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journal or publication title	Senri Ethnological Reports
volume	143
page range	119-138
year	2017-12-01
URL	http://doi.org/10.15021/00008647

Establishing Therapy Networks in the Era of Global Health: The Case of Procuring for Malaria Treatment among the Egun People in Lagos State, Nigeria

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This paper discusses the changes in the social networks of therapy with a particular focus on malaria treatment among immigrants from Benin called Egun in the area of Makoko, a well-known urban slum in Lagos State, Nigeria. Previous studies in the field of medical anthropology have revealed mutual support among relatives and friends to secure efficient therapy and medical care, as well as dynamic changes in social networks since the 1990s, caused by direct involvement of NGOs and UN organizations in local societies to fill health gaps left by the state. What is less obvious is the fact that people tend to foreclose social networks of therapy by adhering to ethnic boundaries when in need of biomedical healthcare.

The Egun, a minority ethnic group in Lagos State, have experienced various public healthcare campaigns since the 2000s. At the same time, more and more Egun professionals with medical background migrated from Benin to Nigeria. Egun people rarely frequent health facilities operated by other ethnic groups such as the Yoruba, but prefer to interact with other Egun people in Makoko as well as those in their respective hometowns in Benin. They maintain a negative perception of the Yoruba, often suspecting them as the cause behind serious social issues such as the governments' forced eviction programs and reoccurring gang violence in Egun neighborhoods. This paper explores how the social networks of malaria therapy are conditioned by ethnic boundaries.

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1. Introduction

This paper discusses changes in the social networks of therapy with a particular focus on malaria treatment among immigrants from Benin called Egun in the area of Makoko, a well-known urban slum in Lagos state, Nigeria.

People in contemporary sub-Saharan Africa have experienced biomedical intervention into their societies not only through various governments' efforts to improve public health, but also through direct involvement of NGOs and UN organizations in local societies intended to fill health care gaps left by the state. Public health in Africa is often not only problematized on a national scale but forms part of "global health" issues that are related to broader global political-economic processes (cf. Geissler et al. 2012).

Medical anthropologists have drawn attention on how members of local societies create social networks to procure their biomedical remedies in an era of global health. Researchers previously discussed the social relations of therapy, and provided insights on how people use a variety of medicines available to local societies. One of the most well-known arguments is John Janzen's ethnography concerning the "therapy managing group," a kinship or group of friends and relatives where participants discuss available and appropriate options of medical treatments in the case of sickness (Janzen 1978). The concept of therapy managing groups regards a sick person not as merely a passive patient but as positively situated within social and cultural processes. Other scholars, following Janzen's argument, have further elaborated about this type of face-to-face, mutual support among relatives and friends that enables participants to procure appropriate therapy and care. However, recent studies tend to focus more on the relations with anonymous others, as a consequence from the intervention of various humanitarian actors including NGOs, UN organizations, and private companies that provide biomedical therapies within African societies.

The main share of the ongoing scholarly discussion in Africa has been devoted to cases of HIV/AIDS. For example, Susan Whyte and her colleagues argued about "therapeutic clientship" in Uganda (Whyte et al. 2013). According to their argument, unlike countries such as Botswana and Mozambique where the government distributes standardized ARV packages, people in Uganda since the 2000s have benefitted from a broader range of projects that provide ARV to HIV-positive people. In such "projectified" societies where different donors enter, participate and withdraw from the field repeatedly, patients relying on ARVs become "users of services" of those various projects which may include anything from anonymous but large service providing institutions to rural small clinics that have a more intimate flavor (Whyte et al. 2013: 163). Patients turned clients in these "projectified" societies primarily need to consider how to behave as a "good

patient” in order to sustain relations with those varying healthcare givers. Recent studies in medical anthropology have thus focused on how the people establish these new relationships. The case of Uganda illustrates the struggles of HIV-positive people and their relatives to accommodate their health care needs in a state of flux when humanitarian organizations often come and go without prior notice to the local communities.

In this paper, I explore how and why the members of some communities in urban Africa fail to establish relations with providers of their desired remedies even when these biomedical therapies are available options within their societies. The Egun people in Nigeria provide a suitable case for investigation. They live in a society “projectified” through the various health-related projects by the government and NGOs such as MSF (Médecins Sans Frontières) and an increasing number of private clinics. However, my study reveals that establishing social relations of therapy for the Egun is complicated by the presence of ethnic boundaries. For the Egun, quality, cost or efficacy of biomedical healthcare is not always the main concern, but ethnicity of the provider is an aspect they consider of central importance.

Studies in medical anthropology with focus on ethnicity remain rare, with exceptions such as the ethnographical studies by Libbet Crandon-Malamud in Bolivia. Crandon-Malamud clarified that patients’ behavior and their perception of various medicines reflected the dynamic changes in the perception of ethnicity in post-revolutionary Bolivia (Crandon-Malamud 1991). According to her argument, a sequence of social changes in Bolivia led to unique therapeutic choices, perception of etiology, and medical practices that crossed ethnic boundaries. While the study by Crandon-Malamud was based on the idea of medical pluralism, this present paper addresses a similar point by discussing how ethnicity reflects on people’s social networks of therapy, with an emphasis on the social context of various forms of biomedical intervention into people’s everyday lives in an era of global health.

