THE MANAGEMENT OF ILLNESS IN AN EAST AFRICAN SOCIETY : A STUDY OF CHOICE AND CONSTRAINT IN HEALTH CARE AMONG THE POKOT

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Preface

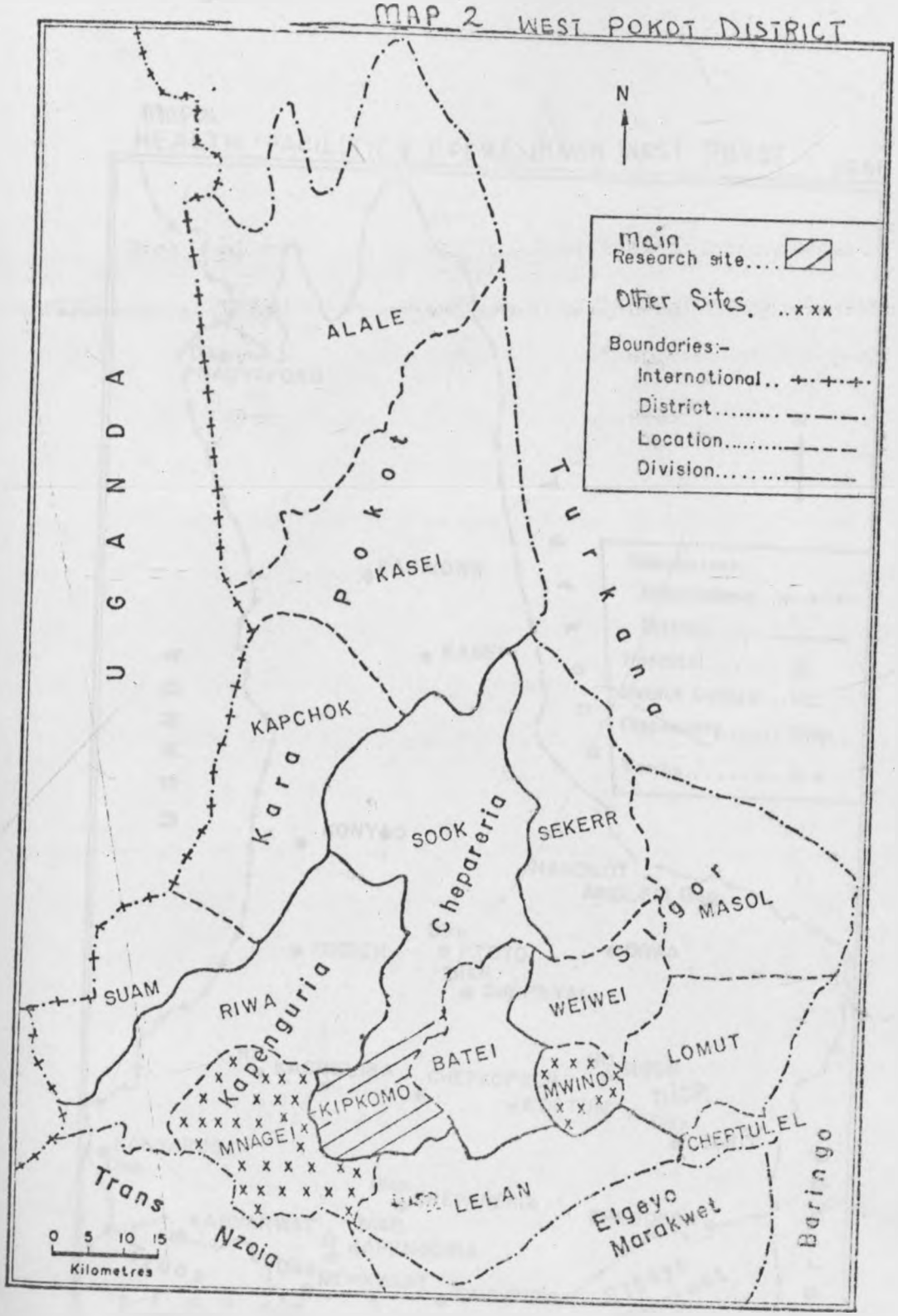
I collected the substantive material for this dissertation during fieldwork among Pokot which lasted for a period of fifteen months. I have also made reference to both primary and secondary sources relating to the research problem all of which are listed in the bibliography. I have analyzed this material within the framework of the sociocultural orientation in the sub-discipline of medical anthropology. This is not just an ethnographic account of the management of illness among Pokot because I also discuss a number of theoretical issues regarding their responses to Western medicine and also the process of health development. I have also made reference to some of the implications of the research findings for the provision of health services to Pokot and similar societies.

Although various people have contributed in different ways (mentioned in the acknowledgements) to this research, this dissertation is the result of my own work and includes nothing which is the outcome of work done in collaboration. It does not exceed 80,000 words.

David Nyamwaya

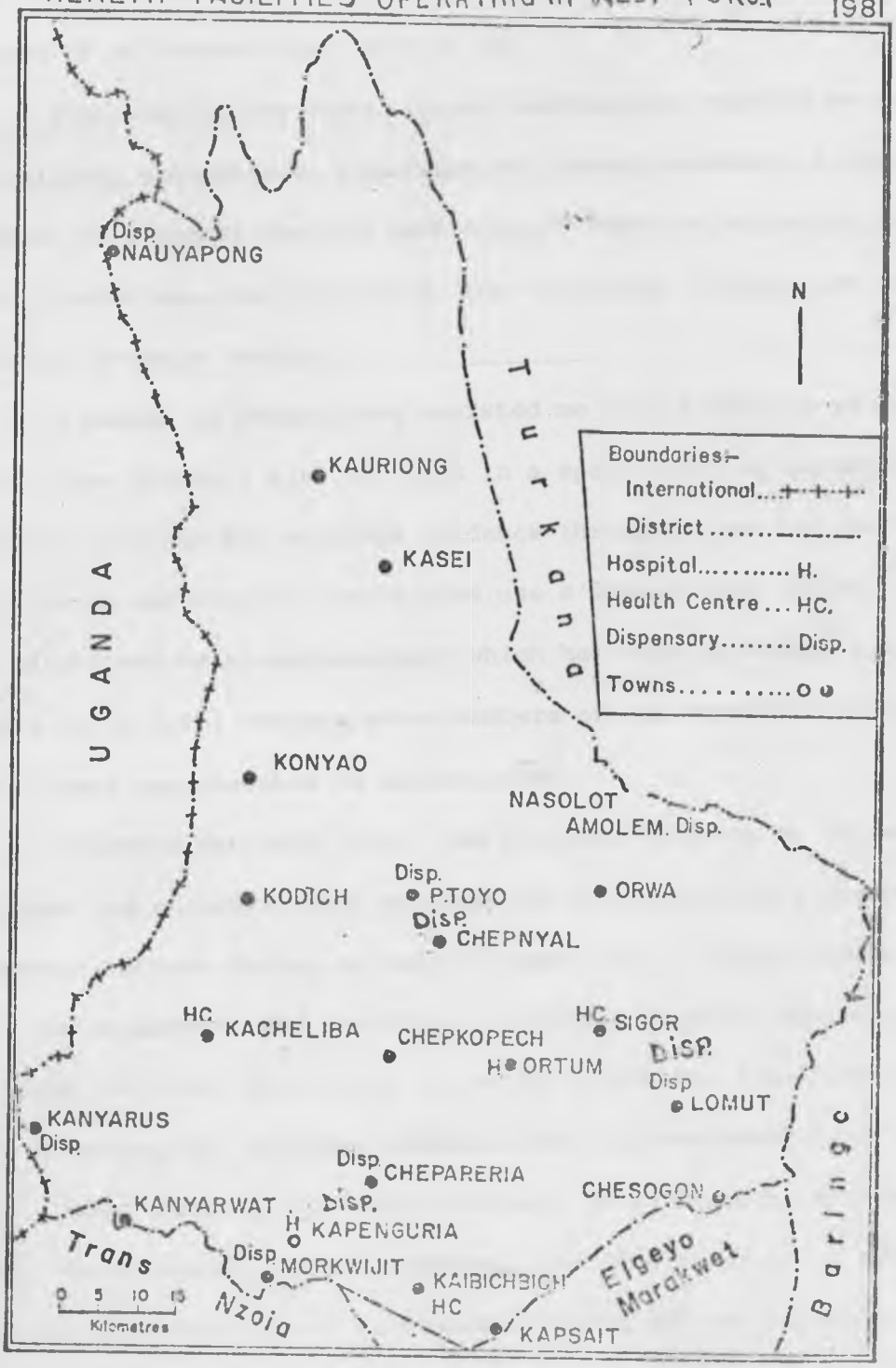
Map1 Kenya Showing Districts

MAP 2 WEST POKOT DISTRICT



Map 3

HEALTH FACILITIES OPERATING IN WEST POKOT 1981



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Without the cooperation of the Pokot people, this dissertation would not have been written. To all of them I say *sro nyoman*. Some of them

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Mrs. Diane Quarrie deserves mention for typing the manuscript. Last, but not least, I say mbuya mono goko to my wife Trufena Bosibori for enduring my absence from our home for many months, to her this dissertation is dedicated.

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Summary of Dissertation

The Management of Illness in an East African Society : A Study of Choice and Constraint in Health Care among the Pokot

David C. Nyamwaya

This dissertation deals with the way Pokot respond to illness given their traditional forms of therapy and Western health services.

The Pokot view of the causation of illness is discussed and their notions regarding the prevention and treatment of illness outlined. Various roles, both lay and specialist, in their health-seeking process are discussed.

In spite of concepts of health and illness shared by members of the society, it is shown that Pokot responses to specific illness are not fixed by custom but vary over time and space. The way their theory of illness facilitates these varied responses to illness is discussed. A number of factors which influence Pokot therapeutic actions and thereby contribute to variation in illness behaviour are identified viz: the perceived efficacy of a form of therapy, its accessibility, practicability, social and moral considerations all of which are assessed by the individuals responsible for making the final decision about therapy.

The dynamic relationship between traditional medicine and its Western counterpart is examined. It is shown that the relationship is not simply one of conflict, but is a complex one involving competition, complementarity and supplementarity. A distinction is made between the cognitive, organizational and behavioural dimensions of the relationship.

It is argued that indigenous beliefs and practices are not necessarily the only obstacles to the extension of Western health services. The role of a low level of socio-economic development and certain national health policies are examined in as far as both hinder the improvement of health conditions among Pokot.

The practical implications of the research findings for health planning in Kenya are considered. The suggestions made relate to the need to adopt an integrated approach to health development in which target populations participate fully, and indigenous resources utilized where possible and necessary.

CHAPTER ONE : INTRODUCTION

1.1 Origins and Objective

My interest in Pokot management of illness began when I was serving as a research assistant to Professor Tanaka (a Japanese physical anthropologist) between June and August 1978. My task was to collect medicinal plants used by Pokot and to document their uses. From the outset I was struck by the high level of general knowledge relating to health and illness which Pokot revealed. Most of them displayed detailed knowledge of their basic premisses and practices relating to therapy. Before I left Pokot that year, an elder invited me to be initiated as a Pokot, but since I had already undergone circumcision, the process was a simple one. I was given the name Kopeyen. I promised to go back and be trained as a Chepsaktian (healer), now that I had been admitted into the Pokot world.

My interest in medical anthropology took root when I was admitted to do the M.Phil. course in social anthropology in Cambridge. For the first time I had the opportunity to read about how several societies viewed and responded to illness. I wrote a dissertation on "Theories of causation of illness in Africa". When I enrolled for the Ph.D. degree I decided to return to Pokot. Cognizant of the fact that Pokot no longer depended entirely on their traditional medical practices, I decided to extend my enquiry so as to include their response to western medicine. This made it necessary that I choose as my main research site an area where the people had had reasonable access to western health services. Agricultural Pokot in Chepareria fulfilled this condition well.

The main objective of this study is the identification of the factors which influence therapeutic actions. Put in another way, I wish to explain why, given various therapeutic alternatives, Pokot choose to

utilize some of them and not others. The study therefore goes beyond Pokot beliefs and practices relating to health to include a consideration of socio-economic factors and the role of the Kenyan government in the Pokot health-seeking process. Certain policy and theoretical issues within Kenya and in international health planning will be discussed in as far as they relate to Pokot management of illness today.

1.2 Methodology

The substantive material for this dissertation was collected during fieldwork among Pokot which lasted for fifteen months between August 1980 and December 1981. The main research site was located in Chepareria sub-location about twenty kilometres from the District headquarters at Kapenguria. I selected a core sample of thirty households with a population of about 250. Each household consists of a man, his wife and unmarried children and kin and friends who may be staying with them. Each of the households was headed by the man.

I spent the first six months doing an intensive study of the core sample. Each household was visited every two weeks unless an episode of illness made it necessary to make more frequent visits. During this period I observed their socio-economic and spiritual activities and explained to the people what I was doing. After the six months were over, I began to focus mainly on the health-seeking processes in the sample for a further four months. The remaining five months were spent in two other areas also inhabited by agricultural Pokot-Kapenguria, regarded as the most westernized of all the agricultural areas, and Tamkal, the area which Pokot think is the most traditional.

Before starting my fieldwork I had some knowledge of the Pokot language, but since it was not sufficient, I spent some time learning more

of it so that by the time I left, I could converse reasonably with the people. Most men know Kiswahili, the National language and I found this quite useful especially during the initial period of my research.

The technique of data collection I used depended on the type of information I was seeking. During the initial period, observations of Pokot in different life situations and activities provided very useful information about behavioural patterns. As I got to be accepted in the community, I began participating in various activities. I joined work parties, family occasions, public meetings, games and ceremonies. On several occasions my advice was sought during episodes of illness. This was because the people of Chepareria thought of me as a health worker, and in fact many of them referred to me as daktarion, the Swahili equivalent of "doctor" which Pokot have indigenized. I also accompanied patients to see medical practitioners and in some cases I was requested to pay the treatment fees. The maendeleo women invited me to several of their meetings to talk to them about health matters.[1]

I also carried out both impromptu and planned interviews to collect data. I found it difficult to send out questionnaires to respondents because many of them cannot read. However, for some information, I prepared interviewing schedules and recorded the answers systematically. Most interviews started off as normal conversation but leading questions were asked to elicit information about various things. Some interviews were repeated when I felt that information had been withheld or intentionally distorted.

Key informants like healers, kokwa elders, teachers, health workers and community leaders were interviewed specially to get information from the expert perspective.[2] "Captive" respondents were also interviewed at health facilities and at individual healers' homes.

Some information was "volunteered" by informants. In such cases I had to try to understand why the information was being offered. I needed to be very careful here because some elders felt that they needed to control what I learned, lest I discovered too many "secrets". Some of the volunteers presented tailored information which I had to cross check with other sources. When responses to particular questions seemed contradictory or confusing, I would call a group of men or women as necessary to a meeting and the issue would be argued out. This proved very useful especially for concepts of health and illness.

The work of my two research assistants was to inform me of episodes of illness which I could then follow. I was able to observe several such episodes most of which are mentioned later in the dissertation. In collecting these cases I was always led into the intricate socio-economic contexts surrounding them. These cases provided me with most of the material around which hinge the main arguments of this dissertation. In reproducing some of these episodes of illness later, it has been necessary in some cases to hide the identity of the key figures by using fictitious names, but otherwise they have been reproduced as accurately as possible.

I also examined records at local dispensaries and the District Hospital to get information about morbidity and attendance. Some medicinal plants were collected and identified at the herbarium in Nairobi (see appendix). Information regarding the historical background of Pokot was obtained mainly through the study of archival material at the National Archives in Nairobi (see bibliography).

1.3 Difficulties and Justification

Fieldwork among Pokot was not without difficulties. By far the

most significant difficulty encountered was Pokot reluctance to discuss notions connected with illness. They believe that talking about illness when no one is sick is an invitation for it to attack someone. But after I had established rapport with the community, it was possible for me to ask people to talk about various aspects of illness. However, it was not very difficult to get information regarding particular cases of illness, because these are rarely private concerns.

On some occasions, informants threatened to withhold information until I explained to them of what practical benefit my study was going to be to them. Few people were prepared to discuss health matters with me unless I promised to tell the government to do something to improve Pokot health conditions. On a number of occasions, my friends were sent by the community to tell me in detail what were felt to be urgent health needs and that I should report these correctly to concerned agencies to do something about them. I was also urged several times not to "report" about certain rituals because the authorities might act to suppress them. I was seen as a broker between the community and various agencies, and it was not always easy to act that role by making promises about what I would do to help - sometimes urgent action was needed, but I was always at a loss at such times.

