PANACEAS FOR URBAN ILLS

Traditional Medicine and the Management of Everyday Crises in Kaduna, Northern Nigeria

by

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This thesis reports the results of 26 months field research in the city of Kaduna, Northern Nigeria. It argues that the complexity of urban medical cultures cannot be understood in terms of a concept of system nor is it adequately grasped by the idea of articulation of local and global medical cultures. Rather, it should be approached from the perspectives of cultural flow and action. Thus, cases of traditional medicine and therapy management should be examined as particular configurations of the forms and distribution of knowledge and power, and the action of individual agencies. In African contexts, it is also important to analyze illness as a part of everyday crises.

In Kaduna, a city that has expanded phenomenally owing to migration, medical cultures are in a state of flux. The agencies that affect health-related action are pluralistic and exercise temporary and limited control over patients. Under these conditions, their quest for therapy is marked by situational action and successive appropriation of different ideas and practices including those which they encounter during the course of this quest. However, such situational action tends to result in temporary solutions and repeated failures, contributing to considerable uncertainty. It is in this condition of uncertainty that traditional medicine thrives.

People employ traditional therapies mostly in combination with other practices (e.g. Western medicine) either serially or simultaneously. The objectives of traditional medicine are diverse, ranging from cures of physical afflictions to solutions for everyday social and economic problems.
Yet the changes in the modes of therapy employed are not dramatic but incremental - they consist of combinations of ethnic and regionally specific elements, conjoined with more universally appealing elements. Hence, traditional medicine exemplifies multiple appropriations of particular cultural forms. It is also highly commercialised and many healers practise them as a diversification of their business strategies. In that sense, healers are entrepreneurs as well as medical practitioners.
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CHAPTER I
INTRODUCTION

This thesis is about the practice of traditional medicine and the management of everyday crises among people in the city of Kaduna, Northern Nigeria. The focus of the thesis is on the nature of the practice of traditional medicine and management of everyday crises in the context of an urban social and cultural environment that has been rapidly formed and is continually transformed.

Urbanisation, rather than industrialisation, is one of the most dramatic social and cultural changes in many parts of the Third World. Especially, urban growth in sub-Saharan Africa is remarkable at present (Gilbert and Gugler 1992; Roberts 1993). While the significance of the study of urban social relationships and cultures is as great as ever, insufficient attention in both urban and medical anthropology has been paid to the management and ideas of illness and misfortune in the urban context in Africa.

Hence, the present study is particularly concerned with: 1) cultural diversity in cities where diverse practices and ideas about illness and other everyday crises are available to people, 2) urban social relationships and identities through which the therapeutic action and crisis management of traditional healers and lay people take place, and 3) the impact of the state and market economy on their action. In this regard, Kaduna offers an ideal site for the study of these issues, since the city is characterised by its rapid growth, cultural diversity and importance as a regional administrative and
industrial centre.

I define traditional medicine as practice that does not originally come from outside Africa. It is not biomedical practice, nor various forms of religious healing associated with major religions such as Christianity and Islam. I do not consider tradition as unchanging practice. The changing aspect of traditional medical practice is indeed one of the important issues with which this study is concerned. However, I also believe that there are certain elements that are relatively durable over time, which people may (or may not) identify as their tradition. In this regard, my definition of traditional medicine in this thesis primarily reflects people's definition of traditional medicine in Kaduna.

I also define the field of my study not as a field of medicine but as a field of everyday crises and their management in which the field of medicine is an important part. As we shall see, this is because the concepts of illness and medicine are so broad and often inseparable from various other misfortunes in African societies.

Field research was conducted for 26 months between 1990 and 1992. The research consists of survey, extended case studies, observation of rituals and meetings, and archive research.

In the survey, I conducted scheduled interviews with 35 traditional healers with regard to their ideas of illness and their practices. I interviewed each healer several times and also observed his or her practice as much as I could. Tape recordings of the divinatory and healing practices of four healers were made. I also interviewed 129 healers' clients about the course of their therapeutic management and the cultural backgrounds. Observation was also made of 32 in- and out-patients of St.Gerald Hospital, of whom 24 were interviewed as to their therapeutic management,
aetiological ideas and cultural backgrounds. Tape recordings of the practice of clinicians were also made. In addition, my research assistants and I surveyed the therapy management and aetiological ideas of 50 people (10 from each of five ethnic categories). We also located on a map healers of all kinds including clinicians, medicine sellers, religious healers and traditional healers in the Nasarawa and Trikanya areas in Kaduna-South.

As to the extended case studies, I attach special importance to this type of research. It is my contention that the significance of medical knowledge, social relationships and material resources on crisis management can be adequately understood only through the detailed investigation of the crisis management of individuals over a relatively long period. I managed to follow the cases of crisis management of five individuals during my stay. In particular, I was lucky to live with a traditional healer, Mr. Ishola, and his family for 22 months and observe and even participate in their crisis management. While scheduled interviews were conducted in the case studies, a great part of important information turned out to be that gathered through informal conversation and casual observation in my everyday interaction with these individuals.

To investigate the activities of various organisations of healers, I attended a number of their rituals and meetings and interviewed the leaders and members of the organisations. The groups I focused on are traditional healers associations, the bori cult of affliction, a Mamy Wota society, Aladura churches and Born-Again churches. Interviews were also carried out with government officials concerning their policy toward traditional healers' associations.

Finally, I collected information from archives and published material at the Ibrahim Kashim library of Ahmadu Bello University in Zaria and Arewa House in
Kaduna.
In this chapter, I review anthropological literature relevant to the main concerns of this thesis, highlight the issues involved and establish my own theoretical framework. There are a relatively large number of medical anthropological studies conducted in African cities. However, many of the studies are not particularly concerned with the issues which are the focus of this study. Thus, while I explore mainly anthropological studies conducted in the African region, I also refer to those conducted in other parts of the world. The main issues examined are: 1) the practice of traditional medicine and therapeutic action in complex medical cultures where diverse medical practices and aetiological ideas coexist; 2) relations between medical practices and therapeutic action on the one hand and social relationships and identities on the other, especially in the urban context, and 3) the impact of the state and national and international economy on the practice of traditional medicine and therapeutic action in the African context.

COMPLEX MEDICAL CULTURES

As already noted, Kaduna is a culturally diverse setting and a major focus of this thesis is the analysis of such culturally diverse situations where a multitude of different therapies are practised and
various competing concepts of illness are available to people. Anthropological studies have tended to focus on the culturally distinctive ideas and practices of illness and medicine of particular groups of people in societies, such as ethnic or religious groups. However, it has become increasingly clear that people do not employ medical knowledge and practice derived exclusively from their ethnic and religious cultures alone.

In most societies, there coexist a plurality of medical practices and ideas which people choose to employ. Africa is no exception here; several kinds of healers work side by side in communities (Feierman 1985). We have therefore to examine therapy management and choice and the practice of any particular therapy in the context of pluralistic medical cultures. A number of studies have been conducted on this issue, and their findings have been accumulated. Yet, the findings of the researchers are contradictory and pose serious questions for theoretical generalisation. Broadly, there are three features explored in these studies: 1) pattern and coherence, 2) situationality and inconsistency, and 3) innovation.

1) **Variation in Complex Medical Cultures:** To begin with, there is ethnographic evidence that the coexistence of and interaction between different medical cultures may result in the development of coherent relationships between different therapies and a degree of pattern in the therapeutic management of lay people. Thus, in Africa, several studies suggest that there is a certain degree of complementary relationship between biomedicine and traditional medicine (Frankenburg and Leeson 1976; Chavunduka 1978; Katz et al. 1982; Good 1987). These studies indicate that people tend to use biomedicine as a first resort and traditional medicine as a second resort onward. The studies also show that there is
often a certain relationship between choice of therapy and concepts of illness and the efficacy of therapies. Thus, Chavunduka (1978) argues that the Shona in Zimbabwe tend to consult clinical doctors in cases where they have acute and precipitate ailments and in illness which they attribute to natural causes, whereas they consult traditional healers in cases where they suffer from chronic ailments and illness which they attribute to human or spiritual agents. Good (1987) notes that traditional healers in Nairobi often refer their clients to hospitals in cases they find it difficult to handle the illness in question. Thus, in such cases, there appears to be a general knowledge of the comparative efficacies of different therapies that brings about a degree of patterning in the management of therapies among lay people.

Coherence can also be a matter of coherence in cognition and cosmology that underlies medical knowledge and practices. There are a growing number of ethnographies that point out consistency of interrelations between coexisting local medical cultures and modern, Western medical cultures coexisting in terms of their cognitive and cosmological articulations. The studies show that the practices and ideas of Western medicine are interpreted and appropriated by local people on the basis of their cognitive schemes and cosmologies and their ideas of illness and medicine.

Thus, Logan’s (1973) study among a peasant population in Guatemala shows that biomedicine is articulated with a local binary classification of illness and medicine, which he considers as derived from humoral science. At the hospital, patients often refuse to take medication because they realise that their illness and prescribed medicine are in the same temperature category—cold illness and cold medicine (or hot illness and hot medicine), for in their view
illness in one temperature category should be treated by medicine in the opposite temperature category. Similarly, according to Welsch’s study (1991), the Ningerum in Papua New Guinea consider biomedical treatment as "positive medicine" according to their binary classification of medicine. Welsch argues that it is important to view popular therapy management as operating within a single system.

In Africa, Alland (1979) notes that the Abron in Ivory Coast identify Western doctors and nurses with *sisogo* (secular healers) and missionary doctors with *kparese* (priest healers) in accordance with their indigenous classification of healers. Bledsoe and Gouband (1988) point out that the choice of remedies among the Mende in Sierra Leone is remarkably consistent with their traditional interpretation of the causes and cures of various types of illness. Thus, for the treatment of fever, the Mende commonly employ any pharmaceutical medicine that is white in colour and bitter in taste, Mentholatum (orally administered), and alcoholic drinks, because they consider these as medicine to make the body warm just like their indigenous equivalents such as chili peppers. On the other hand, they take any pill and capsulated medicine that is red in colour, Orange Fanta and Guinness for the treatment of blood related illnesses, just like their use of palm oil for such ailments. There also appears to be a growing interest among Africanist scholars in the articulation between the concept of traditional healers (and their healing) and that of Christian ministers (and their rituals) (Comaroff 1985; Peel 1990; Kiernan 1994; Schoffeleers 1994; MacGaffey 1994). Thus, Schoffeleers (1994), drawing on ethnographic evidence mainly from Bantu speaking peoples, argues that on the one hand both Christ and Christian ministers have been popularly conceptualised as *nganga* (a traditional healer),
whereas on the other hand the nganga has been reconceptualised in the framework of Christ and Christian ministers by religious groups such as the Khambageu of Tanzania, the Mbona of Malawi and the Bwiti of Gabon.

So far, I have presented ethnographic material that indicates a coherence and patterning of complex medical cultures. However, there are also several important studies that suggest otherwise. These studies clearly show that such coherent patterning is lacking in the complex medical cultures which they investigate. Here, people do not necessarily articulate diverse medical practices and ideas, but rather employ bits and pieces of medical knowledge and practices situationally without following or constructing a durable overarching conceptual structure.

Thus, according to Beals' (1976) study of medical pluralism in villages in Mysore State in South India, popular choices regarding the consultation of curers are marked by inconsistency and casualness. People do not employ a fixed strategy for choosing which curers to consult except for such illnesses as malaria and scabies and, in many cases, are ready to attempt a variety of treatments simultaneously. They lack uniformity in their concepts of illness, diagnosis and treatment - single individuals embrace a variety of explanations for illness, and different individuals differ considerably in their interpretations of the nature, cause and cure of illness. For instance, his informants list multiple causes and treatments for headache. However, the contents of these lists differ significantly from individual to individual. While all of his informants make use of humoral theory, there are great differences in the names given to particular humours by different individuals. Differences are also found in the kinds of diseases that individuals
ascribe to particular humoral problems. Beals relates this casual and inconsistent attitude to the complex and pluralistic nature of the Indian world.

In Africa, such inconsistency and situationality in medical concepts and therapy management are shown by Last's (1981) influential study of the Malumfashi area in Northern Nigeria. Medical cultures in the area have been diversified owing to the spread of Islamic medicine and then biomedicine. Here, both traditional healers and patients are not necessarily interested in aetiology. There is a lack of an agreed medical vocabulary or standard meaning for medical words. Traditional healing also has no standard array of treatments - individual innovation and manipulation of biomedicine are the rule. People accept different systems and methods of medicine without following a single consistent conceptual theory. They do not experience intellectual problems concerning the differences in the systems - they do not know and do not care about them. Moreover, they are generally sceptical about all kinds of medicine. In this anarchic situation, however, Last suggests the possibility for the emergence of one dominant medical culture due to government impetus.

Beals' and Last's cases may be somewhat extreme. However, the phenomenon of shopping around among various therapies appears to be common in the therapy management of chronic illness in Africa (Janzen 1978b; Janzen and Feierman eds 1979; Feierman 1985). Thus, Janzen's (1978b) detailed case studies show that his informants move back and forth between a hospital, a local dispensary, traditional and religious healers and healing rituals held by kin.

A third feature of complex medical cultures is the tendency for innovation in medical practices. There are a number of ethnographic reports about such innovation in traditional healing throughout the
world. Apparently, healers are consciously experimenting and inventing new practices. Thus, in India it now appears to be common practice for Ayurvedic healers to make use of injections in their treatment (Burghart 1988). Burghart reports that his informant, an Ayurvedic practitioner, appropriated penicillin for the treatment of various ailments in accordance with Ayurvedic physiology. In Indonesia, the makers of a traditional medicine known as jamu produce the medicine in modern factories (Afδhal and Welsch 1988).

In Africa, while the mass manufacture of herbal medicine does not seem to have been reported, bottling and packaging of herbal medicine appears to be common in southern Nigeria. The use of cans and bottles for storing herbal medicine is also a common practice in Nairobi (Katz et al. 1982). Equally common is the appropriation of ideas and healing techniques of overseas medical cultures. Good (1987) reports that Kamba and Kikuyu healers in Nairobi commonly appropriate English terms such as tb, pneumonia and gonorrhoea for their diagnosis, and even administer antibiotics. Whyte (1982) has witnessed Nyole healers in Uganda apply "Zandu" medicine manufactured in Bombay and make use of battery acid and rat poison for sorcery medicine. According to Hackett (1987), in Nigeria, traditional healers are increasingly taking on a "neo-traditional" character, supplementing and even supplanting their traditional healing forms with new ideas and techniques. Many of the new ideas and techniques which the "neo-traditional" healers appropriate are imports from overseas such as those of spiritual sciences, of astrology, "Indian talisman" and "secret biblical texts". Borrowing from Islamic healing also appears common among traditional healers in regions inhabited by Muslim populations. Swantz (1990) notes that Zaramo traditional healers in Dar es
Salaam commonly make use of the Koran for treatment and practise Islamic divination.

In Africa, it appears to be more common for traditional healers to appropriate the existing healing techniques of other healing cultures and to syncretise them with their own practice rather than to create entirely new techniques. In that sense, the innovation of African traditional healing can be characterised by its incremental character and syncretism.

Thus, there are distinctive and contradictory features of complex medical cultures noted in the literature. On the one hand, it is certain that the features of complex medical cultures differ according to societies. On the other hand, it is also conceivable that the complex medical cultures of the same societies simultaneously have all the features noted in the above ethnographies, even if researchers tend to illuminate only one of them due to their theoretical inclinations. Subsequently, I shall examine the theoretical approaches to complex medical cultures formulated by some of the leading medical anthropologists and shall include the theoretical perspectives implicit in some of the ethnographies mentioned above. Broadly, five approaches can be identified in the literature in the analysis of complex medical cultures: 1) medical system, 2) role adaptation, 3) structural approach, 4) rational choice, and 5) phenomenological approach.

2) The Notion of Medical System: To understand the pluralistic nature of medical cultures in contemporary societies, scholars at first had recourse to the notion of system. Leslie (1980), who is a pioneer of the study of medical pluralism, argues that all medical systems can be conceived of as pluralistic structures in which cosmopolitan medicine is one component standing in competitive or complementary
relationship to numerous alternative therapies. In the case of India, for instance, Leslie (1977) considers all the different medical structures such as Ayurvedic, Yunani, homeopathic and Western medicine as constituting a single medical system. In a similar vein, Kleinman (1980) advocates the importance of viewing medical cultures as forming a single system in any society. Thus he (1980:24) argues:

The single most important concept of cross-cultural studies of medicine is a radical appreciation that in all societies health care activities are more or less interrelated. Therefore, they need to be studied in a holistic manner as socially organised responses to disease that constitute a special cultural system: the health care system. In the same sense in which we speak of religion or language or kinship as cultural systems, we can view medicine as a cultural system, a system of symbolic meaning anchored in particular arrangements of social institutions and patterns of interpersonal relationships. In every culture, illness, the responses to it, individuals experiencing it and treating it are all systematically interconnected. The totality of these interrelationships is the health care system. Put somewhat differently, the health care system, like other cultural systems, integrates the health-related components of society. These include patterns of belief about the causes of illness; norms governing choice and evaluation of treatment; socially-legitimated statuses, roles, power relationships, interaction settings, and institutions.

The main concern of these scholars is comparison of the medical cultures of different societies. To make such comparison possible, in their view, it is necessary to consider all the ideas, practices and social relationships and institutions concerning illness and medicine as forming a single interconnected whole in any society.

The problem with the concept of a system as used by these scholars is that it is so broad and ambiguous that it runs counter not only to the structural
functionalists' elaborate view of a system but also to the conventional idea of a system (Parsons 1951). The word "system" denotes regularity and orderliness of interrelationships (Oxford English Dictionary), whereas Leslie and Kleinman's idea of a medical system includes situations where different medical practices and ideas coexist without much regular interrelationships. For instance, Kleinman (1980:39) considers medical cultures in New York as "a multiple and unintegrated" health care system, where separate groups such as Hispanic American and Hasidic Jewish may view and use the health care systems distinctly, even if they share the same health facilities.

The ambiguity of the concept is evident, if we take into consideration the fact that other scholars see medical cultures in India or Taiwan as consisting of different medical "systems" rather than a single system (Montgomery 1977; Unschuld 1977). By examining extensively various notions of a medical system, Press (1980) proposes that a medical system should be defined as a patterned, interrelated body of values and deliberate practices, governed by a single paradigm of meaning, identification, prevention and treatment of sickness, whereas the coexistence of plural medical systems in a society should be viewed as constituting a "medical configuration". The distinction between system and configuration is useful in that it acknowledges that the coexistence of different medical practices and ideas may or may not lead to coherent relationships. In any case, Leslie and Kleinman's idea of medical system cannot explain why variation in complex medical cultures comes about.

3) **Role Adaptation**: From a more interactionist perspective, Landy (1974) proposes the utility of role theory to understand interrelationships between different therapies. Landy argues that, under the influence of biomedical practice, traditional medical
practice is taking on particular curing roles in various parts of the world. He classifies the curing roles of traditional healing into three: an adaptive curing role (specialisation in certain areas of healing and formation of compartmentality between traditional healing and biomedical practice), an attenuated curing role (decline and marginalisation of traditional healing) and an emergent curing role (development of new traditional healing inspired by biomedical practice).

The idea of role adaptation can explain patterns of therapeutic management and coherent relationships between therapies as well as innovations of practices as a result of the interaction between therapies. However, it is important to note that such general patterns are themselves based on widespread popular knowledge of medical efficacy in societies, but not necessarily efficacy in the objective sense. In other words, interaction between therapies may lead to the construction of such general knowledge of medical efficacy among lay people in societies. The point is, however, that the construction and flow of knowledge of medical efficacy may just as well be differentiated among people in the same societies; it is probable that different groups of people have different ideas of medical efficacy in the same societies.

Thus, for example, Slikkerveer's comprehensive survey (1990) in the rural community of Babile in Ethiopia reveals that popular utilisation of traditional medicine and modern medicine has considerable variation according to the ethnic and religious affiliations of different people. According to the survey, the Christian Amhara make regular use of modern medicine and sporadic use of traditional medicine, while the Muslim Oromo and Somali employ traditional medicine more often than modern medicine. Slikkerveer argues that the predisposing factors of
ethnic and religious affiliation are the most significant predictors of utilisation of traditional and modern medical practices, followed by perceived illness.

It should be added that the idea of role adaptation cannot explain situationality and inconsistency in the therapeutic action which is apparently common among lay people.

4) **Structural Approach**: Complex medical cultures can also be approached from the point of view of articulation (or synthesis) of structures. This is implicit in ethnographies that emphasise cognitive coherence in the combination of global and local medical cultures. These studies consider local cognitive schemes and symbolic classifications as articulated with global cultures, namely, biomedical culture, in such a way as to form a coherent whole. In this conception, there is a transformation of medical cultures which nonetheless involves structural reproduction (Sahlins 1981: 68).

The idea of structural articulation can explain cognitive consistency in the use of both traditional medicine and biomedicine among people in certain social groups, most notably ethnic groups. However, from this, one cannot assume that such cognitive schemes are shared also by other groups of people in the same societies. This is particularly problematic in the cases of urban societies which have a large population of migrants with diverse cultural backgrounds. Again, the distributive view of cultural knowledge has to be taken into consideration.

It is debatable whether actors always interconnect certain cognitive schemes with other knowledge, that is, knowledge concerning actors' social identities and economic situations, and contingent information about medicine and the outcome of therapies, in therapeutic action.
Related to this, while binary classification or four humoral categories may be indeed pervasive in certain societies, interconnection between particular temperature categories on the one hand and particular illness and medicine on the other may not necessarily be widely shared in societies but rather constructed situationally by individual actors, as Beals (1976) indicates.

Finally, the process of structural articulation, or what Sahlins (1981: 72) calls "the structure of conjuncture", is more or less viewed as unconscious. However, actors may consciously reflect upon the knowledge they possess in relation to events and information they encounter. As ethnographies suggest, healers consciously synthesise different therapeutic practices for their particular ends. Such conscious action is outside the scope of the structural approach. Thus, the evidence of situational action by lay people and conscious innovation by healers inevitably shift our attention from structure to action.

5) **Rational Choice**: Rational choice theory has never been very popular in medical anthropology for good reason. Foster and Anderson (1978) argue that people are remarkably pragmatic in their pursuit of therapy and choose the therapy that seems the most appropriate for the particular problem at hand on the basis of empirical evidence. However, the problem with such an argument is that such "empirical facts" on the basis of which people choose a therapy are inseparable from their cultural conceptions of medical efficacy. Young (1979) illustrates this point in his study of Amhara medicine in Ethiopia. He argues that Amhara therapy management is rational in so far as its consequences are consistent with their assumptions about the real world - their therapy "always" works in so far as it produces certain results in a predictable
way, even if it does not do so from Western medical point of view. Thus, an "empirical fact" of medical efficacy is socially constructed and multiply interpreted. Such interpretive multiplicity and the social construction of reality are the foci of the phenomenological approach.

6) **Phenomenological Approach:** The phenomenological approach (and its radical version, ethnomethodology) is useful for the analysis of complex medical cultures in that it acknowledges multiplicity (or "indexicality") of meanings and views individual action as continuously organising multiple meanings according to actors' "projects" and situations. In medical anthropology, one of the proponents of this approach is Byron Good.

Employing Iser's (1978) literary theory of reading, Good (1994) has recently elaborated the phenomenological approach in medical anthropology. Good argues that the pursuit of therapy should not be seen as the enactment of a single textual perspective but as an act of synthesis of plural perspectives. His analysis of chronic illness indicates that patients encounter multiple voices and perspectives on illness and therapies in the form of clinicians' diagnoses, medical documents, popular literatures, alternative healers' views and families' opinions. During the course of their therapeutic action, patients interconnect these perspectives and produces networks of perspectives. Good views this act of synthesis as never complete but rather as an ongoing process, that is, what Iser calls "wondering view points".

Previously, his analysis was more inclined to focus on the structural aspects of therapy management. Thus, in his study of the therapeutic management of people in a rural community in Iran, he argued that various perspectives and experiences of illness were integrated into existing semantic networks that were
"deep" in the sense that they were largely outside of explicit cultural awareness and that they were enduring, appeared to be natural and were generative of popular and professional discourse and behaviour (1994: 172). However, he apparently discounts the significance of such semantic networks in his current analysis and considers these to be just one of various factors that affect the course of therapy management; other factors include social and political relationships in which patients and healers are involved.

Good's approach can explain innovative action, that is, conscious acts of synthesis of different ideas and practices. This is particularly appropriate to the analysis of innovative healers. On the other hand, it is not entirely clear whether chronically ill patients always synthesise different ideas and practices during the course of their therapy management, as Good argues. As indicated in Beals's and Last's studies, patients more often than not shop around among different therapies and employ different medical ideas without considering the interrelationships between them. It is probably fair to say that such situational action is not synthesis of different ideas but rather movement from one to the next.

Secondly, while it is certain that the acknowledgment of the existence of multiple perspectives on illness and their continuous appropriation are essential for the analysis of the therapy management of chronically ill patients, such appropriation of multiple perspectives may vary according to a number of factors including types of illness, process of healing (success and failure of healing), forms of medical knowledge that actors have and social identities and political positions of actors. Thus, in general, it can be said that the
therapeutic action of healers is more consistent than that of lay people - healers tend to stick to "textual knowledge" within their medical traditions rather than synthesising ideas derived from different medical traditions. Patients, too, may routinely employ particular medicine, for example, the use of aspirin for minor fever.

Thirdly, if in medical anthropology the act of synthesis as the focus of analysis is pursued too far, then the ethnographies will be reduced to the description of the complexities of individual action concerning illness and medicine. There will be no way to talk about something collective and general (and therefore specific to a particular society), that is, a culture, any more. As many medical anthropological studies show, it is, however, undeniable that there often exist certain distinctive elements in the therapeutic action of people belonging to particular social groups. In this regard, what Good does not do is to bridge the analytical gap between the act of synthesis on the one hand and semantic associations of medical knowledge and social relationships involved in therapy management on the other.

Thus, I have been concerned mainly with the cognitive aspect of traditional medicine and therapeutic management in complex medical cultures. However, analysis of the cognitive aspect alone cannot adequately encapsulate the nature of therapeutic action and medical cultures. While religious fundamentalists may know a lot about biomedical therapy, they may not employ such knowledge on the grounds of their religious faith and identities. Economic conditions of actors, too, significantly affect their management of therapy. In the following two sections, I shall therefore explore the political and economic dimensions of traditional medicine and therapy in Africa and elsewhere.
SOCIAL RELATIONSHIPS AND IDENTITIES

In relation to the dimension of power in healing and therapy management, this thesis is concerned with: 1) a pluralistic situation where different healers are competing to control lay people, 2) an urban social context in which the therapeutic action of healers and lay people is operating, 3) the influence of the state over the practice of traditional medicine and popular management of therapy, and 4) the impact of national and international economy on the practice of traditional medicine and popular management of therapy. I shall examine the first two issues in this section and the last two in the next section.

While medical anthropology appears to be increasingly concerned with the issue of contestation of plural medicines (Lindenbaum and Lock eds 1993), there have not been many studies conducted specifically on these issues. On the other hand, there have been a number of medical anthropological studies conducted in cities. However, not many studies have specifically focused upon the issue of urban social relationships in which therapeutic action is operating. Here, I shall review some of the major ethnographies that look into the political dimension of social relationships and identities in relation to healing and therapeutic management in general. In this regard, five features of power order and social relationships are distinguishable in the literatures: 1) domination, 2) resistance, 3) solidarity, 4) pluralism, and 5) autonomy. At the end of this section, I shall comment on some of the analytical and methodological problems of these studies.

1) **Domination:** Medical sociologists have long been interested in power relationships between clinicians and patients (Friedson 1970; Zola 1972;
Turner 1987; Scambler ed. 1987; Gerhardt 1989). In recent years, sociological studies of relation between power and medical knowledge has been revitalised by Foucault's work (Foucault 1973, 1977; Turner 1986; Armstrong 1987). By contrast, medical anthropology has not been concerned with the political dimension of healing and therapy management until recently. In this regard, one of the first anthropologists to emphasise the significance of the relations between power and medical knowledge is Allan Young.

Young (1982) points out that medical knowledge has an ideological dimension. In his view, medical knowledge is determined by social relationships in the sense that the actors' knowledge of their social relationships affects the kinds of knowledge that they are likely to produce and act on during the course of their therapeutic management. Conversely, medical knowledge is conducive to the reproduction of specific patterns of social control over actors.

In his case study of post-traumatic stress disorder (PTSD), Young (1993) traces the way in which particular medical knowledge is produced and inculcated into both medical workers and patients in such a way as to serve the social order of a medical institute. PTSD is a recently identified psychiatric disorder. It was defined mainly in the context of diagnosis of mental disorders from which Vietnam War veterans suffer as a result of their traumatic experiences. Apart from such traumatic experiences, the symptoms of PTSD are indistinguishable from depression disorders and other anxiety disorders.

Young carried out his research at the Institute of PTSD which was established by the US government after lobbying by veteran organisations. The aetiological theory and treatment programmes of PTSD at the Institute have been created largely by the director of the Institute and disseminated to medical
workers and patients. The point Young makes is that this medical knowledge serves the hierarchy of authorities and division of labour, with the director at the Institute at the top of the apex. The therapists and patients sometimes resist the Institute's treatment programme. But such resistance is either sanctioned or appropriated within the framework of medical knowledge operating at the Institute. The strength of this ideological knowledge is that both therapists and patients are encouraged and encourage themselves to keep to the treatment programme for the sake of efficacy and construction of respectable identities.

Young's study is focused on the process by which individuals are controlled by a form of medical knowledge and therefore by the medical institute that produces this medical knowledge. In other words, this is a scenario of domination. However, there are studies indicating that the opposite view of medical knowledge and practice is just as possible, that is, a scenario of resistance. Here, medical knowledge and practice are viewed as means of resistance against the dominant class and groups in societies. A major contributor to this approach is I.M. Lewis.

2) **Resistance**: Lewis (1971) surveys various cults of affliction in the world and shows that the practitioners and patients of cults of affliction tend to be those who are marginalised in societies - women in male dominated societies, people in a lower class or caste, ethnic minorities, homosexuals, and disabled people. In his view, cults of affliction provide the marginalised members of societies with a subtle means of protest against the dominant members. Thus, through their affliction, 1) the marginalised get the attention of the dominant, 2) the marginalised openly utter their aggression against the dominant by means of the words of spirits during trances, and 3) the
marginalised achieve some redistribution of the income of the dominant at healing sessions - the meeting of such a request is in fact viewed as the dominant group's shadowy recognition of their injustice. While Lewis is not so much concerned with the wider social contexts in which rituals of protest operate, there have been an increasing number of studies that situate the ritual in wider political contexts. I will examine these studies later.

3) **Solidarity:** A third conceptualisation of healing and aetiology in the context of political relations would be to view healing and aetiology as symbols of solidarity of groups and communities. This perspective is explored by Press (1978) in relation to urban healers. Examining a range of ethnographies about healers in cities, Press argues that in cities traditional healers function to minimise the trauma of acculturation and dislocation that migrants experience. They do this by applying familiar concepts of illness and treatment in the language of the migrants. At the same time, traditional healing also serves to maintain migrants' communal identity - here the occurrence of sickness is considered as a sanction against the neglect of certain traditional roles, and healing acts to restore such a role.

In Africa, Swantz (1990) notes that one of the roles of the maganga among the Zaramo in Dar es Salaam is as a preserver of the Zaramo's social and religious patterns. The Zaramo maganga, who is one of the sole surviving professional functionaries of traditional practice, reinforce the Zaramo world view and promote "Zaramo-ness" through their healing practice. Through diagnosis of spiritual afflictions, they also remind urban Zaramo of the importance of their clan membership.

Likewise, Jules-Rosette (1981) maintains that traditional healers, nganga, in Lusaka, Zambia are
psychological entrepreneurs who exploit the problems of urban adjustment. They achieve this by redefining these problems as the result of non-natural causes and developing a sense of religious, moral and familial obligation among clients. In her view, healing is a transitional symbol, that is, a concrete signifier or "bricolage" that is appropriate to both rural and urban forms of life.

Similar arguments are made from a Marxist point of view as well. Thus, employing the idea of articulation of modes of production, Van Binsbergen (1981) analyses the Bituma healing ritual among the Nkoya in Lusaka. According to him, the Bituma healing ritual represents the articulation of the capitalist mode of production with the domestic mode of production. Nkoya people in Lusaka are in a low class and economically insecure position. Women especially are entirely dependent on men's income, unlike their village counterparts. In this context, the Bituma ritual urges men to redistribute the income they earn in the urban capitalist sector to women and to the domestic and rural sectors - it helps the domestic sector to reproduce itself. Likewise, Mullings (1984) considers traditional healing in Accra to contribute to the perpetuation of a village mode of production, that is, the maintenance of kinship, authority of the elders and reciprocity extended from village communities to the city. On the other hand, Mullings notes that the modes of the healing and symbols employed are individualised in the city context under the influence of predominantly capitalist relationships.

Thus these studies, based largely on a structural-functionalist point of view, suggest that traditional medicine in cities can be seen as serving to solidify migrant communities, to maintain their ties with rural communities and to mitigate
difficulties of adjustment in urban environments.

4) Pluralism: The above studies which I have classified under the rubric of domination, resistance and solidarity have largely been conducted among particular groups and communities such as medical institutes, cults of affliction and migrant communities. However, in the pursuit of therapy, people are not necessarily solely dependent on a particular social relationship or community of which they are members. Especially, in urban contexts, people are likely to be involved in a plurality of social relationships and possess different identities. It is thus necessary to broaden the scope of research to examine the relation between the therapeutic actions of individuals and their plural social relationships. In this regard, while studies on this issue are not yet very numerous, there are some important works to be noted here.

Perhaps the most important study on this subject is Janzen's (1978b) study of therapeutic management among the Bakongo in lower Zaire. Janzen's detailed case studies show that the decision-making of healthseekers is influenced by their various social relationships (close families, patrilateral kinship, matrilateral kinship, friends, various healers and religious groups) which entail internal political relationships. To describe such social relationships, Janzen creates the term, "therapy managing groups". The significance of this concept is to allow researchers to broaden the focus of analysis from patient-healer dyadic relations and from a supposedly homogeneous community to diverse agents and their political relations that affect the therapy management of actors. This approach also draws our attention to the particular configuration of social relationships of healthseekers and the differential importance attached to the relationships - among the Bakongo,
kinship, especially the matrilineal relationship, is of central importance for therapeutic management.

Exploring the medical anthropological literature in Africa, Feierman (1985) argues that in Africa, lay people generally have a very wide range of therapeutic choice, and that lay control over patients is much greater than healers' control over them - the latter merely present therapeutic options from which those in control choose. Feierman's point is, however, that lay therapy managers' control is subject to general authority in the domestic and community sphere, which is in turn under the influence of wider political and economic relationships in societies.

5) Autonomy: Janzen's study emphasises the jural relationships of healthseekers, that is, the way in which individuals' decision-making is affected by social norm. Feierman, too, is concerned with the structure of authority in societies which, in his view, can be adequately understood only in the context of the total history of the societies. However, one could also focus on individuals' autonomy and their choices of social relationships and identities in relation to therapeutic management. It is conceivable that individuals seek their therapy not just to cure their affliction but to construct their identities. Such strategic use of therapies and aetiology for the construction of identities has been studied by some anthropologists.

Thus, in her Bolivian ethnography, Crandon-Malamud (1991) describes the complex process through which the shifting identity of villagers is reflected in their appropriation of therapy and aetiology. Here, the relative decline of the social and economic position of mestizos encourages some to seek their social ties with Indians by appropriating Indian therapies and aetiology, whereas relative upward mobility among Indians has produced a situation where
one of Crandon-Malamud's informants (a clinical doctor of Indian origin) emphasises his identity with a class category and disregards Indian healing and aetiology.

Sargent's study (1985) indicates that Bariba women in the city of Parakou in Benin prefer a hospital delivery partly because they consider a hospital delivery as a requisite for the urban woman, that is, "civilizee", and a home delivery as an indication of a peasant mentality. However, Sargent adds that urban women have mixed values and goals such that most of them still express admiration for the virtuous women who deliver at home.

In contrast, Last's (1979) study indicates that actors can use aetiological explanations and therapies to maintain their identities in a situation where they might otherwise be identified with a social category which they do not like. Thus, in his study, Maguzawa women in Northern Nigeria try to perpetuate their identity as women who can bear children by increasingly attributing their various ailments to gishiri illness and applying cutting treatment to their vagina to cause bleeding. Women who have reached menopause have a high chance of being identified as witches in the communities where social and economic change is taking place.

Thus, in the above literature are discussed different features of power orders in relation to healing and therapeutic management. Once again, we are confronted with variation and contradictions in the features to be explained.

First of all, these differences are partially a reflection of the theoretical perspectives of these researchers and the kinds of methodology they have employed for their researches. As noted, the studies that emphasise aspects of domination, resistance and solidarity in healing and aetiology are based on relatively bounded groups and communities. The problem
with this methodology is that it often fails to acknowledge the action of individuals outside the context of the groups with which the research has been concerned. It may well be that the therapeutic actions of individuals, which appears at first glance to be controlled by the particular groups in which they are involved, turn out to be just one part of a broader range of therapeutic action through which they also try various other groups and healers. In that sense, studies that trace the therapy management of individuals without focusing exclusively on particular groups have an advantage.

On the other hand, it seems clear that under certain situations, the control of therapeutic action is quite durable and fixed. The point is that within the same society, the therapeutic action of some individuals is fluid, whereas that of others is fairly fixed. It is also conceivable that fixedness and fluidity of social control vary in different societies. It appears to me that such variation in the ordering of power within and between societies leads us to acknowledge that there exists a plurality of relatively autonomous agencies (therapists, medical institutions and therapy managing groups) with varying power within societies; the configuration of these agencies differ according to societies, and fixedness and fluidity in therapeutic action also depend very much on the particular construction of actors' identities with therapies and aetiological ideas. However, such configuration of social agencies is in turn strongly influenced by the state and the wider economy, as Feierman argues.

**POLITICAL ECONOMY AND THE STATE**

Here, I review studies dealing with the impact of
the state and national and international economy on the practice of traditional medicine and therapy management in Africa. While my main concern is with urban social contexts, studies specifically examining the impact of the state and economy on the practice of traditional medicine and therapy management in urban societies are still far from abundant. Again, I will generally examine some of the major studies that look into the impact of the state and economy on traditional medicine and therapeutic management in Africa. In this regard, there are three areas that have attracted scholarly attention: 1) the development of capitalism, 2) the perspective of healing, witchcraft and sorcery as resistance against the state and global forces, and 3) the professionalisation of traditional medicine.

1) Marxist Perspectives: While medical anthropology has increasingly been concerned with the political economy of health and medicine (Morsy 1996), insufficient attention has been paid to the political economy of traditional medicine and therapy management in Africa. Obviously, the quest for therapy cannot be pursued without material support, while healers cannot practise healing without material reward. In sub-Saharan Africa, the economic aspect of healing and therapy management has been analyzed largely within the Marxist paradigm.

For scholars working along these lines, mostly medical sociologists and political scientists, the most vital factor in healing and therapy management is the class formations of capital and labour in societies, that is, healing and therapy management are considered to be integrated into the capitalist system. It is argued that in Africa and other parts of the Third World, use of biomedical institutions and their services are limited mainly to the rich ruling class, whereas the poor majority are deprived of
adequate medical services, or at best services are provided for them only in so far as it is considered to be beneficial to the growth of the capitalist economy (Doyal 1979). A number of studies have shown the existence of inequality in the distribution of biomedical institutions between cities and rural areas in African countries (Pearce 1992; Stock and Anyinam 1992). It should be added that in the Marxist perspective, the state is seen as an apparatus of capitalist domination.

The capitalist enterprise of medicine is also becoming an important area for investigation. Apparently, the pharmaceutical medicines produced by multinational companies are now indispensable for popular self-medication in the Third World (Van der Geest and Whyte eds 1988). Van der Geest (1982) argues that people prefer pharmaceutical self-medication to consultation with biomedical doctors in many parts of the world. Applying Gramsci’s idea of hegemony, he suggests that pharmaceutical medicine may be going through a first phase in the continuing process of establishment of medical hegemony. The use of pharmaceutical medicine by traditional healers is also widely reported (Van der Geest and Whyte eds 1988).

Marxist analyses, however, have not paid sufficient attention to traditional medicine. Elling (1981) argues that the mix of traditional and modern medicine is a matter of social control and subject to the interests of ruling classes in capitalist states. In his view, in capitalist states, modern medicine is unequally distributed in favour of the ruling classes; working classes employ mainly traditional medicine in countries with low resources and both traditional medicine and modern medicine of poor quality in countries with high resources. In the case of socialist states, however, depending on the countries’ resources, either modern medicine or the combination
of modern medicine and traditional medicine are equally available.

One of the main problems of the Marxist approach is its lack of detailed studies of the therapeutic action of healers and lay people in particular societies. While the Marxist analyses look into statistical data on the utilisation and distribution of medical facilities and personnel at national and regional levels, they rarely examine the situation of both healers and lay people in particular communities at the micro-level. It is a truism that the material conditions of healers and lay people affect the course of their therapeutic action. However, we need to push beyond this very general observation and examine in what ways the material conditions of individuals affect their therapeutic action and to what extent therapeutic action differs according to people’s class positions in particular societies.

The Marxist approach tends to view state ministries, medical institutes, pharmaceutical companies and individual medical practitioners as all integrated into the capitalist system. However, these agencies may in fact display a degree of autonomy, and their interests may be contradictory to one another in certain cases. Thus, in Nigeria, conflicts between clinical doctors and the state led the former to embark on a series of strikes (Forrest 1995). In general, the power of the state to regulate medical practices can be overemphasized in Africa. Last's comparative study of professionalisation of medical practices (1996) shows that African governments, especially those of former British colonies, are generally tolerant towards the practice of traditional medicine. As noted above, the attitudes of the governments are also changeable and increasingly supportive of traditional healers in Africa.

It is also essential to pay attention to local
cultural logics in therapeutic action in African societies. According to some recent studies of rituals, sorcery and witchcraft in Africa, such local cultural logics are not just surviving but being actively appropriated by people as a means of resistance against the logic of capitalism in African societies, as we shall see in the next section.

2) Power Relations in Healing, Witchcraft and Sorcery: Recently, anthropological studies of rituals in Africa have been increasingly looking into their resistance potential (Comaroff 1985; Lan 1985; Echard 1991; Masquelier 1993). As noted previously, the perspective of rituals and religious movements as forms of protest is nothing new in anthropology. What is new in these studies, however, is that they are highly concerned with the wider social contexts, colonialism, capitalism and the state, in which the rituals are carried out.

Influential in this approach is Comaroff's study (1985) of Zionist churches among the Tshidi in South Africa. Under the apartheid system, colonial and neo-colonial orders, Tshidi people have been marginalised into a peasant-proletariat class. In this social context, Comaroff argues that the healing ritual of Zionist churches can be seen as a "bricolage" that primarily signifies their resistance against those orders that have marginalised them. In her view, both precapitalist Tshidi symbols and symbols derived from capitalism and mainstream Protestant Christianity, for example, Methodist symbols, music with pounding drums, the use of English, hair styles, colour symbolism in dress, abstention from some foods and drinks, are articulated in the healing ritual in such a way as to bring about a subtle but systematic breach of authoritative cultural codes. In other words, Tshidi Zionism and its healing are conceived as "counter-hegemonic".
Such counter-hegemonic potential has also been noted in the bori cult in Niger. Thus Echard (1991) argues that bori adept interpret social and political contradictions affecting them in terms of spirits, especially new spirits associated with dominant ethnic groups and Westerners. She points out that the bori was used by the peasantry for dissident and rebellious action against the colonial conquest (see also Stoller 1996.) Masquelier’s study (1993) also focuses on the bori members’ strategy of resistance against Muslims in a rural town in Niger. Here members of the bori have been politically, economically and ritually marginalised by Muslims. However, they try to reassert their control over a marketplace in the town and threaten the hegemony of Islam by using the threat of the doguwa spirit, which can bring misfortune to offenders.

In this respect, the recent revival of studies of sorcery and witchcraft follows the same trend (Rowlands and Warnier 1988; Geschiere 1988; Comaroff and Comaroff eds 1993). The recent ethnographies of sorcery and witchcraft in Africa analyse the phenomenon in relation to state domination, development of the capitalist economy and urban-rural relationships. While these studies acknowledge complex relationships between sorcery and witchcraft on the one hand and hegemonic agencies on the other, they are inclined to emphasise that, in local communities, the destructive aspect of hegemonic agencies is understood in terms of sorcery and witchcraft, and therefore the accusations of sorcery and witchcraft can be considered to be a local strategy of resistance against hegemony.

Thus, in their pioneering study on this subject, Rowlands and Warnier (1988) reveal complex relationships between sorcery (evu) and the modern Cameroonian state. According to them, on the one hand,
the state has its own logic to suppress sorcery (though its implementation has ironically ended up by increasing sorcery accusations). On the other hand, the rich and those at the centre of the state are popularly considered as sorcerers - they have the attributes of the sorcerer, such as power, conspicuous consumption and selfish accumulation. Rich people's awareness of potential sorcery accusations against them and their fear of the sorcery of their rural relatives encourage them to redistribute some of their wealth in the form of cash and employment to their fellow people. Thus, in Rowlands and Warnier's view, following Geschiere (1982), sorcery has a levelling mechanism - it is one of the local strategies against the state.

Similarly, Geschiere (1988) primarily conceives of sorcery as a popular mode of political action against the state. Noting the levelling implication of sorcery beliefs, Geschiere discusses in his study of the Maka in East Cameroon a case of a local politician who became ill when he visited his home village. His affliction was believed to be caused by the sorcery, djambe, of a relative who was angry about the neglect of the elite's redistributive obligation to his kin. Thus, through the idea of sorcery, villagers could pressurise their rich relatives to redistribute wealth. However, Geschiere is doubtful about the efficacy of sorcery beliefs, since these new elites tend to keep their distance from their home villages, fearing sorcery attack.

In terms of urban and rural relationships, Bastian (1993) situates the significance of witchcraft in the context of increasing separation between city dwellers and village dwellers in Eastern Nigeria. On the one hand, the village dwellers who have little control over their urban relatives consider the city dwellers as selfish accumulators who do not meet
reciprocal obligations. They are therefore seen as witches - the city itself is like a witch for villagers. On the other hand, the city dwellers who have little control over village affairs, especially ancestral rituals, identify the village dwellers with witches who are jealous of their success - the city dwellers' feeling is reflected in their newspapers and popular magazines, which in a way function as a vehicle for witchcraft accusations.

If Marxist analyses have been concerned primarily with the incorporation of local societies into the capitalist system, these recent anthropological studies of the power dimensions of healing, sorcery and witchcraft are characterised by dualistic views of social relationships such as the dominant versus the dominated, the state versus civil society, and the global versus the local. However, it is these dualisms to which many of their analytical problems are attributable.

Thus, a prominent problem of studies that emphasize the resistance aspect of healing rituals is their methodological difficulties in identifying the act of resistance. Apart from cases where overt conflicts are involved, what is considered to be the act of resistance is often subtle and ambiguous, and therefore subject to different interpretations. Thus, while Comaroff (1985) considers various symbols employed in Zionist healing ritual as signifying resistance against capitalism and the apartheid system, Schoffeleers (1991) shows that an almost diametrically opposite interpretation of such rituals is possible. Comparing a broad range of independent churches in South Africa, he finds an inverse relationship between the importance of healing rituals and tendencies towards political activism among these churches. The more therapeutically oriented the churches are, the less politically active they become,
and Zionist churches represent such politically acquiescent churches; Schoffeleers even notes that Zionist churches collaborated with the South African government during the apartheid period. In his view, healing tends to individualise and thereby depoliticise the cause of one's illness.

The same methodological problem is observable in current studies of sorcery and witchcraft. Rowlands and Warnier (1988) emphasise the importance of the levelling mechanism of sorcery as a protest against the state. However, the evidence that this levelling actually occurs appears to be rather slim. If it indeed occurs, it may just as well be interpreted as evidence of the strength of reciprocal ties between government officials and their fellow villagers. It appears to me that in the studies sorcery is viewed as a sign of increased separation between the two, whereas its supposed effect is contradictory to the assumption of such separation.

Thus, for Bastian (1993), the large houses urbanites have built in rural areas serve to indicate such separateness and to embody the selfish accumulation that evokes envious thought in villagers and challenges the authority of the elders. However, one could also suspect that urban elites build houses at villages as a part of their reciprocal obligation to kin. If that is the case, the houses can be considered as a symbol of communality and continuity between urbanites and villagers. The crucial question Bastian does not address is why urbanites are still attached to their villages despite their fear of witchcraft.

Despite their emphasis on the resistance aspect of witchcraft, these scholars acknowledge that the rich and dominant also make use of witchcraft accusation to defend and pursue their interests. Thus, Geschiere (1988) notes that, on the one hand, *djambe*
as a levelling force is virtually ineffectual; however, on the other hand, the new state elite manipulate the rumour of *djambe* protection in order to strengthen their personal positions, not just against their fellow villagers, but more importantly against their rivals within the new elites. Given this situation, it should be acknowledged that *djambe* is not just a popular mode of political action, but can also be a part of any political action including that of domination.

It appears to me that the methodological problems of these studies are due mainly to their dualistic view of contemporary African societies. As noted, they tend to divide societies into two components with rather distinctive cultures; the dominant (the global) and the dominated (the local). They tend to see healing rituals, sorcery and witchcraft as cultural traits by which the actors of the latter social component understand and counteract the actors of the former social component. Problems arise when such cultural traits are found out to be used by the actors of the former as well and when the two social components are found to be not as polarised as is imagined. In other words, binary analysis tends to ignore the complexity of social relationships and the cultural flows through which some social relationships bridge different classes and some cultural elements are evenly distributed among them.

It is conceivable that under certain configurations of social relationships, particular identities are heightened within societies and serve to dichotomise them. In a war situation, traditional medicine might be used by people as a weapon against their enemies (Lan 1985). Yet, again, political situations are variable according to the configuration of social relationships and identities at a particular time and place. Thus, while Echard (1991) and
Masquelier (1993) emphasise the resistance aspect of bori (and hauka) rituals in Niger, across the border in Northern Nigeria, Last (1991) argues that bori is transformed into therapy and entertainment, that is, acceptable forms of a traditional cult in a predominantly Islamic society. He notes that bori performance is even broadcasted on television as one of the folk cultures in the region. Such folklorisation has also been happening in the case of rituals of afflictions such as ngoma in the Bantu-speaking region (Janzen 1994). In this regard, a recent widespread phenomenon of professionalisation of traditional medicine appears to indicate the cooperation between traditional healers and governments rather than the former's resistance against the latter.

3) Professionalisation of Traditional Medicine:
Since the beginning of the 1980s, there has been a remarkable movement among traditional healers throughout sub-Saharan Africa, as traditional healers attempt to organise themselves in professional associations in cooperation with governments and international organisations. A number of studies have been carried out on this issue and some of the results have been assembled in a book, Professionalisation of African Medicine edited by Last and Chavunduka (1986).

The professionalisation movement is closely related to the change of attitude of African governments and international organisations towards traditional medicine. It appears that until the 1970s, the attitude of African governments towards traditional medicine was generally ambiguous, it being largely ignored and its practitioners occasionally harassed. For instance, in the 1960s, the Cameroonian government lumped traditional healing with sorcery and outlawed these practices (Rowlands and Warnier 1988). However, since the 1970s, African governments have
been increasingly supportive of traditional medicine and its practitioners. There appear several reasons for this change - the deterioration of national economies is one, while the influence of the World Health Organization (WHO) and other international organizations is also significant (Bibeau 1979; Bannermann 1982). Thus, the professionalisation of traditional medicine has become one of the major issues for policymakers involved in health delivery in Africa.

Apparently, there have long existed organisations of traditional healers in Africa. Oyebola (1981) notes that associations were founded among Yoruba healers in the 19th century. Ngubane (1981) argues that Zulu diviners have their own elaborate networks throughout South Africa, which are not derived from Western models of organisations but indigenous with historical depth. Yet, for the past 20 years, healers' associations have been formally recognised by African governments and organised according to Western bureaucratic structures. Membership certificates are issued and codes of practice and constitutions are written. Among a number of healers' associations in various countries, perhaps the most advanced is the Zimbabwe National Traditional Healers' Association (ZINATHA) founded in 1980 (Chavunduka 1986). ZINATHA is a national organisation with a hierarchical structure composed of a national executive committee, district committees and branches. At one point it even ran two medical schools and four clinics of its own.

In a number of African countries, national governments have also attempted to integrate traditional healers into their primary health care services. Thus, Warren reports from Ghana that between 1979 and 1983 a primary health care training programme was developed for traditional healers through the collaboration of healers' associations, the Ministry
of Health, biomedical institutions, the Catholic Church and the US Peace Corps. The programme included training in hygienic preparation, preservation of herbs, basic nutrition, storage of medicine and first aid (Warren et al. 1982; Warren 1986). In Swaziland the government and USAID carried out a training programme in the use of oral rehydration salt with traditional healers (Green and Makhubu 1984). In some African countries, biomedical institutions, notably in the field of pharmacology and psychiatry, have also developed an interest in traditional healing, even though, in general, clinical doctors are sceptical and even hostile towards traditional healing (Lambo 1964).

It should be added that some anthropologists have been actively involved in the professionalisation of traditional healers and their integration into national health services. They have not only monitored the process of professionalisation but also have made practical proposals for the implementation of the programmes (MacCormack 1981; Bibeau et al. 1979). In one case, an anthropologist has even become the first president of a national herbalist association (Chavunduka 1986).

These studies were conducted mostly at the time when the professionalisation of traditional medicine just started. Coupled with the practical concern and involvement of the anthropologists, this appears to explain their hopeful prospect for the professionalisation of traditional medicine in the sense of standardisation and improvement of traditional medical practices and their integration into national and international primary health care policies and programmes. However, detail studies that monitor this process have yet to be seen.

CULTURAL FLOW, FIELD AND ACTION
In this final section, I propose to discuss the issues that have emerged in the literature review and clarify my analytical framework in this thesis. To begin with, I will present the idea of cultural flow to understand complex medical cultures.

1) Cultural Flow: The idea of cultural flow has been recently developed by Hannerz (1992). The principles underpinning Hannerz's idea are rather simple: 1) there are diverse cultures (he views cultures as networks of meanings) in the world; 2) these cultures are, however, no longer confined within particular groups of people but travel widely between individuals and between groups; 3) interaction between different cultures and perspectives is conducive to the production of new cultures and perspectives; 4) however, the cultural repertoires of members of even the same societies are never the same and make the coherence of the shared culture unlikely. Hannerz examines the distribution and production of cultures in terms of four frameworks (the state, market, movement and form of life), two modes of flow (symmetrical and asymmetrical) and various constraints on flow (ideology, secrecy, identity, credence and expertise). In his view, the continuous process of cultural flow and human interaction generates the creolisation of cultures and thus never leads to the homogenisation of cultures in the contemporary world.

The idea of cultural flow has an advantage in the analysis of complex medical cultures in that it does not view cultures as segregated between groups nor entirely homogenous in societies. Thus, some medical knowledge and practices are evenly distributed among the members of a society, while others are unevenly distributed to particular individuals. The combination of different kinds of medical knowledge and practices that each member possesses may overlap among them but is never the same. While certain medical knowledge and
practices are reproduced time and again in societies, individuals also encounter and learn new knowledge and practices. The learning of new medical knowledge, however, necessarily involves the process of interpretation of the new knowledge on the basis of the existing knowledge that individuals possess.

Thus, it is possible that some medical knowledge and practices can be more or less exclusively distributed to certain groups of people. Undoubtedly, this is the case of medical knowledge and practices of biomedical practitioners and possibly that of certain religious groups. Among lay people, however, it is likely that some medical knowledge and practices are fairly evenly distributed in many societies. The similarity of therapeutic management among people in societies, as indicated in ethnographies, is partially attributable to such general knowledge. It is important to note that the use of medical knowledge does not only enable actors to understand illness and manage their therapies but at the same time constrains their action. Structure is both enabling and constraining, a characteristic Giddens (1979) calls the "duality of structure". Phenomenological approaches tend to focus on the enabling factor of structure alone.

In this regard, the structural articulation of biomedical culture and indigenous medical culture noted in ethnographies would be a case where the understanding and interpretation of biomedical practices on the basis of indigenous medical knowledge are not only widely shared but reproduced time and again by people in relatively culturally homogenous societies. In the case of innovative action by healers, the synthesis of various kinds of knowledge and practices is consciously sought for their particular goals. On the other hand, the situations of the almost chaotic medical cultures depicted by Beals
and Last would be cases where cultural flow is marked by unevenness and fragmentation. It is also possible that these medical cultures are in a state of flux where health seekers encounter diverse new medical knowledge and practices during the course of their therapy management.

Where medical cultures are in a state of flux, actors may have to interpret a multitude of new ideas and practices on the basis of their existing ideas. Such a task may sound complex and contradictory. However, in reality, this may not be the case. Actors may interpret diverse ideas and practices according to relatively simple conceptual frameworks without looking into the complexity and detail of the new ideas. In other words, it is conceivable that in such an extremely pluralistic situation, the primary act of interpretation is to simplify medical ideas. It appears to me that Last (1981) makes such a point when he remarks on the "significance of not knowing". Obviously, Last is not arguing that people do not know anything about medicine and illness, but that while encountering and having bits and pieces of ideas about illness and medicine, they do not work out interconnections between all of these. For example, on the one hand, actors may learn from various people that fever is caused by mosquitos; that fever is caused by witchcraft; that fever is cured by chloroquine; that fever is cured by a sacrificial ritual. On the other hand, actors may not consider nor care about how these contradictory ideas fit together. Yet, it appears to me that actors should have at least some basic ideas to make sense of their encounters. For instance, the general concepts of causes and medicine (both mosquitos and witchcraft are 'causes'; both chloroquine and a sacrificial ritual are 'medicine'). This point leads us to another theoretical consideration: forms of knowledge.
2) **Forms of Knowledge:** It appears to me that forms of medical knowledge are partially responsible for the variation in therapeutic action. Forms of medical knowledge can be distinguished according to a range of possible interpretations of that knowledge. If we compare the idea of fever as 1) simply certain symptomatic features versus 2) malarial fever as the fever caused by the plasmodium injected into blood by the female *Anopheles* mosquito, the idea of fever is more useable than the idea of malarial fever. If someone describes the symptomatic features of his or her illness without using the words, 'fever' or 'malarial fever', we can more easily identify the symptoms with the more general term, 'fever', than the more precise term, 'malarial fever'. The idea of fever is more useable not in the sense that it is associated with a wider range of realities (ideas) in a fixed manner but that it can be associated with a wider range of unknown realities (ideas). In other words, the concrete idea of fever as an almost visualised image is less contradictory to other ideas than the more elaborate idea of malarial fever which presupposes the equally elaborate ideas of other types of fever.

In this regard, Levi-Strauss's (1966) distinction between *bricoleurs* and engineers throws light on the understanding of relationships between forms of knowledge, ranges of interpretations and duality of forms. To draw a contrast between primitive thought and scientific thought, Levi-Strauss employs the metaphor of *bricoleurs* as those who manipulate a limited set of existing tools to handle a diversity of problems; engineers are those who invent a new set of tools to handle a specific problem. Against Levi-Bruhl, Levi-Strauss argues that the operation of primitive thought is as logical as that of scientific thought. But the differences are that in primitive
thought, lay people, like bricoleurs, use existing concrete images and signs to understand diverse phenomena and events, whereas in scientific thought, abstract concepts are employed or even invented to understand a specific phenomenon.

Thus, Lévi-Strauss clearly recognises a correlation between concrete forms, multiple significations, and duality of forms on the one hand and a correlation between abstract forms, specific significations and change of forms on the other. It appears to me that this distinction is relevant for understanding differences in forms of medical knowledge. Medical knowledge can be concrete in form and be used situationally for the understanding of diverse illnesses and their treatment, while it can form an elaborate and abstract system in which each concept is tightly defined.

While Lévi-Strauss is clearly wrong in labelling concrete knowledge as primitive thought and abstract knowledge as scientific thought - even nuclear physicists use concrete images and signs, not molecular formulae, to understand the world in their everyday life - a range and forms of medical knowledge might have some variation according to individuals and groups. In that sense, it is important to examine relationships between flow and forms of knowledge.

Thus, in general, elaborate medical knowledge is distributed mainly among medical practitioners, while concrete medical knowledge is more widely spread in societies. Certain concrete medical ideas may well be pervasive in certain societies, widely shared and reproduced repeatedly. This may be the case of binary classification in Guatemala or the symbol of heart in Iran (Logan 1973; Good 1994). However, concrete forms of medical knowledge can be in a state of flux - there may be a wide variety of different concrete medical knowledge elements in certain societies and people may
encounter them through their therapeutic action. This may be the case in South India and Northern Nigeria depicted in Beals (1976) and Last (1981) respectively. It can be said that, in general, concrete forms of knowledge can spread widely because it is easy to learn and make sense of them, whereas in comparison elaborate systems of knowledge are not good travellers, because it is difficult to learn them.

In this regard, it appears that a number of anthropological studies of medicine and religion in Africa have been attracted to the significance of such concrete forms of knowledge. Thus, medical knowledge and religious knowledge in African societies are often characterised by multiplicity, fluidity and a certain stability (Evans-Prichard 1937; Horton 1967; Prins 1979; Janzen 1981; Westerlund 1989; Barber 1990; Blakely, van Beek and Thomson 1994). Thus, while we have to be cautious about sweeping generalisations in the characterisation of forms of knowledge in Africa, it is nonetheless relevant to pay sufficient attention to the significance of concrete forms of knowledge in local contexts.

Yet, clearly, the idea of cultural flow and forms is by itself incomplete for the understanding of complex medical culture and therapeutic action. As Young (1982) argues, the examination of power dimension is indispensable for the analysis of therapeutic action.

3) Field: To study complex medical cultures, one cannot make the a priori assumption that the cultural domain of medicine constitutes an integrated system in which therapeutic agencies and individual healthseekers are linked parts. Rather, it is necessary to take into account the autonomy of agencies and individuals whose power and internal relationships are variable from society to society. In this regard, Bourdieu's (1977, see also Robbins 1991)
idea of 'field' is relevant here, even though it needs to be qualified to some extent.

Central to Bourdieu's idea of 'field' is the view that cultural fields, such as the field of religion, of art and of economy, do not naturally and spontaneously exist in societies, but are created by particular agents. In particular, these agents are the dominant class and specialists, such as artists and religious leaders, and it is they who inculcate these perspectives into the rest of the population. While the classificatory schemes, symbols and values attached to particular fields, as 'doxa', are taken for granted by people, they serve the interests of the dominant class and maintain social order. However, Bourdieu envisions a possibility of transformation of 'doxa' into orthodoxy as a result of the emergence of heterodox oppositional views. The dominated can be aware of the power implication of 'doxa' and obtain symbolic and material means to create alternatives.

The idea of 'field' is useful for the analysis of complex medical cultures in urban context in that it opens a perspective on cultural domains as constituting an arena where different opinions and ideas are contested. However, the problem of the application of Bourdieu's theoretical perspective is, first of all, that it appears that Bourdieu is concerned mainly with the process of domination rather than contestation. Bourdieu considers cultural fields as basically delimited by the dominant class and specialists. This aspect of the idea of 'field' has to be qualified, since, as we have seen, the cultural field of medicine may contain plurality of agencies, none of which necessarily has a hegemonic position. In such pluralistic situations, the delimitation of boundary of the field of medicine may vary, if overlapping, according to institutions, groups and individuals, and therefore it is misleading to study
the field of medicine on the basis of the definition of the field by particular groups or individuals.

To analyse such a pluralistic cultural field, it appears to be necessary to bring in the idea of cultural flow. As noted, the flow of cultural elements are both even and uneven within the same societies. Even where different institutions and groups exist, there are certain elements that are relatively widely distributed among them. It appears to me that one can establish the boundary of a particular cultural field on the basis of such widely shared cultural elements.

In this thesis, I have delimited the focus of analysis as that of everyday crises and their management rather than the field of medicine. It appears to me that medical anthropology has tended to focus narrowly on the field of medicine as the cultural field concerning physical and mental illnesses and their therapies. The problem of this focus of analysis is that even if this delimitation of the field corresponds to that of a particular institution or a group, it does not necessarily cover all the conceptualisations of the field by different institutions, groups and individuals in societies. This is particularly problematic in African contexts, because it appears that the generally shared views of illness and medicine are much broader than that of physical and mental afflictions and their treatments, and are inclusive of everyday crises and their management that are not "medical" in Western sense.

Thus, overviewing a series of studies about African medicine in the 1980s, Feierman and Janzen (1992) emphasise the importance of studying therapeutics in total social history, as they are an integral part of politics, kinship, religions, trade, farming and sexual life. For instance, among the Hausa, the concept of lafiya, which is often translated as health, in fact means a state of
wellbeing, while the concept of cuta simultaneously denotes illness and deceit (Wall 1988) and harm (Last, personal communication). Among the Tiv, a group of illnesses called akombo can be at the same time various emblems used to protect farm and houses (Bohannan and Bohannan 1969; Price-Williams 1962). Aetiological ideas are often inseparable from kinship norms in Africa, as in the case of Ndembu (Turner 1968) and Bakongo (Janzen 1978b). Criticising studies that aim to delineate discrete medical systems in African societies, Pool (1994) argues that among the Winmbum in Cameroon, there is no clear distinction between disease and non-disease misfortunes, both of which can be caused by witchcraft. In his view, the prevalence and significance of witchcraft in African societies are indicative of the non-existence of medical systems.

It is also a well-known fact that the distinction between religion and medicine is not clearcut in Africa. It is important to note that classical ethnographies, such as Evans-Pritchard's study of witchcraft and Turner's study of a ritual of affliction can be considered as a study of medicine as well as religion and cosmology. Whyte (1989) traces the history of anthropological studies concerning healing, divination and ideas of misfortune in African societies. She notes that medicine and illness had not originally formed a distinctive area of investigation but had been dealt with as a part of studies of religion and cosmology in Africa until more specialised medical anthropology developed and started to deal with these "religious" phenomena as "medical" phenomena. However, the study of religion in Africa is still in no small part the study of medicine. This is evident in a recent collection of essays about African religions edited by Blakely, van Beek and Thomson (1994). In the introduction, the editors point to
instrumentality as one of the essential characteristics of African religions. Thus, African religions are often a means for the solution of practical problems including physical afflictions.

Thus, in an African context, it appears to be adequate to analyse illness in a broader framework of misfortunes in everyday life and reconsider medicine as a means for the solution of everyday crises in which cure of physical afflictions is merely a part, just as Evans-Prichard did. In other words, the perspective of the field of everyday crises can incorporate a much wider range of views and ideas of illness, misfortunes and their management of different agents and individuals than the perspective of cultural field of medicine.

