culture in which indigenous knowledge has taken a back seat to Western understandings. As we saw, diabetes is no longer seen as a relational or spiritual illness but instead as a physical illness, caused predominantly by excess intake of sugar. This almost strictly biomedical/physical attribution is a product of Western knowledge infiltrating institutions of higher education (frequently only an option for the wealthy) in Nigeria and in the broader Igbo diaspora. The etiology of this disease is particularly important because of its rising prevalence in the local and global community. Epidemiologist Jane Mbanya, in several reports on global estimates and projection has confirmed a diabetes epidemic, strongly indicating a

significant rise in the number of people with diabetes.⁸⁶ She later directs her research at sub-Saharan Africa, concluding that the prevalence and burden of type II diabetes is sure to rise in this area as a result of urbanization and westernization.⁸⁷ Research conducted by scientists such as Mbanya demonstrate the importance of diabetes comprehension in a sub-Saharan community. This disease not only manifests a Western mindset, but also a Western manner of information transmission. Diabetes information is passed on through class, from the upper-class to the middle- and lower-classes. This most likely occurs through the universities, or other post-colonial institutions.⁸⁸ These post-colonial institutions provided the upper-classes with exposure to Western ideas. Medical anthropologist Linda Hunt explains that in repeated and long term exposure in these institutions (which provide an authoritative biomedical perspective), patients (or system users) often develop similar concepts of disease as the provider, who are in this case the institutions with biomedical Western practices.⁸⁹ These users then go on to transmit their exposure to the rest of society and progressively alter the cultural opinion of a disease.

Understanding this presentation of information as well as its transmission provides community public health individuals and local health providers a method for the most efficient health information delivery system in regards to diabetes. Information, both indigenous and foreign related to diabetes, would be best transmitted through the universities or other such institutions. These educated individuals transfer this information to the rest of the community through daily contact in friendships, marriage, employment, etc. This type of transfer is frequently referred to as horizontal transmission, amongst peers. This method of information

⁸⁶ Jean Claude N Mbanya et al., Diabetes in sub-Saharan Africa, *Lancet* 375, (2010): 1175

⁸⁷ *Ibid.*, 2254

⁸⁸ Abigogun Jamiaine. Western Education Impact on Northern Igbo gender Roles in Nnsuja Nigeria. *Africa TODAY* p. 29

⁸⁹ Hunt, Linda M and Arar, Nedal H. "An Analytical Framework for Contrasting Patient and Provider Views of the Process of Chronic Disease Management" *Medical Anthropology Quarterly*, New Series 15, no. 3 (2001): 350

distribution is both practical as opposed to other techniques that could force information against its gradient. I recognize that it might not be the most expedient process but it is potentially more permanent than other methods.

It may seem that an influx of Western information about disease has become the standard but that is by no means the case for some aspects of health. Infertility presents itself as an adversary to the diabetes model of etiology. Infertility demonstrates the perseverance of Igbo cultural understandings in Igbo medical thought. As seen by the interviews in chapter two, the etiology of infertility was almost solely dominated by indigenous medical beliefs and practices. These beliefs are transmitted through generational dialogue and exchange. Elders in the community are the source of information; they pass it down to youth through storytelling or other cultural communications. Mothers who become elders of the community as they age teach their children knowledge, particularly that knowledge which relates to marriage, family, and children. At the same time, these youth observe the experiences of those older than them and learn the workings of family and related cultural understandings. This method of knowledge transmission is notably different from the education bases learning that is present in Western societies, being that it is a direct reflection of Igbo cultural dynamics.

This difference between the Igbo and Western way needs to be accounted for in public health initiatives in the community and by local health workers. Linda Hunt addresses this dimension of patient-provider communication, noting, “Incongruence between patient and provider viewpoints may negatively influence patient compliance, satisfaction, etc.”⁹⁰ In this case, the medical understandings of those working in the Igbo community need to align with general belief. When this happens there is increased efficacy in health initiatives that are

⁹⁰ Hunt, Linda M and Arar, Nedal H. “An Analytical Framework for Contrasting Patient and Provider Views of the Process of Chronic Disease Management” *Medical Anthropology Quarterly*, New Series 15, no. 3 (2001): 349

undertaken in that community. Instead of following a Western outline for health services and information delivery that takes place in hospitals, schools or media, we need to head directly to the elders and leaders of the community and relay the information which they will transmit to the young as they see fit. This vertical transmission (from elder to youth as opposed to horizontal-among peers) seems to be the most effective method of information transmission in regards to infertility and potentially other family related diseases.

On a similar note of cultural sensitivity, Western medical practitioners, who due to technology and finances constitute the majority of those making health decisions for Nigeria and Igboland, need to comprehend and integrate indigenous understandings into their policies and methods. With this shift in methodology and alongside indigenous Igbo medical officials, they can work toward adequately addressing any increase in infertility.