Another, perhaps the most serious, difficulty I faced during my fieldwork was to alleviate the suspicions of the indigenous health practitioners. Initially some thought that I was out to discover who they were so that I could expose them to the authorities. For reasons I explain in later chapters, the practitioners have come to think that the Government intends to eliminate them. Such suspicions made it necessary to explain my motives to close kin or friends of the practitioners. The friends or kin would then assure them that I had no intention of

reporting them to anybody. Many of the practitioners insisted that I did not write down what they said or take pictures. But some did not mind my writing down what they said and they even requested me to take pictures of them - however, such were a minority.

Pokot also found it strange that an African should ask them such questions as were regarded to be common knowledge to all, except the white man. Some people wondered why I had not gone to study my own people, the Gusii, but instead choose to study Pokot. Educated Pokot were particularly suspicious of my intentions because they thought that I went to study their society because it is not "progressive". These educated Pokot were especially concerned about the type of pictures I took. The issue was raised about researchers who had been to the area and only took pictures showing "things of the past" and not of life as it was then. But I think such problems are not unique to Pokot and they did not alter my research in any significant way. Finding solutions to these problems was a challenging experience in itself.

There are a number of reasons why I consider this study is justifiable. The study may make some contribution to the substantive material on the socio-economic and cultural aspects of health and illness in developing countries. It is also an illustration of the complex process of cognitive and behavioural changes resulting from contact between non-industrial societies and Western technology; especially important in this respect is the fact that the study confirms the postulate that behaviour change usually precedes change in ideas. At the practical level, the study provides information which may enable health workers among Pokot and other rural areas in Kenya to realize the importance of understanding indigenous perceptions of health problems and how they can be solved. Health planners in Kenya may also find the

material in this dissertation useful in highlighting some of the issues they face in their attempts to improve the health of the people in rural Kenya. For me, this study marks only the beginning of a programme of research in medical anthropology aimed at exploring further the ideas introduced here.

1.4 The Research Problem

In this dissertation, I question three major assumptions in most of the existing literature on the management of illness in non-Western societies where both indigenous and Western forms of health services exist. The assumptions I wish to question may be summarized as follows:

(i) The response to illness in non-Western societies is usually viewed as generalized patterns of behaviour specific to a culture that are fixed across time. Descriptions of illness behaviour tend to emphasize general features at the expense of the recognition, definition and treatment of symptoms related to specific illnesses and which affect a specific individual (Fortes 1976:XVI). Such descriptions tend to convey intra-societal uniformity in illness behaviour which may not be realized in practice.

(ii) The relationship between indigenous and Western forms of therapy is usually regarded as being largely one of conflict. Adversary models which regard indigenous therapies as always being on the defensive and Western medicine on the offensive (Foster and Anderson 1978:227) have been used widely while there is evidence which indicates that the interaction between the two can take several different forms.

(iii) Anthropological studies of attempts to extend Western health services in non-Western societies tend to regard traditional beliefs as the major obstacles to the process. Little attention has been paid to

socio-economic factors and national health policies and health delivery systems in developing countries in as far as these may be hindrances to the extension of Western health services (Van Etten 1976).

My response to these assumptions consists of three postulates around which the dissertation is developed which may be stated as follows:

(i) Though Pokot have a set of beliefs about the causation of illness (and how it should be treated) that are generally accepted by members of the society, their management of particular illnesses is not fixed by custom, but rather is affected by a wide variety of factors such as the perceived efficacy of therapy, its accessibility, its practicability, social and moral constraints and individual judgement. Because of these factors, their responses to illness varies over time and space. This is facilitated by their theory of illness which has a high degree of fluidity.

(ii) The Pokot response to Western medicine is quite varied and dynamic and the interaction between their traditional forms of therapy and Western medicine includes elements of competition, complementarity and supplementarity.

(iii) While it is true that certain beliefs and practices held by Pokot are incompatible with health development, socio-economic conditions and health policies and the organization of the national health care system are major obstacles to the utilization of Western health services and consequently the improvement of health conditions.

I find it necessary, for analytical purposes, to make a distinction between "traditional medicine" by which I mean all the concepts, pharmacopoeia, practices and personnel related to the management of health which Pokot have developed over the years or borrowed from their neighbours, and "Western medicine" by which I mean the concepts,

facilities, drugs and personnel belonging to the Western biomedical tradition introduced to Pokot since the beginning of the century. However, I show later on that this destinction is not regarded as crucial by Pokot, because they perceive a single hierarchy of therapeutic alternatives including both types of medicine.

In later chapters, I use the phrase "therapy managing group". According to Janzen (1978) this is usually an ad hoc group which comes into being whenever an individual or set of individuals becomes ill or is confronted with overwhelming problems. Among Bakongo this group is usually made up of kinsmen. The way such a group comes into being among Pokot is described in Chapter Three.

1.5 Literature Review

1.5.1 Medical anthropology as a sub-discipline is relatively new, though it is a fast-growing area of specialization within anthropology (Logan and Hunt 1979:xi). The medical institutions of non-Western societies have attracted anthropologists for many years. The term "medical anthropology" came into common use in the early sixties. Foster (in ibid p.3) argues that he sub-discipline can be traced to three different sources: the traditional interest in primitive medicine, including witchcraft and magic, the culture and personality movement of the 1950s and 1940s, and the international public health movement after World War II. In the following paragraphs, I trace the salient developments in the study of medical beliefs and practices in non-Western societies so as to contextualize this study. Special emphasis is given to such studies in African societies wherever possible.

Before the fifties, most anthropological works relating to health matters focused on psychological and psychiatric phenomena. Prior to this

date, medical phenomena in non-Western societies were viewed as appendages of wider problems of social structure and culture. A sharp distinction was made between "primitive" and "modern" medicine with the former being regarded as consisting of magical and non-rational elements believed to be absent from the latter. Examples of publications during this period are Ackerknecht (1942,a,b); Clements (1932); Evans-Pritchard (1937); Hallowel (1934); Henry (1944); and Rivers (1926,27).

In the period between the early fifties and the early sixties anthropologists began turning to the study of medical phenomena per se in non-Western societies. "Folk medicine" which meant the study of both lay and expert beliefs and practices of medicine became a major focus of interest. There were two main features of folk medicine which received much attention from anthropologists: notions of causality and psycho-social therapy. Mystical causation and its treatment received much attention at the expense of traditional surgery and chemotherapy. Labels like "shaman" and "witch doctor" were popular. Concepts like witch-craft and sorcery were given stereotype meanings. Examples of publica-tions during this period include: Whiting on the theory of disease (1950) and in Africa, Messing on group therapy in Ethiopia (1958), and Middleton and Winter (1963) on the distinction between witchcraft and sorcery. The last publication has had a lot of influence on subsequent literature but Turner soon wrote a critique regarding the distinction between witchcraft and sorcery made in the book (1964:314-324).

During this period, anthropologists became more involved in public health programmes introduced to developing countries from the West. The main interest was to find reasons why the "obviously superior" Western medical practices introduced to improve people's health were not easily accepted. Notable examples of publications of this nature are Paul

(1955 and 58) and Khare (1962). Khare discusses in detail how notions of ritual purity and pollution had a negative effect on sanitation programmes in North India.

Specific medical problems also received attention from anthropologists, who usually collaborated with medical personnel to find out socio-cultural aspects of, for example, hypertension among the Zulu (Scotch 1960), Kuru among the Fore (Fisher and Fisher 1961) and Eskimo psychopathology (Parker 1962). Scotch (1963) in reviewing developments in medical anthropological studies to the early sixties notes that there was little theoretical development that had occurred, but that plenty of substantive material had been produced. Because of the increased interest in practical problems, medical anthropologists gained experience in interdisciplinary research by working with other professionals interested in similar problems. Scotch (ibid) summarized the position of medical anthropology in the early sixties thus:

> A decent beginning has been made in the collection of description materials, and there is evidence that researchers are currently concerned with conceptual schemes ... and are beginning to test them in field research (p.40).

During the last two decades, a number of what Scotch calls "conceptual schemes" have appeared though no single dominant theory has emerged so far. However, during this period, medical anthropology has become firmly established as a sub-discipline, though it has drawn upon literature by medical sociologists and medical doctors. At the moment, studies in this sub-discipline have become so complex that categorization is difficult; this is a result of the fact that more factors have now been seen to affect illness. Medical anthropologists have collaborated increasingly with medical and other professionals in studying various health problems and this has complicated the situation further. Broadly speaking, these studies are based on one of two approaches - the ecologically oriented models and socioculturally oriented models.

In the former category of studies, ecological models with cultural and biological parameters are used to study man's response to illness. Alland (1966, 1970) has vigorously stated the theoretical foundations of the ecological approach. He summarizes the interrelatedness of culture, biology, environment and disease thus:

> In general, the incidence of disease is related to genetic and non-genetic factors. Any change in a behavioural system is likely to have medical consequences, some of which will produce changes in the genetic system. On the other hand, disease-induced changes in the genetic structure can affect the behaviour system ... In addition, induced or natural alterations in the environmental field provide new selective pressures relating to health and disease which must be met through a combination of somatic and non-somatic adaptations (1970:49-50).

According to Lieben (1973) the ecological model views health and disease as measures of how effectively human groups adapt to the environment combining biological, and cultural resources (p.1051). Versions of the ecological model have been used to study nutrition (McCracken 1971) road construction (Hughes and Hunter 1970), urbanization (Foster and Anderson 1978) on human health.

Most of the studies of the sociocultural orientation have mainly been concerned with the explication of particular concepts or characteristics of behavioural and social changes associated with illness. These sociocultural studies of illness may be divided into those whose approach is based on the individual and those whose approach is from the point of view of the collectivity. Examples of the former are: Kasl et al./ (1972), Mechanic (1968) and Rosenstock (1966) and of the latter Chrisman (1977), Suchman (1965, 1968) and Zola (1966). Janzen's study of the Bakongo (1978) goes a step further than most of the studies in the latter group, because he emphasizes the processual nature of illness behaviour. The individually oriented models are not sufficient for studying illness behaviour in a society like the Pokot where illness is rarely an individual matter. A number of the concepts

developed during this period (such as health-seeking process) have proved useful in the writing of this dissertation. A shortcoming that pervades most of the collectivity oriented studies is the emphasis laid on normative behaviour in the management of illness. In this dissertation, I stress intra-societal variation in the health-seeking process.

It can be argued from the foregoing that medical anthropology is still in the making. Kleinman (1978) in introducing a recent book in medical anthropology warns that on reading the book:

> The reader will not find a unified set of concepts and methods, or even agreement on several important issues. This diversity represents the state of the art in a field of enquiry which is both theoretical and applied, contemporary and historical - a field which studies questions that are biological and physiological, social and cultural, and which deals with rapid changes in all these dimensions (p.2).

The same view of medical anthropology is echoed by Frankenberg who says that the medical anthropologist should situate his work in the context of development, the making social of disease and the more general concepts of anthropological analysis (1980:197). Kleinman has refined his views in his recent publication (1980) in which he investigates the psycho-social mechanisms through which sickness experiences, therapeutic relationships, and the healing processes are affected by systems of cultural meanings and institutionalized social patterns of power. This dissertation leans towards the sociocultural orientation in medical anthropology and deals both with theoretical and practical issues in the health-seeking process among Pokot.

Ethnographic material relating specifically to the management of illness in African societies has provided an essential background to this study. This includes Harwood (1970) on the Safwa; Imperato (1977) on Bambara; Janzen (1978) on Bakongo; Ngubane (1977) on Zulu and Turner (1967,68) on Ndembu. A major work produced recently dealing with the

response to illness in African societies in a book by Ademuwagun et al (1979) which is a collection of more than forty articles by medical personnel, health administrators and anthropologists. This publication shows a major shift in the study of responses to illness in that both indigenous and Western forms of therapy are given equal emphasis. The health-seeking process is seen in the context of the process of socio-economic development in various countries. In the third section of the book, various authors emphasize the co-existence between indigenous and Western medicine. Weaknesses in national health care delivery systems are considered and several arguments are given in support of the utilization of traditional practitioners in modern health care delivery systems.

Two special issues of Social Science and Medicine are worth mentioning here because they indicate new trends in research relating to health and disease in Africa. In the first of these two issues, "The Social History of Disease and Medicine in Africa" edited by Janzen and Feirman (1979), the contributors show their awareness of the close interrelationship between disease and changing social, economic, cultural and political processes. For example, Dawson (pp.245-50) shows how the people of central Kenya, when faced with a biological challenge (famine) responded by searching for food in such a way that they were endangered by smallpox. Dawson sees the famine-smallpox occurrence as part of a broad historical process in which colonization, capitalist agriculture and urbanization played integral parts. Some of the authors, for example Gran (339-348) show how medical concepts are influenced by social, economic and political factors. Fierman strongly asserts that multiple medical paradigms can, and often do, coexist in a society (p.277). The papers in this issue should hopefully establish a precedence which will influence researchers in this field to give appropriate emphasis to the part played by socio-economic and political changes in

the development of medical concepts and health care services.

As a follow-up to the above issue of Social Science and Medicine, another issue "Causality and Classification in African Medicine and Health" edited by Janzen and Prins (1981) has been published. This issue focuses on the pluralistic medical systems in Africa today. This issue highlights the complex nature of concepts of causation of illness in Africa and how these are responding to the biomedical paradigm. The issue also has some space devoted to a discussion of the implications of research findings on causation and classification of disease for health policies in African nations. This issue shows that even apparently theoretical issues in African medical systems can hardly be discussed meaningfully without some consideration of their relevance to practical health matters.

1.5.2 There is not much literature that is published on Pokot. Probably the earliest published material dealing exclusively with Pokot is a book by Beech (1911) "The Suk" ("SUK" was the name used for Pokot until the sixties when they complained that their real name was Pokot (see Chapter 2)). Beech traces Pokot history during the period prior to the beginning of this century. He mentions their diverse origins and alludes to wars they fought with the Samburu, Karimojong and Turkana. There are also brief descriptions of some of their beliefs, social institutions and language. It provides a basis for studying changes which Pokot have gone through for the last eighty or so years.

Hennings (1951) has a small section of his book which refers to Pokot. In the diary which he later published, he observed that Pokot engaged in transhumance in order to maximize the use of pasturage for their stock. Pokot were observed to have very independent attitudes.

Agricultural Pokot today do not engage in transhumance, because of restrictions to their movement resulting from changes in land tenure. Informants claimed that these restrictions account in part for the reduction in the size of their flocks.

Schneider (1957, 1959) examines the crucial role of cattle in their economic system. Pokot today regard their cattle very highly but a mongorion, "rich man" is no longer regarded as someone with many cattle only, because land and cash money have become equally important. In the second article, "Pokot Resistance to Change" Schneider argues that Pokot have resisted Western institutions (Christian, agricultural and political) because they are generally conservative. He says that this is because of "the feeling that they are inferior to no one and superior to all" (1959:161) and further that this is a feature common to societies with "a cattle complex". He observes however that in spite of their conservatism, Pokot were in the late fifties borrowing beliefs and practices from Turkana, Karimojong and Europeans. While cultural factors have played a role in Pokot response to Western innovations, it should also be stressed that they live in an area which has been isolated from the mainstream of developments in other parts of Kenya until very recently. West Pokot was one of the "closed districts" and this meant that until the sixties, Pokot were confined in their area and entry into it was very tightly controlled. In the next chapter I discuss other reasons which explain why Pokot lag behind in the process of socio-economic development.

Peristiany, in a series of articles (1951a,b; 1954; 1975), discusses a number of aspects of Pokot social and political life and especially their age organizations. He shows how social control was maintained in an acephalous society through councils of elders,

mystical power and age organizations. He also shows how ecological differences have led to the development of different versions of Pokot institutions among the pastoral and agricultural sections of the society respectively. In the last article (1975) Paristiany shows how "ideals" held by Pokot do not often correspond to the realities of social behaviour.

Conant (1965) discusses the Korok which he describes as "a variable unit of physical and social space among the Pokot". He analyzes the main features of the Korok, namely the fact of settlement, the council of elders and communal labour within it.

