

Born to Die: The *Ogbanje* Phenomenon and its Implication on Childhood Mortality in Southern Nigeria

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ABSTRACT Despite government efforts to curb the ravaging menace of childhood diseases in Nigeria by providing health services and encouraging mothers to utilize the same, the mortality rate of children below five is still significantly high. Various scholars have observed that although the problems confronting maternal and child health are multiplex, the socio-cultural dimension seems to be overwhelming. This article is the result of a study conducted in 2004 and 2005 to investigate the cultural notion of the *ogbanje* phenomenon, which is pervasive in most parts of southern Nigeria. The paper analyzes the results of the study within the Health Belief Model and discusses how the lives of children below five hang precariously on this cultural belief.

INTRODUCTION

In Nigeria the need to reduce infant and child morbidity and mortality is one of the greatest challenges confronting the federal government. It has been estimated that the mortality rate of children below five years of age in Nigeria hovers between 97 and 120 per thousand births (UNICEF, 2002; WHO, 2004; FOS, 2005). The greatest health challenge to the federal government of Nigeria is to reduce this rate to the barest minimum; but despite the efforts of various successive governments to tackle the problem the results have been dismally poor. Various researchers who are interested in maternal and child health in Nigeria have identified some key factors that may be adduced to this problem and some of these factors include poverty (Owumi and Ezeogu, 2003); ignorance by mothers (Bradley and Gilles, 1984); and the lack of political will by the federal government (Iyun and Oke, 2000). For these and other similar reasons, morbidity and mortality from childhood diseases continue their debilitating effects on the health of young children. One researcher who has shown a remarkable insight into this problem is Rhode (1980) who identified beliefs as a major factor for poor response by mothers to participate actively in government health efforts. It is in this perspective that a study, from which this article is derived, was conducted. The paper discusses the general concept of *ogbanje* as it is conceived by various ethnic groups in southern Nigeria and weaves its socio-cultural relevance to our understanding of infant and child morbidity and mortality in that part of

the country. Overall, it is argued in the paper that belief in *ogbanje*, does not only influence mothers' perception towards childhood diseases, but it also builds a framework in the mental psyche of mothers, which influences their health seeking behaviour and ultimately their non-preventive measures against major childhood killer diseases.

THE OGBANJE PHENOMENON

Soyinka's (1967) poem and that of Clark (1967) both titled *Abiku*¹ give a vivid idea of the world and power of *ogbanje* children and the response of the household towards such children who are believed to have such powers. It is generally held among the Yoruba, Igbo and Urhobo of southwestern, southeastern and midwestern Nigeria respectively, that in the distant past, some children were born into this world but realized, with their psychic power, that the world would be too difficult for them to make any significant mark due to the stiff competition that characterizes it. Acknowledging their laziness and their inability to compete with others, they decided to die and go back to heaven. On getting to heaven, the gatekeeper interrogated them and found that their lack of zeal to work had brought them back. To discourage indolence, this group of children was not allowed entry to heaven and was told to go back to the world. Not to be regarded as non-achievers in life, they decided to form a society in the spirit world with a selected forest as their abode. Their rendezvous is usually on big trees such as the baobab and other similar trees. But because they are spirit beings, they cannot be

seen with the naked eyes. In this forest, they indulge in playful activities and once in a while may decide to be born into the physical world just to have a taste of it and after a while they would die and return to their spirit kins. An oath is usually sworn to keep the bond of comradeship perpetual while a pact is made with their spirit kindred in the spirit world detailing what they would do after their birth and the very day they would return to the spirit world. The date they decide on is usually significant in the life of the family the child is born into: the child may decide to die when the father is celebrating an important occasion or on the child's own birthday, usually before his/her fifth birthday. However, this is not to say that *ogbanje* children do not live beyond their fifth birthday. Some have been known to live to an adult age only to die on the day of their marriage. The ultimate aim of choosing such a date is for the child to be the centre of attraction so that what he could not achieve by dint of hard work is achieved by his sudden death. After his death, the cycle is repeated usually to be reborn into the same family.