4) Configuration of Agencies: Thus, there may exist a plurality of agencies that control healers and lay people in the field of everyday crises and their management. They may exercise their controls through knowledge, social norms and identities, and material resources. These agencies may consist of various healers and their organisations, lay people and their various groups ranging from kinship, friends and neighbours to religious groups, and economic organisations such as various business corporations, companies and shops, and the state and its apparatus.

Some agencies may be more powerful in controlling actors, that is healers and healthseekers, than others. They may have hegemonic positions in societies and structure other agencies according to their principles. However, the configurations and power order of these agencies are obviously variable according to the society. Internal relationships between agencies can be relatively stable, or fluid and changing, while relationships of individuals to these agencies can be relatively stable, or fluid and changing.
In this regard, interrelationships between healers, and between healers and clients, can be seen as constituting a market situation (Last 1991). This perspective allows for either the autonomy or dependency of agencies and actors in the analysis of pluralistic medical situations. It is particularly appropriate in cases where the market economy is in the process of penetrating the practices of social agencies. Thus, relationships between healers can be seen as competitive in their struggles to control their clients. Their competition may lead to the elaboration of roles and certain specialisation between them, even though such roles cannot be seen as fixed. On the other hand, competition may promote innovation of practice, as many ethnographies indicate. The relationships between healers and lay people can thus be seen as that of producers and consumers. Here, lay people as consumers are not permanently controlled by particular healers and their institutions but rather can shift from one to another. Obviously, market situations are variable from society to society.

Another important area of investigation on the power dimension of therapeutic action is the construction of actors' identities via particular therapies and aetiological ideas. The question to be tackled is under which circumstances the formation of actors' identities in relation to therapies and aetiological concepts tends to be fixed or to be fluid. In this regard, it appears to be important to look into relations between the flow and forms of therapy and aetiological concepts on the one hand and the strength and fixedness of identities on the other. As Hannerz (1992) argues, the formation of identities affects cultural flow. However, conversely, cultural flows and forms may contribute to the strength and durability of identities.
Thus, it is conceivable that the larger the diversity of therapies and aetiological ideas that actors encounter in their therapeutic action, the more difficult it is for actors to develop and maintain their durable identities on the basis of particular therapies and aetiological ideas (i.e., the case of chronically ill patients who try various therapies and aetiological ideas). On the other hand, the more the actors employ therapies and aetiological ideas that are reproduced repeatedly and unevenly distributed among actors, the more durable and well defined the actors' identities with these therapies and aetiological ideas may be (i.e., the case of the identities of medical practitioners). Yet, it is also conceivable that in a state of flux of therapies and aetiology where actors are exposed to a plurality of contradictory persuasions, they withdraw themselves into a single therapy and keep to a single aetiological explanation; they therefore exclusively identify themselves with that particular therapy and aetiology (i.e., the case of religious fundamentalists).

In terms of cultural forms, it is probable that if actors develop their identities with therapies and aetiological ideas that have an aspect of bricolage, such identities are durable, since such therapies and ideas can be used for the understanding and management of diverse problems and events (i.e. the case of religious fundamentalists' idea of the God as the ultimate healer and the devil as the cause of all misfortunes).

The field of everyday crises, however, does not consist only of the activities of therapists and lay people. These are interwoven within numerous other social relationships. The acknowledgement of plural relationships is particularly important for the analysis of urban situations. In this regard, one can
make use of the fruits of urban studies in sociology and anthropology.

5) Variation in Urban Social Relationships: In studies of urbanism, social relationships and cultures in cities have been variously characterised by their impersonality and specialised relationships (Simmel 1905; Wirth 1938), their village-like relationships and communities (Gans 1962; Young and Willmot 1957) and their creation of new cultures and groups (Fischer 1975). Apparently, however, such distinctive characteristics can coexist within a single city. Pointing out the urban dwellers' experience of all the different aspects of city life, Flanagan (1993: 23) suggests that questions should be asked regarding the varying circumstances in which these features are found.

One of the more useful devices to analyse variation in urban social relationships is the idea of social networks. Mitchell (1986) distinguished three aspects of social networks: 1) multiplexity (dyadic relationships with multiple functions and dimensions) versus single stranded relationships (dyadic relationships with a specialised function), 2) mesh, ranging from close knit (relationships with direct contact) to loose knit (relationships without such direct contact) and 3) intensity (frequency of contact and interaction). Thus, the configuration of social networks of individuals can be conceptualised according to the combinations of these factors.

In relation to power, Mitchell argues that the more intense relationships are, the more demanding their obligations become. It is also obvious that in close-knit networks, individuals' choices of roles and activities is more restricted than in loose-knit networks. Thus, for our present purpose of characterising the strength and durability of social control over healers and lay people in their
therapeutic action, it may well be that the therapeutic action of healers and lay people involved in a close-knit network with small mesh tends to be heavily constrained by the social relationships and therefore coherent, whereas the therapeutic action of those in a loose-knit network with large mesh tends to be weakly constrained by the social relationships and has considerable autonomy to choose therapies and innovate new practice.

Relationships between healers and lay people, too, can be conceived in network terms. Thus, their relationship may be single stranded, that is, the roles of each parties are specific, namely that of healers and clients, whereas it may be multiplex, that is, it entails many roles such as friendships and master-apprentices. In the former case, healers' control over lay people's therapeutic action may be strong, while their relationship may be shortlived if the therapy fails to produce the expected efficacy. In the latter case, healers' control over lay people's therapeutic action may or may not be strong, whereas their relationship may be sustainable, since failure of the therapy may not necessarily undermine all the roles between them, even if the significance of the role of healer-client is diminished.

While the configuration of social networks and power order may be variable according to individuals within the same cities, there may be general tendencies in the forms of social relationships of particular cities as a whole. Hannerz (1980), for instance, develops various contrasts between two types of cities (viewed as two extremes along a continuum) such as soft cities versus hard cities, fox-like cities versus hedgehog-like cities, and multicentric cities versus uncentric cities. These types roughly correspond to the degrees of flexibility or fixedness of cultural repertoires and choices of social roles.
among different city dwellers. Hannerz points out the significance of the domain of provision (the occupational and economic sector) as the city-forming sector to affect social relationships of cities as a whole.

Thus, the configuration of social relationships and power order in cities is bound up with the nature of the state and the market economy. State and business enterprises attempt to structure social relationships in cities according to their respective logics, thus tending to stabilise the repertoires of roles of city dwellers. They also directly influence therapeutic action of healers and lay people through the regulation and control of material resources. However, one should not overestimate the power and hegemonic logic of the state and the market economy. Especially in African contexts, an assumption of the total incorporation in capitalist system and dualistic power relation is problematic. In this regard, it is useful to incorporate the findings of recent studies in the political economy of Africa.

6) Political Economy of Urban Africa: In recent years, studies of political economy in Africa appear to have shifted their focus from the straightforward totalisation of the world capitalist system, dualistic class formation and conflict, and the static articulation of modes of production towards an emphasis on the locally specific nature of capitalist development and state formation, in which multiplicity of agencies and social relationships are involved and interact with one another in dynamic ways (Chazan et al. 1992). The key concepts that have emerged out of this discourse are entrepreneurs and patron-client relationships (Iliffe 1983; Bayart 1993; Rothchild and Chazan eds 1988; Berry 1985; MacGaffey 1987; Joseph 1987; Barns 1986; Kennedy 1988; Rowlands 1993; Warnier 1993). Here, entrepreneurs do not quite conform to the
Shumpeterian entrepreneur who innovates new structures of enterprises by combining various existing structures, but are seen rather as those politicians, bureaucrats and business people who move between the domains of politics and economy, make use of the apparatus and resources of one to achieve the objectives of the other, and diversify their means to achieve their ends rather than specialising in particular means and seeking to improve them. Of the various means they employ, patron-client relationships that connect them with office holders in the state ministries, political parties and business organisations are especially significant. On the one hand, these entrepreneurs are individualistic in their pursuit of goals and may accumulate considerable social as well as economic capital, partly by manipulating patron-client networks. On the other hand, they are obliged to adhere to norms of reciprocity in the various social networks in which they are involved, most notably kinship. In this perspective, the state is considered to be weak, hollow and even to have failed in its project (Rothchild and Chazan eds 1988; Mbembe 1992; Davidson 1992). The penetration of patron-client networks and its consequent prebendal politics are apparently partly responsible for the weakening of the bureaucratic order of the state (Joseph 1987).

On the whole, the market economy is based on commerce rather than industry, even though this view is refuted by some scholars (Iliffe 1983; Kennedy 1988; Callaghy 1988; Forrest 1994). The development of working class relations has been observed (Sandbrook and Cohen eds 1975; Lubeck 1986). However, class divisions are vertically intersected by patron-client relationships. Class identities are also bound up with other social identities, most notably ethnic and religious identities. At times, class identities are
merged with other social identities - for examples, it is common that some business people are associated with particular ethnic identities (Cohen 1969; Rowlands 1993), while factory workers may solidify against the management through their religious identities (Lubeck 1986). At other times, class identities are neutralised by other identities - heightened identities may shift from class to ethnicity according to situations (Epstein 1958).

On the whole, it appears to be undeniable that people, from rich politicians to petty traders, have a multiplicity of activities and identities which they appropriate for their political and economic interests. Such entrepreneurial endeavour is, however, apparently characterised with uncertainty and insecurity (Berry 1985; Callaghy 1988; Schatzberg 1991). In particular, uncertainty and insecurity appear to be a remarkable feature of the life of those living in cities.

What is characteristic of urban economy in Africa and other parts of the Third World is the large sector of informal economic sector and the diverse range of social relationships that provide city dwellers with their basic needs outside the context of market exchange (Hart 1973; Gugler and Flanagan 1978; Bromley 1988; Castells and Portes 1989; Gilbert and Gugler 1992; Flanagan 1993). In many countries in the Third World, urbanisation has been accompanied by only limited industrialisation. The major part of urban populations is engaged in trade, craft and service activities, many of which are not recognised by the government nor by trade unions (and are therefore untaxed and unprotected). Such informal economy includes an enormous range of activities; some are lucrative and generate higher incomes than many jobs in the formal sector; others are highly competitive and unstable; and yet others are a last resort for
city dwellers and barely provide subsistence. On the other hand, in the formal sector, many jobs are casual and underpaid. A large number of city dwellers are also often out of work, if not permanently (Gilbert and Gugler 1992). In this situation, mobility between jobs appears to be high (Little 1974; Jules-Rosette 1981; Lloyd 1982). It also appears to be a common strategy that urban dwellers attempt to diversify their economic activities.

On the other hand, such economic insecurity is compensated to a degree by the multiplicity of social relationships in which city dwellers are involved (Little 1974; Gugler and Flanagan 1978; Lomnitz 1988). They are often provided with basic needs such as food and shelter by their kin, friends, members of religious organisations, neighbours, voluntary associations and others. Job opportunities are also sought through these networks of relationships. Extended kinship networks not only cut across a city but also connect those in the city with their relatives in the village. Many city dwellers are linked with rural communities and often make visits home. In that sense, they live in a dual system of urban and rural social relationships (Gilbert and Gugler 1992: 159). However, it is apparent that such reciprocal networks of support are not normally sufficient to enable city dwellers to live off them - they cannot simply continue to rely on their relatives and friends. For the majority of city dwellers, their problems are not that they cannot subsist themselves, but that they suffer from economic insecurity and uncertainty, movement between various casual and underpaid jobs, self-employment with high competition, and reliance on relatives, friends and others (Hart 1973; Jellinek 1988; Lomnitz 1988). It appears to me to be essential that traditional medicine and crisis management in cities should be understood in this
Thus, it is probable that the cultural field of everyday crises and their management reflects such insecure and uncertain economic conditions of people in urban Africa. Here, traditional medicine may serve as one of the means to cope with the uncertainty and insecurity of lives of urban dwellers. On the other hand, traditional medicine can be seen as one of many informal economic activities. It can be lucrative or highly unstable. Healers may practise healing as a part of an economic diversification strategy and in such cases healers may be one of those entrepreneurs struggling in cities.

7) Therapeutic Action and its Changeability:
Finally, it appears to be useful to distinguish three aspects of therapeutic action and crisis management of both healers and lay people in relation to structures (i.e. cognitive schemes, knowledge, norms and material resources): situational action (contingent and fluid action), routine action (reproduced and consistent action), and innovative action (critical and systematic action). These should be conceived as being situated on a continuum rather than as forming distinct categories.

Situational action refers to the action in which actors either use the plurality of structures without constructing interconnections to understand and manage a particular object and event, or appropriate a particular structure to understand and manage the plurality of objects and events. The practice of chronically ill patients who shop around for various ideas and therapies may be examples of the former, while the practice of religious fundamentalists who employ their religious ideas and healing for diverse afflictions and problems may be examples of the latter.

Routine action is the action that is constrained
by particular structures and maintains them. Actors may or may not be aware of structural constraint. People may routinely use aspirin for treatment of fever. As in Young's study, people may be quite aware of structural constraint, but encouraged or even compelled to follow certain structures (i.e. aetiological ideas and treatment programmes).

Innovative action is the action by which actors critically scrutinise existing structures and change them. This may be the case of medical practitioners who innovate new practices for their particular projects (i.e., improvement of efficacy and increase of profit).

It is conceivable that the three features of action themselves are structured and form 'habitus' (Bourdieu 1977). Chronically ill patients may habitually shop around for different therapies and aetiological ideas, whereas certain medical experts may habitually challenge existing ideas and practices and develop new ones. However, it is also certain that the tendency may change from one to another. It appears to be common that the therapeutic action of lay people follows a routine at the initial stage, whereas the action become increasingly situational, as the therapy employed fails to yield the expected effect. It is also possible that one feature of therapeutic action is particularly remarkable against others in societies at large, as is indicated in the variation of therapeutic management in ethnographies.

The point is, which should be clear in my preceding argument, that all factors mentioned above (cultural flow, forms of knowledge, social relationships and identities, and the state and economy) are bound up with the tendency of therapeutic action and its change. Thus, the objective of the thesis is to examine the complex configuration of these factors in relation to the practice of
traditional medicine and management of everyday crises in Kaduna.

PLAN OF THESIS

In Chapter III, I depict the main characteristics of social relations and cultures in Kaduna. Social relations and cultures in the city are marked by a plurality of institutions and social groups and a lack of hegemonic agencies in different cultural fields, and a remarkable degree of cultural diversity. In Chapter IV, I explore the nature of traditional medicine and its practitioners in Kaduna. At first, I sketch all the types and range of medical practices available in Kaduna. Then I look into the objectives of traditional medicine, the characteristics of clients and their relationships with healers, the nature and change of the practice of traditional medicine, the economic strategies of healers, and the learning process of healing. Some of the points made in Chapter IV are illustrated in the concrete case study of a healer in Chapter V. In Chapter VI, I examine in detail the process of professionalisation of traditional healers' associations. Here, I also describe various groupings in the organisations of traditional healers in the city.

In Chapter VII, I shift my focus to the crisis management of individuals of which the practice of traditional medicine is a part. The chapter consists of detailed case studies of the crisis management of five people, ranging from therapy of mental illness to the management of conflicts with tenants. In Chapter VIII the case studies are analysed. Here, I note the importance of the conceptions of the cultural field of everyday crisis management, cultural flow and configuration of social agencies and reveal the
particular nature of these factors with regard to the cases of four individuals which are bound up with the overall characteristics of the factors in Kaduna. Finally, I summarise my main arguments in the thesis and pursue a wider theoretical implication.
CHAPTER III

KADUNA - An Urban Setting

Kaduna is the capital city of the Kaduna State in Nigeria. The city is situated centrally in the northern region of the country and about 180 kilometres north of the federal capital, Abuja. (See map of Kaduna on the following page.) The area is part of the plain in savanna zone where seasons are divided into the longer dry season and the rainy season. Through the city runs the river Kaduna from which the name of the city derives, even though there is controversy over the meaning of the word between Hausa and Gbagyi people in the city. While no reliable statistics are available for the current population, roughly one million people are estimated to live in the city in 1990.

In the following, I shall focus on the main social and cultural features of Kaduna. The features consist of: 1) rapid growth; 2) a young migrant population; 3) cultural diversity, 4) one of the major political and industrial centres in the country, and 5) historical change from a planned colonial city to a city of cultural flux. The understanding of these features is essential for the subsequent exploration of traditional medicine and everyday crises in Kaduna.

HISTORY

1) Lugard and Colonialism: Kaduna is a colonial creation. Unlike other major cities in Nigeria, the city lacks its own history prior to British colonisation. In 1913, the city was established as the
The capital of the Northern Protectorate of Northern Nigeria by the governor of the British colony, Frederick Lugard.

The capital of the Northern Protectorate was situated initially in Zungeru, about 150 kilometres south-west of Kaduna. The decision to move the capital to Kaduna was made because of: the existence of a railway station on the line from Lagos to Kano, which was strategically significant for military purposes, an abundant and clean water supply from the river Kaduna, and pleasant climate.

Previously, the area was sparsely inhabited by Gbagyi people - some of their settlements were situated in the present Makera and Barnawa areas. Gbagyis, who were mostly agriculturalists, did not have a centralised political system and were under the influence of the emirate of Zazzau. However, the influence of the emirate appears to have been largely tributary, and Gbagyis were not converted to Islam.

In 1911, a railway station was opened in the present Kaduna-South and a settlement of railway workers and traders began to develop in the Makera area. Between 1913 and 1917, Lugard transferred the soldiers of the West African Frontier Force, administrators, clerks and labourers (altogether about 5,000 people) from Zungeru to Kaduna, which has become the foundation of the city.

Kaduna was thus created for the administrative and military purposes of the British colonial government. The city was carefully designed in accordance with this specific objective. First, the residences of British officers and other Europeans were segregated from that of Africans. In the European quarter, streets were laid out in a gridiron pattern, and trees were planted along the streets - considerable attention was paid to the beautification of the city which is still evident in this part of Kaduna. The governor’s office was designed to exhibit...
its architectural beauty and political significance. Not only were administrative offices and secretariats built in this quarter but also leisure facilities such as a race course and a polo field.

On the other hand, the area where the Africans lived consisted of Clerk Quarter, Sabon Gari, Tudun Wada and Makera-Kakuri. There was some variation in the ethnic composition of settlers in these areas, which reflects the way each settlement developed — for instance, Clerk Quarter was inhabited mainly by non-Nigerian clerks from Zungeru, while Tudun Wada was formed out of the settlement of labourers from the Kano Province and the present Niger State. Administratively, Clerk Quarter and Sabon Gari were under the direct control of the colonial government, while the rest was left for the native authority of the emirate of Zazzau.

Kaduna's principal character as the city of administration and the army garrison was unchanged until the 1950s. The colonial government was not interested in the economic development of the city, even though the Niger Company, dealing with local cash crops and imported consumer goods, was stationed there. The construction of administrative offices and housing continued and provided much of the employment for migrants. The population growth of the city appears to have been steady until after the second world war (Bello and Oyedele).

2) **Ahmadu Bello and Regionalism:** The second phase of the development of Kaduna came during the period of decolonisation of Nigeria. The formation of the regional government of the North gave an incentive to the growth of the city. The central figure in this development was the Sardauna of Sokoto, Ahmadu Bello.

By this time, the Northern Region was far behind the Southern Region in the process of modernisation. Ahmadu Bello was very concerned about the situation,
and his policy revolved around the catching up of the North with the South (Paden 1986). Since he became the premier of the Northern Region, he and his government embarked on a series of political and economic reforms of the region, and it is in Kaduna where they designed and implemented the major reforms and development projects.

In 1956, Kaduna became the capital of Northern Nigeria. Ahmadu Bello wanted the city to be the showcase of the development of the North (Paden 1986). Thus, in industry, Kaduna became known for the development of the textile industry. In 1957, Kaduna Textile Ltd, the first major industry in Kaduna, came into operation. The mill was funded by a British company and two governmental financial organisations. It was equipped with the most modern machinery of the time and employed 1,650 workers by 1961. By 1966, two more large textile mills, each of which employed more than 1000 workers, were established. These textile mills provided technical training for workers and even sent some workers abroad for training. The Sardauna was eager to import and implant modern technology as quickly as possible (Paden 1986).

Major development also occurred in the areas of transportation, communication and education. Road networks were being constructed to link Kaduna and other major cities. In 1961, the Broadcasting Corporation of Northern Nigeria was set up in Kaduna to provide television coverage for the whole Northern Region. The first newspaper to print by web-offset in the North, the New Nigerian, was also published during this period. With regard to education, priority was given to technical training, and colleges such as Kaduna Commercial College and the Federal Training Centre were established in Kaduna. Ahmadu Bello was also proud of the Kaduna Capital Primary School where the children of European expatriates and Nigerian
bureaucrats learned together.

For Ahmadu Bello, the reform and development projects were not synonymous with Westernisation. Paden (1986) argues that the goal of Ahmadu Bello's policy was to synthesise traditional, Islamic and Western cultures. In addition to institutionalised relationships and bureaucratic organisations, he made frequent use of informal personal ties to achieve his political objectives, reminiscent of the traditional style of politics. His able civil servants, too, felt personally loyal to him and committed themselves to his cause in addition to abstract bureaucratic objectives. Ahmadu Bello also increasingly espoused Islamic faith. He became the Vice-President of the World Muslim League and travelled around Islamic countries. In 1963, he launched a conversion campaign in an area where the inhabitants were traditional religionists.

As noted, the development policy of Ahmadu Bello and his government was motivated by their regional identity as the Northerners, yan arewa. They tried to promote the Northerners' identity and consider Kaduna as the symbol of the Northerners. However, this was problematic, because Kaduna was not the city of the Northerners alone. By this time, Kaduna had attracted not only migrants from the North but also from the South. With the growth of industry, there was a quantitative leap in migration. Between 1952 and 1963, the population increased almost four-fold, from 38,794 to 149,000 due to the influx of people searching for jobs. In particular, the population of Igbo migrants was noticeable in the township and Sabon Gari (Population Census 1963).

The presence of the Southerners were also significant in key positions of industry, administration and, above all, the military. In this situation, Ahmadu Bello and his government's
northernisation policy was to cause resentment with the Southerners, and eventually led to a military coup and the death of Ahmadu Bello (the fact that the leader of the coup called himself Nzeogwu Kaduna is symbolic). In the history of Kaduna, the death of Ahmadu Bello signifies the failure of the attempt to create the city as the capital and symbol of Northern Nigeria.

3) Oil Boom and Crisis: While the federal-state system of government deprived Kaduna of the status of the regional capital, the city continually increased in economic significance. By 1974, there were 40 industrial establishments in Kaduna (Kaduna State Statistical Year Book 1976). The textile industry was still growing. In 1974, a Peugeot automobile assembly factory was established and, in 1980, the construction of an oil refinery, the largest in the country, was completed.

Kaduna also retained its influence, if somewhat reduced, in regional and national politics. The meeting of the governors of all the Northern States was still held in the city. The concentration of the military establishments was still the highest in Northern Nigeria. However, Kaduna’s political significance from the beginning of 1970s to the middle of the 1980s was associated mainly with the activities of a group known as ‘Kaduna Mafia’.

The term ‘Kaduna Mafia’ was invented by a journalist in the late 1970s and publicised through the media (Takaya and Tyoden eds 1987, Forrest 1993). The Kaduna Mafia was not an organisation of gangsters but an informal network of bureaucrats and technocrats. They were based in Kaduna and had considerable influence on national politics in the 1970s and the beginning of the 1980s. The core members of the Mafia were those who worked as a younger generation of bureaucrats in the Northern Regional
Government, especially directors and senior officers of government funded organisations such as New Nigerian, the Broadcasting Corporations of Northern Nigeria, the Northern Nigerian Development Corporation and the Bank of the North. They were mostly Muslim Northerners and a highly educated intelligentsia. Apart from their common experience in civil service, they were linked together through schooling, kinship, marriage and religion.

The Kaduna Mafia is said to have been particularly influential in national politics during the General Olusegun Obasanjo's regime and then for the short period of Major-General Muhammadu Buhari's regime. However, since then, the Mafia's influence in national politics has apparently declined. It is also notable that the Mafia's influence on politics in Kaduna was rather limited - they failed to get their candidates elected in the elections in 1979 and 1983.

In the late 1970s, when international oil price declined, the whole country began to suffer from the economic crisis, and Kaduna was no exception. Recession soon affected Kaduna's industries. During the 1980s, a number of workers were made redundant in the textile industry, while some foreign investors withdrew their investment. Because government revenue was heavily dependent on oil export, decrease of revenue from oil export forced all sectors of government to cut down on public spending and abandon some public projects. Besides, political instability, a succession of five military governments and two civilian governments until 1990, made it difficult to maintain consistent policy and sustainable projects. The morale of civil servants was lowered and corruption became common.

Yet, despite the deteriorating economic situation in Kaduna, migration has continued. Consequently, it appears that the number of those who do not have a
regular job has increased. The situation is particularly serious among young migrants who come to Kaduna just after completion of their school education.

In the late 1980s, the Nigerian government led by General Ibrahim Babangida adopted International Monetary Fund (IMF) and World Bank economic policy, the Structural Adjustment Program (SAP). It is still too early to assess the impact of SAP on the economic situation of Kaduna. On the one hand, industries based on locally produced raw materials such as the textile industry appear to be benefiting from SAP. On the other hand, industries dependent on imported material and products appear to be devastated (The Nigerian Economist January 7 1991). On the whole, as a result of the devaluation of the naira and inflation, there appears to be a deterioration in the living conditions of the people.

In this situation, it appears that people are increasingly making a living outside the framework of the public sector and the large and organised economic sector which have been the hallmarks of the city. Apparently, the significance of kinship, religious groups and various other social relationships for provision of basic needs has increased. The weakening bureaucratic control of the government also means that people have more autonomy to pursue their interests and organise their activities. Thus, Kaduna has become a city of flux of diverse cultures and autonomous social groups and individuals.

SOCIAL RELATIONS AND CULTURES

1) Age, Gender and Kinship: In Kaduna, the majority of the adult population are young first generation migrants. Max Lock and his partners (1967)
estimated that over 90% of the adult in their sample were migrants, and that 40% migrated to Kaduna within the previous five years. Fourteen years later, Seymour (1979) found a similar demographic situation. Thus, in his survey, 38% of heads of households had migrated to Kaduna within the previous five years, while less than a quarter of migrants had been in the city for more than ten years. While a more recent survey is not available, it appears that the situation has not dramatically changed, even if the proportion of those who were born in Kaduna may be on the increase.

In Seymour's survey, the average number of people in a household was 3.6 people and the age of about three quarters of heads of households fell between 15 and 34 years. Again, while I cannot provide comparable data about the recent situation, it appears that the most common household type consists of parents who are in their thirties, their young children and their relatives visiting them from home. In other words, Kaduna is effectively a city of youth.

A lack of elderly people means that the young adults have considerable autonomy in making decision on various issues including important ones in their everyday lives. By their own choice, the young people involve themselves in various social relationships other than those of kinship and they try to do something new by themselves. They are also open to diverse cultural influences, including the influence of global popular culture.

On the other hand, the young people may devote themselves to a particular cause or faith and try to limit their social interaction to a group of like-minded people. As we shall see soon, ethnic and religious fundamentalism can be seen as part of the youth movement. Yet, without the authority of the elders, young adults often lack an effective means to reconcile their conflicts, and schism in the groups
they establish is apparently common.

However, a lack of the authority of the elders in the city does not necessarily mean that young adults are also free from such authority in their home villages or from the ideology of their extended kinship. In general, people are involved in kinship networks that link not only relatives in the city but also relatives in the villages. For the majority of the city dwellers, such networks are the most important social relationship. First, the extended family tie facilitates migration - the city dwellers are obliged to provide food, accommodation and work for their relatives who have newly migrated to the city. Secondly, the members of an extended family continually support each other. Young adults in the city have to help not only relatives in the city but their parents and other relatives in the villages as well. Such mutual support is particularly important in crisis situations. It is also important to note that kinship networks penetrate various social organisations such as business corporations, the civil service and religious groups, and exercise considerable influence on the process of recruitment and promotion in the organisations.

Thus, there is a situation where people have considerable autonomy in making decisions and carrying out various activities, yet they cannot live without their kin nor avoid kinship obligation. This contradictory situation is often a source of conflict between the members of a family and part of their everyday crises, as we shall see.

Previous surveys (Population Census 1963; Max Lock and Partners 1967; Seymour 1979) have indicated that the male population outnumbered the female population. It is however conceivable that this disparity is now reduced. In general, women’s social position is lower than men’s and their job
opportunities are more limited. However, compared to other parts of the Northern regions, women appear to be more actively involved in various activities (Coles 1991, 1996). Thus, in 1991, the deputy governor of Kaduna State was a woman. Among senior civil servants and medical doctors, women are noticeable, even if they are numerically smaller than men. In the religious field, women play a significant role in Aladura and Born-Again churches. While seclusion appears to be strictly practised among Islam fundamentalists, in general, the practice is not as common as in a place like Kano. In traditional religious and cult groups, too, the presence of women in important positions is significant, as we shall see. Yet, again, the view that women should serve their husbands and do domestic work is still strong among older generations. The dissatisfaction and crises of young women are partly attributable to this contradictory situation.

2) Ethnicity, Locality and Language: Kaduna is extreme in the diversity of ethnic, local and language cultural backgrounds of its people and has no single ethnic group that can be considered as ethnic majority. It is impossible to estimate how many different ethnic groups are in Kaduna. Peil (1975) found over 70 different ethnic groups in the Kakuri area, while Hinchliffe (1973) counted 127 different ethnic groups in five textile factories, even though only 20 groups had more than ten members in any single firm. It is likely that ethnic diversity has further increased since their surveys.

While this is due mainly to the migrant base of the city’s growth, three factors appears to be important here. The first is the fact that Kaduna is not located in the middle of any area where a single ethnic group is numerically predominant. Certainly, the Hausa are politically and culturally influential in
the area. However, unlike other major cities in Northern Nigeria, Kaduna is situated on the southern border of Hausaland - an area which is known for extreme ethnic diversity. Secondly, Kaduna is a colonial creation and lacks an indigenous foundation for its development - the indigenous people of the area, the Gbagyi, have not been demographically and politically influential. Thirdly, diversity of ethnic cultures and languages are maintained through the extended kinship networks of city dwellers, a continuous influx of people from their home areas and the activities of local and ethnic associations in the city. In this regard, a relatively developed transport system is not just conducive to the growth of general cultures but to the maintenance of distinctive ethnic-language cultures in Nigeria.

In general, direct confrontation between different ethnic groups is not common in the everyday life of people in Kaduna. Occasionally, however, violent conflict takes place between groups, for example, the conflict between Katafs and Hausas in 1992. Yet, in most of the cases, ethnic or religious conflicts have started somewhere else in Kaduna State or other parts of Northern Nigeria and then spread to Kaduna.

More common is the ill feeling of individuals against certain ethnic groups. Such ill feeling is sometimes expressed in everyday conversation but rarely leads to direct confrontation. Among Christian ethnic minorities in Kaduna State and the Christian population from Southern Nigeria, the "Hausa" are often the target of resentment. On the other hand, it is the same Hausa people who are often associated with trustworthiness - there are widely shared stereotyped images of ethnic groups. There are also animosity among ethnic minorities. For instance, among ethnic minorities in Kaduna State, the Bajjiu, who appears to
have a larger population than others, are often spoken ill of by others. These ill feelings among ethnic groups are often related to political and economic interests. The reason why the Hausas are the target of resentment among others is because they are considered to control the government and administration in Kaduna State. While such perspectives of inequality may be sometimes exaggerated, there is certainly a concentration of people of particular ethnic identities in particular occupations and jobs in Kaduna.6

However, the strength of ethnic identity and the distinctiveness of ethnic cultures in Kaduna should not be overemphasised. At first, the city dwellers have more specific identity derived from their home villages, towns or local government areas, or combinations of these. In some cases, there are even rivalry and ill feelings among people from different localities who nonetheless share the same ethnic identity. For instance, among Hausa people, such rivalry is observable between those from different major cities such as Kano, Katsina and Sokoto.

In Kaduna, there are numerous associations that represent these local groups. It is these local associations in which people actively participate. The associations of local groups are subdivided into groups such as the youth group or women's group. These groups are very active. On Saturday and Sunday when the meetings of these groups take place, public transport becomes paralysed due to the massive movement of people who travel to the meeting places.

On the other hand, in Kaduna, ethnic minorities from various parts of the country may identify themselves with a major ethnic category in their home areas or a certain regional category, or may be identified so by other people. Thus, it appears that ethnic minorities in Western Nigeria, especially those
from Kwara State and Kogi State, do not identify themselves primarily with their own ethnic category in public, but rather identify themselves with a category that is associated with a particular area, for instance, Kabba province, where people are considered to speak a 'dialect' of the Yoruba language. These people are often considered to belong to the Yoruba by Yoruba people from the central part of Yorubaland. Likewise, ethnic minorities from the Bendel State often call themselves, and are called by others, "Bendelites". Some people from the South consider any people living in Northern Nigeria and speaking Hausa, whether they are Christian or Muslim, "Hausa", while others lump together any Muslims in Northern Nigeria as "Hausa".

By contrast, there has been growing ethnic fundamentalism among some ethnic groups. This is the case of ethnic minorities in Kaduna State and its surrounding areas. This is the area where violent confrontation has been taking place between ethnic minorities and Hausa people. Apart from such conflicts, ethnic sentiments of the minority groups can be seen in the use of languages. People such as Bajjiu and Gbagyi, especially those young and educated, dislike to be called with Hausa names such as Kaje and Gwari. As noted above, educated Gbagyi people believe that a word, Kaduna, is derived from the Gbagyi language, and not from the Hausa language.

Nonetheless, it is important to note that even those who emphasise their own ethnic identity do not necessarily know their ethnic traditional cultures in depth. For instance, my young Gbagyi informants are not so familiar with their traditional deities, ashaa. Many of those young people of ethnic minorities who were born and brought up in Kaduna appear to lack a large vocabulary and a deep understanding of their own languages, even though they generally speak the
languages fluently.

Above all, people, irrespective of their ethnic regional cultural backgrounds, do share common sense knowledge and common customs and ethics, that is, there exist general cultures that are more or less evenly spread among people in Kaduna. The ways in which Kaduna people understand their world are similar enough to enable them to communicate with each other without causing too much misunderstanding. In this regard, the impact of global culture, mass media and school education is undeniable.

It should be added that national identity among people is by no means negligible in Kaduna. In everyday casual conversation about politics, which my male adult informants are so fond of, the expression, "We, Nigerian!" commonly appears. In this regard, the fact that there is a considerable number of foreigners in Kaduna may be enhancing awareness of national identity.

With regard to languages, the majority of people in Kaduna can communicate by means of common languages. In Kaduna, lingua francas are Hausa and English. Many people can speak both languages in addition to their ethnic languages. Those young people of ethnic minorities from the South who were brought up in Kaduna are likely to speak no less than four languages. Thus, people often switch from one language to another in relation to those to whom they speak - they speak their ethnic language within the family, speak English to their co-tenants from the South and speak Hausa to their colleagues at the workplace. However, it is noteworthy that their understanding of common languages appears to be generally shallow. I have observed multilingual speakers face difficulties in understanding certain phrases and words in Hausa when they communicate with native Hausa speakers.

In short, people in Kaduna identify themselves
with their ethnic category and maintain the customs and languages derived from the ethnic cultures, whereas such ethnic identity and cultural practice, if important, constitute merely part of their diverse identities and cultural practices, ranging from the ones widely shared (national identity, customs and languages) to the ones specific to a small group of people (local identity, customs and languages).

3) **Religion:** Kaduna is also remarkable in its religious diversity and the active participation of people in religious practices. Again, religious diversity is at first due to the migrant base of the city's growth and its location in the country. Thus, with migrants come their religious groups from all over the country. As the capital of the Northern Region, however, Kaduna was a spearhead of missionary activities during the colonial period, and then established as a centre of Muslim organisations by Ahmadu Bello. Thus, Kaduna is the seat of Jama'atu Nasr Islam (JNI) and the regional headquarters of the Christian Association of Nigeria (CAN), umbrella organisations of all Muslim groups and all Christian groups in the country respectively. It should also be pointed out that in Kaduna, there is considerable freedom for people to establish religious groups and activities. Those who are not satisfied with the religious groups of which they are the members often break away and set up their own groups. In other cases, small religious circles and churches are created by and consist of only members of particular families and their friends. Such freedom itself is indicative of religious diversity in which none of the groups can claim the majority position. However, it may also be related to the Government's limited control over religious activities in the city.

Religious diversity is first of all seen divided more or less equally between the Muslim and Christian
populations in the city (population census 1963). Within each religious category, however, there exist a number of different groups, sects and movements. Thus, the majority of Muslim Northerners identify themselves as members of a major Islamic group called Darika in Kaduna. The word, *Darika*, is derived from *tariqa*, that is, sufi brotherhoods. Sufi brotherhoods, especially *Tijaniyya* and *Qadiriyya*, have been influential among Muslims in Northern Nigeria (Paden 1973; Hiskett 1984; Cruise O’Brien and Coulon eds 1988). However, in Kaduna, while these sufi orders are followed by some people, the majority of Muslim Northerners do not seem to be actively involved in the brotherhoods. Thus, when they identify themselves as Darika, they are actually indicating that they belong to the orthodox group, but not a heterodox group, namely, Izala.

*Izala* (*Jama’atu Izalat al-Bid’ā wa Iqamati al-Sunna*: ‘those who reject innovation’) is known for its anti-sufi standing (Umar 1993). It was founded in the late 1970s under the influence of the Grand Kadi of Northern Nigeria, Abubakar Gumi, and Kaduna has become one of the centres of the movement. Gumi emphasised the importance of going back to the teaching of the Prophet Muhammad and his immediately succeeding generations which is the only true revelation of the God— for Gumi, any Islamic practice and teaching that emerged after this period is not truly Islam. Living in Kaduna, Gumi advocated his teaching through radio, television and a newspaper. There have been a series of frictions between Izala followers and Darika followers. Izala followers have built their own mosques and conduct their prayer one hour before Darika’s prayer. On the whole, however, Izala remains minority in Kaduna and is apparently on decline. Currently more active and radical in Kaduna is the Islamic Movement led by El-Zakzaky based in Zaria.
The Islamic Movement was born out of a Muslim student association at Ahmadu Bello University in the early 1980s (News Watch 10 October 1988; Citizen 29 July 1991; Haynes 1996). The movement is, however, popularly known as a Shi’ite group in Nigeria. The Iranian Revolution in 1979 appears to have made some impact on Muslims in Nigeria. Some Nigerian Muslims are attracted to the ideal of the Islamic Revolution in Iran and Shi’ite doctrines. While members of the Islamic Movement deny the label of Shi’ite, they admit that they were inspired by the Iranian Revolution and, certainly, their appearance (a long beard, for instance) is reminiscent of Shi’ite Muslims. The movement has an anti-Western ideology. Its ultimate goal is the establishment of Nigeria as an Islamic state. Members are active in demonstrating against publications and policy that they consider as un-Islamic. Their involvement into the Kafanchan and other riots in Northern Nigeria was suspected by Government officials, and El-Zakzaky has been arrested by the police several times. Members appear to be mostly young Northerners, some of whom are highly educated.

In Kaduna, there are also a number of Muslim associations specific to particular ethnic and local groups. For instance, some Muslim Yoruba people in Kaduna attend reforming societies, Ansar Ud-Deen and Nawir Ud-Deen, and send their children to the societies' schools that combine Koranic and Western education.

In Christianity, too, there are a number of different denominations, sects and movements in Kaduna. They can, however, be broadly classified into: 1) the mainline group, 2) the Aladura type group and 3) the Born-Again group.

The mainline group consists of those churches originally established by European missionaries and
subsequently indigenised, including the Catholic, Baptist, Anglican and Methodist Churches and the Evangelical Church of West Africa (ECWA). Some of these churches were set up in Kaduna by European missionaries such as the Sudan Interior Mission, while many others were brought to Kaduna by Nigerian migrants from the South - a number of these churches are made up of people from the same localities.

The Aladura group, which is also referred to as the African Independent Churches, are those churches founded by Nigerians mainly in the Western Region. Aladura means prayer in Yoruba and these churches are characterised by their distinctive style of worship, dressing and above all divinatory and healing practices (Peel 1968; Kalu ed. 1978; Omoyajowo 1982; Clarke 1986; Ludwar-Ene ed. 1990). The group consists of a number of different sects and churches, including the Cherubim and Seraphim Movement, the Celestial Church, the Church of the Lord, the Apostolic Church, and the Christ Apostolic Church (CAC). While there are some variations in the mode of religious practice among these churches, their similarities are remarkable, ranging from white robes worn by the members (except the Apostolic Church and CAC), the particular use of candles and incense in worship, and vigorous dance and music with the use of traditional instruments, to the practice of spirit possession. Another characteristic of the Aladura group is that the churches have a tendency to be factional and of proliferating their number in Kaduna. Related to this is the existence of a number of small Aladura churches which appear to consist mainly of the members of particular families. In addition, members of Aladura churches tend to be those sharing the same ethnic identity or those from the same localities.

The Born-Again group has been rapidly growing in Kaduna. It is a fairly recent movement and was
initiated by university lecturers and students in Ibadan and Lagos in the 1970s and spread in Northern Nigeria in the 1980s (News Watch 6 June 1988; Marshall 1991; Ojo 1992). Apparently, however, the movement is inspired and heavily influenced by evangelical and pentecostal movements in the USA (Gifford 1991). There are considerable resemblances in the mode of religious practice between the two, and some of the Born-Again Church leaders appear to travel to the USA for training, while evangelists from the USA and Europe sometimes preach at the Born-Again churches and organise mass revival services with the assistance of the churches in Kaduna. The mode of their religious practice is characterised by: 1) distinctive prayer through which the members utter their emotions (the practice of which is displeasing to other Christians), 2) prayer groups organised at members' residences, 3) Bible reading, 4) evangelism, and 5) healing.

It appears that Born-Again churches are particularly evangelical and expansionistic in Kaduna. The members of the churches are regularly out in the streets and persuade anyone who is not a Born-Again Christian to come to their churches. One Born-Again church I know has a thorough plan of evangelism in villages, including predominantly Muslim settlements around the city, and make weekly trips to different villages to achieve its goal. Apart from evangelism, however, the members of Born-Again churches are encouraged to confine their social interaction within themselves. Identity as a Born-Again Christian can be significantly fixed and pervasive in the minds of members. Like Izala and the Islamic Movement, Born-Again Christianity is basically a youth movement - it attracts mainly young people, irrespective of their ethnic backgrounds, in Kaduna.

As to traditional religions, few people publicly identify themselves as believers in traditional
religions in Kaduna. In general, there is a negative image attached to traditional religions, that is, the image of a practice that is not acceptable both in Islam and Christianity. Few shrines and temples of traditional deities are found in public places. The situation is undoubtedly related to the high level of activities of both Muslim and Christian groups in Kaduna, past and present.

However, this does not imply that traditional religions are non-existent or insignificant in Kaduna. The practices associated with traditional religion are still an integral part of traditional healing and divination, and the fact that there exist a number of traditional healers in the city is indicative of the significance of the practices. While both healers and clients do not consider such practices as divination and sacrificial rituals to be particularly religious, they are usually aware that the practices are not in accordance with Islam or Christianity - the issue will be examined in detail later.

It should be added that as a major city in Nigeria, Kaduna also attracts religious groups and practitioners from abroad. In 1991, for instance, a German evangelist, Reinhart Bonke, held a revival congregation which attracted tens of thousands of people in the city. As far as I know, there is also a temple of Hari Krishna in the Barnawa area. Though their membership must be small, their presence is certainly noticeable on the streets.

Thus, there is remarkable religious diversity in Kaduna. Different religious groups, however, do not just co-exist but actively compete for new recruits. In that sense, group interrelationships can be seen as forming a 'market'. This also means that to various extents, people can choose and change religious groups, even though conversion between Islam and Christianity does not seem to be common.
particular, people often move around various religious groups and practitioners in pursuit of healing and the solution of everyday crises, as we shall see.

It is also important that, in general, people have more than one religious identity and that there exists the hierarchy of opposition and alliance in religious grouping in Kaduna. Thus, it is common for people to identify themselves as Muslims or Christians and use these broad religious categories to understand the political situations of Nigeria in general and the city in particular. Given extreme ethnic and religious diversity, these broad religious categories provide a base for wider alliance - it enables individuals in political conflicts to draw on wider support and sympathy. It is also certain that differences in lifestyle and custom are more easily recognised by city dwellers in the sphere of religion than ethnicity, since most of them are migrants and are not familiar with the cultures of different ethnic groups except those of neighbouring groups in their home areas.

It is, however, wrong to draw a clear line between ethnic and religious identities. For instance, when Christian Southerners in Kaduna refer to 'Muslims' in their everyday conversations, it is questionable if what they mean by 'Muslims' include Yoruba-speaking people who identify themselves as Muslim - it appears that in this case 'Muslims' are almost synonymous with Muslim Northerners, especially Hausas. It is certain that the broad categories of Muslims and Christians as used by people in Kaduna involve ambiguity and are often subject to political manipulation.

As noted, in recent years, there have been a series of violent conflicts in Northern Nigeria. The conflicts are often said to have been ignited and intensified by religious fundamentalists such as the members of Izala, the Islamic Movement and Born-Again
churches. As previous studies indicate, it appears to be certain that religious conflicts are interwoven with class, ethnic, regional and even international relationships, and their political and economic interests (Lubeck 1985; Usman 1987; Ibrahim 1990; Forrest 1993; Haynes 1996).  

4) Education and Media: As migrants, many of the adult population in Kaduna took part in school education in their home areas. By contrast, their children are likely to experience school education in the city, even if they, especially the children of the Southerners, may be sent to home areas for part of their education. School education in Kaduna can be divided into Western school education, Islamic school education, military school education and technical education provided by industrial firms. 

In Kaduna, there are a number of educational institutions and schools that basically follow the school systems of Western industrial countries. Each district has at least one governmental primary school, and there are several governmental secondary schools and technical colleges in the city. Some of the schools were formerly missionary schools and have considerable prestige. The city also has a well-known polytechnic which is run by all the Northern States and is proud of its scale and curriculum. What is currently remarkable in Western school education in the city is, however, the proliferation of private schools. There are different kinds of private schools ranging from nursery and primary schools for the children of relatively well-off parents to commercial schools, which not only teach children basic English and mathematics, but also provide them with practical training such as typing. In particular, the number of commercial schools is remarkable—it is commonly seen on the streets that students, mostly girls, packed into a room and given lessons by teachers, many of
whom do not seem to have teaching qualifications. The business orientation of these schools is obvious.

The most common type of Islamic education is conducted by *malamai* (singular: *malam*), Koranic teachers, at their residences. *Malamai* teach basic Arabic and the Koran to Muslim children who appear to be mostly the children of Northerners. There are also a number of Islamic schools for adults. The schools are not only meant for Koranic education but for literacy education, and attended by both men and women who are illiterate or could not have primary education (Coles 1996). There are also locally and ethnically based Islamic schools, such as the schools of *Ahmadiyya* group among Yoruba-speaking people, as noted above.

In Kaduna, the military has nursery schools, a primary school, a secondary school and the Nigerian Defence Academy. These schools enjoy considerable prestige and admission to the school is difficult. The Nigerian Defence Academy is, especially, known to have trained many of the present high ranking officers in Nigeria.

Finally, new employees of industrial firms are given technical education for the initial several months. In the past, some of the workers were even sent abroad for training for one or two years - quite a few senior workers in these industrial firms have experience of living in Europe or Japan.

The impact of school education appears to spread both evenly and unevenly among people in the city. In general, the level and distribution of Western style school education among people in Kaduna are likely to be higher than other major cities in Northern Nigeria. According to Seymour's (1979) survey, almost 70% of his informants had full-time primary school education, even though there is considerable variation according to districts in the city. This relatively high level
of distribution of primary school education among people is attributable to the significance of educational qualifications for employment. Many industrial firms require workers to have at least full-time primary school education. On the other hand, considerable inequality is also found in the distribution of Western school education. Thus, roughly, the level of education appears to be higher among Southerners, Christians, young people and men on the one hand, and lower among Northerners, Muslims, older people and women on the other.

It is certain that those who have higher educational qualifications have a better chance of a job and promotion, especially in administration and industry. Thus, higher school education may grant considerable power to individuals - it is notable that those who are part of the Kaduna Mafia are basically the intelligentsia. Higher school education may also promote the identity of elite. However, it is also clear that the qualification of higher school education is not the sole criterion for leadership and power. More importantly, in the current economic situation, there is no guarantee of a job in Kaduna for young people who have high educational qualifications.

With regard to the media, there are diverse and well developed media in Kaduna. First of all, Kaduna has newspaper companies and publishers whose publications are distributed to major cities in the country. Radio and television stations have been in operation since as early as the 1960s. People, regardless of their economic backgrounds, have access to videos, while some wealthy people enjoy satellite television.

There is certainly inequality in the distribution of these media. While both English and Hausa are used in all forms of media in Kaduna, it is undeniable that
English speakers have access to a wider range of media. Written media are available only to a literate population, and those who regularly read newspapers and magazines have to be relatively well-off. A radio or tape recorder is owned by most households, whereas a television set is owned by only relatively well-off people. Yet, it is remarkable how widely and quickly those who have access to these media orally transmit and translate the information they obtain through the media to their poor or illiterate relatives and friends. Those who do not own a television set can easily watch television or even videos at the residences of their better-off relatives or friends. In other words, to some extent, the networks of kinship and friendship promote even flow of information among those involved in the networks.

Thus, through these media and oral communication, people gather a wide range of information. It is certain that governmental media have some specific ideological inclination. However, as far as written media are concerned, diversity of opinion and ideological position is considerable, reflecting not only individual perspectives but interests and ideas of various social groups in the city. Global cultural influence also inevitably permeates the city through the media. In particular, the impact of electronic media is significant. Thus, children commonly imitate American English accents, play 'Chinese Kung Fu' and talk about an Indian film they watched on video. Both adults and children are familiar with the American life style and rich Lagosian life style through soap operas on television. On the other hand, media may promote 'traditional culture' as well. Common genres in popular magazines are the topics of witchcraft, spirits and traditional medicine. There are quite a few films and TV dramas about Yoruba mythology and rural life among Yoruba-speaking people. However, it
is important to remark that a great deal of interpretation and transformation of the information occur in the course of their transmission both from media to people and people to media.\(^\text{12}\)

In short, the impact of education and the media is complex. Coupled with oral communication, education and media promote both an even and uneven flow of culture and its interpretation. On the whole, however, it appears to be undeniable that they are conducive to increasing the cultural repertoires of individuals in the city.

5) **Residence and Neighbourhood**: Kaduna is rapidly sprawling outward. Its rapid expansion is not based on any city planning. In most areas, the State government has limited control over estate development. The growth of new residential areas is concentric with the old areas which are at their centre and the newly developed area at the periphery (Ikudabo 1986). One can easily distinguish the old areas from the new. Some of the old areas are based on a city plan formulated during the colonial administration with streets and houses neatly laid out. Other old areas are distinctive with old houses built in traditional style and with traditional materials. Also, there is a community atmosphere in the old areas: many of the residents are early settlers and know each other fairly well; the activities of associations are noticeable; there are chiefs in the areas, which were a part of Native Authority during the colonial period.

By contrast, in new areas which cover most of the city, such neighbourhood communities are non existent. Here, most residents are recent migrants and strangers to each other. The primary social interaction of these residents is conducted with their relatives and friends from home who are not necessarily living in the same neighbourhoods. Moreover, the interaction
among even those living in the same compound can be limited. This is because: 1) those working for factories have rotating work schedules - some may work during the day, while others work at night; 2) many adult women go out to work, and 3) during Saturday and Sunday, they attend the congregations of different religious groups and the meetings of different local or ethnic associations.

With regard to the cultural backgrounds of residents, there is considerable ethnic diversity in most areas. While in some places those who share a particular ethnic or local identity live in close proximity, such a concentration of ethnic category hardly goes beyond part of a street or part of a block. On the other hand, in many areas, especially newly developed areas, one may easily find a few dozen ethnic categories among residents within a few blocks. Even within the same compound, the ethnicity of households commonly differs.

There may be more residential separation in terms of the religious and regional backgrounds of residents. Thus, the population of Muslim Northerners appears to be larger than that of Christian Southerners' in areas such as Tudun Wada and Unguwan Shano, while the population of Christian Southerners appears to be larger than that of Muslim Northerners' in areas such as Kakuri and Sabon Tasha. Yet, again, there are few areas where a particular regional and religious group occupies the position of the overwhelming majority.

In terms of the income level of residents, there exist areas inhabited exclusively by those who have a much higher income than the majority in the city. The areas are called Government Reservation Areas (GRAs) and used to be the residential areas of British administrators and other Europeans. At present, the residents of the areas consist of high ranking
government officials, managers of private firms, retired army officers and various foreigners working for companies. Apparently, however, GRAs do not have much room for newcomers. As Ikudabo's (1986) study shows, a number of well-off people have no chance but to build their houses in newly developed areas. As a result, the residents of new areas are mixed even in terms of income levels and material living. While the proportion of the well-off in new areas is low, their presence is easily recognised in their large houses surrounded by high walls. They do not interact frequently with their less well-off neighbours - they commute to their workplaces by car and send their children to better schools. Apparently, they do not feel safe in their neighbourhoods; certainly theft, if not robbery, is common.

On the other hand, considering the influx of migrants to the city and the city's current economic situation, there is a surprisingly small number of homeless people. This appears to indicate the strength of kinship and other social relationships through which migrants are provided, at least temporarily, with shelters.

In general, the residential mobility of people within the city, especially among those who do not own their houses, appears to be high. While there is a general pattern of movement, the movement is apparently further promoted by conflicts with landlords or co-tenants and financial problems.

Moreover, movement can be extended outside the city. As noted, people are still attached to their home villages and, from time to time, make a trip back home. Adult male residents occasionally go home to attend ceremonial occasions or to solve some problems such as land disputes. Their wives and children, especially those from the middle belt area (Kwara, Kogi and Benue States), often go home to help with
farming; it is common among people from the middle belt area for husbands to live alone in Kaduna during the farming season. As we shall see, treatment of illness is another important reason for going home. There are two occasions of mass exodus from Kaduna to home; one is the 'Lesser Festival' (Karamar Sallah) at the end of Ramadan among the Muslim population; the other is Christmas among the Christian population.

It should be added that, while living in Kaduna, a number of traders and business people frequently travel around the country and even abroad - some of the rich even have residences in Europe. As a major political and economic centre of the country, Kaduna also attracts transitory visitors, including both Nigerian and foreign business people, government officials and religious missions.

5) Class and Patronage: There is considerable economic differentiation among people in Kaduna. However, differences in material living cannot be understood in terms of a dualistic class structure. Thus, there exists a small population of rich people at one end of the continuum of material living and small population of extremely poor people at the other, whereas the majority of people exist in-between. In the following, I shall focus on the rich and the majority.  

The material possession of the rich is truly conspicuous - large houses with satellite dishes, luxurious cars and expensive clothes. Their life styles are distinctive from the rest of the population in the city. These rich people are made up of high-ranking government officials, military officers, company executives and professionals.

The majority of people live their material lives between the two extremes. Within this vast group, there are certainly considerable differences in income and material living. However, such differences do not
seem to be as large as differences between the very rich and the very poor on the one hand and the majority on the other. It is the people in this major economic group with which the present thesis is mainly concerned.

In terms of class consciousness and action, first of all, it is hard to know to what extent the wealthy share a common class identity. While they may be conscious of their elite position, they do not seem to use a particular term with which they collectively identify themselves - it is doubtful whether they use a term such as 'upper class' or 'sarauta' (a ruling class in Hausa) to describe the whole group. They certainly have considerable power in their spheres of influence, whether these are government ministries or private firms. However, their interests and opinions are more divided than united as is evident in political division and rivalry during times of party politics.

On the other hand, the majority appear to be quite conscious of the existence of the rich. They often express their resentment against the rich who, in their view, "chop" (embezzle) the country's resources and money. In relation to the rich, they often identify themselves as "poor". However, the broad identity of "poor" has as yet to provide a basis for mass mobilisation among the majority in Kaduna. Industrial action is certainly common in the city. Workers at the oil refinery, minibus drivers and teachers embarked on strikes during my stay. However, general industrial action that unites workers of different firms and industries appears still to be rare.

It appears to me that, while awareness of class identities are sometimes heightened and industrial action is taken, these should be viewed as being additional to and sometimes merged with various other
identities and social action of people in the city. Plurality of social relationships and identities appears to be often conducive to the underdevelopment of broad class identity and mobilisation. Thus, the class consciousness of the rich is apparently intersected by kinship, ethnic, local or religious identities. Accordingly, the political and economic interests of the rich are by no means unified. The political and economic interests of Kaduna Mafia, who may be still influential in governmental media and financial organisations, are likely to differ from those of the management of textile industry, which is associated with the interests of people from the middle belt area and multinational corporations. The same situation undoubtedly applies to the majority of the population in Kaduna.

It is also important that various social relationships vertically link rich individuals and individuals in the majority. The rich are obliged to support their poorer relatives, people from their home areas or members of the same religious groups in such matters as financial problems and jobs. Such personal ties, especially kinship, provide primary identities for both rich and poor individuals. Within the economic majority, too, the better-off are obliged to support the worse-off and both of them may identify themselves as members of particular families or other groups.

The networks of personal relationships also penetrates social organisations with bureaucratic structures, such as industrial firms or government offices, and influence the activities of such organisations especially in the areas of recruitment and promotion. Such personal ties are not always based on certain social categories and norms such as obligation to kin or religious members. Personal relationships between office holders and clients are
easily made through informal monetary transactions. In Kaduna, bribery is a part of everyday practice among people. Moreover, office holders who have a plurality of clients are in a position to select their clients. However, such personal transactions in formal organisations, whether they are based on certain social norms or not, appear to undermine the principles of the organisations and cause a sense of inequality and distrust among those who are outside personal ties. Uncertainty surrounding patron-client relationships is an important factor in the use of traditional medicine, as we shall see.

Finally, it should be remarked that the sense of inequality is often directed towards particular individuals. People often complain about particular relatives or friends who neglected their reciprocal obligation. Conversely, they are also worried if they are considered as neglecting their obligation. The point is that for such a sense of inequality to emerge, differences in material conditions between two individuals do not have to be very large nor permanently fixed. Those who happen to have more are an easy target of the resentment of those who happen to have less. It appears to me that this egalitarianism is much more commonly expressed, successfully or not, than organised class action in the everyday life of people in the city, and is the key to understanding the phenomenon of witchcraft and sorcery.

6) Administration, Party Politics and Military:
The administration of Kaduna is part of a three tier system of federal, state and local administration in Nigeria which grants considerable autonomy to the state and local governments. Most of the revenue of the state and local governments comes from the federal government which ultimately depends on the export of oil.
The autonomy of the state and local governments to decide public projects on the one hand, and their dependency on the allocation of revenue from the federal government on the other, generates considerable distributive concern with the state and local governments (Forrest 1993). Thus, the state and local governments are primarily concerned with the amount of revenue allocated to them rather than the feasibility of policy and public projects. Their dependence on revenue allocation and lack of tax-raising also have made them vulnerable to oil crisis.

Since the oil crises of 1978 and 1980, the state and local governments have been suffering from decrease of revenue. Coupled with constant change in political regimes, the situation has resulted in the abandonment or the cutting down of public projects, ad hoc policy and lowering of morale of civil servants in the state and local governments. In Kaduna, the ruins of uncompleted housing projects symbolise the whole situation.

Thus, the state and local governments have lost considerable financial resources and ideological incentive to implement their policy and public projects. As noted above, in Kaduna, the government offices are also subject to patron and client ties. The reputation of civil servants as incorruptible in Kaduna appears to have become a story of the past. Among the civil servants, the police are particularly notorious for corruption. In this situation, the bureaucratic control over people through law and regulation is significantly limited in Kaduna.

During times of party politics, Kaduna showed remarkable political division and rivalry. Thus, in the 1950s, despite the fact that the Northern Regional Government, based in Kaduna, was in the hand of the Northern People's Congress (NPC), Kaduna was a strong base of Northern Elements Progressive Union (NEPU). In
the 1957 election, three out of the four local
councils were dominated by NEPU. In the 1961 election,
however, NPC narrowly defeated NEPU in Kaduna, and the
former consolidated its power up to 1966 when a
military coup d'état took place. During the Second
Republic, once again, Kaduna's politics were divided
between the governor, Babarabe Musa, who was one of
the leaders of the People's Redemption Party (PRP) and
the State Assembly which was dominated by the National
Party of Nigeria (NPN). The divisive political
situation appears to reflect the coexistence of
diverse opinions and interests in the city.

However, civilian control lasted altogether for
ten years. For most of the time, the country was ruled
by the military. The military government can exercise
considerable influence on the administration and
economy of the country and has certainly introduced a
number of important administrative and economic
reforms - it was the Babangida regime that introduced
the Structural Adjustment Program into the country.
However, in terms of the actual implementation of the
policy, the military relies on civil administration.
At the level of State, the military governors hold
highest authority, but, apart from passing directives
from the Armed Force Ruling Council to the civil
administration, the military governors do not seem to
be actively involved in policy-making and initiatives
in changing policy in State government. More
importantly, the military government, at least in
public, identifies itself as being transitory. Being
aware of its legitimate role (which is not the
governing of the country), the military rationalises
its control over the country as an emergency measure.
From the beginning, it promises to hand over power to
a civilian government in future, even though in
reality it stays in power for many years. Thus, the
military is not integrated into, nor entirely
independent from the overall state system.

The relative autonomy of the military is also seen in its internal structure, which is exemplified by the military establishments in Kaduna. Kaduna has the highest concentration of military establishments in Northern Nigeria, which include not only military and air force bases, but various other institutions such as the Defence Academy, Command Schools, a military hospital, and the Defence Industries Corporation, which not only manufactures weaponry but also various commercial products for civil purposes. In this sense, it can be said that the military forms almost a self-contained community in Kaduna.

Such a transitory and autonomous position is reflected in the popular image of the military in Kaduna. The popular image of the military can be illuminated in the lyric of a well-known musician, Fela Kuti's song, "soldiers go, soldiers come, soldiers go, soldiers come..." One could add "chop" to this. That is, for ordinary people, the military, especially the generals and other high-ranking officers, are to take over power through coup d'etat, embezzle the country's money and leave the government without doing anything good for, or worse impoverishing the nation.

7) Economy: Kaduna is the second largest centre of economy in Northern Nigeria, after Kano. It is known for the concentration of middle- and large-scale industries. They include the textile industry, the automobile industry, the construction industry, a brewery, fertiliser industry, the defence industry, an oil refinery and the petro chemical industry. Many industrial firms employ more than 1,000 people. Textile mills, in particular, have been associated with Kaduna's economic development. In the mid-1970s, the textile industry occupied 50% of industrial estate in the city and employed 80% of industrial workers
The scale of each mill is also large - United Textile is considered to be the largest textile mill in West Africa.

These middle- and large-scale industries have grown rapidly through government initiatives and in cooperation with foreign investors and industries. Unlike Kano, Kaduna lacks an indigenous base of market economy and industries. It has not observed the emergence of entrepreneurs and business families comparable to the Dantata or the Gashash family in Kano. Technologically, Kaduna’s middle- and large-scale industries are based on the importation of advanced technology from industrial countries. Foreign presence is still noticeable in the investment, management and technical supervision of the industries: in textile mills, most managing directors and technical advisors are foreigners; in the oil refinery, the overhaul and modification of the plants are dependent on foreign plant industries. The nationalities of the foreign workers are diverse and include Chinese, Japanese, Indian, French and Italian.

As to commercial and service sectors, Kaduna has several financial institutions established by the government to promote regional infrastructure and economy. The development of commercial banking is also remarkable - most of the major commercial banks in Nigeria have their branches in Kaduna. Other large business corporations include: retail trading firms, such as department stores and a shoe company, transport businesses including a bus company and oil trailer companies, newspaper and magazine publishers, and a number of hotels including two deluxe hotels.

However, it is likely that the majority of the adult population are not employed at these large business and industrial organisations in Kaduna. First of all, most of the workers in large firms are male,
whereas adult females are most commonly engaged in trade. In the 1980s, a number of textile workers lost their jobs due to recession and had to look for alternative sources of income. At present, those who secure employment at large firms are generally considered to be lucky. While there is no current survey on this subject, it is certain that a large number of people are currently engaged in small trading and manufacturing activities in Kaduna.\(^16\)

There are a myriad of economic activities in this sector. Thus, trading activities include sales of food, clothes, shoes, groceries, electrical goods, music tapes, building materials, and machine parts. The service sector includes restaurants, beer parlours, cinemas, prostitutes, and schooling. There is also a large number of repairing and manufacturing businesses ranging from automechanics, electrical goods repairers, furniture makers and carpenters, to the recycling industry. Besides, smuggling, especially of textile products and petroleum, is a common business practice. Many occupations in this sector do not seem to require large capital and high running costs.\(^17\)

Yet, a great number of people appear to be often out of jobs in Kaduna. Again, there is no current statistical data available about the rate of unemployment among the city dwellers. It is, however, likely that the number of people who do not have a regular job have been increasing. Especially, recent migrants, most of whom are young school leavers, appear to have considerable difficulties in finding regular jobs. Their problem is not that they are permanently jobless, but that they have to make their living by means of a series of underpaid casual jobs and the support of their relatives and friends in the city.

Thus, in general, there is considerable
insecurity in the economic situations of people in the city. Such insecurity appears to be particularly high among those working outside the formal economic sector, while even those employed at large companies have no guarantee of job security. In this insecure economic situation, occupational mobility appears to be high. A number of people also try to diversify their economic activities. As Andrea's (1992) study indicates, farming is one of the common side-lines of industrial workers. They have small farms on the outskirts of the city and, when they are on night duty at their factories, they are also able to farm during the day.

I have also noted the significance of reciprocal relationships such as those of kinship and friendship for the provision of food, shelter and jobs. These social networks penetrate business corporations and industrial firms and affect their organisational principles. Under the current uncertain economic situation, the significance of these ties must be increasing. However, it is important to note that the increased significance of kinship and other social relationships in the field of economy means, at the same time, that transactions among members of these groups are more and more oriented toward economic interests. Such commercialisation of social relationships is also promoted by the almost ubiquitous use of money. As noted, in Kaduna, there is a wide-spread culture of bribery. People employ money to achieve various goals outside legitimate economic transactions. Thus, they buy (or at least attempt to buy) employment, admission to schools, court judgement, religious blessing and so on. As noted, patron client relationships appear to be often based on the logic of bribery in addition to (or rather than) the logic of reciprocity - there is a thin line between reciprocity and bribery. In short, reciprocity
and monetary economy are influencing one another; consequently the distinction between the field of economy and other cultural fields are being blurred; families and religious groups are increasing their significance as economic organisations, whereas capitalist enterprises are partially serving these social groups.