In considering this set of problems, I use the term “therapy network” to describe social linkage that comprises mutual support when in need of biomedical treatment and information sharing about available biomedical therapies. The notion of therapy networks is derived from Janzen’s concept of the “therapy managing group” mentioned above. In order to stress the people’s flows and the social linkage beyond national borders as well as within their areas of residence, I use the term “network” instead of “group.”

As I will discuss in more detail later, I focus on the Egun peoples’ practice of treating malaria because malaria for the Egun is perceived as an everyday occurrence and thus an unavoidable illness. Malaria is also suited for the purpose of this study because when procuring biomedical treatment for Malaria Egun people rarely use “traditional” medicine except certain herbal treatments but they

almost always go to see a doctor in a biomedical health care facility¹).

2. Background: Creating Ethnic Boundaries between Egun and Yoruba

2.1 Research Site: Egun Residential Areas in Makoko

I conducted my field research including participant observation and interviews for about 9 months from 2011 to 2015 in Makoko. I also carried out a field trip by road from Makoko to So-Ava and Cotonou in Benin in order to trace people's migration flows to and from their respective hometowns, accompanied by two of my informants who originally came from these areas.

In both global and domestic media, Makoko is often portrayed as a slum of particularly severe living conditions. Some researchers specifically point out the prevalence of infectious diseases, low income, the lack of education, the poor housing situation, and insanitary conditions in Makoko (Gambo et al. 2012; Yadua 2012; Akinwale et al. 2013). The population of Makoko has been increasing at a tremendous rate. For example, Akinwale *et al.* (2013) reported 141,277 residents in 2012, with a projected growth rate of 7.5 percent. Makoko is located in the central part of Lagos State at the waterfront, and is part of the Lagos lagoon.

Makoko consists of five geographical areas: Okoagbon, Aiyetoro, New Makoko, Old Makoko, and Top of Water. Most Egun people in Makoko live in dense housing conditions in Top of Water on the Lagos lagoon and the coastal part of Old Makoko. In general, it is difficult to reach the Egun residential areas without proper knowledge of the geography of Makoko because one needs to pass through a complex of narrow, muddy and unpaved streets. In other words, it is rare to see members of other ethnic groups in Egun residential areas. The Egun construct their own houses, small shops, schools, churches, mosques and so forth to sustain their everyday lives autonomously. They use the Egun language, but some also speak French, Yoruba, and English. The Yoruba, on the other hand, are the majority ethnic group in Lagos state².

2.2 Egun Communities in Makoko

According to the *Ethnologue*, the name of "Egun" to designate a language or ethnicity is used interchangeably with "Gun" (Simons et al. 2017). Sociolinguistic studies centered on southeastern Benin have suggested that the Gun language is one of the varieties of the Gbe language continuum, but this classification remains tentative (Kluge 2011).

For the most part, Egun people identify as members of the Egun ethnic group only when they settle in Makoko. In other words, once they return to their respective hometowns in the southeastern part of Benin, they will identify as

members of ethnic groups such as Tofin, Alada, or Ayizo, all of which belong to the Gbe language continuum. The Tofin constitute the majority of the Egun people in Makoko. They are originally based in the fishing villages of So-Ava and along the So River. Tofin are known as the first settlers in Makoko. According to the interviews I conducted in one of the villages in So-Ava, some of the Tofin moved from So-Ava to Makoko at the end of the 19th century either to search for new fishing sites or to escape wars with the Dahomey Kingdom. The number of Tofin in Makoko has increased especially since the 1980s due to a prolonged period of poor catch of fish in Benin³⁾ (Gambo et al.2012; Babalobi 2013). Most of the Tofin people construct and live in houses on the Lagos lagoon the same way as they do in their hometown, So-Ava, and engage in fishing.

On the other hand, both Alada and Ayizo are known and identify as farmers. They originally lived in southeastern Benin, but in areas different from those inhabited by the Tofin. Alada and Ayizo began moving to Makoko during the 1950s in search of new employment opportunities, and their numbers have rapidly increased since the 1980s. However, their overall lifestyle remains ill-suited to the conditions of the lagoon.

From the 1950s onward, when Tofin, Alada and Ayizo all had established communities in Makoko, they started to jointly re-identify as “Egun,” sharing the same residential areas (on the Lagos lagoon and its coastal area in Makoko), language (Egun language) and homecountry (Benin). According to some of my informants, Tofin, Alada and Ayizo share such a broader identity as Egun as the result of various practices of mutual help that cross the ethnic boundaries amongst each other, for instance sharing food, accommodation, and money. These practices provide efficient support especially for the newcomers from Benin, most of whom are poor migrant workers who cannot expect to receive social and welfare benefits from the Lagos State government. Some informants also explained to me that different migrant groups cooperated to reclaim land from the sea for Alada and Ayizo people who are not used to the lifestyle on the lagoon. For such projects, Tofin people would dive to dig the sand, and the Alada and Ayizo waited on the lagoon shore to retrieve it from the divers. This way Egun people kept expanding their residential area in Makoko throughout the 1970s-1990s.