Patterson (1969) in an unpublished thesis examines Pokot response to British Colonial rule. He traces the developments through which Pokot became integrated into Kenya's national polities. He shares Schneider's view that Pokot are generally "conservative". According to Patterson, Dini Ya Msambwa, a religious sect which originated from the Bukusu in Western Kenya, was readily embraced by Pokot as a form of passive resistance to British institutions.

Edgerton (1971), in a cross-cultural study including Pokot, attempts to show the relationship between ecology and Pokot values, attitudes and personality. Using psychological tests he concludes that the features which indicate Pokot distinctiveness are: their love for cattle, physical beauty and sex. He also states that independence of action and bravery are highly valued among Pokot.

Meyerhoff (1982) in a Ph.D. thesis examines the socio-economic and ritual roles of Pokot women. She discusses the differing perspectives held by men and women and how these differences are articulated and muted. She also discusses the extent to which each sex acknowledges and accepts the perspectives of the other. The discussion is hinged around

female initiation rituals.

I have found these publications on Pokot a useful frame of reference especially in writing Chapter two, where I examine the operation of various institutions among Pokot today. I am able to talk about change because of some of these studies which give an idea of how these institutions were in the past. However, except where indicated, the ethnographic material for this dissertation is derived from my own fieldwork among Pokot.

Footnotes to Chapter One

1 & 2 *maendeleo* and *kokwa* are explained in detail in Chapter Two.

CHAPTER TWO : THE RESEARCH AREA - BACKGROUND INFORMATION

2.1 The Land and the People

2.1.1 Pokot live in the central-western part of the Republic of Kenya (see map). The Pokot I studied live in West Pokot District, most of which consists of semi-arid plains. Though a majority of the ethnic group called Pokot live in the District a significant number are to be found in neighbouring Baringo District. The District has an area of about nine hundred thousand hectares which ecologically can be divided into the highlands and the plains. The highlands usually rise from about 1750 metres to 3370 metres above sea level, with temperatures varying from 9°C to 18°C and rainfall from 1200-1500 mm per annum. The highlands comprise Kapenguria and sections of Chepareria and Sigor administrative divisions of the District. The plains occupy Sigor, Karapokot and part of Chepareria divisions. The altitude in the plains varies between 1000 to 1200 metres above sea level, and mean daily temperatures between 16°C and 34°C with 400-1000 mm of rain per year.

In the highlands live the Pipopagh "grain people" Pokot who depend mainly on agriculture though they keep some livestock. The plains are mainly semi-arid with grasslands dotted with acacias. Pastoralism is the main occupation of the people but when there is enough rainfall, some cultivation is carried out. In the plains live those Pokot called Pipotich "cattle people". The Pipopagh and Pipotich live in a symbiotic relationship by exchanging agricultural and animal products and speak more or less the same language. However, because of ecological and other influences mentioned below, the two sections have developed some differences in their institutions so that it is quite difficult to generalize about both of them. Material for this dissertation, unless otherwise stated, refers to agricultural Pokot.

Because of the rough topography of the land, road construction is difficult. In the wet season, streams and rivers appear from nowhere only to disappear after the rains. Landslides are quite common and obstruct the few roads which exist in the area. All over the District, there are about one thousand kilometres of roads of which less than a half are motorable throughout the year.[1] There is no public form of transport and private vehicles are almost non-existent. The vehicles commonly seen on the road are those belonging to various government departments. A tarmac road is now under construction and when completed will open some parts of the District to other parts of the country.

For most of the year, most of West Pokot is extremely dry and in some parts Pokot are compelled to dig in dry riverbeds to extract water from the sand for animals and domestic use. In the last few years, Pokot have had to depend heavily on famine relief supplies from the Government and voluntary agencies.

2.1.2 The People

There are about 158 000 people in the District, and of these, 90% are Pokot.[2] The rest are mainly Kikuyu, Luhyia, Sabaot and Cheranganyi immigrants. Most of these immigrants live in the highlands of the District especially Kapenguria. The density of the population is rather low by Kenyan standards, being only 17 people per square kilometre - though some areas like Kapenguria have 39 people per square kilometre. The growth rate is also low, estimated at 2.2% per annum compared to the national average of about 4%.

The low rate of population growth may be due partly to the harsh physical environment and high infant mortality, but cultural mechanisms play a part in this process. For example, Pokot say that a woman should

stop bearing children when her daughter becomes a mother. There are also regulations about the spacing of births - a woman should conceive only when the other child has been weaned. Most pregnancies contracted outside marriage are aborted, unless the woman is sure of getting married before or soon after the birth of the child.

The Pokot belong to the Kalenjin speaking group of people who have been classified as Nilotes (cf Ehret 1968:158-175). Oral traditions I collected suggest that they come from the East - (Kong-asis) "from the direction of sunrise". Most Pokot clans mention Suguta now in Turkana as the place they stayed before moving to the Mmno-Cheptulel area which they consider their cradle- land. In Mwno-Cheptulel they displaced a people they called Mtia and fought and absorbed some of them. They also fought with the Kuop who wanted to occupy the same area. They moved into the cradleland area as separate clans which later adopted the name Pokot to refer to themselves. Informants told me that the Pokot are an amalgamation of people from different origins in most cases war fugitives. Informants interpreted "Pokot" to mean "those of the home" meaning those escaping home after others had been killed. The term "suk" used in the past for Pokot is derived according to my informants from msuk, a term which refers to a tree stump. It was a pseudonym which Pokot used to refer to themselves when talking with strangers before they established their identity as a group. By the 1960s Pokot identity was fully developed and they therefore pressurized the government to abolish the name suk. My informants refuted the allegation made by Beech (1911) that suk is a maasai nickname for Pokot.

Throughout their history, Pokot have maintained close contacts with their Kalenjin cousins and especially the Nandi and Marakwet. Such contacts have also been extended to include the Karimojong and Turkana

and cultural borrowing has occurred either way. For example, the Sapana ceremony and colour symbolism among Pokot have been borrowed from Turkana. The Adonga dance and the Kapolokion type of healer have Turkana origins. The Yomat concept of causation and its corresponding healing ceremony, Kilokat were introduced among the Pokot from the late forties and some informants remember this very well. Yomat as an explanation of illness exists among the Karimojong from whom the Pokot borrowed it. Pokot living close to the Karimojong border do not circumcise and the language they speak has many Karimojong elements. Starting from the thirties a number of Bantu groups, especially Kikuyu and Luhyia, moved in to settle among the agricultural Pokot. These groups live in clusters and have not been assimilated by the Pokot as have a number of Nandi, Sabaot, Cherenganyi and Marakwet, who the Pokot consider to be brothers. The Pokot are therefore a hybrid group, and a study of the origins of their clans clearly attests to this.

During the Colonial period (to 1963) it was the policy of the Government to assist economically those districts which were considered productive, and this meant those areas where the inhabitants were sedentary and predominantly agricultural. Because the Pokot were neither, they were left very much on their own by the Colonial administration. Few modern social amenities were put up during this period though the Pokot paid taxes as required by the administration.[3] This policy did not change very much after independence and today, West Pokot is one of the ten least developed districts in Kenya.[4] For a long time and until recently, the Pokot have had few large-scale contacts with the rest of the country. This has meant that their social institutions have not been disrupted as much as in those areas where communication networks are well developed such as in Central Province. The situation is now changing very rapidly chiefly because the agricultural Pokot are now engaged

in cash cropping and a number of them have become retail traders. The Government, through various ministries, is trying to "develop" or more accurately, to "modernize" the Pokot. The impact of government and religious institutions on Pokot life is being felt by them and the older members of the society deplore this onslaught of the process of modernization.

2.2 Social and Political Organization

A Pokot passes through a number of age-grades between birth and death. For men someone is karachinin before circumcision and muren from the time he is circumcised until he becomes a poiyon, an elder. A woman is tipin before initiation, chepto before marriage, mrar between marriage and her first child, korko when she is bearing children and konyon as an old woman. Any person of a junior age-grade owes respect to any other person of a senior age-grade, irrespective of whether they know each other or not.

The Pokot, like the rest of the Kalenjin, have an age-set organization. There are two types of age organization, the first of which is the cyclic type very similar to the Nandi one described by Peristiany (1959) called pün (pl. pünwoi) by the Pokot. A person is initiated into an age set by circumcision which usually takes place every 3-5 years. Two to three batches of initiates are grouped into one set, which takes about ten to fifteen years to form. There are usually eight sets at any one time among the agricultural Pokot, though the names given to the sets exceed that number.[5] The elders at Chepareria gave the following as the present order of age-sets from oldest to youngest: Murkutwo, Nyong, Tukoi, Maina, Chumwo, Sowo, Koroncoro and Kapleiach. The second type of age organization is based on the Sapana ceremony and is most common

among the pastoral Pokot, while the first type is found throughout the District. After circumcision, a man undergoes the Sapana ceremony and has his hair plastered with mud to form the siolip and aturo on his head. He then joins either of two Sapana sets each of which is divided into two colour groups, themselves further divided into sub-sets.

Age organization is an important element of Pokot social relations. A man is not supposed to marry the daughter of an age-set mate. At feasts, each set eats separately. In the past, the Council of elders kokwa could instruct a particular age-set to perform some task for the good of the community. In times of crisis, a man usually seeks the assistance of his age mates. A man usually lends cattle to his age mates in the tilia relationship described by Schneider (1959:152). During his wedding, the groom is assisted by members of his age set to bring the bride home. Wives belong to age-sets corresponding to those of their husbands.

Pokot trace descent through the male line. Their lineages are quite shallow and usually go no farther than the great grandfather. The whole society is divided into clans (lilo) each with a totem (tiombu wuw). The clan is exogamous and some clans do not intermarry. Bridewealth is given to the bride's family and can be anything from five to fifteen cattle and small stock among agricultural Pokot, but up to sixty cattle among Pastoral Pokot. Residence after marriage is virilocal. Uxorilocal residence occurs only rarely where the husband is extremely poor or where the wife is the only child of her mother.

The husband can send his wife away for any of a number of reasons, the commonest of which is barrenness, but the wife can also request a divorce. When divorce occurs, the number of animals returned to the wife's family depends on the number of children she has had with the man,

being more when she has not borne any. Children stay with the husband, unless he refuses to complete bridewealth payments.

Members of the same clan regard each other as brothers and sisters, more so if they belong to the same sub-clan (or pl. orten). Each sub-clan is named after its founder; all descendants of the founder use his name for their or until a member of such a sub-clan becomes rich and important enough to confer a name on a new one. The sub-clans therefore increase with time. The sub-clan name is applied to individual members, with the prefix ka - used to denote male members and che - female members. Except in a few areas like Mwino and Cheptulel, the members of a clan are scattered all over Pokot country. Lineages of several different clans live side by side. There is no institutionalized clan headship, but in any local area, if a number of lineages of the same clan are co-residential, one of the poi (elders) is recognized as a leader and called tilil. He advises the clan members about what to do when problems like sickness occur. The clan has a number of important functions which it still performs today. A person should not marry, kill or commit adultery with a clansman. If a clan member has problems - sickness, financial or legal - clan members, as many as learn of the problem, are supposed to offer help. If a clansman is killed by a person of another clan, his clansmen claim the lupai (bloodwealth) by force if necessary. In Chepareria Sub-location, 26 clans were counted (1981) which were sub-divided into sub-clans ranging from three in the Ngusur clan to nine in the Sochon and Sikow clans.

Traditionally, the Pokot were an acephalous society with social power at the lowest level effected through the head of the family living in one kraal. "Family" in this sense refers to a man with his wife or wives and sons and daughters - the sons may also be married. The head of such a family called kuko controls the people in the kraal, some of whom

may be non-family members. Inter-familial matters are handled by the heads of the families concerned in a meeting called a kokwa. In any locality, a respected person referred to as kiruokin can rise to prominence and act as an adviser to various families in a neighbourhood. However, the kiruokin cannot dictate decisions nor enforce them. This is not an institutionalized position and except for the plains Pokot, is not as important as it used to be. At a higher level than the one mentioned above, the kokwa is a council of elders of a korok - a neighbourhood marked off by physical features like rivers, mountains or valleys. All elderly men are eligible to attend the kokwa and any of them can initiate a discussion but any decision made must be supported by all elders to be binding. Any of the elders can summon the kokwa to settle a dispute or discuss issues affecting the community. The kokwa makes decisions regarding epidemics, rituals and other matters which concern individuals or the community at large. If the elders of one kokwa cannot reach a decision, representatives from another kokwa are invited to help reach a decision. Matters affecting several korok are discussed at a large kokwa with representatives from the korok involved. It is believed that the council of elders can invoke supernatural power to enforce their decisions and this is accomplished by the use of oathing and cursing. In former days, the council could order the members of a certain age set to use physical force to punish offenders - this is no longer possible because the national administration would not permit it.

The Pokot have "a prophet" (werkoyon, pl. werkoi) who, especially in the past, was an important political figure. There are several of them at any one point but every region has at least one who is considered important. The prophet warns Pokot of what is forthcoming - a raid, illness, famine or drought. He advises the community or individuals

concerned on what to do to prevent the impending or prevailing misfortune. Pokot claim that one such prophet told them not to resist the British occupation because this would have been useless. When a cholera epidemic broke out among the Pokot in 1980, various werkoi advised people to perform rituals and pray to God to avert the epidemic. The werkoyon is believed to dream and communicate with God (Tororot) and pass on messages to the people. The prophet cannot however, force people to obey his decisions. Each werkoyon commands respect over a certain region of the Pokot area, and his influence can expand or contract - there are no fixed boundaries. Most of the work of the werkoi is underground for fear of the National Government.

The modern Kenyan administration is superimposed on the traditional organization discussed above. This system was introduced during the Colonial period and has not changed besides the introduction of representation in parliament after Independence. At the lowest level, there is a headman who settles minor disputes at korok level. Above the headman, who is not paid for his services, is the sub-chief whose job is salaried. He deals with civil cases referred to him from the headman. The chief is in charge of a location and answerable to the Central government through the District Officer and the District Commissioner. All the administrators below the Chief are Pokot and the term kiruokin is now applied to them. The District Officer interprets government policy to the people and handles cases (civil) which the Chief cannot solve. The local party chairman, member of parliament (two for the whole of Pokot) and the councillor (the last represents his people in the County Council) are all elected and to stay in power have to present local needs to the Central Government for solutions. They are also Pokot, unlike the District Officer and District Commissioner who are usually non-Pokot.

The three elected personalities - Party Chairman, Councillor and member of parliament need the support of the chief and his assistants to muster enough votes to enter or stay in office. This leads to a complicated network of patron-client relationships which I need not go into here.

In certain instances, the two systems openly compete in the process of dispute settlement. This is especially so at the lower levels of administration. Though the headman and the sub-chief try to have all minor civil cases referred to them, the people prefer to refer most such cases to the indigenous kokwa. The chief has a number of elders elected by the community to help him settle disputes. In theory, he should be the chairman when he and the elders meet to consider a case; in practice, an elder can distinguish himself and act as chairman. This is mainly because most chiefs are younger than the elders - because the former are usually people who have some education which most elders do not.

Even for some criminal cases, such as those involving murder, theft and causing actual bodily harm, the traditional system still plays an important role. Pokot insist that even when a murderer has been sentenced at the magistrate's court, he or his clan should pay blood-wealth (lüpoi) to the slain person's clan. The compensation is usually claimed by force. The case is only considered closed when the slain man's kin are satisfied that enough compensation has been paid. A case involving theft or actual bodily harm may be dealt with at the magistrate's court, but Pokot insist that the two parties should be reconciled in a kokwa . Most cases involving divorce and marriage are largely dealt with by the elders and are rarely taken to the magistrates' court.

The two systems are interwoven so closely that one can suggest that

we are here dealing with a single judicial and political system, with both indigenous and national elements, in spite of the fact that it is only the latter which is official.

2.2 The Economy of Agricultural Pokot

Since the economic resources in any society play a significant role in the management of illness, some remarks about the economy of agricultural Pokot are in order here. The term "agricultural" is a somewhat misleading description because the pipopagh keep a number of cattle and small stock and regard them as an important element of their life. What distinguishes them from their pastoral brothers is the fact that they are sedentary and grow crops as the main source of subsistence and sometimes cash. I have already indicated that in terms of economic development, West Pokot is regarded quite backward. It is aptly observed in the District Development plan that this backwardness is not due only to the harsh physical environment which makes the development of physical infrastructure difficult but also due to faulty planning in the past (p.1).