ENVIRONMENT, HEALTH AND DISEASE

I) Environment and Pollution: Pollution and a lack of hygiene are now at critical levels in Kaduna. Broadly, there are two sources of pollution in the city: domestic waste and industrial waste. The population density of residential areas is very high. In Seymour's (1979) survey, the average density of four districts was 535 people per hectare, even though the density varied according to district (Kakuri scored 661 people per hectare). The old parts of residential areas are especially heavily congested. A lack of air space is one of the complaints of the residents, according to Seymour's study.

However, the most serious problems are pollution and a lack of hygiene. Most households use pit latrines. A latrine is also shared by a number of people (17 people on average in Seymour's study). In the 1980s, a 'bucket system' appears to have been still common (Nigerian Institute of Architects 1986). While the 'bucket system' is no longer so common, people sometimes defecate on open ground. While public drainage has been constructed in many areas, a waterborne sewerage system is still underdeveloped and open drains are very common. During the rainy season, the lower parts of areas are quickly flooded by evening storms and dirty domestic waste floats and is scattered around in the water.
Rubbish is not properly collected and is often left on open spaces such as road sides or river banks. In Kakuri, there is a huge refuse place right in the middle of the congested residential area, and it is further expanding. Another problem is animals (especially pig) excretions. In Kaduna-South, a number of people keep pigs as a side-line to complement their main economic activities. They do not confine the pigs, but let them wander around their neighbourhood.

In most districts, piped water supply is available. However, it covers only part of each district. Wells are still in use in many areas. Predictably, the ground water of wells is heavily contaminated, both by domestic waste and industrial effluent. According to the study of the Federal Ministry of Water Resources (cited in the report of the Nigerian Institute of Architects 1986), microbiological contamination of wells is alarming - a high level of bacterial colonies, including Salmonella is recorded. People are apparently aware of contamination and normally use piped water for drinking. Since water pipes do not reach all the compounds, people, mostly children, often fetch piped water from the nearest taps.

Industrial waste is the second major source of pollution in the city. According to the estimate of the Nigerian Institute of Architects (1986), the load of Kaduna's industrial waste was equivalent to the domestic sewage generated by 325,000 people. The Institute expressed a grave concern about toxic substances which were discharged directly into open drainage from factories. They were especially concerned about the pollution of drainage in the Kakuri and Makera areas, where the textile industry, the Federal Fertiliser factory and the transport depot are situated. The drainage into which the textile industry discharges its waste runs in the middle of
the residential area and then into an open space where vegetables are grown. The Kaduna River which eventually accommodates most of the sewage is inevitably badly polluted. According to the investigation of the Institute (1986), aquatic life is impossible for several kilometres down stream of the Western Bypass Bridge during the dry season.

2) Health and Disease: The adult population in the city appears to be generally healthy and energetic, since most of them are young. Fatal diseases associated with ageing are likely to be uncommon among young adults. However, this does not mean that they are relatively free from illnesses. As we shall see, even young adults commonly get minor ailments such as fever, headache and abdominal disorders.

As to infectious diseases, available statistical data indicate that the common infectious diseases are malaria, dysentery (amoebic, bacillary and others), pneumonia, gonorrhoea, measles and smallpox (Northern Central State Year Book and Kaduna State Year Book 1968 - 1976). The data, which are based on a survey conducted during the 1960s and the 1970s, also suggest that, in comparison with infectious diseases recorded in the former Katsina and Zaria Provinces, noticeable in Kaduna is a high incidence of dysentery, food poisoning, infectious hepatitis, filariasis and schistosomiasis. While the occurrence of cerebrospinal meningitis is observed every year in the data, the number of cases is constantly low in comparison with Katsina Province. In the case of children’s illnesses, again, while available data are limited (Northern Central State Year Book 1968), it indicates that the common illnesses are gastroenteritis, respiratory infection, malaria, skin infection, malnutrition, eye infection and measles. On the whole, it appears to be certain that many common
illnesses and infectious diseases are related to contaminated drinking water and food, and a lack of hygiene in general in Kaduna. Compared to other parts of Northern Nigeria, the seasonal type of infectious diseases appear to be less common.

It should be also pointed out that the working conditions of the city dwellers cannot be ignored with regard to health and safety. First of all, the rotating working time schedule which many industrial firms have adopted is not favourable to the health conditions of their workers. Also, there are a number of materials damaging to the workers' health. For instance, in the textile industry, the health of workers in the spinning section may be affected by cotton fibre flying in the air, while those in the printing section have to deal with chemicals and work in intensive heat. A number of people are also working in high risk of accidents. Some of the workers at the oil refinery are working at high places in the plant—apparently, quite a few workers died during the construction of the plant. The drivers of taxis, buses and lorries, and business people who often travel by these means of transport, have a high chance of being involved in traffic accidents.

Finally, few data are available about the significance of psychosomatic and psychiatric illnesses in Kaduna. As we shall see in Chapter VII, however, the physical ailments of my informants are often conceived as part of a series of crises and inseparable from their psychological situations, which are in turn bound up with their political and economic situations. Whether these ailments are to be called psychosomatic or not, in order to understand such afflictions, it is essential to examine the social relationships and cultures of the individuals in the city.

In short, many illnesses and diseases in Kaduna
are generated by the particular human-made urban environment. Therefore, the sustainable health and well-being, *lafiya*, of the people can never be achieved without the understanding of the overall social and cultural environment of the city.

**CONCLUSION**

Social relations in Kaduna are first marked by a multiplicity of institutions and groups, a lack of hegemonic institution and the relative autonomy of individuals in various cultural fields and the city at large. Thus, while kinship is undoubtedly the most important social relationship for the majority of the city dwellers, a lack of the authority of the elder members of families and distance between the city and home villages grant considerable autonomy to young adult residents. There is a considerable degree of fragmentation in the diversity of ethnic groups and religious groups; there are hundreds of different groups, and no single group can claim the majority position. In class relationships, too, one cannot simply assume that the educated elite and wealthy business people have exclusive control over institutions; these elites are not necessarily united, and class divisions are often undermined by patron-client relationships.

In the past, the city was under stronger bureaucratic control of the state, and a large-scale industry, especially the textile industry, dominated the economy in the city. However, the strength of these institutions has significantly declined, which has resulted in an increase in the importance and autonomy of various social relationships and informal economic activities.

In this situation, people have autonomy to choose
their social identities and can belong to a number of
groups at the same time; people identify themselves
with local, ethnic, regional and even national
categories according to the situation. Such multiple
social affiliations partially explain a wider
repertoire of cultural practices and knowledge used by
individuals in their everyday lives in the city. While
members of particular groups display their shared
distinctive practices and knowledge, these practices
and knowledge form merely part of the cultural
repertoires of these individuals. People do share some
cultural practices and knowledge available in the
city, whereas they do not share others. Moreover, the
city accommodates influx of information and knowledge;
the city dwellers, most of whom are migrants, are
always in a position to learn something new.
Inevitably, they interpret new ideas and practices
with their existing knowledge. Thus, this situation
can be best understood in terms of cultural flow.

This particular nature of configuration of social
agencies and cultural flow in the city is bound up
with: 1) rapid growth (the city has experienced a
demographic leap in the past 40 years); 2) a lack of
indigenous foundation (the city is a colonial
creation); 3) the migrant base of development (the
majority of the adult population are migrants); 4)
cultural diversity in the region and country, and 5)
weakness of the bureaucratic control of the state and
decline of industries. It is important to emphasise,
again, that the current features in the configuration
of social agencies and cultural flow should be placed
in a historical perspective. The city has undergone
marked changes from a planned colonial city based on
specific objectives, via an attempt to establish the
city as a regional community, to a city of cultural
flux.

It appears to me that the understanding of the
nature of configuration of social agencies and cultural flow in the city as a whole is essential for the analysis of the practice of traditional medicine and management of everyday crises. In the following chapter, I shall begin by examining the general features of the practice of traditional medicine in Kaduna.
In this chapter, I explore the main characteristics of the practice of traditional medicine in Kaduna. In Chapter II, I suggested the importance of viewing complex medical cultures in terms of the flow and forms of their practices and knowledge. The components of complex medical cultures cannot be seen either as being segregated from each other or as being uniform. Rather, different practices and knowledge are distributed in particular ways. Thus, examination of the particular flow and forms of medical cultures is essential for the understanding of therapeutic action by healers and lay people.

I also argued that internal relationships among healers, and between healers and lay people can be considered as constituting a kind of 'market' where different therapists and consumers are influencing one another. In that sense, one cannot adequately understand the significance of traditional medicine and its practitioners without looking into the overall medical market within a society. Moreover, in an African context, it is important that the study of traditional medicine should go beyond the analysis of 'medicine' and 'illness'. Here, traditional medicine reflects the diversity of social and economic crises.

Examination also has to be made into the configuration of social relationships and the political and economic situations in which healers and lay people live in cities. Thus, the focus of this chapter is on: 1) the nature of traditional medicine in the context of the overall medical market in Kaduna; 2) the significance of traditional medicine in
the field of everyday crises; 3) the cultural backgrounds and identities of clients and healers; 4) the cultural flow and forms of traditional medicine, and 5) the economics of traditional medicine. In the following, I shall start by examining the plurality of medical cultures and their practitioners available to people in Kaduna. (See following page for map showing distribution of medical practitioners in the Nasarawa quarter of Kaduna.)

TYPES AND RANGE OF THERAPIES

1) Biomedicine: In this thesis, I chose a term, biomedicine, to refer to medical practice and knowledge which originated in Western countries but now has a cosmopolitan character and is based on biology and other natural sciences. I also subdivide biomedicine into clinical medicine, as medical practice and knowledge of hospitals and clinics on the one hand and pharmaceutical medicine, as medicine manufactured by pharmaceutical companies on the other.

While I was not able to obtain current data on the number of hospitals and clinics in Kaduna, the city has no shortage of these biomedical institutions and facilities. There are three large general hospitals: Ahmadu Bello University Teaching Hospital, a military hospital and St. Gerald’s Hospital. The Kaduna State Government has established several hospitals and dispensaries inside and outside Kaduna city. There are also a number of missionary clinics and dispensaries, since the city and its surrounding area have been a centre of missionary activities. It is also important to note that many medium- and large-scale industries and business corporations have their own clinics. Textile companies, for instance, have a clinic for junior workers and a company doctor for
senior workers and their families, including foreign workers. What is most remarkable, however, is the sheer number of private clinics in the city. These clinics vary in size, ranging from small ones with one doctor and one or two nurses to large ones with several doctors and nurses. Some clinics are equipped with high tech machines which even Ahmadu Bello University Teaching Hospital does not possess. Some of these clinics have contracts with companies and function as company clinics as well as providing services for the general public.

In Kaduna, pharmaceutical medicine is distributed through different agents. First of all, there are pharmacies that can prepare medicine according to clinical doctors' prescriptions. These are mostly large stores run by qualified pharmacists and located on the main streets. Secondly, there are numerous small chemists run by those without a pharmacist’s qualification. They do not deal with prescription medicines but only over-the-counter medicines such as painkillers, cures for digestion and heartburn, and chloroquine and other antimalarial tablets. Thirdly, there are itinerant medicine sellers who usually carry their merchandise on their heads from one place to another. The kinds of medicine they sell are similar to those sold by chemists.

The medical practice and knowledge of these institutions and practitioners are supposedly based on the biomedical paradigm. However, the actual medical knowledge of the practitioners varies considerably. Likewise, the occupational goals and ethics of these practitioners are significantly variable. Thus, the occupational ethics of clinicians and, especially, of nurses working for missionary hospitals should be inseparable from their Christian faith, whereas one of the main goals of private clinics and chemists is undoubtedly the increase of profit. It is important to
note that government hospitals are currently suffering from lack of funds. In general, clinical doctors are not happy about their low salaries. I have heard clinical doctors talking about changing their jobs. On the other hand, private clinics appear to be increasing in number in Kaduna.

It is also interesting to note that there is a degree of ethnic division of labour in these occupations in Kaduna. Thus, the majority of clinical doctors appear to be either Yoruba- or Igbo-speaking people, while most of nurses are from the Christian dominated areas of Kaduna State. The majority of qualified pharmacists are Yoruba-speaking, whereas the overwhelming majority of chemists are Igbo-speaking. Itinerant medicine sellers appear to be mostly Muslim Northerners.

2) Religious Medicine: In Kaduna, many religious organisations practise healing for their members and the public in general. Among Muslims, Koranic teachers, called in Hausa mallamai (singular, mallam), are at the same time active as diviner-healers. Mallamai practise divination with sand (kasa) spread on a slate. With their fingers, they mark on the sand geometrical wave-like figures. Mallamai then tell clients about the causes and solution of their problems. Their healing mainly consists of prayer and inky medical solutions (rubutu). For rubutu medicine, they write Koranic verses on a wooden board, wash off the ink into a bowl and let clients drink it. Some mallamai prepare herbal medicine and protective amulets (laya). As we shall see, in this regard differences between the divinatory and healing practices of mallamai and those of Muslim traditional healers in Kaduna are often minor.

While mainline Christianity offers a degree of healing for their members, there are various Christian groups putting a special importance on healing.
Broadly, these Christian groups can be divided into Aladura churches and Born Again churches. As we noted previously, Aladura churches comprise a number of different groups. There are, however, considerable similarities in the mode of rituals, dress, healing and divination. Aladura healing practice is characterised by prayer, fasting, anointment with water and oil, use of candles and incense, and the practice of night vigil. The churches also organise special healing sessions for those suffering from particular problems such as infertility. Perhaps more conspicuous is their divinatory practice through spirit possession. In spirit possession, some of the members go into trance and speak in tongues. They are believed to instruct other members through the words of 'Holy Angels'. Those who are particularly susceptible to trance and regularly play the diviner's role are called 'Prophet' or 'Prophetess'. The leaders of the churches and prophets and prophetesses are also personally consulted at their residences both by those who are not members of the churches and by the church members. They often charge for their consultations and healing.

The other Christian groups for which healing is of major importance are the Born-Again churches. Their healing consists of prayer that can be characterised by emotional verbal utterance, fasting and, above all, the laying-on of hands. While speaking in tongues may occur, spirit possession is not part of their activities. There is a special weekly healing session called variously, 'Deliverance Service' or 'Miracle Service'. Apparently, such a service is one of the important strategies for churches to recruit new members. The leaders and senior members are also personally consulted by their members.

As noted earlier, both Aladura and Born-Again churches have been proliferating in Kaduna.
Especially, Born-Again churches are currently mushrooming and attracting a number of young people. Bearing in mind their anti-traditional medical stance, the impact of Born-Again churches can hardly be ignored in the analysis of popular therapeutic management in Kaduna.

3) Traditional Medicine: There are several types of traditional medical practitioners in Kaduna. To begin with, there are herb sellers who sell herbs, barks, animal parts and medicated soaps. They have a stall in a market place, or display their merchandise on the street near a market place. The majority of herb sellers are either Muslim Northerners or Yoruba-speaking people. There are also traditional bonesetters and barber-surgeons in Kaduna. However, I have come across only one bonesetter and one surgeon. While further investigation is necessary, at least it is certain that they are not numerically remarkable in Kaduna. The same applies to the situation of traditional midwifery. I have not come across either a single traditional midwife in the city or a single case of child delivery at a place other than hospitals and clinics. I have to admit that I was not looking into the issue of maternity and childbirth in my research. It is conceivable that in old parts of the city where Gbagyi and Hausa people have been settled for many years, midwifery is still practised by elderly women. However, since the majority of the city dwellers are young migrants and there are a number of maternity clinics and hospitals with gynaecological departments, it is safe to assume that traditional midwifery is on the whole insignificant in Kaduna.

By contrast, there is a remarkable number of general practitioners of traditional medicine, that is, those who practise divination and herbal and ritual healing in the city, and it is on these practitioners that the present study is focused. As we
shall see, while there are some variations in the mode of practice according to their cultural backgrounds, there are considerable similarities in their practice and, more importantly, they share a common identity as traditional healers. The terms for these practitioners vary according to different languages: native doctors and herbalists (in English), boka (in Hausa), babalawo (in Yoruba) and dibia (in Igbo).

Some of the healers are also associated with cults of affliction. Among them, the most remarkable is bori, a well-known spirit possession cult group in Northern Nigeria and Niger. Apparently, the majority of Hausa healers are associated with bori in Kaduna. The other notable cult of affliction I know is a mamy wota society. Most of the healers and members of the society are Igbo people in Kaduna. In this thesis, I refer mostly to these general practitioners and members of cults of affliction as traditional healers (and to the practitioners of traditional medicine of all kinds as traditional medical practitioners).

I estimate the number of traditional healers to be about 1,000 people in the city. The number is probably larger than that of clinical doctors. Indeed, it is not difficult to find at least a few healers within a few blocks in many areas in the city. On one street in Nasarawa area, for instance, I have found six healers within a distance of about 500 metres (See Map ). The ethnic composition of traditional healers in Kaduna, as a rough estimate, is about 40% Hausa, 30% Yoruba and 20% Igbo. The rest are composed of Gbagyi, Fulani, I gala and other healers. Most of the healers are migrants; of all the healers I interviewed, only one healer, a male Gbagyi healer, was born in Kaduna (see Appendix 1 for the cultural backgrounds of my informants). The majority of healers identify themselves with Islam, while the rest do not necessarily adhere to a Christian identity, some
healers, especially Igbo, identifying themselves with traditional deities. Male healers probably outnumber female healers. As to age, in our survey, the average age of healers is about 50. However, I must say that the survey does not reflect the general picture in this regard. I tended to interview well-known healers in different areas, who were mostly male and middle aged; some are very old. However, there appears to be a number of young healers who have recently migrated to the city.

4) Aetiological Knowledge: All the medical practitioners mentioned above are distinctive mainly in their mode of healing and diagnostic (divinatory) practices. Obviously, these medical traditions have their distinctive aetiological theories and knowledge as well. Thus, biomedicine has the most elaborate system of aetiological knowledge, whose enquiry is, of course, outside the scope of this study. As to medicine practised within certain religious groups, whether in Islam or Christianity, the emphasis is on God as the ultimate healer and judge of one’s fate. A binary view of good (God) and evil (Satan) is also common among religious healers. Some religious fundamentalists, especially the Born-Again group, tend to link afflictions and misfortunes to the idea of sin, and sin is in their view synonymous with a failure to be a true Christian. In the case of traditional healers, some healers, especially those in cults of affliction, have elaborate ideas about spiritual beings that can cause different illnesses and misfortunes. There are also distinctive aetiological ideas that vary according to the ethnic backgrounds of the traditional healer.

However, it is wrong to exaggerate such distinctiveness of aetiological knowledge as held by different medical practitioners. There are certain aetiological ideas that are fairly common among them.
In these common aetiological ideas, two types of causal agents are often acknowledged: 1) natural causal agents and 2) personal or spiritual causal agents. Natural causal agents include climatic conditions, food and hygiene. Personal and spiritual causal agents are those human beings and spiritual beings that cause people illness and other misfortunes. Among them, particularly common are what English speakers call 'poison', 'witches' and 'spirits' or what Hausa speakers call 'sammu', 'mayu' and 'aljannu'. Here, poison does not only mean a material concoction to affect human bodies directly but also ritual practices to harm someone, that is, the practice of sorcery. Witches are human beings who have magical powers to harm someone. They can fly and change their shape and hunt human souls. Spirits are not human but invisible beings with intelligence. They are considered to live in various places and sometimes attack humans, causing physical or mental afflictions.

Thus, I have introduced the range of different therapies and their practitioners available to people in Kaduna. In general, people have a wide range of choice of therapies. However, their choices are bound up with the particular nature of the medical market in Kaduna. In the following, I shall examine the objectives of traditional medicine in the context of the overall medical market situation in the city.

**THE OBJECTIVES OF TRADITIONAL MEDICINE**

In Kaduna, traditional medicine is practised not only for the treatment of various physical and mental afflictions, but also for the solution of various social and economic problems. While the range of problems it deals with is enormous, the objectives of traditional medicine have certain features in relation
to various other therapies and various activities in everyday lives of people in Kaduna.

1) Illness: In cases of the treatment of illness, traditional medicine is mostly employed as the second resort onward (see Table 1). For the first resort, people tend to use biomedicine, either pharmaceutical or clinical medicine. On the other hand, in the case of prolonged therapeutic management, such a pattern of usage is hard to find.

It appears that the significance of biomedicine in the first resort reflects the fact that there exists a general knowledge of the efficacy of biomedicine in relation to other medical practices. The idea of the efficacy of biomedicine appears to cover all kinds of illness in terms of their symptomatic features. Thus, in our survey, there are few symptomatic features specific to the ailments treated by clinical medicine (see Table 2). However, there are certain areas of special competency attached to biomedicine. Thus, our survey indicates pharmaceutical medicine is most commonly used for the treatment of the most common minor ailments. Of 50 people interviewed, 33 had either fever, or headache, or abdominal disorder, or a combination of some of these during the three months prior to the interview. Of the 33 people, 25 used pharmaceutical medicine. On the other hand, in my observation, serious and acute ailments are the most likely to be treated by clinical medicine. As noted earlier, clinical medicine also appears to be predominant in the area of child delivery, if not maternity care as a whole.

Thus, traditional medicine is employed mainly when biomedicine fails to cure ailments. In other words, the practice of traditional medicine is often complementary to that of biomedicine. However, this does not indicate that the use of traditional medicine is dramatically reduced under the influence of
Table 1: Course of Therapy Management

1. Patients of St. Gerald's Hospital (14 cases)

<table>
<thead>
<tr>
<th>No.</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>5th</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>clinical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>pharmaceutical - clinical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>clinical - clinical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>traditional - clinical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>pharmaceutical - clinical - clinical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>clinical - clinical - clinical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>clinical - traditional - clinical - clinical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>pharmaceutical - traditional - traditional - clinical - clinical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Patients of traditional Healers (28 cases)

<table>
<thead>
<tr>
<th>No.</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>traditional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>clinical - traditional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>church - traditional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>clinical - traditional - traditional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>clinical - church - traditional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>clinical - clinical - traditional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>pharmaceutical - clinical - traditional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>clinical - traditional - church - traditional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>clinical - clinical - traditional - traditional</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Data in the first table is based on survey conducted among patients of St. Gerald's Hospital in Kakuri (Kaduna-South). Data in the second table is based on survey of patients of 12 traditional healers, 3 each, from 4 ethnic groups (Hausa, Yoruba, Igbo and Gbagyi). In the first row indicated is the sequence of therapy application (therapy resort). Each number in the first column indicates the number of patients who followed the same pattern of the therapy management shown on the same row in the second column.
<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Clinical Therapy (N = 33 cases)</th>
<th>Traditional Therapy (N = 60 cases)</th>
</tr>
</thead>
<tbody>
<tr>
<td>symptoms</td>
<td>number of cases</td>
<td>symptoms</td>
</tr>
<tr>
<td>fever</td>
<td>11 (2) 33%</td>
<td>fever</td>
</tr>
<tr>
<td>stomachache</td>
<td>13 (6) 39%</td>
<td>stomachache</td>
</tr>
<tr>
<td>diarrhoea</td>
<td>2</td>
<td>diarrhoea</td>
</tr>
<tr>
<td>vomiting</td>
<td>2</td>
<td>headache</td>
</tr>
<tr>
<td>headache</td>
<td>3</td>
<td>concern for pregnancy</td>
</tr>
<tr>
<td>menstruation disorder</td>
<td>4 (1) 12%</td>
<td>infertility</td>
</tr>
<tr>
<td>concern, pregnancy</td>
<td>2</td>
<td>impotence</td>
</tr>
<tr>
<td>V.D.</td>
<td>1</td>
<td>abortion</td>
</tr>
<tr>
<td>swelling, leg</td>
<td>1</td>
<td>V.D.</td>
</tr>
<tr>
<td>swelling, breast</td>
<td>1</td>
<td>swelling, leg</td>
</tr>
<tr>
<td>swelling, abdomen</td>
<td>2</td>
<td>swelling, breast</td>
</tr>
<tr>
<td>pain, joints</td>
<td>3</td>
<td>swelling, neck</td>
</tr>
<tr>
<td>pain, feet</td>
<td>2</td>
<td>pain, bones</td>
</tr>
<tr>
<td>pain, chest</td>
<td>1</td>
<td>pain, leg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>pain, chest</td>
</tr>
<tr>
<td></td>
<td></td>
<td>pain, breast</td>
</tr>
<tr>
<td></td>
<td></td>
<td>pain, back</td>
</tr>
<tr>
<td></td>
<td></td>
<td>pain, body</td>
</tr>
<tr>
<td></td>
<td></td>
<td>cough</td>
</tr>
<tr>
<td></td>
<td></td>
<td>eye problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>measles</td>
</tr>
<tr>
<td>wound</td>
<td>1</td>
<td>fainting</td>
</tr>
<tr>
<td>burn</td>
<td>1</td>
<td>weakness</td>
</tr>
<tr>
<td>dizziness</td>
<td>2</td>
<td>feel something moving</td>
</tr>
<tr>
<td>weakness</td>
<td>1</td>
<td>abnormal behaviour</td>
</tr>
<tr>
<td>others</td>
<td>4</td>
<td>bad dream</td>
</tr>
<tr>
<td></td>
<td></td>
<td>others</td>
</tr>
</tbody>
</table>

Note: In the left column is shown the symptomatic characteristics of 33 clinical cases at St. Gerald's Hospital. On the right 60 cases of traditional therapy. Each number in parentheses indicates the number of cases in which ailments were solely manifested with the symptoms concerned. Since some patients reported more than one symptom, the total numbers of cases add up to more than 33 and 60 respectively.
### Table 3: Duration of Ailments since their Onset

<table>
<thead>
<tr>
<th>Duration</th>
<th>Clinical therapy (cases)</th>
<th>Traditional therapy (cases)</th>
</tr>
</thead>
<tbody>
<tr>
<td>less than 1 month</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>1 month - 1 year</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>1 year - 2 years</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>more than 2 years</td>
<td>2</td>
<td>24</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>48</td>
</tr>
</tbody>
</table>

### Table 4: Causes - Clinical and Traditional Therapies

<table>
<thead>
<tr>
<th></th>
<th>Clinical therapy</th>
<th>Traditional therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>causes</td>
<td>number of cases</td>
<td>causes</td>
</tr>
<tr>
<td>no idea</td>
<td>3</td>
<td>no idea</td>
</tr>
<tr>
<td>sorcery</td>
<td>3</td>
<td>witches</td>
</tr>
<tr>
<td>witches</td>
<td></td>
<td>spirits</td>
</tr>
<tr>
<td>spirits</td>
<td></td>
<td>mysterious man</td>
</tr>
<tr>
<td>mysterious man</td>
<td></td>
<td>ancestor</td>
</tr>
<tr>
<td>ancestor</td>
<td></td>
<td>evil force</td>
</tr>
<tr>
<td>evil force</td>
<td></td>
<td>gonorrhoea</td>
</tr>
<tr>
<td>gonorrhoea</td>
<td></td>
<td>soft drink</td>
</tr>
<tr>
<td>soft drink</td>
<td></td>
<td>marijuana</td>
</tr>
<tr>
<td>marijuana</td>
<td></td>
<td>natural</td>
</tr>
<tr>
<td>typhoid fever</td>
<td>1</td>
<td>total</td>
</tr>
<tr>
<td>faulty injection</td>
<td>1</td>
<td>total</td>
</tr>
<tr>
<td>thinking too much</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>hard work</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>industrial accident</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>

Note: In the left column is shown the self-diagnosis of the patients in 9 cases of clinical therapy at St. Gerald's Hospital. In the right column is the self-diagnosis of the patients of traditional healers in 20 cases of traditional therapy.
biomedicine. When therapy management is prolonged, traditional medicine is frequently practised. This is the case in the therapy management of chronic illnesses of various kinds. In our survey, the duration of ailments treated by means of traditional medicine is found to be much longer than that of ailments treated by means of clinical medicine (Table 3).

It is also important that widely shared ideas of personal and spiritual causal agents are conducive to the use of traditional medicine. In the survey, a number of clients of traditional healers attributed their afflictions to personal and spiritual agents such as sorcery, witchcraft and spirits (Table 4). However, one should not overemphasise the significance of causal agents in the therapeutic choice of lay people. The survey also indicates that a considerable number of clients of both traditional healers and a hospital did not really know the causes of their ailments.

Furthermore, the lack of pattern in therapeutic choice in prolonged therapeutic management is suggestive of the fact that people employ various medical practices in a trial and error fashion. As we shall see in the detailed case studies later, it is indeed this situational aspect of therapeutic action that is most remarkable in the popular management of therapy in Kaduna. In this regard, it has to be said that the survey type of research has considerable limitations as a research method for studies of therapy management. First of all, it cannot penetrate into the details of the actions of those seeking health. Secondly, the information collected through formal interview is usually the informants' reflection on their own experience in the past, which is often selective and influenced by various factors from the present.
2) Social and Economic Problems: Medical anthropalogy tends to concentrate on the study of cultural understanding of the nature and treatment of illness. However, a focus on illness alone would be quite misleading in the analysis of traditional medicine in Kaduna. In our survey, over half of the cases traditional healers handle are not illness but diverse social and economic problems that clients face in their everyday life (Table 5). The range of these problems are strikingly wide (Table 6). Nonetheless, several common problems are identifiable: 1) business problems; 2) problems about love and prospective marriage; 3) employment; 4) timing and safety of travel; 5) theft; 6) problems with existing marital relationships; 7) missing money, and 8) court cases.

Business problems are, for example, the problems of traders whose sales and numbers of customers are declining. The use of traditional medicine is expected to increase sales and ward off the malevolent force causing the problems. Problems about love and prospective marriage are mostly those of young people who want to find their partners, charm their prospective partners or change the mind of their present partners to keep their love through the power of medicine. Those who are looking for jobs or waiting for the result of a job interview consult healers in order to know the prospects of getting a job, to have the good luck to get it or to prevent an evil force from blocking it. Given the high rate of traffic accidents, many of those who travel by car are concerned about the safety of their travel. They consult healers to determine the auspicious time for their journeys. Timing of travel is also related to business success. Theft is very common in Kaduna, and healers are consulted to find out who stole the properties of clients. In the case of marital problems, traditional medicine is used typically to
Table 5: Number of Cases of Illness and Social and Economic Problems Treated by Traditional Healers

<table>
<thead>
<tr>
<th>Problems treated</th>
<th>Hausa Healers</th>
<th>Yoruba Healers</th>
<th>Igbo Healers</th>
<th>Gbagyi Healers</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illness</td>
<td>27</td>
<td>16</td>
<td>10</td>
<td>9</td>
<td>62</td>
</tr>
<tr>
<td>Social and economic problems</td>
<td>11</td>
<td>31</td>
<td>9</td>
<td>20</td>
<td>71</td>
</tr>
<tr>
<td>Total</td>
<td>38</td>
<td>47</td>
<td>19</td>
<td>29</td>
<td>133</td>
</tr>
</tbody>
</table>
### Table 6: Range of Social and Economic Problems Dealt with by Traditional Healers

<table>
<thead>
<tr>
<th></th>
<th>Hausa Healers</th>
<th>Yoruba Healers</th>
<th>Igbo Healers</th>
<th>Gbagyi Healers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>court cases 2</td>
<td>employment 2</td>
<td>love 2</td>
<td>business</td>
<td>business</td>
</tr>
<tr>
<td></td>
<td>theft 1</td>
<td>love 5</td>
<td>economic</td>
<td>problems 3</td>
<td>problems 17</td>
</tr>
<tr>
<td></td>
<td>business</td>
<td>employment 2</td>
<td>problems 1</td>
<td>issues</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>problems 1</td>
<td>progress in life</td>
<td>theft 1</td>
<td>travel 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>improvement of business 1</td>
<td>expected</td>
<td>travel 1</td>
<td>love 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>love 1</td>
<td>expenditure 1</td>
<td>motor accident 1</td>
<td>missing money 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>travel 1</td>
<td>money vanishing 1</td>
<td>personal problem 1</td>
<td>court case 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>marital</td>
<td>no increment and promotion 1</td>
<td>marital relationship 1</td>
<td>marital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>relationships 1</td>
<td>child</td>
<td>relationship 1</td>
<td>relationship</td>
<td></td>
</tr>
<tr>
<td></td>
<td>admission to</td>
<td>misbehaviour 1</td>
<td>missing money 1</td>
<td>employment 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>school 1</td>
<td>marital</td>
<td>personal problem 1</td>
<td>promotion 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>relationships 1</td>
<td></td>
<td>improvement of business 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>dream of land dispute 1</td>
<td></td>
<td>damage of property 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>evil force from home 1</td>
<td></td>
<td>school 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>many worts 1</td>
<td></td>
<td>examination 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>11 cases</td>
<td>31 cases</td>
<td>9 cases</td>
<td>20 cases</td>
<td>71 cases</td>
</tr>
</tbody>
</table>
Table 7: Social and Economic Problems and Causal Explanation of Clients of Traditional Healers

<table>
<thead>
<tr>
<th>Causal Explanation</th>
<th>Clients of Hausa healers</th>
<th>Clients of Yoruba healers</th>
<th>Clients of Igbo healers</th>
<th>Clients of Gbagyi healers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>causal factors not relevant</td>
<td>6</td>
<td>7</td>
<td>5</td>
<td>13</td>
<td>31</td>
</tr>
<tr>
<td>personal and spiritual agents</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>sorcery</td>
<td>2</td>
<td>7</td>
<td>2</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>witch</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sorcery or witch</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>many wots</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>amere</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sorcery and witch</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>several evil agents</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>magical money</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>bad premonition</td>
<td>2</td>
<td>20</td>
<td>1</td>
<td>3</td>
<td>26</td>
</tr>
<tr>
<td>unclear</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>31</td>
<td>9</td>
<td>20</td>
<td>71</td>
</tr>
</tbody>
</table>
change the mind of marital partners, whether to maintain the relationship or to break their relationships with others. Missing money is another common problem; money mysteriously disappears from where it is kept and theft is not necessarily suspected. Traditional medicine is used to protect money from such mysterious forces. Finally, traditional healers are also commonly consulted by clients involved in court cases. These clients want healers to help them to win the case by medicine.

Broadly, the social and economic problems dealt with by traditional healers can be divided into: 1) the present problems of their clients, that is, the failure of certain activities and social relationships in which clients are involved, such as business failure and marital conflicts, or troubles and unexpected incidences such as theft and missing money; 2) the concern of clients about their future, that is, concern about the possible unsuccessful outcome of their actions and the assurance of success such as in job interviews, court cases, travel, school admission and finding marital partners. Thus, in either case, it appears that the social and economic problems of clients are centred on the failure, or the possibility of failure, to succeed in their endeavours, and that traditional medicine is used largely in addition to their ordinary activities to ensure success; there is no medicine to create money or to get employment, without also the action of carrying out business activities and job hunting.

In relation to causal explanations, in about a third of the cases (21 out of 71) of social and economic problems dealt with by healers, their clients suspect that their problems are caused or will be caused by certain personal and spiritual agents (Table 7). The most common personal and spiritual agents are 'poison' or 'medicine', that is, sorcery, followed by
'witches' and then 'mamy wota.' It is, however, sometimes difficult for the clients to decide whether the causal agents are sorcery or witches. Some of them think that their 'enemies', whether they are ordinary people or witches, are people in their home villages. Others attribute their problems to their business rivals, or to someone at their workplace, or to their neighbours or to others. Apart from mamy wota, spiritual beings are not important causal agents of the social and economic problems interviewed in the survey.

However, what is remarkable is that in more than a third of the cases (31 out of 71), the intervention of such evil forces is not suspected. In many of these cases, clients simply want to achieve certain ends with the help of traditional medicine, whether these are the solution of present problems or the success of future action. In other cases, most notably the case of theft, they attribute their problems to the acts of individuals which have nothing to do with supernatural agencies.

Thus, on the whole, it can be argued that the practices of traditional medicine are largely complementary to various other means, therapies and activities, to achieve various ends. In other words, what underlies the use of traditional medicine is people's perception of the possible failure of an action and uncertainty attached to the outcome of action, even though their ideas of personal and causal agents are not an insignificant factor. This point will be further illustrated in later chapters.

CLIENTS

It may be argued that those who consult traditional healers represent people with certain
social and economic backgrounds. It may also be conceivable that relationships between healers and their clients are also part of particular social relationships such as kinship and ethnicity.

1) Cultural Backgrounds: In Tables 8 and 9, the cultural backgrounds of hospital patients and of traditional healers' patients are contrasted. While the sample sizes are not large, I believe that it can still give a clue to understanding of the cultural backgrounds of patients. Thus, in most attributes, that is, gender, marital status, age, ethnicity, occupation and education, there do not seem to be features that distinguish hospital patients from traditional healers' patients. Significant differences are found only in the religious backgrounds of patients. The majority of hospital patients are Christian, whereas in the case of traditional healers' patients, the proportion of Christians is larger than that of Muslims, but the difference is not great.

Two factors have to be considered in this regard. The high proportion of Christians among hospital healers in the survey is mainly attributable to the fact that the hospital where I took this survey is a Catholic missionary hospital. Secondly, the slightly larger proportion of Christians among traditional healers' patients may be related to the fact that most of the healers I investigated in this survey live in Kaduna-South where the Christian population is likely to outnumber the Muslim population. My impression is that the proportion of Muslims is larger among the patients of governmental hospitals and among the patients of healers living in Kaduna-North, where the Muslim population is larger. It is therefore safe to argue that there are few distinctive features in the cultural backgrounds of hospital patients and traditional healers' patients; religious differences have more to do with the overall geographical
### Table 8: Cultural Background of Patients
- Clinical Patients (14 people)

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>male 5-40%, female 9-60%</td>
</tr>
<tr>
<td>Marital Status</td>
<td>married 10-70%, single 4-30%</td>
</tr>
<tr>
<td>Age</td>
<td>31 years old on average</td>
</tr>
<tr>
<td>Stay in Kaduna</td>
<td>10 years on average</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Hausa 2-10%, Igbo 2, Jaba 1, Bajjiu 1, Gbagyi 1, Idoma 1, and others</td>
</tr>
<tr>
<td>Religion</td>
<td>Christian 11-80% (Chathoric 5-40%, Baptist 2, ECWA 2 and others including Deeper Life Church 1 and Apostolic Church 1) Muslim 3-20% (Darica)</td>
</tr>
<tr>
<td>Education</td>
<td>primary 8-60%, secondary 4-30%, higher 0, Kolanic 0 and no school education 2-10%</td>
</tr>
<tr>
<td>Occupation</td>
<td>house wife 5-40%, trader 2, student 1, farmer 1, unemployed 1 and others</td>
</tr>
<tr>
<td>Income</td>
<td>N.A.</td>
</tr>
</tbody>
</table>

Note: Data is based on 14 patients of St. Gerald's Hospital.
Table 9: Cultural Background of Patients  
- Traditional Healers’ Patients (60 people)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>gender</strong></td>
<td>male 30-50%</td>
</tr>
<tr>
<td></td>
<td>female 30-50%</td>
</tr>
<tr>
<td><strong>marital status</strong></td>
<td>married 47-80%</td>
</tr>
<tr>
<td></td>
<td>single 13-20%</td>
</tr>
<tr>
<td><strong>age</strong></td>
<td>32 years old on average</td>
</tr>
<tr>
<td><strong>stay in Kaduna</strong></td>
<td>12 years on average</td>
</tr>
<tr>
<td><strong>ethnicity</strong></td>
<td>Hausa 13-20%, Igbo 9, Jaba 9, Yoruba 8, Gbagyi 6, Idoma 3, Bajjiu 2 and others</td>
</tr>
<tr>
<td><strong>religion</strong></td>
<td>Christian 31-50% (Catholic 11, Baptist 10, ECWA 3 and others including Deeper Life Church 1 and Cherubim &amp; Seraphim 1)</td>
</tr>
<tr>
<td></td>
<td>Muslim 25-40% (Darica 21, Isala 3 and Tijjaniya 1)</td>
</tr>
<tr>
<td></td>
<td>Mamy Wota member 2</td>
</tr>
<tr>
<td></td>
<td>no religion 1</td>
</tr>
<tr>
<td><strong>education</strong></td>
<td>primary 24-40%, secondary 13-20%, Higher 3, kolanic 5 and no education 5-10%</td>
</tr>
<tr>
<td><strong>occupation</strong></td>
<td>house wife 17-30%, trader 7-10%, textile worker 6-10%, student 6, civil servant 3, factory worker 2, security guard 2, unemployed 2 and others</td>
</tr>
<tr>
<td><strong>income</strong></td>
<td>about 500 nairas on average</td>
</tr>
</tbody>
</table>

Note: Data is based on 60 patients of 12 traditional healers from 4 ethnic groups.
distribution of religions in the city.

It is certain that the proportion of the wealthy and the highly educated (university graduates) is low among clients of traditional healers. However, this appears to be primarily a reflection of the low proportion of these people in the entire population in the city. On the other hand, it is only the well-off who can afford to pay the expensive charges that traditional healers sometimes request for their practices. It is also certain that the highly educated do consult traditional healers; I have seen those who have a university degree consult traditional healers.

Perhaps the groups of people who do not, or at least try not to, consult traditional healers are medical practitioners of other kinds and religious fundamentalists. It does not seem to be so common for clinical doctors, religious healers and members of religious groups, such as Izala Muslims and Born-Again Christians, to consult traditional healers. Yet, again, I have seen at least one clinical doctor get a traditional healer to conduct a sacrificial ritual. As we shall see in the next chapter, an Iyagba healer I know is often consulted by priests of Aladura churches. Members of the Izala group and Born-Again churches are also found among clients of traditional healers, even if the proportion is certainly low. Thus, in short, it appears to me that the clients of traditional healers more or less represent the majority of people living in Kaduna. In other words, traditional medicine is widely practised by people irrespective of their cultural backgrounds in the city.

2) Relationships with Healers: In our survey, on average, almost half the clients of traditional healers share the same ethnic background as their healers. On the other hand, the other half of course do not. The matter is, however, more complex. The
proportion of co-ethnic to non co-ethnic clients in any one practice varies according to the ethnicity of healers. Almost two-thirds (11 out of 17) of the clients of Igbo healers are Igbo, while only about a quarter (7 out of 29) of Gbagyi healers’ clients are Gbagyi. The proportion of co-ethnicity also varies according to the popularity of healers; the more popular the healers, the larger the proportion of their non co-ethnic or co-regional clients becomes.

It is hard to explain the relatively high proportion of co-ethnicity among healers and clients. According to 50 people from five ethnic groups we interviewed, 13 stated that they preferred to consult healers of the same ethnic groups as theirs, while 30 stated that they were not concerned with ethnicity in their choice of healers. It is certain that, unlike religious identity, ethnic identity does not oblige people to choose healers with the same ethnicity. My impression is that the incidence of co-ethnicity is attributable partly to the way information about healers is circulated among people - information about co-ethnic healers may be more available - and to partly familiarity with the practice of co-ethnic healers. It is, however, important to note that the proportion of clients who are from the same town as the healers and the proportion of clients who are kin of healers are both negligible. In that sense, healers and clients are basically strangers whose relationships are not within close-knitted communities.

Yet, it is also important to add that relationships between healers and clients may develop other dimensions. Relationships between healers who are also leaders of a cult of affliction and their clients sometimes become relationships between leaders (initiators) and members (initiates) of these cults. Healers and clients may develop friendships as well.
Thus, their relationships can be multifaceted. The point will be explored in the next chapter and in Chapter VII.

3) Image of Healers: The popular images of traditional healers are largely ambiguous and by no means generally positive. Despite the fact that people, irrespective of their cultural backgrounds, consult healers, some people are reluctant to admit it. Healers have, to a certain degree, a derogatory image. Such a negative image is sometimes expressed in the term for healers, baban juju, the master of juju. Juju is an ambiguous concept. It generally means magical practice and power associated with traditional religions, including traditional medicine and sorcery. Even a Hausa name for traditional healers, boka, denotes a certain untrustworthiness. Healers are aware of such negative images and are keen to improve their image (see Chapter VI).

Such an image is basically related to the enormous amount of religious activity in the city. The plurality of religious groups means that they compete for prospective recruits. For many religious groups, especially those groups that practise healing as one of their main activities, traditional healers are major competitors. This is precisely because people often consult traditional healers regardless of religious identity. Christians do not generally consult a mallam and Muslims do not go to churches for healing, whereas both of them do consult traditional healers.

Thus, there is a peculiar situation where people consult traditional healers whereas they do not consider it as being a religiously good act. In this regard, the fact that people are mostly migrants and strangers to one another in this vast city enables them to consult healers with impunity. Without the knowledge of their relatives, friends and especially
the members of their religious groups, they can easily consult traditional healers merely by travelling to see healers in other parts of the city.

CORE PRACTICES

There are considerable differences as well as similarities in the mode of practice of traditional healers in Kaduna. Differences are mainly due to differences in the cultural backgrounds of healers, especially ethnicity. Thus, in general, similarities in practice among healers of the same ethnic background are greater than the similarities of practice among healers with different ethnic backgrounds. In the following, I shall examine the main features of the practices of traditional healers of three ethnic groups, Hausa, Yoruba, and Igbo. (See Table 10 for a summary of the main symbols and deities used by traditional healers in Kaduna.)

1) Hausa Medicine: Probably the most common divinatory technique among Hausa healers is throwing cowry shells (wuri). Cowry shells are usually combined with some other items such as small stones collected at a river, old coins, pins and certain kinds of nuts. Healers throw these objects on to a mat. When the objects fall on a mat, each object faces either up or down. This combination is interpreted by healers for their clients. Through the oracle, healers are supposed to tell their clients about their lives and problems without verbally enquiring into it. In reality it is often the case that healers lead clients to narrate their problems by themselves in a discrete manner. Sand (kasa) is also a common oracular device among Hausa healers. In Kaduna, the sand oracle is never monopolised by mallamai. It is also practised by Hausa, Yoruba, Gbagyi and other healers who are
Table 10: Main Symbols and Deities in Practice of Traditional Healers

<table>
<thead>
<tr>
<th>Names of healers</th>
<th>Ethnic identity</th>
<th>State of origin</th>
<th>Religious identity</th>
<th>Main symbols and deities in practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shaib</td>
<td>Hausa</td>
<td>Kano</td>
<td>Muslim</td>
<td>Islamic (kasa, rubutu), bori</td>
</tr>
<tr>
<td>Garba</td>
<td>Hausa</td>
<td>Kano</td>
<td>Muslim</td>
<td>Islamic and others</td>
</tr>
<tr>
<td>Hanza</td>
<td>Hausa</td>
<td>Kano</td>
<td>Muslim</td>
<td>Islamic, bori</td>
</tr>
<tr>
<td>Maazu</td>
<td>Hausa</td>
<td>Kaduna</td>
<td>Muslim</td>
<td>Islamic (kasa, rubutu), bori</td>
</tr>
<tr>
<td>Harbarude</td>
<td>Hausa</td>
<td>Kaduna</td>
<td>Muslim</td>
<td>bori</td>
</tr>
<tr>
<td>Rami</td>
<td>Hausa</td>
<td>Kaduna</td>
<td>Muslim</td>
<td>bori (especially Dan Galadima)</td>
</tr>
<tr>
<td>Biye</td>
<td>Hausa</td>
<td>Kaduna</td>
<td>Muslim</td>
<td>bori</td>
</tr>
<tr>
<td>Mai Jirgi</td>
<td>Hausa</td>
<td>Sokoto</td>
<td>Muslim</td>
<td>n.a.</td>
</tr>
<tr>
<td>B. Shageri</td>
<td>Yoruba</td>
<td>Oyo</td>
<td>Muslim</td>
<td>Islamic and others</td>
</tr>
<tr>
<td>Kamoru</td>
<td>Yoruba</td>
<td>Oyo</td>
<td>Muslim</td>
<td>Orisha (especially osayin)</td>
</tr>
<tr>
<td>Abdulrasyfu</td>
<td>Yoruba</td>
<td>Kwara</td>
<td>Muslim</td>
<td>Islamic (kasa) and others</td>
</tr>
<tr>
<td>Olaodudu</td>
<td>Yoruba</td>
<td>Kwara</td>
<td>Muslim</td>
<td>Islamic (kasa) and others</td>
</tr>
<tr>
<td>Busali</td>
<td>Yoruba</td>
<td>Kwara</td>
<td>Muslim</td>
<td>n.a.</td>
</tr>
<tr>
<td>B. Irelubo</td>
<td>Yoruba</td>
<td>Ogun</td>
<td>Muslim</td>
<td>Orisha (ogun and others)</td>
</tr>
<tr>
<td>Garba</td>
<td>Yoruba</td>
<td>Ogun</td>
<td>Muslim</td>
<td>Islamic and others (mirror oracle)</td>
</tr>
<tr>
<td>Lamidi</td>
<td>Yoruba</td>
<td>n.a.</td>
<td>Muslim</td>
<td>Orisha (osayin, ayelala and others)</td>
</tr>
<tr>
<td>Kini</td>
<td>Yoruba</td>
<td>Kwara</td>
<td>Muslim</td>
<td>Orisha (especially ifa)</td>
</tr>
<tr>
<td>Ughoh</td>
<td>Igbo</td>
<td>Imo</td>
<td>traditional</td>
<td>mamy wota and agu</td>
</tr>
<tr>
<td>Yellow</td>
<td>Igbo</td>
<td>Imo</td>
<td>Christian</td>
<td>many wota and others</td>
</tr>
<tr>
<td>Eberemba</td>
<td>Igbo</td>
<td>Imo</td>
<td>traditional</td>
<td>agu and practice of offo</td>
</tr>
<tr>
<td>Emeneke</td>
<td>Igbo</td>
<td>Imo</td>
<td>traditional</td>
<td>many wota and others</td>
</tr>
<tr>
<td>Nchocha</td>
<td>Igbo</td>
<td>Imo</td>
<td>traditional</td>
<td>many wota and others</td>
</tr>
<tr>
<td>Fabian</td>
<td>Igbo</td>
<td>Imo</td>
<td>traditional</td>
<td>various symbols including ikenga</td>
</tr>
<tr>
<td>Nnana</td>
<td>Igbo</td>
<td>Imo</td>
<td>n.a.</td>
<td>possession of offo</td>
</tr>
<tr>
<td>Karfe</td>
<td>Gbagyi</td>
<td>Kaduna</td>
<td>Muslim</td>
<td>practice associated with ashas</td>
</tr>
<tr>
<td>Madaki</td>
<td>Gbagyi</td>
<td>Kaduna</td>
<td>Muslim</td>
<td>Islamic</td>
</tr>
<tr>
<td>Jagaba</td>
<td>Gbagyi</td>
<td>Kaduna</td>
<td>Christian</td>
<td>possession of tortas oracle</td>
</tr>
<tr>
<td>Garukuwa</td>
<td>Gbagyi</td>
<td>Kaduna</td>
<td>Muslim</td>
<td>Islamic (kasa) and others</td>
</tr>
<tr>
<td>Shonono</td>
<td>Fulani</td>
<td>n.a.</td>
<td>Muslim</td>
<td>Islamic (kasa)</td>
</tr>
<tr>
<td>Juji</td>
<td>Fulani</td>
<td>n.a.</td>
<td>Muslim</td>
<td>no divinatory practice</td>
</tr>
<tr>
<td>Sevav</td>
<td>Titu</td>
<td>Benue</td>
<td>n.a.</td>
<td>no specific deity</td>
</tr>
<tr>
<td>A. Igala</td>
<td>Igala</td>
<td>Benue</td>
<td>Muslim</td>
<td>Islamic and various deities including many wota</td>
</tr>
<tr>
<td>Awolo</td>
<td>Ijumu</td>
<td>Kwara</td>
<td>traditional</td>
<td>Orisha (especially shapono)</td>
</tr>
<tr>
<td>Azees</td>
<td>Abunu</td>
<td>Kwara</td>
<td>Christian</td>
<td>Orisha (especially ifa)</td>
</tr>
<tr>
<td>Ishola</td>
<td>Iyagba</td>
<td>Kwara</td>
<td>Christian</td>
<td>Christian and Orisha (ifa, ogun and eau)</td>
</tr>
</tbody>
</table>
More ethnically confined is the practice of spirit possession among *bori* cult members. As noted above, many Hausa healers are members of *bori* in Kaduna. They perform the ritual of spirit possession whereby dancers get into a state of trance and behave like spirits which are said to be possessing them. After the performance, dancers are consulted by spectators. It is believed that they speak the words of spirits and are able to discern the problems of clients, even though they actually use oracular devices (details will be given in Chapter VI).

After oracular diagnosis, healing practice is carried out. The healing of Hausa healers consists of herbal medication, Koranic medicine (*rubutu*), offering of alms and prayer. Herbal medicine is administered in the form of powder, liquid or smoke. Various parts of plants and animals are dried in the sunshine and ground into powder, or ingredients are cooked with water and the solution is extracted. Medicine can be taken orally in water or food. It can be externally applied through water-bathing or immersion in smoke. For smoke medicine, patients burn herbs on a charcoal fire and immerses themselves in the smoke that rises from the burning herbs. Smoke medicine is employed mainly for the treatment of mental illness caused by spirits (*iskoki*) and for the protection of patients from spiritual attack and witchcraft (*maita*). Healing practices associated with Islam are also common among Hausa healers. *Rubutu* is practised by over 40% of our informants. Amulets (*Laya*) are also commonly prepared for protective purposes. Prayer is indispensable at every stage of healing. Healers pray for Allah to help to make the medicine work and cure illness. Whether illness is healed or not ultimately depends on the will of Allah. In this respect, the healing practice of Hausa healers is not significantly different from
that of mallamai. Indeed, some healers including those who practise bori, argue that they are mallamai, a more socially acceptable identity but not boka.

Alms-giving (sadaka) is another important healing practice among Hausa healers. It is in part based on Koranic teaching. Healers instruct their clients about kinds of offerings and who should receive them. Common offerings are beans, maize, rice, oil, cakes and kola nuts. The common recipients are children, beggars and anybody living in the patients’ compound.

Although Hausa healers are reluctant to talk about the practice of offerings to spiritual beings, sacrificial rituals are apparently an important healing practice, especially among healers associated with bori. It is also important to note that bori practitioner-healers initiate their clients whenever the affliction of a client is considered to be caused by spirits. Through an initiation ritual, girka, clients are believed to establish cordial and enduring relationships with particular spirits, thereby preventing the spirits from afflicting them.

While, on the whole, the practice of Hausa healers in Kaduna is similar to the practice of Hausa healers in other parts of Northern Nigeria as studied by a number of scholars (Last 1976, 1991; Stock 1983 & 1985; Etkin 1979; Etkin & Ross 1982; Besmer 1983; Wall 1988; Abdalla 1991; Kabir 1991), my impression is that the bori cult is particularly active in Kaduna (details will be given in Chapter VI).

2) Yoruba Medicine: The divinatory and healing practices of Yoruba healers, babalawo, have attracted great scholarly interest (Prince 1964; MacLean 1971; 1979; Oyebola 1980; Simpson 1980; Buckley 1976; 1985). In particular, so many studies (Idowu 1962; Bascom 1969, 1980; Abimbola 1976, 1977; Simpson 1980; Pearce 1993; Epega and Neimark 1994) have been done about ifa divination that it is almost synonymous with Yoruba
divination as a whole. In Kaduna, however, *ifa* divination does not seem to be commonly practised by Yoruba healers. The most respected form of *ifa* oracle in Yoruba land consists of 16 palm nuts (*ikin*) and other objects, and I have not come across a single healer who practises it. Among our informants, there are three healers who practise *opere* for their divination. *Opere* is another oracular device associated with *Ifa* (the god of divination). The device is made up of eight half pods of nut shells strung together in a cord. Holding the cord in the middle, the diviner throws *opere* on a mat. When it falls, each pod faces either up or down. The diviner interprets a combination of the faces which corresponds to a particular verse (*odu*). However, it is important to note that of the three informants who practise *opere*, two are not Yoruba but belong to Abunu and Iyaqba, ethnic groups who are closely related to the Yoruba.

In our survey, another oracle associated with Yoruba deities (*orishara*) is the practice of *Osayin* divination. Among our informants, there are two Yoruba healers who practise this divination. *Osayin* is the god of medicine who, in the Yoruba mythology, taught *babalawo* (a healer) the secret of medicine. In Kaduna, *Osayin* is known as a talking symbol among Yoruba healers. The symbol of *Osayin* is kept behind a screen and appears to consist of a human-like statue and other objects (unfortunately I was not able to observe the symbol closely). During the seance of the divination, the diviner consults *Osayin* about the client's problem through verbal communication with the symbol. *Osayin* actually 'talk' to the diviner. Apparently, however, the diviner I know is a ventriloquist. In any case, like *ifa* divination, *osayin* divination is not common in Kaduna.

More common practices among Yoruba healers are
the cowry shell oracle, the sand oracle and the kola nut oracle. Apparently, cowry shells are widely used as an oracular device by healers regardless of their cultural background. The practice of the sand oracle, too, is widely spread among Muslim healers. The use of kola nuts for divination, however, appears to be more ethnically specific to Yoruba speaking healers. This simple oracle is used to give a 'yes' or 'no' answer to the diviner's questions. The diviner breaks a kola nut into four lobes and holds them in his palms. Asking a question, the diviner then throws the lobes on to the ground. The combinations of the surfaces of the lobes on the ground form positive, negative and neutral answers to the questions. If the answer is neutral, the diviner will keep on throwing the lobes until a decisive answer is given.

The procedure for herbal treatment by Yoruba healers appears to be on the whole similar to that of Hausa healers, even though I cannot compare the ingredients and prescription of herbal medicine in detail. Yet, there are some practices distinctive to Yoruba healers. Firstly, there is the practice of incision on the external part of the body of patients. With a razor blade, Yoruba healers make a number of small cuts on the skin of the patients and apply herbal medicine to the cuts. The incision can be made on the top of the head, along a line to be horizontally drawn on the breast or along the spinal cord. It can be made on the sick part of the body. For instance, if a patient is suffering from a whitlow, and his arm is swollen up, a healer will incise a part of the swollen arm. While the practice of incision may be done by healers with other ethnic backgrounds, I have not witnessed them practise it in Kaduna.

Secondly, there is the use of medicated soap. Again, while medicated soap is probably used by other healers, its use appears to be particularly noticeable
among Yoruba healers. The soap is produced out of the extract of coconuts, palm oil, herbs and other materials, and used for bathing. Application of herbal medicine by means of incisions and the use of soap medicine are both meant to protect a patient from malevolent forces as well as to cure illness.

Thirdly, Yoruba healers seem to have elaborated medicine and ritual to control people and change their minds. There appears to be various practices of this kind. One of the common practices I have observed is the use of a padlock (kokoro). Healers place herbal medicine and other things in a padlock and bind it with thread. They let clients call the name of the person whom they want to control, pray for whatever they want the person to do and then the padlock is locked.

As to sacrificial ritual, it is an integral part of Yoruba healing, even though clients are not always required to practise it. Requirement of sacrifice depends on the nature of problems. Healers usually tell through an oracle if a sacrifice is required and what kind of foods or animals should be given to whom. Like Hausa healers, they may instruct clients to make an offering to children or beggars. However, in Yoruba healing, it appears that relationships between the givers and receivers of offerings are more directly reciprocal. Thus, the most usual receivers are, for example, spirits (aljannu) and witches (aje) - those who afflict people and are expected to cease their activities in return for offerings, and orisara deities - those who are expected to protect givers from the evil forces. Animals and various items are symbolically offered in ritual to spiritual beings.

In this regard, it is interesting to note that Hausa healers do not appear to practise sacrifice to witches (mayu), despite the fact that aje and mayu are generally regarded as the same. This seems to indicate
that, although the two concepts are quite similar and translated in English as 'witches' by Yoruba and Hausa people who speak English, they are not identical and are used differently within their own cultural frameworks.

Among orishara deities, relatively common in Kaduna is Ogun, the god of iron and hunters. Ogun is believed to protect people from any accident or fight involving metal objects. The symbols of Ogun take the form of metal objects such as iron pipes, slates and nails, and are usually kept inside or outside the healer's counselling room. When healers are consulted by clients concerned about travelling by a car or the possibility of an accident, they often practise a sacrificial rite to Ogun by offering kola nuts, palm oil and blood of a killed animal.

3) Igbo Medicine: With regard to Igbo healers, there are two types of healers in Kaduna. One is the healer whose main work is the sale of herbal medicine. These healers have a shop with bottles of herbal medicine displayed on shelves. Most of the medicines are kept in liquid form and appear to be manufactured somewhere else. The healers may counsel patients about their problems but do not seem commonly to practise divination.

By contrast, the second type of healer can be characterised by the practice of ritualistic healing. Like Hausa and Yoruba healers, these healers use an oracle to detect the problems of clients. While they do administer herbal medication, it is sacrificial rituals that particularly mark their healing practice. Igbo healers worship various deities and spiritual beings. The symbols of these beings are set up in the counselling rooms, and offerings such as the blood of animals, eggs, liquor and yams are regularly made to them. Unlike Hausa and Yoruba healers, many Igbo healers state explicitly that they serve these
deities. Thus, there is a stronger sense of religiosity in the practice of Igbo healing.

Among the different Igbo deities, the most common is Mamy Wota, followed by Agu. Mamy Wota is the spirit of water and prominent deity in Igbo religion. While there are various local names for this deity, the pidgin English name, Mamy Wota, is commonly used in Kaduna. The form of the symbol varies according to individual healers. It appears to be fashionable to have a printed picture of Mamy Wota whose figure is a woman with an Indian-like face and blueish in complexion, holding a snake around her shoulder. In Igbo aetiology, illnesses and other misfortunes can be associated with Mamy Wota. When Mamy Wota is suspected to be the cause of the misfortune, healers perform sacrificial rituals for Mamy Wota so that she will leave the patients. Like the bori cult, if healers are priests (or priestesses) of Mamy Wota societies, they may initiate patients into their societies so that patients will be in control of the spirits.

Agu is another prominent guardian deity in Igbo religion. Its symbol is made of an animal’s skull and bones, plant roots and other objects all of which are coated with herbal medicine and combined together in a large metal box. The ritual of Agu which I have observed, however, is not curative but divinatory. Like Ifa or Osayin, Agu is believed to instruct healers about the nature and treatment of afflictions. The method of Agu divination resembles that of Osayin, that is, the symbol of Ogu talks to the diviners. The practice I have seen is, however, again ventriloquial. Divination is revealed in such a way the symbol appears to be talking to him.

These are the distinctive practices of Igbo healers. However, they also share some common practices with other healers. For instance, the most common divinatory practice of Igbo healers is the use
4) Flow and Form of Traditional Medicine: Thus, I have examined the differences and similarities of the practice of healers in Kaduna. Distinctive features are clearly seen according to the ethnic background of healers. In other words, certain practices and ideas of traditional medicine are mainly distributed to healers with a particular ethnic identity. Yet, some of these practices are apparently spread beyond ethnic boundaries and are shared by healers who have different ethnic identities but who come from the same region. There is no doubt that the similarities in the practices of healers from the same region are greater than those of healers from different regions. This is indicative of the influence of the medical culture of dominant ethnic groups in particular regions, namely Hausa, Yoruba and Igbo. As noted, ifa diviners in our survey are not Yoruba but ethnic minorities from the Yoruba-dominated Western region. The practice of Gbagyi healers I know in Kaduna has considerable similarities to that of Hausa healers. As the Gbagyi are people living in dominantly Hausa Northern region, the practice of their traditional healing has been apparently influenced by Hausa healing. Obviously, I am not arguing that medical cultures of ethnic minorities are wiped out by those of ethnic majorities. Ethnic minorities apparently maintain distinctive elements in their medical cultures. In the case of Gbagyi healing practice, for instance, I have seen a unique divinatory practice and concept of deities, ashaa. Nonetheless, it is also certain that the practices and ideas of traditional medicine, which may have originated in particular ethnic groups, can spread beyond the social boundaries of ethnic groups in a region.

Moreover, some of the practices of traditional
medicine have been spread not only within the same regions but among different regions in the country. The use of cowry shells for oracles appears to be universal throughout the country. The practice of Islamic divination is also common among Muslim healers from different regions.

It is important to add, however, that the flow of a particular medical culture is often differentiated. Thus, even among healers possessing the same ethnic identity or the same religious identities, their practices are not entirely homogeneous - some practices are common among them, whereas others are not. For instance, among Yoruba healers, the use of ogun is fairly common, while the practice of ifa divination is not so common. Among Muslim healers, sand oracle is common regardless of the ethnic identities of healers, while rubutu healing appears to be practised mainly by Hausa healers. Thus, medical cultures do not flow in their entirety but rather in pieces. One of the reasons for such differential flow of medical cultures seems to be the technical difficulties of learning. This may be the case in the restricted flow of ifa divination among our informants - the learning of this complex divination requires the healer to memorize 256 verses (odu), at least in theory.

Thus, on the one hand, there are distinctive features in the practice of traditional healing according to the ethnic-regional backgrounds of healers in Kaduna. On the other hand, many common elements are also found in their practices, indicating the growth and even flow of traditional medical cultures in the country. However, their similarities are also attributable to the interaction of different healers in Kaduna and the particular social and cultural conditions of the city.

In this regard, two general features of the
practice of traditional healing in Kaduna have to be noted. First of all, the mode of traditional healing is generally individualistic. All the cases of practice I have observed involve only healers and clients, or healers and clients with one or two people who are either their relatives or friends. In other words, the mode of practice is basically dyadic. At times, healing necessitates the participation of family members in rituals. For instance, this is often the case in healing afflictions attributed to ancestral spirits among the Igbo, or the case of healing of some akombo illnesses among the Tiv (see Chapter VII). In such cases, however, people tend to go back to their home villages to hold the healing rituals, either following the instruction of healers in Kaduna or of their own accord.

Several reasons are conceivable for the lack of kinship-based rituals of healing in Kaduna. First of all, in Kaduna where many people are first-generation migrants, it is impractical to hold a ritual that requires a number of kin, since important kin are still in the home village. Secondly, the development of transport networks and especially rapid road transportation make it easy for the city dwellers to go back to their villages for rituals. Thirdly, in the congested neighbourhoods of the city, people do not have enough space to hold rituals on a large scale, unless they own a large compound with a yard where only their family members reside. Fourthly, in the city, it is unlikely that healers possess the expertise to carry out kinship-based rituals for clients, most of whom are strangers - people need to consult ritual specialists found perhaps only in their home villages. It is also conceivable that healers in the city prefer simple practices and a quick turn over of clients rather than time-consuming preparation of elaborate rituals for clients. Fifthly, as noted
above, despite the pervasiveness of the practice of traditional medicine, there is the general sense of the secretiveness in any practice associated with traditional religions in Kaduna. The city dwellers, most of whom identify themselves with either Christians or Muslims, would be therefore reluctant to organise healing rituals that draw public attention. Given the fact that religious fundamentalism is currently growing, there is more reason for people not to organise conspicuous healing rituals in the city. Finally, kinship based rituals may necessitate the presence of shrines and symbols of deities and spiritual beings that are set up in home villages and not removable from there. As noted above, in Kaduna, there are few large shrines of deities and spiritual beings comparable to those found in other parts of Nigeria. Perhaps, the only symbols and shrines of traditional religions found in Kaduna are those that healers keep in their residences. These symbols are portable, small in size and often kept in metal boxes. In that sense, it is conceivable that these are simplified versions of the more elaborate symbols in their homelands.