Lastly, infertility etiology should serve as an introduction of indigenous medical understandings into the Western academic sphere. Throughout the trials of colonialism and other battles, certain indigenous Igbo knowledge has persisted as an adequate or superior explanation of health problems. This is the case of infertility, in which indigenous knowledge still mostly accounts for the etiology of the disease among Igbos. This etiology, which includes relational, spiritual and psychological explanations, should be considered as vital in the biomedical arena of knowledge. There are currently many aspects of infertility that remain unexplainable by Western science and biomedical fact. These holes in ‘knowledge’ should encourage biomedicine to be open to the exploration of other explanations, such as those provided by Igbo people.

High blood pressure rounds out the three diseases that were explored. Not to be outdone, high blood pressure presented in its own intriguing manner, a coexistence of Western biomedical beliefs and indigenous Igbo beliefs around etiology. This disease most clearly illustrates both

cultural adaptability and insularity. Igbo people adapted physical definitions of high blood pressure from Western biomedicine, while maintaining indigenous psychological and spiritual causations for the disease. I observed no trajectory or pattern for the transmission of knowledge in this disease. This does not necessarily mean that there is not one, but that this begs for further research.

The integration of indigenous ideas into the academic spheres of Western biomedicine presented above for infertility etiology proves to be equally, if not more, important when it comes to high blood pressure. Non-physical causation that was presented by the women needs to be strongly researched in the biomedical fields. This process has already begun, starting with the exploration of stress as a source of disease causation, and should continue to expand. The open-mindedness of Igbo people in the adoption of foreign ideas is the path that Western biomedicine should continue to explore. I hypothesize that examination of these indigenous causations will explain many elusive aspects of disease in biomedicine.

There are several limitations in this research that if explored could further illuminate Igbo culture, colonial influence, and medical understandings, further deepening the paper and opening it up for a wider debate and authority.

The first area that demands further research is treatment (as opposed to etiology). With the minimal amount of treatment-related information that I was able to gather, I can deduct that Igbo people use both indigenous practices and medicines, such as herbs, alongside Western biomedical drugs and practices for treatment. For example, Igbo people consume unripe plantain to reduce the effects of diabetes.⁹¹ At the same time, many Igbo women seek in vitro fertilization as a cure for their infertility. Lastly Igbos frequently use the power of prayer to address issues

⁹¹ Unripe plantain, like similar whole foods with a low glycemic index, has the capacity slow down the processing of sugar and insulin, keeping the body from severe high or low spikes in blood sugar, therefore curbing diabetes symptoms.

with high blood pressure. Treatments for disease, similar to etiology, span the Western biomedical to indigenous medical range. The connections between disease and treatment are extremely complex and can only be uncovered with further research. The correlation for each disease and the treatment as it relates to age, wealth, and education is significantly weaker than that of etiology, possibly due to the limitation on treatment options associated with wealth and education.

In order to accurately comprehend Igbo culture and the medical understandings of Igbo people we need to look at all sides of the picture, including etiology, diagnosis, treatment and prevention. Knowing all dimensions from an Igbo perspective will provide public health individuals with the best base to begin any health initiative. Mbanya succinctly explains this idea, writing, “a multisectoral approach to [disease] control and care is vital for expansion of socioculturally-appropriate problems in sub-Saharan Africa.

As stated in the preface, the point of this research was to provide a voice for Igbo people. Other opportunities to present the opinions and methods of indigenously African populations are much needed and will make for richer and more effective health initiatives in the community. Information gathered from this study can also be extrapolated and applied to culturally analogous communities in a careful manner. This can prove more efficient in comparison to solely Western methods. Physicians and medical anthropologists agree that health behaviors must be understood as a response to particular episodes of illness within specific clinical and life world contexts.⁹²

Lastly, this paper focuses solely on non-communicable diseases. As noted in the introduction, this is an area that has received a minimal amount of research in these areas,

⁹² Hunt, Linda M and Arar, Nedal H. “An Analytical Framework for Contrasting Patient and Provider Views of the Process of Chronic Disease Management” *Medical Anthropology Quarterly*, New Series 15, no. 3 (2001): 349

historically due to a perception that these diseases were insignificant in sub-Saharan Africa, alongside other prejudices of sub-Saharan communities. “World leaders have recognized the magnitude and impact of [non-communicable] diseases and the urgent need for action.”⁹³ It is noteworthy to further research in comparable areas such as cancer and aging, or genetic disorders especially as they relate to culture and community.

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⁹³ Hult, Matrin et al. “Hypertension, Diabetes and Overweight: Looming Legacies of Biafran Famine’ *PLoS One* 5, no. 2 (2010) DOI: 10.1371/journal.pone.0013582

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APPENDIX A