In spite of a late start, agricultural Pokot today are participating increasingly in the cash economy, and are no longer satisfied with production for subsistence only. Today many of them are involved in a wide range of economic activities such as petty trade, cash cropping, wage employment and livestock farming and trading. Though most people engage in several of these activities at any one time, there is now a tendancy for individuals, especially in Kapenguria and Chepareria, to specialize in one or two activities.

Cash cropping is now an important activity among Pokot because it provides much needed money for school fees, medical expenses and domestic goods. In Mwino and Chepareria, maize, beans, vegetables and fruit are

grown for sale. In Kapenguria, potatoes and garden crops; sunflower, some of which is also grown in Chepareria, can be added to the list of cash crops. In Chepareria and Kapenguria farms are very big, and though a farmer may own several plots scattered in different places, the sizes range between five and a hundred hectares. In Mwino, the farms are usually less than two hectares. Poultry is kept in some homes, most of it for sale.

Among agricultural Pokot, the number of cattle in a household usually ranges between ten and twenty though a few people have up to a hundred. Sheep are kept in the highest areas, especially in Lelan Location. Animals are the main exports from West Pokot and the demand for them from other parts of Kenya is very high because of the low prices at which Pokot sell them. Most of the people who are involved in this trade are mostly non-Pokot.

The District Development Plan estimates that in the high-potential areas such as Mnagei in Kapenguria and Kipkomo in Chepareria, the peasants can make Kshs 400-1475/hectare/year. In the middle-potential areas such as parts of Chepareria and Kapenguria, they can make a maximum of Kshs 922.50/hectare/year. However, I should note that because of the uncertainties of the weather, pests and lack of organized marketing, most Pokot peasants make very little money.

Most Pokot do not have a continuous flow of cash throughout the year. Most crops are ready for sale around October and therefore during the rest of the year, not much is available for sale. Crops are sold immediately after harvest because of the fear of pests and lack of storage facilities - prices are very low at this time. Livestock are usually sold around the same period before the drought sets in. Except for maize, the price which Pokot get for their products is very low relative to other areas in Kenya. This is mainly because market outlets

are few for their products. Most peasants market their products individually and they sometimes compete in offering low prices. The co-operative marketing system which is well developed in other parts of Kenya and which could solve this problem is not yet well developed in this area.

An increasing number of Pokot engage in various types of trade, of which the most important in terms of the number of people involved, is the petty type dominated by women. The women sell clothes, utensils and other domestic items at retail prices in open air market places. These markets are of the rotating type as are found in West Africa (Hodder 1962:103-117). Though the capital outlay in the petty trade is small, usually less than Kshs. 1000, the profits made can be quite substantial because the goods sell quickly and most of them have no fixed prices. This type of trade has given a number of women a lot of say in the family - because of their economic power - the significance of this in relation to decision taking in the management of illness will be discussed later. Petty trade is also carried out in market stalls which are also dominated by women in most shopping centres. For example, in Chepareria market, there are 65 stalls and kiosks where food, soap and patent medicines are sold, of these, 48 are operated by women. Shopkeeping involves more capital and higher risks than most women can manage because of domestic work. So nearly all shop businesses in the area are run by men. The owners of such shops are quite wealthy by Pokot standards and in most cases they are at the same time successful farmers.

Livestock trade is in the hands of non-Pokot. To participate in this trade a person has to have several contacts and a substantial amount of money with which to buy many animals and transport them by lorry to as far as Nairobi, 300 miles away. The only Pokot who participate here

do so as middle men who buy cattle and goats from other Pokot and then sell them at a profit to the "foreign" traders. Such Pokot middlemen are considered very rich and usually have better houses and furnishings than the rest of the people.

Salaried employment has attracted a number of educated Pokot who are now teachers, policemen and clerks in the Civil Service. Few Pokot, however, occupy senior positions in either the public or private sectors, a fact which may be attributed to there being only a few of them with high educational qualifications. Most of these salaried workers are employed outside the District though some work near their homes as primary school teachers. This category of Pokot are highly respected and their opinion is usually sought when decisions about sickness have to be made.

Traditionally, there was strict division of labour based on sex and age. Women's tasks included cultivation, milking, food gathering, and building houses. Men cleared the ground for cultivation, minded the cattle and protected the territory. Children minded the calves assisted by their mothers. The children also helped with household chores. The situation has now changed. Children go to school so the women have more duties to perform at home than before. Men now engage in cultivation and house construction. Both men and women engage in trade but there is a tendency for men to dominate the cattle and shopkeeping business while women are more interested in petty trade. Money from cash crops (except garden products) is regarded as belonging to the husband.

Economic cooperation, traditionally an important feature of Pokot economic life, is said to be decreasing. Work parties the kiyech and the sikom are used to pool labour to accomplish tasks requiring many hands. The kiyech is an adult people's workparty where people work for food and

drink. The composition of the party depends on physical proximity to the person calling the party. The sikom is a young people's work-party. Any youth, if requested by someone, can summon his friends at short notice to form a sikom to perform some task without being paid directly. The youth who summons the party is given a present by the person worked for. This youth is then obliged to join any work-party summoned by one of those who assisted him. Such work-parties are not common now because contract and wage labour are now more attractive because of the cash payment involved.

Land has now become a more important economic asset than it was before. Formerly individual Pokot had access to any piece of land in their neighbourhood though in some areas like Mwino and Chepkulel clans claimed certain plots as theirs. Now the land demarcation and adjudication exercise is complete in most of the agricultural areas. The people who have managed to get the largest pieces of land are those who are economically powerful enough to buy large tracts of land or to influence the land committee to allocate them bigger pieces than the rest of the people.

The concept of a rich person (mongorion) has changed significantly. Formerly it meant men with many cattle and control over many people - sons, wives and relatives.[6] Such people did not necessarily occupy positions of leadership such as the kiruokin - moral uprightness and wisdom were considered more important than the number of cattle owned. Now a rich man is one who has much land and cash (or the potential to realize it) such as the shopkeeper and the cashcropper - and usually one person is both. The most successful traders are also in most cases successful farmers. These people are the ones who occupy positions of leadership - in various development committees, local administration

and politics. For example in Kapenguria and Chepareria Divisions, a list of the leading traders and farmers would correspond very closely to a list of councillors, chiefs, sub-chiefs, party chairmen and harambee and land committee members.

One overall effect of the diversification of the economy which the Pokot now lament is the decrease in community cooperation. Traditionally Pokot living in a neighbourhood spent a lot of work and leisure time together. The pastoral Pokot still do this and a number of my informants referred to them with nostalgia. The size of the economic unit is also decreasing. In the past, and to a small extent today, the economic unit consisted of a man, his wife (or wives), unmarried daughters and sons, and married sons and their children. Over most of the agricultural Pokot area, the standard economic unit is now a man, his wife or wives and unmarried children with or without hired labourers. This is especially the case with those who have distinguished themselves in trade or farming. Married sons tend to remain in the larger, traditional economic unit if their father is a wealthy man.

2.4 Education and Religion

Pokot contacts with Christianity and Western education began about fifty years ago with the introduction of "bush schools" and mission stations. As in several other places during the Colonial era, Christianity and Western education were closely linked. Pokot response to both was rather negative and their attitudes have changed only recently. The Pokot are proud of their culture and regard it as equal if not superior to any other. So when missionaries and bush-school teachers implied in their teachings that Pokot culture was evil and only fit to be discarded, Pokot responded by trying to keep themselves and their children off. The missionary policy regarding African culture was quite negative. In the

bush schools, those children who attended were taught by Christian teachers who discouraged them from singing 'folk' songs and participating in indigenous rituals. At home the children tried to "teach" their parents to quit believing in ancestor spirits and healing rituals, but such teaching was not very successful. Those young people who were converted to Christianity or went through the bush schools to the intermediate school at Kapenguria were considered uncultured and disrespectful. However, the art of reading and writing impressed Pokot and especially the fact that someone could communicate with a relative at a distance through a letter. It was also observed that graduates of the intermediate school at Kapenguria could be employed as agricultural instructors and bush school teachers. As the benefits of modern education were seen, more and more Pokot children were allowed to go to the missionary-dominated schools. Pokot themselves through their local Native Council, put up a number of schools - but by around Independence time, there were only 1700 pupils all over West Pokot (population about 60 000) and a number of them were non-Pokot.[7]

Records indicate that as the benefits of Western education became clear to Pokot, the demand for it increased. This increased demand was such that the District Commissioner in 1963 was able to report that "in Mnagei and Kipkomo the schools are full and the Assistant Education Officer has had some difficulty in finding places for all standard five children.[8] Although Pokot are still enthusiastic about sending their children to school, many are disillusioned to find that after spending a lot in educating the children, the latter return home without getting jobs.

Adult education is becoming popular among Pokot and especially among women. Most Pokot men are reluctant to attend the same afternoon

classes with their wives, some of whom may prove to be better students than them. The elders lament the decrease in the value of their wisdom, which many young people show little interest in. However, indigenous knowledge is still imparted through socialisation and during initiation more formal instruction takes place. I shall discuss how medical knowledge is imparted to initiates in the next Chapter.

Modern education has made Pokot aware of the generation gap between young and old. Most youth now know far more about the outside world than their parents. This makes them despise their parents who are usually poorly informed about matters outside Pokot country. The adults, however, are still aware that they control knowledge of ritual which the youth have little access to. But more and more schools are being constructed. In 1979 the ratio of Primary School children to the total population was about 1 to 12.[9] Higher education is, however, out of the reach of a majority of Pokot children. A number of them have managed to go to the three secondary schools in the district and others elsewhere - but these are still very few.

Christianity and education have always been closely related during the past and today in West Pokot. It was the Christian missionaries who introduced "bush schools" in the District and most teachers in the area until recently have been Christians. To-date there are 23 denominations in the area but exact figures about the number of Pokot who are Christians, are not available. In Chepareria Sub-location, there are about 1500 Christians in a population of 5000.[10] Three-quarters of the health facilities and a majority of the schools in the District are sponsored by Christian churches. This means that a number of Pokot are exposed to a different world view and mode of thought, but most of them have not discarded their traditional concepts of God, sin and punishment. Pokot

Christians are forbidden by their faith, to participate in indigenous rituals but they can pray for their sick, this, however, is the theory, in a later chapter it will be shown how social pressure makes them participate in indigenous rituals.

Pokot traditional religion lives on, and the majority of the adult population practise it. Only the salient features are discussed here and especially those that relate to illness. The world was created and is controlled by a powerful being, Tororot who lives above (Yim). The creator is generally benevolent but can manifest his power in thunder and lightning. Tororot sustains all human, plant and animal life and controls various invisible spirits, hence it is believed that big rivers which run throughout the year are manifestations of his power. Tororot is also thought to inhabit the evergreen milk trees in the area which produce food for livestock during the dry season. He provides general protection to all people, but anyone in need of help can pray to him at any time.

Man, the physical and spiritual worlds are in constant interaction. Changes in the physical environment can affect man just as can various spiritual forces. Man is not only a physical being, but also a socio-spiritual entity whose actions may lead to famine, drought or disease. To ward off misfortunes, man seeks the help of benign spiritual forces and Tororot. The close interrelatedness between man and the physical and spiritual worlds is best illustrated during illness as I show in the next chapter.

There are no fixed, regular days of worship. The annual cycle of events determines the performance of two major rituals punyon and sindagh. Punyon is celebrated around December when the dry season is well under-way. Girls are the protagonists in this ritual. Girls from neighbouring

Korok gather in the evening and there is dancing and singing. The girls are joined by their lovers and women may participate for a short while before leaving the girls and their lovers to sleep in the bush. The songs request God to kill all the enemies - human beings, diseases, pests and any other forces which may prevent the community from seeing another planting season. The following day, the girls simulate an attack on "the enemy" in this case a bush and spear it with wooden spears. Various punyon are performed in different parts of the District.

Sindagh is a ritual which Pokot say was instituted by God himself, to test their allegiance to Him. Sindagh consists of a number of performances where fire is lit in various parts of the Disttict depending on observations of heavenly bodies. The performances culminate in one grand ceremony in a place called Tamkal in June. A big fire is lit and if the smoke rises straight up, then God is pleased with the people. If the smoke is bent, a sacrifice is offered to propitiate Him.

The planet Venus (tapogh) is thought to be the custodian of fertility. A women's cult has developed around it. If too many children die at any one moment or if there are many women who cannot conceive, women go up certain mountains in the evenings and pray to tapogh to give them more children and preserve the health of those already born. The women say that tapogh communicates their demands to God who then answers their prayers.

Individuals can also pray to Tororot when sickness strikes, and offer a sacrifice, amoros. Sacrifices are usually offered near a river or in the bush. The Werkoyon (prophet) can advise a particular community to perform certain rituals to prevent some impending catastrophe which he has foreseen in a dream. A diviner can also suggest that ritual be performed to end a misfortune.

Some conditions are considered to be ritually defiling. For example, a menstruating woman should not cook for any man. Contact with a dead body is also defiling, as is killing. There are rituals which Pokot perform to remove ritual defilement. The commonest cleansing ritual is called tso. Tso is thought necessary if for example a person has been involved in burying somebody or when a sexual offence has been committed. Both make the person dirty and he has to be "washed". The washing in the case of tso involves the smearing of all members of a family with a mixture of honey, milk, the offender's urine and blood from a sheep slaughtered specifically for the purpose. The person who directs the performance of tso is called tsin. Another cleansing ritual is riwoi, a ritual which is usually performed in connection with births which are considered unnatural. For example, the birth of twins, birth before the monthly periods are seen, and babies appearing legs first, all necessitate riwoi. A woman who experiences any of the above covers herself with blankets and stays indoors until riwoi is performed. When riwoi is performed, only those who have had riwoi performed for themselves participate in the ritual. A sheep is killed and its fat mixed with milk and smeared on the woman. The women dance while ringing a metal bell to expel the filth which they say the stated occurrences bring to the family concerned. After the woman has been "washed" as Pokot call the riwoi performances, she can now cook for her family without any fear of defilement. Only a sheep is killed for cleansing ritual because, unlike the goat, it is considered an animal that is "clean" and "upright", tilil as Pokot describe it. Cleansing rituals are performed, as informants stated, to prevent the occurrence of misfortunes.

Before a couple have their first child, it is considered important that the parpara ritual should be performed to cleanse them of any sins which they may have committed and which may prevent them from founding

a successful family. Parpara is also performed to annul the effects of any enmity between the respective clans of the husband and the wife. In the next chapter, I shall describe in detail those rituals which relate especially to healing.

Supernatural power can be invoked in various ways so as to bring about misfortune. If an individual proves a nuisance to the community, the elders can curse him and it is thought he will be afflicted by spirits. If a person denies an offence, he may be forced to take the oath (muma) which is also thought to be capable of afflicting social offenders.

Ancestor spirits, oi, both protect and afflict. They do the latter when provoked by their descendants. The ancestors are propitiated by gifts placed in the bush or on a particular grave. Snakes are regarded to be the ancestors' messengers and should be therefore well treated, unless they attack someone. Pokot also believe in onyet (pl. onyetei) spiritual forces thought to have human-like characteristics. Onyetei, unlike oi, cause misfortune without provocation but God is thought to be capable of controlling them when requested to do so.

Pokot do not have unified doctrines about their religion - in fact many elders hold some very divergent views regarding spiritual matters. But all are agreed about the supremacy of God and the need to offer to Him prayers and sacrifices as need be.

Pokot indigenous religion pervades all aspects of their life and is very much an acted religion. Tororot is seen in healthy crops, animals and people. He makes the birth of children possible and takes care of them as they grow. The household head is the "priest" in the home and is expected to guide whoever lives in the household regarding religious matters. The elders are believed to be capable of manipulating divine power - they

are regarded as God's spokesmen. No one is excommunicated - because all Pokot by birth belong to their indigenous religion, which is one of the features which distinguishes them from others. Religion is especially manifested in illness, because a number of sicknesses are linked to moral issues. I shall refer to this in more detail in the next chapter.