The second general feature of traditional medicine in Kaduna is that it has relatively limited sets of practice and ideas to handle an enormous range of problems and afflictions. Ethnically and regionally, specific core practices are used to tackle the diversity of not only physical afflictions but also social and economic problems of the city dwellers, as noted earlier.

I have to admit that I was not able to look in detail into the ingredients and prescription of herbal medication and materials for rituals. Some healers have a bunch of notebooks about prescription of medicine and ritual practice. My impression is, however, that the herbal medicine and ritual healing
most commonly employed are generally multipurpose and modified in an improvised manner. Given the myriad of problems that healers encounter in their consultations, it is unlikely that healers possess or create the prescription of medication and rituals specific to each problem.

Many medication and rituals appear to be employed for general purposes such as general protection, charming or luck, even though they are adjusted to and probably slightly modified for particular problems. Thus, divinatory practices, from *ifa* divination to cowry oracle, and healing practices, from *rubutu* medicine to sacrificial ritual for *mamy wota*, are appropriated to tackle a wide variety of the everyday crises of people in the city.

However, this does not imply that the practice of traditional medicine is unchanging. On the contrary, healers are generally keen to learn and experiment with new practices. Yet, in general, the innovation of new practices does not aim at the elaboration of healing techniques and ideas for specific ailments and problems.

**INNOVATION**

Despite ethnically and regionally specific core elements in the practice of traditional healing, healers are keen on innovating their practices. Such innovation, however, can be characterised by its syncretism, commercialism and concrete and simplified forms.

1) *Synthesis:* As noted above, Islamic healing and divinatory practice have been incorporated into the practice of Hausa and Yoruba medicine for a long time. Healers, especially those who speak English, are also using terms and ideas of illness and medicine derived
from biomedical culture. In this regard, the most remarkable syncretic practice of traditional medicine and biomedicine that I have seen is the practice of an Igbo healer, Mr. Fabian.

In his consultation, Mr. Fabian often makes reference to three volumes of medical books. He diagnoses the illnesses of clients with biomedical terminology as well as with concepts derived from traditional medical cultures. His treatment consists of herbal medication, pharmaceutical medication and ritual practices. One of his remarkable practices is the use of an injection to administer herbal medicine. The following are two cases of his practice of injection:

Case 1

The patient is a forty year old Igbo lady. She is a housewife and a member of the Assembly of the God. Since she delivered a child in 1985, she has not been able to conceive. She tried many hospitals only to find it impossible for them to solve her problem. Then she came to Mr. Fabian. According to his diagnosis there are worms in her womb which kill sperms before they reach an egg. We witnessed him administer medicine by means of an injection into her arm. The medicine was meant to get rid of the worms. It appears that she was regularly having the injection.

Case 2

This patient has been suffering from the swelling of lower part of the leg. He is about fifty years old, an Igbo trader who sells food stuffs in a market. He currently attends the Deeper Life Church. He has been to many traditional healers as well as hospitals. It appears that he sometimes had both traditional and hospital treatment simultaneously. Mr. Fabian identifies the sickness as beriberi and attributes it to his overdose of medicines and to his ancestral spirit. He told the trader not to take any other medicine but the medicine he gave to him. The medicine was ‘Haemoglobin tonic B 12’ which he purchased somewhere. The trader was also directed to go to his village to perform a sacrificial
ritual for his deceased father.

The medical solution to be injected is made with herb and boiled water. According to Mr. Fabian, herbal medicine works quickly in this way. But it has to be said that the practice can be dangerous. I observed that the injection caused dizziness in one of his patients who was unable to move for a while.

In Kaduna, the use of injection by traditional healers is not common. The appropriation of biomedicine is apparently related to Mr. Fabian's personal experience and career; he has been trading in pharmaceutical medicines and is well educated, having completed college education in Lagos. On the other hand, he is also ambitious to develop traditional healing and has a number of spiritual symbols collected at different places over time.

In addition to the appropriation of biomedical practice, some healers are keen to incorporate occultism and spiritualism from other parts of the world. There are healers who advertise their practice of De Lawrence's spiritualism on the signboard. Books and objects on this American-based spiritualism are widely sold in Nigeria. In Kaduna, while its presence is noticeable, healers who are involved in De Lawrence are not numerically large. Many of those who claim to practise it appear to be from East Nigeria. Many healers are, however, interested in learning any kind of occult practices from abroad, including Judaeo-Christian mysticism, Islamic mysticism and Indian talismans.

2) Magic: Mr. Fabian points out the efficacy of his syncretic use of injection. However, it is conceivable that, through such a practice, he may just as well try to establish his image as a knowledgeable and educated healer comparable to clinical doctors. It is indeed the question of how to impress clients which
primarily concerns healers in their introduction of new practices. This also means that healers are more interested in increasing profit than improving efficacy. In this regard, what is particularly remarkable in their innovative practice is the practice of magic. Here, I am referring to magic as conjuring tricks. In the following, I shall depict some of the magical practices I have observed in Kaduna.

Some of the magic healers perform are a version of practices observable in other parts of the world, even though healers often creatively synthesise such practices with the elements of various cultures including traditional medicine and world religions. This is exemplified by a divinatory practice of an Igala healer, Alhaji Igala. The following is the practice he demonstrated for me.

He began his performance by praying to 'Mamy Wota', 'ogbanje' and 'aljannu'. He then spread 16 rectangular pieces of wood with a number written on one side of each piece. He sorted them into two lines, the numbered side facing down. He told me to choose one piece, write its number on a piece of paper, keep the paper in my pocket and return the piece of wood into the line. While I was doing this, he stayed outside the room to show that he had no chance of seeing it. Then he let me point out the line that contained the piece. He broke the lines, shuffled the pieces and sorted them into two lines again. He told me to point out the line where the chosen piece was situated this time. We repeated this four times. After the final break of lines, he let me divide the pieces scattered on the table into two blocks by drawing a line with my finger; he put one block aside. We continued in this way, halving the number of remaining pieces each time. Eventually, I drew a line between the last two pieces; he put one aside. The remaining
piece was, of course, the one I had chosen.

After this performance, he brought a booklet which appears to have contained some esoteric knowledge about Islam. He opened a page with the number on the wooden piece I had selected. According to him, there is divinatory information on my life and problems on that page. I have observed the same mathematical magic practised by a prophet of the Cherubim and Seraphim Church as well.

Magical practices have a concrete and visible effect. Clients are surprised to see what should not happen actually happen or what should happen not happen. They are ‘miracles’, tangible to anyone. Thus, a Hausa healer, Mr. Hamza, performs his miracle (as he calls it) with a paper and candle. First of all, he draws a symbolic figure on a piece of paper. The figure consists of certain Arabic letters and three layers of rectangles that surround the letters. There is an entrance-like mark in the middle of each line of the rectangles. Then, he spreads oil on the paper and holds it over the fire of a candle. Surprisingly, the paper does not get burnt (see also a similar type of magic in the next chapter).

What should not happen is made to happen by healers, too. A secretary of one of the healers’ associations, Mr. Sadiq, demonstrated a piece of magic whereby a piece of paper turned into money. He uses a purse like case made of paper for this performance. The paper case is about half the size and shape of the naira note and can be opened through four wings. At first, he gave a piece of paper to me so that I could check if it was really paper. He then put it in the case and performed a ritual. Reciting an incantation, he held up the case over his head and moved it in a circle. Soon, he stopped the ritual and opened the case, where I found a one naira note, not the piece of paper he put there.
The trick is simple. The case has a secret pocket where money is hidden. He put a piece of paper in the pocket on one side of the case and took money out of the secret pocket on the other side. As he gave me this magical case, I performed it by myself to some people including a traditional healer who did not know the trick. It turned out that they were very much impressed by my performance.

These magic tricks are mostly simple - it is not difficult to learn how to practise them. Rather more sophisticated magic is, however, performed by an osayin diviner, Mr. Kamoru. This young healer can perform various tricks. For instance, he once showed me a trick with razor blades. He put three blades one by one into his mouth and supposedly swallowed them. He opened his mouth to show that there was nothing left there. Then he 'threw up' one blade, put it on my palm and made me close it. After a short incantation made over it, he let me open my palm and there we found three blades. The performance was done at a beer parlour and attracted the attention of people who happened to be there. After the performance, one of the spectators came up to him, asking him if he could see him personally.

In this regard, it is worth mentioning another trick with razor blades which I have experienced. In this case, my research assistant and I actually each ate a razor blade. This practice was done by a Yoruba healer, Baba Shagari. He gave us each a razor blade and herbal powder, putting a blade in one hand and powder in the other. He then instructed us to put powder on the tongue, bite a blade with powder gradually and eat it. After some hesitation, we actually did it. Surprisingly, we did not get any cuts in the mouth; presumably, the herbal powder coated the mouth and protected it from the fragments of the blade. According to Baba Shagari, this was a medicine
of protection against any accident or fight that involves metal objects, such as a car or a knife. We were supposed to be free from injury if such an accident or a fight took place, until the effect of the medicine had worn off (he even told us the precise due date).

It should be noted that there exist some fashionable tricks among healers. Among Hausa and other Muslim healers, it is trendy to have a magical bottle, a glass bottle in which a certain solid object is kept. The object, which appears to be made with leather, is far larger than the mouth of the bottle and almost fills up the whole bottle. So, the question is how does the object get into the bottle? Apparently, the bottles are manufactured somewhere.

It is clear that the aim of all these practices is to attract more clients and increase profit rather than to improve the efficacy of healing. In that sense, these practices can be considered as a part of advertising or 'PR' activities. Indeed, in addition to magical practices, healers are keen to advertise their work and impress their clients by various means, most notably the use of business cards, signboards and membership certificates of healers' associations.

3) Advertisement: In Kaduna, many healers, irrespective of their ethnic backgrounds, have printed cards on which their names, addresses and the areas of their specialisation are written. Their preferred prefix is Dr. and sometimes even Prof.. Kinds of illness commonly listed on the cards include epilepsy, convulsion, mental illness, barrenness and gonorrhoea, even though some of these are not commonly treated, as we have seen. Certainly, there is a degree of exaggeration. For instance, one of the cards I have obtained says that the healer can deal with 'all disease and general problems'.

The use of signboards is also common among
healers. However, unlike business cards, signboards tend to be employed by healers from Southern Nigeria. This may be related to a widely shared idea among healers that competent healers do not openly advertise their practice. On the board are written the names and addresses of healers and their areas of specialisation, usually with some drawings.

The widespread display of the membership certificates of healers’ associations should be considered in the context of advertisement, too. When one enters into a healer’s counselling room—of healers, one of the first things that attract attention would be the healers’ association certificates put in a frame and hung on the wall. As we shall see in detail in Chapter VI, these certificates have nothing to do with official qualifications or licence— they are simply to certify that the healers are member of healers’ associations. However, with the certificates, healers may create an impression that they are qualified healers.

4) Efficacy of The Concrete: Thus, to summarise the characteristics of innovative practices, these practices are, first of all, made to be universally appealing to clients. Such universal elements are partly indicative of the existence of a general knowledge among people of the medical efficacy and competence of healers. The appropriation of biomedical practices and membership certificates of healers’ associations are apparently based on the widespread idea of the general efficacy of biomedicine and credentialism. Universal elements are also found in the practice of magic whose visible effects transcend the cultural differences of most people. Secondly, the innovation of practices primarily aims at the increase of monetary profits rather than the improvement of medical efficacy. Thirdly, on the whole, the innovation is simplified. It is mainly the synthesis
of concrete elements of different medical cultures which do not require the long and difficult process of learning.

The final point inevitably leads us to the question of the nature of the knowledge of medical efficacy among lay people in Kaduna. Lay people are inclined to attach the idea of efficacy to concrete forms of medicine, their visual image and, above all, to particular healers. They can establish the idea of efficacy with any style of healing and any healer that produces visible effects. In other words, the elaborate knowledge of aetiology and process of healing is of secondary importance for popular therapeutic choice. It is probable that once the idea of efficacy is attached to a healer, whatever medication is practised, it is considered to be effective.

The ideas of medical efficacy are produced and spread mainly by lay people themselves — they are basically rumours about good healers and good medicine. It is certain that people have a priori ideas about medical efficacy attributed to particular styles of healing or to the particular cultural backgrounds of healers, and that these a priori ideas are conducive to the production of rumours concerning the efficacy of particular healers and their concrete practices. However, the significance of such a priori knowledge should not be overemphasised — it is mainly complementary to the rumour of concrete efficacy. This point can be illustrated in the case of perhaps the most popular healer in Kaduna.

During my research, from time to time, I heard a rumour about a Fulani healer who attracted numerous clients. However, I did not have a chance to see him until near the end of the research, partly because he practised healing on the outskirts of the city, which was inconvenient to reach by public transport.
The Fulani healer, Mr. Juji has a small hut in a field just outside the city. He commutes to the hut from his residence some distance away to treat his clients. He comes to his hut several times a week and attends his clients for only a few hours each time. Despite the inconvenient location of his hut and the unpredictability of his attendance, dozens of people, mostly women, wait for hours to see him in the field. The procedure of his healing is extremely simple. At first, he lets clients talk about their problems. Then, he prescribes herbal medicine, instructs clients how to use it and gives it to them. He does not spend more than a few minutes on each client. I observed him treat 64 people in one hour and a half. Sometimes, he does not even allow clients to explain the details of their problems. The following is an example of dialogue between him and his clients.

Patient A: I have stomachache.

Mr. Juji: Take this medicine with kanwa (potash). You can mix them with porridge and eat together. Take three times a day, the first one in the morning. Then come back and tell me the result.

Patient B: I want medicine to get a man.

Mr. Juji: O.K. Take this medicine. Drink it with milk. It will charge you very well.

He has a limited variety of medicine, such as medicine for headache, medicine for swelling, medicine for spiritual problems, medicine for good luck and so forth. Altogether, seven or eight kinds of medicine are kept separately in a can or a piece of paper. However, he employs these medicines for most of the cases he handles. In other words, although he
classifies the medicine according to a specific function, he appropriates each medicine for diverse ailments.

Apparently, his clients are not concerned with the types and kinds of his medication and the procedure of his treatment. It is conceivable that his popularity is related to his ethnic background as a Fulani man who is often considered to be knowledgeable about medicine in the bush and also to the location of the hut situated near the bush, which is often associated with wilderness and power. It is also certain that the fact that he takes only alms (mostly five naira) is conducive to his popularity. However, other Fulani healers I know are not as popular as he is, nor do all the healers living outside the city seem to have such popularity. It appears to me that what is primarily significant for his clients, who willingly travel a long distance and wait for hours to see him, is the widespread rumour of his popularity and his successful healing. They must have been told by their friends or relatives that this healer is exceptionally popular and has cured many illness, just as I was told so.

Thus, popular knowledge of medical efficacy is often simplistic and concrete, and it is essential for healers to ensure that their practices appeal to such knowledge. It is interesting to add that Mr. Juji’s medication may not be so special. I once coincidentally observed him collect medicine from another healer who was less popular than he was.

**ECONOMIC STRATEGY AND LEARNING PROCESS OF HEALERS**

If traditional healers are mainly concerned with profit-making, one has to look into the economics of healing in Kaduna. The economics of healing is also
inseparable from the overall economic situation of the city.

1) Economics of Healing: The charge for traditional medicine varies considerably according to the kinds of practice. For divinatory practice, clients are expected to pay two to five naira as a gift, putting the money beside the oracular device, just before healers start to put it into practice. Herbal medication costs a minimum of five naira to several dozen naira. If a sacrificial ritual is involved, clients are required to pay hundreds of naira for the practice in addition to the cost of materials such as animals and grain for sacrifice.

Since divination alone is not profitable, it is essential for healers to convince clients about the need for medication and rituals. However, there is still the idea among healers of payment as a gift. Some healers do not explicitly charge clients but receive any sum of money that clients wish to pay. Charges also depend on relationships between healers and clients. Healers often either do not charge their friends or discount the payment. They also consider the financial situation of clients — they may make concessions to those in financial trouble, whereas they may inflate charges for well-off clients. Thus, there is considerable ambiguity and arbitrariness in economic transactions between healers and clients.

In general, capital and cost required for the healing business is relatively low. To start the business, healers need: 1) materials and ingredients for medicine and rituals; 2) a place to do their business, and 3) expertise.

In Kaduna, healers usually buy ingredients for medicines at markets. However, the ingredients are not something that healers have to buy every day. Healers, especially those living on the outskirts of the city, sometimes collect herbs in the bush. They also
occasionally go back to their home villages to obtain some ingredients. Ingredients and materials are also provided by clients in cases where sacrificial rituals are to be conducted.

Most healers carry out their practices in one room. The room is usually small and minimally furnished. Thus, in terms of a place and facilities for the business, all they need is a single small room. They can rent such a room for 30 to 40 naira per month, even though many of my informants own a whole compound. In this regard, the location of their workplace in the city is apparently of secondary importance for their business. The most popular healer does his business on the outskirts of the city, whereas healers doing business on the main streets are not necessarily popular.

With regard to the cost of learning expertise, it is difficult to know how much prospective healers have to spend for an apprenticeship and to learn medicine. Many of those learning from healers are working as an assistant for healers in Kaduna. It appears to me that they are not paying fees for apprenticeships but offer their labour to healers. Moreover, healers at times give some money to their assistants for their services. Yet, I was also told that in some case, apprentices have to pay considerable sums of money before their masters will prepare certain symbols for healing, such as the symbols of deities. However, it is safe to argue that once prospective healers obtain the symbols, they can start off their businesses without further large expenditure, unless they are keen on collecting more symbolic items. Thus, in general, the cost of learning medical practice is not so great, even if there may be some variation according to individual healers.

Finally, the question is whether traditional healing is lucrative or not. It is extremely difficult
to look into the income of healers. The information on healers' incomes is hard to obtain and hardly reliable if it is obtained. However, one can roughly guess their overall economic situation through their material possessions (Table 11).

Thus, 21 out of 35 healers are the owners of no less than one house. Out of them, three own two houses and another three own three houses. This proportion of the ownership of the houses is remarkably high, considering the present economic situation and housing conditions. Most of the adult population cannot afford to have their own houses in Kaduna. Four of our informants enjoy watching their own TV and two even possess their own videos. Three have motor cycles, while another three drive their own cars. As far as our informants are concerned, it is certain that their material life is fairly good. It is much better than, for instance, that of textile workers who have been working over 20 years and earn about 1,000 naira per month.

However, there is apparently considerable variation in the income level of healers in Kaduna. First of all, as noted earlier, our survey was mainly conducted with well-known healers. They are likely to be better off than many other healers in the city. Even within our survey, variation in their material lives is certainly found. Successful healers are in possession of houses and other material goods mentioned above, while there are healers who just get by in their day-to-day living. The poorest healer I have come across is an old Yoruba man from the Kwara State. He is a newcomer to the city and lives in a small room without paying rent. His belongings are minimal - in his room there is nothing but a chair given by the owner of the house and a mat where he sleeps. I did not see a single client with him during my research.
Table 11: Material Possessions, Side-lines, Occupational Change and Movement of 35 Traditional Healers

<table>
<thead>
<tr>
<th>Material possessions</th>
<th>Sidelines</th>
<th>Previous jobs</th>
<th>Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shaib</td>
<td>a house</td>
<td>keeping sheep</td>
<td>farming</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Kano-Kaduna (KW-TW-US-MK-KK)</td>
</tr>
<tr>
<td>Garba</td>
<td>a house</td>
<td>security guard (textile)</td>
<td>tax collector, policeman, company employee, security guard (DIC)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Kano (village)-Kaduna (Gari-Kakao-KG)</td>
</tr>
<tr>
<td>Hanza</td>
<td>n.a.</td>
<td>security guard (textile)</td>
<td>farming</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>n.a.</td>
</tr>
<tr>
<td>Maazu</td>
<td>a house</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>village-Zaria-Kaduna (KW-KK-TK), travel (Enugu, Abuja, Mina and others)</td>
</tr>
<tr>
<td>Mai Jirgi</td>
<td>a house</td>
<td>leader of a healers association</td>
<td>n.a.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Sokoto-Kaduna</td>
</tr>
<tr>
<td>Haribarude</td>
<td>3 houses</td>
<td>letting rooms</td>
<td>house wife</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Zaria-Kaduna-Kano-Kaduna-Mecce, travel (Central Africa, Cameroon, Niger, Sudan)</td>
</tr>
<tr>
<td>Rani</td>
<td>a house</td>
<td>no</td>
<td>trading (cooked food, clothes, metal pots, jewelry)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Kano-Kaduna (Gari-MR-UK-TK)</td>
</tr>
<tr>
<td>Biye</td>
<td>a house</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>n.a.</td>
</tr>
<tr>
<td>S. Shagri</td>
<td>2 houses, a m.cycle</td>
<td>letting rooms</td>
<td>teacher, bricklayer, soldier, company employee, water board, company employer, party official, bricklayer, textile worker</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lome-Ilaro (Ogun)-Ogbomosho-Kaduna, travel (Lagos, Abeokuta, Togo, Niger, Kenya, Abijan)</td>
</tr>
<tr>
<td>Kamoru</td>
<td>renting</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Oyo-Ibadan-Lagos-Oyo-Abijan-Portnovo-Jineta-Kaduna</td>
</tr>
<tr>
<td>Abudirasyu</td>
<td>2 houses, a car, TV</td>
<td>letting rooms, farming</td>
<td>motor electrician, transport (taxi)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Guni-Kaduna (TN-N)</td>
</tr>
<tr>
<td>Oladodudu</td>
<td>2 houses</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td>Buseli</td>
<td>poor</td>
<td>no</td>
<td>farmer</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ilorin-Kaduna</td>
</tr>
<tr>
<td>B. Irelubo</td>
<td>a house</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Sango Ota-Ghana-Sango Ota</td>
</tr>
<tr>
<td>Garba</td>
<td>a house, TV, video</td>
<td>letting rooms, others</td>
<td>n.a.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ijebu-Otumpo-Enugu-Kaduna</td>
</tr>
<tr>
<td>Lamidi</td>
<td>renting</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td>Rimi</td>
<td>minimal</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>itenerant healer</td>
</tr>
<tr>
<td>Ugoh</td>
<td>a house, TV, video, a car</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>village-Jos-home-Abijan-home-Ibada-Kaduna</td>
</tr>
<tr>
<td>Yellow</td>
<td>n.a.</td>
<td>no</td>
<td>n.a.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>village-Kaduna</td>
</tr>
<tr>
<td>Eberemba</td>
<td>n.a.</td>
<td>no</td>
<td>n.a.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>n.a.</td>
</tr>
<tr>
<td>Nchocha</td>
<td>renting</td>
<td>n.a.</td>
<td>teacher, fuel station, plantation (Cameroon), plantation (E. Guinea), NNPC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>village-Cameroon-France-E. Guinea-Warri-village-Kaduna</td>
</tr>
<tr>
<td>Emeneke</td>
<td>renting</td>
<td>m. cycle taxi</td>
<td>tailor, soldier, tailor, bank employee</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>village-Lagos-Enugu-Lagos-home-Kano-Benin-Kaduna</td>
</tr>
<tr>
<td>Name</td>
<td>Type</td>
<td>Occupation</td>
<td>Place</td>
</tr>
<tr>
<td>------------</td>
<td>----------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>Fabian</td>
<td>a house</td>
<td>manufacturing plastic bags, finance, trading electric goods, trading general goods</td>
<td>village-Lagos-US-Gaiana-Kaduna</td>
</tr>
<tr>
<td>Nhuma</td>
<td>renting</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td>Karfe</td>
<td>a house</td>
<td>farming</td>
<td>n.a.</td>
</tr>
<tr>
<td>Madaki</td>
<td>a house</td>
<td>no farming, the guard of chief</td>
<td>Kaduna (KK-B-US-KG)</td>
</tr>
<tr>
<td>Jagaba</td>
<td>a house</td>
<td>farming, craft (baskets)</td>
<td>Karife-other villages-KG</td>
</tr>
<tr>
<td>Garukuwa</td>
<td>a house</td>
<td>no farming</td>
<td>Abuja-Bima-Bauchi-Kaduna</td>
</tr>
<tr>
<td>Shanomo</td>
<td>a house</td>
<td>leader of a healers association</td>
<td>n.a.</td>
</tr>
<tr>
<td>Juji</td>
<td>n.a.</td>
<td>(pastoralist)</td>
<td>n.a.</td>
</tr>
<tr>
<td>Sevav</td>
<td>renting</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td>A. Igala</td>
<td>3 houses, TV a car letting rooms, transporting textile factory</td>
<td>village-Kaduna (Gari-KK)</td>
<td></td>
</tr>
<tr>
<td>Awolo</td>
<td>poor</td>
<td>n.a.</td>
<td>many places</td>
</tr>
<tr>
<td>Anee</td>
<td>n.a.</td>
<td>brick contractor</td>
<td>many places</td>
</tr>
<tr>
<td>Ishola</td>
<td>3 houses, TV, m.cycle letting rooms, carpenter, company employee, contractor, transport</td>
<td>Mopa-Lagos-Mopa-Kaduna</td>
<td></td>
</tr>
</tbody>
</table>

Note: Abbreviations in the section of movement stand for the names of districts in Kaduna (KK-Kakuri, KG-Krumin Gwari, TK-Trikanya, MK-Maker, N-Nasarawa, B-Barna, UK-Ungwan Kavo, TW-Tudun Wada, TN-Tudun Nupawa, US-Ungwan Shano, KW-Kawo)
Thus, on the one hand, traditional healing requires low capital, has low running costs and can be lucrative. On the other hand, it apparently has a considerable risk of failure. In that sense, the practice of traditional medicine shares the features of many economic activities in the so-called informal sector of the economy of third world cities. Moreover, it is in the context of the general uncertainty and insecurity of the economic situation of people in Kaduna where the significance of traditional healing as a business is adequately understood. It appears that many healers in the city are basically business people who practise healing as part of their diverse economic activities.

2) Career: Thus, in our survey, a considerable proportion of healers turn out to be occupied with various economic activities either simultaneously or serially. Of 35 healers, 13 stated that they are involved in some kind of economic activity in addition to healing practice, while 9 said that they do not do any other job, even though I suspect they might be doing occasional work such as that of business contractor (Table 11, see also Appendix 2 for case studies). Common economic activities are letting rooms or houses (6), security guard (2), farming (3). It is hard to estimate the length of time healers allocate to healing work and to other occupations. Those who let rooms and houses could spend ample time on healing work, whereas those who work as night security guards can attend clients during the day time. Farmer-healers have sufficient time for healing work during the dry season, but little time during the rainy season when they are preoccupied with farming. On the whole, however, it appears that they have ample time to practise healing.

On the other hand, it is certain that healing work does not hinder other economic activities too
much, unless healers are extremely popular. As noted above, the practice of healing does not require a regular supply of materials like many other trading activities, nor is it necessary for healers to fix regular business hours. Healers can attend clients by appointments. In other words, healing practice is an ideal side-line.

This should be one of the reasons why some people practise healing in addition to their regular jobs. On the other hand, healers diversify their economic activities, being aware of the risk of failure involved in healing business. On being asked about this subject, a Hausa healer, Mr. Garba, who is also a security guard, replied that healing practice does not generate stable income, whereas the job of security guard provides a regular income for him. This view is probably shared by the majority of healers who diversify their economic activities.

The occupational diversification of healers is seen even more clearly over time. Sixteen out of 35 healers stated that they had made a living doing jobs other than healing work before, while only four argued that they had never done any job other than healing work. Almost half of those who have done other jobs have done more than two different jobs.

There appears to be various reasons for our informants to leave previous jobs and enter the healing business. Several healers, most of whom are Igbo, argued that they started healing work due to the call of spiritual beings. They either became ill or could not do the previous job well owing to the intervention of spiritual beings. The only way to solve their problems was to serve the spirits by becoming a healer.

Obviously, it is impossible to know whether such a call was the real reason for the involvement of these informants in healing. While healers tend to
emphasise such a call as evidence of their legitimacy and talent for healing, my impression is that their aetiological ideas of spiritual beings were perhaps conducive to their decision to start healing work. Yet, the point is that whether they attributed their problems to spiritual beings or not, they certainly had some troubles that made it impossible for them to continue their previous jobs. Thus, in their cases, it is crisis situations that led them to healing work as an alternative source of income.

In other cases, the involvement of our informants in healing has more to do with their entrepreneurial ambitions. As noted above, healers are very much profit-oriented. Healers may initially do healing as part-time work to complement other economic activities, whereas they may quit other work and concentrate on healing as their full-time work, once they find it lucrative. The entrepreneurship of a healer will be examined in detail in the next chapter.

Thus, to a large extent, the practice of traditional healing can be considered as part of business diversification strategy in Kaduna. Under the uncertain economic situation in the city, on the one hand, people need side-lines for economic security, whereas on the other hand, they have a chance of making themselves successful. The practice of healing provides a means for both economic security and success. However, if people can start healing work later in life, this would pose a question as to the nature of the process of learning and training in healing practice.

3) Training: In our survey, out of 35 healers, 13 stated that they learned healing from their close relatives alone, 9 stated that they learned it from those who are not their relatives (Table 12, see Appendix 3 for cases). However, the claim that their healing practice is hereditary work cannot be taken at
Table 12: Learning Process of Traditional Healing

<table>
<thead>
<tr>
<th>Decision to be a healer</th>
<th>Process of training</th>
<th>Start of practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shaib</td>
<td>mental illness (spiritual calling), father’s instruction</td>
<td>from father</td>
</tr>
<tr>
<td>Garba</td>
<td>n.a.</td>
<td>other healer</td>
</tr>
<tr>
<td>Hansa</td>
<td>n.a.</td>
<td>from mother</td>
</tr>
<tr>
<td>Haazu</td>
<td>father’s instruction</td>
<td>from father, later from other healers</td>
</tr>
<tr>
<td>Mai Jirgi</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td>Rami</td>
<td>mental illness, initiation into bori by a healer (Maikoko)</td>
<td>n.a.</td>
</tr>
<tr>
<td>Biye</td>
<td>initiation into bori by Maikoko</td>
<td>n.a.</td>
</tr>
<tr>
<td>Mai Jirgi</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td>B. Shagari</td>
<td>n.a.</td>
<td>from father</td>
</tr>
<tr>
<td>Kamoru</td>
<td>father’s decision</td>
<td>from father, more than 3 years of training</td>
</tr>
<tr>
<td>Abdulrafi u</td>
<td>father’s advice</td>
<td>from father, between 1968 and 1975</td>
</tr>
<tr>
<td>Olaodudu</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td>Russali</td>
<td>n.a.</td>
<td>from many healers in Yoruba land</td>
</tr>
<tr>
<td>B. Irelubo</td>
<td>father’s instruction</td>
<td>n.a.</td>
</tr>
<tr>
<td>Garba</td>
<td>n.a.</td>
<td>from father</td>
</tr>
<tr>
<td>Lamidi</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td>Rimi</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td>Ugoh</td>
<td>mental illness, initiated into a many wota society</td>
<td>from spirits through initiation</td>
</tr>
<tr>
<td>Yellow</td>
<td>dream, initiated into a many wota society</td>
<td>from elder people in the village, later a healer from Bendel State taught him practice in Kaduna</td>
</tr>
<tr>
<td>Eberemba</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td>Emeneke</td>
<td>mental illness, maternal grandfather's instruction</td>
<td>from maternal grandfather</td>
</tr>
<tr>
<td>Nchocha</td>
<td>vision and voice in childhood, father’s instruction, initiation</td>
<td>from father</td>
</tr>
<tr>
<td>Fabian</td>
<td>temporary blindness, initiated into agu society 1965</td>
<td>from many healers in different areas</td>
</tr>
<tr>
<td>Nnana</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td>Karfe</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td>Madaki</td>
<td>n.a.</td>
<td>from paternal uncle</td>
</tr>
<tr>
<td>Jagaba</td>
<td>father’s decision</td>
<td>from father</td>
</tr>
<tr>
<td>Garukuwa</td>
<td>spirits</td>
<td>from spirits, mother taught him bori</td>
</tr>
<tr>
<td>Name</td>
<td>Method</td>
<td>From</td>
</tr>
<tr>
<td>----------</td>
<td>-------------------------------</td>
<td>---------------</td>
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<tr>
<td>Shanono</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td>Juji</td>
<td>n.a.</td>
<td>n.a.</td>
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<tr>
<td>Sevav</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td>A.Igala</td>
<td>many wota's calling, father's instruction</td>
<td>from father</td>
</tr>
<tr>
<td>Awolo</td>
<td>vision of shopono, mental illness</td>
<td>n.a.</td>
</tr>
<tr>
<td>Azeel</td>
<td>n.a.</td>
<td>through dream</td>
</tr>
<tr>
<td>Ishola</td>
<td>by himself</td>
<td>from a healer in Kaduna and from several healers in Yoruba land for 7 years</td>
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face value. It appears that healers tend to emphasise the hereditary aspect of their work. This is because there is a widely shared idea that healers who inherited healing from their father (or mother) are competent and reliable.

In my observation, the exchange of information about medical prescription and healing techniques is very common among healers in Kaduna (see Chapter V & VI). Healers are often helped by assistants who intend to practise healing by themselves. These assistant-apprentices are not necessarily healers' relatives. Thus, while family tradition of healing work is probably still important, it is conceivable that the proportion of healers who learned the practice from non-relatives would be actually higher than the survey result suggests.

In this regard, it is important to note that in this vast city of migrants, one can easily pretend to be a healer. The clients, most of whom are unrelated to healers, are in no position to know the real backgrounds of healers. Besides, given the significance of simple innovative practice, one can relatively easily acquire a technique good enough to impress clients without a long process of apprenticeship.

Finally, it should be remarked again that clients are sometimes encouraged to practise healing. This is the case of clients who consult healers associated with cults of affliction. While initiation rituals alone may not turn clients into healers instantly, clients are given an incentive and opportunity to learn the practice of healing from the initiators.

In short, the distinction between healers and lay people is not so great, and the latter can relatively easily make themselves healers in Kaduna.
CONCLUSION

To summarise the nature of traditional medicine in Kaduna, first of all, it is essential to place the practice of traditional medicine in the entire field of everyday crisis management. The significance of traditional medicine is centred on the failure, and the possibility of failure, of various activities and practices in the everyday life of the city dwellers.

Within the medical market in the city, traditional medicine has a complementary relationship to biomedicine. Thus, traditional medicine is mostly employed when biomedicine fails to heal afflictions. In part, this is a reflection of a spreading of knowledge of the general efficacy of biomedicine. In certain areas such as child delivery and the treatment of serious illness, biomedicine has oligopolistic control in the medical market. However, this does not imply that the significance of traditional medicine as the healing of illness is generally weakened - traditional medicine is frequently employed in prolonged therapy management. It is also important that the idea of the efficacy of traditional medicine for the treatment of afflictions caused by personal and spiritual beings is widely shared by people and conducive to the use of traditional medicine in the city.

Traditional medicine is also employed to cope with an extremely wide range of social and economic problems. It is used when activities, whatever they are, fail to produce the expected outcome. It is also used as a means of protection and ensuring success when the possibility of failure of action is considered as being high. In this regard, the prevalence of traditional medicine is indicative of the high level of uncertainty and insecurity in the everyday lives of people in the city.
The practice of traditional medicine consists of stable ethnic and regional elements and innovative and universally appealing elements. Changes in the mode of practice are therefore incremental rather than dramatic. This also suggests that similarities and differences in the practices and ideas of healing should be understood in terms of a flow of traditional medical cultures. Thus, some practices and ideas are unevenly distributed among healers sharing a particular ethnic identity. Others are more widely distributed among healers from the same region. Yet still others are almost universally spread among healers from all over the country. In terms of the forms of traditional medical practice, while some practices are elaborate, others, especially innovative practices, are remarkably simple. It is the latter kind of practice that is widely spread among healers in Kaduna. On the whole, healers appropriate rather limited sets of practices and aetiological ideas to achieve diverse objectives. In that sense, the practice of traditional medicine exemplifies the multiple appropriation of a particular cultural form in the city.

In general, the practice of traditional healing is oriented toward profit-making. It can be highly lucrative, whereas the possibility of failure is equally high. On the other hand, the practice of healing is an ideal side-line for various economic activities. This is because entry into this business is relatively easy: 1) it does not involve large capital and high running costs; 2) it does not always necessitate a long and difficult process of apprenticeship, and 3) the anonymity and limited social networks of city dwellers make the monitoring of the authenticity and legitimacy of healers difficult and make it easy for anyone to be a healer.

Thus, traditional healing can be seen as one of
the informal economic activities in the city. Many healers practise healing as a part of their economic diversification strategy. In that sense, they are basically entrepreneurs who are ambitious and yet insecure amid the uncertainties of everyday life in the city. In the following chapter, I shall illustrate this point the case of Mr. Ishola.
The daily activities of Mr. Ishola and his family begin with prayer. Around six o’clock every morning, they get up and pray at their residence. The ritual is conducted in the manner of Aladura Christianity. At first, Mr. Ishola sings a hymn, ringing a conical bell to make a rhythm with it. Soon his family join him and sing in chorus. Mr. Ishola is a good singer and, by changing the tone of his voice, brings a beautiful harmony to the song. Then he leads prayer. He prays to God that his family must be healthy and protected from evil forces and his business successful. While praying, he walks around in the room and rings a bell. He never opens the door until he has finished the prayer even if his client is waiting for him outside. He is a babalawo, a traditional healer.

Mr. Ishola is a Iyagba man from Mopa in Kogi State. Iyagbas are an ethnic group strongly influenced by Yoruba culture. They can speak Yoruba fluently and have adopted some Yoruba customs. Mr. Ishola, who was around 45 years old during my research period, came to Kaduna in 1967 and is currently living with his wife and children. His residence is situated in a newly developed area called Makera New Extension in Kaduna-South. The area shares many characteristics with other newly developed areas in Kaduna; most adult residents are young migrants from various parts of the country; the cultural backgrounds of the residents are extremely diverse, and even the levels of their income are significantly different; there is a marked lack of community based on residential proximity, that is, the residents are basically strangers who do not know much
about each other.¹

I lived with the Ishola family for 22 months. Initially, I settled in his house as his tenant, but later our relationship developed beyond that of landlord and tenant; he and his family became not only some of my most important informants but also my closest friends in Kaduna. In this chapter, I explore the work and life of Mr. Ishola. In particular, I focus on his healing practice and other economic activities - I shall later deal with his crisis management in Chapter VII.

PRACTICE OF TRADITIONAL MEDICINE

As a babalawo, Mr. Ishola spends much of his time in attending his clients. He has no room or building specifically designed for healing practices but carries out healing in an empty house belonging to him. This uncompleted house is situated about 50 metres away from where he and his family live and is intended to be let out on its completion. Inside one compartment of the house, he sits on a small stool and spreads a leather mat in front of him. Beside him is ashe, a ritual instrument which is made of a horn stuffed with a herbal concoction. Some herbal medicines are kept in a card-board box. Other things including calabash bowls, grinding stones and notebooks, are scattered around the floor. In another compartment he places the symbol of Ogun, the god of iron and hunting. The symbol is made up of metal products such as pipes, plates and nails, and kept together in a wooden box.

His clients bring him a wide range of problems, which include illness and misfortunes attributed to witchcraft and sorcery, love affairs, business slumps and court cases. There are more social and economic
problems than physical afflictions, even though these two types of problems are often inseparable in the aetiological understanding of both Mr. Ishola and his clients. Clients also frequently consult him about several problems once.

Mr. Ishola’s medical practice has two parts: 1) divinatory practice to find out the cause, solution and prospect of clients’ problems and concerns; 2) herbal and sacrificial healing to solve the problems and protect clients. For divination, he practises ifa. As noted in the previous chapter, Ifa is the god of oracle in Yoruba religion and also denotes oracular practice associated with the god. In his case, he uses opere for his oracle. In theory, opere enables him to see the nature of clients’ problems without verbally enquiring into them. It is indeed important for diviners to see through the problems of clients, since this is how they can convince clients of their skills and talents and build up trust.

Apparently, Mr. Ishola has substantial knowledge and experience in guessing the nature of clients’ problems merely by glancing at their appearance. For instance, he appears to take into consideration the ethnic background of clients, as he once said to me, "Yorubas are worried about aje [witches]. Kajes are also worried about aje. Mamy wota is for Igbos." He also skilfully leads clients to explain about their problems and adjusts his oracular statements according to the response of clients. In any case, clients are usually willing to talk about their problems. In that sense, his divinatory practices are basically in the form of dialogue - it is not one-way transmission of oracular information from a diviner to clients.

The divination is followed by healing practice, even though a number of clients consult his oracle alone. Since he benefits mainly from healing practices, it is important for him to convince clients
of the necessity of healing. His healing practices consist of herbal medication and sacrificial rituals. The herbal medication takes the form of powder and smoke. To prepare powder medicines, he grinds ingredients into a fine powder or burns them into ash. These medicines may be administered orally with food or water, mixed with a local soap for bathing, or applied on the skin through incisions made by a razor blade. Smoke medicines are made out of ingredients burnt on a charcoal fire. Clients immerse themselves in the smoke or spread it in a doorway, a room or a building as a whole. The smoke medicines appear to be used mainly for protection against witchcraft.

Sacrificial rituals are also important in his healing practice. He offers animals and food for personal and spiritual beings. Kinds of offerings are determined by ifa. The common items are a goat, a sheep, chickens, guinea fowls, pieces of beef, maize, beans, pieces of white cloth, liquors, kola nuts and bitter-kola. In the case of animal sacrifice, he slaughters an animal by cutting its throat with a knife; the blood is collected in a calabash bowl. He pours blood to opere and the symbol of Ogun. The receivers of the offerings are either those who are considered to be responsible for the suffering of clients, such as witches and spirits, or those who save and protect clients such as Ogun. The following describes one of the cases in which Mr.Ishola’s divinatory and sacrificial rituals were practised. Originally, the conversation between Mr.Ishola and his client was conducted in pidgin English, while his incantation and prayer were conducted partly in Iyagba and partly in Yoruba.

The client, Hajiya, was a middle-aged woman living in Kabara Doki, Kaduna-East. She was a Muslim Igala and was an apparently successful
trader. She had been Mr. Ishola's client for some time and always came to see him in her own car.

(Reciting a short incantation in Ifagba language, Mr. Ishola hits opere with a stick and throws it on to a mat.)

Hajiya: My child got an accident.

Mr. Ishola: Which one? Is it the one in Lagos?

Hajiya: No, the one who is a doctor, the senior one.

Mr. Ishola: What is her name?

Hajiya: Kureratu.

(Reciting an incantation, he throws opere.)

Mr. Ishola: We are going to do a sacrifice. The accident from where [meaning: where is the evil practice originated from]? Is it from home or Kaduna?

(He hits opere and throws it.)

Mr. Ishola: It's from home! Look (pointing at opere), here. We are going to make a sacrifice.

(Reciting an incantation, he throws opere.)

Mr. Ishola: It's from home. It's a woman. She is from your husband's family. Yellow person, tall!

However, this was not quite what Hajiya herself suspected about the cause of her daughter's accident. She started to talk about the accident. The car her daughter was driving collided with other cars in Kaduna. While the daughter was fortunately unhurt, Hajiya was concerned that this was caused by the sorcery of her father living at their home town. The news that her father intended to visit her in Kaduna exacerbated her concern. Responding to her explanation, Mr. Ishola again emphasised the need for a sacrificial ritual to the god of iron, Ogun.
Mr. Ishola: Why is your father doing something like this? They want to victimise and kill you. This sacrifice will help you. I think I told you so.

Hajiya: May God not let them kill me but let them kill themselves.

Assistant: The God will save you, you know.

Mr. Ishola: That is why we are going to make a sacrifice. You cannot make a sacrifice and think [meaning: you cannot afford keep thinking about the matter without acting].

Hajiya: I will do it! I will do it! I will buy things we need.

(Mr. Ishola tells his assistant to write down items for the sacrifice.)

Mr. Ishola: We are going to make a sacrifice with a hen, red dry gin. If they say they will put your blood on the ground, that’s a lie. We use these to cross their plan. Alligator pepper, six. Bitter kola, six. White cloth, six yards. Three kola. One bottle of oil to the god of iron. We will use these for prayer. We will put pure oil and water on the ground. A guinea fowl for a person who gets an accident. Guinea corn, a half mude [a bowl used to measure grains]. Millet, a half mude. Maize, a half mude (throwing opere). If we put all these together, their intention will be in vain. If they write to you and tell you to come back home, don’t go oh!

Hajiya was also suspicious of her brother’s involvement in sorcery practice. Besides, she recalled that there was a neighbour, a woman who fitted the description Mr. Ishola had initially made. Mr. Ishola’s oracle confirmed her suspicion of these two individuals. He persuaded her to go to a market with his son to get materials for the sacrificial ritual and to come back with her daughter later. In the evening, she came back with her daughter. Her daughter was a medical doctor at Ahmadu Bello Teaching Hospital and was also appointed to a position to accompany
pilgrims to Mecca. Mr.Ishola carried out a ritual, first with the daughter.

(He lets her hold a bottle of red dry gin and a piece of white cloth above her head - his assistant helps her to do it - and starts to recite an incantation in Yoruba)

Mr.Ishola: Up to your head. Up to your head. Up to your head. We must not use a vulture for an offering for ifa. We must not use a vulture to make a sacrifice. Let her overcome her enemies. Let her overcome her enemies (repeat seven times altogether)...(asking Hajiya) What is her name?

Hajiya: Kureratu.

Mr.Ishola: Kureratu, let her overcome her enemies. Let her overcome her enemies. Whatever we tell ogbo [a kind of leaf, which literally means 'what you hear'], ogbo will listen. Let her overcome her enemies. Any word a large rat tells the ground, the ground will understand....

Then Mr.Ishola let her hold other items, a guinea fowl and then bags of maize, guinea corn and beans, while he continued incantations. After this, he led her to the backyard to offer these materials. At first, he let her say a prayer and throw half of the grains into the yard. Then Mr.Ishola’s assistant killed the guinea fowl and put the blood over the symbol of ogun. It was now Hajiya’s turn.

(Mr.Ishola lets her hold a hen and begins an incantation.)

Mr.Ishola: Needle must not refuse cloth work. Let it be good for her. A frog must not refuse a river. Let it be good for her. A crab is the one that said it was your turn today. So we are making incantation. Let it be good for her....
Finally, the hen was sacrificed, and its blood was poured over the symbol of ogun. Then Mr. Ishola applied herbal medicine to Hajiya’s daughter by making 12 cuts on her skin and rubbing medicine there. He also gave Hajiya medicine to be taken with food for a week.

While his divinatory and healing practices basically follow those of an orthodox babalawo’s, there are some elements of syncretism and innovation. For instance, he uses the prayer of Aladura Christianity for his healing. He is also eager to learn new practices and prescriptions that include not only traditional healing practices he does not know, but also certain types of American and Indian spiritualism. For instance, one of the practices he learned from other healers during my stay was ‘yam medicine’. The medicine is a kind of magical practice mainly to impress his clients. Thus, he put sliced pieces of yam, herbal medicine and water inside a calabash bowl and placed the bowl directly on to the kerosine stove. Interestingly enough, yam is usually cooked before the bowl catches fire. At one stage, he used this medicine almost every day. He keeps all these prescriptions and methods of practices in notebooks. He has a number of such notebooks and often looks up a prescription in a notebook during his counselling.

Mr. Ishola is often assisted by his son, friends who used to be his clients, or someone who is learning traditional medicine. Their assistance is invaluable especially when he needs someone to obtain ingredients
for healing from a market. It is also important to note that he works with other healers from time to time. It is relatively common for healers in Kaduna to accommodate healers from other parts of Nigeria and enable them to carry out healing practice at their residences. Between 1990 and 1992, there were at least two healers who, on separate occasions, visited Mr.Ishola and carried out their healing practices at his residence. Mr.Ishola provided not only accommodation and food but also some of his clients for them. In return, he could expect them to teach him new healing practices and prescriptions.²

Although Mr.Ishola is a popular healer in the Nasarawa and Makera areas, the number of his clients fluctuates significantly according to the day or month. At times, he works almost continuously from morning, as early as seven o’clock, to evening. At other times, he has few clients and spends much of his time in doing some other work or just resting. It also appears that, during my research period, he was generally busier in the second half of 1991 than he had been in 1990. If a slack period continues, he becomes anxious about it and suspects that a certain evil force, namely Mama Sunday, is causing the problem (see Appendix 5).

About half his clients are Yoruba-speaking people and the rest are ethnically mixed. While he conducts divination and healing rituals in Iyagba and Yoruba, he communicates with his clients in Yoruba, Hausa or English according to the languages they speak. Clients are also religiously mixed; both Muslims and Christians are found among his clients. Female clients slightly outnumber male clients. Most of his clients are between 20 and 40 years old - there are not many elderly people or children among his clients. The level of education of his clients appears to reflect the levels of education of the population in Kaduna.
Thus, there is only a small number of university graduates and those who have an equivalent educational qualification among his clients. However, this does not mean that these people do not consult him. With regard to the occupations of his clients, they are diverse. In general, however, self-employed business people and traders are more noticeable than industrial workers, despite the large population of industrial workers in Mr. Ishola’s neighbourhood.

Almost all the clients consult him for divination at first. Then some go on to healing, while others stop coming to see him. When clients take medication or take part in healing rituals, they usually come to see him several times. There are regular clients who consult him from time to time. Though I am referring to the relation between Mr. Ishola and those who consult him as the relation between a traditional healer and his clients, the relation cannot be narrowly defined in this occupational category alone. It is sometimes multidimensional. Thus, friendships not infrequently develop out of the transaction between Mr. Ishola and his clients. Some of his ex-clients, who have no regular job, sometimes work as his assistants. As we shall see in Chapter VII, he was once involved in the business problems of a client not as a healer but as a business partner. Furthermore, the relation between him and his clients can be similar to that between a wholesaler and retailers.¹

BUSINESS STRATEGY

Charges for Mr. Ishola’s medical practices vary according to the kind of practice. He does not charge for divinatory practices but receives a tip from clients which is normally from two to five nairas. Herbal medication alone costs from five to dozens of
nairas. When a sacrificial ritual is involved in treatment, the charge sometimes goes up to several hundreds of nairas. In addition, clients have to buy sacrificial animals and ingredients. Sacrificial rituals also provide Mr. Ishola with a considerable amount of meat. Naturally he looks happy on a day when he carries out a "big work".

Variations in his charges are also due to his consideration of the personality and financial situations of clients. Thus, he argues, "Some people come and see me to harm someone [by medicine]. I do nothing for them but charge a lot. Can they take me to the court? No. Because I would tell a judge what they wanted me to do." He once said to me after treating a football player, "This man has money. But he wastes it for women. He asked me for medicine to make money. Medicine to make money! I have never seen it myself. So I gave him medicine for nothing and charged a lot. Later he came back and complained that the medicine I gave him did not work. So I said to him, 'that is because the money you gave me was not enough. If you give me more money, I will give you powerful medicine.' This is how I chop a person like him!" Thus, he sometimes inflates charges for well-off clients. On the other hand, he sometimes discounts charges for clients who have financial problems, especially those who are his friends. On a few occasions, I saw that he did not charge his friends who were in financial trouble.

Thus, on the one hand, healing practices at times enable Mr. Ishola to earn a large sum of money in one day. On the other hand, fluctuation in the number of clients and arbitrariness in his charges mean that the income through healing practices is highly unstable. On the whole, however, it is undeniable that Mr. Ishola practises healing mainly for profit. It is indeed essential to situate his healing practices in the
context of his overall business strategy. While he allocates much of his time to his healing business, it is one of the two major economic activities in which he is currently engaged. The other business is the letting of rooms and houses. Mr. Ishola is the owner of four houses (one of them is still uncompleted). He lets out all the rooms (about 30) except two, which he and his family occupy for their own use. In 1991, he was charging a monthly rent of forty naira per room, five naira higher than the year before. Since, due to continuous migration, demand for rooms always exceeds supply in Kaduna, room-letting is a profitable business. Thus, the rent provides Mr. Ishola not only with a relatively large sum of income but with a steady income, which more than compensates for the fluctuation in income through the healing business.

However, room-letting is by no means an easy business. In fact, Mr. Ishola's letting business is stricken with many troubles. He has to deal with the default of payment of rent and electricity bills and the untidy use of yards and other common facilities in the houses. Conflicts often occur between Mr. Ishola and his tenants. While he is not particularly harsh about the payment of rent, he, with his short temper, can be quickly annoyed by a quarrel with tenants and gives them notice to quit the rooms. Police officers are often called to intervene in the quarrels and the matter is sometimes taken to the magistrates court. In such cases, he often tips officials to gain their favour. What primarily underlies the conflicts between Mr. Ishola and his tenants is, however, his suspicion of witchcraft practised by them. I shall examine this issue in detail in Chapter VII.

Despite all these troubles, Mr. Ishola is very eager to expand his letting business. Once he finds time and money, he makes himself busy building a new house. In fact, his hard work and thrifty life style
is bound up with this ambition. Having been a carpenter, he can manage to do most of the building work with the assistance of his family members. By 1991, he had built three houses and was preoccupied with the construction of his fourth house during my stay. To build a house, however, is increasingly difficult in Kaduna owing to inflation in the price of building materials. Therefore, one may assume that saving is essential for the purchase of such building materials. However, Mr. Ishola has a different strategy. He argues, "As soon as I get a little money by this work [healing practices], I buy building materials. Maybe I buy a plank and keep it [without using it]. Next time I get money, I buy cement and keep it. Gradually I collect everything I want. This is local man's knowledge!" One of the reasons why he tries not to save cash appears to be related to his reciprocal obligations to his relatives and friends. It is not wise for him to keep cash, because cash is distributable.

Because of his relative prosperity, Mr. Ishola is visited by relatives and friends, especially those who have financial problems. While the number of these people is not necessarily large, some of them visit him almost every day. Usually, they do not ask him directly for money. Instead, they do some work for him, such as carpentry or working as an assistant for healing. While he certainly benefits from their work, his financial burden is also considerable. For the work they do, he pays no less than ten nairas per person per day (in 1991). When he earns a large sum of money through healing which they have assisted, he distributes the substantial part of the gain to them. For example, I once observed him divide about 200 nairas equally among his assistants and himself. In addition to this daily financial assistance, he has to meet their special needs. In 1991, he financed two
naming ceremonies for his younger brother and cousin. Given the general inflation, it must have cost him no less than 300 nairas to organise each ceremony (more than a third of a junior textile worker’s monthly salary). Every year, he holds Christmas and New Year parties to which he invites his close relatives who consist of seven or eight adults and more than 15 children. These occasions no doubt provide his family members with solidarity and communal feeling. However, this does not mean that he is always happy about his financial assistance. Conflicts relating to economic problems are not uncommon between him and his relatives.

In this regard, a thrifty lifestyle is perhaps indispensable for his business success. He minimises his and his family’s living expenses. He neither drinks too much nor involves himself with prostitutes. He does not allow his family to live in any luxury, for instance, wearing nice clothes and eating expensive foods. In fact, considering his substantial income, his children look rather poor in appearance. Unlike his rich neighbours, he is not interested in demonstrating wealth. His asceticism, however, is not welcomed by his family members. It is often the centre of the conflicts between them. His wife is not happy about the fact that he does not provide enough food, clothes and medical expenses for her and her baby. His children often complain that he does not like to spend money for their education. Far from negligible, such dissatisfaction contributes to schisms in his family. (See Appendix 4).

Thus, Mr. Ishola is basically an entrepreneur who carries out different economic activities in which healing is a part. He does not only meet his obligations but also gets round them. On the other hand, he is often involved in various conflicts and troubles. Indeed, his entire life is marked by such
entrepreneurship and struggle.

**LIFE, CAREER AND QUEST FOR TRADITIONAL MEDICINE**

Mr. Ishola was born at Mopa in the present Kogi State in 1948. His father was a farmer and a senior member of the Christ Apostolic Church (CAC). His mother was a housewife and helped his father to farm. He is the second child of their seven children. He had an elder sister who is still alive at Mopa and often visits him in Kaduna. The family was poor. Although his father had a farm, its harvest just allowed the family to get by. When he was in grade six at a primary school, his father died of illness. Mr. Ishola believes that his father's death was partially attributable to his faith in Christian healing - he refused to use Western and traditional medicine. After he managed to finish his primary school education, he went to Lagos and stayed with his sister and her husband. He then became apprenticed to a carpenter from his home area. From early in the morning to late at night, he worked hard at the master's workshop. A little pocket money which his sister gave him barely satisfied his empty stomach. After his sister left Lagos, he had to find shelter at a Cherubim and Seraphim Church. For two years, he slept in the church hall at night. It was a hard time for him. He was freed from the apprenticeship seven years after he came to Lagos. Then he went back to Mopa. What waited for him at home, however, was the same poverty. For a while, he helped his mother to farm and did different minor jobs. However, soon he thought that it was a waste of time to continue in this way. With just enough money for a one way journey in his pocket, he left Mopa for Kaduna in June 1967.

For the initial two months, he was accommodated
by a fellow townsman living in the central part of Kaduna. Meanwhile, he was able to secure a job at a carpentry workshop. Then he moved to the Nasarawa area in Kaduna-South and rented a room. By the following year, he was courted by a woman whose ethnic identity was however different from his. She was a Bajju woman from Zonkowa, a town 100 kilometres south-east of Kaduna. Their marriage was accepted by her parents on condition that he would pay bridewealth to them. He saved the required sum of money through strenuous effort and care; to hide the money he earned, he buried it under the ground. However, he encountered another problem. Her elder brothers tried to act as go-betweens for him and his future wife’s parents in Zonkowa. They demanded the money, promising him that they would take it to their parents. Apprehensive of their conduct, he refused to give it to them. This caused a serious dispute between Mr. Ishola and her brothers. In the end, the matter was settled at a local court. Handing the bridewealth to her parents, Mr. Ishola finally married her in 1968.

That year, he was employed at an Italian construction company, D’Alberto. The company operated throughout Northern Nigeria. He became carpenters’ foreman and was sent to construction sites in various places including Zaria, Funtua, Yola and Maiduguri. Workers were required to lodge near the construction sites until the projects were completed, which took from a few weeks to several months. His first child, Isaac, was born in Zaria. He worked for the company until 1975. He eventually quit the job, because he found it too tiring to move around to different places. For a while, he made a living with his carpentry, setting up his own workshop in Kaduna. However, gradually he developed his interest in traditional medicine.

In Nasarawa, there was a healer from his home
This elderly man was an ifa diviner who practised opere. He paid frequent visits to the healer and was eventually permitted to learn the divinatory technique. As a kind of apprenticeship, he had to do a lot of work for the healer, sweeping the healer's compound, washing his clothes and running errands for him. Looking back, he now feels that it was too much effort for what he learned from him. Nonetheless, by 1978, he managed to master the practice of opere and began to attend clients at the healer's compound. Eventually, the healer told him to establish his own healing business.

From this time onward, his entrepreneurial character became apparent. Instead of going into the healing business, he at first established a contract business. Just outside the Nasarawa area where he lived, there was a public project to build a rehabilitation centre for disabled people. The construction was managed by an American firm and carpenters and labourers were being recruited. Looking over the site, he thought that he could supply building materials and labourers to the company. He recalls, "When I went to the place, I saw an oyinbo man, a white man, supervising workers. His name was Bob. I noticed that he had [boiled] eggs and oranges for lunch. So I brought lots of eggs and oranges for him. Next day I did the same thing. He was impressed. He asked me if I wanted to work as a labourer there. I said no. I said I wanted to make a contract with his company, and I could supply building materials and labourers. Then he told his boss about me. This is how I got the contract."

He took good care of his relationship with Bob by giving him presents and introducing a woman to him. This personal relationship provided him with an opportunity to do 'informal' business dealings and was also helpful when he was in trouble. Given free access
to the stores, he came up with the idea that he could appropriate materials and tools kept from the stores for his personal ends. Once in a while, he took some of the materials and tools to Panteka, a recycling manufacturing section in the central market, and sold them there. Bob not only turned a blind eye to this but also stood by him when he bumped into the manager and Bob inspecting the stolen goods at Panteka.

After the construction work was over, he invested the money he had earned in transport. He bought a second hand van and hired a driver to operate a taxi business. However, he soon realised that the business was not profitable. The car often broke down and the cost of its maintenance was unexpectedly high. Abandoning the taxi business, he then decided to invest in housing. He managed to obtain the right of occupancy of several plots near the rehabilitation centre. Since then, he has been building houses for room-letting.

In the mean-time, Mr. Ishola travelled extensively around the Western Region of the country to learn new healing practices and herbal medicines from different healers. Although he had mastered the practice of opere, he was not satisfied with the healing practices and prescriptions he had learned from his teacher. There is a popular belief that traditional medicine at home is genuine and effective. On his travels, he introduced himself to healers who were well-known locally. He explained his intention to the healers, while showing the highest respect to them and presenting them with money and palm wine. His requests were usually granted by healers. Sometimes they verbally taught him how to prescribe the medicine he wanted to learn, while at other times they allowed him to transcribe prescriptions from their notebooks. Some healers even directed him to other healers who knew more about specific medicines. To a lesser extent, he
still goes on research trips.

Until 1978, he had lived with his first wife, Mama Isaac, and their three children. In that year, he acquired a second wife, Mama Sunday. Mama Sunday was a Iyagba woman from his home town, Mopa. She had been married previously and had a child. The problem was that the two wives could not get on with each other, and eventually the first wife had to leave. Since then, he has married three more women, Mama Monday, Mama Bukora and Mama Olagoke. His relations with Mama Monday and Mama Bukora were short-lived. On the other hand, his relation with Mama Sunday lasted until 1989. He blames Mama Sunday for the separation of the two wives. In fact, he has subsequently become almost paranoid about the witchcraft of Mama Sunday. (See Appendix 5). In 1989 when he had a fifth wife, Mama Olagoke, however, it was Mama Sunday who had to leave his house.

With regard to his religious life, the establishment of his own church was a significant event in 1984. The idea of establishing a church came to him through a dream. In the dream, he recalls, an angel appeared and told him to "praise the Lord". He interpreted this as a revelation that he should establish a church. The church he set up at first consisted of his family members alone. He converted one of the rooms at his compound into a place for worship; the service was conducted only on Sundays. The mode of worship was in line with the Cherubim and Seraphim Church, since he had become a member of the church in Lagos, and his second wife was a "prophetess" of the church.

The organisation of the church was, however, expanded in 1987. Mr. Ishola was one day visited by a man looking for a room to be used for a church. The man was a "prophet" of the Christ Ambassador Church and wanted to set up a branch of the church. This
church has its headquarters at Sabon Tasha in Kaduna-South and appears to be a breakaway from the Cherubim and Seraphim Church. Mr. Ishola agreed to offer two rooms to the prophet on condition that Mr. Ishola's church was merged into the Christ Ambassador Church. Now the church consisted of the Ishola family and those who followed the prophet, and Mr. Ishola became the leader of this branch of the Christ Ambassador Church. They carried out the service every day; a revival service was included during which some members went into trance and prophesied the problems of other members. Two years later, however, the church was closed down. There was a misunderstanding between Mr. Ishola and the 'prophet' over the procedure of a revival service and the use of the church's finance. Also there were many complaints by tenants living in the same compound about the loudness of the service.

Although Mr. Ishola has had a diverse career, his primary occupational identity appears to be that of a babalawo. He once said to me, "I have built five compounds by this small work [healing]. If my son asks me what to do, I will tell him to do this work. Why? Because this is the quickest way to get money in Nigeria." His ambition in healing is clear in his attempt to go abroad to learn the practice of "powerful medicine". In 1986, he tried to travel to the USA to take part in a De Lawrence's spiritualism course. De Lawrence's spiritualism appears to have made an inroad in Nigeria. As noted in the previous chapter, in Kaduna, some healers claim to practise it. While Mr. Ishola spurns such practices available in Kaduna as fakes, he believes that there is a genuine one abroad. Being informed of a spiritualism course in Chicago, he wrote a letter to De Lawrence's office. The reply giving details of the course, tuition fees and travel expenses seems to have greatly encouraged him to go to Chicago. He went to the US Embassy to
obtain a visa. His son even made an international telephone call to De Lawrence’s office. However, in the end, he had to give up this plan, mainly because he was not able to get his visa. This was not his first attempt to go abroad. Previously, he had attempted to go to India to learn Indian spiritualism, which had also become known in Nigeria.

However, Mr. Ishola’s identity as a babalawo is a problematic one. As noted in the previous chapter, there is a negative popular image attached to traditional healers, and Mr. Ishola is quite aware of this. Apparently, his relatives at Mopa were not happy about his practice of traditional medicine, at least in the beginning. He said, “When I received their letter, I knew what they wanted to tell me. So I put the envelope into the fire [without opening it].” He is also sensitive to the way his neighbours look at him as a babalawo. Certainly, there is a degree of unpleasant feeling among his neighbours over his practice of traditional medicine, especially among the members of Born-Again churches. In this regard, one may speculate that the establishment of his own church was partially the reflection of his awareness of the negative image of babalawo.

ENTREPRENEURIAL ACTION

Thus, Mr. Ishola’s life and work are marked by diversification of activities and synthesis of various practices and ideas. In this sense, his orientation in action is almost the opposite of that of an expert or professional who specialises in certain activities. I would like to consider such tendency in action as entrepreneurial. Here, I am defining the term, ‘entrepreneur’ not just as a person who organises business but also as a person who achieves certain
ends by any means. Thus, Mr. Ishola has been involved in a diversity of activities, not only within the field of economic activities but also within various other cultural fields. There have been alternative activities and relationships to which he could turn. Thus, within the field of economic activities, he has been a farmer, a carpenter, a company employee, a contractor, a transporter, and a traditional healer. In his healing practice, on the one hand, he follows the tradition of a Yoruba-speaking babalawo. On the other hand, he is eager to incorporate and experiment with new healing practices, including magic practices and spiritualism from abroad. In his religious practices, while he identifies himself as a Christian, he combines the elements of traditional religion and Aladura Christianity in his everyday life. As to his marital relationships, he married five times and divorced four times, while maintaining the relationship with his second wife until recently. Geographically, too, he has lived in Mopa, Lagos and Kaduna, and travelled widely in the Northern and Western Regions of the country, even though his attempt to go abroad failed.

By the same token, Mr. Ishola appropriates particular practices and cultural forms for multiple purposes. Among the various practices and symbols he appropriates, the following three are particularly important: money, traditional medicine and God. Mr. Ishola often employs these symbolic tokens to achieve concrete and immediate ends in his everyday life. The point is that the objectives for which he employs these symbolic tokens are extremely diverse and cut across virtually all the different cultural fields: he uses money for various ends some of which are outside legitimate economic transactions; he practises traditional medicine and Christian rituals for the promotion of successful activities and
protection against evil practices of any kind. Thus, these symbolic tokens have aspects of bricolage. However, it is important to note that he does not completely trust their efficacy. He basically uses them to complement various other practices and activities. He also recognises differences in efficacy between them; as he once told me, "In Nigeria, if you have money and a 'witch', you can do anything you want. God can help you. But his work is too slow. You cannot really wait."