Such tales, which are pervasive in different cultural groups in southern Nigeria, although may be analyzed as myth, are nevertheless engrained in the belief system of the people and they form important ingredients that shape their cosmology and ultimately their social behaviour. While parents sometimes engage medicine men to intervene in stopping the trend, as reported by respondents, others implore such children by giving them names that suggest persuasion. This belief finds expression in such names as *Kokumo* (he will not die again); *Malomo* (don't die again) among the Yoruba; *Onwubiko* (death, I implore you) among the Igbo; and *Akpoyoma* (the world is good) among the Urhobo. These names suggest that the phenomenon has been culturally defined and accepted as given among these groups and it is the cultural belief that by giving such names, they might appeal to the child's emotion and therefore persuade him to stay. However, where these pleas are ineffective, the parents of the child may seek the help of a medicine man who mutilates the body of the dead child based on the premise that his/her kindred spirits would reject him due to the scarification and ugliness that would result from the mutilation. By this rejection, the child is then forced to stay in the physical world when next he is reborn.

Ethnographic study carried out among the

Uvwie (a sub-ethnic group of the Urhobo) in Effurun town revealed that parents who suspect that their child is an *ogbanje* might adopt a third approach by engaging the services of a medicine man *before* the death of the child. When the child (who may be above five years old) is suspected to be an *ogbanje*, due to frequent illness and convulsion, a medicine man is contracted. Through series of persuasions and cajoling, the child may willingly lead the medicine man to where his spiritual paraphernalia are buried. These objects, which come in various forms, may include cowries, beads, threads, and shells among other items. After excavating these materials, which are usually buried behind the house or under a big tree, the medicine man produces a charm out of them, which the child's parents keep. Sometimes the child may wear the talisman round the neck or wrist and in some cases the materials are ritually destroyed to sever any link between the child and the spirit world.

Interviews carried out revealed that the belief in *ogbanje* children is by no means restricted to non-Christians. Most Christian respondents that were interviewed believed in the existence of other spirits, which are not from God. For this reason, coupled with their cultural background, they also believe in the existence of *ogbanje* spirits who are believed to possess children in order to inflict pain on their parents. Based on this belief, the average Christian, especially among the Pentecostals, takes such children to men or women of God for deliverance. It is believed that after such an exercise, the child would be free from any spiritual manipulations and the power to initiate his death would be nullified through the name of Jesus Christ. To guard against the coming of such children into a Christian family, the couple may engage in series of prayers and fasting to cleanse the child's mother against any contrary spirits when she eventually becomes pregnant again. Unlike non-Christians, Christian parents do not plead with the child to stay; once it is established that the child has a contrary spirit, different from that of God, the parents take authority over such powers, which they command to come out of the child usually with the assistance of Christian ministers.

BELIEF IN OGBANJE AND ITS THEORETICAL IMPLICATIONS

The health belief model (HBM) as a theory in the field of medical anthropology seeks to explain preventive health behaviour of individuals and

groups (Mikhail, 1981; Igun, 1982; Rosenstock and Becker, 1988). The HBM assumes that people's actions toward health preventive measures are based on their beliefs and attitudes. It also acknowledges that beliefs and attitudes are not spontaneous; rather, they are a function of the processual experience of the individual. Hence, in a general sense, the model does not only look at the individual as a unit of analysis but also considers the socio-cultural environment, which conditions the individual to adhere to certain beliefs and predisposes him or her towards behaving in a defined and culturally prescribed manner. Human behaviours that may be rational or irrational (depending on the context) are influenced by different variables and are imbibed through the mechanisms of the learning process that are available to the individual.