Dini Ya Msambwa is a religio-political movement which started in the thirties by Bukusu ex-mission converts who rejected particular Christian teachings, especially monogamy.[11] Elijah Masinde, the leading figure of the Movement, sent one of his disciples, Lukas Pketch, to West Pokot in the late forties. Pketch and other believers were readily welcomed by Pokot. Informants told me that Dini Ya Msambwa was readily accepted by Pokot because though it was a new religion, it did not negate indigenous customs as much as Christianity.[12] At the same time certain Christian practices were also accepted - to Pokot the movement gave an individual the best of both worlds, the new and the old. The movement also expressed nationalistic sentiments which Pokot had not expressed directly before. During most of the forties and fifties, a ruthless campaign was waged against the members of the movement, many of whom were detained. This campaign made the movement more attractive but it went underground. Members of the movement still exist among Pokot though few communal rituals are performed. The night provides the cover necessary for members of the movement to sing in mountains and occasionally communal worship takes place. In 1980 a group of Dini Ya Msambwa members moved to one settlement in Sook location and here they pray for their sick and others who experience misfortunes. Members of Dini Ya Msambwa in Pokot are usually old men and women but there seems to be a resurgence of the movement in several parts of the District. They believe in demons, witchcraft and spirit possession, all of which

can be cured at their religious rituals.

2.5 Western Health Services

As a background to the health services available to Pokot, I provide a brief description of the general conditions relating to health in the Nation as a whole.

As a developing country, Kenya cannot afford to provide all the Western health services needed by the population. Because of this constraint, many people, especially in rural Kenya, have little access to Western health care, and so have to depend largely on traditional medicine. However, according to a recent report by UNICEF (1981)

> Levels of health and nutrition (in Kenya) have improved with the spread of health care facilities and improved standards of living. In the last ten years, life expectancy has increased by 10% while infant mortality has dropped by nearly 30% (p.2).

While it is true that at the general level health conditions have improved in Kenya since the start of this century, as I shall show in later chapters, some areas in Kenya, especially the urban areas, have received more attention than others, therefore leading to marked inequalities in health development. West Pokot is one of the areas which have received little attention because of factors already mentioned. The problem of financial shortages for health services has been compounded by a high rate of population growth, now estimated at 3.5% per annum. Mainly because of this reason, expenditure on Western-type health services has dropped since 1977 by about 1% and now stands at 6% of total recurrent and capital expenditure on government services (ibid:4). The Government, in order to overcome the difficulty of financial limitations on health development, has encouraged self-help activities, (harambee) in health (and general) development. Through the harambee

movement various communities, assisted by politicians and civil servants, construct dispensaries and health centres which are then taken over by the Government which employs health workers and provides the drugs and equipment. Unfortunately Pokot have not been very enthusiastic about the harambee movement and hardly any health facility in the area has been constructed through self-help, poverty and lack of community leadership being the major hindrances.

Manpower shortage is another serious problem in Kenya's health services, and this stems directly from financial limitations, which make difficult the attempt to train the required health workers. I shall later raise the issue regarding the relevance of the health personnel in Kenya's health services with regard to their training and the type of clients they serve.

Kenya is also faced with an acute shortage of drugs and equipment, especially for rural dispensaries and health centres. This is not only due to financial limitations, but also to a poor distribution system, brought about by poor communication networks. West Pokot, with less than 500 miles of roads motorable throughout the year, is badly affected by the shortage of drugs and equipment. Immunizations have not been applied to the majority of Pokot, because many of them live far from areas reachable by vehicles carrying the vaccines.

The morbidity and mortality rates and patterns in Kenya are those typical of most developing countries - gastro-enteritis, measles, intestinal worms, malnutrition, skin infections, eye infections, and malaria, conditions which are no longer serious problems in developed countries (Bonte in Vogel et al. 1974:84-85).

Government health services are "free" in the sense that prescription and drugs are obtainable without payment. Christian churches, the

Muslim community, voluntary agencies and private individuals also run various facilities for which a fee has to be paid in most cases. In West Pokot, the facilities available are given in Table 1. The Pokot have responded to modern Western medicine very positively, in spite of initial suspicions. Though a health unit was put up in the District in 1915, it was only in the late thirties that any significant number of Pokot came into contact with modern Western medicine. During the Colonial period, (1929) a hospital was put up at the District Headquarters - out of the reach of a majority of the population - and in 1956 another one was put up by a Christian church. During this period, three health centres were operated by the Local Native Council intermittently. In 1957 a Mobile Clinic was initiated and each location was visited once a month, during the same year, a medical officer who had previously been operating from Kitale, became resident in the District.

The 1960s saw the emergence in the District of women's development groups - Maendeleo ya Wanawake - which have played, and still do, an important role in the introduction of Western medicine. In their meetings the women are taught personal hygiene, gardening and healthful child-rearing. Today these clubs are assisted by the Ministry of Culture and Social Services. As a result of these clubs, Pokot women have made more contacts with Western medicine than their male counterparts.

The facilities shown in Table 1 and the personnel in Table 2 are devoted almost entirely to curative care, with little attention paid to prevention and promotive health work. The Maternal and Child Health Programme operates intermittently in various parts of the District, but transport and manpower problems have hindered it from having the impact it was intended to have. Community involvement in modern health care has yet to be stimulated in West Pokot, while traditional medicine

Table 1

Modern Health Facilities in West Pokot : 1980

Type of facility	Funding agency	Number
District hospital	Government	1
Hospital	Church	1
Health Centre	Government	3
Dispensary	Government	2
Dispensary	Church	9
Clinic	Private individual	1

Source: Annual Report Kapenguria Hospital, 1980

Table 2

Modern Western-trained Health Workers in West Pokot 1980

Medical Doctors	6
Clinical Officers	9
Nurses	55 (13)
Physiotherapists	1
Public Health Officers	3
Public Health Technicians	15
	89

Source: Annual Report, Kapenguria Hospital, 1980

is community medicine, modern medicine is seen as something "from above". Side by side with the official health care services are the unofficial indigenous health services. In the next chapter, I examine in detail the main concepts and practices relating to these indigenous health services.

The brief outline above of the physical and socio-economic

conditions is relevant to this dissertation because it provides the context within which I studied Pokot responses to illness. Some of the conditions impose restrictions upon, while some others assist in ways mentioned later, the health-seeking process.

2.6 The Research Site

Since most of my detailed observations of the health-seeking process took place in Chepareria sub-location, I wish to present an outline of the socio-economic environment and the therapeutic alternatives in and around the area. The sub-location is about 64 sq.km. and is situated mid-way between the highlands of Kapenguria and the plains. Because of its geographical position, it has sufficient rain to sustain crop production but is also suited to cattle keeping. The average size of plots owned by heads of extended families is about 20 acres but most of this is not under cultivation. The sub-location consists of small-scale peasants growing maize, beans and sunflower for cash and the former two for food. Cattle per extended family range from five to thirty, and goats average 20, but there are about 10 families with herds of about a hundred. Some vegetables are grown and chickens kept for both cash and subsistence. Chepareria shopping centre is situated at the centre of the sub-location and is growing rapidly with its retail shops, food kiosks and vegetable stalls. Thursday is a market day when farm produce is sold and manufactured goods bought. Most residents of Chepareria claim they suffer a perennial shortage of cash because it can only be generated after harvest and when animals are sold.

The Divisional Headquarters' offices and the District Officer are situated in the shopping centre as are the Locational Chief, Community Development Assistant and Public Health technician. Six Christian

denominations conduct services in the area with 30% of the population attending services. There are six primary schools in the area and most children under fifteen attend classes regularly under the National Free Primary Education Scheme. Two adult literacy classes are conducted but are only popular with women who also have formed six development clubs (Maendeleo Ya Wanawake).

For a majority of non-serious medical conditions, the people use herbal and shop medicines at the lay care level. Most of the herbal medicines are collected from the bush but some can only be procured from individual herbalists at the market or in their individual homes. Stocks of shop medicines are kept in most homes having been bought at Chepareria, Kapenguria or Kitale. Some are left-overs from previous prescriptions. The traditional practitioners available in the sub-location are listed in Table 3. Other healers can be consulted in other areas of the District, especially in Mwino. Non-Pokot healers can also be reached in other districts and some have settled in Pokot. There is also an unknown number of "bush-doctors" - people with some Western education who have acquired paraphernalia used in Western medicine. The "bush-doctors" have not been given any specific Pokot name and are just referred to as "daktarion", a term which is used for most Western-trained health workers. The bush-doctors obtain drugs like penicillin and chloroquin from the black market and use them to treat almost all the illnesses referred to them. Their practice is clandestine for fear of being discovered by the police. They normally charge very little for their services.

There is only one Western-type health worker resident in the sub-location, a nurse who runs the local Catholic mission dispensary. A fee of five shillings is charged for every visit to the dispensary. A

Table 3

Traditional Medical Practitioners resident in Chepareria Sub-location 1981

Herbalists	20
Circumcision experts	6
Clitoridectomy experts	4
Uvula excisors	3
Tooth extractors	9
Tonsil removers	4
False teeth experts	3
Diviners	4
Birth attendants	22
Total	77

Maternal and Child Health Clinic is conducted every fortnight at the dispensary by nurses and midwives from the Mission Hospital at Ortum. The clinic is free but attendance is quite poor (about fifty women attend regularly) because of its irregularities. Ortum Hospital is about twenty kilometres away and charges fees for both out- and in-patients. Kapenguria District Hospital is a government institution about eighteen kilometres away and services are free. The District Hospital is always crowded because it deals with complicated cases from all other parts of the District. There is a private clinic at Makutano near Kapenguria which treats out-patients for a fee. Here services are given quickly and there is no over-crowding. Patients are handled very well, unlike at the District Hospital. A return journey to either of the hospitals and the private clinic costs twenty shillings per person. Most travel is by truck or government Land-Rover of which the drivers charge the usual fare. A few matatus have now started operating between

Kapenguria and Ortum and around Kapenguria but the rest of the agricultural Pokot area has no public form of transport.[14] Some Pokot who can afford it, travel outside the District in search of health services, both traditional and Western. Compared to many other areas in the District, Chepareria has a relatively easy access to Western health facilities.

Footnotes to Chapter Two

1 District Development Plan 1979-83 under "Transport".

2 1979 Census, Central Bureau of Statistics, Nairobi.

3 The District Commissioner of the District in 1945 expressed great dissatisfaction with policy of the Colonial government to help only the "haves" while leaving places like West Pokot to lag behind in socio-economic development. (See District Annual Report (1945:1). There were several similar complaints but this did not change government policy.

4 District Development Plan, op.cit. Introduction.

5 Nandi and Marakwet have seven age sets each (cf. Peristiany 1939 and Kipkorir (1973) respectively.

6 Schneider states Pokot attitudes to cattle very clearly. "...a man with a hundred head of cattle or more is rich, one with ten is poor, and a man with no cattle is 'dead'" (1957:280). Today, a Pokot who has a lot of money may have few cattle but he will not be considered poor or dead if he did not have any cattle.

7 District Annual Report 1961 under "education".

8 Cf. West Pokot Monthly Report, Jan. 1963 p.1.

9 District Development Plan 1980 under "Education".

10 These are the "church-goers" most of whom are women and children.

11 Detailed study of Dini Ya Msambwa made by Wipper (1977).

12 Cf. District Annual Reports especially 1957.

13 This figure does not include those nurses employed by agencies other than the government, who number about the same figure.

14 Matatus - these are vans modified to carry passengers in most parts of Kenya.

CHAPTER THREE : POKOT TRADITIONAL CONCEPTS AND PRACTICES RELATING TO HEALTH AND ILLNESS

In this chapter I deal with the various beliefs and practices which the Pokot consider appropriate to the management of the different medical problems which affect them. The ideas and techniques which I discuss in this chapter are those that have become generally accepted by Pokot but from the outset, I should stress that new concepts, skills and medical experts relating to the management of illness among Pokot have usually been assimilated by them when these have been perceived to be effective in dealing with particular medical problems. Examples of this assimilation of new techniques, concepts and practices will be given in following chapters as appropriate.

A high level of knowledge of medical concepts is maintained among Pokot through both informal and formal instruction. The acquisition of appropriate medical knowledge is an essential part of Pokot social development. Informal instruction is done by adult Pokot on a father (or sometimes grandfather)-to-son and mother-to-daughter basis. Through this process, Pokot young people learn the names of most commonly used herbs, what they are used for, and about the moral rules kirurut, observance of which is regarded as necessary for healthful living. Such knowledge is exchanged freely among peers. However, it is during initiation that the most intensive and comprehensive teaching of medical concepts and skills occurs. For the boys, this occurs in the seclusion hut, the menjo. During their seclusion in the menjo, the boys are examined on the medical knowledge and skills they have acquired so far (by adult Pokot who have expert knowledge). Common medicinal plants such as moykut, nyermen, chelewo and kapkop are brought to the menjo for the initiates to identify and state their medicinal use. Though most initiates would have participated

in various rituals, the meaning and reason for each specific ritual is explained to them by a group of experienced Pokot who act as trainers. The initiates ask questions and if an instructor makes mistakes about medicines or ritual, his colleagues correct him. Female initiates are given instruction in individual houses where they are secluded (singly in most cases). They receive instruction regarding conception, birth, and child rearing. Appropriate medicines and ritual observances are revealed to them in detail.[1] Ideally, by the time the initiates emerge from seclusion, they should know most of the concepts and practices which they require to deal with common illnesses which will affect their families and the role they should play to maintain a healthy korok. Most Pokot medical experts begin their training after initiation, because that is when they are expected to have become socially mature. Informants were agreed that the learning of the ideas and behaviours necessary for healthful living is considered to be a crucial aspect of the process of initiation. The knowledge acquired during initiation is perfected with actual participation in episodes of illness. Those Pokot who choose to become medical experts receive specialized instruction through being apprenticed to the appropriate healer.

In the first section, I discuss Pokot concepts of health and illness. Section two deals with notions of treatment and prevention while the third one deals with lay and expert roles in the health-seeking process. The fourth section is devoted to an examination of the major therapeutic techniques currently in use among Pokot. Most of the material in this chapter is presented in summary form and will be filled out in other parts of this dissertation.

3.1 Pokot Concepts of Health and Illness

Though disease occurs in all human populations, different societies perceive, interpret and respond to it and its effects variously. Most medical anthropologists (and others studying illness) today make a distinction between the terms "disease" and "illness". Kleinman for example says that we can call disease "any primary malfunctioning in biological and psychological processes" and illness "the secondary psychosocial and cultural responses to disease i.e. how the patient, his family, and social network react to this disease" (1979:8). Therefore throughout this dissertation I use disease to refer to biological and psychological pathology in the human body as may be recognized by a clinician and illness as the cultural interpretation of disease.

In trying to explain what Pokot regard as health, it is necessary to analyze their understanding of illness i.e. how they think it is caused and should be treated. Medical anthropological literature usually recognizes two major types of theories of illness in non-Western societies. These are termed the naturalistic and personalistic (Foster and Anderson 1978) the natural and supernatural (Murdock 1980) the naturalistic and supernatural or sociointerpersonal (Fabrega 1974). Societies are then divided between those whose theories of illness are largely naturalistic or personalistic respectively. However, evidence from several places, especially in Africa, suggests that many societies have theories of illness with both naturalistic and personalistic elements. Evans-Pritchard (1937) points out that though Azande believe in witchcraft as a "cause" of illness, this does not mean that they do not accept natural causation, for, as he puts it, they did not

> Attempt to account for the existence of phenomena, or even the action of phenomena, by mystical causation alone. What they explained by witchcraft were the particular conditions in a chain of causation which related an individual to natural happenings (p.67).

It is interesting therefore, to note that few studies following the Azande one have developed Evans-Pritchard's ideas regarding the causation of illness. Material from this Pokot study suggests that their view of illness combines both naturalistic and personalistic aspects in one theory of illness. This "unified" view of illness (Fabrega 1974) has also been shown to exist among the Mandari, Nyakyusa, Zulu and Gusii of Africa.[2]

Pokot seek to explain the causation of illness by referring to different realms of existence which may be seen to affect the biological condition of a person. Though Pokot traditionally do not have the germ theory of disease as understood in Western medicine today, they conceive of most illnesses as stemming from biological pathology, but capable of extending to embrace other facets of human existence. Hence, Pokot think that inter-personal and spiritual agencies can bear on an individual's health in a variety of ways. At a superficial level, Pokot explanations of illness appear to consist of a series of "causes" of a similar nature. Close examination of their notions of causation shows that they fall into three different but closely related categories. As will be shown presently, the operation of causal agents in the three categories does not imply the same degree of causation. The causation of most illnesses among Pokot is a dynamic, processual phenomenon, because though the physical symptoms of an illness may remain unchanged, the number of factors thought to be contributing to its causation may be seen to increase or decrease as it progresses.