Mr. Ishola's entrepreneurial activities are undoubtedly related to the nature of cultural flow in the city where a multiplicity of cultural practices and knowledge are widely available to individuals; there are always ideas and information about new healing practices, personal connections and job opportunities available to Mr. Ishola. His entrepreneurial action is also related to limited social control over what he does, that is, his individual autonomy. Being the head of his family, he is not subject to the authority of the elders. He is relatively free from his church's authority. Even state authority, in the sense of bureaucratic control, appears to be limited. Thus, he can innovate his practice or combine traditional and religious healings without the interference of these institutions. The fact that his clients are strangers also promotes his business orientation and experimental practices in healing. Finally, his diversification strategy is, to a large extent, the reflection of the uncertain economic situation in Kaduna. Clearly, it is too risky for him to depend entirely on healing practice for making his and his family's living, even though healing can be lucrative and at times can provide him quickly with a large income.

Among the many healers I met, Mr. Ishola is certainly remarkable in entrepreneurship. However, as
noted in the previous chapter, there is often an entrepreneurial aspect to the work of healers in Kaduna, which is closely related to the nature of cultural flow, the significance of bricolage, plurality, and limited social control, and uncertain economic conditions.

After a long day’s work, Mr. Ishola stays outside his compound, sitting on a bench and enjoying the cool evening breeze, and I often accompanied him. Before he goes to bed, he puts herbal medicine on a charcoal fire and spreads its smoke inside and outside the compound (he was kind enough to spread it in my room as well). Then he closes the door and starts to pray. Striking a bell, he prays to God that his family might be protected and his business successful.
As noted in Chapter II, since the late 1970s, the development of professional associations of traditional healers has become a continent-wide phenomenon in Africa (Last and Chavunduka eds 1986). Organisations of traditional healers are nothing new in Africa. There have long been various cults of affliction and networks of healers (Janzen 1979; Ngubane 1981; Feierman 1985). However during the 1980s, groups of traditional healers did not just proliferate in number but, more importantly, they incorporated the structure of professional organisations. The impetus for this development has partly come from WHO and other international organisations that have been promoting the use of traditional healing in primary health care in Third World countries. Under this global influence, the governments of African countries have been supportive of the establishment of professional associations of traditional healers in order to utilise traditional healing in national health care services. The movement is also bound up with deteriorating economic conditions and the acceptance by African countries of IMF economic policy, the Structural Adjustment Programme and especially, a policy of privatisation.

Traditional healers in Kaduna are not exceptional in this change. Since the beginning of the 1980s, traditional healers have established their own associations in Kaduna, even though the development of the associations has been marked by political conflicts. The aim of this chapter is to explore the
various organisations of traditional healers and the political history of their professional associations in Kaduna. In this regard, I am concerned with: 1) the formation of traditional healers' identities; 2) the structure of healers' organisations, especially their bureaucratisation; 3) the development of a system of credentials which is considered to be central to any professionalisation in the sociological literature, (Friedson 1986; B.S. Turner 1987), and 4) configuration of social agencies involved in the professionalisation process, that is, power relationships among these institutions and between the institutions and healers.

In the first section, I will depict the structures and activities of various traditional healers' organisations in Kaduna. In the second section, I trace in detail the political histories of the professional associations of traditional healers. I then explore the four issues just mentioned in the final section.

GROUPS, MEMBERSHIPS AND ACTIVITIES

Traditional healers' organisations are numerous in Kaduna - there coexist various healers' associations and groups. Here, I classify the groups of traditional healers into the following five types: formal associations, ethnic associations, cult groups, neighbourhood associations, and personal networks.

1) **Formal Associations:** The formal healers' associations are the groups recognised by government. There is a range of governmental bodies that can grant recognition to healers' associations through registration. These include the Kaduna State Ministry of Social Development, the Kaduna State Ministry of Health and the Federal Ministry of Internal Affairs.
The formal healers' associations in Kaduna have been constantly changing their group formations. While the details will be seen in the next section, there has been a cycle of unification and schism among the groups. By the late 1980s, however, the following three formal associations emerged: the Nigerian Association of Medical Herbalists (NAMH), the Nigerian Union of Herbal Practitioners (NUHP) and the Northern States Traditional Doctors and Healers (NSTD). The Nigerian Association of Medical Herbalists was the first formal association set up in Kaduna. It was a Kaduna State branch of the national organisation whose headquarters is located in Lagos. The members of the association were ethnically mixed and included a large number of members of bori (a spirit-possession cult). The Nigerian Union of Medical Herbalists was a breakaway of Nigerian Association of Medical Herbalists. The members were mostly Hausa-speaking healers and their residences were concentrated in Kaduna-North. The Northern States Traditional Doctors and Healers was a local organisation since, unlike the above organisations, it was not a branch of a national association. Although it claimed to be an association that extended all over the Northern States, the members appear to have been mostly Hausa-speaking healers living inside Kaduna city. Yet, by the end of 1980s, the three associations agreed to dissolve under the direction of the state government. In 1992, there emerged the Gamji Herbalist Association that incorporated the members of the former associations.

The organisation of formal associations is modelled on Western bureaucratic lines. Each has a constitution that defines its objectives, code of conduct, conditions for membership, and the activities and duties of members. Functionally specific duties are allocated to executive members such as general secretary, treasurer, public relations officer and
research director. However the existence of such a bureaucratic framework should not be taken to reflect the actual operation of the institution. The associations have only been working according such bureaucratic principles to a minimal extent. First of all, most members of these associations, including executives, do not know much about their duties, code of conduct or the constitutions of their associations. The constitutions of associations were not really written by healers in Kaduna themselves but either simply duplicated from those of Lagos headquarters or drafted by government officials. Apart from those who hold the post of general secretary and treasurer, the executive members have only a slight idea about the work of the administrative posts they hold. It appears that they consider such posts as titles rather than as specialised duties. It is interesting that some posts are sometimes instantly created at a meeting and distributed to those on attendance - as a result, the number of posts tends to increase continually.

There is also a general lack of understanding about the objectives of these associations among their members. On being asked about the goals of associations, the members usually point out the importance of unity among healers. However their answer is primarily a reflection of the political situation that they have been going through, that is, factional conflicts. Otherwise they only come up with a broad idea of mutual help and getting to know each other, once such unity is achieved. Even the chairpersons of the associations do not seem to have a clear policy and opinion about the associations.

Another notable feature of the formal associations is their membership certificates. Membership certificates are to certify herbalists as members of a particular association - each association has its own certificates. Printed in English, these
certificates obviously are not an official license for their practice; such a license is not legally required. Nor are the certificates proof of proficiency to practice. No examination is given to healers about their skills and knowledge in order to obtain these certificates. Healers simply buy their certificates from the associations. Although the price of certificates fluctuates, it was 15 nairas in the middle 1980s. In theory, sale of certificates could generate a significant revenue for the associations. However these funds have been misappropriated by some members and have become a major problem in the management of the associations, as we shall see.

For the majority of members, the certificates are considered to be useful for their business, especially in cases of trouble with their clients and subsequent legal cases. As mentioned in Chapter IV, a number of healers display their membership certificates, sometimes more than one, in a frame on the wall of their consulting rooms. Apparently this is to give their client an impression that they are registered and qualified practitioners. Given such negative popular images of traditional healers as baban juju (practitioners of magic), such ‘legitimacy’ and ‘qualification’ is all the more significant for individual healers. However, from the clients’ point of view, such certificates are not all that important. Certainly some of my informants argue that they prefer healers who have certificates. However, in the actual management of therapy, people choose healers on the basis of information about the efficacy of particular healers, that is, on the basis of stories or examples of successful healing (see Chapter IV and VII). Thus, certificates are of limited importance for a patient’s choice of healers. Indeed some healers, especially popular ones, do not display their certificates. As for the security function, legally speaking,
membership certificates do not provide protection for healers since they are not official licenses. Yet a Yoruba healer told me about a case in which he believed his certificate protected him. According to him, he was once taken to a police station due to his customer's accusation of malpractice. But the police did not detain him because, he assumed, his certificate proved to the officers that he was a qualified healer. Thus the protective effect of certificates would vary from case to case, depending upon how far those involved believe in the 'legitimacy' of the certificates.

The problem of certificates and other issues are discussed at meetings, usually held at the chairperson's residence, which are divided into executive meetings and general meetings. Meetings rarely start on time, and a few hours of delay is normal. Only when the attendance of most of the important members is confirmed that the meeting finally starts. The participants commence a meeting by prayer. The prayer is usually Islamic since a majority of the members are Muslim. At first, the general secretary introduces the agenda and the issues to be discussed. Then participants express their opinion about the issues. Two features stand out here. The first is the fact that the style of speech is just as important as the content. While there are considerable similarities and repetition among the opinions expressed by speakers, all the speeches are made eloquently, with rhetorical flourish. Secondly, there is an egalitarian ethic underlying the management of discussion. Anyone who wishes to speak is given an opportunity to speak regardless of the speaker's gender, age or ethnicity. This, however, often results in a redundancy of discussion. Arguments and even quarrels between participants are not uncommon, which often bring the meeting to halt. Another problem in
discussion has to do with differences in the languages the participants speak. Because the participants generally include speakers of no less that three different languages and many of them cannot communicate well in any language other than their mother tongue, interpretation is indispensable for discussion. Thus when a Hausa speaker speaks, it is interpreted into Yoruba and Igbo or English. When a Yoruba speaker speaks, it is interpreted into Hausa and Igbo or English. There are usually several participants who have a command of two or three languages and can work as interpreters. While the agenda of the meeting can vary, between 1990 and 1991 all the formal associations were preoccupied with politics - the problem of their unification. After discussion, a levy and donations are collected from the participants. Donations are aimed at specific as well as general purposes. Unlike other types of associations, however, mutual help such as exchange of prescriptions and financial assistance between members does not seem central. At least, during my field work, this was overshadowed by political issues. It is also notable that attendance at the meeting itself may have political implications. This is particularly the case for newcomers. Those healers who are not known in a healers’ circle in Kaduna may attend a meeting and make a large donation in order to get recognition from the association.

2) **Ethnic Associations**: As far as I know, at least two traditional healers’ organisations in Kaduna are almost exclusively composed of the healers belonging to the same ethnic-language category. One is a Yoruba herbalist association whose membership is only open to healers who are considered to be ‘Yoruba’. The other is an Igbo herbalist association whose members are mostly, if not completely, Igbo-speaking healers. The Yoruba association appears to
have been in Kaduna for some time - I was not able to ascertain when it was founded. The office - their meeting place - was initially set up at the residence of the first chairman of the association in Nasarawa, and then moved to the residence in Tudun Wada of a Yoruba herbalist who succeeded to the chairmanship. Of all the healers' organisations I have observed, the Yoruba association is the most well-organised. The administration has a general secretary, treasurer and other functionally specialised posts. There are sub-branches that are organised in different areas in Kaduna city. Each subgroup has its own chair person and meetings. While the association has a large number of members, the possession of membership is not compulsory to all the Yoruba healers living in Kaduna. The general meeting is attended by about 20 people of whom males outnumber females. Almost all are Muslim, even if some practise healing and divination associated with Yoruba traditional religion. Chairmanship of the association is based primarily on seniority in age. Thus if a chairman dies, one of the elder members succeeds to the post. While I was conducting research, the chairman of association, Mr. Lowe, died. Unlike the case of formal association, however, the vacancy of the post does not seem to have caused much conflict among the members - one of the elder members succeeded to the post. It is conceivable that a cultural tradition of age grades is partially contributing to the stability of the organisation.

The association of Igbo healers was formed amidst the political upheaval of the formal herbalist associations in 1991. It is named the Ikenga Herbalist Association. The Ikenga Association was established apparently in order to mobilise Igbo healers and strengthen their position in a unstable political situation. The members are mostly Igbo, though the membership is not restricted to Igbo-speaking healers
there are a few Igala healers as well. While the number of the healers enrolled probably reaches 50, about 20 people regularly attend the meetings held at the chairman's house. It is notable that some of the members (15 or so) are also members of the mamy wota society headed by the same chairperson. It appears, however, that the group experiences some internal conflict. Rivalry and ill-feeling are fairly common among the members, with even the chairperson expressing the view to me that many of these herbalists were crooks. Thus, even though they have mobilised themselves to further their common interests and their unity is strengthened against the Hausa majority and to a lesser degree the Yoruba group, they have not established a strong solidarity among members.

The activities of these associations are similar to those of voluntary associations such as home town associations and rotating credit associations (Little 1965, Barnes and Peil 1977). Their main function is mutual help of the members. At each meeting, the members discuss not only general issues but also the problems of individual members. Where a member is in need of financial assistance, donations may be collected and given to him or her. The associations also collect donations for condolence to the members who have lost their relatives. The association could act for a member in legal trouble as well. For instance, I observed that the Ikenga Association tried to help one of the members who was taken into custody because he was alleged to have accidentally killed his patient by his medicine.

3) Cult Groups: Cult groups comprise healers and their former and present patients who have suffered from the same spiritual afflictions. Where such afflictions are confirmed, these healers sometimes initiate patients into their society so that the
patients can control the spirits afflicting them. Thus, the relation between the healers and their patients can also at the same time be a relation between initiators and initiates. Moreover, once patients become members of cult societies, they are encouraged to become healers - they can learn healing skills from their initiators. They may even initiate their own patients and form their own groups. Cult groups are obviously religious organisations as well - they are associated with particular spiritual beings and the members hold rituals for them. In Kaduna, I have been able to observe two cult organisations. One is a bori spirit possession cult group and the other is a Mamy Wota society.

Bori is a well-known cult of spirit possession in Northern Nigeria and the Republic of Niger (King 1966, 1967, Onwuejeogwu 1969, Besmer 1983, Wall 1988, Last 1991, Echard 1991, Masquelier 1993, Stoller 1996). Its central feature is a performance practised by musicians, dancers and their supporters, during the course of which the dancers go into trance and are considered to be possessed by particular spirits. Practitioners, yan bori (singular, dan bori), have experience of spiritual afflictions and were initiated into a bori group by herbalists who are the leaders of bori, often referred to as sarkin bori (the king of bori) or sarauniyan bori (the queen of bori). Thus, there are the networks of yan bori extending from the leaders.

In Kaduna, many of the important practitioners and leaders are the initiates of one lady, Bawumani Maikoko. In 1970s Maikoko appears to have emerged as the overall leader of yan bori in Kaduna. Through the initiation ritual, girka, Maikoko initiated a number of her patients and established extensive networks of yan bori throughout Kaduna. Indeed it is this prominent position that made her the first chairperson
of the Kaduna branch of the NAMH, as we shall see. After her death, however, the networks have been split into factions led by some of her initiates and other practitioners. These practitioners have been initiating their patients and there is rivalry among them. Until recently, they have been unable to agree upon the succession to Maikoko's post.

Yan bori are mostly Hausa-speaking northerners. Female members outnumber male members. Some male members appear to be homosexual and at least two members I know are transvestites. I was also told that some female members are lesbian. Residentially they are scattered around Kaduna and its outskirts. Some healer-leaders are relatively well-off. Especially Maikoko appears to have enjoyed a great deal of material prosperity. Otherwise, however, the majority of the members are poor, doing jobs such as petty trade and craft work, complemented by divinatory and healing practice. A number of female members are said to be prostitutes, some of whom are apparently high class prostitutes.

As to the activities of bori groups, the most significant feature is the performance of spirit possession. The following is one of the occasions I observed.

I came to the compound of the late Maikoko in the evening of 21 June 1990. The yard was packed with spectators, even though the central part was kept open for dancers. The performance began around 9 p.m. Initially it was only music played by chaki (calabash instrument) players, a garaya (traditional guitar) player and a singer. There was a man acting as a master of ceremonies (M.C.). He was also a good comedian, cracking jokes and making people laugh. Some people gave him money for the jokes they particularly liked. It was explained to me that the occasion for this gathering was a celebration of marriage. The bridegroom, although he was present, was hardly noticeable among the crowd. Then the M.C. called for donations and collected money from spectators. A part of this donation was soon
distributed among some *bori* performers. Then the music stopped. Some important *bori* members gathered to discuss certain issues. I was told that they were arranging tonight’s performance. After the discussion, the music started again.

Now the music changed its tempo and loudness - it was up-tempo and louder. The dancers began their performance. Standing in a queue at the edge of the central area, one by one they went into the middle of the area, showed their dance and then came back to the end of the queue. Spectators’ attention was therefore focused on the performance of each individual. One of the dancers performed acrobatic jumps - they are characteristics of *bori* dance. He jumped high, stretched his legs upwardly in front, opened the legs in that position and landed on his bottom on the ground - his bottom must have hit hard on the ground as it made a considerable sound. Then three prominent *bori* members, Audu, Dojyo and Rogo, went to the middle and sat down on the ground, waiting for spirits to ride on them. Then each dancer paid his or her respect to the three men by displaying *bori* jumps in front of them - jumps varied in style according to the jumpers. Chaki players stood up and played the instrument just beside the three. This was apparently aimed at provoking their possession. The first possession fell on Audu. He started to vomit saliva and his body was shaking. I was told that he was possessed with a spirit called Maigogo. Rogo was also having the first sign of a trance as his body trembled. Meanwhile some dancers independently went into a trance. A woman crawling on the ground was said to be possessed with Inna. Another woman holding a stick was said to be possessed with a Fulani spirit. Then the music stopped.

Some of those in a trance went into a room where they got their supporters (*yan kwariya*) to change their clothes. As they came out, music started again. This time the players lowered the tempo and loudness. Audu and a woman dressed themselves in Fulani clothes and held a stick in their hands. Audu stood like a pastoral Fulani man, while the woman kept dancing alone. Some spectators gave her money, putting naira notes on her forehead - the money was picked up by supporters for her. There was a man crawling on the ground and making sounds like snoring. He was said to be possessed with a pagan spirit. A man in uniform walked around spectators and saluted to them. He was said to be possessed with the spirit of a soldier. Putting on more clothes, Audu changed his appearance again. He spoke to spectators in a language that no one understood.
Now the spirit riding on him was the spirit of a European (Bature). There were some other spirits such as Barhansa and Dan Galadima falling on dancers. The performance continued until late in the night and spectators dispersed without my notice. Eventually the musicians stopped playing the music any more.

Although the major part was over, this was not the end of the entire bori performance. Last came the "divinatory session". Those in a trance now stayed inside rooms and worked as diviners. Each diviner saw his or her clients individually in a room. During the consultation, the diviners were supposed to speak the words of the spirits possessing them. However they also used an oracular device such as cowries. The diviners might advise their clients to come back to see them later for medication or for ritual practice to solve the clients' problems. I consulted 'Dan Galadima' and was told to make a sacrifice for my problem. The consultations continued until early in the morning.

There is lots of fun and gaiety. Bori is at first an entertainment. It is sometimes organised for ceremonial occasions such as a wedding. Secondly bori is a divinatory and healing activity. Bori is, however, not only an occasion for entertainment and divination, but one for mutual help and distribution. In the beginning of the performance, donations may be collected for a member who is in financial need. It has a judicial function as well - I observed a dispute between two bori members solved at a bori gathering by prominent members. It should be added that the places where bori is regularly performed - normally the compounds of the leaders - may be used as brothels (gidan mata) or the meeting points of prostitutes, who may be bori members, and their customers.

In short, bori is multifaceted. Apart from the performance, everyday interaction takes place between like-minded members. Hence, networks of friendship exist within the group. Recruitment of new members is conducted through girka rituals by the leaders. In the girka ritual, initiates are isolated inside the
residence of the initiators. During this period, initiates appear to learn the secret knowledge of spirits and medicine, though the ritual does not seem to make the initiates into bori performers instantly. The frequency of girka rituals is apparently a source of pride for leaders within a bori circle.

It appears that bori members now face some difficulties in holding gatherings in Kaduna. This is partly due to Muslim fundamentalists who consider bori as a satanic practice. It is also in part due to the use of loudspeakers which cause considerable noise in congested neighbourhoods at night. An informant complained that stones or excrement were occasionally thrown into the place where the performance was conducted. It is said that bori is not allowed to be performed after midnight at Ungwan Dutsa, and it is entirely banned at Ungwan Shano. On the other hand, in recent years bori members have been invited to festive occasions by the Kaduna state government. At the opening ceremony of the Trade Fair, which is held at a stadium every year, they regularly show their performance in front of a crowd of spectators and guests including the state governor and the representatives of the federal government. These occasions are also televised. In this respects, bori is partially incorporated into the state and serves as a representative of the folk culture of the region.

The other cult group that I know is a Mamy Wota society. The group was called the Iyafor Society and was established by an Igbo healer, Bernard Ugoh, in 1970’s. It comprises the herbalist and his former and present patients who have suffered from the affliction attributed to Mamy Wota. Mamy Wota is a water spirit and believed to bring not only sickness and misfortunes but also wealth. In order to cure a Mamy Wota affliction, patients are sometimes persuaded to join the society and to conduct a sacrificial ritual.
The notion of *Mamy Wota* is widespread but particularly noteworthy among Igbo-speaking people in Kaduna. The members of the Iyafor Society are therefore largely Igbo speaking, even though the membership is not restricted to the Igbo; there are non-Igbo members such as some Igala members as well. Female members slightly outnumber male members. The occupations of the members are various; there are housewives, traders, a typist, a cook, a lawyer and others. The meeting is held weekly at Ugoh's residence at Kakuri in Kaduna-South. About 15 people regularly attend the meeting.

One of the essential activities of the society is the ritual for *Mamy Wota*. The ritual is conducted both in a group and by individuals. In a group the members gather at the residence of their leader every Friday evening. Inside his compound there is a shrine of *Mamy Wota* where the symbols of the deity are situated. The symbolic objects consist of animal bones and a statue covered with herbal medicine and are kept in a metal box. At the Friday meeting, liquor, eggs, yams and other things are offered to the shrine. During a ritual, the leader paints the faces of members with white or yellow chalk, and they pray at the shrine. The meeting is, however, also an occasion for fun. Like a bori performance, music and dance are integral to the occasion. The members play traditional instruments which the leader keeps at his residence. However, unlike a bori performance, spirit possession is not meant to occur. Liquor, kola nuts and snacks are distributed. Levies and donations are collected. Apart from Friday meetings, members pay visits to each other. In particular, the leader is frequently visited by his people. They come to see him not just to chat but for oracular consultations. The leader may prepare the symbols for his members and teach them how to practise herbal medicine. In this way, some of his
members have become healers and now practise healing for business. At the beginning of the dry season, they hold the 'New Yam Festival' at the leader's compound. The occasion is full of festivity. While members enjoy nice food (especially yam), drink, music and dance, a sacrificial ritual is still central to the occasion - the members offer new yams to the deity.

4) **Neighbourhood Associations**: The fourth type of traditional healers' group is based upon the residential proximity of healers living in Kaduna. Healers living in the same residential area tend to know each other, even if their relationships are not necessarily cordial. However, out of their interactions may grow an organised association. The case I know is an association in the Nasarawa area of Kaduna-South. This association appears to have been founded by a Yoruba traditional healer in the 1970's. But, for some reason, it had virtually stopped its activities after a while. However, in 1991, when healers were concerned about the problems of formal associations, some healers in Nasarawa revived their association. The membership of the association is voluntary. Therefore the association does not incorporate all the traditional healers living in the Nasarawa area. The number of active members is between 10 and 20. Out of them, about half are Yoruba healers and the rest are mixed in terms of ethnicity. The number of male members appears to be much greater than that of female members. The chairperson is currently a Yoruba healer, whose residence is used as a meeting place. The main objective of the association appears to be mutual help - again, it can be classified as a voluntary association. Like other associations, financial assistance appears to be its central aim. It has a judicial function as well. I have observed the association intervene when two of its members were in dispute. The associations are also helpful in forming
personal networks. Through the association, some herbalists who were previously isolated have got to know each other. Compared to formal associations and ethnic associations, there is a more relaxed atmosphere among the members. The group also organises festive occasions. Again fun is an important factor here too.

5) **Personal Networks:** Finally, in general, the most frequent interactions among herbalists do not occur within the institutional frameworks of the above associations but through more informal relationships. Healers usually have friends who are also healers. However their friendships are more often than not practical. They are, first of all, reciprocal - healers exchange medicines, prescriptions, food, accommodation, money and so on. Such personal ties may develop within the associations depicted above. However it is not uncommon that healers have extensive networks of personal ties that span wider regions. They travel out of Kaduna and visit their healer friends in other states. The main purpose of such visits is to learn new medical prescriptions and to do business there. In return they receive their visitors at their residences in Kaduna, and at times allow them to do business there. In such a case, visitors are provided not only with food and accommodation but with some of the customers of their hosts. It is noteworthy that there are healers who are not settled at a particular place for a long time but who travel from one place to another, doing their business at their host’s place of residence. For such itinerant healers, personal networks must be indispensable. Another important service healers provide for one another is divinatory practice. When healers need divination for themselves, they may consult their own oracles, but more often than not they go and consult the oracle of their healer friends.
I have identified five different types of traditional healers' organisations. It is important to note that the fact that a healer is a member of one type of association does not preclude him or her from being a member of another type. In other words a healer may belong to more than one type of association. For instance, in 1990, a Yoruba healer, Baba Shagari, was a member of the NAMH, a healers' association in Nasarawa and a Yoruba healers' group. An Igbo healer, Bernard Ugoh, was a member of the NAMH, the Ikenga Association and a mamy wota society.

POLITICAL PROCESS

In this section, I will examine in detail the political history of formal healers' associations in Kaduna from their inception at the start of the 1980s to 1992.

There are two individuals who can suitably be called the founders of formal associations in Kaduna. They are Aishatu Bubayero and Burmani Maikoko. The incentive to organise formal associations in Kaduna did not come from within but from without. It was Aishatu, an executive member of the Nigerian Association of Medical Herbalists (NAMH) in Lagos, who initiated the whole process of the development of formal healers' associations in Kaduna. Aishatu, a Fulani woman who is said to have been related to the Emir of Gombe, was a native of Gombe in Bauchi State. She came to Lagos in the 1960's and joined the NAMH. Her fluency in English and ability in administrative work appear to have helped her to hold an executive post in the association. In the middle of 1970s she was sent to Kaduna to set up a branch of the association. Here she met Burmani Maikoko, the leader of bori in Kaduna. Aishatu persuaded Maikoko to
mobilise traditional healers under the name of the NAMH, and then took her to its headquarters in Lagos. Thus the Kaduna Branch of the NAMH was established and headed jointly by Aishatu and Maikoko.

In 1979 the presidency at the Lagos headquarters was taken over by a man who had been the secretary of the NAMH, J.O. Lambo. Lambo's leadership, however, caused divisions inside the association. In 1980 Sodupe and other executive members left the association and formed a new group, the Nigerian Union of Herbal Practitioners (NUHP). Those who followed Sodupe and joined the NUHP appear to have included a number of herb sellers in Musin in Lagos. Aishatu was among the rebels. Appointed as the leader of the northern zone for the NUHP, she was assigned to establish, this time, the Kaduna branch of NUHP. Aishato managed to mobilise healers who were mostly Northerners for the Kaduna branch of NUHP. Maikoko, on the other hand, remained in the NAMH, and was appointed the Northern zonal leader of the association by Lambo in 1982.

By 1985, the members of the Yoruba healers’ group appear to have joined the Kaduna NAMH. While Igbo healers were yet to have their own group, the leader of a Mamy Wota society, Ugoh, was approached by both Maikoko and Aishatu, and eventually joined Maikoko’s group with his followers. In 1985, an election was held to decide the executive posts of the Kaduna NAMH. Here Maikoko’s position as the leader of the whole Northern region was confirmed. The post of the chairperson in charge of Kaduna state was given to a Hausa medicine seller, Ibrahim Auta. Ugoh and the leader of the Yoruba healers, Sarau Lowe, were appointed the deputy chairmen in Kaduna. The Kaduna NAMH at this time was relatively free from leadership tussles. The meeting was held at Maikoko’s residence every Saturday. The membership certificates of the
Kaduna NAMH were printed and distributed to healers for 15 naira each. It appears that Maikoko became not only famous but also prosperous through the association. It is said that she owned 5 houses and 2 cars and was able to finance her followers’ pilgrimages. It is conceivable that her prosperity and prestige made a significant impact on politically ambitious healers.

The Kaduna NUHP was even better organised under Aishatu’s leadership. A whole compound at Badarawa area was kept for the association, where a number of bottled herbal medicines were shelved and made readily available for the members. The Kaduna NUHP was also active in participating in conferences and projects organised by the state ministries and Ahmadu Bello University. In the middle of the 1980s, some of the executive members went to Washington D.C. with their counterparts in Lagos. They were invited to a conference on Traditional Medicine in Africa (they were proud of plastic binder given to them at the conference). In 1986, however, a tragedy happened. Aishatu was killed in a traffic accident. Since her death, the Kaduna NUHP got into a leadership problem. Some of the members had been unhappy about the administration of its Lagos Headquarters, which seemed to them to have always favoured the Southerners. The group was led by Mijin Yawa Maibaka, who was a clerical officer at the Ministry of Education of Kaduna State. In 1986 the group was registered at the Federal Ministry of Internal Affairs and named itself the Northern States Traditional Doctors and Healers. As noted previously, most of the members were Hausa-Fulani herbalists living in Kaduna-North. When Maibaka was transferred to Katsina state, the chairmanship was taken over by Sule Shanono, a Fulani healer who was once the chairman of the Kaduna NUHP as well.

In the meantime, fraud over membership
certificates put the Kaduna NAMH into serious trouble. Some members of the association apparently forged the membership certificates and sold them for 50 nairas each. On the forged certificates, the name of the association was printed as 'National Association' instead of the correct one, 'Nigerian Association'. While Maikoko was on her pilgrimage in Mecca, several executives of the association including Ibrahim Auta were arrested at Rigasa area by the police. This caused considerable distrust among the members of association toward the executive members. Particularly Yoruba and Igbo healers were angry about these individuals. The matter was taken up to the Department of Social Welfare of the Ministry of Health in Kaduna State. John Kazah, an officer in charge, recommended the association to set up a ten man committee to investigate the problems.

This committee was chaired by Ugoh and included Maikoko and at least two Yoruba and two Igbo healers. Despite their minority position, the Igbo and Yoruba healers appear to have played a leading role in the committee. This may be in part attributable to the fact that they were literate in English and capable of writing a report to the ministry. In July 1987, they submitted the report to the Social Welfare Office. In the report, several recommendations were made: 1) termination and suspension of those involved in the sale of fake certificate and embezzlement of the proceeds from the sale of the certificate; 2) repayment of the embezzled money; 3) cancellation of all the certificates; 4) preparation for a new election to the executive posts; 5) unification of all the formal healers' associations in Kaduna.

However, Auta and others who were alleged to be involved in the certificate fraud did not simply accept their termination. Instead they made an alliance with the Kaduna NUHP and approached Yohana
Madaki, an officer in the Health Management Board of the Ministry of Health for help. By November, the Auta group and the Kaduna NUHP set up an Ad Hoc Committee for the unification of all the groups under the auspices of the Health Management Board (later they changed the name from the Ad Hoc Committee to the Nigerian Herbal Association and Union Practitioners). A meeting was held regularly at a nursing training school, which the Health Management Board allowed them to use. Apparently, however, the setting up of the Ad Hoc Committee was not acknowledged by John Kaza and the Social Welfare Department. There appears to have been a lack of coordination between the Health Managing Board and the Social Welfare Department within the Ministry of Health (though the latter was later incorporated into the Ministry of Social Development).

In December 1987, the executives of all three associations were summoned by the Social Welfare Department to discuss the issue of unification. They all agreed to merge into one association and cancel their membership certificates until the united association could issue its certificates. The department also recommended them to set up a caretaker committee which was supposed to be composed of seven people from each group. The committee aimed at coordinating the groups and preparing the election for the chairman and executives of the new association. However this merger plan was never realised. The idea of a caretaker committee was problematic, since the alliance of the Auta group and the Kaduna NUHP was bound to cause the problem of the representation of three associations. Thus, instead of moving toward unification, the matter of creating formal associations turned into power game among individuals. The situation was exacerbated by the death of Maikoko in 1988.
After Maikoko’s death, the Kaduna NAMH virtually ceased to exist. No meeting was held for sometime. However, there was a turning point. A daughter of Maikoko, Haribarude, came back from Saudi Arabia to Kaduna. Haribarude had been away from Kaduna for many years. She had married three times and had lived in countries where her husbands worked. Unlike her mother, she was not a traditional healer. However, when she came back to Kaduna, she apparently felt that it was legitimate for her to succeed to Maikoko’s position. She was also fortunate have a reliable supporter who could help to mobilise healers for her. This individual, Ayodeji Lambo, was a son of the president of the NAMH, J.O.Lambo. At that time, he was posted as a Youth Corps member at Kachia, a town some 120 kilometres away from Kaduna. In September 1987, he visited Haribarude and told her that he was assigned by his father to help her to reorganise the Kaduna NAMH. Between September and December, a series of meetings were held at her compound. Ayodeji came all the way from Kachia to attend the meetings and acted as a coordinator. The participants agreed to hold an election for the chairmanship and the executive posts.

Meanwhile they received information that J.O.Lambo was coming to Kaduna to attend a conference at Ahmadu Bello University on the 8th of December 1988. In the letter, Lambo added that he wanted the Kaduna NAMH to hold an election on the 10th so that he could oversee the election during his stay. The news of Lambo’s coming appears to have stirred not only the members of the Kaduna NAMH but also the members of the Ad Hoc Committee. On the third of December, a joint meeting was held between the three groups in order to discuss the Lambo’s matter. The main issue was how to finance his transportation from the airport to the city. However, in the middle of the meeting, the issue was shifted from transportation to leadership. At
whose residence should Lambo be welcomed? Would it be Haribarude’s, Auta’s or any other leaders’? The issue caused strife among those at the meeting and eventually the meeting collapsed. On the day of Lambo’s arrival, the members of the Kaduna NAMH gathered at Maikoko’s compound. But in the end they were informed that the conference was postponed and Lambo was not coming to Kaduna. Nonetheless, those who had gathered seized this occasion to elect the chairperson and executive posts. They elected Haribarude as the chairperson. Out of 16 posts, 4 were given to Yoruba healers and 3 to Igbo healers. The appointment of the posts was approved by Lambo, and Haribarude went to see him in March 1990.

From Auta’s and the Ad Hoc Committee’s point of view, the election was not acceptable. Since Ad Hoc Committee had been formed, in their view, the Kaduna NAMH had been dissolved and merged with the others. Auta wrote petitions to the Ministry of Health and other governmental bodies. Against his petitions, Haribarude and her followers wrote counter-petitions. The State Service Department of the police finally intervened in the dispute. From March to April 1990, a series of meetings were held at the police headquarters. The attendants comprised the Director of the State Security Department of Police, Madaki, Ladam, Kaza and the important members of the three groups including Haribarude and Auta. What was decided at the end of these meetings was: 1) dissolution of the Ad Hoc Committee; 2) setting up of an election committee consisting of four people from each group; 3) submission of the names of the candidates who wished to contest the election by May 2nd. This resolution caused all the politically ambitious healers to become extremely busy in preparing for the election. On the one hand, those who had joined the Ad Hoc Committee allied with the members of the former
Northern States Traditional Healers and Doctors for the election. They made a list of contestants with Auta as the candidate for the chairman. On the other hand, the Kaduna NAMH submitted a list of the contestants that basically followed the list of their executive members appointed on December 8th 1989. Thus two groups, the Auta group and the Haribarude group, emerged to contest the election.

The Ministry of Health informed them that the election was scheduled at Murtala Square on June 14th, and that the Commissioners of the Ministry of Health and the Ministry of Social Development would make speeches. The election campaign therefore took place in haste. The Haribarude group embarked on a campaign tour by car throughout the city and around several local government areas. A number of healers also paid a visit to her as the election day approached. Apparently she was spending a lot of money for this campaign. Just one day before the election, however, they were informed that the schedule of the election was changed from the 14th to the 19th of June. This made them angry, since extra money was required for further campaigning. However, the election finally took place on June 19th 1990. The following is an extract from my field notes concerning the election.

We arrived at Murtala Stadium around 10 a.m.. There were already about 400 people gathering at the central part of the stadium. The area was divided between the two sides; on one side sitting quietly were Haribarude’s supporters, while on the other side were Auta’s supporters making a lot of noise, singing and playing instruments. By midday, the number of healers had increased to about 800. As they arrived at the stadium, they had to decide on which side they should be sitting. To win the new arrivals to their side, the Auta group employed various tactics. They brought a van with loud speakers and had a group of performers called yan tauri display their performance with swords and snakes. Perhaps partly owing to these demonstrations, Auta’s supporters slightly outnumbered
Haribarude's. The supporters of Haribarude were ethnically mixed - there was a considerable number of Yoruba and Igbo healers, while Hausa healers were still the largest in number, including yan bori. Auta's supporters were mostly Hausa speakers and contained a remarkable number of young people. Some of the prominent bori leaders also sided with Auta - yan bori were apparently internally divided on this.

Then an argument occurred between the executive members of two groups. Haribarude's executive officers complained that many of Auta's supporter were not genuine traditional healers. They were joined by a press reporter who had found that some of Auta's supporters had been recruited for money without knowing the purpose of the occasion. In addition, some of his supporters were apparently from other states. The police and ministry officials, who were presiding over the election, were asked to intervene in the matter. However, the problem was that while they also had a suspicion of election rigging, they were unable to distinguish genuine healers from fake ones. For them, some young women were definitely prostitutes, whereas according to healers' definition, they were yan bori.

In the meantime, a minor accident happened with a sword performer - he injured himself during his performance. Haribarude's supporters, however, seized this opportunity to argue that Auta's supporters were in possession of dangerous weapons. The police then summoned those who were responsible for the performance and warned them. By 3 p.m., the number of healers had reached about 1000. The senior officials of the ministries and police arrived at the stadium and discussed whether they should proceed with the voting. In the end, they announced the cancellation of the election for security reasons. However my impression was that while the security problem was certainly present, the real reason for the cancellation had to do with their inability to define genuine voters.

After the abortive election, Haribarude became extremely busy in meeting a number of visitors. Although cancelled, the election had enhanced her public image. She had to welcome a number of visitors and was interviewed by a journalist whose article was later published in a women's magazine. She was also invited by healers in local areas. These courtesy
visits and invitations were, however, very much a part of healers' political action. The point can be illustrated with a visit made by Haribarude and her executive staff to a village outside Kaduna. On August 28th, Haribarude and the executive members of the Kaduna NAMH were invited by a healer, Hajiya Uwani, to her residence in Kaswan Magani, a village about 20 kilometres from Kaduna. It appears that Uwani had a good reason to invite Haribarude. Although she was a dan bori initiated by Maikoko, she was also a member of the Kaduna NUHP. Now that Maikoko's daughter had established a prominent position, Uwani may have felt it beneficial for her to show her loyalty to Haribarude and get recognition from Haribarude and her executive members. However this has to be understood against the competitive nature of the healing business in the area.

Haribarude and about a dozen of her supporters hired a van and came down to Kasuwan Magani. At the compound of Uwani there was festive air—a large number of people, lots of food and bori performance. Bori musicians and dancers were entertaining their audiences, and the dance was soon joined by some of Haribarude's supporters who were yan bori themselves. However the most important part of gathering, the making of a speech, was not forthcoming.

Haribarude insisted that it was not appropriate to hold a meeting without the presence of Hajiya Biye, one of the most well-known healers in the area. This prideful lady was also an initiate of Maikoko and had initiated a number of yan bori by herself. Haribarude was told by her delegates that Biye was angry about the gathering as she was not informed of the occasion and that she told her followers not to attend. Then Haribarude herself went over to Biye's compound and finally persuaded her to attend the gathering. The meeting finally started.

After prayer, the general secretary of the Kaduna NAMH introduced those in attendance and announced that Haribarude was now the elected leader of the Kaduna NAMH. This was followed by Haribarude's short speech. Then Uwani's turn came. Before making her speech, however, she
performed bori jumps in front of Haribarude and Biye. Then she said, "My mother, Maikoko, died. Now my senior sister has succeeded. I have invited her so that everyone knows her". One of the speakers that followed maintained that Biye was the leader of the area. Indeed Biye herself made this very clear in her speech. She announced, "I bless this girl - Uwani (Biye called Uwani a girl [yarinya] all the time). I am the leader of traditional healers in Chukun, Kajuru and Kachia local government areas..... Without my permission no meeting should be held." She also said that she would hold a meeting to appoint executive posts in her areas. At the end of the meeting Biye looked happy. On the other hand, Uwani's position as the host of the meeting was certainly undermined by Biye's presence.

Around this time it looked as though the Kaduna NAMH - Haribarude's group - had consolidated its power and was holding meetings regularly and discussing how to expand its influence. Yet the unity of the group turned out to be short-lived. It did not take long for the association to fall apart. Rifts soon emerged between Haribarude (chairperson) and Sadiq (director of research) on one hand, and Ugoh (vice chairperson) and Abdullahi (general secretary) on the other hand. At first there was lack of communication and coordination between these individuals. Ugoh and Abdullahi were not happy that Haribarude did not consult them about important issues. They were worried about Sadiq's influence over Haribarude, since he was acting her personal secretary. Sadiq Mohammed was a Fulani man from Gongola State. This young man in his 20s was not a healer but had been working as a secretary for the Kaduna NAMH for a few years. He had a remarkable writing skill in English and was an articulate speaker both in Hausa and English. Ugoh and Abdullahi were also concerned about the fact that all the association's documents were in the hands of Haribarude and Sadiq. However, what was decisive was that Haribarude and Sadiq printed and sold certificates and ID cards without the approval of the
executive. Haribarude and Sadiq insisted that the certificates and ID cards were only for Hausa herbalists since they should form their own group within the association. But for Ugoh and Abdullahi, this was totally unacceptable. In addition, Sadiq printed a new official letter head for the association. Haribarude’s absence from Kaduna was also untimely - Ugoh and Abdullahi considered it as a mark of irresponsibility. By the end of November, Ugoh, Abdullahi and Lowe, the Yoruba vice-chairman, decided to dismiss Sadiq from the association. They wrote letters about his termination to the Ministry of Social Development, the Ministry of Health and the police. Sadiq reacted immediately by writing counter­letters to these governmental bodies. However, from this time onward, Haribarude and Sadiq were increasingly isolated from other executives. While their conflict was in part a clash of personalities - Ugoh and Sadiq particularly disliked each other, it is interesting also to note the way in which they appropriated ethnic and gender categorisations to accuse each other. Thus Sadiq complained, "Yoruba and Igbo are not really helping the association." In Ugoh’s opinion, "A woman as a leader is not good."

After the cancellation of the election, the government did not give any further directives to the healers. Yet in November, the government attempted again to sort out the problem. On November 12th, the Ministry of Social Development summoned the executives of both the Haribarude and Auta groups. The point at issue was the definition of traditional healers and a new election for president. The ministry was particularly concerned with yan tauri (sword performers) who were officially considered as the cause of the cancellation of the previous election. Auta group, predictably, insisted that they were indeed traditional healers, whereas the Haribarude
group retorted that they were not. Because this contradiction was never resolved, in the end, the ministry gave up attempting to define traditional healers. Nonetheless, the ministry put the election back on the agenda and requested the healers to submit the names of the candidates within 18 days. While the Auta group accepted that plan, the Haribarude group maintained that they could only accept the plan if the government would give them financial support for the election preparations.

At the end of November, dozens of traditional healers gathered at the Ministry of Social Development in order to appeal to the commissioner that they needed the financial support of the government for the next election. However, the effect of the demonstration turned out to be contrary to their expectation - it led the ministry to abandon the new election plan altogether. Another interesting development around this time was a political deal proposed by bori leaders to Haribarude. Haribarude was approached by Sule Sarkinbori and other bori leaders. They proposed to her that they could enthrone her as the overall leader of bori if she gave up being the president of the new formal association. However, she rejected this deal, since she considered herself as the de facto leader of all traditional healers. Meanwhile the Auta group was far from inactive. They were busy in lobbying with the Ministry of Health. They frequented the ministry and managed to connect themselves with a coordinator of the primary health care section, Aliyu Ladam. Through his approval, they re-established the Ad Hoc Committee. However, the re-establishment of the Ad Hoc Committee was not acknowledged by the Ministry of Social Development.

This time, however, the Ad Hoc Committee was going to be joined by the members of the Kaduna NAMH as well. The executives of the association were now
turning their back on Haribarude and took part in the committee. At the meeting, Ugoh denounced Sadiq, saying that it was he who was causing all the trouble in the association. This view was soon shared by all the participants of the committee. From the third meeting onward, Haribarude and Sadiq started to attend the committee. At this point, however, they only found themselves isolated from the majority of the participants, including those who had been their supporters just a while ago. Haribarude refused the dissolution of her group, the Kaduna NAMH, and argued that she was virtually accepted as the leader of all healers in Kaduna. In her support, Sadiq expanded upon her arguments. However his provocative style of speech sparked quarrels. From the point of view of senior participants, his speech lacked respect for them. The argument was especially serious between him and the Yoruba participants - one Yoruba healer was about to physically fight with Sadiq. I suspect that this derived from the fact that Yoruba culture gives so much importance to age differences. As a result of this confrontation, most of the participants, who were previously divided, were now united against Sadiq. In this sense, ironically, Sadiq's presence contributed to the unification of the factions. In other words, Sadiq was victimised as a scapegoat. Since then, the denunciation of Sadiq became a common practice at the meeting, which can be seen as the reinforcement of their unity. The enmity against him was further intensified by a subsequent incident, the Daria issue.

This man, Zakaria Daria, first became involved in the association issue as early as in 1987. He identified himself as a military intelligence agent working directly for the military governor of Kaduna State. According to him, he was assigned by the governor to act as a coordinator for traditional healers to establish an association that could
cooperate with hospitals for research and primary health care programmes. Approaching the executive members of the associations, he maintained that he was acquainted with government officials and could mediate between the healers and the officials. While the executive members and Daria lost contact for sometime, he started to attend the Ad Hoc Committee and soon made an impression on the participants. In the middle of February 1991, Daria and Yai Saadu, the secretary of the former Kaduna NUHP, announced that they were going to Lagos. According to Daria, he had a connection with the "Lagos government". By this, Haribarude and Sadiq understood that Daria and Yai were actually going to see Lambo. What worried Haribarude and Sadiq was that Daria and Yai might win over Lambo's support. There was also news that a Yoruba healer had already gone to Lagos to see Lambo. They tried to phone Lambo only to fail. Thus they had no alternative but to go to Lagos as well.

On February 21, the two groups, Daria and Yai, and Haribarude and Sadiq, left Kaduna for Lagos by taxi. Although they made the journey separately, they bumped into each other at Lambo's residence. The following is Sadiq's account of the event.

Lambo asked Daria for his identification. Daria introduced himself as a representative of the Ad Hoc Committee in Kaduna and gave Lambo a letter concerning the dissolution of healers' associations in Kaduna. Reading the letter, Lambo argued that the NAMH was an internationally recognised organisation, and no state government had a right to dissolve it. He told Daria that there was information that somebody had received 5,000 nairas from a local healer in Kaduna, and asked Daria if he was the one who took the money. This made Daria confused and he accused me of spreading such a story. Lambo continued that Daria should cooperate with Hajiya and gave Daria a membership certificate in the NAMH with some money. Then Lambo told us to find a reliable and well-known person to act as Hajiya's vice, adding that the work of vice chairperson was to go
around the villages to inform local healers that the Kaduna NAMH was intact. After Daria and Yai left the place, Lambo told us that they should deceive Daria by giving him the position of secretary and make use of his connection with the government. He wrote a letter to the ministries and gave it to us. We distributed the copies of the letter to the ministries when we returned to Kaduna.

In Kaduna a rumour quickly spread that Daria had received 5,000 naira from Lambo. This became one of the central issues at the Ad Hoc committee meetings. Sadiq, who was said to be the source of the rumour, was interrogated as to whether he was the one who started the rumour. He was again thrown into the centre of the conflict. Daria and Yai argued that the story was totally made up. At a meeting, Daria even brought policemen, arguing that the police would arrest anybody who disturbed the meeting. Apparently this was his demonstration to prove that he was really connected with the government. Yet the matter was taken to the State Security Department of Police by Ugoh and Abullahi. Since then, Daria disappeared without trace. According to the Director of State Security Department, Daria had nothing to do with the government.

In April 1991, Ugoh, Abdullahi and Lowe finally made a decision to terminate Haribarude from the Kaduna NAMH. They wrote a letter about her termination to Lambo (while in the same letter they also enquired about the matter of the 5,000 naira). Ugoh also asked the Director of State Security to arrest Sadiq - for this, he gave the director 60 nairas as a gift. By this time, Ugoh, Abdullahi, Lowe and the other executive members of Kaduna NAMH had almost determined to leave the association and establish a new association together with their former opponents. They had already approached Maijirgi with the intention of backing him for the presidency. Maijirgi was a healer
from Sokoto State. He was one of the few politically ambitious healers whose name was not implicated in fraudulent affairs. On the other hand, Haribarude tried hard to recover her position. She paid a visit to Lowe to persuade him to stay on her side. She also met Ladam who was in charge of the Ad Hoc Committee. A letter was written by Sadiq to Lambo to seek his advice. Around this time there was another man who acted as one of her advisers. The man, Mai Takarumi, a shoe repairer, appears to have been one of usual visitors at her compound since Maikoko’s time. Despite his occupation which is regarded as a job of low social status, it was believed that he had sufficient finance to support her; in particular, he could provide her with money to print certificates. He encouraged her to see the head of Metropolitan Police, the person who was in charge of the security at the cancelled election in the previous year. However all her efforts were too late to reverse the situation. The tide had already turned toward the Ad Hoc Committee. This direction was made decisive by a governmental agent, Ismaila, from the Ministry of Social Development.

Ismaila was a zonal community development officer as well as the head of the Research and Planning Unit of the ministry. This young officer, who was a native of Kaduna city, a son of a well-known Hausa mallam and a graduate of Ahmadu Bello University, had a strong sense of contribution to the community - he was the president of a youth association in Kaduna as well. In the beginning of April 1991, Ismaila was assigned by the ministry to deal with the problem of healers’ associations. Unlike his predecessors, he actively helped healers to unite and establish a single association in Kaduna. At first he laid down guidelines for the establishment of a new association. Thus, at the meeting of 5th May, he requested the Ad
Hoc Committee members to sort out the following issues: the name of the association, its constitution, a permanent address, the identification of traditional healers, a caretaker committee for conduct of the election, a procedure for registration of healers, a code of conduct, frequency of meetings, a procedure for linguistic interpretation, a list of executive posts, and the location of the head office. In particular, he urged healers to draft a constitution for the new association.

By the middle of May 1991, the constitution drafting committee was set up to discuss and write the draft constitution. However, in practice, it was Ismaila who carried out this work for the healers. He got the members of the committee to submit the constitutions of the three former associations to him, and then wrote the draft for the new association out of these constitutions. The work of the committee was therefore reduced to the examination of the draft which Ismaila wrote. The name of the new association was decided as the Gamji Medical Herbalist Association. The procedure of the meetings and the conditions for presidency were also fixed through Ismaila's instructions. By the beginning of July, the work of drafting the constitution was completed and on 12th of July, Ismaila read out the draft at the meeting and explained the role of the officer posts and committees. The motto of the Gamji Association was decided by healers themselves as "Health is Wealth". Thus what was left to be decided was who should be the president.

The issue of the presidency was settled in a rather abrupt manner. On 9th August 1991, the Ministry of Social Development directed the Gamji Association to appoint persons to the posts of president, general secretary, treasurer and financial secretary, and submit their names by August 12th. Thus only five days
were given to the association to do this job. Yet far from complaining such a short notice, Ugoh, Abdullahi and Lowe saw this as an opportunity. By this time there appears to have been a secret agreement between the Igbo and Yoruba groups that they should back Maijirgi for the presidency. They were also quick to decide the other executive posts: Abdullahi (Hausa) for the general secretary, Abdulrafyu (Yoruba) for the treasurer, and Fabian (Igbo) for the financial secretary. On August 11th, a meeting was held at Uguwan Shanno to decide these posts by means of nomination. The following extract from my field notes summarises the proceedings of nomination.

On the day Ugoh and Lowe managed to mobilise about 40 Igbo and Yoruba healers. On the other hand, the number of Hausa healers was smaller than that of the Igbo and Yoruba alliance. Thus even if all the Hausa participants had nominated a single person for the presidency, they could not have won the nomination against Igbo-Yoruba alliance. Besides, the Hausa healers were not unanimous about the presidency.

The nomination was conducted inside a large compound. First of all, Abdullahi and Yai were nominated for the post of general secretary. However, Auta made an objection against the nomination. He argued, "This is not fair. Not all of us has been informed of today's nomination...." Yai also objected to the nomination, saying, "This nomination will cause division among us...." But Ugoh refuted their arguments, "This is an emergency. We have to submit the names to the ministry by tomorrow." Ugoh tried to take votes for general secretaryship between Abdullahi and Yai. But Auta strongly objected. The meeting came to halt. However, Abdullahi announced, "For the sake of unity I withdraw myself from the post. Yai is general secretary!" The speech delighted most of the participants. With applause, Yai was appointed the general secretary. Then the nominations for other posts followed. Ugoh nominated Fabian for the financial secretary, whereas Abdullahi nominated Abdulrafyu for the treasurer. The whole process was so fast that Auta was hardly given a chance to oppose. Finally Maijirgi was nominated the president. Immediately after this, Igbo and Yoruba healers rushed out of
the place without listening to objection. It was a triumph for the Igbo and Yoruba alliance.

When Majirigi became the president, the meeting place of the Gamji Association was shifted from Kaduna-North to his residence in Kaduna-South (Trikaniya area). Over the course of subsequent meetings, Majirigi appears to have consolidated his position. By the beginning of September 1991, all the executive posts were filled by nomination. It is interesting that some extra posts were created and distributed to certain persons attending the meetings on the spot. Thus the number of posts was increased - there were patron, matron, security officer, assistant security officer and so forth. Delegates were sent to various local government areas to inform local healers of the establishment of the Gamji Association and process of registration of healers. Thus, healers from a distance began to attend the meetings. The numbers of these healers were multiplied in due course and, by November, meetings were attended by healers from all the local government areas in Kaduna State. The Gamji executives requested these local healers to fix the leadership of their areas. This, however, apparently caused conflicts among healers within the local government areas. At a meeting in the middle of October, for instance, two healers from Zaria quarrelled over the leadership in their area. The very fact that these local healers came all the way from their areas to attend the Gamji meeting had political implications. A quite generous donations often made by these healers were apparently aimed to impress the Gamji executive members to win the recognition of their leadership in the local areas. Nevertheless, by the end of October, their leadership problems appear to have been largely settled if temporarily. The next task was to carry out the registration of healers.
By September 1991, registration forms had already been printed. This was made possible by borrowing money from Ismaila. The main problem of registration was how to prevent fraud. Ismaila recommended that the committee of registration should be set up at both state and local levels to be responsible for registration. Ugoh, Abdulrafyu and some other executives were appointed as the members of the committee at the state level. Forms were to be stamped by the members of the committee at the state level before being filled by the individual healers, and then by the local level representatives were to stamp them again after being filled in. Healers were to pay 30 nairas for registration, and receive an ID card in return. The revenue realised through registration was to be divided between local branches of the Gamji Association, the headquarters and government. Distribution of registration forms was conducted throughout November. 100 copies were given to healers' representatives of each local government area, though the representatives of the Kaduna local government area - Kaduna Metropolis - were given 500 copies, since the area had the largest number of healers. While the distribution of the forms was smoothly conducted, the registration process itself was apparently fraught with considerable difficulties. By the end of December 1991, few local representatives had completed the registration of healers in their areas.

Meanwhile, suspicion arouse over the distribution of registration forms. When the forms were printed, 500 copies of the forms were at first handed to the president, Maijirgi. Then it was said that he gave the copies to the chairman of the Kaduna local government area, Maimachiji. In the process, 163 copies out of 500 went missing. Predictably, this made many suspect that the copies were stolen by somebody. Yoruba
healers were particularly angry about the matter, arguing that they would not conduct the registration until the missing copies were found. Some executives were also unhappy about the association’s bank account. They harboured a suspicion toward the financial secretary, Fabian, that he might be embezzling the association’s money. Discord grew, especially between Ugoh and Fabian. A Hausa healer, Rabo, even wrote petitions to the various ministries that the Gamji Association was involved in fraud. Thus the Gamji Association already began to suffer from the same old problem.

As for Haribarude, she never gave up her interest in leadership. She addressed a letter to the Ministry of Social Development, saying that since the ministry had registered her association after the 1990 election, it should not now recognise the Gamji Association. She also warned that she was ready to sue the ministry if necessary. A rumour spread that she had even hired a lawyer for this end. Thus, although her power was considerably weakened, she could still play an oppositional role for the Gamji Association. However, it appears to me that whether she could become a real threat to the Gamji Association or not depended on how she could make use of Lambo’s authority.

Thus, by the beginning of 1992, the Gamji Association was yet to have a solid foundation. The registration of healers made little progress. By this time, Ismaila was fed up with the association issue. He told me that he wanted to leave the matter as soon as possible, complaining, "These people are hopeless." It was a pity that I had to leave Kaduna at this point. I do not know whether the registration was ever completed or not. Even if it was, however, I believe that the organisation of the Gamji Association will remain precarious.
In this final section, I analyze the development process of formal herbalist associations in Kaduna, focusing on the four issues I addressed at the beginning of this chapter, namely: 1) the formation of the identities of traditional healers; 2) the structure of healers' organisations, especially, their bureaucratisation; 3) the development of a credential system, and 4) the configuration of social agencies (institutions and groups), that is, power relationships between these agencies and between the agencies and healers.

First of all, it is essential to note that the development of formal herbalist associations was not initiated by traditional healers in Kaduna themselves, but by an external agent, that is, an agent of a national herbalist association in Lagos. It was Aishatu Bubayero who laid down the structural foundations of the associations such as bureaucratic organisational principles, membership certificates, the recognition by governmental bodies and participation in health-related conferences. Her primary concern was to let traditional healers in Kaduna join national herbalist associations. Thus, in the beginning, the development of formal associations in Kaduna meant not only mobilisation of traditional healers and the bureaucratization of their organisations but also their integration into herbalist associations at a national level.

The role of the government has been significant, too. The governmental bodies in Kaduna State have helped healers to organise themselves according to a purportedly bureaucratic institutional framework and have granted official recognition to the associations. They have intermittently intervened in the leadership
problems of the associations and have staged an
election for them. It is certain that without the
efforts of a government officer, Ismaila, the Gamji
Association would not have come to being.

The development of formal associations has made
an impact on traditional healers in rural areas in
Kaduna State as well. Especially, the impact of the
presidential election and its campaign and the
formation of the Gamji Association, were far-reaching.
Healers in local governmental areas have been
incorporated into the herbalist associations in the
Kaduna city. Here the fact that Kaduna is a regional
centre is significant. The herbalist associations in
Kaduna have become agents of change for local healers,
just as the national associations have been to healers
in Kaduna.

Regarding the identities of traditional healers,
the development of formal associations has promoted
the growth of a common identity among healers. It is
conceivable that even in the past, traditional healers
had an idea that they belonged to the same
occupational category. But the development of formal
associations has undoubtedly heightened the awareness
of their common identity and has provided a label,
'Herbalists' with which to express their common
identity. The word, 'Herbalists' is felt to connote an
image of 'Medical' and 'Modern' practitioners
comparable to Western clinical doctors. Together with
'Native Doctors' and a Hausa term, 'Mai Magani
Gargajya', 'Herbalists' has become a popular term
among traditional healers for their occupational
identification.

However, the processes of the bureaucratization
of the healers' organisations and the homogenisation
of the identities of healers have turned out to be
quite limited in impact. The mere fact that a
bureaucratic organisational framework has been laid
down does not necessarily mean that the associations have actually functioned according to bureaucratic principles. After the deaths of the founders, Aishato and Maikoko, the activities of formal associations have been almost paralysed. The associations have suffered from a series of mismanagement crises and factionalisation. Such schisms are bound up with the competition for the presidency and other administrative posts, and the distribution of membership certificates.

It is arguable that the functions of the associations have been reduced virtually to the acquisition and the control of administrative posts and membership certificates. The primary concern of politically ambitious healers is with the prestige of presidency. Otherwise, they do not have clear opinions and policies concerning the objectives of herbalist associations. While a constitution does exist for each association, most of the members including the executive members simply do not know what is written in their constitution. For the majority of healers, formal associations are no more than organisations that grant them membership certificates - they do not actively participate in formal associations, except on occasions such as elections. The lack of common interests is also probably due to the mismanagement of formal associations and their leadership problems. It is, however, also attributable to the lack of concrete projects and goals within the associations. Apart from occasional attendance at health-related conferences, there have been few constructive projects in which the members of associations could be collectively engaged.

Likewise, the mere existence of membership certificates cannot be interpreted as the sign of the effective development of a credential system. Membership certificates are not official licences nor certificates of qualification - they are simply to
prove that healers belong to certain herbalist associations. However, they are utilised by healers for purposes beyond this official meaning. Thus, membership certificates have been utilised as a means of fraud and quick accumulation by some healers. The majority of healers make use of membership certificates for business and security purposes as if they are licenses or qualifications. To obtain membership certificates, healers do not have to know the conditions of membership nor take any examination - they simply purchase the certificates. In a way, any distinction between genuine certificates and forged ones is marginal since both of them can be purchased, even by persons who are not healers. In short, membership certificates are effectively spurious.

Such spuriousness is also recognised with the definition of traditional healers on which the rules of membership is supposed to be based. As noted above, the term, 'Herbalists' and its Hausa equivalent 'Mai Magani Gargajya', are now commonly used by healers. However, these terms are so ambiguous that they can allow the users to define themselves in a situational manner. As the issue over the cancellation of presidential election clearly shows, the government was powerless to identify 'Herbalists' (or 'Mai Magani Gargajya'), whereas healers could manipulate the definition of the category. For the government, prostitutes were not 'Herbalists', whereas healers insisted that they were yan bori who were authentic 'Herbalists'. One faction of healers identified yan tauri with 'Herbalists', whereas the other faction did not agree. The word, 'Herbalists' through which healers want to establish the modern and clinical image of their practice lacks a substantive content, too. As we have seen in Chapter IV, there is no evidence of the specialisation of healers towards medical practice in a Western sense - over half of the
problems they treat are social and economic matters of their clients such as improvement of business, employment, love affairs and protection. At one point, I even heard one of the executive members argue for the invitation of church healers to join herbalist associations in future. As noted previously (Chapter IV), the distinction between Koranic healers and herbalists is often blurred, too. Thus, the word, 'Herbalists' (and 'Mai Magani Gargajya') is conceptually elusive.

Moreover, the possession of a common label as an element of identity, has not significantly altered the various other aspects of healers' identities. The idea of 'Herbalists' has not cancelled the identity of, for instance, yan bori or of the members of a mamy wota society. Nor has the use of the word stopped healers from using their indigenous equivalent words such as boka, babalawo or debia, even if healers may prefer to be called otherwise. Furthermore, the development of formal associations has not only allowed the various existing groups to continue but also has activated them and has even promoted the establishment of at least one new group. As a result, a number of healers are in possession of more than one kind of healers' identity and of multiple memberships in different healers' organisations. It is obvious that such a multiplication of the memberships and identities of healers is by no means conducive to the development of the solidarity among the members of a formal association.

Thus, there is a considerable degree of fluidity and contestation in the bureaucratic structuring of the healers' associations. Related to this are the limited control of the national herbalist associations and government bodies over healers' activities in Kaduna and the internal division of these organisations. The intention of the national
associations was to integrate traditional healers into their organisations. As mentioned above, to a degree, such an integration did take place. In the process, an agent of the national association, Aishato, also introduced a bureaucratic institutional framework and membership certificates. However, the national associations are not united but divided between the NAMH led by Lambo and the NUHP by Sodupe. The schism at a national level was reflected among herbalist associations in Kaduna. More importantly, these national associations have not actively tried to intervene in the affairs of herbalist associations in Kaduna. After all, the president of the NAMH, Lambo, has never come to Kaduna.

A lack of commitment and internal division are also observable in the actions of the government in Kaduna. First of all, while the government played a significant role in the development of formal associations in Kaduna, its motivations and policy concerning traditional healers were by no means clear. A senior official of the Ministry of Health pointed out to me that, potentially, traditional healers could collaborate with clinical doctors and hospitals and participate in governmental health delivery projects. He was aware of WHO’s recommendation of the promotion of traditional healing in national health care services. However, my impression is that the ministry does not seem to have a concrete policy regarding traditional healing beyond this general view of the potential utility of traditional healing. At least it is certain that there is no urgent felt need for the government to promote the development of formal herbalist associations in Kaduna. The attitude of the government towards traditional healers has been therefore ad hoc - they have intervened into their affairs, in cases where they have been persuaded by healers to do so. Secondly, the government lacks
internal coordination. A lack of coordination was seen within and between ministries in Kaduna.

On the other hand, healers have never been passive receivers of the directives of these institutions. They have been actively and competitively attempting to persuade the agents of these institutions to support the development of their associations in Kaduna. Lobbying and demonstration were their usual strategies. The government officials must have been fed up with the dozens of petitions written by healers. By their frequent lobbying, they have established patron-client ties with some officials in ministries - such lobbying of course involves bribery. Divisions between ministries have been widened by these patron-client ties. Political contestants were also willing to make a long trip to Lagos in order to win over Lambo's support. In this sense, it is the healers who have manipulated the agents of the government and the national associations, not the other way around.

It appears to me that one of the important implications of the manipulation of the agencies of these institutions is that it inhibits the growth of bureaucratic culture in herbalist associations. When healers needed to elect their leaders and organise their groups along bureaucratic principles, they made use of the agents of national associations and the state ministries. It was Aishato, Ayodeji Lambo, Kaza and Ismaila who laid down a bureaucratic framework for the organisations - Ismaila virtually wrote the constitution for the Gamji Association, for instance. In other words, healers do not have to possess the knowledge required for the bureaucratic structuring of their associations but rather utilise the agencies of government bodies and national herbalist associations.

One may argue that herbalist associations are in fact based on the logic of indigenous organisational
principles, that is, the associations are the product of the articulation between indigenous and global cultural elements. I believe that, to some degree, such a synthesis has taken place. There are considerable similarities between formal associations and various other types of existing healers’ organisations as regards the management styles of these organisations. The procedures of the meetings of the formal associations is characterised by a rhetorical style of speech, an ethos of egalitarianism and an ethos of seniority - so is the procedure of the meetings of other types of healers’ organisations. Though limited, there is an element of reciprocity in the meetings of formal associations. It is conceivable that the administrative posts are interpreted as 'titles' rather than functionally specialised duties by the members of formal associations.