The social process that caused migrants from Benin to self-identify as Egun can also be explained through the presence of others, namely the Yoruba who currently form the ethnic majority of Lagos state. The Yoruba are often more favorably positioned in political, economical, and social terms despite of the fact that they also started to settle in Makoko no earlier than in the late 19th century.

During my research from 2011 to 2015, I rarely observed direct interaction between Egun and Yoruba. For example, I cannot confirm any intermarriage between them, except in one case of a 22-year old Egun man who was born in

Makoko and graduated from a junior high school outside of the Egun residential area. Most Egun marry partners from the same ethnic group or at least among the Tofin, Alada, or Ayizo.

Since the Egun rarely seek interaction with the Yoruba, their day-to-day lives almost completely take place within their own Egun communities. In respect to education, this means, for instance, that the Egun people build their own private primary schools where lessons are taught in French and Egun. Some of those schools in the 2000s were funded by foreign Christian individual donors. To graduate, students take the official examination test, called Certificat d'Etudes Primaires, which is regarded equivalent to the degrees in Benin. The Egun maintain a strong attachment to their respective hometowns. It usually takes Egun people at least seven hours to reach these hometowns, which includes changing from one crowded bus to the other several times. However, none of my interviewees, old or young, ever complained to me about the hardships of travel. In fact, they do travel frequently, which usually means at least twice per year, but sometimes even take the round trip within a single day. The reasons for travel vary and include participation in funerals, weddings, celebrating Christmas, homecoming visits, business, visiting schools, receiving medical treatment, and so forth. Also, since Egun people often return to their hometowns when getting older, most of the Egun in Makoko actually are first-generation migrants.

Not surprisingly, the Egun people's tendency to interact mostly within their own ethnic group can also be observed when they procure treatment for malaria. Generally, the Egun harbor a strong negative perception of the Yoruba whom they regard as the cause of various problems that hamper them in their everyday lives. These underlying negative views condition the ethnic boundaries between the Egun and the Yoruba.

2.3 Yoruba as the Others

One major social issue that troubles the Egun people's everyday lives is forced evictions by the Lagos state government. Makoko is included into a list of slums targeted by the Lagos Metropolitan Development and Governance Project of the Lagos State Government in 2006-13, funded by the World Bank. As a part of this project, forced evictions of some parts of the Egun residential areas in Makoko have been repeatedly conducted, and in consequence a substantial number of Egun people lost their houses in 2005, 2010 (twice) and 2012 (Amnesty International 2013). During my interviews with Egun people, I regularly heard complaints about the decision-making processes of those forced eviction measures that largely unfolded without any involvement of the Egun. The Egun in Makoko thus feel strongly concerned about the possibility of further demolition of their homes.

Makoko is also considered as one of the hotbeds of street gangs called "Area

Boys,” who have a reputation for indulging in criminal acts such as demolishing, vandalizing shops and houses, and committing robbery or theft. Egun people commonly assume that the members of those gangs are Yoruba. The victims of gang activities are mostly Egun, and some of my informants were injured or robbed during the time of my fieldwork.

The fact that Egun people maintain these negative opinions about the Yoruba plays into the way they perceive these social conflicts. For instance, when my informants commented negatively on the Area Boy gangs, the Lagos State Government or the notion of ‘Nigerian’ or ‘Lagosian’ (indigene of Lagos) in general, their complaints were always directed against the Yoruba. This is despite of the Egun being aware that some gang members are not Yoruba but belong to other ethnic groups such as Igbo. Some Baale (traditional chiefs) I talked to also mentioned conflicts between Egun and Yoruba about the land ownership of some of the Egun residential areas in Makoko during the 1980s. Yoruba constitute the majority of the population in Lagos State and often find themselves in socially more desirable positions than the Egun. In contrast, the Egun people I talked to in Makoko frequently described themselves with terms such as ‘immigrant,’ ‘foreigner,’ ‘poor’ and ‘minority,’ and emphasized that they speak a different language from the Yoruba.