The three categories of causes which Pokot use to explain illness

may be designated the physiological (or biological), interpersonal and spiritual. I choose to call the categories of causes "planes" in this discussion. The biological plane involves the "how" aspects of an illness. On this plane, Pokot are concerned with the mode of transmission of the natural cause(s) of illness into the human body. Such causes are seen to emanate from the physical environment, from sick human beings or as incipient in the process of ageing. To give an example, Pokot say that kakatan (malaria) is caused by the consumption of excessive amounts of sugar, being caught in heavy rain and some now attribute it to mosquito bites. "Cause" here is understood in the sense of transmission and not in the sense of the particular parasites (plasmodia) which cause the disease. In this sense, Pokot say venereal diseases are caused by sexual intercourse. In explaining the "how" of an illness, Pokot concentrate on the diagnosis of symptoms and signs shown by the patient. His waste products are examined and he (or others if he is too ill or a child) is asked about his appetite, physical strength, change in temperature and sleep pattern. Depending on the symptoms and signs, a specific name is given to the condition and this marks the end of diagnosis on the how level. This examination is also extended to the social and spiritual conditions as I show presently. In this discussion I refer to this as the primary definition of illness.

The definition of an illness by Pokot does not stop at the "how" level; for certain, actually most, illnesses, a "why" explanation is also sought. The why explanation of illness involves both or either of the two planes interpersonal and spiritual. When a "why" explanation is sought, the focus of attention shifts from the physical symptoms to interpersonal and/or spiritual conditions which are thought to contribute to the illness. For the why explanation, several sets of different

physical symptoms, each set definable at the primary level, may be said to be due to the presence of a single interpersonal or spiritual condition. Such a condition may be a sexual offence, a curse, a dishonoured oath, human feelings, evil spirits or Tororot. I call the "why" definition of illness the secondary definition, because it is an additional description of an illness which already bears a specific name derived from its physical symptoms. Both chronic and acute illness can be given both primary and secondary definitions, though it is the former which are more likely to have this double definition.

Table 1 is a list of some common diseases and the biological causes ascribed to them.

Table 1

Diseases and their Biological Causation

Illness	Cause
Kokikei (whooping cough)	air, dust
Sonsarion (measles)	wind, contact
Kakatan (malaria)	sugar, milk, rain, mosquitoes
Tinyon (common cold)	rain, hot sun
Termes (Kala-azar)	blood, milk
Kayitan (diarrhoea)	food, false teeth (children)
Kata (venereal disease)	sexual intercourse

At this point I should introduce the notion of multiple causality. Pokot say that several causal agents may be present in any single illness and that these agents may belong to one or more of the three planes - the biological, interpersonal and spiritual - of causation. On the biological plane, for example, a single episode of malaria may be said to be due to

all of the causes I have listed above acting on the patient at the same time. Though in some cases only one of these causes is thought to be relevant in explaining an episode of malaria, on most occasions several of these factors are regarded as being involved. Such multiple causality is intra-plane, because a number of factors on one plane are seen to be involved in the causation of malaria.

Multiple causality can also be seen to occur on the interpersonal plane. For example, an episode of illness which starts as malaria may be thought to also involve a number of interpersonal conditions. Pokot have moral rules kirurut, which guide them in their interpersonal relations. Kirurut entails rights and obligations. According to kirurut, quarreling, theft from a fellow Pokot, homicide and sexual offences (chepores) should be avoided. If a person violates kirurut rules, he or his children will be afflicted with illness. A person should not take an oath if he knows he is in the wrong. A person's illness may also be exacerbated by the actions and feelings of others. For example, the elders can invoke mystical power to afflict an individual with illness by performing chupo - cursing him - if he is a habitual social offender. An individual whose actions anger a whole community may be afflicted by what Pokot call eywei. Eywei is an interjection used when abominable behaviour is witnessed. It is thus a feeling of horror, which need not be expressed verbally. For example, a youth who hits an old person for no apparent reason will cause the feeling of eywei. If several people feel eywei against an individual, any future illness affecting him will be said to involve eywei. Pokot also say that an individual can afflict another with illness by using pan. Pan involves the manipulation of medicines, words and various bodily actions so as to affect somebody at a distance with illness. Some pan involves only medicines while

other types involve the doctoring of items belonging to the intended victim - hair, footprints or clothes. I find it difficult to describe pan as either witchcraft or sorcery (Middleton 1963) because it involves both. Pokot use only a single term ponin to describe the individual who causes pan. Some pan is legitimate, when it is protective, but some is also illegitimate and condemnable, when it is used because of envy or hatred. Pan can be acquired from any ponin but is never inherited in the Azande fashion (Evans-Pritchard 1937). In this discussion therefore, I use the Pokot term because it is not easily translated into English. An episode of malaria may be thought to involve the effects of the curse, oath, eywei or pan all at the same time.

When several of these interpersonal agents are thought to be involved, we have another type of intra-plane multiple causality, but of a different nature from the biological one. Causality on this plane is different because the designation of an illness as eywei or pan actually subsumes the biological plane of causality - because malaria for example, can be defined as eywei while Pokot "know" that at the how level, it is caused by sugar etc. On the interpersonal plane, most illnesses are thought to involve ngoku which may be glossed as "sin". Ngoku is used to refer to the infringement of kirurut, moral rules. As I show later, causation on this plane usually implies moral connotations, as it involves the imputation of responsibility for an illness to the patient, his kin or other Pokot. Ngoku may be given as an explanation of an illness by the therapy managing group or by a diviner. It is therefore arguable that causation on the interpersonal plane differs from that on the biological plane not only because the former is thought to subsume the latter, but also because it involves the imputation of responsibility for an illness.

Multiple causality can also occur within the spiritual plane of

causation. On this plane, causation is thought to involve the agency of oi, onyetei and Tororot. These forces are sometimes thought of in anthropomorphic terms. Pokot say that Tororot is the custodian of their moral rules. He expects to be prayed to and receive sacrifices from household heads and the community at large on certain occasions. He punishes social offenders and those who neglect their religious duties. Pokot say that the curse or eywei is effective because God wills it. Muma, as the Pokot call the oath, has its effect because God wills it. Oi are the ancestor spirits which both protect and punish offenders. Pokot use oi to refer to ancestor spirits as a collectivity or to individual ancestors. It is said that when an individual commits Ngoku, ancestor spirits will punish him, usually with illness. Oi also afflict when the appropriate sacrifices and prayers to them have been neglected. Onyet (pl. onyetei) are evil spiritual beings which move about invisibly afflicting people with illnesses arbitrarily. Pokot refer to the Biblical Satan as onyet. An illness may be attributed to oi and Tororot at the same time, because both punish infringement of ngoku. This is then multiple causality on the spiritual plane.

So far I have been discussing intra-plane multiple causality. It is also possible to talk about inter-plane multiple causality. This occurs when both how and why causes are thought to be involved in an illness. When Pokot say that an illness involves ngoku, it is assumed that ngoku exacerbates an already existing illness. Multiple causality can be seen to embrace all the three planes of causation. Causation on the spiritual plane usually subsumes the other two planes. When Pokot say that an illness is "kechonu Tororot", the implication conveyed is that the creator is punishing an offender who has committed ngoku. So causation involving the spiritual plane is a step further than that involving the

interpersonal. I wish to illustrate the principle of inter-plane multiple causality by describing a condition Pokot call Yomat.

Yomat is a medical condition which a person gets by coming into contact with water in certain areas. It is thought to be due to a substance which enters the human body through water, mist or fog. Yomat can manifest itself through different sets of physical symptoms. It is said that it affects a person (or his children) when he has committed sins that are unknown to his kin and neighbours or when he has neglected his ritual duties. But Pokot go further to say that the illness is sent by Tororot as a reminder to the person that he has committed some sins unknown to his community. Yomat is treated by various medicines according to the specific symptoms manifested but also by the performance of a ritual called kilokat, described later. The person should also confess his hidden sins to the community before he will be pronounced tilil "healthy".

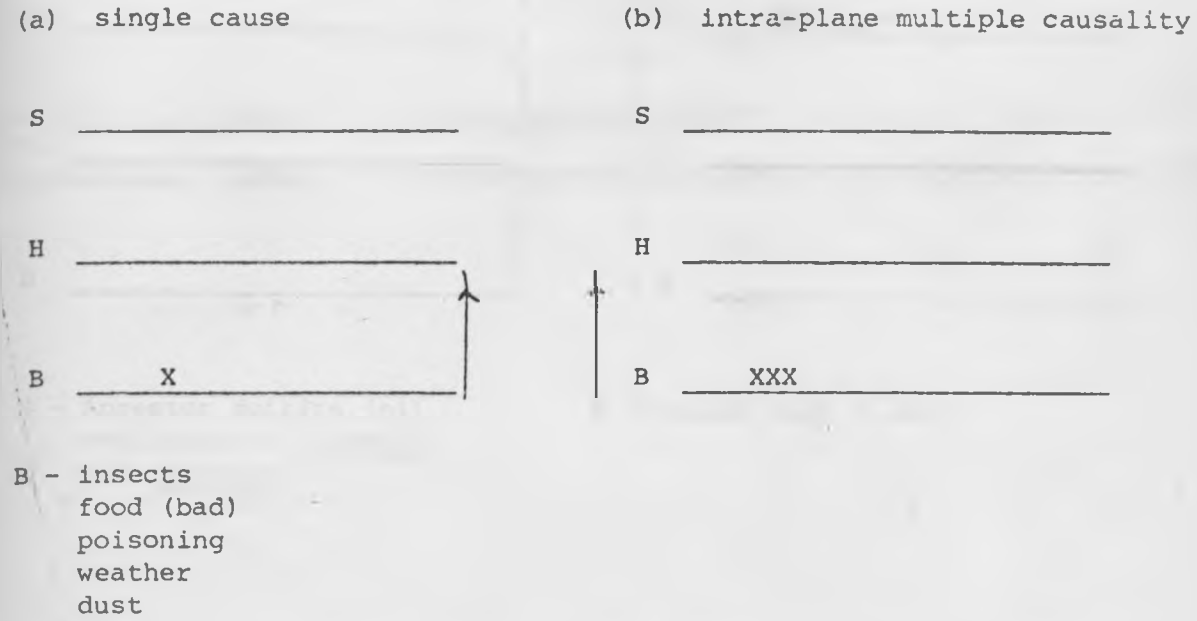
In seeking to explain how an episode of illness has been caused, Pokot usually begin with a primary definition of the illness. If the primary definition is not sufficient, they will then move onto the interpersonal and finally to the spiritual planes. In this sense it can be argued that Pokot perceive illness as a dynamic and processual occurrence. There is a developmental element in this process, because explanations begin at the how of the illness but tend to be extended in most cases to encompass the interpersonal and spiritual, the why planes. Different categories of persons tend to explain the same physical symptoms by referring to interpersonal or spiritual forces which they think are relevant for the particular episode of illness. Close kin of the patient may see the involvement of malicious individuals as contributing to the patients' debility through the agency of pan. Neighbours with no kin

links with the patient may say that the illness is due to punishment from Tororot for some hidden ngoku committed by the patient or kin. Yet others may claim that a curse invoked in the past is operative. Pokot are not concerned with the notion of planes as such, because all causal agents thought to be involved in a patient's illness have the same effect - they are debilitating. However they are aware of the different planes of causation and the differences between the how and why aspects of illness as will be shown when I discuss treatment and prevention later on.

The concept of multiple causation can be clarified by the use of diagrams. B stands for the biological plane of causation, H for the interpersonal (human) and S for the spiritual. X represents one causal agent. Arrows indicate usual progression of causation. The figures represent the ideal process of perceiving the causation of illness. Figure 3 represents the full-scale of causation. Pokot rarely mention all the causes that are thought to be involved in an illness. They are most concerned with the explanation that is considered to be socially relevant. Biological causes are rarely mentioned in explanations of illness, not because they are unimportant, but because they are assumed to be common knowledge among Pokot. They discuss the interpersonal and spiritual aspects of an illness in a lot of detail but show little interest in biological explanations. When it comes to treatment however, elimination of biological pathology is of major concern. Causation on the biological plane is viewed by Pokot in very specific terms - a particular set of physical symptoms is given a specific name and specific medicines are required. Causation on the interpersonal and spiritual planes on the other hand is rather diffuse. There is no fixed set of physical symptoms which is connected to a specific interpersonal or

Figure 1

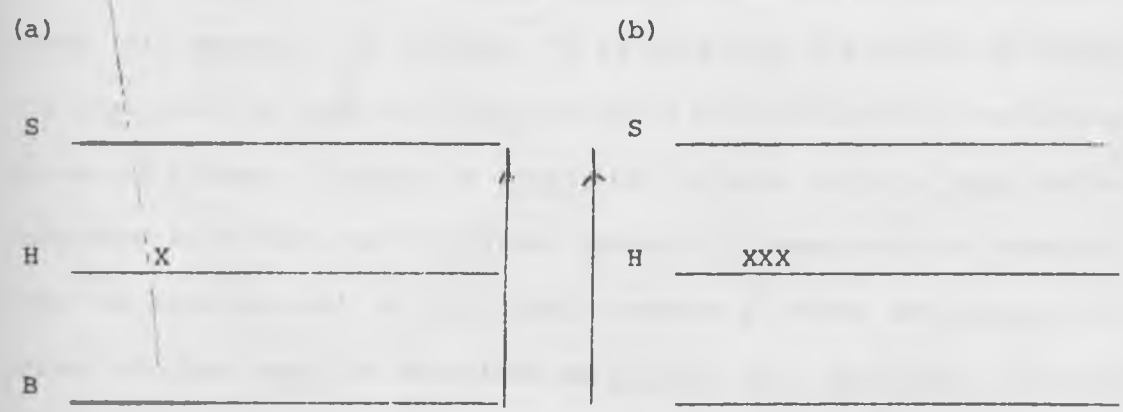
Causation on Biological Plane



B - insects
food (bad)
poisoning
weather
dust

Figure 2

Causation on the Interpersonal Plane

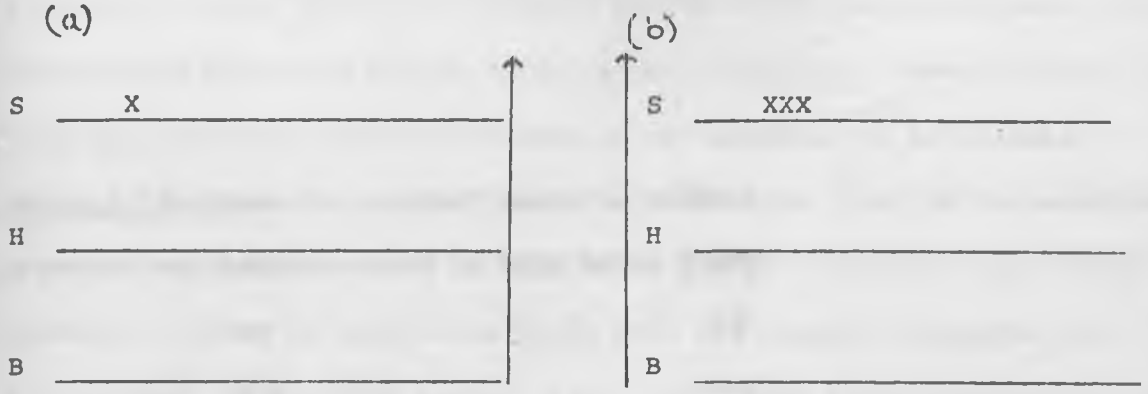


H - sexual offences
oath
curse
homicide
Pan
Eywei

H subsumes B

Figure 3

Causation on the Spiritual Plane



S - Ancestor spirits (oi)
evil spirits (onyetei)
God (Tororot)

S subsumes both B and H

spiritual causal agent. The specificity of biological causation on the one hand and the diffusness of the interpersonal and spiritual causation on the other is best shown during treatment, which I deal with later.