Yet, what is remarkable in this regard is that even these indigenous elements do not seem to have fully come into play. Except during the time of the founders, the normal activities of formal associations have virtually ceased to operate. The meetings have not been held regularly. When they were held, they tended to revolve around the issues of mismanagement and leadership. For the past five years or so, it has been a series of committees such as the 'Caretaker Committee' or the 'Ad Hoc Committee' that has occupied the central place in the activities of politically active healers - it looks as though the structure of the formal associations is permanently transitory. The point is that the malfunction of formal associations does not significantly affect the majority of healers as regards their need of mutual help and reciprocity, since they can seek such services from other types of healers organisations. The existence of these alternative organisations certainly reduces the significance of the formal associations.
Thus, traditional healers shuttle between national associations, ministries and various existing groups for their organisational needs. Such movement serves to limit synthesis of the elements derived from these institutions. So far, the history of formal herbalist associations has shown no evidence of substantial transfer of bureaucratic culture nor evidence of the full operation of indigenous organisational functions. The synthesis at this level is, therefore, unachieved.

Finally, it is clear that the development of formal herbalist associations has not been motivated by protest against the government. In Kaduna, the attitude of the state government is favourable, if not enthusiastic, toward the development of herbalist associations. Among traditional healers, there is no strong sense of grievance against the government in the latter's handling of traditional healers. Healers are more concerned with particular office holders in the government rather than the government as a collective entity. Moreover, patron-client relationships between these officials and politically ambitious healers are likely to prevent the growth of the conflict between healers and the government.

It might be argued that the development of formal healers associations should be looked at as a reaction of traditional healers to the mainline religions of Islam and Christianity in Kaduna. It is true that at an individual level, healers are aware of a negative image attached to traditional healers, as words such as baban juju or boka imply. Bori performances are said to be occasionally interrupted by members of fundamentalist Muslim groups such as Izala. However, popular views and uses of traditional healers and their practice involve a great deal of ambiguity, as we have seen in Chapter IV and V. People including religious fundamentalists do consult traditional
healers, even if they express negative views of traditional healers in public.

Ambiguity is also seen in traditional healers' own views of themselves. Except for Igbo healers, the majority of healers religiously identify themselves with Islam, even if they are aware that some of their practices are not compatible with Muslim religious doctrine. The meetings of most healers' groups begin with Islamic prayer and are often interrupted by one of the five prayers. Thus there is no evidence that traditional healers aim to challenge the authority of mainline religions. It seems more appropriate to consider the development of herbalist associations partially as an attempt by traditional healers to improve their public image by emphasising the 'medical' aspects of their practice. The primary concern of traditional healers with membership certificates can be interpreted in this perspective.

It should be added that the bori cult has been a part of this political process. A counter-hegemony aspect of the bori and the hauka cults in Niger has recently been emphasised by several scholars (Echard 1991, Masquelier 1993, Stoller 1995). Certainly, some degree of social and economic marginality is observable with bori members in Kaduna. Yet, as Maikoko's case exemplifies, the leaders can be quite wealthy. The bori organisation has also been internally divided by ambitious leaders. Generally, the political actions of these bori leaders are based on the individual pursuit of symbolic and material capital rather than aimed to challenge any political authority. The opposition between bori and mainline religious groups is not clear cut either. Unlike Kano where Islam has a dominant religious position, Kaduna accommodates a multitude of different religious groups and sects. Here religious differences are simply too great and fragmentary. Thus, I would argue that a
perspective of counter-hegemony is not applicable to the situation of the bori group in Kaduna.
In previous chapters, I have examined traditional medicine and its practitioners in Kaduna. The main points are, 1) traditional medicine is widely used by people regardless of their cultural background (with the exception of religious fundamentalists) - there is an even cultural flow in the use of traditional medicine; 2) the objectives of traditional medicine are diverse, including not only treatment of physical illness but also management of clients' various social and economic problems; 3) it mainly serves individual interests and is practised in a individualistic manner; 4) while there is ethnic and regional distinctiveness in the styles and forms of the practice, there is a common emphasis on the forms universally appealing to clients, including the practice of 'magic'; 5) it is highly commercialised and should be understood as a part of the informal economic activity in the city; 6) its practitioners can be best described as entrepreneurs whose main concern is monetary benefit; 7) many healers are not specialists in that the practice of healing forms merely a part of their diverse career, and often lack long term training in healing, and 8) while there is an attempt to regulate the practice of traditional medicine by the government, and healers are under the influence of national healers associations, the power of the government and the national associations is limited and appropriated by healers in Kaduna.

My argument is that these features are closely related to the overall social and cultural situation of the city which is marked by, 1) the flux of diverse
cultures which defies sustainable articulation of cultural elements; 2) the weakness of the bureaucratic control of the state and the strength of patron-client relationship; 3) the level of industrial growth outstripped by urban growth and the proliferation of diverse and yet temporary economic activities; 4) the high level of monetisation of social relationships, and 5) the relative autonomy of individuals and the plurality of social relationships and institutions in which they are involved.

In this chapter, though traditional medicine is an important issue, I will shift my main concern to the management and aetiological understanding of crises among people in Kaduna. While the previous chapters are focused on the significance of a particular cultural practice (traditional medicine) and its practitioners in this diverse social and cultural setting, the present chapter is concerned with the diverse cultural practice and social relationships which people use in the course of the management and understanding of their crisis situations.

I will explore 5 individual cases. Their problems range from mental illness to conflict between a landlord and tenants. However, here again, what underlies their diverse crisis situations and their management of them are the general social and cultural features of the city depicted above. I will examine the cases in relation to these general features at the end of the chapter.

**LOST IN DIVERSITY - The Case of Patricia**

In a Western clinical sense, Patricia's problem would be a psychiatric one. It was manifested with
auditory and visual hallucinations that could be easily diagnosed as schizophrenia. What is significant in her case, however, is, 1) given the plural medical cultural situation in Kaduna, she has gone through diverse and contradictory therapies and aetiological explanations; 2) nonetheless, with some of the therapies, she has in due course developed her identity, and 3) accordingly, the failure of the therapies has also meant a crisis in her sense of identity.

In this section, I will examine the history of Patricia’s therapy management. The account of the events that happened prior to my enquiry was largely based on Patricia’s own narrative. Despite her illness, her narrative was remarkably coherent. Nonetheless, it certainly contains her account of hallucinatory experiences. I will briefly attempt to distinguish between her account of external events and her account of hallucinatory experiences. It appears to me that both external events and hallucinations are very much part of her reality in the sense that they were certainly experienced by her.

Patricia Chinya Onuenz was born at Orulu village in Isikeues area in Imo State at the beginning of 1960s. She is an Igbo and her family are members of the Methodist Church. She came to Kaduna in 1974. Since then, she has been living with her family at Tudun Nupawa in the central part of the city. Her father farms on the outskirts of the city and spends considerable time commuting to and from his farm by train. Her mother and her elder brother are traders dealing with ingredients for soup such as crayfish and vegetables at the central market. Apart from her parents, living with her are her younger sister and her daughter who has been adopted by her mother.

The history of her sickness can be traced back to 1977 when she was a student on a typing course at the
Staff College. In the beginning, she experienced just fever and headache. She had the symptom continuously and also realised that she was losing weight in spite of her having a normal appetite. Then, she went to a college clinic. Apparently finding nothing particularly wrong, a doctor suggested to her that she needed more relaxation and advised her to find a boyfriend. She was given vitamin B complex. However, the medication was of no use and the symptoms continued. Following her mother’s instruction, she started to attend a Christ Apostolic Church at Kawo in Kaduna-North. The members of the church were mostly people from her home village. At the church, she was told that her sickness was caused by ‘bad people’ at home who were jealous of her, that is, she was under the spell of their sorcery. She attended the church for 2 years in total, and eventually became a prophetess - she was given two crosses for this. However, the church healing failed to cure her ailment completely.

In 1978, she started to have auditory and visual hallucinations. From time to time, she saw people dance around her and heard some unintelligible voices, and even tried to dance with these people. This made her father decide to take her back to their home village. According to her father, they consulted two traditional healers at the village. The first healer told them that she was an ogbanje, a person associated with a water spirit. However, since he did not believe in the existence of ogbanje, he took her to another healer. This healer attributed her problem to ‘poison’ - sorcery. She took his treatment, and it apparently worked; the symptoms disappeared after the treatment. According to her father, he had to pay ‘5000 nairas’ for this treatment. She remained at the village for a few months.

Between 1979 and 1986, it appears that she did not suffer from the affliction. In 1981, she was
employed by a consultancy company (Arewa Consultancy), and worked as a secretary for the company's chairperson. In 1984, she changed her job and started to work for a German construction company (Nocaco). Her peaceful life was, however, once again disturbed by a fit of the affliction. In May 1986, she was working for the company's exhibition at the International Trade Fair in Kaduna. While working at the exhibition site, she saw a 'handsome man' among the crowd and for no reason could not help laughing at him. During the lunch time, she went to a cafeteria and noticed the same man having lunch there. Suddenly another man came up to her and took her to the man who was then leaving the table. Grabbing her hand, he forced her to shake the man's hand, saying, "He is your husband!" After this incident, her co-workers began to keep their distance from her. Soon, she had to leave the job.

She was taken back to her home village. She consulted a female traditional healer who was serving Mamy Wota. According to the healer, she was an ogbanje and required to serve the spirit in order to get her problem solved. Patricia stayed at the healer's residence for 14 days and set up the symbol of Mamy Wota - a clay pot filled with water collected from the confluence of the River Imo and the River Anambra. A sacrificial ritual was performed. A large sum of money appears to have been paid for the healing. The healer told her not to go back to Kaduna but to live in the village and marry there. She remained in the village for about 6 months.

In 1987, she came back to Kaduna despite the healer's advice. She was employed as a typist at a construction company and then in a lawyer's office. Meanwhile, she started to go out with a man from Imo State, Mr. Ishikeku. In January 1988, they got married. In May, she gave birth to a child - a daughter.
However, in July the affliction recurred. It began at night. One night, she got up from bed and went to toilet. On her way back, she suddenly saw "lightning fall on the door and mark a cross there". She commanded her husband to recite Moses's ten commandments and continuously switched on and off the light in the room.

The following day, she was taken to a psychiatric hospital at Barnawa in Kaduna-South, and admitted for two weeks. The medication given her, however, only worsened her condition. She sometimes could not prevent herself singing and dancing inside the ward. Unable to cure her ailments, all that the clinicians could do was to give her a Bible. She was also visited by a church minister. Eventually she was advised to go and seek healing from a church and was discharged from the hospital. She then chose to attend the United Church of Christ on Enugu road. The seven prophets of the church conducted healing for her, praying and anointing olive oil on her eyes and mouth. According to them, her problem was attributed to the fact that she had lost the two crosses which she had been given when she had become a 'prophetess' of the Christ Apostolic Church - she is still concerned about the loss of the two crosses.

In 1989, she attended the Living Faith Church in the Barnawa area. Her attendance at the church came about almost by coincidence. One day, while waiting for a taxi on the street, she was given a lift by a man whom she had never met before. The driver introduced himself as the pastor of the Living Faith Church and asked her if she had any problem. Instead of taking her back home, he took her to his residence, where he strongly persuaded her to attend his church. So she joined the church and attended its service. However, about 8 months later, she stopped going to the church, because she was uncomfortable with the way women
dressed themselves in the service - she found it too sumptuous. In the meantime, she had become divorced from her husband. While she was not afflicted with the sickness, she did not have a job and concentrated on looking after her child.

However, this lull did not last long. In 1990, she was once again troubled by her mental illness manifested this time by wander-lust. One day, she suddenly went out of her house and wandered around without any particular reason. While walking along the express way in the Bakin Ruwa area, she saw a young man in white dress and talked to him. He was a Yoruba man and a member of the Celestial Church. Listening to her problem, he gave her 10 nairas and took her to his church in Ungwan Mission. At the church, some members persuaded her to undergo healing in their church. According to them, her problem was caused by a witch or a wizard in her home village, and in order to heal her, she had to stay at the church for three months and practise fasting, prayer and other rituals. She ended up staying at the church for a month, doing these rituals. She was then allowed to go back home, even though she was required to complete three months fasting. Her family spent 1,000 nairas for the healing service and materials used such as candles and coconuts. By this time, her abnormal behaviour had disappeared, and she was able to go back to work - working as a typist for a bakery (Viva Bakery).

Despite the fact that most of the members of the Celestial Church were Yoruba and she hardly understood the language used in the service, she liked the church best of all the churches she had attended, and continued attending services. She was granted the status of ‘prophetess’, because of her ability to go into a trance and speak in tongues, even though no one was able to interpret her words. She was also good at healing children. Meanwhile, she began to go out with
the Yoruba man who had introduced her to the church.

By May 1991, her situation was calm. Although she changed jobs twice, it does not seem to have been related to mental problems. However, it was unfortunate that her next disturbance was triggered by a series of conflicts in which she got involved at her work and at her church. In May, she was employed by a consultancy company (Apen Nigeria), again working as a typist for the managing director. The general manager, an Igbo man from Imo State, fancied her and asked her to sleep with him, but she refused the request. Being upset by her refusal, he started to harass her at work. While the managing director was away from Kaduna, he and the financial secretary tried to drive her away from the office by abusing her. Here the fact that the general manager was the pastor of Grace Methodist Church (one of Born Again churches?) appears to have reinforced his abuse toward her - he spoke ill of the Celestial Church and condemned her for attending it. Eventually, after a serious quarrel, she stormed out of the office and went straight to the church. She decided to spend a night at the church.

Around midnight, she woke up from her sleep and went to toilet. On her way back, she suddenly felt that she had to go to the cross at the altar and pray. During her prayer, she heard two people quarrelling outside. So she stopped praying and went to see what was going on. There she saw another Igbo member of the church and a security guard quarrelling. It was so loud that other members staying at the church also came out to check. Eventually, the leader of the church ordered those involved in the quarrel to get out of the church. Unfortunately, Patricia was mistaken for one of the trouble makers and had to leave the church as well. After this, all she remembers is that she found herself on the hill of Kabara Doki and prayed there throughout the night.
While she was praying, she saw the moon come up and "talk to her". Then the moon revealed to her that she was going to have a baby. On the following day, she went down the hill and hung around a nearby church. Around noon, she was finally found by her elder brother and taken home.

She then was taken to a traditional healer at Badarawa in Kaduna-North. The healer was an Igbo woman from Imo State serving Mamy Wota. However, her healing was of little help. She was then referred to another specialist dealing with Mamy Wota problems, Mr. Ugoh in Kakuri in Kaduna-South. According to Mr. Ugoh, her problem was caused by her having a spiritual husband, who was Mamy Wota. She was admitted into Mr. Ugoh's house and stayed there for about a month. He conducted a series of sacrificial rituals that involved the offering of various items including a sheep, a goat, rice, eggs and kola nuts. Her face was painted with red chalk for a fortnight and with white chalk for another fortnight. Mr. Ugoh also told her that her father should go back to his home village and offer a sacrifice to his ancestors, because her affliction was attributed not only to Mamy Wota but to her father's ancestors. According to him, her father's ancestors were angry with her father, as he neglected them owing to his Christian faith. Mr. Ugoh also told her to join his Mamy Wota society. All in all, "about 5,000 nairas" was paid for Mr. Ugoh's healing.

After being discharged, she started attending Friday Meetings of the Mamy Wota society and regularly consulted Mr. Ugoh. She looked quite normal and healthy. Indeed, during six months of my research, she did not show signs of such a dramatic abnormality as she had before. However, her stable condition appears to have been fragile as I will show in what follows.

Between the middle of July and the middle of
September, her major concern was about her pregnancy. She had conceived a child by the Yoruba man who introduced her to the Celestial Church. While he promised her marriage, he wanted her to have an abortion. On the other hand, she was reluctant to have an abortion, even though she was not happy about him. Her family, especially her elder brother, were against their marriage. Mr. Ugoh also opposed their marriage and advised her to have an abortion. During the middle of September, she finally went to a clinic and aborted the child. The operation cost 200 nairas and was paid for by the Yoruba man.

Since then, she became preoccupied with two issues: securing a job and finding a marital partner. From September to November, she got temporary jobs. At first, she was employed as a saleswoman by a private technical school. Her work was to distribute pamphlets on the streets. But the pay was so low that she quit within a month. She then worked for a few days as a typist for the Nigerian Electoral Commission. She also applied for a secretarial job with two companies. As to marriage, her relation with the Yoruba man had come to an end by November. According to her, the reason was that the man found out that she was consulting a traditional healer and was associated with Mamy Wota; as she put it, "He feared me!"

Meanwhile, she was approached by two boys at the Mamy Wota society, even though she was not attracted to them. She was so concerned about the issue that her consultation with Mr. Ugoh was inevitably concentrated on these points. On December 3, for instance, she consulted him about two dreams she had had. In the first dream, she was running with a child in her arms in a forest, chased by people. While she was running, the child got hit on the head by a branch, and developed a lump on his head. She had then woken up from the dream. In the second dream, on her way to
some place, she was confronted by an old woman. She reached a place where a party was going on and people were eating yams. Although she was offered a yam, she refused to eat it. According to Mr. Ugoh, the first dream was a caution that she should be careful about having affairs with boys. His interpretation of the second dream was that a yam in itself was a good sign, whereas eating a yam was rather bad. He told her that she would certainly get a good job, but it would be the following year.

Although Patricia frequently consulted Mr. Ugoh, and consistently attended Friday Meetings, by November she did not feel comfortable with being associated with a Mamy Wota society. Mr. Ugoh advised her to be a traditional healer and practise healing as a business. He promised her that he would provide her with a table for the ritual in her room. She was certainly interested in starting a healing business on a part time basis in order to supplement her income. But she thought that her healing ought to be based on Christian healing, not Mamy Wota healing. She wanted to set up an "Altar" in her room, and practise Christian healing, as she had done at the Celestial Church. In other words, her shift from Christian healing to Mamy Wota healing in her therapy could not really lead to the shift in her identity from a Christian to a member of a Mamy Wota society. By the end of the year, her visits to Mr. Ugoh had become less frequent, and she stopped attending Friday Meetings. On the other hand, despite Mr. Ugoh's warning that she should not go to a spiritual church, she started to attend a service of a Born Again church.

Around the turn of the year, she was courted by another man. He was an Igbo man from Imo State, working at the Kaduna State Sports Council in Zaria. She met this man through her friend who was working at the same place. He travelled from Zaria to Kaduna to
see her every weekend. He told her that he was serious about marriage. Although she was a little wary of accepting his proposal, she looked happy during this time.

However, the seed of dissonance was present in their relationship. There was a possibility that her association with a Mamy Wota society could jeopardize relations with her suitor, as had happened before. Particularly, given the fact that her suitor was a member of the Holy Sabbath Church (one of the Aladura churches hostile to traditional medicine), it could prove disastrous to their relationship if her secret were disclosed. The break-up of their relationship might result in the recurrence of her illness.

In the course of her therapy management, Patricia encountered a wide range of diagnoses and treatments. Thus, she was told that her illness was caused by: insufficient relaxation, sorcery, the loss of two crosses, witchcraft, Mamy Wota and ancestral spirits. In search of a cure, she resorted to: a college clinic and a psychiatric hospital, healing from at least 5 different churches, traditional medicine including the practices of at least 3 Mamy Wota specialists. Yet, it has to be pointed out that the range of therapies and aetiological explanations was more or less confined within her cultural affiliations. Thus she tried the healing practices of a number of churches - but never Islamic healing. She tried Mamy Wota specialists and Igbo healers at her home village - but never traditional healers who were not Igbo.

However, it is also significant that she and her family did not know much about the therapies and aetiological ideas she took prior to her undergoing therapy. Thus she was unfamiliar with healing at Aladura churches before the onset of her illness. Initially, her father did not agree to consulting a Mamy Wota specialist. It was during the course of her
therapy management that Patricia and her family became familiar with these therapies and aetiological ideas. Given their encounter with all the diverse therapies and aetiologies of which they had had only a slight idea, it must have been very difficult for them to manage these therapies in a systematic way. Coupled with the failure of these therapies, this situation was conducive to the development of a trial-and-error attitude to her therapy management. Thus, her therapy management did not follow a single coherent logic—it was a context dependent 'journey' around various therapies and healers. It is also significant to note that her tour around various therapies were financially sustained by her family. Despite the fact that her family was not well off, they managed to raise money for her medical expenses which were often quite considerable.

However, such a movement between diverse therapies was bound to cause a significant problem with her sense of identity, because in her case, the therapy management was inseparable from the construction of her identity. Most of the therapies she took required her to accept the identity associated with the therapies, that is, to join the groups providing therapy and even abstain from taking other therapies. Thus, frequent movement between these therapies meant that she was constantly required to change her identity. However, the shift in her therapies did not really keep in step with the shift of her identity. While the failure of Christian healing led her to Mamy Wota societies, she still wanted to identify herself as a Christian prophetess, not ogbanje. Thus, there is a situation where she wants to identify herself with a therapy that failed to heal her illness, whereas she does not want to be identified with a therapy that healed her illness at least temporarily. In other words, there is a
contradiction between the outcome of the therapies she received and the construction of her identity. It appears to me that such a contradiction tends to render her therapy management to be unstable and her identities to be precarious. At the end of my research, I asked her if she ever believed that Mamy Wota had caused her illness. She replied, "I don't know....Maybe.... Maybe, Mamy Wota is the one, as my sickness stopped after Dr.Ugoh's treatment.... but...." Such uncertainties may increase unless she finds a way to ensure her therapy and identity converge.

PAINS OF HOPE AND DESPAIR - The Case of Mr.Barki

Patricia's case shows how on the one hand, one may develop an identity via a therapy, whereas on the other hand, such an identity is bound to be precarious in a situation of pluralistic medical culture. In Mr.Barki's case, though his social identity has certainly affected his choice of therapies, his therapy management is overwhelmingly based on his concern with the immediate and concrete efficacy of the therapy - he is not so much concerned with aetiological explanations and styles of healing, so long as information on efficacy is attached to them.

James Barki is a Tiv man from Gboko area in Eastern part of Benue State. He was in his late 30s or early 40s during my research, and worked in the welfare section of a textile company - United Textile Ltd.(UNTL). He has a wife and 6 children, though he has been living alone at Nasarawa in Kaduna-South, as they have gone back to their home village, since the advent of his illness. He is a Christian and attends Sunday mass at the Church of Christ.

His affliction is a swelling of the abdomen. His
abdomen is massively enlarged with its left side being hard. It sometimes feels painful and sometimes itchy. In his own words; "I feel my belly is tied with a rope." He can not eat a large quantity of food nor any spicy or salty food. He also has to abstain from drinking alcohol and soft drinks. He has difficulties in sleeping and sometimes even in breathing. Swelling occasionally develops in his legs as well. He has been suffering from this sickness since 1989.

The problem started on 21 August in 1989. It was the day when he came back to Kaduna from his home village at the end of his casual leave. At night, he felt weak and feverish, and had a pain on the left side of his belly. Then, he found his abdomen had swelled up. Next morning, he went to a company clinic at UNTL. Having found his case beyond its range of care, the clinic referred him to the Kakuri General Hospital run by Kaduna State. He was immediately admitted at the hospital and given medical examinations. While he was at first told that his sickness was "Hernia", the diagnosis was later changed to "Ascites". He stayed at the hospital for a month and half, and then was referred to a private clinic in Tudun Wada for a surgical operation (I was not able to ascertain what kind of operation it was). 3 days after the operation (at the beginning of October), he was discharged from the clinic and was given medication for 4 weeks. For the operation, 300 nairas was paid by his company. In Kaduna, many medium- and large-scale companies pay a medical allowance to their workers. In his case, a part of the medical costs for treatment at hospitals and private clinics and for the prescribed medicines was borne by the company, even though this was not the case of expenses incurred for any other therapies.

Despite the operation and medication, however, the swelling did not diminish. In November, he
consulted a Yoruba female traditional healer, suggested by his Yoruba supervisor at his work place. The healer gave him a medicinal black soap and liquid medicine without any diagnosis. Following her instruction, he washed his body with the soap and drunk the herbal liquid. He visited her 3 times and paid 250 nairas for the medication. However, the treatment was of no avail. In January 1990, he went to Ahmadu Bello University Teaching Hospital (henceforth referred to as ABUTH) in Kaduna-North. After various medical examinations, he was again told that he was suffering from "Ascites". He was given medicine, for which his company paid 635 nairas. However, there was little improvement.

Then he decided to take a sick leave and went back to his home village in April 1990. At first, he went to a Tiv traditional healer living at Apir near Makurdi, suggested by one of his Tiv friends at UNTL. The healer, who was dressed strangely and spoke the Idoma language, told him that there was something in his belly. He prescribed herbal medicine and instructed him to use it 3 times a day. Having found no sign of change, he then consulted a Tiv traditional healer at his own village. The healer put some ointment on his belly and rubbed it there. The 300 nairas in fees were, however, wasted.

He came back to Kaduna in May. When he was about to resume work, he was told by the company that his job had now been changed from the maintenance to the welfare section. He thinks that the change was due to the company's consideration for his ill-health - the new section requires much lighter work, namely watering flowers in the company yard. Then he revisited ABUTH. He went through another set of medical examinations and received medicine. While he was taking the hospital medication, however, he also pursued church healing. His Yoruba friend at his work
place took him to a Celestial Church in Kakuri. The church, whose members were mostly Yoruba, promised him that it would cure the sickness. For 2 weeks, he attended its service in the evening. The members prayed for him and he practised 3 days fasting. However, no improvement was made. He was also encouraged to attend another church by his assistant supervisor at his work place who was again a Yoruba man. The church situated near ABUTH was apparently again one of the Aladura churches, although he does not remember the name. He attended their service only once. In the service, the members, all of whom appeared to be Yoruba, prayed for him throughout the night. However, this also failed to cure his illness.

From June to July, he took an annual leave. He went to ABUTH again and was given a medical prescription based on the results of a medical test he had taken a month earlier. For 3 months, he concentrated on using the hospital medication without trying any other therapy. He resumed work in August. In October, however, he decided to attend Reinhart Bonke’s revival service. Reinhart Bonke is a German evangelist who was touring African countries. He came to Kaduna and held a series of revival services at Murutala Stadium in the evening, which attracted tens of thousands of people. When the evangelist started the service, the rumour quickly spread that he miraculously cured a blind person and made a person with a wheel chair stand up. Mr. Barki went to the service every night and sought healing, even though he realised that a "miracle" would not happen for him. He could do nothing but take another sick leave and returned to his home village again. He stayed there until December, and consulted a Tiv traditional healer. The herbal medicine the healer administered was, however, of little use.

In January 1991, he came back to Kaduna and
resumed work. He visited ABUTH again and was given the same sort of medicine. He continued to take the hospital medication until May. In May, however, he consulted a Tiv traditional healer at Nasarawa in Kaduna. The healer, Mr. Sevav, was a newcomer to Kaduna. When he started his healing business in Nasarawa, he attracted a number of patients, and Mr. Barki was one of them. He gave Mr. Barki 4 different kinds of medicine and instructed him to take one medicine with kanwa (potash), two medicines with cold water and one medicine with hot water. The charge was 300 nairas. Without finding any immediate improvement, however, Mr. Barki discontinued the medication.

In June, he took annual leave and went back to his home village once again. On July 19, he was admitted to St. Thomas Hospital in Gboko. He was given a treatment for "Ascites" in which water was tapped from his abdomen. The tapping was done 4 times, and each time 1 litre of water was taken out. He was discharged from the hospital on 23 June.

In August, he came back to Kaduna. However, around this time, the symptom got worse. Swelling also occurred on his legs. He had to take further sick leave from the company. He went to a private clinic, PIAT clinic, at Nasarawa, and got water tapped out of his belly again. He was also told to apply Menthol Balm - a kind of ointment manufactured by PZ in Nigeria. After the treatment which cost him 60 nairas, he felt better and recovered his appetite, if temporarily. In September, his Mada friend brought a Mada traditional healer to him. The healer prescribed medicine for 6 days and charged 105 nairas. No improvement was, however, made. On 16 September, he resumed work. By this time, he was still taking medicine prescribed by ABUTH as well as St. Thomas Hospital, which means that he must have taken more than 3 different sets of medicine at some point at the
beginning of September. He was also frequented by evangelists of the Deeper Life Bible Church - one of the Born Again Churches. They came to his rooms and prayed for him. Though they tried to persuade him to come to their church, he did not attend their services.

By the beginning of November, he had finished all the hospital medicine. While he did not have a strong pain in his abdomen, he still felt as if the abdomen was tied with a rope. On 26 November, he went to ABUTH once again, this time being accompanied by me. We left Nasarawa as early as 7 o'clock in the morning and reached the hospital around 8 o'clock. We were not too late and got a position in the middle of the queue waiting on the bench outside a treatment room. Nevertheless, the people who came behind us were called before, and we had to wait for 4 hours to see a doctor. The reason for this, Mr. Barki believed, was that he had not turned up for his previous appointment - he was certainly accused of having not kept the appointment by a nurse who checked his file. Finally, they let us into the room. The doctor was a woman who was about 30 years old and was most probably from the Eastern region of Nigeria. The following is the conversation between the doctor and Mr. Barki.

Doctor: How are you feeling?
Mr. Barki: Stomach is swollen up and hard and a little painful.
Doctor: How about other pain?
Mr. Barki: Legs are also swollen up, and were painful before.
Doctor: Do you have any difficulty in breathing? Do you drink or smoke?
Mr. Barki: No, I don't. I don't smoke. I don't drink now. I stopped drinking.
Doctor: What about your belly? Isn't it going
down?

Mr. Barki: It's going down a little, but still sometime painful.

Doctor: Does pain become worse sometime? Do you have fever?

Mr. Barki: Yes. When I eat, it sometimes becomes worse.

She directed him to a bed behind a screen and examined his abdomen. Then she wrote a report about his case, and told him to take 3 kinds of medical tests. She asked him since when he had stopped taking the medicine prescribed at the Teaching Hospital, and then said that she would prescribe the same medicine as before and that he was to keep taking it until the next appointment. After the consultation, the doctor told me that a chronic liver dysfunction could be the cause of the swelling, even though it was speculative at this stage, as the previous investigation had not confirmed it. The previous medication was based on the assumption that the sickness was related to liver dysfunction. She said that while a full investigation was required, she would give him the same medicine and see how it worked. Mr. Barki was given the next appointment on February 4, in more than two months time.

On 4 February, Mr. Barki came back to ABUTH (I accompanied him again). He was attended by the same doctor. She checked his pulse, blood pressure, breathing and heart beat. She let him lie down on a bed and examined his abdomen. The examination was, however, interrupted by visitors, final-year medical students doing practicals. The doctor told them to analyze the symptom and allowed them to examine his abdomen. Then she asked a few questions about the possible causes of the swelling. For a while, he looked as if he was a guinea pig.
Apparently, the result of the medical tests and the unchanged symptoms despite the medication led the doctor to one conclusion - it was not liver depression but tuberculosis that had caused the swelling. Her assumption was that TB infection had spread down to his heart and was affecting its function, which in turn caused blockage in the passage of water. She prescribed medication for TB and told him to take further medical tests. Then he had to wait for another 4 hours to have an x-ray and blood test, and then had to go to a private hospital to undergo an ECG (electrocardiogram) examination. The tests at the Teaching Hospital alone cost him 187 nairas.

One of the notable features of his quest for therapy is his relatively weak concern, when choosing a therapy, to identify the causes of his sickness or to differentiate between therapies. He went to a hospital not because he attributed the swelling to a certain causal agent. Nor, because he was concerned about witchcraft, did he consult a traditional healer. His therapy management was based primarily on the information about the method's efficacy. He has tried various therapies because his friends and co-workers told him that the therapies were effective. He tried a revival ritual because of rumours of its miraculous healing. If ever a story of successful healing accompanies a therapy, he has tried his luck with it.

However, this does not mean that considerations over types of healing and causal agents is completely lacking in his quest for therapies. In fact, he has a rather adamant belief in the non-existence of witches and spiritual beings, which is quite unusual among my informants. He said, "Tsav (witchcraft), Akombo, I don't believe all these." His friends and relatives both at home and in Kaduna apparently suggested that his problem might have been caused by such evil forces. For instance, he was once told at home that
his problem was caused by his mother's curse, which was uttered against him when she was still alive. One of his friends in Kaduna attributed his affliction to the witchcraft of those jealous of him at home. However, he does not seem to have ever listened to them. He said to me, "I don't fear anything. At home I can walk anywhere, even places where people don’t go." His non-belief in spiritual beings appears to be related to his Christian faith. He said, "Anything that happens is the will of the God." According to him, there used to be lots of Akombo practice in Gboko area, but they were reduced thanks to the activities of the churches. "I am happy that my children do not know Tsav.», he said. It is certain that such a Christian identity has affected the course of his therapy management in that it has limited the range of therapies he has employed. Thus, although he did consult traditional healers, he does not seem to have practised sacrificial rituals which are often a prerequisite for Akombo healing. Also, he does not seem to have consulted Koranic healers.

While his religious identity has played a significant role in his therapy management, the range of the therapies he has taken is still impressive. For 27 months from 21 August 1989 to 26 November 1991, he tried no less than 16 different healers and hospitals and changed healers every two months on average. He could not sustain a particular healing method for a long time, trying one method after another. He has applied more than one therapy simultaneously – he consulted a traditional healer and then a church healer while he was still taking hospital medicine. The point is that, like Patricia, he does not exactly know what kind of healers and therapies are available to him – he encounters therapies in the course of his search for healing, being told about them by his friends and co-workers. There are always alternative
healers and therapies of which he has no knowledge. Given the fact that most healers and therapies, except tapping as a treatment, failed to produce immediate efficacy, he is naturally tempted to move on to new healers and therapies. As a result, his practice of any particular therapy is unsustainable. The problem is that if the efficacy of healing is partially derived from trust in that healing, as the studies of placebo effect shows, such a movement between therapies may undermine the efficacy of each therapy. What is also significant is the impact of repeated failure on the knowledge he has of illness and therapies he has employed. It appears to me that the more he fails, the less important the methods of healing become, and the more important the success stories of specific healers and therapies become. Since such stories are in a state of flux and freely flows in Kaduna, his therapy management may be increasingly a matter of running around after these stories. Thus, the pains of hope and despair continue with him.

BUSINESS WITHOUT TRUST - The Case of Alhaji Sadiq

Alhaji Sadiq is an entrepreneur in the literal sense of the word. He plans, invests in and carries out various business ventures. He undertakes enterprises in spite of the high risk of failure involved. I met this intelligent, experienced and proud gentleman at Mr.Ishola’s residence. He is a graduate of an university in the USA and speaks Hausa, Yoruba and English fluently. He is experienced, having lived outside Nigeria and travelled in many countries, and he has also had various careers including that of army officer and journalist. He is proud, travelling around in his Peugeot 505 and wearing a simple but expensive
riga (a gown) in spite of his declining economic condition. The way he speaks and the knowledge he has would easily convince people that he is a 'big man'. Indeed, he was a successful businessman who handled business worth of an annual profit of over a million nairas. However, for the past 10 years, he has not been able to run his business affairs successfully. Accordingly, his material prosperity has declined. He said, "When I came to Kaduna (1989), I had 100,000 nairas in my pocket. By September (in that year) I have only 20,000. Now (1991) I had only 350 in my pocket. I invested most of the money...". He used to live at his own house in Lagos, but now he is living with his wife at her family's house in Kaduna. It is in this situation that he started to consult Mr.Ishola. In the beginning, he consulted Mr.Ishola about his business slump in general, while later the consultation revolved around a particular business problem he had to face. In this case study, I explore the management and aetiological explanation of his business crises, especially the problem he had from 1991 to 1992. I will begin by sketching his upbringing which appears to me to have had an effect on his later career.

Muhammadu Abubakar Sadiq was born in Kaduna in 1948. His father's residence was located in the central part of the city. The neighbourhood was ethnically heterogeneous with a substantial population of Yoruba speaking people. His father, a Jukun man, was a senior nurse, and his mother, a Hausa woman, was the father's second wife, though she died when Mr.Sadiq was a little boy. He was the fifth child of his father and the only child of his mother. His family communicated with each other in Hausa, and as far as he remembers, his father never spoke Jukun language. This might have affected his ethnic identity. On the one hand, Mr.Sadiq identifies himself
primarily with Hausa. On the other hand, he respects the fact that he has the blood of the Jukun as he believes that the Jukun were the people who once conquered Hausa land. His father appears to have been acquainted with the Western individualistic lifestyle. His father did not seclude his wives and was of the opinion that children should pursue their own lives. He emphasised what Islam and Christianity have in common. Mr. Sadiq was his favourite child. However, young Sadiq was brought up at his father's compound for just six years. When he was six years old, he was sent to an Englishman, Dr. Jones.

Dr. Jones was a medical doctor working at a hospital in Kaduna. Mr. Sadiq worked for him as a house boy and lived with him for more than six years. He cared for Mr. Sadiq and taught him English, cookery and many other things. While Mr. Sadiq later left his house to attend a boarding school, the St. John's Secondary School (now Rimi College), he still spent most of the weekends with Dr. Jones. His grades were good throughout his school days. He wanted to be a medical doctor at that time. After graduation, following Dr. Jones's advice, he took an examination for the Ford Foundation scholarship. Meanwhile, however, the civil war broke out. In 1967 he joined the army and was posted to Enugu base in Eastern Nigeria. He took part in a series of fierce battles at the front line. However, he was fortunate enough to receive a letter of admission for the scholarship and managed to get himself back to Kaduna. In 1967, he flew to the USA with two other students. He was admitted to the Denver University in Colorado state where he studied mass communication and journalism. His university life was enjoyable, and he got on with white students rather than black students. After graduation, he undertook a practical training course in journalism and worked on the New York Times in Chicago.
In 1971, Mr. Sadiq flew back to Nigeria. He started to work for a newspaper company, New Nigerian. As an investigative journalist, he scooped two scandals which involved high government officials. However, one of his articles entitled "Irresponsibility at its highest" caused friction with the governor of Kano state and eventually led to his arrest. Without the support of his company which was owned by all the Northern States, he had to resign from the company only three months later.

In 1972, he decided to move to Lagos. He resided in the Sulu Rere area and, through a personal contact, he was employed by an Italian construction company, DTV. Soon he was sent to a town called Quaseta near Tolino in Italy for nine months' training. Returning to Nigeria, he was appointed supervisor for construction work. As a supervisor, he was popular among the workers and actively involved in the trade union. In 1973, he was elected as chairman of the union. In 1974, however, he set up his own business, while working for the company. It was an agency for two foreign companies: Eucatex in Brazil dealing with sound proofing boards and Simplex in Taiwan, a button company. His gain was 5% of the price of the products of these companies. While he operated the business with five members of staff, his work schedule became extremely tight. In 1979, he finally left the construction company and began to concentrate on his own business. By that time, he had expanded his business into transport, operating taxies and trucks. However, in 1980, things went wrong. His vehicles for the transport business were involved in a series of accidents. Then he lost the indentorship of Eucatex, due to the Nigerian government indigenisation policy. To make matters worse, the Taiwanese button company, Simplex, declared bankrupt. He was therefore forced to close down his business.
Yet such adversity did not affect his business ventures. In the same year, he set up another business, this time, a public-private consultancy company. The business was to link public sector (Federal and State ministries) and private sector (private companies and individual business people) for the implementation of public projects. He charged commission on the gain accrued to private companies. However, his role appears to have gone beyond that of a mere convenor - apparently, he often acted as a planner and manager of projects. From 1980 to 1981, he was involved in a project from which he could have gained an annual profit of over a million nairas. The project was to supply fuel by oil tankers to power stations situated along creeks on the coast. He was approached for consultation by a businessman, J.C.Emeka, who was also a member of the House of Assembly. Then he introduced Mr.Emeka to the general manager of the Nigerian Electric Power Authority (NEPA) with whom he was acquainted, and laid out the blueprint for the project. In due course, Mr.Emeka offered him a partnership which guaranteed him 30% of the total profit. Then together they established a company called CoCo Holding Ltd. They travelled to the UK, Holland and Germany to obtain vessels. Five tankers - three at Rotterdam and two at Liverpool - were purchased by Mr.Emeka. It looked as though everything was under control. However, faced with the actual payment of Mr.Sadiq's share, Mr.Emeka suddenly changed his mind and insisted that Mr.Sadiq should be paid a salary, not a share of the profit. Mr.Sadiq was outraged by such a change. He refused this new offer and hinted at the possibility of legal action against Mr.Emeka. Eventually he abandoned the whole project and made it impossible for Mr.Emeka to renew a contract with NEPA by explaining the situation to the general manager. In his view, Mr.Emeka realised that
Mr. Sadiq could set up his own company and become a rival unless he was tied down to the company as an employee.

In 1983, Mr. Sadiq left Lagos for Kano to engage himself in a bore-hole project in rural areas in Kano state. He was offered business by the Federal Ministry of Water Resources. Lacking initial capital for the project, he proposed a business partnership to Alhaji Idris, a businessman who owned a bus company. The share of profit was agreed at 60% for Mr. Idris and 40% for Mr. Sadiq. Having sorted out the problem of the initial capital, equipment and labour, Mr. Sadiq started to implement the project. Yet, again, the project was destined to collapse. After four holes out of ten had been constructed, they realised that the ministry was not prepared to pay for the construction of the rest of the bore-holes. In addition, the relationship between Mr. Sadiq and Mr. Idris soon fell apart. Mr. Idris accused Mr. Sadiq of mismanagement, whereas Mr. Sadiq could not tolerate such a personal accusation. Without much gain, Mr. Sadiq had to give up the business.

In 1989, he came finally to Kaduna and settled himself in his wife's family's compound. He decided to move there, as he got a chance to do business in Bauchi State and found it convenient to pursue the business from Kaduna. The business was the supply of laboratory equipment to a hospital run by the Ministry of Health in Bauchi State. As he could obtain the equipment from his business partners in London, he thought that he had a good chance to get the contract from the ministry. However, once again, his plan was shattered. While he struggled for over a year to get the contract, the project was eventually suspended by the ministry. It is under these circumstances that he started to consult Mr. Ishola.

Before proceeding to further examination of his
business problems, I should like to one of the significant aspects of his cultural background. His cultural background is marked by diversity. He was brought up by a Muslim Jukun father acquainted with Western culture and a Hausa step—mother in an ethnically heterogeneous neighbourhood. During school days, Dr. Jones, a British medical doctor, was undoubtedly his mentor. He was educated at a British missionary school in Kaduna and then at university in the USA where he lived for five years. In Lagos, he worked for an Italian construction company, which sent him to Italy for nine months’ training. Needless to say, Yoruba was the most influential ethnic culture in Lagos. He has adopted the language and in part Yoruba customs; for instance, he can greet in the Yoruba manner. His business partners, however, include people of various nationalities and ethnic origins such as Taiwanese, Brazilian, British, and Igbo. Occupationally, too, his career has been diverse: army officer, journalist, company employee, indentor, transporter, public-private business consultant and even interior decorator for a short period. Within a business consultancy, he handled various services and merchandise such as the transport of a petro-product and construction of bore-holes. Geographically, he has lived at Kaduna, Denver, Chicago, Quaseta, Lagos and Kano, and has travelled around many countries including Saudi Arabia. In this regard, while Islam and the culture of Northern Nigeria might have the most pervasive influence on his life, he can be considered cosmopolitan, acculturated by a multitude of ethnic, national and occupational cultures.

Mr. Sadiq started to consult Mr. Ishola in the middle of January 1991. It was his wife, Hajiya, who introduced him to Mr. Ishola. Hajiya had been Mr. Ishola’s client and was acquainted with him through her ex-husband who was a fellow of Mr. Ishola. She
calls Mr. Ishola 'Brother Ishola'. Initially, Mr. Sadiq consulted Mr. Ishola about his business slump in general. According to Mr. Ishola, the continuous troubles of Mr. Sadiq were caused by the witchcraft of his stepmother in cooperation with those who were envious about his career. Mr. Ishola gave him herbal medicine for protection and conducted sacrificial rituals for him. Mr. Sadiq was impressed with Mr. Ishola's work at this point, as he argued, "Since I started to visit Brother Ishola, many people came to me and begged my forgiveness." Subsequently, however, Mr. Sadiq became increasingly concerned about the prospect of a business project in which he was currently engaged. Accordingly, Mr. Ishola's divinatory consultation and healing practice were going to be focused on this particular problem.

At the beginning of February, Mr. Sadiq had an opportunity to do business with the Nigerian National Petroleum Company (NNPC) in Kaduna. Kaduna has a huge oil refinery at its southern tip. He personally knew the general manager of one of the NNPC's subsidiary companies (Unipetro) at the refinery. The business the manager offered him was to transport LPFO and other petro-products by trailers between Kaduna and Lagos. From that time on, he was preoccupied with this business project. His immediate problem was how to obtain $^{\text{the}}$ initial capital for the project and hire trailers. Consequently, he started to consult Mr. Ishola and his friend, Baba Rimi, about the prospect of the business. On 14th February, Mr. Ishola conducted a sacrificial ritual for him. On the following day, he was going to seek a loan for the project from a merchant bank in Kano. The ritual was to protect him from an evil force and ensure that he would be granted a loan. In Kano, he managed to find a bank to support his business. The bank, Devocome Merchant Bank, agreed to provide 250,000 nairas for
his business, of which 60,000 nairas were soon to be released as the first instalment.

At that time, both Mr. Sadiq and Hajiya were worried about another witch problem. Accommodated at Hajiya's residence were her parents, relatives and tenants. Following several incidents, they suspected that one of the tenants, a middle aged Fulani woman. One night, Hajiya's mother had a bad dream in which the woman appeared and tried to stab her eye with a knife. This dream was followed by the mother feeling feverish. She was later cured by Mr. Ishola's medicine. On 17th March, Hajiya and Mr. Sadiq came with Hajiya's daughter to Mr. Ishola. The daughter, who was working for a commercial bank in Bauchi, injured herself when she fell from a motor cycle. Hajiya herself was afflicted with backache at this time. They suspected that all these incidents were caused by the woman's witchcraft. Their suspicion was confirmed by Mr. Ishola and Baba Rimi's oracle. To protect Hajiya and her daughter, Mr. Ishola applied herbal medicine through incision on their skin. Although Mr. Sadiq did not express his anxiety about the woman's possible obstruction to his business, he was certainly annoyed by her and stopped greeting her. He said, "How come can I greet somebody who ruins my life?".

Between the middle of March and the middle of April, Mr. Sadiq made himself extremely busy contacting the merchant bank and the oil company in order to proceed to the contract. On 19th April, the oil company gave him the conditions for the contract. The following is a summary of the letter from the company.

Please furnish us within 21 days of the receipt of this letter documentation for the following:
- Vehicle Licence
- Road Worthiness
- Vehicle Insurance
- Goods in Transit Insurance
- Current Calibration Chart
Mr. Sadiq estimated the gain to be 4000 nairas for each outward and return journey between Kaduna and Lagos. He aimed to hire 10 trailers and achieve at least four return journeys per month. By his calculations, the total monthly profit would be a minimum of 160,000 nairas and a maximum of 320,000 nairas. Meanwhile, Mr. Sadiq had to negotiate with the bank manager, Mr. Adeforaju, over the payment of the loan. Mr. Adeforaju told Mr. Sadiq that he could prepare the first instalment of the loan (60,000 nairas) for Mr. Sadiq prior to the official approval of the loan from bank headquarters in Lagos, provided he was presented with 15,000 nairas for his personal gift - bribe. At the end of April, the gift for Mr. Adeforaju was agreed at 5000 nairas, and a part (15,000 nairas) of the first instalment was unofficially released to Mr. Sadiq. Out of this sum, Mr. Sadiq paid the bribe to Mr. Adeforaju and the charge for a goods-in-transit insurance to an insurance company in Kaduna. The rest of the first instalment was going to be given to Mr. Sadiq in a few weeks time.

Around this time, Mr. Sadiq visited Mr. Ishola almost every day. It turned out that he was not just seeking divinatory consultation and herbal protection but also financial assistance from Mr. Ishola. As well as free protective medicine for Mr. Sadiq, Mr. Ishola was giving him some money, and trying to introduce him to a person who could finance his project. Thus, Mr. Ishola got involved in Mr. Sadiq’s project as a business partner.

A period between May and June can be considered as a turning point. By this time, Mr. Sadiq was hopeful about the prospect of the business, but from this time, he had to face tremendous difficulties in making progress in his business. First of all, it was extremely difficult for him to find trailer owners who would agree to lease trailers in good condition for a
reasonable price. In order to find such owners, Mr. Sadiq travelled around Katsina, Bauchi and Jos as well as several places within Kaduna. All the owners he met, however, did not accept the conditions for the contract he offered them. In his view, they were not brave enough to take the risk of making a long-term contract (Unipetro requested one year's contract). His frustration was made worse by a delay in the payment of the loan. The rest of the loan had yet to be released to him. Mr. Adeforaju explained that the delay was caused by "cross-checking", a procedure required before a loan could be officially released.

On 26th May, when I visited him at his residence, I saw him praying. He recited the verse of the creation from Koran 1111 times, counting the number with the beads of a rosary and matchsticks, so that his wish would come true, that is, that the rest of the loan would be released. Baba Rimi's oracle revealed that his loan must have already been approved by the Lagos headquarters. Mr. Sadiq visited the Kano branch again and enquired about the loan. A member of staff (not Mr. Adeforaju) told him that he certainly had seen at the office the letter giving approval of his loan sent from Lagos headquarters. This made Mr. Sadiq suspicious of Mr. Adeforaju's behaviour. It appeared to him that Mr. Adeforaju had deliberately hidden from him the fact that the loan had already been approved. It is also important to note that he began to feel unhappy about the work of Mr. Ishola and Baba Rimi. He said to me, "I decided not to consult Brother Ishola and Baba. Because I feel the oracle offends the God...and it is not always correct. They keep on telling me that my journey (to Kano) will be fine, whereas it has never been successful!" However, at this stage, he did not completely lose his trust in their work, as he argued, "As I started with sacrifice, I want to finish with sacrifice."
By the end of August, the loan was yet to be released. He was convinced that the management of the Kano branch was acting fraudulently. He suggested that the Kano management might have received the approval of the loans from Lagos headquarters for a group of applicants whose number was padded out - it was larger than the number of applicants the management should actually support. Concealing from the applicants the fact that their loans were approved, the management could tell the applicants individually that, although approval was under way, due to competition with other applicants, a further push was needed for assurance. In this way, the management could get an upper hand to inflate bribery from the applicants. As Mr. Sadiq was not in a good financial situation to compete with other applicants for bribery, he may not have been given a loan in the end. Action had to be taken to break through the situation.

He wrote a letter to Mr. Adeforaju about his intention to visit the bank's headquarters in Lagos and demand an explanation from the managing director and executive members of the bank for the delay in the approval of his loan. Mr. Adeforaju then paid several visits to Mr. Sadiq. Mr. Adeforaju asked him not to go to the headquarters and promised him that the rest of the whole loan (239,000 nairas) would be paid to him as soon as possible. However, Mr. Sadiq gave Mr. Adeforaju an option: instead of releasing the loan to him, Mr. Adeforaju could provide him with 200,000 nairas to enable him to buy three of the trailers that were seized at the border by the government on the charge of smuggling. By his calculations, it would cost less to buy these trailers (about 50,000 nairas for one trailer) than to hire trailers. Nevertheless, there was no sign that Mr. Adeforaju would bring the money to him. He therefore had no choice but to go to Lagos.
Prior to his journey to Lagos, he visited Mr. Ishola again and received herbal medicine to ensure a successful journey. Yet, by this time, his distrust of traditional medicine was deepening. In parallel to this, there was a change in his conceptualisation of the problem. On 3rd July, he said, "Until I met Brother Ishola, I had never thought that all the problems in my business were caused by a witch. Even now I do not really believe in that. Because things have not really changed in spite of all the sacrifices I did." Furthermore, he harboured a suspicion that Baba Rimi was partially responsible for the loan situation. He assumed that Baba practised his ritual incompletely in that on the one hand it was powerful enough to let the headquarters approve his loan quickly, but on the other hand it was not powerful enough to prevent somebody from blocking the release of the loan. In his view, Baba deliberately did this because he could not pay the full fee for his sacrificial ritual to Baba.

In the second week of July, Mr. Sadiq went to Lagos and met the managing director and other executives of the bank. They assured him that the matter would be investigated and the draft of the loan would be dispatched in a few weeks time. He told them that he would take legal action if they failed to do so. By the beginning of August, however, the loan had not been released to him, even though he was told that Mr. Adeforaju had been removed from the Kano office. Meanwhile, his suspicion over Baba Rimi's malevolence came to a head. He argued, "After the first sacrifice, Baba must have changed his mind and decided to challenge me. It is a honour of a evil person to get down a person with power and position. It is possible that Baba even engineered Adeforaju...But I have a gifted power. Anybody who tries to ruin my life will get repercussion. For sure, they say that Baba is now
seriously ill and almost dies!"

Between September and October, his business project was at a standstill. No progress was made in obtaining his loan and hiring trailers. It was said that Mr. Adeforaju was arrested and the court case was to be held on 15th December. Moreover, he learned that a shop Mr. Adeforaju owned in Kano was burnt down during the Kano riot in October. This, he believed, was the reaction against what Mr. Adeforaju had done.

A period between the middle of November and the middle of January, however, showed a quite different picture. While the loan was not yet released, Mr. Sadiq appeared to have found three individuals who might be able to give financial support to his project. He was also told that the loan would be released by the bank in the new fiscal year. He travelled to Zaria with Mr. Ishola to see a trailer owner. The owner, however, demanded a large share of the profit, which he and Mr. Ishola could not accept. Yet, by the middle of January, he appeared to have found a trailer owner in Kaduna who agreed to provide three trailers on condition that the profit would be evenly shared with the owner. He was full of hope. He planned to set up an office equipped with a telephone. He was also developing his interest in another business, that is, the export of crude oil.

Reflecting on this change in his business prospects, his conceptualisation of the problem was once again transformed. On 17th January, he said to me, "This could be some kind of trial. The God teaches you through suffering. It is during the time of hardship that you learn a lot. I have been in this situation since 1980." His hopeful business prospect at this time apparently had an influence on Mr. Ishola's divination. In Mr. Ishola's words, on 18th January, "Darkness is over. Now the door is open for him. I see a good sign in my oracle.... You (the
researcher) must leave your address for us (Mr. Ishola and Mr. Sadiq) so that we can visit you in London.... Alhaji (Mr. Sadiq) knows a big, big man. Somebody working for Babangida. He can help him." He went so far as to say that he could mortgage one of his houses so that he could borrow money from the bank to finance Mr. Sadiq's project.

Suddenly, however, this prospect was shattered at the end of January. Mr. Sadiq became far less confident about his business than he had been a few weeks previously. Mr. Ishola's view of the business prospect also became negative. On 30th January, Mr. Ishola said to me, "There is a witch in his compound. It still worries him.... People are just dabbling him...."

Although unfortunately I was not able to investigate this drastic change in detail, it appears to have been related to the difficulties in obtaining financial support. By the middle of February, none of the financiers seemed to have given him any concrete support. There was no sign of the release of the bank loan either.

There was also a certain incident that interrupted his activities. He lost his car key. The key suddenly disappeared from his room at Hajiya's compound. For a while, therefore, he was not able to go out in his car. Suspecting that one of Hajiya's tenants had stolen it, he told me that he practised yashin in order to get it back. A few days later, the key was found on the floor of his room where he had thoroughly checked and found nothing before. Then, according to him, this woman became mentally disturbed and was eventually driven out by her husband. In his view, this was the effect of yashin. Although Mr. Sadiq felt sorry for her, he could do nothing to change the situation.

While he consulted Mr. Ishola about the problem of the key, it appeared that he was also consulting
another diviner. The diviner was said to be a Nupe mallam in Unguan Maazu. The mallam appeared to have told him that there was a woman who stole the key in Hajiya’s compound, even though she was not a witch. Consultation with the mallam implies that Mr. Sadiq was again dissatisfied with Mr. Ishola’s work. On 10th February, he said, “You see. (While Hajiya is consulting Mr. Ishola,) I sometime stay inside my car. I come to Brother Ishola just because he is a nice man and helped me. But I do not come for oracle.” This is not true as we have seen. He did consult Mr. Ishola’s oracle.

What is significant in Mr. Sadiq’s case is that his understanding and management of the crisis situations were bound up with his sense of distrust. First of all, the problem of his distrust is linked to his suspicion of personal manipulation, which was a major cause of his business failure. Certainly, his business problems were attributable to various factors: the change of government economic policy; the bankruptcy of his business partner; accidents, and the fiscal crisis of the government after the oil crisis. However, out of his five major business operations, in three cases, the problem of a lack of trust between him and his business partners was the major cause of their failures.

Thus, the failure of the oil business on the coast was caused by the break of the contract between Mr. Sadiq and Mr. Emeka, for which Mr. Sadiq laid the blame on Mr. Emeka who, in Mr. Sadiq’s view, was apprehensive that Mr. Sadiq might set up his own business and become a business rival. The abandonment of the bore-hole project resulted partially from Mr. Idris’s accusation to Mr. Sadiq of mismanagement. The progress of his project of transporting oil product in Kaduna was also hindered by his distrust of a bank manager. In all cases, there is little clear
evidence that either Mr. Sadiq or his partners were involved in fraud. It is therefore the mere suspicion of mismanagement that caused the discontinuation with their business. It is also important to note that Mr. Sadiq's suspicion of mismanagement was not only his suspicion of his business partners' mismanagement but his suspicion of his business partners' suspicion of his mismanagement.

It appears to me that there are three factors that contributed to distrust in his business relationships. First of all, his business endeavour was basically to exploit an intermediary position in business relationships, that is, to link financiers, the owners of means of business and production and government officials. He is a prime example of "a contractor" (see Chapter III note 17, a type of business people commonly found in Kaduna. On the one hand, Mr. Sadiq retained his individual autonomy by not being involved in employment relationships - he was neither an employee nor an employer. On the other hand, he was dependent upon his business partners for capital and means of business, since his only assets are his expertise and personal acquaintances. However, this is where his problem arose. His business partners' apprehension was derived from the fact that while they delegated the management of their capital to him, they could do little to scrutinise his management and sanction wrongdoing. In other words, he was dangerously clever and autonomous. The point is that he was acutely aware of his partners' suspicion of his mismanagement. In such a situation, it is understandable that a minor incident immediately caused a rift between him and his partner.

Secondly, the autonomy of Mr. Sadiq and his partners was reinforced by a lack of social relationships between him and his business partners except for business relationships on the one hand and
a weakness of legal and contractual frameworks to regulate business relationships on the other. It is true that Mr. Sadiq found business opportunities through his personal ties with government officials. He claimed that he belonged to an "Old Boys Association", that is, the association of those who were educated in the same schools. However, as far as his business partners in private sector were concerned, they were mostly those whom he had never met prior to their business operation and had no social relationships such as kinship, local associations or religious affiliations. Their relationships therefore lacked the cohesion derivative of these social groups. On the other hand, the legal and contractual framework they should have abided by in their business operations does not seem to have been effective; despite his threat of legal action against his partners, Mr. Sadiq does not seem to have taken the matter to court.

Related to this, thirdly, it appears that the combination of a legal and contractual relationship and a patron-client relationship tend mutually to undermine the two relationships and generate distrust among those involved. It is common knowledge in Kaduna that officials and personnel of governmental organisations and business corporations holders do not always act within their institutional frameworks but act on the basis of particular patron-client relationships. In this situation, it appears to me that office holders enjoy relative autonomy from both legal frameworks and patron-client ties. On the one hand, the legal framework of organisations drives patron-client relationships underground. The illegal nature of patron-client relationships increases the bargaining power of office holders to determine the terms of personal transaction with their clients, since they can claim that they take their official
position in order to give personal favours to their clients. The bargaining power of officials should be particularly strong when they have more than one client to deal with. On the other hand, the personalities of officials clearly undermine the legal and bureaucratic order of organisations. In such a situation, it is natural that people have a general distrust of any office holders in a double sense—officials do not abide either by the legal framework of organisations or by the proper conduct expected with patrons. Mr. Sadiq’s distrust of a bank manager, Mr. Adeforaju, exemplifies this situation.

His problem of trust is, however, also a matter of contradiction between the expected outcome of action and perceived outcome of action, that is, his sense of failure of promise. He was promised by his business partners and healers that there would be a successful outcome to his particular business operations. Thus, Mr. Emeke promised him about a 40% share of the revenue. Mr. Adeforaju promised him about the immediate release of bank loan. Mr. Ishola and Baba Rimi assured him of the success of his business dealings. However, none of the promises were realised in the end, which inevitably led him to distrust these people and their practices.

In terms of his own aetiological explanations for the failure of his business operations, it is important to note that he tended to blame someone for the failure of his business. Thus, he attributed the failure of his business operations to the misconduct of his business partners and their suspicion of his misconduct. He also ascribed his problems to the witchcraft of his stepmother and the sorcery of Baba Rimi. In any case, his aetiological explanations were mostly based on personal and external agents. He hardly attributed the business failure to his own mishandling and miscalculation. Thus, in a sense, his
aetiological understanding has an aspect of excuse.

It is also notable that he changed his explanations according to situations and multiplied them in the course of his business management. Thus, during the course of a business project in Kaduna, he considerably changed his aetiological explanation. He was initially worried about his stepmother's witchcraft. Then he was preoccupied with Mr. Adeforaju's fraudulent behaviour. He then suspected Baba Rimi of conspiracy in the whole malpractice. When he was hopeful of the business prospect, he attributed his suffering to a trial given by God. In this regard, healers were not in a position to impose their diagnoses on him. Even though Mr. Ishola's diagnosis of witchcraft was initially accepted by Mr. Sadiq, later he more or less abandoned the view. Moreover, it appears that the healers' explanation was influenced by Mr. Sadiq's own account of the situation. Mr. Ishola's hopeful divination in the middle of January was certainly the reflection of Mr. Sadiq's own hopeful prospect of the business.

Movement and diversification are also the main characteristics of his management of business crises. At an initial stage, Mr. Sadiq was systematic in his business management. He carefully planned a project and calculated its cost and benefit. As he encountered series of troubles, his business operation was increasingly based on situational change of the original plans and movement to alternative means. Thus, facing difficulties in pursuing a petro-business in Kaduna according to his blueprint, he tried to find alternative financiers and trailer owners. When he found the work of Mr. Ishola and Baba Rimi unsatisfactory, he tried other practitioners and practices. In his business career, he more or less constantly changed his business interests. As soon as he found it difficult to pursue one business, he
shifted to another business opportunity rather than keeping to the original operation. In that sense, movement as crisis management has an aspect of escape.

It is also important to note that he re-identified his relationships with other people in the course of his business management. Thus, he changed his relationship with Mr. Emeke from one of clients to partner by establishing a joint venture. He re-identified a healer, Mr. Ishola, as a business partner and another healer, Baba Rimi, as a sorcerer. Such appropriation of personal relationships could be of a surreptitious nature. When he realised that a bank manager, Mr. Adeforaju, was acting fraudulently against him, he tried an eye for an eye method of retaliation against the bank manager; rather than pursuing a legal action against the bank, he tried to force the manager to make a personal deal with him by blackmailing the manager.

However, it appears to me that it is precisely such manipulative practice that would have reinforced his suspicion of his partners' suspicion of his misconduct, as well as his suspicion of their misconduct. At least in a crisis situation, he certainly did something to generate the distrust of his partners. He was not only acutely aware of it but also tended to overreact against the slightest hint of accusation. Thus, the problem of trust is ultimately embedded in the nature of his entrepreneurship.

BETWEEN HOME AND CITY - The Case of Peter

Previously we have looked at case studies of a particular ailment, Patricia's psychiatric problem, Mr. Barki's abdominal swelling and the business problems of Alhaji Sadiq. In this section, I examine a series of problems experienced by 32-year-old (in
textile worker, Peter Angambe, in his everyday life, particularly during the period from February 1991 to January 1992. The problems that afflicted him were diverse: various sicknesses, including those of wife and child, the burden of kinship obligation, financial and other socio-economic problems. Yet, one of his central problems is a chronic headache from which he has been suffering for over 15 years. It is important to note that many of the problems were interrelated, not only from the observer’s point of view, but also from his own point of view in which kinship holds a pivotal position. It appears to me that his everyday crises are largely attributable to disjunction between his kinship order at home and his industrial order in Kaduna.

Peter Tyaunum Angambe was born in 1960 in Moilgbo village, Gwer division, Benue State. The village was situated along the railway about 50 kilometres away from Makurdi to the south, and not far from Idoma and Igbo lands. There are substantial Idoma and Igbo populations in the area. He is the fourth child of his father, Atar Angambe and his mother, Nyioon. His father is a farmer who is not particularly well-off but who owns a large unmechanised farm where shifting cultivation is practised. Peter grew up in the village until he was eight years old. He was then taken to his mother’s village, Mbloon, by his maternal uncle (his mother’s younger brother). The uncle, who was working for a local court, looked after him as one of his family members, even though Peter could not get along with his uncle’s wife. The family moved around many villages in the area. Peter received his primary education at both Catholic and Protestant missionary schools. He did well at school. This is why he suspects that his uncle’s wife was jealous of him. He attended a secondary school at Gboko, but he was not able to complete his studies, because he was mistaken
for one of the student rebels and expelled. In 1984 he came back finally to his father’s village and helped his father with the farm.

His major physical affliction, chronic headache, can be traced back to 1977 when he was a primary school seventh year student. One day, he had an episode of severe headache with fever at his uncle’s residence. It was so severe that he felt as if the upper part of his head above the eyes was twisted. At first, his uncle gave him painkiller tablets and then took him to a local dispensary, where he was treated with a chloroquine injection. The fever soon mitigated, but it took some time for the headache to disappear. The second attack of headache occurred during the dry season in 1980. When the attack seized him, he was at his secondary school and his schoolmate escorted him to his nephew’s house. The nephew took him by car to a village called Tyuoleen to see a traditional healer. The healer instructed him to put one kobo coin into a wooden pot, gbada containing water and to stand beside the pot. Looking into the water, the healer described a tall woman with yellowish complexion at his mother’s village and told them that the woman was a oba tsav, a witch, and gave him poison in the form of smoke. Moreover, the healer revealed that she poisoned him because she was asked by his uncle’s wife to do so. He knew that there was a woman at his maternal village who was regarded as a oba tsav and looked just like the woman the healer described. Moreover, he remembered that he once passed by the woman smoking her pipe. So, he could not but believe that the divination was true. The healer told him to prepare a wooden pipe, tobacco, dried fish and a cock for the healing ritual. She also gave him herbal medicine. Although he told his father about it, his father did not take it seriously. Thus, he was not able to perform the ritual. As we shall see, he
considers the failure to hold the ritual as the main reason for the persistence of the illness up to the present.