The theory assumes the principal mechanisms to include the definition of the phenomenon (which is culturally defined); and the cognitive perception of the consequence of the ailment (which is both socially and culturally influenced). These mechanisms present favorable or unfavorable contexts which function as discriminative (cue) stimuli for health seeking behaviour. Hence, if parents evaluate *ogbanje* as undesirable, they would engage in culturally defined methods of preventing the occurrence of the phenomenon. Indeed mothers *do* engage in some preventive measures against the sick child or in preventing the birth of an *ogbanje* but the danger in engaging in such preventive measures (which are mostly spiritual) is manifest in their neglect of themselves and their immediate environment, which run contrary to modern preventive measures. As is commonly practised, when a woman becomes pregnant she deliberately keeps herself and her environment untidy, with the belief that the filth would discourage an *ogbanje* from coming into the family. Such belief is antithetical to modern preventive measures because rather than promote personal hygiene, it creates an environment that is conducive for the breeding of germs awaiting the arrival of the baby. The infection of the child, especially during the weaning process and at the age of crawling, could lead to the death of the child and the cycle would continue. For successful intervention programmes, therefore, this fact must be taken into consideration so that mothers are properly educated on the relationship between dirt and death among children.

It follows from the foregoing that perception as a psychological process affects individuals' expectations by the physical capacity of their sensory apparatus. In other words, a society can construct perceived reality to the extent that its culturally constructed beliefs will shape members' expectations, perception and attitude. The cultural definition of *ogbanje* and the inherent power conferred on the baby influence people's attitudes toward the manifestation of that phenomenon and, ultimately, the health seeking behaviour of mothers and the entire household. With such stereotyped belief a child that is suspected to be an *ogbanje* would not be taken to an appropriate health centre but to a traditional medicine man, thereby foreclosing alternative medical therapy. This monolithic help seeking behaviour in relation to the *ogbanje* phenomenon is significant, at least in part, in understanding infant and child mortality in southern Nigeria, because, in areas where the belief is still rife, children who are suffering from other childhood diseases may be taken to a traditional medicine man by the parents who should rather have sought appropriate and proper medical attention in health centers.

DISCUSSION

In an attempt to analyze the *ogbanje* myth, it is tempting to explain the phenomenon from the medical point of view. *Ogbanje* children may not have the powers that are conferred on them; such children may not even exist but may be real only in the imagination of traditional peoples. Children so labeled may actually be sickle cell patients or victims of other childhood diseases that were/are prevalent in most parts of southern Nigeria. It has been established that most homozygotes (SS) die prematurely unless advanced medical care is available (Harrison et al., 1988:224). The human hemoglobin-S (the hemoglobin of sickle cell anemia) is a lethal blood disorder that usually incapacitates the victim and because the gene is recessive, sickle cell anemia is only apparent in homozygous individuals. It is known as sickle cell anemia because the red blood cells collapse when the oxygen concentration is lowered and they then appear sickle-shaped under the microscope. The heterozygote (AS), however, does not suffer from anemia, though he shows traces of sickling of his blood cells if the oxygen concentration is very low (Hoffbrand and Pettit, 1984). But because the AS red blood cells invade

the malaria parasites and possibly because the mutant form of haemoglobin cannot be digested by malaria parasites the child is protected from mortality due to malaria, the prime cause of death in the tropics, especially among children below five. It has been reported that in the tropics where malaria is endemic, nearly all children are infected before they mark their second birthday, but the number of parasites in the blood declines with age as the acquired immunological defenses of the body become more effective (Darwin, 1979).

With this knowledge, it is easy to understand why the *ogbanje* myth is associated mostly with children. But because the heterozygote (AS) confers protection against malaria, specifically the malaria caused by the protozoan *Plasmodium falciparum* and because falciparum malaria in southern Nigeria is holendemic due to high precipitation and a humid environment, AS children have better chances of survival due to this unique advantage, while AA and SS children would suffer a much higher mortality. If this explanation is correct, could it then explain why some children survive to adulthood and therefore escaped being labeled *ogbanje*? What were those circumstances that could have led to their survival? Were they normal children (that is, AA/SS) who were lucky to escape lethal infections or were they merely destined to survive (that is AS children)? A plausible explanation could be sought on the mechanism of natural selection.