In summary, this chapter has briefly examined how the ethnic boundaries between the Egun and the Yoruba are dynamically constructed. The process of creating an ethnic group “Egun” cannot be explained by the notion of “primordial sentiment” but instead is based on practical or “instrumental” ties of choosing between different concepts of ethnicity depending on whether members of the Egun communities situate themselves in Makoko or in their hometowns in Benin (cf. Mitchell 1956; Cohen 1969). A common identity as Egun helps migrant populations to persist in the severe urban living conditions of Makoko. In contrast, the Yoruba, from an Egun point of view, are constructed as “others” who share neither ethnicity, history, language, nor hometowns with the Egun, and who are seen as the cause of social problems that negatively affect their everyday lives. The Egun can fluctuate between Makoko and their hometowns in Benin. This enables them to avoid the tension-filled relations with the Yoruba. While the Egun remain connected to their hometowns in Benin, they re-identify as members of an ethnic group “Egun” once they cross the national border to Nigeria and have to cope with the Yoruba (the others) in Makoko. The dynamics of negotiating these ethnic boundaries between Egun and Yoruba also impact the social processes of their therapy networks, as I describe below.

3. Biomedicine in Makoko: Multiple Ways of Obtaining Malaria Treatment

Controlling malaria has been one of the central public health concerns both in Nigeria and Benin. The public health policies in Nigeria proved to be largely inefficient during the 1980s and 1990s at a time of cuts to the public health budget and the privatization of the health sector under the Structural Adjustment Programs (SAP) (Turshen 1999). However, the Ministry of Health in Nigeria, NGOs, and private companies have gradually implemented various public health projects to ensure free healthcare access for the prevention and treatment of malaria, especially since the enactment of the Nigerian National Malaria Policy in 1996 (NPC and NMCP 2012).

The most substantial changes to the biomedical setting in Makoko in respect to malaria treatment occurred in the 1980s under the SAP policies, as well as in the 2000s through an increase of public health campaigns by NGOs, the government and private sectors. These changes have been accelerated further by new inflows of Egun people with medical training, and pharmaceutical products. The available healthcare options in Makoko of relevance to the treatment of malaria can be divided as follows:

1. *Private healthcare facilities operated by the Egun in Makoko.* There are more than 10 private hospitals operated by the Egun near and on the lagoon. When a larger number of migrants from Benin began to move to Makoko since the 1980s, some of those who had a license or practical capacity in the medical profession (doctors, nurses, and pharmacists) opened hospitals. These people sometimes brought medication with them from their hometowns in Benin where they were available at a lower cost than in Lagos. The Egun people frequently rely on these hospitals, even as they (and the medical staff alike) are keenly aware of the facilities' often insanitary conditions, high consultation fees, and dissatisfactory quality of the medication. Some of these hospitals in the past were forcibly closed down by the police when it came to light they had been operating without proper registration with the Lagos State Government. Medical consultation is conducted mostly in the Egun language. Those living outside of Makoko usually will not frequent these hospitals, and often do not even know of them.

2. *Healthcare campaigns by the Lagos state government, NGOs, and private companies.* Medical support provided by NGOs and private companies has substantially increased since 2000. For example, MTN Nigeria, one of the largest cellphone companies in Nigeria, organized the malaria control campaign "Change A Life" in 2010. They provided free medical consultation, distributed anti-malaria

medication, and taught preventive measures specifically aimed at children. The Lagos State Ministry of Health has also conducted various kinds of campaigns to combat malaria in Makoko, such as a free diagnosis campaign (“one day free medical mission”), free distribution of mosquito nets, and educational activities for the prevention of malaria. The largest public health program in Makoko was conducted by a Spanish team of MSF. MSF opened a free mobile clinic specifically for the people living on the lagoon, and for two years in 2010-2012 operated a primary health care (PHC) center in Makoko, called Aiyetoro PHC Center, providing primary and reproductive healthcare as well as inpatient and emergency services. More than 19 thousand people relied on the medical consultation offered through the program (MSF 2013). Egun women especially deplored the eventual withdrawal of the MSF from an hospital that had offered them facilities for safe delivery. Men, on the other hand, frequented it less often because they perceived it as too crowded. In any case, patients generally appeared to be more or less satisfied with the MSF hospital.

3. *Public/ Private healthcare facilities operated by other ethnic groups (mostly by the Yoruba) in and out of Makoko.* After MSF withdrew from the hospital in Makoko in 2012, the Ministry of Health took over the facility and reopened it as a public PHC center (Aiyetoro PHC Center) in 2013. Other public hospitals are situated in Ebute-Metta and Yaba and can be reached from Makoko by *danfu* (mini bus) or *okada* (motorcycle taxi) within 10 minutes. Compared to the situation of both public and private medical services during the times of the SAP policies in the 1980s and 1990s, the recent efforts of the Lagos State Ministry of Health have resulted in an improved quality of the medical services of public hospitals. However, the Egun people still feel strong reservations towards the use of the public hospitals, even if they are located closer to their homes and free of charge. More private hospitals and clinics can be found in and out of Makoko, but the Egun rarely use them. The quality of medical services and the costs involved differ by each hospital.

4. *Healthcare in the migrants' hometowns in Benin.* Almost all of the Egun in Makoko that I interviewed told me that the healthcare facilities in Benin are better than those in Nigeria. They preferred the option of returning to their hometowns when in need of malaria treatment, especially in emergency situations and often even in spite of the costs involved in terms of both the time and money spent on the journey.