The next serious headache occurred during the dry season of 1984. This time, a kind of wound developed at both ends of his mouth - it looked like a "ringworm". Suspecting the illness was akombo dam, his father took him to a man associated with akombo dam. In Tiv aetiology, akombo are a group of illnesses associated with magical forces. There are various akombo illnesses such as swende, igbe, and twer. Each akombo illness has a distinctive feature. In Peter's account, akombo dam is a illness whose symptom typically manifests with headache. Akombo illnesses are believed to be caused by the breach of taboo and protective emblems, and by witchcraft. Their treatment often, if not always, requires a ritual for akombo called kwasoron akombo, and the ritual is led by a person who is associated with a particular akombo (the person is called oru akombo).

In Peter's case, kwasoron akombo was held at the oru akombo's compound, while his father collected sacrificial materials for the ritual: a large hen, a yam, palm oil, red chalk, and a ceramic pot. At first, the oru akombo drew a line on the ground to signify running water. He said, "Shan Konde" (meaning: let it go). Then, he held the hen and placed it around Peter's feet. He painted Peter's navel and forehead with red chalk. He then killed the hen, rubbed its blood on Peter's body and poured the rest of the blood over a tree, reciting an incantation, "The red would come back to Peter's body." After this, the hen was cooked with palm oil, and pounded yam was prepared. Peter was made to eat the whole chicken, whereas the pounded yam was shared by all the participants. His father paid 3 nairas and 6 glass beads for this service to the oru akombo. Peter, however, did not see
the effect of the ritual so much, as the headache was disappearing naturally even before the ritual had been carried out. He remained at his father’s village until the beginning of 1987.

In January 1987, he came to Kaduna, hoping to get a job. He knew someone who could arrange a job for him at a textile company. This person, Christopher Ubo, was the deputy production manager of United Textile Ltd (UNTL) and his agnostic, if distant, relative. Previously Mr. Ubo tried to help Peter’s elder brother to get a job at the company. Because of this connection, Peter was soon employed, although he worked initially as a casual labourer. His accommodation in Kaduna was also provided at first by his agnostic kin. He was initially accommodated by his cousin (his father’s elder brother’s daughter) and her husband at their residence in Makera, Kaduna-South. However, about five months later, he moved out and rented a room for himself, as he could not get along with his cousin’s husband. He managed to save some money to pay a deposit of a few months’ rent. By this time, his employment had been upgraded to full-time employment in the finishing department.

In 1988, he married a girl from his neighbouring village. He met the girl – I shall call her Mama Taikenbe – in Kaduna while she was visiting her elder sister there. They sought approval of their marriage at first from her sister and her sister’s husband, then from his father and finally from her father. Then, his father and her father exchanged visits. Thus, their marriage was approved and Mama Taikenbe was allowed to live with him in Kaduna. However, a problem still remained that Peter was not able to pay bridewealth to her father.

In March 1989, Mama Taikenbe conceived a child. This was, however, doomed to be Peter’s first major crisis since he had been settled in Kaduna. Sometime
in December, when he returned from work, he found his wife lying down on a bed and suffering from abdominal pain. He immediately took her to hospital. She gave birth to a boy. However, the baby was premature and died on the following day. Peter was immensely shocked by the death of the baby and its memory still hurts him. A week after the tragedy, he developed a headache. He could not do any hard work and had to return from work earlier than usual - he took Panadol and other painkillers.

While his wife was recovering, he accompanied her to his home village. This was not just because she needed a rest, but because they developed a suspicion that her premature delivery had something to do with a spiritual force, namely swende - one of akombo. At first, they went to see his father who then took her to her own father (Peter left them for Kaduna). Then they consulted a diviner. The diviner told them that her premature delivery was swende, which was attributable to her having seen a dead dog in the past. It is believed among some of my Tiv informants that for women to see a dead dog is taboo and its breach causes miscarriage and premature birth known as swende. She admitted that when she was a child she played with the skull of a dog without knowing that it was a dog’s. She and her father were instructed to hold the ritual for swende. The ritual, kwasoron akombo, was organised by her father at his compound. (See Appendix 7 for kinds of akombo illnesses).

Fortunately, in the following year, his wife gave birth to a healthy child, Taikenbe. In that year, Peter and his family seem to have lived a peaceful life. The only problem he recalled was a change of his section at the factory from finishing to the more tiresome weaving. He attributed the change of his section to his supervisor at the finishing department with whom he had a personal clash. Prior to the
change, he was cautioned by his elder brother that Mr. Ubo was not happy about the way he behaved at work. Then, the order came that he should henceforth work at the weaving section. In his view, the supervisor secretly slandered him to Mr. Ubo, saying that he was not working hard.

It appears that the year 1991 was a tough year for Peter. He had to face a series of problems, which I closely observed. Between February and April 1991, he had to dedicate most of his spare time to meeting his obligations for both his wife's and his own kin. On February, he was visited by his wife's mother. She stayed at his rooms for a week or so. He made great effort to entertain her, buying her clothes and food and giving her some money. Altogether he spent about 600 nairas for this. He managed this with his savings.

Then he was visited by two agnatic relatives. He called them 'junior brothers'. They were in their early twenties and came from home to search for jobs in Kaduna. He provided accommodation and food for them and tried to introduce them to Mr. Ubo. However, as his savings were exhausted, he was short of money until his payday. So, for instance, in the evening of 26th February, he complained that he and his 'junior brothers' had not eaten food since morning; he went to see one of his relatives to borrow some money as the man had promised to lend it, but the man was not at home. The brothers stayed with him for more than a month, even though they were unable to get jobs.

In the middle of March, he was again visited by relative of his wife, this time, his wife's stepmother (another wife of his wife's father). He thought that the fact that his wife's own mother had benefited from visiting him encouraged her stepmother to visit him as well. He had to entertain her and gave her gifts and some money. In total, he spent 200 nairas for this. He raised the money through his 'native bank' - a
rotating loan society at his workplace. However, this was not the end of the story. In April, he had to meet another kinship obligation, this time, for his own parents.

As a farming season approached, he sent his wife to his parents so that she could help them to farm. However, he could not do so without his wife taking gifts for them. The gifts consisted of a bag of rice and provisions, such as soap and cooking utensils. A bag of rice cost him 300 nairas and the provisions 800 nairas. His salary, about 700 nairas, did not cover the whole expense. He had to borrow 200 nairas from a Tiv money lender at an extremely high rate of interest, and 500 nairas from me.

Throughout this period, he was frequently worried about his financial burden and kinship obligations. His anxiety was indeed serious - he once suddenly lapsed into thought in the middle of our conversation at a table in a beer parlour. It appears that this anxiety was related to the recurrence of his headache around this time. In the middle of February, he developed a headache and 'Kata' (catarrh). He attributed the illness to the fact that he was thinking too much about his financial problems. He remarked that a headache tended to develop when he was worried about something or studied hard. However, he also recalled his experience of being 'poisoned' by a oba tsav during his childhood. He believed that the smoke 'poison' that the woman had given him was still causing the headache.

Between the beginning of May and the middle of August, his life was relatively untroubled. Apart from exhaustion caused by his industrial work, the only physical ailment he had, as far as I know, was a pain in the joints of his right arm, and a small boil on his upper lip. The two conditions appear to have developed almost simultaneously. He considered both as
manifestations of the same illness called twer - a kind of akombo illness. Though he argued that twer was a akombo, he did not relate its occurrence to sorcery or to any other spiritual force. Certainly he was not concerned about the sickness, and it apparently disappeared naturally. At the beginning of August, again, he sent Mama Taikenbe and their son, Taikenbe, to their home villages, hoping that she would bring some food from home after the harvest time.

This tranquillity was, however, broken in the middle of August when his wife returned unexpectedly from home with his seriously ill child and accompanied by his uncle. Taikenbe was afflicted with severe diarrhoea. Mama Taikenbe and Taikenbe stayed at Peter's father's compound for two weeks and at Mama Taikenbe's mother's compound for five days. Though it appears that Taikenbe showed signs of illness at his paternal home, it was at his maternal home that his illness became serious (Mama Taikenbe felt ill there, too). They decided that it was better for Mama Taikenbe to take him back to Kaduna for treatment. She travelled with Taikenbe by taxi to Kaduna. On the way to Kaduna, Taikenbe's condition became worse. They had to stop over at Abuja, and sought help from Peter's agnatic uncle who was living there. The uncle immediately took Taikenbe to a general hospital. When they reached the hospital, Taikenbe was so weak that he did not seem even to have the strength to open his mouth - a doctor appears to have said that his blood pressure was low. After the hospital medication, fortunately, there were signs of recovery. Then they came back to Kaduna with the uncle. For the medication, the uncle spent 40 nairas.

Initially, Peter told me that Taikenbe's sickness was caused by the change of diet. In his account, foods at home contained too much carbohydrate and too little protein. They were often too hard and served at
an unsuitable time for children. However, during the course of the conversation, he disclosed his suspicion of a malevolent force as a cause of the sickness. He noticed that whenever Taikenbe went home, he was not well; so far he had been home twice and each time he had become ill. He developed his illness particularly when he visited his wife's mother's home. What Peter suspected was that Mama Taikenbe's grandmother was practising sorcery against Taikenbe.

In his view, Mama Taikenbe's grandmother was envious about her daughter, that is, Mama Taikenbe's mother, because Mama Taikenbe's mother was 'enjoying' Mama Taikenbe whose husband was 'rich' in Kaduna. Thus, Mama Taikenbe's grandmother was trying to spoil the source of Mama Taikenbe's mother's joy by causing Taikenbe's illness and making Peter suffer from it, not only psychologically but also financially; obviously, Peter had to spend money for Taikenbe's treatment and, more importantly, if they could not stay home at harvest time but had to return to Kaduna empty-handed, he would merely have wasted money for their transport. He believed that the grandmother was a *oba tsav*. Nonetheless, as Taikenbe recovered his health, he decided to send them home again and let them stay there until October, even though he would not allow them to be at his mother-in-law's place for more than 'two hours'.

Mama Taikenbe and her son came back to Kaduna on 29th September. Taikenbe was, again, ill. While it was not as serious as before, he was afflicted with diarrhoea and nausea. Mama Taikenbe was not well either. This time, Taikenbe's illness occurred at his paternal home. According to what Peter learned from Mama Taikenbe, Taikenbe started to shiver and his body became stiff, at the time when Peter's father was blaming Peter during the conversation. Peter's father realised that it was his 'curse' that caused
Taikenbe’s affliction. Then, both Peter’s father and mother washed their mouths to ward off the effect of their ‘curse’.

While Taikenbe eventually recovered his health in Kaduna, Peter had another problem around this time. His ‘junior brothers’, this time three of them, visited him from home. They were again hoping to get a job in Kaduna. He had to provide them with accommodation and food and try to help them find jobs. This whole unlucky situation, the illnesses of his son and wife and the visit of his ‘junior brothers’, he could not help thinking, was created by evil practice at home. He knew that his own father and probably his mother-in-law were angry about him, because in their view he was not ‘helping’ them enough. To confirm his suspicion, someone who just met his mother-in-law at home told him that she was complaining bitterly about him.

With regard to his own health, Peter was troubled with an eye condition from the end of September to the beginning of October. A small boil, white in colour, developed on the white part of his right eye, and each end of the eye became red. He felt pain as if he had smoke in the eye. When he went to his company clinic, the doctor told him to go to Ahmadu Bello University Teaching Hospital. What is notable is that he gave three different accounts for the illness on different occasions. At first, he asserted that it was caused by what he called ‘floria worm’. In fact, from time to time this ‘floria worm’ appeared in his aetiological account for illness. He also suggested that cotton fibre at his work place might be the possible cause of the sickness. In his weaving section, there are a lot of particles of fibre in the air. Yet again, he argued that it could be nothing but the illness ‘from family’, that is, the sickness caused by sorcery at home, if the teaching hospital could not identify it.
Instead of going to the hospital, however, he consulted a traditional healer, Mr. Sevav. Mr. Sevav told him that it was caused by a worm, and gave him liquid herbal medicine free of charge. He was instructed to put it in the eye. When he tried it, however, it caused a white screen on the eyeball, and the eye became red. He stopped using it immediately. However, although I also gave him eye drops, the illness appears to have been cured naturally in time. Yet, his real health problem was to come in the middle of November.

From the middle of November to January, he suffered almost constantly from illnesses. Symptomatically the main problem was headache, though various other symptoms were also manifested. On 14th November, he complained that he had diarrhoea with blood. He also had a serious headache and felt feverish. He went to the company clinic and was given Fansidar and two other kinds of medicine. He ascribed the diarrhoea to eating too much ‘pepe’ (chili) a few days previously. On 17th November, a small boil developed on the top of his tongue. The affected part was red and he felt pain there when food touched it. He also had blisters inside his nostrils, and felt itchy there. The headache still remained, but the fever had gone. He considered these symptoms as some features of akombo dam and told me that they usually developed after a headache. He also felt itchy all over the body which, he believed, was a side-effect of the medicine he was taking. On the 24th, the itchy feeling continued, and he could not stop scratching the itchy parts of the skin. This time, he argued that it was caused by ‘floria worm’.

On the 27th, he was afflicted with a headache all day. I found that he was again worried about his financial situation as Christmas approached; he was expected to buy clothes and food for his wife and
child. A piece of 'rapha' cloth might cost over 100 nairas and a chicken 30 nairas before Christmas. Besides, it appears that he was supposed to pay back a part of his debt by the end of November. Thus, it appears to me that his anxiety and headache were undeniably connected, even if the anxiety was not the sole cause of the headache.

On the 29th, just before going on night duty at the factory (around 10.30 p.m.), he complained about his headache. Apparently his condition was getting worse. At his workplace, he did not only have a severe headache but felt shivery and feverish. Around 4.0 a.m., he had to stop operating machines and went to see a nurse at the company clinic, having obtained permission. He took two kinds of medicine and was then allowed to have a sleep. From 30th, he took two days off, but there was no sign of recovery. He lamented the fact that he could have had his headache cured, if he had conducted the ritual following the diviner's instruction in 1980.

In the morning of December 3, I saw him sitting on the street outside his compound and sniffing up herbal medicine and water to clear his stuffed nostrils. He was shivering and suffering from a severe headache. In the previous night, he went to bed around 12 midnight just after he came back from work. He had a bad dream and woke up. Then he found himself afflicted with a terrible headache and 'kata'. I realised that he had become obsessed with the memory of the sorcery.

"Poison went inside my head! This is poison, not ordinary headache! Since primary 7.... My head moves like this. That woman really poisoned me! I feel something moving in my head....", he complained. It seemed to me that the situation was quite serious, so I accompanied him to the St.Gerald Catholic Hospital in Kakuri, where I was acquainted with a medical
doctor. He consulted the doctor, Dr.Chukuma. The following is the conversation between them:

Doctor: How do you feel?
Peter: (pointing to the part) I have headache.
Doctor: Is it only this side?
Peter: Yes, mostly this side.
Doctor: Did you have any dizziness before you got headache?
Peter: Yes.
Doctor: (examining Peter’s blood pressure) Do you know what kind of medicine you took?
Kondo: He took aspirin that I gave him.
Doctor: Blood pressure is OK. How long does your headache last?
Peter: It usually starts in the morning and ends around 1 o’clock.
Doctor: This is a migraine kind of headache. Do you take coffee?
Peter: Yes. I took this morning. He (Kondo) gave me.
Doctor: Does it help? Take black coffee. Caffeine may help you. I will give you Cafegol. See how it helps. Come back in two weeks.

Peter was not very much impressed with this counselling and medication. On 6th December, Peter told me that Cafegol did not work very well; although it reduced the ‘hotness’ of his body and ‘kata’, he was still afflicted with headache. From 6th to 11th, he took casual leave. Surprisingly, however, by the middle of December, the symptoms were largely gone. It appears that his illness had healed naturally again. However, it turned out that this was not the end of his physical affliction.
On December 14, Taikenbe got blisters all over his body. It appeared to me that his condition resembled chickenpox or German measles. Peter took him to a ECWA church clinic in Nasarawa. He argued it was 'smallpox' (according to him the doctor at the clinic confirmed his diagnosis), and did not relate it to any malevolent force. While Taikenbe's symptom was soon gone, Peter developed the same symptom on 26th December. At first he complained about backache and fever (but not headache). Then blisters appeared all over his body. They were itchy, if not terribly. He went to his company clinic and was given four injections for four days. He took two days off for treatment. Again, he did not ascribe the sickness to sorcery or to any other evil practice. By the middle of January 1992, the blisters were mostly dried up and he was recovering his health.

We have seen the headache and other ailments that afflicted Peter between February 1991 and January 1992. Aside from these distinctive ailments, he often looked exhausted after work. The working conditions of textile factories are by no means favourable to the workers' health. The work is mechanical, monotonous and continuous. Under three shift-work time systems, the workers have to adjust themselves to three different work times (7.0 a.m to 3.0 p.m, 3.0 p.m to 11.0 p.m, and 11.0 p.m to 7.0 a.m.) in three consecutive weeks. Most of the workers do overtime and do not take holidays on Saturdays and Sundays, because payment is higher on these two days. The factories are also equipped with materials that could jeopardize the workers' health. In the printing section, the workers deal with chemicals inside a hot building without much ventilation. In the spinning section, there are particles of fibre flying in the air, and the workers inevitably inhale them. The following outlines Peter's work when he is on his morning duty.
Peter leaves home for work around 6.30 a.m. He does not normally eat breakfast because he cannot eat food early in the morning. He walks for about 20 minutes to the factory. Passing the gate, he goes to a locker room and changes clothes. Then he gives a time card to an operator and goes to the weaving department. There are about 150 workers in his section and 500 in the whole department. The first thing he does is to change the meter to his shift, that is, morning shift in this case. He starts to operate machines at 7.0 a.m. He is in charge of 12 to 20 weaving machines that extend in a line up to 100 metres. His main work is mending yarn. Almost every five minutes a cut occurs on yarn and the machine stops. He makes a knot in the thread quickly so that 12 to 13 machines can be constantly in operation. Until 12 noon the workers have to be at work except for going to the toilet or drinking water. If a worker leaves his position, a headboy or an overlooker takes care of his machines until he comes back to the position. At 12 noon, there is a short lunch break. A small piece of bread is distributed to each worker. After the break, the same work continues. He finishes his work at 3.0 p.m. Then a worker on afternoon duty takes over his position, changing the meter to the afternoon shift.

The work appears to have affected his health not only physically but also psychologically. He sometimes complained that the sound of the weaving machine was impressed on his mind and he could not forget the sound even when he was not at work.

"Chon Chon (his onomatopoeia of the sound of weaving machine) never leaves me. I usually stroll after work. I can not stay at home because Chon Chon worries me in my mind. This work makes me weak and limits my social life." The shift work time system particularly disrupted his life. He had to readjust
the schedule of his activities - eating, meeting people and sleeping - every week. He could not have enough sleep when he was on night duty, as it was hard for him to sleep during the day. Thus, he sometimes fell asleep during night duty. On 21st March, for instance, "I slept for about thirty minutes (during the work). So eight machines stopped operation. I saw a dream. In the dream somebody is coming to me. Then I suddenly woke up. I saw a supervisor coming to inspect my work." Because of the shift work schedule, it is not unusual for him not to see some of his co-tenants living in the same compound for more than a week, as they also work according to their shift work schedules.

In 1991, he earned about 700 nairas (basic salary 327 nairas, housing and other allowances 269 nairas plus payment for overtime work) on average per month. By his calculations, the monthly food expenditure was about 250 nairas. Rent was 40 nairas per month. He could therefore get by with his income if his expenditure was only for his wife and child. However, if he had extra expenditure, it was a quite different matter, and this appears to have been often the case, even though the extra expenditure in 1991 was particularly heavy. In that year, the expense for kinship obligation affected his financial situation throughout the year. This appears to have been reflected in their diet. He had a meal only once or twice a day. Though his family had a substantial meal at dinner, it was by no means a balanced diet. Rice and tuo was often served without meat or fish. He himself believed that the diet was not balanced. He once attributed to this unbalanced diet the dizziness that he sometimes felt during his night duty.

What is significant in Peter's case appears to me that his various problems were derived largely from contradictions between the logic of a factory and the
logic of kinship, that is, between industrial order in the city and reciprocal obligation at home. First of all, many of his problems were related to the burden of his reciprocal obligation to his extended family. Thus, the headache attack was apparently triggered by concern about his financial difficulties to meet the reciprocal obligation. His anxiety over the reciprocity was closely linked to his identification of sorcery and witchcraft with the cause of his child’s illness and other problems. The point is not only his failure to fulfil the obligation but also his success in doing so generated his suspicion of sorcery and witchcraft. This is because in his view, his meeting of obligation to some of his relatives inevitably created inequality between them and other relatives, and there was no way he could satisfy all the relatives equally.

His financial difficulties in meeting kinship obligations were bound up with the logic of a factory; the salary system of his textile factory was mainly geared to the maintenance of the workers’ nuclear families. Thus, his salary was not sufficient to meet the expenditure for his extended family members. In that sense, the industrial logic was to hinder the implementation of kinship reciprocal order. Inevitably, he had to turn to various alternative sources of finance including a rotation loan association, usury and friends.

Ironically, the fact that he was an industrial worker in Kaduna appears to have increased his kinship obligations. First of all, this is how he perceived the situation. In his view, he was considered by his relatives as a rich man in the city who could redistribute his income to them and help them to find food, accommodation and a job. It is indeed probable for his relatives to have high expectations of him, since he himself had expectations of his relatives in
Kaduna before he moved to the city. What underlies the heightened expectation was the fact that industrial order was partially modified by kinship order.

In Kaduna, it appears that kinship and social networks based on locality and ethnicity commonly penetrate into textile factories and other industrial organisations. Such social networks influence the recruitment and promotion of workers. In his case, he was given employment through his agnatic tie with a production manager of the company. However, this does not indicate that the factories are entirely under the control of these social relationships. Rather it means that the social relationships partially modify industrial order, whereas their control is limited by industrial order. In the current economic situation, Peter was rather lucky to get a job - his younger relatives were unable to get one. Thus, here is a situation where kinship logic modified industrial logic to the extent that it heightened the expectation of kin, whereas there was no guarantee that the expectation would be met.

It would be out of the question for him to free himself from extended kinship ties and become an urban industrial man taking care of his nuclear family alone. This is not mainly because of his fear of sorcery and witchcraft, but rather because of his practical needs and emotional attachments. On his arrival in Kaduna, he was provided with food, accommodation and a job by his relatives. He could expect food from home at the harvest season. He sought the healing of his wife's affliction at home. His aspiration was also tied with home. On being asked what he would do if he had 10,000 nairas, he said to me, "If I have 10,000 nairas, I will build a house at home so that even if I die, my family can stay there. Building a house also develops the village....You must remember your home. If you build a house, people
respect you. They respect you more than you have a car.... After house, I want to start business."

On the other hand, it would be impossible for him to leave the factory and go back to a rural life. This would not be the wish of his relatives at home. He had to work at the factory not only for his nuclear family but also for his extended family. The problem is that the factory has its own mechanism of causing illhealth with him. The mechanical work and shift work schedule significantly affected his physical and psychological health. Failure to meet such industrial discipline would result in dismissal or relegation as once happened to him.

Thus, Peter's problems were largely the result of contradictions between kinship and industrial order which mutually affected each other without forming an integrated system. In short, Peter was suffering between his home and city.

**EJECTIVE SOLUTION - The Case of Mr.Ishola and His Tenants**

In this final section, I explore Mr.Ishola's management and aetiological understanding of troubles with his tenants. His relationship with tenants was remarkably conflict-ridden, and his understanding and solution of the troubles were marked by his suspicion of witchcraft and the eviction of tenants. What underlies the troubles and their management is, however, particular nature of housing economy, petit-landlordism and urban social relationships and culture in Kaduna.

For two years between 1990 and 1991, I became the oldest tenant at Mr.Ishola's own residence in terms of length of stay. During this period, he dislodged five tenants from his house as a result of troubles
between him and his tenants. In the following, two of these cases which I was able to observe closely, are depicted.

Baba Chijoke and his family stayed at our compound for about six months from 1990 to 1991. They were Igbo from a village near Enugu in Eastern Nigeria. He was about 40 years old and worked for a textile company. His wife, who was much younger than him, was a hairdresser. They had three children. The first two were at nursery school and the last one, Chijoke, was looked after by a girl named Nkechi. Nkechi was a distant relative of Mama Chijoke and 14 years old at that time. As Mama Chijoke was not at home for most of the day, Nkechi took care of domestic work and nursed Chijoke. The family previously lived at a compound next to ours but, due to quarrel between Mama Chijoke and the wife of their landlord, they moved to our compound. Initially the relationship between his family and Mr. Ishola’s family was not too bad - they did not interfere with each other’s affairs. However, the trouble started when Mama Chijoke brought her younger sister from her home town.

The problem was that Nkechi and the sister could not get on with each other and often quarrelled. According to Baba Chijoke, Nkechi claimed her superiority over the domestic work, while the sister was not happy about it as she was older than Nkechi. Meanwhile, Mr. Ishola and Mama Goke became annoyed by Nkechi. Mama Goke complained that Nkechi did not use the compound tidily; she did not dispose of rubbish in the right place, nor did she always remove Chijoke’s excreta. One day, Mr. Ishola told Baba Chijoke that Nkechi should carry rubbish that she had left just outside the compound to the refuse place. Baba Chijoke immediately ordered Nkechi to do so. However, she was not happy about it, saying, "Weitin concern me [What has it got to do with me]!" Apparently such a reaction
gave Mr. Ishola the impression of Nkechi as a stubborn child, as he said, "This girl looks at us in common eyes [she does not respect senior people like us]."

After that, Nkechi stopped greeting Mr. Ishola. Then, a few weeks later, Mr. Ishola, who was increasingly annoyed by Nkechi, had a discussion with Mama Chijoke about Nkechi. On the same day, he carried out a certain ritual. He threw away the ash of herbal medicine wrapped with green leaves outside his newly built house. He said, "Secret in our yard will leak by this sacrifice!" On the following day, there was a fight between Nkechi and the sister, and the sister was injured. Mama Chijoke was totally upset by this and took Nkechi to the railway station and sent her off to her home town. In the evening, Mr. Ishola told me that Nkechi was a witch.

According to him, he practised that sacrifice in order to drive Nkechi out of his compound, because Ifa told him that she was a witch. I do not know how far his statement was based on facts. It was certain, however, that he was convinced that Nkechi was a witch and that she even charmed Baba Chijoke. At that time, Baba Chijoke was not in Kaduna but at his home village, sorting out land dispute. When Nkechi was sent back home, he was preparing for his journey back to Kaduna. Coincidentally, they bumped into each other at Enugu station. He told me how he met Nkechi, "I wanted to travel back to Kaduna by taxi. But when I was about to go to motor park, I suddenly felt sick and realised that there would be something wrong on the road. So I changed my mind and decided to go by train. I went to Enugu station and waited for a train for Kaduna on the platform. Then a train from Kaduna came. To my surprise, among people getting off the train, I saw Nkechi! She narrated me everything. It was not acceptable for a wife to make a decision like this with the absence of her husband. So I took her
back to Kaduna with me."

When they arrived at our compound, we were woken up by their quarrel. Baba Chijoke stood up for Nkechi. Watching this, Mr.Ishola said mockingly, "He wants to marry this girl." On the following day, another fight broke out. Mr.Ishola finally called in a policeman, who took those involved in the fight and Mr.Ishola to the police station. Being tired of troubles, Mr.Ishola gave them notice to quit their rooms. A few weeks later, they packed up and left our house.

In the second case, a confrontation between Mr.Ishola and his tenants was more tense, if not more direct. Mr. and Mrs.David stayed at Mr.Ishola's house for about three months in 1991. Mr.David was from Mopa and Mrs.David from a town near Mopa. Mr.David, who used to be a lecturer at a college was unemployed at that time, and it was Mrs.David who earned their living by sewing clothes. They did not have a child and Mrs.David was deeply concerned about it. She was an ardent Christian and a member of the Apostolic Church. Her frequent prayer was apparently aimed at conceiving a child. However, it was her childlessness and prayer that had much to do with the subsequent conflict with Mr.Ishola.

At first, the relationship between the couple and the Ishola family was a cordial one. Mr.David often shared the cool air with Mr.Ishola after evening meals. Mrs.David and Mama Goke became good companions, and behaved respectfully towards Mr.Ishola. They did not cause any trouble about the use of the house and the payment of rent. The only problem was Mrs.David's seriousness in Christianity. She spent a long time in prayer from early in the morning. During the day, she was often visited by the pastor of her church, a Gbagyi man who spoke Yoruba fluently, and they prayed together. She also sang hymns almost constantly while she was doing her work. Her religious enthusiasm was
sometimes turned towards other people in the compound. She tried to persuade Mama Goke and Mr. Ishola's children to attend her church.

Gradually, Mr. Ishola became concerned about her distinctive prayer and evangelism. He said, "She always sings! A Christian does not sing like that...[When she tried to take my children to her church] I told her that this was none of her business." It is certain that at this point he began to suspect that she was a witch. Then, there were two events that apparently confirmed his suspicion. First of all, his youngest child, Ola Goke, became ill. He woke up in the night and went on crying. He then developed a cough and lost his appetite. As the symptoms were prolonged, Mr. Ishola and Mama Goke became anxious about him. Secondly, Mr. Ishola had a dream of an angel. He said, "[in the dream] Angel told me this and that...In the next morning, the first person I saw was that woman!" He told his family that Mrs. David was a witch and that Ola Goke should not be near her. Their relationship was then dramatically transformed. The Ishola family stopped greeting the couple. Mr. Ishola tried to avoid Mrs. David as much as he could. In his view, she was jealous of him, because he had children. He said, "Black men are bad! I have children. She may not like it!"

Mr. Ishola was more and more disturbed by Mrs. David. His suspicion of her witchcraft was confirmed by the oracle of Baba Garukwa, an elderly traditional healer whom he sometimes consulted. According to Baba Garukwa, he said to me, the woman was a witch and planned to burn his house. Thus, it was clear to him that he had to turn them out of his house as soon as possible. First of all, he gave them notice to quit their room in two weeks, explaining that he would need their room for his relative. He then put smoke herbal medicine in front of their room,
while they were not present at the house. It appears that he even hinted in Mrs. David’s presence that there was a witch in the house. By this time, he was almost obsessed with Mrs. David’s behaviour. Her morning prayer was particularly threatening to him. "It is not a prayer. It is incantation, curse!", he said. To protect his family and house, he conducted a counter-prayers. As early as three o’clock in the morning, both Mrs. David and Mr. Ishola prayed loudly in their rooms. She was apparently aware of his prayer directed against her and prayed louder than usual, which led Mr. Ishola to pray even louder. Sleepless nights continued. During the day, Mr. Ishola looked completely exhausted.

Then, one evening, almost two weeks after they had been given notice to quit, Mr. Ishola put Oladuowe’s song on his stereo at high volume. The songs were full of Yoruba proverbs and quite abusive. It said, "You cannot harm me.... The God is my companion...." It appears to me that this was his deliberate choice to open the ‘ritual’ of refunding the deposit. He called Mr. David, Mama Goke and me in order to refund the deposit of rent he had collected from Mr. David. He told me to be a witness and let me count the money. Mama Goke wrote a letter of confirmation for the refunding signed by Mr. David, Mama Goke and myself. While Mr. David was upset by the event, he nonetheless received the money. Mr. Ishola might have calculated that once the deposit was refunded, there was no excuse for the couple to remain at his house - they were supposed to leave their room in a few days according to the notice given to them.

However, they stayed on even after the deadline. In the mean time, Ola Goke became sick again and developed asthmatic symptoms. Mama Goke asked me for financial help to take him to a clinic. According to her, Mr. Ishola refused to give her money for a clinic.
It seems conceivable that he considered the Ola Goke's sickness to have been caused by Mrs. David's witchcraft and therefore not curable by hospital medicine. Then, a few days later, Mr. Sadiq and several men came in his car to the house. While they were not in uniform, they were introduced as soldiers by Mr. Sadiq. Mr. Sadiq, who knew about Mr. Ishola's trouble with the tenant, extended his help to Mr. Ishola. He said that he knew the commander of the military base in Kakuri and could use the soldiers at his disposal. He intimidated Mr. and Mrs. David telling them that, if they did not move out by the following day, they would be forced out by these soldiers. It was an ultimatum. Later in the night, the couple packed up and left the house. I was told that they found shelter at Mrs. David's church.

Of five cases of eviction of tenants from Mr. Ishola's residence, in four, the development of troubles and his understanding and management of the troubles followed a similar pattern: at first, Mr. Ishola was annoyed by minor incidents caused by either a wife or children of a tenant; secondly, he began to suspect that a wife (a child in Nkechi's case) was a witch; thirdly, he tried to evict a tenant's family, by means of various tactics; and, after eviction, he soon accommodated a new tenant. Thus, a quick turn over of tenants, witchcraft and eviction were the characteristics of his management of tenants. It appears to me, however, that this has to be understood in terms of the particular nature of housing economy, petty-landlordism, urban social relationships and culture in Kaduna.

As noted in Chapter III, rapid urbanisation has resulted in a chronic shortage of rooms to let in Kaduna. Vacant rooms are hard to find. This sellers' market situation allows landlords to fix the terms of rent and other conditions in their favour. Landlords are also in a position to choose their prospective
tenants. They may even be tempted to dislodge present tenants in order to take on new ones who will pay six months' to one year's rent in advance. It is at least certain that the moving out of tenants is not a loss for landlords, since they can shortly expect new tenants.

Thus, Mr. Ishola's frequent eviction of tenants can be understood in this context. However, it appears that Mr. Ishola was aware that minor troubles caused by his tenants did not always justify his eviction of them. In this situation, it is conceivable that his suspicion of witchcraft could provide self-justification for his conduct. In all four cases, troubles caused by tenants preceded his identification of tenants as witches, and it appears to me that Mr. Ishola was already quite annoyed by the troubles prior to his suspicion of witchcraft. Thus, in Nkechi's case, Mr. Ishola was at first annoyed by her untidy use of the house and her attitude towards older people, and then by the fight between Nkechi and a sister. It appears to me that Mr. Ishola's decision to evict Nkechi's family was more or less made by these troubles alone. In due course, he developed an idea that Nkechi was a witch. However, it does not seem that he was really threatened by her witchcraft. At least, it is certain that his identification of Nkechi as a witch was not the main reason for his decision to evict her, but rather complementary to the troubles caused by her and her family. In other words, it was to reinforce and justify the decision to evict which he had already made.

It is important to note that, in most cases, including his eviction of tenants from his other houses, tenants eventually moved out after notice to quit had been given to them, even though, as we shall see, the matter was taken to court in some cases. They somehow managed to find a place to stay. It is indeed
surprising that despite the shortage of rooms for letting, people were accommodated somewhere in this city - there are not many homeless people nor squatters in Kaduna. It appears to me that this is mainly due to the existence of various social relationships that could provide at least temporary accommodation for people. Thus, they are given shelter by their kin (as in the cases of Peter), friends (in the case of Baba Rimi [see note 2 in Chapter V]), religious groups (as in the case of Mrs. David) and possibly by local associations. The point is that the fact that people can depend upon these social relationships for temporary accommodation could help them to decide to move out of the rooms they rent. Thus, a combination of the current market situation of room-letting and multiple social ties of mutual help is conducive to movement of tenants in the city in the sense that landlords have alternative tenants to accommodate, while tenants have alternative places to be accommodated in cases of emergency.

Mr. Ishola's identification of tenants as witches and his eviction of tenants appear to be also related to the nature of his petty-landlordism, that is, the fact that he accommodates his tenants at his own residence. I have suggested that identification of tenants as witches has an aspect of excuse for Mr. Ishola to evict tenants. However, it is also certain that his suspicion of witchcraft does not just rationalise his action but, in some cases, emotionally charges it. This is clear in Mrs. David's case where her presence was a real threat to him. It appears to me that this threat was partly attributable to the fact that she was living beside him and his family in the same house. She and other tenants whom Mr. Ishola identified as witches all lived in his residence - it is remarkable that, as far as I know, he did not identify particular tenants living at his other houses...
as witches, nor was he disturbed by witchcraft from the other houses. It is understandable that witchcraft was particularly threatening in cases where suspected witches lived under his nose.

The lodging of tenants at Mr.Ishola’s residence is not just a matter of their being in close proximity, but also indicates that they are in a position to observe the sphere of domesticity and consumption of the Ishola family. In general, witchcraft is closely associated with a sense of inequality in Kaduna, and Mr.Ishola’s case is not exceptional in this regard. The point is that such a sense of inequality is particularly noticeable in the domain of consumption. Envy can be easily provoked by differences in housing, mode of dress and material possessions. Mr.Ishola was aware, perhaps too much, of the differences in material prosperity between him and his lodgers. Under such circumstances, his suspicion of witchcraft could be triggered by even minor incidents. Thus, his sense of inequality appears to be vital for the understanding of Mrs.David’s case in that his suspicion of her witchcraft appears to have been inseparable from his awareness of the fact that her husband was jobless at that time. They were also childless and Mrs.David was particularly concerned about it.

It has to be mentioned, however, that Mr.Ishola’s sense of inequality and his conflicts with tenants are not necessarily indicative of the development of class consciousness in landlords and tenants. First of all, Mr.Ishola does not see landlords as a group and himself as a member of such a group. He is not involved in a landlords’ association, nor does he view his neighbours who let rooms for tenants primarily as his fellow landlords. Secondly, although tenants can unite themselves against Mr.Ishola (I have come across two cases where all the tenants in the same house were
united against him on a particular issue), their identity with co-tenants is not particularly strong - after all, they do not live in the same house for long. More importantly, the sense of inequality is relative. Mr. Ishola and his tenants share a sense of inequality against rich politicians, army officers and business people. On the other hand, even tenants can be considered as "rich" - this is how they think that their rural relatives think of them, as is clear in the case of Peter.

Mr. Ishola’s identification of tenants as witches and his eviction of tenants appear to be also bound up with the nature of urban social relationships and culture in Kaduna. As far as I know, all the tenants except Mr. and Mrs. David were strangers, that is, those who were not from his home town, nor co-ethnic, nor even friends. In most cases, he had never previously met his tenants. This cannot be explained solely by demography those who were from his home town constitute only a small proportion of the population in the city. People commonly accommodate their relatives and friends from home. Thus, it appears that to take strangers as his tenants was partially his deliberate choice. Once he told me that he did not want to live with his relatives. What is significant here is that he was in a relatively autonomous position to choose strangers as his tenants and resist the obligation to accommodate his relatives.

It appears to me that his preference for strangers has much to do with the fact that strangers are easier for him to manage, compared to relatives and friends. It is certain that he would not feel as free to evict his relatives as he would strangers. Also, it would not be as easy for him to identify his relatives as witches. It is important to note that his identification of particular tenants as witches was
not always shared by his family members. Of four cases that I know, it was only Mrs. David’s case in which his family members shared his view and felt threatened by her (in other cases, in their view, the witch identity of the tenants was ambiguous). In other words, the idea of tenants as witches was his own perspective.

Mr. Ishola’s identification of witches as his individual perspective indicates that there was certain arbitrariness in his identification. Four women whom he identified as witches and eventually evicted out of his residence did not seem to have many common and clear features that gave rise to his suspicion of witches. Thus, the first woman was a housewife in her late twenties and from Bendel State, and Mr. Ishola’s trouble with her was that she was a gossip and, in his view, spoke ill of him in his absence. The second woman was an Igala housewife in her early thirties, and his problem with the lady was that she did not discipline her children well in their use of his house. The other two cases, those of Nkechi and Mrs. David, have already been noted. Thus, apart from Mrs. David’s barrenness, which is generally associated with witches, it is hard to find definitive characteristics of witches in them.

It is, however, certainly significant that all four people he identified as witches were women who stayed mainly at his residence, doing domestic and other work. In general, women are more subject to suspicion and accusation of witchcraft in Kaduna as elsewhere in Nigeria. In this regard, he certainly followed a general tendency.

As soon as he was convinced that the tenants were witches, Mr. Ishola tried to evict them out of his residence by some means or another. In all the cases, he at first gave notice to quit. Then he used traditional medicine to ensure their departure, as in the cases of Nkechi and Mrs. David. In Mrs. David’s
case, even "soldiers" were employed to evict her and her husband. This almost crude exercise of power made me ponder over the state of the law concerning landlords and tenants. Obviously, Kaduna State has regulations (the Kaduna State Landlords and Tenants Edict) that clarifies relations between landlords and tenants, the nature of contract, tenancy and payment of rent (Annual Volume of the Laws of Kaduna State of Nigeria 1990). As far as I know, Mr.Ishola was involved in two court cases over troubles with his tenants. Thus, it looks as though the existence of the law and his involvement in court cases indicate that he could not entirely ignore legal procedure in the management of his tenants. However, as the following case shows, such judicial intervention cannot be taken for granted. It appears to me that the state control and legal framework should be characterised by its weakness rather than its strength here.

In May 1990, a judge of a local court and policemen came to inspect one of Mr.Ishola’s houses, following an allegation made by a group of his tenants that they were unlawfully evicted from their rooms by the landlord. During the inspection, the Ishola family and tenants gathered at the house, and the judge, a Yoruba woman, questioned Mr.Ishola over the issue. However, in the tense atmosphere, a quarrel soon broke out among them. Upset by the situation, the judge ordered the policemen to arrest Mr.Ishola and his son, Isaac, and left the place. Then, his family tried to locate the whereabouts of Mr.Ishola and Isaac, checking several police stations. They were finally found at a police station quite far away from their neighbourhood.

At the station, Mr.Ishola instructed his wife and children to contact one of his relatives whose husband was working for the high court, and to collect as much money as they could. On the following day, while the
relative came over to see him, he realised that she was not prepared to help him out. Meanwhile, his family collected money from all the possible sources including borrowing from his relatives and friends. Two days later, the court hearing regarding the case of Mr. Ishola and Isaac was held. Mr. Ishola, Isaac and one of the policemen who made the arrest were present at the court. According to Mr. Ishola, however, just before the court was open, he managed to meet a judge who was going to preside over their case (the judge was different from the one who had inspected his house). He then discretely offered the judge the money his family had collected and the judge actually took it. The deal was made. They were then released on the spot. Later, Mr. Ishola told me that the Yoruba judge and policemen who had arrested him and Isaac were bribed by the tenants to do so. Moreover, he suspected that there was someone who had plotted the whole situation and manipulated the tenants through magical power, namely Mama Sunday and her witchcraft.

Thus, the weakness of judicial power rendered conflicts between Mr. Ishola and his tenants to be almost a naked power game. Mr. Ishola is successful in conflict resolution; his success, however, is of temporary nature. Thus, even if he successfully evicts tenants from his house, there is no guarantee that his new tenants will be any better. His suspicion of witches will surely occur again. Thus, his ‘ejective solution’ is not a permanent solution. It seems as if he merely invites witches into his house over and over again.
CHAPTER VIII
MANAGEMENT, AETIOLOGY AND NATURE
OF EVERYDAY CRISIS

In this chapter, I analyse the management, aetiology and nature of crisis situations in our case studies. I highlight both the general characteristics and variations in the cases studied with regard to: 1) cultural flow, 2) agencies and power, 3) action, and 4) the nature of everyday crises. But, first, I point out the importance of the idea of cultural field in the analysis of everyday crisis management.

MANAGEMENT OF EVERYDAY CRISIS AS A CULTURAL FIELD

In Chapter II, I suggested that the issues of illness and medicine should be understood in the wider framework of everyday crisis and its management in an African context. The case studies clearly support this view. In our cases, physical afflictions and their treatment are often inseparable from various other misfortunes and their management. The informants aetiollogically interlinked illness and other crises that afflicted them.

Thus, the interlinkage of diverse crisis events is most clearly seen in the case of Peter. Peter did not see the various problems he encountered as separate events but often related them. In particular, his aetiological understanding revolved around his kinship obligations and his idea of witchcraft. Mr. Ishola, too, often understood physical illness as one of the manifestations of witchcraft, as is clear in the case of his son’s, Ola Goke’s, illness which he
attributed to the witchcraft of a tenant, Mrs. David. (See also Appendix 5 about Mr. Ishola's idea of witchcraft).

It is important to note that traditional medicine was used by our informants to tackle not only illness but also social and economic problems. It is also clear that no rigid separation can analytically be made between the field of medicine and that of religion in the pursuit of therapy in the cases of our informants. Patricia, Mr. Barki and Mr. Sadiq all carried out religious practices to cope with illness and their other crises.

The management and etiological understanding of everyday crises by our informants, however, reveal significant variation as well as similarity. Such coexistence of both general and distinctive features has to be understood in terms of cultural flow.

CULTURAL FLOW

First of all, it is remarkable that our informants know and use an enormous range of ideas, practices and social relationships to understand and manage their everyday crises. The point is that the cultural repertoires of the informants do not entirely vary according to individuals nor are they uniform among them. The cultural repertoires of the informants are partially overlapping and are partially discrete. In other words, they should be understood in terms of cultural flow in which some cultural elements (ideas and practice) are evenly distributed among the informants, while others are unevenly distributed among them.

Thus, despite the diversity of the problems the informants had to tackle, there are similar ideas and practices that they share in the understanding and
management of their problems. In the aetiological explanations of the informants, remarkably similar is their attribution of problems to witchcraft, sorcery and personal agents. Thus, Mr. Sadiq, Peter and Mr. Ishola considered witchcraft and sorcery to be a major cause of their problems, even though Mr. Sadiq and Peter ascribed their problems to other causal agents as well. As noted in Chapter IV, "witch" and "poison" are common causes of illness and misfortune among people in Kaduna regardless of their cultural backgrounds. Apart from Patricia and Mr. Barki, the informants also tend to attribute their problems to other individuals, that is, to blame people such as kin, friends and business partners.

Otherwise, causal agents to which our informants attributed their problems differ according to the kind of problem. However, some aetiological attributions for particular problems are apparently common in Kaduna. For example, on several occasions, Peter attributed his headache to "overthinking", that is, anxiety. Our survey of 50 people from five ethnic categories indicates that such "overthinking" is a common cause of headache. (See Appendix 6). Peter also attributes his son's stomach disorder to improper diet as well as to sorcery. The idea of improper diet, such as eating foods that are too spicy and excessive eating as causes of abdominal disorder is also found to be common in the survey.

With regard to common strategies in the management of crises, noticeable is the prevalent use of money by our informants. Informants commonly pay money in order to solve their problems. This does not just mean that they paid fees for commercial therapies and medications, but, as in the cases of Mr. Sadiq and Mr. Ishola, money was also used to win a personal favour from individuals who have authority in certain areas or have access to resources such as a bank.
manager, police officers and a judge. It is important to note that religious healing is very much commercialised, as Patricia and Mr. Barki's cases show. The use of traditional medicine and divination is also common among the informants. All the informants used traditional medicine in one way or another. Among various social relationships on which informants relied in their crisis situations, kinship is undoubtedly the most important one, even though reliance on kinship varies in degree according to individuals.

As far as the initial stage of the management of illness is concerned, a certain tendency can be detected in the cases of our informants. Thus, informants first employed clinical therapy after the onset of their illnesses, even though little general patterning in the choice of therapies is identifiable after the first resort. As noted in Chapter IV, this is consistent with the result of survey research.

However, such common and similar elements are conjoined by a wide range of more discrete and distinctive elements. Thus, there is an uneven distribution of cultural elements, the most notable being ethnic and religious elements, that forms distinctiveness in the management and aetiology of each informant's crisis situation. Thus, in Patricia's case, diagnoses of ogbanje and Mamy Wota healing are derived from her ethnic and regional cultural background. In Peter's case, the idea of akombo illness and its ritual healing at home are a part of Tiv culture. (See Appendix 7 for the concepts of Akombo illnesses). The management of crises are also clearly influenced by the religious affiliations of our informants. Our Christian informants, especially Patricia and Mr. Barki, employed church healing, not Islamic healing, whereas our Muslim informant, Mr. Sadiq, practised Islamic ritual, not Christian ritual.
Yet, differences are not derived just from ethnic, religious and generational cultures but are also a matter of each individual's unique appropriation of ideas. It is not that our informants had individually idiosyncratic ideas in the understanding of their crises, but rather that the ways they used the ideas, that is, their analyses of the crises, were at times unique in the sense that other people who knew their crises did not necessarily share the same views. Thus, Mr. Ishola identified his tenants with witches, whereas not all his children and relatives shared his view, even though they pretended to do so in his presence. Peter and Mr. Sadiq came up with various causal agents for their particular problems; Peter, for instance, once attributed his eye problem to "floria worm [filaria]", cotton fibre and then to sorcery. It is certain that some of the causal agents to which these individuals attributed their problems are common in Kaduna. However, it is unlikely that other people also would come up with the same combination of causal agents for the same problems. Thus, some of our informants' aetiological explanations have aspects of individual perspectives.

However, it is important to emphasise that these distinctive and unique elements form only part of informants' wide repertoires of knowledge and practices for their management of crises. Furthermore, in the course of their management of crises, our informants were encountering ideas and practices about which they had known little. Patricia might have heard of Mamy Wota societies and their healing and might have seen Aladura churches and their healing before. However, it is not until she received the healings that she knew exactly what they were like. Mr. Barki, too, encountered a number of different therapies, and he had had only a slight idea of some of these. It can even be said that both Patricia and Mr. Barki were
looking for something new to cure their afflictions.

Finally, it is important to look into the forms of knowledge and practices that informants commonly used to understand and manage their crises; the practice of traditional medicine and the idea of witchcraft. One striking feature of traditional medicine and witchcraft is that these reflected diverse reality and were associated with so many different kinds of events in the everyday lives of our informants. Thus, the range of the objectives of traditional medicine is truly wide: the kinds of illness for which the informants applied traditional medicine included mental illness, swelling of the abdomen, miscarriage, headache and eye troubles; in the case of socio-economic problems, traditional medicines were used to ensure a safe journey, the release of a loan, the eviction of tenants, protection for those living in a house and for their property, and general success and protection. Traditional medicine is more or less a catch-all panacea so to speak.

The informants used traditional medicine mostly in combination with other methods and practices, sometimes simultaneously with them, at other times only after failure. They employed it in addition to clinical medicine, religious practice, careful planning and implementation of certain procedures, verbal statements and written notices to achieve particular ends. In this respect, the significance of traditional medicine appears to be related to the failure, and the possibility of failure, of the various other activities. In other words, the significance of traditional medicine consists in uncertainty surrounding goal-oriented activities.

Witchcraft, too, was associated with a number of different events by the informants, ranging from various illnesses to business problems. In an extreme
case, any bad event that happened to an individual could be considered to be caused by witchcraft. (See Appendix 5). The idea of "witches" can also be used as a means to rationalise one's action which would otherwise be unjustifiable. This is the case in Mr. Ishola's identification of his tenants as "witches", which gave him an excuse to evict them.

Thus, the case studies appear to indicate that traditional medicine and witchcraft can be situationally associated with and used for an infinite number of events and problems that people encounter in their everyday life. In that sense, they have an aspect of bricolage.

CONFIGURATION OF AGENCIES

The diversity of cultural flow is bound up with the numerous agencies and social relationships in the cultural field of everyday crisis of our informants. In general, the multiplicity of healers and therapy managing groups contributes to the ephemerality of the control these agencies have over the action of our informants. However, the configuration of the agencies varies according to the individuals. It is also important to note that the therapeutic action of our informants is closely related to the construction of the identity of our informants through particular therapies and aetiological ideas.

Thus, throughout the course of Patricia's management of therapy, her family, especially her parents, played a significant role in deciding the choice of therapies and in financially and emotionally taking care of her. It was their decision to take her to most of the traditional healers she visited, and they instructed her to attend at least one church for healing. She was, however, also under the control of
churches and mamy wota societies, since she became a member of these religious groups. Her parents, too, were to some extent subject to the control of these groups, as they had to comply with the requests of these groups in allowing her to attend their services and in paying fees for treatment. However, it is significant that the control of each religious-therapy group over her therapeutic action was unsustainable. Her longest membership of a group lasted two years. Otherwise, she stopped attending the services of these groups within a year. She was also self-determining in the choice of churches - apart from the first church, she herself chose which churches she would attend.

However, her case also indicates that while healseekers can develop their identity through therapy, such identity can be precarious in pluralistic medical situations. Thus, on the one hand, Patricia developed her identity through the therapy of Aladura Christianity. On the other hand, since the Aladura therapy failed to heal her illness permanently, she had to try other therapies including Mammy Wota therapy in which she was required to accept her new identity as ogbanje. The problem is that the change of her therapies did not correspond to the change of her identities. Such a contradiction made the construction of her identity precarious - she was not sure who she was - and perhaps reduced the efficacy of the therapies she applied.

Autonomy in the choice of therapies was even clearer in Mr. Barki’s case. First of all, his kin were hardly important as a therapy managing group, even though they appear to have played a role in the care of his children and wife at his home village. On the other hand, the role of workmates was noticeable in his case. These workmates, some of whom were members of Aladura churches, did not merely give him information about healers but persuaded him to consult
them. However, while he followed their advice, he simply stopped consulting the healers, once he found their healing ineffective. His longest admission to hospital was for one and a half months and his longest participation in church healing lasted two weeks. While he visited a university teaching hospital five times, he also ignored a few appointments. Thus, he could not stick to a particular healer for more than two months on average.

Yet, this does not mean that his therapeutic action was free from any sustainable social control. His social identity, especially his identity as a Christian, to some extent narrowed his choice of therapies; for instance, he never carried out a sacrificial ritual. His consistent labelling of his illness as "ascites" and his rejection of witchcraft as the cause of his illness might have been also related to his identity as a Christian and, perhaps, as a 'modern' person.

Autonomy in crisis management is also clear in the case of Mr. Sadiq. Like Mr. Barki's case, the role of kinship, with the exception of his wife, was insignificant in Mr. Sadiq's crisis management. What was remarkable in his case was that he tried to make use of anybody he found helpful for his business dealing and crisis management. Certainly, he claimed that, in his crisis situation, he had personal networks on which he depended, such as members of what he called the "Old Boys' Association". Thus, he was at times provided with business opportunities by his friends who worked for governmental bodies. However, most of those with whom he had dealings in his business were otherwise 'strangers', that is, people whom he had never met and with whom he had no social connection. As we have seen, his relationships with these customers and partners tended to be shortlived due to their mutual suspicion of mismanagement. He
also distrusted healers' diagnoses of his problem, their protective practices and, above all, a healer himself in the case of Baba Rimi. However, it is important to note that his suspicion was often the suspicion of his partners' suspicion of his misconduct; he was extremely sensitive about personal accusations against him. There is no doubt that such a high sensitivity about personal accusation is related to his identity as a respectable person.

By contrast, Peter's case shows the vital importance of the extended family in crisis management. His extended family played a significant role in providing food, accommodation, a job and therapy for Peter and his wife and child. His aetiological thinking, too, was centred on his suspicion of sorcery and witchcraft which were closely related to kinship ideology. However, even in Peter's case, the role and ideology of kinship should not be overemphasised. Thus, his extended family was not the only therapy managing group; he went around different individuals to solve his financial problems and employed not only a ritual healing at his home village but also the medications at his company clinic and at hospitals to cure the illnesses of his wife, child and himself. His aetiological ideas were not limited to sorcery and witchcraft either. Furthermore, his diagnosis and management of his afflictions and his son's illness were based largely on his own decisions.

Likewise, lacking elder members in his family, Mr. Ishola was in a clearly autonomous position in decision making. His decision to evict tenants was not effectively mediated by any individual or institution. While his friends and younger brothers played an important role in mediating between him and his opposition, on the whole, they were on his side. (See Appendix 5). The identification of his tenants and wife as witches was also more or less based on his
idea. Yet, his fear of witchcraft was pervasive, and was bound up with his sense of inequality, that is, his identity as a person better off than his tenants, and his aspiration to expand his housing business.

With regard to the influence of the state, on the whole the presence of the state is not significant in the crisis management of our informants. It is certain that, to some extent, the state could influence the crisis management of our informants through regulation, law and apparatuses such as governmental hospitals for their health problems and police and courts for their disputes and conflicts. However, state control over the crisis management of our informants was limited, since the state apparatuses form merely part of institutions and groups on which informants depended in their crisis situations, and because the existence of the governmental bodies and organisations does not necessarily mean that their personnel acted according to institutional principles and orders.

Thus, while both Patricia and Mr. Barki utilised governmental hospitals, these hospitals merely formed a part of the diverse therapeutic institutions and practices they tried. As a "public-private consultant", Mr. Sadiq was involved in projects for governmental bodies. However, he was often given opportunities to take on projects through his personal acquaintances in these organisations, that is, through his patron-client networks. Such personal relationships may not always coincide with the institutional orders of governmental bodies. This point is clear in the case of Mr. Ishola. Mr. Ishola frequently called policemen and appealed to a magistrate court when he had troubles with his tenants. However, this can not be taken literally as evidence of the intervention of state authority and the implementation of law, because he tried to win
personal favour, often successfully, from policemen and a judge by bribing them.

There is no doubt that the material conditions of our informants affected their crisis management. It is a truism that, in Kaduna too, the richer individuals are, the more choices they have to tackle their problems. However, our cases illuminate that even those who are not welloff could manage to get finance for therapy. Patricia, Mr.Barki and Peter, all of whom are not particularly welloff, managed to pay sometimes expensive medical charges. In Patricia's case, kinship played a significant role in financing her therapies. In Mr.Barki and Peter's cases, their factory's medical allowance and free treatment at the factory's clinic were essential to their therapy management, even though such allowances were not sufficient by themselves. It is important to note the resources of Patricia and Mr.Barki enabled them to go on trying various therapies.

However, this does not mean that it was easy for the informants to finance their therapy management nor were resources for therapies always available to the informants. Apparently, medical expenses were a heavy burden for Patricia's parents and Mr.Barki. Moreover, it was indeed financial problems that constituted a part of the crises of some informants. The point is not that they could not solve their financial difficulties, but that the financial assistance they obtained from particular individuals or groups tended to be insufficient and temporary; they therefore had to search for other financial sources and had to move around various sources. Thus, Peter managed to solve the financial burden of his kinship obligation by borrowing money from various sources. Mr. Sadiq tended to diversify his financiers, while his relationship with each financier was unsustainable. (See also Appendix 4 for insufficiency and uncertainty in
financial support).

Another important economic aspect of the management of crises is the pervasive use of money on the one hand and the significance of reciprocity on the other. As already noted, the informants' frequent use of money is indicative of the high level of commercialisation of social relationships in Kaduna. Social organisations ranging from government offices to religious groups carry out informal economic activities.

However, this does not imply that these social organisations are transformed purely into business enterprises. The point is that monetisation appears to increase the economic aspects of the various social organisations without completely undermining various other aspects of the organisations. On the other hand, reciprocity is still vital in all the cases of crisis management. Furthermore, as Peter's case indicates, the logic of an industrial organisation is partly modified by the logic of the reciprocal relationships of workers. On the other hand, the logic of such reciprocal relationships is conditioned by the capitalist logic. Thus, there is interpenetration of the logic of capitalism and the logic of reciprocity, which appears to me to be conducive to a blurring of the boundary between economy and other cultural fields in Kaduna.

To summarise the arguments I have made so far, the cultural field of crisis management of our informants is marked by: 1) diversity of cultural flow in time and space, 2) the significance of *bricolage* of knowledge and practice, 3) multiplicity of agencies and relative autonomy of the individuals, 4) the limited bureaucratic control of the state, and 5) interpenetration of the logic of capitalism and the logic of reciprocity. This general configuration of cultural flow and agencies appears also to explain the
remarkable situationality of the therapeutic action of our informants.

**MOTILITY OF ACTION**

Thus, what is striking in the management of our informants' crises is the extent to which they moved between and appropriated diverse ideas, practices and social relationships to solve their problems. Here, the actions of our informants were not necessarily based on knowledge that helped them to understand interrelationships between different ideas and practice concerning causes and solution of crises, nor did they always systematically and critically compare all the options available to them. While in some cases, certain coherences and patterns are evident at the initial stage of the management of crises, the actions of our informants, in response to the ideas and practices that they encountered in the course of their management of crises, were increasingly on a trial-and-error basis. They moved from one idea, one practice and one social relationship to another without constructing a reproducible logic of movement.

Thus, as noted, while at an initial stage, both Patricia and Mr. Barki appear to have followed a similar logic in their pursuit of therapy, since both of them first resorted to clinical practitioners and then employed other therapies, such a pattern soon collapsed into more or less trial-and-error behaviour. They moved around traditional healers, church healers, clinics and hospitals, and encountered various styles of treatment and aetiological explanations.

For years, Mr. Sadiq moved from one business enterprise to another, as soon as he had trouble in pursuing it. In the course of the management of an oil transport business in Kaduna, Mr. Sadiq, who was a
systematic planner, modified his original plan in such a way as to pursue alternative financiers and transporters, and also alternative protective rituals and their practitioners. Peter, too, moved around various sources of finance to meet his reciprocal obligations to his kin, and employed both therapies in Kaduna and therapies at home to solve his and his family's health problems.

By contrast, Mr. Ishola's solution of his troubles with his tenants was to let them move out of his house, that is, he constantly replaced his tenants. To do so, he employed various means including appeal to the courts and use of traditional medicine. It is certain that Mr. Ishola employed ejection as a solution to deal with trouble with his wives as well.

Movement was also a matter of reinterpretation and reidentification of crises, practices and social relationships, that is, a matter of appropriation. Our informants commonly reidentified the causes of their crises and redefined various practices and their social relationships to solve their crises. One of the effects of appropriation was to undermine distinctive cultural elements and turn roles and the division of labour into multifaceted corporate categories.

Thus, both Patricia and Mr. Barki's pursuit of therapy was marked by their relative lack of concern for the causes of their afflictions as the basis for the choice of their therapies. Given the fact that, for therapists like clinical doctors and Mamy Wota healers, identification of causal agents are prerequisite for their healing practices, this means that Patricia and Mr. Barki appropriated the therapists' distinctive theories of healing in such a way as to shorten the elaborate chains of ideas. Particularly, Mr. Barki was not even so much concerned with styles of healing - he was mainly concerned with stories of how effectively particular healers and
healing practices actually healed the afflictions.

The reidentification of social relationships was the usual practice of Mr. Sadiq in his business dealings. He typically turned his customers, friends and healers into his business partners. Thus, he reidentified Mr. Emeka and Mr. Ishola as business partners, and tried to force Mr. Adeforaju to cooperate with him not as a bank manager but as a personal patron by means of blackmail. It is also notable that he made a healer, Baba Rimi, a sorcerer. As to the causes of his business problems, he changed his aetiological explanations from witchcraft and God’s "trial" to fraud, as the situation required. The change of diagnosis of crisis was also seen in Peter’s case. While his aetiological explanations were centred on witchcraft and sorcery at home, he frequently changed his explanations of his own ailments and his son’s sickness.

Thus, movement between meanings, between identities, between practices and between social relationships are the most remarkable feature of our informants’ management of crises. It is also noteworthy that such movement often entailed geographical movement as well. In order to solve their problems, our informants did not only move around Kaduna, which is a vast city, but travelled widely in the country. Thus, Patricia and Mr. Barki did not move around Kaduna but travelled back to their home areas where they also moved around. Mr. Sadiq travelled to Kano, Jos, Katsina and Lagos to find his financier and transporter. Peter sent his wife to their home villages to conduct a ritual healing, whereas his wife carried her sick child from home to Kaduna via Abuja for treatment. (See also Appendix 4).

Indeed, high geographical mobility is one of the characteristics of the lives of our informants as a whole. All these informants are migrants - born
somewhere else and coming to Kaduna later. Some of them had moved around several places prior to settling in Kaduna. In this respect, Mr. Sadiq is a quintessential mover - he travelled around and lived in many places in Nigeria and foreign countries. Even after settling in Kaduna, our informants made journeys to their home towns from time to time. Alternatively, they sent their family members back home.

It should be added that mobility is salient in the occupations of our informants, too. First of all, all the informants have an experience of farming. Some of them, notably, Patricia, Mr. Sadiq and Mr. Ishola changed their jobs a number of times.

NATURE OF CRISSES

Thus, diversity of cultural flow, plurality of agencies and situational action of the individuals characterise the management strategies and aetiology of crises of our informants.

It appears, however, that these general characteristics of the management and aetiology of the informants' crisis situations also hold a key to the understanding of the nature of their crises. Thus, first of all, cultural diversity may lead to conflicts, when actors maintain and insist on their particular cultural traits. What is remarkable in our cases is that, as cultural differences are fragmentary, conflicts tend to occur between individuals over interpretation and identification. Thus, Patricia had a personal clash with one of her bosses over the interpretation of true Christianity, as was the case in Mr. Ishola's initial problem with Mrs. David.

Secondly, problems apparently arise due to the fact that, on the one hand, such cultural and social
differences are maintained by actors, whereas on the other hand, they are often ignored and appropriated by actors as well. Conflicts take place between those who maintain particular cultural knowledge and practice and stick to particular social relationships, settlers, as it were, and those who appropriate these cultural elements and move between different relationships, movers, as it were. Here, settlers suffer from a sense of betrayal, while movers suffer from the accusation of disloyalty and neglect of obligation. The intermediary position of movers may subject them to contradiction between two social relationships (or institutions). This is the problem of Peter whose sufferings are derived mainly from contradiction between kinship and factory orders. (See also Appendix 4 for the problems of disloyalty and neglect of reciprocal obligation).

In more extreme cases, movement between diverse cultural elements and social relationships may result in the loss of meaning and identity. Patricia's problem was apparently worsened by the fact that her identity was being pulled apart by a number of different therapists. In Mr. Barki's case, frequent movement between therapies and the failure of the therapies to cure his illness were apparently conducive to the loss of his interest in the styles of therapies and elaborate aetiological explanations. On the other hand, extreme appropriation of a particular idea or practice may lead to obsession with that idea or practice. Such a cultural element becomes ubiquitous in an actor's life, because it can explain almost any event and phenomenon and can be employed in almost any situation. This is the case of Mr. Ishola's obsession with Mama Sunday's witchcraft. (Appendix 5).

Thirdly, problems are also due to interaction between movers, that is, those who appropriate various cultural elements and move between different social
relationships. Here, the problems are essentially the problem of trust. Mr. Sadiq's case is precisely this. His business failure is largely attributable to distrust between him and those others who were involved in his business. In the course of his business, mutual suspicion over appropriation of the business relationships arose between him and his partners and brought the business to an end.

Finally, an important part of our informants' crises consists in the very management of their crises itself. Movement and appropriation as crisis management more often than not brought temporary solutions to the problems of our informants. Movement between different means of solutions and between different understandings of problems was often lacking in the feedback process. That is, the outcome of the action of our informants tended not to be critically used for testing the validity of the knowledge on the basis of which the action was conducted. Instead, it tended to lead informants to shift to alternative idea and practice. In other words, movement as crisis management has an aspect of escape and excuse which often promises hope and yet end up in despair. Short-term success and repeated failure appear to have thrown our informants into a state of uncertainty and unsustainable trust. Thus, Mr. Barki, Mr. Sadiq and Mr. Ishola moved endlessly to alternative therapies, business and tenants respectively, only to find the same old problems. The pain and hardship can be eased by therapy and crisis management. But they are always potentially present. Crisis management, therefore, never ends, is never complete.
In this final chapter, I summarise the findings of the present study. In doing so, I also intend to examine the theoretical framework I proposed at the beginning of the thesis. I shall then discuss the generalities and peculiarities of everyday crisis management in Kaduna.