Having discussed how Pokot perceive illness is caused, I now turn to their concept of health. When a person is ill he is said to have semeu (pl. semewut), an illness. It is said that for him to be cured, the semeu must be removed. Semeu refers to both the primary and secondary phases of illness. Kakatan is semeu, but so also is pan. Semeu refers therefore to either the biological phase of illness only or together with the interpersonal or spiritual elements if these are present. A person who has semeu is described as chirate (pl. chiriote). Literally chirate means a person who is ill. But the term implies that somebody is "out of order". It also refers to physical malfunctioning or to a person who is below an expected medical standard, which depends on age. An old Pokot who has a minor ailment is not necessarily described as chirate, because a certain amount of malfunctioning in him is expected

because of his age. The term is also used to refer to a disturbance in a person's normal social or economic functions. On enquiring about some uncompleted task, one may be told that it is chirate - meaning that the task has not been completed because of the presence of an illness. Kesopoi "to cause to recover" means to restore to life, or to re-activate. A person who has recovered is said to be kisöp - restored, made whole or normal. A person is said to be kisöp when his physical symptoms have disappeared: to be fully healed "tilil" he should resume his normal life - including the performance of social and economic roles. When this has happened, tililin "health" is said to prevail. Tililin is used to refer to an orderly situation in a family or a community, in the absence of sickness or social discord. The term implies cleanliness, purity and moral uprightness.

Before ending this section on Pokot notions of health and illness, I wish to make brief remarks about the imputation of responsibility for an illness. On the first plane of causation, there is usually no blame imputed to human beings for the occurrence of the illness - nature takes the blame. However, if an illness on this plane is thought to result from negligence on the part of the patient or some other person, the patient or other person may be blamed for example, when a person contracts a venereal disease, they are blamed for it because it shows that a sexual offence has been committed. When a child does not seem to be growing normally and loses much weight, the mother is blamed for not feeding the child well.

On the second and third planes of causation, responsibility for the illness is in most cases imputed to the patient, his kin or other Pokot. The patient is blamed if he has committed ngoku, or neglected to perform requisite rituals if he is a household head. There is usually

little agreement about who is to blame for an illness on these two planes. An illness may be thought to involve the effects of a curse invoked to punish a thief - but the patient or his kin will blame some other person. Illnesses that are from God are not blamed on him,because He only metes out illness as a punishment for someone or a community that has committed an offence. Examples of the imputation of responsibility for illness will be given in the next chapter.

In the foregoing, I have dealt with those medical conditions whose initial causation Pokot perceive to involve biological agencies, but with the potential of progressing to include interpersonal and/or spiritual causation. There are, however, a few medical conditions which are perceived to result solely from interpersonal and/or spiritual causation. I wish to explain this type of causation by referring to infertility and mental illness.

Pokot say that it is unnatural for any human being to be infertile. It is said that both men and women are born potentially fertile. Should a couple fail to have children, it is said that the fertility of one of the partners has been tempered with. Infertility is thought to be caused by the intervention of malicious human beings using pan or as a result of a curse invoked on one or both of the partners (or their ancestors). Spirits oi and onyotei and also Tororot can cause infertility. Pokot do not say that infertility is due to some illness or congenital abnormality. When infertility occurs, the appropriate ritual should be carried out so as to "open the womb". It is usually the woman who is blamed for barrenness - but not in all cases. Pokot know for example that some men are incapable of impregnating if they are impotent.

The appropriate ritual is performed to cure infertility, but medicines should also be given by a herbalist. There are some herbalists

who claim to specialize only in dealing with infertility. In the case of infertility.therefore, Pokot think that human or spiritual agencies can somehow affect natural processes in the human body. These agencies are seen to be capable of causing a condition (infertility) which is biological and necessitating both drug and ritual therapy.

A person with a mental problem among Pokot is termed chepiyu, a term which covers a wide range of conditions from mild psychological disturbances to complete madness. The degree of a person's mental illness is indicated by the use of adjectives. Pokot say that there are two major types of chepiyu. One type of chepiyu is said to develop from any disease which "enters the head" and "spoils it". Such mental illness is treated with material medicines only. However, the majority of chepiyu cases result from the agency of human beings or spirits. Like infertility, a mental illness may be perceived to result solely from interpersonal or spiritual causation, for example a curse, pan or oi. A person with this type of mental illness should be treated by material medicines and the performance of appropriate ritual, as determined by the causation thought to be involved (see case 11, Chapter 4).

It should be stressed here that those medical problems Pokot perceive to stem from interpersonal and spiritual causation (excluding the first plane of causality) are regarded to be just like any other semeu. The fact that biological causation is not seen to be involved does not make such illnesses less real to Pokot than say a disease like malaria. That this is so has wide implications for the provision of health services to Pokot. It would seem that health services in the Pokot view must of necessity include a consideration of those social and spiritual processes which they consider pathological but which the biomedical view of disease may consider to be insignificant. They see a direct causal

relationship between interpersonal and spiritual forces and biological processes in the human body.

The view of illness I have analyzed is shared by both lay Pokot and their medical specialists. The latter, however, in most cases possess esoteric knowledge regarding the technicalities of treatment - but in carrying out treatment, the specialists make reference to the general theory of illness. The esoteric knowledge which the traditional healers have does not constitute an alternative view of illness. The ideas which specialists have regarding appropriate therapy differ depending on the various types of healers. Individual healers within a single category can possess knowledge which is their own - and this is especially so for the herbalists - who tend to have individual repertoires. The Pokot situation is therefore different from that reported for some Asian societies where professional and lay views of illness which are quite different exist in a single society (cf. Kleinman 1980, Leslie 1976).

Though the general view of illness as a multi-causal process is rarely openly rejected by Pokot, individuals often express scepticism regarding specific agencies of causation and the efficacy of certain rituals. Informants for example, expressed doubts as to whether pan and ngoku can cause disease. Scepticism regarding specific aspects of the Pokot view of illness seems to be on the increase, especially among younger educated Pokot. This scepticism is best inferred from the way such Pokot respond to actual cases of illness in which they or their kin are involved.

3.2 Treatment and Prevention

The principles of treatment and prevention held by Pokot follow logically from their theory of causation of illness. Treatment may involve

actions directed at the biological, social or spiritual aspects of human life. The different planes of causation necessitate corresponding therapeutic responses.

The first form of treatment applied to a patient is usually directed at the physical self. This type of treatment is referred to as kitö sakt which literally means "giving medicines". Kitö sakt involves materia medica considered appropriate to the physical symptoms. The medicines may be herbal concoctions, shop patent drugs or hospital medicine. Physiotherapy, child delivery, tooth extraction and all forms of surgery also deal with the physical aspects of the patient. If intra-plane multiple causality is believed to be operative, different medicines appropriate to the different causes are given to the patient. Treatment on this plane may be accompanied by regulations about food, movement and exposure to the natural environment. A patient with malaria is given purgatives and emetics and nowadays, chloroquin. He should abstain from all sugary foods and drink plenty of goats' soup. On this plane then, treatment may be described as empirical and there is thought to be a direct relationship between the medicine and the illness. Bitter medicines are regarded as being more effective in treating illness. In fact most people think chloroquin is effective in the treatment of malaria because of its bitter qualities. For the same reason, many Pokot prefer injections to tablets (or other oral medicines). The pain effected by the injection is regarded as having the same effect on the illness.

Besides kitö sakt, Pokot perform various types of rituals to effect complete cure. "Tum" (pl. tumwoi) is the term used for any ritual whether this is connected with illness or not. When an illness is considered to involve either or both the interpersonal and the spiritual planes of causation, a specific tum may be performed. The tum performed depends on

an assessment of the social and spiritual environment to determine which conditions need redressing. Most rituals performed when an illness occurs have a wide spectrum of intended action. One ritual, for example, can be performed to deal with a number of conditions which are thought to be involved in the illness. As shown later, in one ritual, Pokot may attempt to deal with several interpersonal relations and spiritual forces. Indeed one ritual may be performed because of the occurrence of many illnesses at the same time in one family. Sometimes, illness may be incidental to the performance of a ritual aimed at general misfortunes in a family or the community at large. Treatment on the interpersonal and spiritual planes is not as specific as on the biological plane.

Though kitö sakt usually precedes tum in Pokot treatment both are considered essential to enable a patient to be fully healed. Kitö sakt usually continues even when tum has been performed. Pokot say that the reason for tum is to cure the patient by removing the social or spiritual forces thought to contribute to his biological pathology. However, as argued later, it may also be important in leading to the removal, or at least the exposure, of socio-spiritual pathology. But Pokot stress that ritual, where required in the treatment of a patient, should not be neglected because this may invalidate the effect of medicines. Failure to perform tum during illness can itself be seen as ngoku, and therefore capable of afflicting people with further illness.

Like treatment, prevention of illness involves the physical, interpersonal and spiritual aspects of a person's life. Pokot believe that the body needs to be strengthened with medicines to prevent the occurrence of disease. This is done by the use of a wide variety of materia medica the commonest of which is called moykut, which every household should possess. Periodically the household head prepares and dispenses to each

member a mixture of over ten different substances (plants) in a session called ighat. This mixture is believed to possess prophylactic qualities. plenty of goats' soup is drunk during ighat and is also regarded as a necessary ingredient needed for strengthening the body.

Proper social conduct should be maintained through the observance of moral rules. Harmonious interpersonal relationships are also regarded as necessary for healthful living. Pokot are expected to refrain from harbouring bitter feelings against one another as doing so may exacerbate illness.

Pokot also emphasize the importance of appropriate prayers and sacrifices to their Creator. As already pointed out, failure to worship God through prayer and sacrifice can lead to affliction with illness. The ancestors should also be propitiated with appropriate gifts. The homage due to ancestors is however more of veneration than worship. The observance of social and spiritual rules is regarded as an important aspect of the endeavour to prevent the occurrence of illness. It complements the use of medicines thought to have prophylactic powers. Some Pokot now know that vaccination can prevent various illnesses, in fact many mothers at Chepareria indicated their desire to have as many of their children immunized as possible. The idea of immunization does not seem completely new to Pokot, because many regard it as a form of ighat.

In concluding this discussion about Pokot concepts of health and illness and how the latter should be treated and prevented, I wish to point out that their theory approximates to what in psychosomatic medical literature is called the "unified view" of illness. According to this view of illness:

> Not only are the manifestations or expressions of what we term disease seen as interconnected and hierarchically organized... but in addition, the determinants of disease are also conceptualized holistically. Disease is seen as a natural consequence of man's open relationship with his physical and social environment. Thus cause is multifactorial, processes are interconnected, and manifestations are multi-faceted (Fabrega 1974:140).

Pokot are not alone in viewing health and illness holistically. The Tiv view illness as closely related to relationships between kin, and matters pertaining to the control of land, but as Price-Williams notes, disease as a biological state is recognized by them (1962:25). Among some American Indians, bodily and mental affliction is regarded as an indicator of moral transgression against societal norms. Man is thought of as continuous with both the social and non-social aspects of his environment, and that what happens in his surroundings affects his bodily well-being. Not only a person's own actions, but also those of others around him can cause disease (Hughes in Logan and Hunt 1978:152). The Mandari, Zulu and Nyakyusa share the same view of illness with Pokot. This view of illness implies a concept of health that is more than just the absence of physical disease. However, unlike some other societies, notably the Azande in Africa, Pokot do not think that any single force (for example witchcraft among the Azande) is the ultimate cause of all illnesses.

3.3 Roles in the Management of Illness

The management of illness among Pokot involves various individuals in different roles all aimed at coping with the occurrence of illness and the social disturbances this occasions. In this section are described the various roles that exist in the indigenous health services but as is indicated in the next chapter, some of these roles are changing because

of changes in the socio-economic environment.

An episode of illness among Pokot is not traditionally an individual affair. When an individual falls sick, a number of consultations at the lay level take place to determine what course of action is to be followed in dealing with the illness. At the lowest level, the household head has a responsibility for all the individuals in the household. If one of them has a medical problem, the household head is informed about it. The household head then consults the family head (papo) who controls various households consisting of lineage members (usually three generations and rarely four). The latter then decides whether the illness is to be treated without referring the patient to a medical expert, and if a medical expert is to be consulted, whether he will be an indigenous or Western trained health worker. In cases where socio-spiritual factors are believed to be involved in a sickness, the family head will contact as many agnatic kin as possible so that an ad hoc therapy managing group is formed. The group may increase or decrease as the illness progresses and most of its members are men. Such a group is usually directed by any distinguished person among lineage members who may be residing close by.[3] The group takes full responsibility for all expenses incurred in managing the illness. Contributions are usually made from all the members of the group according to ability. In some cases, affines may join the therapy managing group as may some friendly neighbours. Affines and neighbours when involved in the agnatic kin-based therapy managing group, usually provide financial and manpower resources but do not participate in the decision-taking process. Neighbours and kin outside the therapy managing group are expected to visit the patient and express their sympathies and if need be, help out with household chores or farmwork.

Some medical problems cannot be handled by the therapy managing

group alone. For example, the Pokot prophet may advise people living in a particular neighbourhood that there is need to perform certain rituals to prevent illnesses which may result from interpersonal conflicts or failure to offer the appropriate supplications and sacrifices to God. In such a case, the kokwa (council of elders) of the area concerned will discuss and decide who should provide the required animals, food and drink and when the ritual will be performed. The kokwa also takes charge of affairs should an epidemic break out.

A number of medical experts exist among the Pokot who perform specialized medical roles. In this specialization, there is a clear distinction between male and female roles. Women have a monopoly of herbal medications and physical diagnosis. Women seem to know a lot more about the diagnosis and labelling of most common illnesses and have a wider knowledge of medicinal plants than men. Pokot claim that traditionally the sick were left at home with the women to nurse them, while the men went out to mind the cattle and defend the territory. Women are also the sole experts in child-bearing and related problems. This is a sphere where men have little to do. Childhood illnesses are mainly the domain of women experts. The sexual division of labour in therapy is shown in Table 2 of this chapter.

I now turn to a brief description of indigenous medical practitioners and their functions among Pokot. Because terms like "shaman" or "witch-doctor" have acquired stereotyped meanings and have become somewhat ambiguous, I have decided to use "indigenous healers" (or medical practitioners) when referring to these experts. The major types of indigenous healers are shown in Table 2. The table also shows the number of each type of healer found in three korok (in Tamkal, Chepareria and Mnagei) each with a population of about 600.

Pokot use the term chepsakitian literally "person of medicine" to cover all their medical experts. The term is also used to refer to the herbalist in particular. Since some of the types of healers in Table 2 are self-explanatory, I only need to explain those whose functions are not sufficiently conveyed through the table. Pokot have three main types of diviners - the cheposogoyon (sometimes referred to as chesokoyon), the pkwanyan and pkweghion. Informants claimed that the cheposogoyon is a relatively new arrival on the scene. He uses cowrie shells and a gourd to divine the secondary causes of an illness. In some cases, he may also acquire the knowledge of herbal cures so that he combines divination and the dispensing of medicines. In most cases, however, he refers his clients to a herbalist or ritual expert and nowadays the hospital. The pkwanyan is a diviner who examines the entrails of a goat, sheep or cow to determine the secondary causes of illnesses and fortell others which may occur in future. He also gives advice regarding the prevention of illness by the performance of appropriate ritual. He usually does not give medicines but refers his clients to the appropriate experts depending on the nature of the problem. The pkweghion is a diviner who uses sandals to determine the causes or likely development of an episode of illness. He is usually consulted when there is need to predict which one of two possible results is likely to occur. For example, he is approached when people want to know whether a patient is going to die or live. If a person develops a mental problem, the pkweghion will be consulted to predict whether the person will eventually be cured or become "mad" (chepiyu). The therapy managing group may also wish to know whether the patient has committed some moral offence which may be exacerbating his illness, or whether the exacerbation is due to the actions of a malicious individual using pan. The diviners of course

deal with misfortunes other than illness but in this thesis I wish to restrict myself to their role in the health-seeking process. Diviners are not approached to diagnose physical symptoms, unless they happen to be herbalists as well. They only deal with ultimate causes. The diviner's verdict is not always considered as final - sometimes it is rejected and a lay explanation of an illness prevails.

The kapolokion is believed to have access to mystical forces such as onyetei and oi. He can "direct" these forces from a person whom they are afflicting. He can also use these forces to afflict social offenders who prove a menace to communal peace. To do this, he has to be approached by the elders of the community concerned. The kapolokion can also punish a runaway wife or an irresponsible husband. In the past, he was greatly respected, if not actually feared.

The liokin counteracts the effects of pan which is brought about by the activities of a ponin. The liokin is very secretive and Pokot say that this is mainly because of the witchcraft ordinances passed during the Colonial period (see Chapter Six).

The tsin and parparin are ritual experts in the sense that they possess special knowledge regarding the procedure of ritual. They preside when ritual is being performed and they are usually very old men. The tsin presides in rituals of cleansing such as those performed when a person has been in contact with a dead person or committed a sexual offence.

The werkoyon is literally a "prophet" who forsees misfortunes before they occur and is regarded the highest authority in relation to the why aspects of illness. When epidemics occur, he advises the community what to do to get rid of it. His political roles have already been discussed.