5. *Pharmacies and Herbal Shops.* For the self-medication of malaria, people frequent pharmacies and herbal shops in and out of Makoko. I confirmed that there

were at least 10 pharmacies in Makoko which sell supplement tablets and medicines, including anti-malaria medication such as ACT (Artemisinin-based Combination Therapy), SP (sulfadoxine and pyrimethamine), Chloroquine, and Mefloquine. Some of these pharmacies are managed by registered pharmacists, others are not. People frequently rely on both traditional herbal treatments and modern pharmaceutical drugs for the self-medication of malaria unless the case is severe.

4. Negative Perception of the Yoruba

During my research in Makoko, I frequently encountered a negative perception of Yoruba biomedical healthcare services among the Egun people. Most of the Egun suggest that they hesitate to use medical facilities operated by the Yoruba because of the language barrier. However, some Egun also felt exposed to discrimination at hospitals operated by Yoruba. Others complained to me that the doctors overcharged them on consultation fees, or offered inefficient medication, some of which turned out to be fake or counterfeit products⁴). The concerns among the Egun people against hospitals not operated by their own ethnic group are not attributed only to the language barrier or discrimination. Rather, they are indicative of more widely shared attitudes among the Egun in Makoko. I will briefly discuss the hesitation among the Egun people to use hospitals operated by Yoruba through the cases of two of my informants, Emmanuel and Elizabeth.

Emmanuel is 40 years old and belongs to the Alada ethnic group. He came to Makoko from Port Novo in Benin in 1986 and speaks English, French, Yoruba and Egun. I interviewed Emmanuel in a friends' house after the Mass at the Catholic Church in Makoko. When I asked about hospitals operated by Yoruba outside of Makoko, he explained as below:

It costs a lot of money in public hospitals, at least, 2,000-3,000 Naira (12.5-19 USD). You know, if you use the hospitals outside of Makoko, you must be referred to another hospital especially when the condition is severe. If so, it is better to go back to our hometowns! (...) For example, it may cost 5,000 Naira (31 USD) at the first hospital (outside of Makoko), then you are referred, and it costs 5,000 Naira at the second hospital again, and then, referred again, it costs 3,000 Naira at the third hospital. If so, we'd better go back to Benin from the start. (...) The Yoruba know very well how to make money. They ask us to buy many drugs. "You need to buy this, this, and this." After we buy all of them, the doctor will throw away some of the receipts, and put the money into his own pocket. This is how Yoruba people behave.

Other people who were present during the interview agreed with his explanation. I routinely encountered this type of negative perception of Yoruba

people during my research in Makoko and even in Benin. Emmanuel actually never visited a hospital operated by Yoruba in his whole life, but described the Yoruba mostly based on his preconception of “how Yoruba people behave.”

The case of Elizabeth’s therapeutic behavior illustrates the negative perception of Yoruba even more clearly. Elizabeth belongs to the Tofin group, is about 40 years old, and has lived on the lagoon since the 1970s with her husband and their six children. She speaks Egun and some French. I conducted 5 interviews with Elizabeth during 2011-13.

Elizabeth told me that malaria was the worst indisposition she ever experienced. When she contracted the disease, she at first used herbs and tablets though she knew that the quality of herbal treatment in Lagos was worse than in her hometown. Since her condition did not improve, she visited hospitals operated by Egun on the lagoon in order to receive treatment. During 2010-12, she relied on the aforementioned PHC center operated by the MSF and was impressed with their high standards and free-of-charge medical services.

In September 2013 when I visited her house, she recounted her recent experience of just two weeks ago at the Aiyetoro PHC center after the MSF had withdrawn from the hospital, and the Ministry of Health reopened it as a public PHC center. Elizabeth has an uncle who works as a doctor on the lagoon, and whose hospital she frequently visits because the consultation is free of charge. When she contracted malaria this time, she also visited her uncle first (they would usually refer to the PHC center operated by the MSF as “the white man’s hospital”). At that time, both of them did not know that the MSF had withdrawn and that the government had taken over the facility. When Elizabeth finally there, she realized that no “white man” was in the hospital anymore. She described her visit there as below:

I went to the MSF hospital. But the white man did not treat me. Yoruba did. This is why my sickness came back. (...) The white man had gone, and Yoruba treated me. (...) I asked the staff where the white men were. But they just replied to me that they (MSF staff) were gone.

The quality of the medical services in the Aiyetoro PHC center now operated by the government is presumably about on the same level as before with the MSF. However, even with the same treatment, Elizabeth anticipated her condition to not improve because the success of treatment for her depends on *who* is treating her. From her point of view, to receive medical treatment from a Yoruba doctor was the least desirable option.

These two cases reflect the perception of ethnic boundaries between the Egun and the Yoruba as I described in the previous chapter. In regards to therapy

networks, the Egun people consider Yoruba doctors as part of “the others” with whom one should not interact, even if the biomedical practices are the same. In other words, the Egun peoples’ therapy networks ideally only include those who of Egun origin themselves.