Natural selection is based on the principle of survival of the fittest which proposes that as environmental conditions change, nature "selects" those members of a species that are best able to cope with the rigors of life (due to some special traits in them) and thus ensures the perpetuity of that species population (Darwin, 1979). Because traditional people, in centuries past, did not exactly understand the sickle cell disease, a spiritual dimension could have been sought to explain the phenomenon. It stands to reason, therefore, that the provision of medical facilities and the increase in medical knowledge would greatly undermine the belief in *ogbanje* in contemporary Nigerian communities. As mothers become more knowledgeable about common childhood diseases as well as the availability of effective drugs and vaccination the *ogbanje* phenomenon would be pushed from the cities to peripheral, core traditional, rural areas, a situation that is becoming apparent in Nigeria.

Apart from the advancement in medical

knowledge, another socio-cultural factor that may reduce the belief in *ogbanje* in the cities is the introduction of western education, which brings with it a concomitant change in attitude towards spiritual explanations. The significant relationship between western education and health status has been well established in the literature on the subject. But this does not negate the fact that the phenomenon has ceased to exist or people do not acknowledge its existence. What it attempts to explain is that even though this phenomenon may exist among educated elites, their religious leaning as well as their educational attainment ensures that children's deaths are not explained as arising from the *ogbanje* phenomenon. However rational and plausible this explanation may be, it is true that, even in cosmopolitan cities such as Lagos, Ibadan and Port Harcourt, mothers, including some very educated ones, still believe in the reality of *ogbanje* and rather than visit government established health centres would prefer to handle such health problem spiritually.

The seemingly rational and plausible explanation given above, however, does not negate the fact that *ogbanje* children are real, at least from an emic perspective. The questions that arise from the belief in *ogbanje* are varied and complex and they are by no means restricted to medical explanations. Indeed, majority of them border on the realm of the supernatural and metaphysics: a realm of enquiry that makes scientific explanation both irrational and antithetical. For example, how do we explicate the power behind the dead child to "assemble" a mutilated body to be reborn if we hold that after interment the body disintegrates? Or how do we rationalize the idea that a child could 'relocate' the womb that first gave birth to him? How can science explain the serrated marks given to a dead child and yet those same scars would be visible on the succulent body of another baby that has just been born as has been experienced by some mothers? An attempt to explain this phenomenon using, for example, Mendel's laws of inheritance, falls like a pack of cards. It suffices, therefore, to say that this belief and other similar beliefs must not be disregarded as phantom ideas arising from simple minds. Indeed, it is about time scholars in this part of the world started probing into the interface of religion and science and between traditional belief systems and Western rationality. It is only by so doing that we will begin to reconstruct traditional people's ideas and ultimately to understand the

underlying reasons why they behave the way they do. One fundamental issue, which arises from the foregoing, therefore, is that local beliefs and traditional cosmology must be properly analyzed, using the appropriate tools, to uncover the deep meaning they contain.

CONCLUSION

The belief in *ogbanje* and what characterizes it has various theoretical implications not only for mothers and other care-givers but also for health workers who are saddled with the onerous task of planning and implementing health intervention programs. We may never be able to give satisfactory answers to the myriad of questions that inevitably arise from the *ogbanje* phenomenon, but one thing stands clear: the belief in the phenomenon has profound influence on mothers' responses to childhood diseases and their responses toward modern preventive actions, as well as their treatment behaviour. Delimiting our discussion to mothers' preventive measures and their health seeking behaviour within the Health Belief Model does not in any way exhaust all the possible implications of the *ogbanje* phenomenon. The analysis and discussion made here are grounded only in one premise and that is, not all deaths that are ascribed to the *ogbanje* phenomenon are correct. Some of the deaths that are associated with the phenomenon could have been easily prevented if mothers were to engage in simple personal hygiene and take advantage of the advances in medical knowledge. For an effective intervention programme to reduce child mortality in Nigeria therefore, health workers must consider various traditional beliefs that may negatively influence mothers' attitude and perception toward modern advances in medical knowledge. Health workers would only succeed if ethnographic studies are encouraged and appropriate campaign strategies are designed to enlighten mothers and significant members in households on the relationship between other forms of preventive measures and child survival.

NOTE

Among the Yoruba of southwestern Nigeria and some other cultural groups in the southern part of Nigeria, for example the Itsekiri of Warri in the Niger Delta, they refer to *ogbanje* children as *abiku*

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