FIELD OF EVERYDAY CRISIS MANAGEMENT

In Chapter II, I discussed that it can be misleading for anthropological analysis to focus narrowly upon the domain of physical and mental afflictions and their healing in an African context, since the conceptions of 'illness' and 'medicine' are generally broad, and there exist a plurality of agencies (medical institutions and practitioners, kinship, religious groups and numerous other groups and individuals) that affect the therapeutic action of both healers and lay people. I proposed the idea of the cultural field of everyday crisis and its management as the analytical focus.

My ethnographic data from Kaduna appear to support the feasibility of this focus of the analysis. Thus, in Kaduna, traditional medicine is used to tackle not only illness but also almost any kind of social and economic problem. It is clear in Chapter VII that actors often aetio logically relate illness and various other misfortunes, and that a plurality of groups and individuals are involved in the management of therapy.
CULTURAL FLOW AND FORM

As noted in Chapter II, in the past, medical anthropology tended to focus on distinctive aspects of therapy management and aetiological ideas of particular social groups. However, the management and aetiological understanding of everyday crises exhibit both similarities and differences among lay people and among healers in Kaduna. Cultural elements (knowledge and practices) in crisis management are not either entirely segregated according to those who share certain common identities or entirely homogeneous, but rather there exist the overlapping multiple layers of cultural elements among individuals in the city. People have access to, and are in possession of, various ideas and knowledge concerning everyday crises and their management, whereas individual repertoires of these cultural elements, that is, the combinations of these, are partially overlapping and partially discrete. To describe this situation as forming a single medical system, as Kleinman (1980) and Leslie (1977) would do, appears to run counter to the conception of a system which denotes consistency and pattern.

Thus, in the field of crisis management, some cultural elements are widely shared by people regardless of their cultural backgrounds, as is clear in the case studies in Chapter VII. In the practice of traditional medicine, too, there exist practices and ideas that spread among healers across ethnic and religious boundaries, as I noted in Chapter III. On the other hand, there are cultural elements shared only by those who possess particular social identities. Such uneven flow of cultural elements are particularly remarkable in the domains of ethnicity and religion. As noted in Chapter III, ethnically and
regionally specific practices form the core part of traditional medicine. Lay people's crisis management also displays such ethnically distinctive elements. Yet, individuals have more idiosyncratic practices and ideas concerning crisis management, too. This is clearly the case of the innovative practice of traditional healers. The case studies in Chapter VII also indicate that informants often came up with the self-diagnoses of their problems which no one else shared.

The flow of cultural elements is also variable in terms of time dimension. First of all, certain practices and knowledge have apparently been transmitted from generation to generation. The core practices of traditional medicine appear to exemplify such durable cultural elements. Certain aetiological ideas, especially those specific to ethnic groups are apparently deeply rooted among members of ethnic groups. In this regard, we should take seriously Burnham's (1996) recent critique of the situationist's approach to ethnicity which exaggerates the inventedness and situationality of ethnicity. His comparative study of three ethnic groups in Northern Cameroon clearly shows that cultural logics specific to particular ethnic groups are deeply ingrained in their political and social practices.

Yet, secondly, it is also clear in my case studies that people learn new ideas and encounter previously unknown practices during the course of their crisis management. It is such encounter of knowledge and practices that marks crisis management in Kaduna. There are always healers, therapeutic practices and aetiological ideas which are unknown to lay people in this vast city of cultural diversity. Information about healers and their practices are almost in a state of flux; people learn it through relatives, friends, workmates, or rumours in general.
Traditional healers, too, are generally keen to learn new practices and prescriptions of medicine, while maintaining ethnically and regionally specific core elements.

In this situation, people inevitably interpret new elements on the basis of the knowledge they have already acquired. Such unconscious synthesis of new and old elements may be seen as evidence of the structuralist argument of change (Sahlins 1981). However, what is remarkable in the field of crisis management in Kaduna is fluidity and situationality of interconnection between old and new elements. Thus, ranging from traditional medicine, "witches" and "herbalists" to traditional healers' certificates, both healers and lay people situationally appropriate these practices and ideas in order to understand numerous events and misfortunes and to solve numerous problems. To understand such multiple signification and appropriation of particular cultural forms, it appears to be useful to employ the concept of bricolage (Levi-Strauss 1966). It is important to note that such fluidity and situationality in the use of bricolage are not contradictory to the existence of certain core elements in them. Firstly, it can be said that the externalised form of these cultural elements, the signifier, are not substantially transformed by their users; it is safe to say that the sound of the word, "witches", is widely shared and almost similarly pronounced by my informants. Secondly, there are certain core associations of meanings or concrete images attached to bricolage. Thus, the images attached to "witches" are fairly similar among my informants, even though misfortunes they attributed to "witches" are extremely diverse. It appears to me that such concrete core elements, as opposed to elaborate systems of knowledge, allow actors to use them in an improvisatory manner.
Thus, the field of crisis management in Kaduna exhibits the complexity of cultural flow and forms, a situation which defies any simplistic generalisation. However, I would argue that one does not have to have recourse to the subjectivism of phenomenological approach to which B.J. Good (1994) appears to be heading. Even in such a situation, one can establish certain generalities in the management of the everyday crises of individuals and of groups. Such generalities are, however, inevitably based on multiple cultural logics, not on a single one. For example, it is clearly insufficient and even misleading to analyse the crisis management of a young Tiv male adult factory worker educated in primary school solely in terms of practices and knowledge derived from Tiv ethnicity. It is likely that cultural elements derived from age, gender, education and occupation, all, play varying roles in his crisis management. The pursuit of such generalities is never precise; only an approximation of the general tendency in the action of individuals or groups can be achieved. Interestingly enough, such approximation is what competent traditional healers arrive at when they practise divination for their clients; they take into consideration cultural backgrounds (gender, age, ethnicity, occupation, income and so on) of clients and attempt to guess what kinds of problems clients are experiencing and to what kinds of causes clients attribute their problems.

CONFIGURATION OF SOCIAL AGENCIES

The complex cultural flow in the field of everyday crisis management in Kaduna is also bound up with the particular configuration of agencies that affect the action of individuals concerning everyday
crises; these agencies include medical institutions and practitioners, kinship, religious groups, the state and economic organisations. As noted in Chapters III, IV and VII, in Kaduna, the configuration of these institutions and groups are marked by enormous plurality, the lack of a hegemonic institution, looseness of social networks and their unreachability, and relative individual autonomy in the field of crisis management. Thus, lay people have significant autonomy in choosing healers, medical institutions and social relationships in order to solve their crises. Certainly, religious identities sometimes inhibited our informants in the use of therapies unacceptable to their religious groups. However, in this city, people can easily hide the fact of visiting healers from their fellow religious members. Such individual autonomy of lay people obviously cannot be understood from the perspective of domination (Young 1993) by particular institutions. Traditional healers, too, enjoy considerable autonomy in innovating their practices and pursuing economic interests in dealing with their clients, most of whom are strangers. The practice of traditional medicine cannot therefore be considered to solidify migrant communities here (Press 1978). It is certain that, as Crandon-Malamud's (1991) study indicates, that the pursuit of therapy is sometimes inseparable from the pursuit of identity. However, in Kaduna, as Patricia's case shows, the construction of identities through therapy can be problematic. In the configuration of social agencies characterised by their extremely plurality and a high degree of individual autonomy, the pursuit of identity can be contradictory to the pursuit of cure.

With regard to state control over the practice of traditional medicine and lay crisis management, it is clear in Chapters VI and VII that the bureaucratic control of the state is limited, while patron-client
relationships play a significant role in the organisations of healers' groups and the management of crises. Here, a binary view of the state versus civil society and the perspective of counter-hegemony (Comaroff 1985) of traditional healers cannot adequately describe the situation. The Marxist perspective (Doyal 1979), too, is limited in the understanding of crisis management. Despite the fact that informants are not particularly well off, they managed to obtain finance for their crisis management. Here, reciprocal relationships are vital for financial support. Yet, it is also certain that none of these social ties provide sufficient support for our informants by themselves. Thus, the problem of informants is not that they are totally deprived of material resources, but that there is considerable uncertainty and insecurity in obtaining them.

Thus, it appears to me that fragmentation and influx in cultural flow, the significance of bricolage, the configuration of social agencies marked by plurality and individual autonomy are generally conducive to the situationality of action in everyday crisis management.

**TENDENCY IN ACTION AND HISTORICAL CHANGE**

Thus, the action of both lay people and traditional healers in everyday crisis management is remarkable in its situationality in Kaduna. Such situational action can be characterised either by movement around the different signifiers (externalised forms of cultures) on the basis of the same signified (meanings and ideas) or by appropriation of the same signifier for the different signified, even though these are basically two sides of the same coin. While lay people's action in their crisis management shows
certain coherence and pattern at the initial stage, their action is increasingly marked by movement around different aetiological ideas, different therapies, medical practitioners, and various other individuals and groups to understand and solve their problems. On the other hand, traditional healers appropriate their core divinatory and healing practices to handle numerous problems in the city, even though they certainly innovate part of their practices as well.

It seems clear that the characteristics of the field of everyday crisis depicted above, that is, diversity of cultural flow, plurality of agencies and significance of the situational aspect of action, apply in a large part to the general characteristics of the cultures of Kaduna as a whole. However, it is essential to view the general characteristics of the configuration of cultural flow and agencies in the city as being historically constituted. There has been a marked shift towards this particular configuration of cultural flow and agencies in the past.

From the colonial time to the late 1960s, the state had much greater bureaucratic control over different cultural fields in the city. The colonial government systematically constructed the city as a centre of administration and a military base. The Northern Regional government made a considerable effort to develop the city as the capital of the Northern Region. Until the oil crisis in the late 1970s, Kaduna's economy was dominated by large- and medium-scale industries. Especially, the textile industry provided employment for a large proportion of the adult male population. Thus, it is probable that during this period, the cultural fields of the city were more organised on the basis of the logic and hegemonic power of the state and industries.

Since the oil crisis, the bureaucratic control of the state has declined, and industry has been
suffering from recession in Kaduna. Nonetheless, Kaduna has continuously attracted migrants with diverse cultural backgrounds from all over the country and beyond. The fact that Kaduna is in a pivotal position in the relatively developed transport and mass media systems in the country helps to promote the influx of not only migrants but also information. Thus, Kaduna was to become the city of cultural diversity. The general characteristics of the cultural field of everyday crisis management and of the city as a whole are indeed a part of this historical change.

The question is whether such configuration of cultural flow, agencies and tendency in action in the field of everyday crisis is peculiar to Kaduna. It appears to me that while Kaduna is extreme in its ethnic and religious diversity, to a lesser extent, similar conditions exist in many cities in Africa and other parts of the Third World. These are the cities that can be characterised by: 1) rapid growth, 2) lack of indigenous base (colonial cities), 3) migrant base of growth, 4) weakness of the bureaucratic control of the state, 5) lack of a dominant industry, and 6) general cultural diversity in the region and country where cities are situated. In Nigeria, cities that fit these criteria are, for instance, Kafanchan, Jos and Port Harcourt. It is also conceivable that the peripheral areas of the metropolises such as Lagos, Ibadan and Kano share these features, if not all of them. Moreover, similar conditions may exist in cities in North America, Western Europe and the Far East as well. This may be the situation in cities that have undergone de-industrialisation or decline in centralised authorities, while attracting massive migration from other countries and regions. In this regard, I hope that the present study will offer some contribution to not only medical anthropology and urban anthropology but also to studies concerning
issues of 'modernity' in general.
### APPENDIX 1

#### CULTURAL BACKGROUNDS OF 35 TRADITIONAL HEALERS

<table>
<thead>
<tr>
<th>Names of Healers</th>
<th>Gender</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Religion</th>
<th>State of Origin</th>
<th>Came to Kaduna</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shaib</td>
<td>male</td>
<td>48</td>
<td>Hausa</td>
<td>Muslim - bori</td>
<td>Kano</td>
<td>1957</td>
<td>Koranic</td>
</tr>
<tr>
<td>Garba</td>
<td>male</td>
<td>n.a.</td>
<td>Hausa</td>
<td>Muslim</td>
<td>Kano</td>
<td>n.a.</td>
<td>Koranic</td>
</tr>
<tr>
<td>Hanza</td>
<td>male</td>
<td>52</td>
<td>Hausa</td>
<td>Muslim - bori</td>
<td>Kano</td>
<td>childhood</td>
<td>Koranic</td>
</tr>
<tr>
<td>Maazu</td>
<td>male</td>
<td>46</td>
<td>Hausa</td>
<td>Muslim - bori</td>
<td>Kaduna</td>
<td>1963</td>
<td>Koranic</td>
</tr>
<tr>
<td>Mai Jirgi</td>
<td>male</td>
<td>n.a.</td>
<td>Hausa</td>
<td>Muslim</td>
<td>Sokoto</td>
<td>n.a.</td>
<td>Koranic</td>
</tr>
<tr>
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APPENDIX 2

CAREER OF HEALERS

The following six cases show the multitude of economic activities in which healers have been engaged serially and simultaneously.

Case 1

Mr. Garba, a Hausa healer from Kano, has been living in Kaduna for a long time. As his side-line or even main job, he is working as a security guard for a local court. He attends clients only when he is on night duty for his security work and stays at home during the day. Obviously, time spent in his security work is longer than time spent in healing. Previously, he has done various jobs including that of tax collector and police officer.

Case 2

The main work of Mr. Karfe, a Gbagyi healer, is farming. Being born and brought up as a native of Kaduna, he has a farm on the outskirts of the city. Although he has sold part of his father's land, he maintains a farm large enough to feed his family. His healing work is mainly conducted during the dry season. We had to give up interviewing him as the rainy season approached.

Case 3

Hajiya Rami, a Hausa healer who is also a bori performer, has been a trader for a long time. She came to Kaduna after she divorced. There she soon developed a mental disorder. Her problem disappeared when she was initiated into bori by its leader, a female Hausa healer, Hajiya Maikoko.

Then she started her business career. Her first business was selling cooked food such as rice, yam and cake. Her second merchandise was clothes. She travelled to Kano and Onitsha to obtain the clothes and sold them from house to house in Kaduna. Later the merchandise was changed to kwano, metal pots and plates, which she obtained at Kano. The last item she handled was jewellery.

After she got married again, however, the business hit a problem. Her merchandise and money were mysteriously stolen. Hajiya Maikoko told her that it was a spirit, Dan Galadima, who did it and she needed to be a healer. Since then, she has stopped trading and has been practising healing (In the meantime her second husband died and now she is married to a third one.)

Case 4

Mr. Nchochia, an Igbo healer from Imo State, began his career as a school teacher at his village. The teaching work continued for 12 years. But in 1961, he had to leave the job due to 'lack of management' which he attributes to spiritual forces.

Then he was employed by a French man who owned petrol stations and a cocoa plantation. He worked for him for six and a half years, staying in Cameroon, France and Equatorial Guinea. When he came back to Nigeria, he got
employment at Nigerian National Petroleum Corporation (NNPC) at Warri and worked there from 1972 to 1979. What caused him to quit NNPC was again spiritual. He became forgetful and unable to concentrate on his work.

At his village, his father, the chief priest of ala (the god of the earth) and other deities, told him that it was time for him to serve the spirit. He assisted his father in practising healing work. In 1983, when his father died, his uncle succeeded the priestship after his father; he therefore had to leave the village. In 1987, he came to Kaduna and since then he has been working as a full-time healer.

Case 5

Mr. Fabian's career began when he was employed at an electroengineering company in his town at the age of 18. But it did not take long for him to quit the job, owing to a mysterious sickness, temporary blindness. Fortunately, his sickness was almost naturally cured, after many treatments at hospitals and by traditional healers were found to be in vain.

Then he went to USA and stayed with his brother for one and a half year. In 1963 and 1964, he found himself in Guiana searching for gold. Without any success, he returned home in 1965, and there he got the same sickness. He was initiated into the agu society. Hereafter the sickness has never occurred again.

In 1972, he came to Kaduna where his first job was to carry goods by means of a one-wheel trolley for those shopping at the central market. Then he sold shoes, carrying around the merchandise on his head. In the meantime, capital was gradually accumulated. In 1974, he opened a medical store, which has become one of his major businesses and is still operating.

It was in 1977 when he started healing work, though the idea of doing healing practice had come to him before he came to Kaduna. He learned the work by travelling around many places and gathering information from herbalists and church healers there. On the other hand, he has not given up his other businesses for healing work. Far from it, he expanded his business activities into various areas. He is now proud of being the owner and manager of four enterprises.

Case 6

Baba Shagari, a Yoruba healer, also started his career as a teacher. He worked for a Baptist day school from 1957 up to 1964 when the government disqualified teachers who only had a certificate of Modern School. Then he made a living as a mason for a while. During the civil war, he joined the army.

In 1970, he came to Kaduna and was able to get employment at a construction company. But his job was changed twice up to 1978. He worked at the state water board for three years and at another construction company for four years. In 1978, he took part in politics. He joined National Party of Nigeria (NPN) and became the campaign manager of the Yoruba wing of the party. When the time of politics was over, he inevitably left politics. His last employment was at a textile company. He worked there for seven years.

In 1986, he made up his mind to be a full-time healer, although he had practised healing on a part-time
basis before. Since then, no major changes seem to have occurred in his career.
The following are three cases of the transmission of healing skills. In Case 1, a healer was trained by his father alone. In Case 2, while a healer was initially trained by his father, he later learned medical practices from other healers as well. In Case 3, no kin was involved in training a healer.

**Case 1**

Mr. Abdulrafiyu was born his father's first son in a village in the present Niger State in 1958. His father was a Yoruba healer from Offa (in Kwara State). They came to Kaduna in the beginning of 1960s. He received primary school education from 1965 to 1970.

When he was in primary 5, his father started to teach him healing practice. After completing primary school, however, he was allowed to learn auto electronics. Between 1972 and 1975, he worked as an apprentice. Even after the end of his apprenticeship, he worked at the workshop and was able to get some pocket money. One day his father came up to him and showed him money collected from one of his clients, saying that healing was prestigious work. It was ten times as much as his pocket money for a week.

In 1975, the father held a ritual for him. Then he started to attend clients in one room while his father did so in the other room. In 1983, his father died. But he seems to have inherited not only the father's practice but also his reputation. He is probably one of the most popular healers in Kaduna-South.

**Case 2**

Mr. Maazu was born in a village near Zaria in 1946. His father was a farmer-healer. When he was nine years old, he impressed his father by collecting herbs in the bush. This event made the father decide to train him to be a healer.

By the time his father died, he was able to practise healing by himself. In addition to the initial training by his father, he travelled out to many places and learned healing from other healers. On his arrival at a village, he introduced himself to the village chief and healers. Giving them kola nuts he took great care to greet them properly. Then he asked the healers if he could learn the prescriptions of their medicine. They never failed to teach him what he wanted to know.

In 1962, he left his village for Kaduna. A client asked him to come to Kaduna for treatment. Since then, he has been practising healing in Kaduna. In the meantime, he was affiliated with local bori groups and has been appointed as the leader of Nasarawa area by the overall bori leader in Kaduna.

**Case 3**

Mr. Ugoh was born in Imo state in 1945. At the age of 13 he became afflicted with mental illness. The illness was manifested in the form of a vision and a voice. He saw
mighty water everywhere he looked and heard people talk to him. The problem continued up to 1962 when he got through the initiation ritual to serve the spirit of water.

At first, he was taken to an Igbo healer in Jos. Then the healer came to his village to hold the initial ritual for him. During the ritual, he stayed inside a shrine for four days and learned 'the natural law' in a spiritual way. But it appears that the initiator also taught him healing practice.

Soon after the ritual was completed, he began to practise healing for the villagers. His healing was conducted not only at his village but at other places as well. At the invitation of his clients, he went to Abidjan and Ibadan for treatment, and stayed there for some time. In 1975, again he was asked to accompany a client to Kaduna where the client was involved in a court case. This trip made him decide to move to Kaduna. Since then, he has been doing healing work in Kaduna.

In 1979, he set up the Iyafor society which consists of his ex-clients to serve the spirit of water, Iyafor. Some of the ex-clients were made healers by him.
APPENDIX 4
CHILDREN’S SORROW, FATHER’S WRATH
The Case of Isaac, Avon and Omotayo

Despite the fact that Mr. Ishola has more than 11 children of whom at least seven were below the age of fifteen years old in 1992, there were only three children living with him at his compound at the beginning of that year. His separation from some of the children was a result of the breakup of his marital relationships. No less than four children left with their mothers. However, the case of his first wife’s children, Isaac, Avon and Omotayo, was rather different. Their departure resulted from conflicts with their father. One of the factors that underlies their conflicts is differentiation in the perspective on the norm and role of kin and women. In this section, I examine the process of conflict between Mr. Ishola and three children and the management and etiology of their crises.

Isaac was born in Zaria in 1971. His mother, Mr. Ishola’s first wife, is a Bajju from Zonkowa area and raised him and his two sisters until she divorced his father. Then, he and his sisters were brought up by the second wife of Mr. Ishola, Mama Sunday. He was educated at a primary school in Kaduna, and a secondary school in his father’s home town, Mopa, Kogi State. He was then allowed to take a two year vocational course at YMCA in Kaduna, learning machine fitting. The environment in which he grew up is therefore culturally pluralistic. As a result, he has a command of no less than four languages and has acquired some of the customs of different ethnic groups, even though his knowledge and understanding of different ethnic and language cultures are lacking in depth.

When I met Isaac at Mr. Ishola’s residence, he was doing almost nothing but idly lying on the bed and listening to the music. He complained that sometimes he did not have a meal served to him for a whole day, because of his father. He was bitter about his father. Several months previously, there was a clash between Mr. Ishola and Mama Goke on the one hand and Mama Sunday, Isaac and Avon on the other. The strife started between Mr. Ishola’s two wives, Mama Sunday and Mama Goke. It then involved Isaac, Avon and Mr. Ishola. Eventually, Mr. Ishola called the police and had Isaac and Avon arrested. While the policemen and relatives mediated in the conflict between Mr. Ishola and the two children, relationships have been impaired ever since.

In Isaac’s view, Mr. Ishola never listens to advice nor
admits his mistakes. Isaac is particularly unhappy about the way Mr. Ishola sometimes deals with other people. He also thinks that Mr. Ishola has never fulfilled a father's duty to his children, preoccupied as he has been with his own business and forcing his family to accept a thrifty way of life. On the other hand, Mr. Ishola was resentful about Isaac. For him, it is a son's duty to help his father, whereas Isaac substantially has never helped him. He felt that he had done more for Isaac than what a father might be expected to do for his son - he financed not only Isaac's secondary school education but his technical training. Thus, Isaac's request for further assistance was simply unacceptable. He said, "I am not Isaac's slave." He also resented the fact that Isaac did not respect people senior to him. Isaac's advice to him merely angered him, as he said, "Isaac is arrogant." It is important to note that Isaac's view about Mr. Ishola was shared by Isaac's sisters, whereas Mr. Ishola's view about Isaac was shared by Mr. Ishola's brother and friends. In that sense, the differences in their perspectives are, to some extent, generational. Yet, it is remarkable that not only Mr. Ishola but Isaac basically interpreted their problems in terms of kinship norm - they were unhappy about the neglect of the role of a son to his father and the role of a father to his son respectively, whereas they differed in their views of these kinship roles.

Under these circumstances, it was probably inevitable that Isaac should seek to be independent. He pursued independence in three areas: his residence, livelihood and marriage. Of these, his primary concern was to move out of his father's house and establish his own residence, and he actually managed to achieve this goal. In September 1990, he left Mr. Ishola's house to live with his friend, Florence, at their rented rooms. They rented two rooms for 80 nairas in an area called Kabara Junction. His move obviously caused his father to be resentful, even though his father did not stop him from moving out. I was partially responsible for his departure, as at that time he was working as my research assistant and it was my payment to him that enabled him to pay his rent.

The problem was, however, in the second area, that of earning a living. Even while he was living with his father, he tried to get a job. It was not that he could not find a job, but that all the jobs he did were casual and underpaid. Between 1990 and 1991, he had four different jobs, namely, a security guard at a commercial bank, a research assistant, a labourer at an oil refinery and a labourer for construction work on the Abuja road. Here, he could not make use of his qualification as a machine
fitter. Most of the jobs available to Isaac were for unskilled labour. The problem with such jobs is that there is always an excess of labour supply over demand in Kaduna and the jobs tend to be casual and underpaid. While doing these jobs, he managed to make a living, but more often than not he was out of work. Thus, he was soon thrown into financial difficulties.

He was, however, often helped out by his friends. He had a group of friends from Mopa who helped each other, sharing food and accommodation and hunting jobs together. They maintained their relationships with their friends at Mopa and sometimes travelled back home, for instance, for Christmas or for a local election. Florence was particularly helpful to Isaac, paying off the arrears of his rent. Yet, such financial assistance was not sufficient by itself for him to make a living. Thus, eventually, he had to seek his father's help.

It was significant that, despite their unsettled conflict, Isaac started to visit Mr. Ishola, and Mr. Ishola also accepted his visits. There is no doubt that Mr. Ishola felt pity for Isaac. However, he had a practical need for Isaac, too. There were certain services that Isaac could offer his father - the payment of electricity bills to NEPA, the collection of rent, and assistance in his healing business, as Mr. Ishola did not trust many people to do these jobs. Isaac could expect his father to give him pocket money, 10 nairas or so a day, for his work. In other words, his father provided minor jobs for him, even though they were as such never sufficient for his livelihood.

His third concern was about marriage. He had a girl friend whom he promised to marry. His girl friend, Elizabeth, was from former Bendel State and used to stay at Mr. Ishola's compound. At that time, she was a commercial school student and was looked after by her elder brother and his family who rented rooms at Mr. Ishola's compound. Although she eventually left Kaduna for her home town, she and Isaac managed to maintain their relationship through letters and occasional visits. However, such a long-distance love affair was not easy for Isaac. He was often worried about such things as, if she still loved him, if she was pregnant or if she was able to come to Kaduna - he sometimes consulted traditional healers for divination about these issues. He was also gloomy by the rather poor prospect of their marriage. The chance that his father and her brother would agree upon their marriage was quite slim. This is because his father and her brother had a personal clash - Mr. Ishola considered her brother's wife to be a witch and eventually dislodged them from his compound. Besides, Isaac had no stable job and was in no position to pay bride wealth to her brother. Thus, in all the areas where
he sought autonomy, his achievement was at best partial.

The central problem was in the area of livelihood. While there were various jobs and sources for his material provisions, they were temporary and none of them was sufficient by themselves. He could not totally depend on any of them. Thus, he had to move around them - various temporary jobs, his friends and his father to make a living. However, such movement caused Isaac considerable distress. First of all, although his dependence on his friends and his father was partial, he was certainly helped by them. The problem was that he was expected to reciprocate and he could not fulfil such reciprocity. This unbalanced reciprocity was to cause conflicts among Isaac and his friends and father. Florence was sometimes exasperated by Isaac’s attitude towards him. For Isaac, such an accusation was unfair, as he believed that he had helped Florence when Florence was in trouble. Even though he extended his hand to Isaac, Mr.Ishola was not happy about Isaac at all. Isaac once left him, whereas he still had to depend on him. His resentment could easily burst out. In February 1991, he bitterly condemned Isaac for visiting Mama Sunday (the detail will be seen in the next Appendix).

Thus, Isaac had to live with considerable uncertainty and personal conflicts. He was often dismayed about his current situation and anxious about his future. He often saw himself victimised - he complained of being in such a difficult situation and wondered why he was accused by his father and friends, even though he did nothing wrong. This psychological situation apparently affected his physical condition. Between 1990 and 1991, he was often ill. The typical symptoms were fever and nausea and treated at clinics as either malaria or typhoid. His medical expenses were yet again paid by his friends. Thus, it appears to me that Isaac's crisis was bound up with a situation where he was partially dependent on various social relationships and resources, whereas none of these was entirely reliable, and therefore he had to constantly move around them, entailing further uncertainty and conflicts.

As in Isaac’s case, conflicts between Mr.Ishola and two daughters, Avon and Omotayo, indicate differentiation in the perspective on kinship norm. But, in their cases, differences in perspectives are also clear on the role of women. What is also significant in their cases is that during the course of the conflicts, Mr.Ishola re-identified the status of his daughters in order to mark their separation from him.

Avon was born in 1973. She is Mr.Ishola’s second child and Isaac’s younger sister. She finished her primary education and then learned sewing for a while, though she could not complete
the training, because, she argued, Mr. Ishola stopped paying her tuition fee. She has an outgoing personality and has a number of friends. Hating domestic work, she hardly stayed at home and moved around with her friends - she often came back late at night. Such a behaviour was not appreciated by Mr. Ishola. For him, a daughter is supposed to stay at home and do domestic work for her family until she gets married. He does not believe that women need to have higher education and to pursue a career. He has a view that women do not possess as much intelligence as men.

While I was living with the Ishola family, Avon was concerned about her marriage. Not so long ago, she was promised to marry a man from Ondo State. He was a Yoruba man and used to work as the secretary of Mr. Ishola’s church. Mr. Ishola initially did not oppose their marriage. They went out for more than a year. However, he eventually left Kaduna for his home town. Accordingly, Mr. Ishola became rather negative about the prospect of their marriage. Avon could not forget about him, and in mid-1991, she travelled down to Ondo State to meet him without taking her father’s permission for her travelling. I do not know whether she managed to be reunited with him or not. What was remarkable about her journey, however, was that on her way back to Kaduna, she visited her mother at a village near Zonkowa, a town outside Kaduna. As noted, having been separated from Mr. Ishola, her mother had been living with her own family at the village for many years.

Her journey was bitterly resented by Mr. Ishola, and probably this was the beginning of the change in their relationship. In September 1991, Mr. Ishola sent Avon to Mopa to help his elder sister with farming. The problem was that Avon did not only dislike tedious farming work but did not get along with her aunt. She soon ran away from the aunt’s and disappeared. In January 1992, she came back to Kaduna. Her father was enraged at her conduct, even though he allowed her to stay at his house. Yet, only a week later, she was going to be thrown out of his house.

On that morning, Mr. Ishola summoned Avon and all his family members at his house. He told them about a "vision [dream]" he had seen the previous night. In the "vision", Avon appeared and stood in his way and tried to block it. Then Mama Goke asked Avon if she was responsible for it. But, according to Mama Goke, Avon did not clearly deny it. In the afternoon, Avon had to leave the house with her small bag. Later Mr. Ishola told me that Baba Rimi once suggested to him that Avon was given aje from Mama Sunday. His "vision" was clearly interpreted to confirm Baba Rimi’s divination. However, it appears to be certain that his
identification of Avon with a witch reflected a series of Avon's actions that exasperated him.

Since then, Avon has lost contact with her father. She was given shelter by her aunt, Mr. Ishola's younger sister, living at Gari, Kaduna-Central. When I asked the aunt, who was not on good terms with Mr. Ishola, about Mr. Ishola's view of Avon, she laughed, "Avon is aje? Ha! If she was aje, can she go to church?" Avon started to attend one of the Aladura churches.

Omotayo's problem with Mr. Ishola was at first about her education and then about her marriage. She is the younger sister of Isaac and Avon and the third child of Mr. Ishola. Compared to Avon, she is more domestic and more obedient to her father, as her father put it, "Omotayo fears me small." She was helping her step-mothers to do domestic work. Mr. Ishola also occasionally sent her to Mopa so that she could help his elder sister. She was not, however, satisfied with her present situation. From time to time, she told me that what she really wanted was to have further education. She wanted to go to secondary school, whereas she was acutely aware that her father would never approve it. In 1991, it appears that her dissatisfaction increased. She often complained to me about her father. In this situation, Avon's news about their mother threw light on the prospect of her education.

In November 1991, she made a trip to Zonkowa to see her mother without, of course, telling her father about it. She then stayed there for almost two months. It appears that her mother's relatives agreed to finance her secondary school education. Yet, in order to get admission to a school, she was required to submit her primary school certificate to the school. The problem was that it was Mr. Ishola who kept her school certificate. Thus, she had to come back to Kaduna to retrieve her certificate.

When she returned to the house, Mr. Ishola was furious with her. It was significant that he spoke to her only in Hausa, as he always communicates with his family in his mother tongue, Iyagba. Hausa is a common language in Northern Nigeria which many of the ethnic minorities, including Omotayo's mother's group, Bajju, in the region can speak. Thus, the message in his use of Hausa language was clear. It was to signify that Omotayo left him for her mother and therefore she no longer belonged to his family and group but to her mother's family and group. Having found it impossible to ask her father for her certificate, Omotayo went back empty handed to Zonkowa.

Then, about a month later, Mr. Ishola was visited by a man from Zonkowa. He was a Bajju and a military sergeant. Showing his respect to Mr. Ishola, he explained that he wanted to marry Omotayo and begged him to approve their marriage. While Mr. Ishola
did not openly object their marriage, he did not give him a
definite answer either. Later he told me that he had no intention
of approving their marriage. Although he himself married a Bajju
woman, he did not want his daughter to marry a Bajju man, as he
said, "I don't like the Kaje [Bajju]. They are thieves. I don't
want her to marry a Kaje man." However, it appears that his
objection was not just motivated by his ethnic sentiment, but
with his concern over an affair Omotayo had several months
previously. When she was at Mopa, she had an affair with a boy
and got pregnant. The boy was a son of a rich man in the town and
proposed marriage. However, Omotayo declined his proposal and had
an abortion. Thus, in Mr.Ishola's view, Omotayo's marriage at
that point was still premature and could cause ill feeling with
the boy's father.

As far as I know, by the beginning of February 1992,
Omotayo was still at Zonkowa. Her suitor, the sergeant, visited
Mr.Ishola again only to find it difficult to get any better
response from Mr.Ishola about their marriage.

Thus, conflicts between Mr.Ishola and his children indicate
fragmentation of norms; opinions concerning the role of kin and
women are not the same but differentiated even within one family.
In Mr.Ishola's view, children should help their father and obeys
his order, and repay what they owe to their father. He had an
opinion that women should do domestic work and help their family
rather than pursue a career and education. In this regard, he
thought that his children did not really conform to these norms
and roles. On the other hand, in the children's view, a father
should help his children to be independent and pursue their own
lives. They thought that their father did not care about them,
concentrating on his business and compelling them to accept a
thrifty way of life.

The children's dissatisfaction with their father eventually
caused their separation from him. It appears to me that two
factors were conducive to their separation; the existence of
alternative means for the children to make a living and
alternative social ties for them to depend on, and the lack of
elder members in Mr.Ishola's family.

After moving out of Mr.Ishola's compound, Isaac lived with
his friends and at times depended on their financial assistance,
while he did various kinds of casual work. Omotayo was taken care
of by her mother's kin and soon had a proposal of marriage from
a man at their village. Avon was accommodated by her aunt. It is
also important that separation of the children may not have
affected Mr.Ishola's work so much, since he had a new wife to do
domestic work and some assistants for his healing business.
On the other hand, it is conceivable that the lack of the elder family members who could have stopped the children from leaving their father contributed to their departure. At his age, around 45 years old at that time, Mr. Ishola was more or less the most senior member in his family, and therefore there was no relative who could effectively mediate between him and his children. When a conflict took place between them, it was his friends, younger brother and policemen who acted as mediators. While their role, especially that of his older friends, was not to be ignored, their powers were rather limited.

The point is, however, that despite their separation from their father, the children could not completely achieve their independence from him. Thus, all the jobs Isaac engaged in only allowed him to make a temporary living, whereas the financial assistance of his friends was not in itself sufficient for his living. Inevitably, he had to come back to Mr. Ishola to do some work for him in return for pocket money. Omotayo, too, could not pursue her goals in the area of education and marriage without her father's consent. It is probably Avon who may have been permanently separated from her father, owing to his identification of her as a witch.

The problem of such partial independence was that both parties were not happy about each other. Mr. Ishola was not happy that, while his children once left him, they still depended on him in case of need. He was particularly angry about the fact that Omotayo and Avon reunited themselves with his wife’s kin - it seemed more or less a betrayal to him. The children were not happy that while they wanted to achieve their independence from their father, they could not completely do so, whereas their partial dependence on him was often answered by his anger.
APPENDIX 5
INTIMACY OF OBSESSION
The Case of Mr. Ishola and Mama Sunday

The name of Mama Sunday has already appeared several times in the case studies concerning Mr. Ishola. For Mr. Ishola, Mama Sunday represents all the evilness he encounters in his everyday life. He is literally obsessed with the figure of Mama Sunday as a witch. Here, I examine the omnipresence of and fixation on Mama Sunday in his understanding of the crises and the management of these problems.

Mama Sunday is the second wife of Mr. Ishola. Like Mr. Ishola, she is iyagba from Mopa. She had been married and had two children before she met Mr. Ishola in Kaduna. From the beginning, her marital life with Mr. Ishola was to be shared with his other wives. She lived with his first wife, third wife, fourth wife and then, for a short time, fifth wife, Mama Goke, and looked after their children. Thus, she was his oldest companion. However, it was Mama Sunday’s turn to leave when Mr. Ishola married Mama Goke. Since then, she has been living at her own compound situated about 200 metres away from his compound. She built that house at her own expense. Thus, she is economically independent, earning her income through rent and healing. She is a ‘prophetess’ of an Aladura church and practice healing for her clients. In other words, her livelihood is similar to Mr. Ishola’s.

When I settled myself in Mr. Ishola’s house, Mama Sunday was not living there any more. However, it was only a few days after I moved in that I heard of Mama Sunday for the first time. I was woken up at night by people shouting next door. I rushed outside and saw Mr. Ishola carry a flaming bed mattress out of his room and throw it on to the ground. The mattress made of synthetic materials was instantly burnt up. Looking at the fire, he grumbled, "Mama Sunday!". The mattress caught fire when his child mistakenly dropped a candle on it. However, according to Mr. Ishola, he had a premonition about it. On the night before, he said, he had seen a dream about fire and had then told his children that very morning be careful about handling fire just in that morning. In his view, this was not just an accident but the witchcraft of Mama Sunday.

Mr. Ishola believes that Mama Sunday is a je, a witch (he uses both words). He is seriously worried about her witchcraft and perceives her shadow in almost every trouble he encounters in
his life. Thus, he attributed his business problems to Mama Sunday’s witchcraft. When one of his children was sick, he considered Mama Sunday was causing it. When he had trouble with his tenants, he suspected Mama Sunday’s hand behind the scenes. When he heard a strange noise in the night and found a strange object on the doorstep in the morning, it was nothing but Mama Sunday’s sorcery. He also “knows” that Mama Sunday sometimes visits other traditional healers to get them to harm him by their medicine. The list of Mama Sunday’s evil doings is endless. In that sense, it can be said that she symbolises the whole evilness against Mr. Ishola.

Obviously he has to protect himself, his family and his property from her witchcraft. Here he employs traditional medicine. Although various medicines he uses for his family and himself have a general protective purpose, their main purpose is undoubtedly to protect against Mama Sunday’s witchcraft. Thus, he has a protective medicine lapped in leather and fixed on his waist. He administers medicine through incision to his family and himself. He also experiments with new medicines and spends a considerable amount of money on making protective medicine. I once observed him prepare protective medicine called madarekan which was said to consist of 21 different items. However, the most remarkable protective medicine I have seen is the preparation of an esu symbol.

On 5th March 1991, Mr. Ishola carried out a ritual to set up an esu symbol at his residence. He was instructed by a traditional healer, Baba Rimi, and assisted by his brother and Baba Rimi’s son. Esu is a Yoruba deity (orisara) and often translated as Satan or the devil in English, because of its mischievous character. However, according to some of my informants, esu is also commonly considered as a deity of protection. Mr. Ishola appears to have had a plan to install its symbol at his residence for some years. He said that it took him years to collect all the necessary materials for the ritual. Previously he had kept a stone that symbolises esu under the ground. On 23rd February, he removed the stone to a place just outside the house and buried it again. Then, the major ritual was carried out on 5th March. Around 7.0 p.m., he began by digging up the stone again. The stone was round in shape, about 40 cm in diameter, and looked like a lava stone containing lots of iron. Assisted by his brother and Baba’s son, he made a rectangular hole 40 cm in width, 60 cm in length and 40 cm in depth. At first, he placed four or five bundles of green grass on the bottom. Then he set the stone on the grass and put four pieces of igiabo wood around the stone, one on each side of the hole. He
then put on top of the stone herbal medicine that consisted of four awena leaves (two white and two red), human bones and 16 pieces of women's clitoris (ido obena). He then offered a white cock to the stone, cutting its throat and pouring the blood over it. Then, Baba Rimi took over the final part of the ritual. He put gun powder on the stone and set fire to it. It flashed like a firework with orange light. It was a dramatic ending.

After the stone had been buried, Mr. Ishola wrote down the names of his family members, friends and some of the tenants in his house. Altogether 37 names were listed. Those on the list apparently signified people whom he considered to be on his side. In other words, the list was indicative of the range of his close social networks. It is also interesting to note that some of his tenants in the house were excluded from the list. Facing the place where the esu stone was buried, he read out the names on the list so that esu could not mistakenly attack them. According to Baba Rimi, esu appears in the night as a dwarf-like figure who drives away anyone trying to harm those in the house and steal their property. Mr. Ishola seems to have spent a lot of money for the materials used in the ritual. He said that each ido obena alone cost him 60 nairas and he had collected 16 of them over three years.

Despite all this protection, he never had peace of mind, because of Mama Sunday. Later, he complained that esu was not really effective. It was difficult for me to understand how and why he became obsessed with Mama Sunday. However, it appears to me that there are two keys to the understanding of the omnipresence and fixation on Mama Sunday in his aetiological mind; one is his entrepreneurial pursuit of a housing business and the other is the fact that Mama Sunday is the person closest to Mr. Ishola with the exception of his children and his elder sister.

Mr. Ishola said that Mama Sunday tried to kill him and take his houses. It is not entirely clear that she could get his houses even if he died. In terms of inheritance, she was not the only person who could claim his property. However, his apprehension has to be understood against the background that the houses were not just the most important source of his income but also of his pride and aspiration. He rose from sheer poverty and achieved his present economic position mainly through the letting business.

It appears to me that his apprehension was also due to the nature of the business itself. In Kaduna and elsewhere in Nigeria, building a new house is generally considered to provoke jealousy among people and subject its owner to evil practice.
This, it appears to me, has much to do with the peculiar nature of a house; first of all, a house is conspicuous - everyone can see the achievement of its owner; secondly, it is immobile and cannot be removed from the source of threat; and thirdly, it is indivisible and therefore cannot be distributed among kin and friends unlike cash, unless the whole house is built for them. Under such conditions, it is conceivable that the owner of a new house becomes apprehensive about envy.

Thus, the idea that Mama Sunday was threatening to rob him of his most valuable objects was understandably haunting. However, the question remains why it had to be Mama Sunday who was the most threatening. On being asked about his relationship with Mama Sunday prior to their separation, he tended to express a negative view about their relationship. For instance, he said that Mama Sunday drove all the other wives away, and that she tried to kill him through poison put in his meal. I heard a few times a story about how he turned out Mama Sunday. Thus, he said, "One day, Mama Sunday gave me a bowl of garri. When I took the bowl with my hand, suddenly my hand shook and dropped it. Then I knew poison was inside garri. It was my medicine that protected me. So I told her to get out of my compound."

However, it appears that until 1986, the relationship between Mr. Ishola and Mama Sunday was not necessarily bad. In that year, Mama Sunday bought a piece of land without informing Mr. Ishola. The problem was that the land turned out to be claimed by three people. Inevitably, Mr. Ishola got himself involved in the dispute so that he could help her out. While in the end she was able to obtain the land where she built her present residence, her behaviour was not appreciated by him. However, what was decisive in their relationship appears to have been Mr. Ishola's marriage with Mama Goke in 1989. As noted above, Mama Sunday and Mama Goke could not get along, and when a fight took place between them, Mr. Ishola turned Mama Sunday out of his house.

Judging from the fact that Mr. Ishola dislodged his tenants as soon as he suspected the presence of witchcraft, it appears to be reasonable to assume that he had not really suspected that Mama Sunday was a witch by the time he married Mama Goke. It is probable that his suspicion of Mama Sunday as a witch grew mainly after the separation. If that is the case, it is conceivable that he could have considered Mama Sunday's witchcraft as her revenge for the separation, even though this is speculative.

It appears to me, however, that while it may sound contradictory, his fear of Mama Sunday is closely related to his affectionate memory of the life he shared with Mama Sunday. As
noted, Mama Sunday was the oldest companion of Mr. Ishola with the exception of his children and elder sister. For Mr. Ishola who achieved his present economic position without the assistance of his kin, her presence must have been practically and emotionally invaluable. Indeed, he once told me that he had "loved" her. Thus, it is this intimacy, it appears to me, that partially explains his obsession with her 'witchcraft'.

However, there is another important aspect in his fixation on Mama Sunday as a witch in Mr. Ishola’s mind. That is the fact that she became an emblem of a part of his social boundary. It often looks as though Mr. Ishola recognises only two kinds of people; those who conspire with Mama Sunday to destroy him and those who do not. He identifies as "enemy" people who "collaborate" or "amalgamate" with Mama Sunday (these are his own words). Thus, in his view, most of his neighbours are his enemies, as they "collaborate" with Mama Sunday. His tenants could also be his Mama Sunday’s collaborators, as he said, "I saw a vision last night. There is amalgamation in my compound. Lecturer’s wife and Igala man’s wife are aje. They are collaborating with Mama Sunday. She came here four days ago....I will force them out of my compound!" Thus, in order to maintain a cordial relationship with Mr. Ishola, one must accept his view about Mama Sunday. If his child was found to have visited Mama Sunday, he is outraged with the child, as illustrated in the following case.

In the evening on 7th February, 1991, Mr. Ishola called Isaac into the living room. In the room waiting were not only Mr. Ishola, but his brothers, his friend and Baba Rimi. Then, the brothers started to accuse Isaac of visiting Mama Sunday. One of the brothers said that he saw Isaac visit her compound. Isaac denies it desperately. Listening to their arguments, Mr. Ishola lost his temper and abused Isaac, "You have beaten your father! May your child beat you, too!" Isaac became emotional and left the room with his eyes full of tears. Then, others tried to calm Mr. Ishola down and to seek their reconciliation. Especially, Baba Rimi played a significant role. They came to the conclusion that, when Isaac visited Mama Sunday, he was not himself because he was controlled by Mama Sunday’s medicine. Their reasoning was clever in that, on the one hand, it would not undermine Mr. Ishola’s authority - his anger was justifiable as Isaac actually visited Mama Sunday - and, on the other hand, it would give Isaac an excuse for his visit - it was unavoidable as he was controlled by Mama Sunday. Then Isaac was called back. While they forced him to admit his visit, they also begged Mr. Ishola to forgive him and withdraw his curse. Accepting this, Mr. Ishola washed his mouth
and told Isaac to offer a sacrifice to neutralise his curse completely. Then, he said that Isaac might have been given medicine through incision on his head by Mama Sunday without his being aware of it. "Mama Sunday", he continued, "has tried to kill him so many times. Once I found medicine in his soup. Had I not found it, he could have died." Isaac was thus forgiven.

It is also significant that some people make use of the symbol of Mama Sunday for their own interests. Later, Isaac told me that he never visited Mama Sunday. According to him, Mr.Ishola’s brother told a lie to Mr.Ishola in order to win his favour. In fact, information such as stories of Mama Sunday’s visit to traditional healers is brought to Mr.Ishola from time to time by his friends and brothers. Whether such information is true or not, it is certain that bringing the information is appreciated by Mr.Ishola, perhaps with some money. The problem is that such information only serves to reinforce his anxiety about Mama Sunday.

Thus, it appears to me that his obsession with Mama Sunday was endless. It would continue, so long as he pursues his housing business, and so long as he has a memory of intimacy.
### APPENDIX 6

#### AETIOLOGICAL IDEAS OF COMMON ILLNESSES

The following two tables show the causal ideas of the common six illnesses: fever, headache, stomach ache, swelling of a limb, infertility and mental illness. The first table is based on the survey of 50 lay people; 10 people from 5 ethnic groups (Hausa, Bajju, Gbagyi, Tiv and Iyagba). The second table is based on 19 traditional healers; 5 healers from 3 ethnic groups (Hausa, Yoruba, Igbo) and 4 Gbagyi healers.

#### Lay People

<table>
<thead>
<tr>
<th>Ailments</th>
<th>Causalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>fever</td>
<td>mosquitos 23</td>
</tr>
<tr>
<td></td>
<td>climatic conditions 16</td>
</tr>
<tr>
<td></td>
<td>overwork 10</td>
</tr>
<tr>
<td></td>
<td>unhygienic food &amp; water 2</td>
</tr>
<tr>
<td></td>
<td>manifests abnormal body conditions 1</td>
</tr>
<tr>
<td></td>
<td>excess of sexual activities 1</td>
</tr>
<tr>
<td></td>
<td>no idea 1 no answer 3</td>
</tr>
<tr>
<td></td>
<td>total 45</td>
</tr>
<tr>
<td>headache</td>
<td>climatic conditions 14</td>
</tr>
<tr>
<td></td>
<td>overwork 14</td>
</tr>
<tr>
<td></td>
<td>anxiety 7</td>
</tr>
<tr>
<td></td>
<td>blood-related problems 4.</td>
</tr>
<tr>
<td></td>
<td>overcarrying on the head 3</td>
</tr>
<tr>
<td></td>
<td>short sleep 2</td>
</tr>
<tr>
<td></td>
<td>catarrh 2</td>
</tr>
<tr>
<td></td>
<td>oversleep 1</td>
</tr>
<tr>
<td></td>
<td>overdrinking 1</td>
</tr>
<tr>
<td></td>
<td>natural 1</td>
</tr>
<tr>
<td></td>
<td>dust 1</td>
</tr>
<tr>
<td></td>
<td>no idea 3 no answer 8</td>
</tr>
<tr>
<td></td>
<td>total 47.</td>
</tr>
<tr>
<td>stomach ache</td>
<td>unhygienic food &amp; water 25</td>
</tr>
<tr>
<td></td>
<td>diet &amp; nutrition 10</td>
</tr>
<tr>
<td></td>
<td>germs &amp; worms 4</td>
</tr>
<tr>
<td></td>
<td>poison 2</td>
</tr>
<tr>
<td></td>
<td>bad odour 1</td>
</tr>
<tr>
<td></td>
<td>no idea 4 no answer 9</td>
</tr>
<tr>
<td></td>
<td>total 43</td>
</tr>
<tr>
<td>Condition</td>
<td>Causes</td>
</tr>
<tr>
<td>----------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>swelling of a limb</td>
<td>germs &amp; worms 9, personal &amp; spiritual agents 7, pregnancy-related problems 6, unhygienic water 2, blood-related problems 2, walking or standing too long 2, diet &amp; nutrition 1, climatic conditions 1, too much water in the body 1, no idea 10, no answer 6, total 41</td>
</tr>
<tr>
<td>infertility</td>
<td>continuous abortion 14, personal &amp; spiritual agents 10, by birth 3, pharmaceutical medicine 2, disease infected through sex 1, blood-related problem 1, worms 1, trial by the God 1, no idea 11, no answer 2, total 40</td>
</tr>
<tr>
<td>mental illness</td>
<td>drug abuse 25, personal &amp; spiritual agents 12, injury 7, by birth 2, alcoholism 1, hypertension 1, loiloil? 1, only the God tells 1, no idea 3, no answer 2, total 37</td>
</tr>
<tr>
<td>Ailments</td>
<td>Causalities (and number of cases)</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| fever         | climatic conditions 10  
diet & nutrition 4  
overwork 3  
blood-related problems 3  
other sickness 2  
natural 2  
mosquitos 2  
malfunction of moving organs 1  
personal & spiritual agents 1  
no idea 0  no answer 0  
total 14                                                            |
| headache      | anxiety 6  
other sickness 5  
personal & spiritual agents 4  
c climatic conditions 4  
natural 1  
short sleep 1  
alcohol 1  
diet 1  
blood-related problem 1  
dust 1  
others 3  
no idea 0  no answer 0  
total 14                                                            |
| stomach ache  | germs & worms 12  
unhygienic food & water 7  
poison  
diet & nutrition 3  
swelling of penis 1  
blood-related problem 1  
others 2  
no idea 0  no answer 0  
total 18                                                            |
| swelling of a limb | climatic conditions 7  
personal & spiritual agents 6  
germs & worms 4  
unhygienic food & water 3  
staying in dirty water 3  
diet & nutrition 2  
fat-related problems 2  
others 4  
no idea 0  no answer 0  
total 15                                                            |
<table>
<thead>
<tr>
<th>Problem</th>
<th>Cause</th>
</tr>
</thead>
</table>
| **Infertility** | personal & spiritual agents 10
by birth 3
other sickness 2
continuous abortion 2
hereditary 1
misbehaviour 1
others 3
no idea 0 no answer 0
total 13         |
| **Mental Illness** | personal & spiritual agents 16
by birth 2
guilty consciousness 1
others 2
no idea 0 no answer 0
total 16         |
APPENDIX 7

THE CONCEPTS OF AKOMBO ILLNESSES

The following table is based mainly on one Tiv informant, who is a middle-aged male textile worker.

<table>
<thead>
<tr>
<th>Name</th>
<th>1) Emblems</th>
<th>2) Ailments</th>
<th>3) Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swende</td>
<td>1) feather tied with a string and hung from ceiling.</td>
<td>2) any kind of accident including traffic accident; bone fracture that occurs without external physical force (it is also known as Megh); miscarriage and continuous menstruation - a woman who happens to see a corpse or a dead dog is likely to get it. In general women are more susceptible to Swende.</td>
<td>3) treatment by Oru Akombo of Swende who are decedents of slave and living in Otisha area. Kawasron Akombo is not always required.</td>
</tr>
<tr>
<td>Igbe</td>
<td>1) n.a.</td>
<td>2) diarrhoea which sometimes involves blood, stomach disorder and sweating. It is inheritable from mother who offended Igbe.</td>
<td>3) hospital doctors can not cure it. Kawasron Akombo is required. The family of the patient should gather and sacrifice a hen and a he-goat.</td>
</tr>
<tr>
<td>Twer</td>
<td>1) n.a.</td>
<td>2) serious pain on arms and legs, especially their bones. It is so painful that one can barely walk. Only strong Oru Akombo can treat it. Kawasron Akombo is required in addition to herbal treatment.</td>
<td></td>
</tr>
<tr>
<td>Akombo Dam/Wayo</td>
<td>1) guinea corn ear.</td>
<td>2) serious and recurrent headache, a nose and ears are blocked, and one feels as if his head is falling off - the pain tends to get worsen at dawn and sunset; watery substance comes out of ears, involving headache, and eventually parts of the body get rotten with a nose deformed (it is also known as Wayo).</td>
<td>3) paracetamol and other pain killers are of no avail. Kawasron Akombo is required.</td>
</tr>
<tr>
<td>Emblem</td>
<td>Description</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>-------------</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Iwa** | 1) a piece of brass tied with a thread and hung from ceiling or somewhere, used as protection against a thief.  
2) if a thief touches or passes by the emblem, he will either get struck by lightning or become sick - he gets pain all over the body and feels as if his body is twisted, his hands becoming so numb that he cannot hold anything, or parts of the skin change their colour into red and get hard. The latter type of ailment may develop into Imande.  
3) Kwasoron Akombo may not be required, but sacrifice should be offered. |
| **Imande** | 1) made of a kind of leaves.  
2) leprosy. It may be the advanced stage of Iwa, or a wound could develop into it.  
3) n.a. |
| **Kwambe** | Considered to be a son of Twer (its father).  
1) made of Jank Pande leaves hung with thread.  
2) rheumatism, swelling, cheek gets dented like an old person. A particular type of boils called Kwambe Soho occurs - a boil has oval shape with its mouth on the edge, not the centre.  
3) treated by herbal remedy. Kwasron Akombo is not required, but sacrifice of guinea fowls is necessary. |
| **Ahina** | 1) the emblem is often used to protect yam storage.  
2) Ahina means twin. Twin are considered to be a kind of sickness, especially in case twin are repeatedly born. If a woman touches the emblem, she will give birth to twin. |
NOTES

CHAPTER III


2. The population of Kaduna was 149,000 in 1963 according to the census in that year. Seymour (1979) estimates the annual rate of growth between 8% and 11%, while Adedeji and Rowland (eds 1973) estimate it at 11%. If the annual growth at 8% is taken, the population of Kaduna is estimated to be 1,190,000 in 1990.

3. It appears that Lugard initially wanted Kaduna to be the capital of the whole of Nigeria (Paden 1986:318).

4. Gbagyis believed in traditional deities that consisted of a supreme god, *Shekwo* or *Shikohi*, and a number of intermediary deities, *ashaa*, whose worshippers were organised into cult groups.

5. The racism of the residential segregation was inseparable from medical knowledge and concepts among tropical disease specialists, British colonial administrators and medical officers. They apparently believed that mosquitoes were attracted mainly to Africans and therefore the residential segregation of European from African was essential for the avoidance of infection (Curtin 1985).

6. My small survey in which about 50 people were interviewed on this issue seems to suggest that this demographic situation has been changing but not dramatically - about a third of the informants had migrated to Kaduna within the previous five years (1987-92), while almost a half of the informants had been in the city for more than ten years.

7. In my observation, in Kaduna, women may exercise considerable power by exploiting their supposedly
neutral position in situations where, lacking the authority of an elder, politically ambitious men who compete for leadership cannot come to a decision without electing someone who is outside the competition and therefore satisfies all parties involved. By the same token, however, women can be victimised as scapegoats in situations where men cannot resolve their conflict without making someone their common opponent - the phenomenon of witchcraft can be partly viewed in this context.

8. To give some examples, Hausa people (or more precisely Hausa speaking Muslim Northerners) are noticeable in areas such as high ranking government officials and civil servants, management of government subsidised companies, management of banking, transport business (bus and lorry) and its automechanics (not small vehicles), and beggars. Yoruba people are noticeable in various professional occupations (medical doctor, judicial work) and various technical jobs (automechanics, carpentry, repairer of electric goods, taxi drivers). Igbo people are most remarkable in trading (food stuffs, clothes, groceries). Among workers in the textile industry, people from the middle belt area, most notably Tiv, Igala and Idoma, are in the majority. People from the southern part of Kaduna State are significant in middle- and low-ranking civil servants, school teachers and nurses.

9. While further research is needed on this subject, in my small survey (50 people), over a third of the informants had attended the services of religious groups other than the ones they were currently attending. In a survey I conducted at a Born-Again church, all the members (38 people) said that they had attended a different church before, and most of them had changed their denominational membership.

10. However, what has not been previously discussed in this regard is the contradictory coexistence of religious fundamentalists and religious consumers who move around different religious groups and practitioners. This is a particularly important factor in the analysis of the religious situation in Kaduna.

11. Again, the case of the Kaduna Mafia is illustrative. Basically, the Mafia was not given a chance to exercise its power in a front stage of national and regional politics. Its attempt to gain power in party politics was shattered when Adamu Ciroma, a leading member of the Mafia, was defeated by Shehu Shagari in the presidential nomination of the
National Party of Nigeria for the Second Republic.

12. An example of people’s translation of media would be the case of the Gulf War. The Gulf War was big news among my informants. Many of them, both Muslims and Christians, considered the Gulf War to be primarily a war between Muslims and Christians. On the other hand, global cultural influence, including the use of the English language is evident in the media’s coverage of everyday affairs and events in Nigeria. For instance, when popular magazines deal with witchcraft or spiritual beings, they, to some extent, make these phenomena sound like a part of occultism which is familiar in Western popular culture.

13. The general pattern would be: 1) on their arrival in Kaduna, migrants are accommodated by their relatives; 2) they move out of the relatives’ residence, once they get a job and save money for rent, and 3) they move again when they get married and, especially, when they have children.

14. I was not able to look into the life of the very poor people in Kaduna. However, the following is my general observation. The very poor people make their living mainly by begging on the streets and their material possession is minimal. There are, however, different types of begging on the streets: institutionalised begging in Northern Nigerian in which beggars appeal to those of Islamic faith and ask for sadaka (gift) - many of them are disabled people; almagiris who are also part of institutionalised begging and are children from rural areas in Northern Nigeria; begging which is not Islamic and conducted mainly by disabled adults and children; mentally ill people who wander about on the streets.

   It may be worth mentioning a beggar I came across. This middle-aged man, who had a walking disability and wore ragged clothes, carried out his business on Ahmadu Bello Way (one of the busiest road in Kaduna). One day, I had a chance to visit a village called Gwagwada about 20 kilometres south of Kaduna. At my friend’s compound, there was a visitor whose face was familiar. This man, who was nicely dressed, was unmistakably the beggar on Ahmadu Bello Way. I was told that he commuted to Kaduna from Gwagwada where he lived to carry out his business everyday (the train fair is free for disabled people). At one stage, he appears to have even ridden his own Vespa.

15. As far as I recall, the only policy that the
military governor made by himself during my stay was beautification of the city.

16. According to Seymour's (1979) survey, well over 40% of household heads, mostly male, worked for middle- and large-scale business and industrial organisations, while less than a third of them were self-employed. On the other hand, the survey also indicates that nearly 50% of adult males who were not household heads were unemployed. However, the survey was conducted before the current recession had set in, and it is likely that the number of those working outside the formal sector and those who do not have regular jobs has increased since then.

17. Among a wide range of economic activities in this sector, the following two are noteworthy: contractors and prostitution. 'Contractors' are business people who arrange materials, equipment and workers for particular projects, especially the construction of public buildings and facilities. Contractors do not require their own capital, materials and workers to implement projects and they gain commission for the arrangement and planning of projects. In Kaduna, a number of people are apparently involved in this business, which is evident from the number of their signboards on the streets.

In Kaduna, a great number of young women are involved in prostitution. The word 'prostitute', however, can be misleading as it is applied to the situation in Kaduna. Many of those girls hanging around hotels and standing on the streets in the evening appear to live with their parents or relatives, who are the main breadwinners of their families. During the day time, the girls may help their mothers with domestic work or they may go to school. In that sense, one cannot draw a clear distinction between prostitutes and ordinary girls. On the other hand, there are a number of young women who make their living mainly from prostitution. Many of them rent rooms at hotels where they conduct their business. In any case, given the fact that women’s job opportunities are more limited than men’s, prostitution is an important source of income for young women, especially those who lack educational qualifications and capital to get a job or start a business.
CHAPTER V

1. Mr. Ishola’s compound is situated on an un-tarred road just behind the Kaduna State Rehabilitation Centre. The place is less congested than its surroundings. The road is wide enough to allow residents to cultivate vegetables and corn on the side. To illustrate the cultural diversity of the residents, in the following, I sketch the cultural backgrounds of Mr. Ishola’s immediate neighbours and co-residents, that is, the residents of six compounds built next to each other along the road.

Thus, the ethnicities of the residents (13 households in mid-1991) are as follows: two Yorubas, three Ibos, one Iyagba, Owe, Ishan, Tiv, Igala, Nupe, Bajju and ‘Bendelite’.

Among them, three households are Muslim, while the rest are Christian. Within the two religious categories, however, there are different churches and groups to which the residents adhere. For instance, the head of a Nupe household is a mallam, while one Yoruba household appears to belong to an Ahmadiyya group. The denominations of Christian residents range from Evangelical Church of West Africa (ECWA), Catholic and Aladura churches to Born-Again churches.

In terms of occupations, 14 adult male residents (in mid-1991) are as follows: a worker at an automobile factory (Peugeot), a lawyer, two workers at an oil refinery, two workers at textile factories, a worker at an aluminum company, a secondary school teacher, a trader of food stuffs, a trader of pharmaceutical medicines, a motor-mechanic, a chief accountant of a construction company, a traditional healer, and a mallam. The occupations of six female adult residents, apart from their domestic works are: secondary school teacher, medical doctor, trader in second hand cloth, trader of food stuffs, a typist, and trader in vegetables.

This is also a place where there exists large income gaps between residents. For instance, on the one hand, an accountant’s family and a lawyer’s family live in large houses and commute to their workplaces by means of their own cars. On the other hand, my co-tenants live in one or two rented rooms and commute to their workplaces either on foot or by public transport. A textile worker is unlikely to be able to earn and save enough to own a car such as the accountant drives.

2. One of the two healers was Baba Rimi. This elderly healer, perhaps in his late 50s, was from Offa in Kwara State. He can be best described as an itinerant healer. He travels from one place to another, carrying
a suitcase containing herbal medicine and healing and divinatory instruments.

He visited Mr. Ishola several times between 1990 and 1991 and each time stayed at least for a month, while carrying out business. Mr. Ishola provided him not only with food and accommodation but with some of his clients. In return, Mr. Ishola learned from him healing practices and prescriptions including the ritual practice of esu (see Appendix). Being an older person, Baba Rimi was also in a position to advise Mr. Ishola about various issues and once intervened in a conflict between Mr. Ishola and his son. However, their cordial relationship did not last long, because of several problems including Baba Rimi's bad drinking habit.

3. Mr. Ishola has a client who consults him almost every day. This middle-aged Igbo man comes to see Mr. Ishola either in the morning (he is often the first client of the day) or in the evening. He lives at Kawo in Kaduna-North, which is quite a long way from where Mr. Ishola lives, and visits Mr. Ishola on his own motorcycle. Considering the fact that there are a number of traditional healers in Kawo, it is rather strange for him to travel all the way to see a healer in Kaduna-South. It is also unusual for a client to see a healer almost every day.

However, there is a reason for his routine visit to Mr. Ishola. He is a pastor of an Aladura church in Kawo and apparently uses Mr. Ishola's medicine for his own clients. 'Prophets' and 'prophetesses' of Aladura churches practise healing on a commercial basis. While they have their distinctive mode of healing, this pastor appears secretly to utilise Mr. Ishola's divination and medication for his own clients. The problem is that Aladura churches are, at least officially, antagonistic to traditional healers and their practices. It must therefore be essential for the pastor to hide the fact that he visits a healer by travelling away from his neighbourhood.

4. Another problem of Mr. Ishola's room-letting has to do with the Nigerian Electric Power Authority (NEPA). NEPA issues a bill once in a while to houses to which electricity is supplied. However, electricity meters in houses are not regularly checked, and the bill is hardly reliable. Once Mr. Ishola received a bill, which should not have exceeded 100 nairas, for 1,000 nairas for one month. He angrily said, "Kai, my house is not a factory!" Because he knows that NEPA will never admit to its mistakes, he usually pays a fixed sum to NEPA, regardless of the bills sent to him. Such payment is usually accepted by staff at the office. It appears that such arbitrary bills are indicative of
fraudulent practices within the office.
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