5. Therapy Networks and Obtaining Malaria Treatment

In this chapter, I analyze from a historical point of view how the Egun people manage to obtain malaria treatment and address the problem of their aversion against healthcare services provided by the Yoruba. The case of John in the following section focuses on the changes in his therapy networks since he moved to Makoko in the 1980s. This case illustrates the process of socially constructing ethnic boundaries between the Egun and the Yoruba in response to the increase of medical intervention into Makoko communities. John is a typical Egun resident in Makoko in respect to his perception of and resulting attitudes towards the five healthcare choices I described above.

The Case of John: Changing Behavior Towards Obtaining Malaria Treatment

John was born in a fishing village of So-Ava in Benin in the 1950s as a member of the Tofin ethnic group. He now lives in Makoko together with his wife and 6 children, and works as a schoolteacher and staff in the Catholic Church in Makoko. Like other Egun people in Makoko, John has experienced harassment from the Area Boys since 2010, and witnessed the forced demolition of his school by the Lagos State government in 2012.

John first came to Makoko from his hometown in the 1980s with his parents and siblings to find work. A few years after moving to Makoko, John’s mother became pregnant again. During the pregnancy she experienced strong physical discomfort, “probably malaria”, so she first attempted to consult the hospital in Lagos, but then decided to return to Benin to receive treatment. When I visited John’s hometown in Benin in 2013, I conducted interviews with John’s mother, now in her 70s, about her experiences in Makoko:

I had a very hard time when I was about to deliver. The hospital in Benin was better than the one in Nigeria, they provided good treatment and care. That is why I went back to Benin. (...) At this time I was very sick and I prayed for the help of God.

One of her sons who was with her during the delivery. He added the following:

When we were in Lagos, I took her to the “T” Hospital in Yaba, but we struggled with

the language. They couldn't understand our English. That was the reason why we went back to Benin. (...)

I took my mother to the "C" Hospital in Benin. At that time, she could not even walk. We had to pay a large sum of money (to the hospital for her treatment). (...)

John's mother eventually gave birth to her child safely and the family moved back to their village in Benin. The experience was so shocking to the family that afterwards it was only John who remained in Makoko.

John thereafter relied on the public hospital in Makoko operated by Yoruba when he was sick. The main reason for this choice was the scarcity of hospitals in and around Makoko. There were almost no hospitals operated by Egun up until the 2000s. However, at the end of the 1990s, John began to use a private hospital operated by the Catholic Church outside of Makoko after he had learned from a friend at the church that the medical quality in that hospital had improved. With a letter of introduction from a Father of the Makoko Catholic Church, John could even sometimes receive medication there free of charge.

In 2005, John contracted malaria, which turned out to be the most severe illness in his life. Up until that time, when John got sick he would usually call by cellphone a medical doctor, Peter, an old friend of his from the same village in Benin, to explain his condition and receive instructions on which medication to purchase at the local pharmacy. However, during his malaria infection in 2005, he developed a seriously high fever, was shivering and coughing, and felt strong headaches. Initially, he went to the public hospital in Makoko operated by the Yoruba. The treatment, however, proved insufficient, and John's condition continued to worsen. He considered going to the hospital outside of Makoko operated by the Catholic Church but did not have enough time to get the necessary introduction letter from the Father of the church in Makoko. He then decided to attempt the trip to Benin to consult his doctor friend, Peter, who was working in their hometowns' hospital. With the treatment he received in Benin John eventually recovered.

John explained to me that after the experience of malaria in 2005, he gradually changed his reliance on the public hospital and the private hospital operated by Catholic Church, to the hospitals operated by the Egun inside of Makoko. The public hospital eventually closed in 2005, but another factor here was that some of John's friends with medical licenses had moved to Makoko and opened new hospitals there.

A few years after John's recovery from malaria, his daughter started working as a nurse in a hospital on the lagoon operated by Egun doctors. He told me that this situation made him quite happy, and so he decided to have his family members frequent the hospital whenever one of them contrived an illness. Still, he

was not fully satisfied with the quality of the treatment and the facilities at the hospital. For example, when I visited John at his home in 2013, he suffered from a heart ailment and constantly appeared exhausted. He told me that he already went to the hospital on the lagoon where his daughter worked, and had received their anti-malaria medication. But it didn't help to improve his condition. A few days after talking to me, he decided to visit the general hospital in Cotonou, Benin. His younger brother helped John to travel to Benin, where he recovered, and then returned to Makoko.

A few months after the recovery from his sickness, John received the sad news that the doctor at the hospital where his daughter was working had suddenly died. For John, this meant that he lost a reliable health care provider in Makoko, and thus needed to find a new one.

Again several months later, one of John's daughters, who was 6 years old at that time, had an accident at school resulting in a head injury. John took her to the house of an Egun doctor on the lagoon inside Makoko who also happened to be the current chairperson of the PTA (parent-teacher association) of his school. Seeing that the daughter did recover well, John was satisfied and decided to further frequent the hospital when in need, because, as he put it, 'he is my president of the PTA.' Unfortunately, John could not always rely on this contact because the doctor was often back to his hometown in Benin, and John sometimes could not afford the cellphone credit in order to call him.

In July 2014, one of his sons contracted a severe malaria infection. When John tried to contact a doctor, he realized that the chairperson of the PTA was away to his hometown in Benin. He then asked another medical professional, one of his friends from the same village as John, to treat his son. This nurse operated the hospital alone while the principal doctor was away and treated patients on the lagoon despite of not being a certified physician. John's son fortunately recovered. Unlike the doctor/PTA chairperson, the nurse stays always in Makoko, but John knew that he did not provide the best possible treatment and frequently referred patients in severe condition to other hospitals because of his inability to serve them appropriately. Still, John and others among my informants related to me that this nurse regularly gives the impression of managing the hospital on the lagoon as if he was an actual medical doctor.

During my interview in 2013, John explained his perception of the available health care options in and out of Makoko and his hometown as below:

Here (in Makoko), the quality of medicine is not good. Therefore, I go for treatment to the hospital on the lagoon only if the illness is not serious or I already know how I want it to be treated. However, I go to Benin if I contract an illness of which I don't exactly know what is the cause or how serious it is. (...) All the doctors in Nigeria and

Makoko can do for us is to check blood and blood pressure, the body temperature, and then they usually give me a painful injections, or soemtimes just Paracetamol. On the other hand, the hospitals in Cotonou (in Benin) do a lot for us. (...) When (in the case of sickness) I arrive at Seme (the border city in Benin), I first call my younger brother. If he's not around, I call my mother (to ask her help to take me to the hospital). That's all.

John's perception of the medical facilities in Makoko is negative, even though he actively attempted to obtain the best possible medical treatment there. He has no problems to communicate both in English and in Yoruba, but still felt uncomfortable to frequent hospitals outside of Makoko, though he used them in the 1980s and 1990s.

Changes in Therapy Networks

As discussed in the previous chapter, the Egun people had to deal with various kinds of social conflict such as violence inflicted by the Area Boys, the forced demolition of their neighborhoods by the Lagos State government, and conflicts about land ownership with Yoruba residents in Makoko. Since these incidents usually evolved along the lines of ethnic boundaries it is not surprising that they were perceived as "harassments," caused by "them, the Yoruba" (the other), as opposed to "we, the Egun" (the self). Obviously, the primary concern of this study is the question why the Egun refrain from using biomedical facilities operated by other ethnic groups and instead are much more willing to connect within a closed circuit of relatives and friends to obtain their treatment, even if that treatment is of inferior quality and/or more difficult to procure.

John's therapy networks and the changes they underwent are good examples of these broader issues. I traced John's initially weak therapy network back to the 1980s and 1990s at the era of the SAP policies when most Nigerians experienced a severe lack of healthcare access, and even more so in the case of migrants such as John. When he moved to Makoko with his family members in the 1980s, they experienced many difficulties to find a hospital where their mother could be treated for malaria, including the language barrier, low quality of medication, and their lack of connections to other Egun in Makoko who could step in to help.

After his family moved back to Benin, John and some of the seniors of the Makoko Catholic Church gained access to a church hospital operated by Yoruba outside of Makoko. Egun who did not have access to this kind of therapy network had few biomedical facilities available for them, and they usually traveled back to Benin when in need of the treatment for sickness or care for child bearing. In other words, in 1980s and 1990s, ethnicity was not a main concern for the Egun people in regards to their therapy networks because they had almost no reliable healthcare

access in Lagos State and the only alternative when in need, especially in the case of serious sickness, was to return to their hometowns. This, again, would require them to be at least seven hours on public transport, including transiting the bus several times. The burden of travel to some extent is facilitated by the fact that most Egun can cross the border between Nigeria and Benin without holding a passport.

Since the 2000s, however, Egun people's therapy network tends to exclude Yoruba facilities. John's interactions with health care providers from the Egun community diversified partly due to the growing number of medical facilities in Makoko operated by Egun. In his case, the closing of the public hospital in Makoko and changes to the private hospital operated by the Catholic Church derived him of parts of his therapy network. Some of my informants who had used the hospital of the Catholic Church since the 2000s equally stopped frequenting it and instead went to see Egun doctors in Makoko. One of my informants related that new doctors harassed Egun by charging expensive medical fees, and prioritizing their own (non-Egun) friends and family members. Furthermore, interventions from outside of the community such as the operation of hospitals and the implementation of medical campaigns by NGOs, as discussed in the case of Elizabeth, generally lasted only for a short time, and the local populations often did not receive essential information such as when the MSF hospital closed. Short-term campaigns by NGOs have failed to ensure the Egun's access to appropriate healthcare, in turn the Egun did to not consider them for their therapy networks. In consequence, Egun people's therapy networks in tendency are limited to friends and relatives who happen to be licensed biomedical professionals. Even in the 2000s, Egun people still hold on to the option of returning to their hometowns for medical care, for instance, if they did not succeed in building a therapy network among the Egun in Makoko or have to deal with a serious sickness.

6. Discussion and Conclusion

In this paper, I have drawn attention to the changes in the therapy networks among the urban poor of Lagos, Nigeria in an era of global health, using an example of the Egun people in Makoko, a slum on the Lagos lagoon. Global efforts such as the direct involvement of NGOs and UN organizations to combat infectious diseases since the end of 1990s have resulted in easier access to medical equipment and medication, including anti-malaria drugs, mosquito net and rapid diagnosis test kits, even for poor people in local societies and led to improvements in their overall ability to access to healthcare services (Cueto 2013). Recent studies in the field of medical anthropology have discussed patients' behavior in procuring medical treatment and care, and clarified how they attempt to build and maintain

their therapy networks in “projectified” societies where different aid agencies from developed countries enter, participate and withdraw from the field repeatedly (Prince and Marsland 2014). However, the case of the Egun people in Makoko reveals that previous studies have underestimated the difficulties for local people to rely on foreign aid when dealing with malaria. As we have seen in the case of Elizabeth in Chapter 4, people in need of treatment are often uncertain whether NGOs are still operating in their area or have already gone elsewhere. As Geissler (2014) discussed, people in local communities live in an environment dominated by ephemerality and the unpredictability of sustained presence of non-state actors. This is a critical issue for local residents especially when they need immediate treatment, for instance for sudden high fevers or malaria. In other words, people in these communities show willingness to trust and rely on biomedical treatment provided by various foreign aid agencies, but that willingness at the same time is undermined by the often short-term nature of these agencies’ commitments and the resulting unreliability of their services in these “projectified” societies.

Thus, people in the local communities tend to regard biomedical services provided by foreign aid agencies as uncertain in their continued availability, and therefore place more importance on mutual support among relatives and friends which are considered more reliable. As I suggested in Chapter 1, previous studies in the field of medical anthropology have discussed face-to-face, mutual support networks among relatives and friends to ascertain appropriate therapy and medical care. What these studies have failed to acknowledge, however, is the predisposition to foreclose potential therapy networks of biomedical healthcare once they appear to transgress critical ethnic boundaries. In this regard, I found that in the case of the Egun people therapy networks strikingly conform to ethnic boundaries. Quality and cost of healthcare, in fact, are often of secondary concern, compared to the primary criterion of ethnic affiliation of the caregiver. To ensure their healthcare needs, Egun people in Makoko insist to construct their therapy networks almost exclusively among the members of their own ethnic group, including contacts in their respective hometowns, despite of the fact that some medical facilities in the Egun residential areas have a reputation of providing low-quality care. Egun people are self-conscious of their status as a poor minority in Lagos State, and they perceive themselves as suffering from the majority group of the Yoruba on a daily basis. Consequently, they will avoid crossing these ethnic boundaries in the search for their remedies. This paper, in conclusion, clarifies that the increasing mobility of biomedical personnel and equipment in the era of global health broadens therapeutic options. At the same time these developments allow to foreclose certain therapeutic choices, particularly those that cross ethnic boundaries, and therefore encourage local populations to maintain their exclusive attachment to the members of their own ethnic group.

Notes

- 1) This paper describes people's behavior in search for malaria remedies and their respective therapy networks, I do not specifically examine the people's local perception of malaria which will be the topic of a different paper. Malaria is called "ova" in the Egun language, and its perception is informed of different ethnomedical understandings, in addition to scientifically "correct" (modern) knowledge of malaria as provided by NGOs and governments' campaigns. Egun describe the usual symptoms of ova as high fever, shivering, the feeling of the blood inside the body "drying up" because of the fever, and the eye color turned yellow. The Egun assume that mosquito bites are the main cause of infection, though some indicate other causes such as drinking contaminated water, and breathing in certain fumes.
- 2) Most people in Lagos speak English and Yoruba. People in Benin speak French and their own ethnic language, which may include Egun. That means most migrants from Benin are facing a severe language barrier in Lagos.
- 3) Members of various fishing communities in the coastal belt of the Gulf of Guinea (specifically in Togo, Benin and Nigeria), including the Tofin, since the pre-colonial era have continued to move back and forth these areas when in need of new fishing grounds (Law 1983; Olukoju 2000).
- 4) Counterfeit and fake drugs are a well-known problem in Nigeria, openly discussed by a lot of publications in the media. The National Agency for Food Drug Administration and Control (NAFDAC) has worked to crackdown their sale in pharmacies since 2000 (Taylor et al. 2001; Odili et al. 2006). Egun people in Makoko working in the chemical industries have frequently come forward to warn people of counterfeit and fake drugs, and advised them to verify medicines carefully before purchasing.

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