Table 2

Pokot Indigenous Healers

		Sex	Tamkal	Peritom	Mnagei
Chepsaktian	herbalist	MorF	8	7	5
Mutin	circumcisor	M	1	O	2
Kokomelkong	clitoridectomy expert	F	2	2	2
Mutindo ngaliamunget	uvula remover	M	3	O	2
-	tonsils remover	M	-	4	O
Ghotin	tooth extractor	MorF	4	5	4
Cheposogoyon	diviner	MorF	1	O	O
Pkwanyan	diviner	M			
Pkweghion	diviner	M	-	1	-
Kapolokion	-	M	-	-	-
Tsin	ritual expert	M	2	O	O
Kama-echo	birth attendant	F	12	9	10
Parparin	ritual expert	M	5	3	2
Werkoyon	prophet	M			
			38	31	27

M = male F = female

Most of the indigenous medical practitioner roles are open to all Pokot with the exception of circumcision, clitoridectomy and prophethood.[4] It is true that most healers hand down their practice to their children but there is no rule preventing other people from acquiring specialized medical knowledge from any expert. Training to become a healer is done through apprenticeship and although there are no fixed standards, the trainer has to be satisfied that the apprentice has acquired the relevant knowledge and skills before allowing him to practice on his own.

The practitioner-patient relationship (the therapeutic interview) can be described as "active-active" because both the healer and the

client participate in trying to diagnose the illness. The same concepts are used and communication is therefore easy. The client can question or even reject the practitioner's suggestion during this process and openly say so. The client is usually accompanied by kin or friends who also participate in the therapeutic interview. Anybody who happens to be around at the time can also join in the consultation.

There are no fixed fees for consultation even among healers who perform the same work. The amount paid depends on the structural relationship between practitioner and client. It also depends on the client's socio-economic position - richer people are expected to pay more than poorer ones. In latter chapters I shall give some indication of the different fees charged by various types of healers and how this affects their attitudes to Western medicine. It is now becoming increasingly common for the healers to ask for cash payments unlike in the past when their fees were paid in kind.

There is a complicated network of referral among the various healers in any area, and this usually starts at the level of the herbalist. If the herbalist thinks that his client's illness involves more than physical pathology, he will refer him to a diviner. The diviner may then refer the patient to a ritual leader who will assist the client to arrange for the performance of the appropriate ritual. Alternatively, the diviner can refer the client to the same or another herbalist if the illness is found to require kitö sakt only. Diviners nowadays can advise a patient to go to a Western health facility for treatment. The herbalists and birth attendants also refer cases to hospital.

The practitioner-patient ratio in traditional medicine is very low compared with Western medicine in the same area. For example in Chepareria Sub-location there are 77 indigenous healers resident there, as compared

to only one modern health worker at the local dispensary.

3.4 Indigenous Medical Practices

The Pokot have, through the ages, acquired a wide range of techniques which they use for managing the various types of medical problems which they encounter. These have developed through experimentation and borrowing. Some of the practices are known to most adult Pokot and can be used by laymen, but others are the domain of medical experts with esoteric knowledge not shared by the rest of the Pokot people. An important aspect of Pokot illness behaviour is the large proportion of illnesses which are managed at the lay level. Most families keep an assortment of herbal medicines, and nowadays these are supplemented with patent medicines bought from shops.

In this section are described all the major indigenous practices which are generally accepted by the Pokot though this by no means indicates the extent to which the practices are resorted to. These major types of medical practices can be categorized as follows: herbal medication, surgery, physiotherapy, midwifery and psycho-social therapy. By far the commonest medical practice is that of herbal medication which includes mineral and animal drugs, besides those obtained from flora. Particular plants have been isolated, through trial and error, for use in managing particular diseases. Most herbal concoctions are taken orally but some are burned to form powders which can be rubbed into incisions made on the skin. Some medicines are in ointment form and are used for external application. A number of herbs are used widely as emetics and purgatives e.g. Tuyunu (Balanites Aegyptica), Kwiryon (Teclea Notulis)[5]. The use of emetics and purgatives corresponds with a Pokot belief that

the majority of the illnesses which affect human beings are lodged in the alimentary canal. Emetics and purgatives are used to expel the illnesses in faeces and vomit. Purgatives and emetics are also used to "clean up the system" even when a person is not ill. Their use is believed to prevent illnesses such as malaria.

Specific healers possess a number of surgical skills which enable them to operate on various parts of the body. The uvula is believed to cause chronic coughing and salivation when it grows too long. A Pokot expert uses a razor tied to a piece of stick to excise the uvula, which is then pulled out, having been tied by a string. It is claimed that this operation brings instant relief to the patient. Some healers specialize in draining abscesses using locally made instruments. Scarification of the body for aesthetic purposes is also widely practised by the Pokot. Circumcision of boys and clitoridectomy of girls are carried out on all Pokot without exception. The operations are carried out only by experts and various medicines are used to get the wound to heal quickly. A number of Pokot sustain head injuries and need operations. The Pokot do not have trephining experts but they invite them from neighbouring Marakwet to carry out the operation.

Pokot employ a number of physiotherapy techniques, the most important of which are massage and bone setting. Massage is carried out by women to relieve minor aches, pains and constipation. Most Pokot men, though not all, know how to set dislocated or fractured bones and this is done using bark "plasters" tied with plant fibre. Minor cuts are sutured using buffalo tail hairs. Pokot use steaming to treat measles but this technique is relatively new among them and is not used all over the area. The child with measles is seated in front of a mixture of herbs in water which has been boiled. He is covered with a blanket and the

steam is inhaled and soaks the whole body. The illness is then believed to be expelled from the patient.

Some Pokot are experts in tooth extraction. Decayed teeth are removed using homemade instruments and some medicine applied to stop sepsis. It is a custom to have two incisor teeth on the lower jaw removed. Sometimes the lower lip is pierced so that a passage is created into the mouth through the gap left when the incisor teeth have been removed. Informants said that this gap was made so that a person could be fed through it when the jaw bones became stiff during a tetanus attack. But the piercing of the lip could also be having some cultural meaning, because it is usually decorated with a wooden or metal plug (aponoi).

It is estimated that in 1980, about 6000 babies were born in the District. Of these, only about 1500 were born in modern health facilities - the rest, 75% were delivered in Pokot homes.[6] Traditional midwives carry out most of the baby deliveries not just because there are few modern health facilities in the area, but because Pokot mothers have great faith in their skills. The birth of a baby is not regarded as an illness, but as an important social ceremony where women play a leading role. Pokot mothers claim that delivery in hospital deprives them of the company of other women, worse still, the presence of men during labour is resented. However, Pokot midwives accept the fact that they cannot handle certain complications and especially those requiring surgery. Such cases are increasingly being referred to Western health facilities.

As already stated Pokot may think it necessary to complement treatment with materia medica (kitö sakt) with the performance of healing ritual. The ritual performed depends on the assessment of the socio-spiritual environment to determine which secondary causes of the illness need to be dealt with. Though such rituals are also referred to as tum

"ceremony", they are specifically referred to as saapka (pl. saapken). In this discussion therefore I use saapken when referring to those rituals which are performed mainly in connection with illness. Space does not allow detailed discussion of all healing ritual so I only provide information sufficient to convey a general impression about the role of ritual in the health-seeking process.

Kisoyonet is performed when a household head is faced with recurrent unexplainable illnesses accompanied by interpersonal discord among members of the household. Informants said that kisoyet is a blessing ceremony which should be performed to ensure God's protection. The household head informs a number of elders, usually at short notice. The elders spit on a bunch of green leaves which are then placed on the man's head. They then chorus the following words

Inyoru sopon	Get life
Inget - inget	Be lifted (2)
Lenchino oi ingeta	Let the spirits go
Lenchino tinyon ingeta	Let the colds go
Anyi ye-inget	All will be - go
Karam ye - inget	Everything is all right - go
Isop - Isop - igh - igh	Live live - do - do
Soro - soro	Thanks - thanks

After the chorus, an elder assures the patient that the ancestors and God have heard the prayer and will henceforth offer him protection. He is told that his household will be as healthy as green leaves on a tree by the riverside. Spittle is usually used as a sign of goodwill. According to informants, the elders' spittle has therapeutic efficacy because it comes from the heart, the centre of life. No animal is slaughtered during the ritual. The sick person need not be present at the ritual performance; it is only necessary that the household head be

present.

Moi chepkompis is performed when an ill omen is seen (e.g. an owl landing near the homestead or a donkey entering a house). When an omen has appeared, any illness in the family will be seen to involve spiritual causation - depending on the socio-spiritual environment surrounding the illness. If there is no illness when the omen occurs, moi will nevertheless be carried out to prevent illness heralded by the omen from occurring. A single moi may be performed for several illnesses in a family. Unlike kisoyonet, moi is not restricted to elders only. Women and children participate and usually there are not less than twenty people present.

The main part of the ritual consists of singing four choruses repeated several times. The patient(s) sits in the middle of a circle formed by all those present, with the oldest people and close kin in the inner side. Younger people sit farther away from the patient. A goat skin is tied over the mouth of an earthen pot so that it vibrates when pressed with a stick, producing a sound like that of an owl. As the owl-like sound is produced, the old people present beat the ground with their sticks. Informants said that the sticks "kill" the sound produced from the skin-covered pot. Pokot say that whichever force is afflicting the patient is as evil as the sound of an owl (produced by the pot and "killed" with sticks during the ritual). The words of the four choruses sung during moi change from time to time, but there is general agreement about what message each of them carries. The first chorus refers to the purpose of the ritual - people have gathered to ask God to expel malicious spirits troubling them. The second chorus consists of exclamations to the effect that the spirits involved in the illness are indescribable and dangerous. The third song orders the spirits to go, to sink and fly away. The fourth chorus usually expresses what the people wish and expect to happen. I reproduce the version of the fourth chorus

which I recorded at a moi I attended in Chepareria:

If it is the oi let them go - they will go
If it is the onyet let it go - it will go
If it is Tororot he will leave him - let him leave
Tororot help us
He who sees, let Him see
Let the stars hear
Let the rivers hear
Let the milk trees hear
Let all be so - thanks - thanks

The words used in the second chorus are those which Pokot regard as obscene. Informants said that the obscene words are used so as to embarrass the spiritual forces concerned in front of the congregation so that they may run away. A goat is killed for the occasion and all the meat is eaten by those present. None is offered to the ancestors or Tororot.

Kikatat is performed when or if an illness is not cured after the performance of either kisoyonet or moi chepkompis. It is believed that kikatat becomes necessary if the patient or some kin has committed some serious ngoku or some very powerful pan is operative. It is important, therefore, that those concerned should confess to the elders any moral offences they may have committed. Old senior elders, poi, can participate in kikatat. There is no singing during the ritual.

A cow is slaughtered and its hide removed. The senior elders stick their sheathed spears on the hide and raise it off the ground and cover the patient with it. One elder then addresses God saying

The man has confessed his ngoku
Now let him have life
Let him move
Now we lift the illness from the man
Let's throw it away - it will go

The elders then remove the hide from the patient and throw it away in the bush. They fight a mock battle with the forces believed to be afflicting the patient, but which have now been thrown into the bush with the hide. War cries are sounded and the bushes speared until one elder pronounces the forces dead. The meat is eaten and the elders perform the blessing ceremony (kisoyonet) described above to conclude the ritual.

The rituals so far discussed are performed in response to a wide range of illnesses. Two remaining rituals pütat and kilokat, are performed for a number of illnesses thought to involve pan and yomat respectively. Pütat is performed when it is thought that pan has been directed to afflict the patient. Some people threaten to use pan openly but in most cases its agency in illness is known through divination or by assessing interpersonal relationships. During the ritual, the patient (or a parent if it is a child) names the people he suspects to be afflicting him. These people are called and asked if they accept the allegation. Should a person accept that he is afflicting the patient, he is told to spit on him and promise to revoke the pan. If no-one accepts responsibility for the illness, the elders form a circle and pointing their spears down, curse whoever is afflicting the patient. They then proceed to nullify the effects of pan. The patient is made to sit on the ground and one of the elders works over him (see Plate 7). The patient is then given a piece of mo·kut (cyperus articulatus which Pokot say has both medicinal and mystical therapeutic efficacy. In the past, lengthy litigation followed the accusation or admission of using pan, because the guilty party was usually speared to death. There is no request made to God, because as informants put it, pan is not caused by Him, but by human beings. But ancestors are mentioned because it is believed that

they assist the person using pan to do it successfully, but also assist the patient to recover. The ritual closes with a short chorus

We, the elders have said
The pan will go
The ancestors have heard us
Yes, we have said
He will get life (the patient)

Kilokat is performed for people thought to be afflicted with yomat. The ritual is relatively new among Pokot and not many people know about the relevant details. It is not performed publicly, though there is no harm in a few people from the neighbourhood watching the performance. In most cases however, only the members of a household participate, and a cheposogoyon directs the performance. The salient part of the ritual consists of the sacrificing of a goat near a river. The cheposogoyon performs the sacrifice and invites God to "eat" the meat and heal the patient. The rest of the meat is eaten by the patient and his family, and the cheposogoyon mixes it with medicines.

Before I close this discussion of Pokot practices and beliefs related to illness, I need to make some general remarks about the efficacy of ritual in the health-seeking process. A detailed discussion of this subject is beyond the scope of this dissertation so I restrict myself to a few relevant issues. The central issues here are firstly whether ritual actually works and secondly, how it works in the therapeutic process. Some social scientists for example, Thomas (1971) have argued that some ritual performances in healing may actually be superfluous, because most illnesses are self-limiting anyway, and will recover whether ritual is performed or not. Some scholars have focused on the psychological effect of non-medicinal intervention on the human body. The placebo effect has received much attention - Mechanic (1968), Friedson (1972) and Shapiro (1960). While there is evidence which

suggests that placebos can affect the physiological state of the patient, I do not think it is adequate to judge the efficacy of ritual on the basis of whether it eliminates physical symptoms or not. I shall return to this matter presently.

Anthropologists have done a lot of research on ritual in general which has some relevance to the role of ritual in therapy. Most literature on ritual has focused on the communication of meaning through symbols. As Lewis has shown (1980) there still remain many unresolved problems regarding the interpretation of "codes", who is communicating to whom and what a symbol is. These issues apart, a few examples of the anthropological interpretation of ritual in healing are in order.

Levi-Strauss (1968) in seeking to answer the question as to how what he calls "psychological representations" are involved to combat physiological disturbances, and referring to a song used by shamans among the Cuna of Panama, says:

> In our view, the song constitutes a psychological manipulation of the sick organ, and it is precisely from this manifestation that a cure is effected. The cure would consist, therefore, in making explicit a situation originally existing on the emotional level and rendering acceptable to the mind pains which the body refuses to tolerate. The sick woman believes in the myth and belongs to a society which believes in it (1968:197).

Levi-Strauss then goes further to suggest that the effectiveness of symbols in healing consists in their inductive property by which formally homologous structures built out of different materials at different levels of life - organic processes, unconscious mind, rational thought - are related to one another.

Turner's work on the Ndembu (1968) brings out another dimension of the role of ritual in the health-seeking process. He suggests that a ritual should not be seen as directed to the sick person only - but

to the whole community. Gallin (in Kleinman et al 1978) goes along with Turner's views by stating that in the Chinese sacred medical system:

> The ritual which frequently accompanies the diagnosis of illness serves as a kind of group therapy session in which concerned participants discuss problems and their sources. At the same time, this ritual, in its resemblance to a social event, provides a certain amount of levity, or release of tension (p.176).

While the contribution anthropology has made to our understanding of the role of ritual in healing in non-Western societies is acknowledged, I think that a fundamental weakness still remains. The assessment of the efficacy of ritual in the treatment of illness is usually based on the Western biomedical paradigm, where efficacy is understood as the capacity to remove physical symptoms. The suitability of the Western biomedical paradigm for assessing the efficacy of therapy in non-Western societies can be questioned (Kleinman 1980, Young 1976). Young, for example, suggests that in determining whether therapeutic action has been effective, a distinction should be made between effectiveness as what people hope will happen and what they expect may happen. The two meanings are in some cases congruent - treatment as hoped and expected, restores the patient to health. But treatment has "worked" in the sense that it has met the expectations of family and friends as to what should be done and it has perhaps produced epxected clinical evidence that the diagnosis has been correct (p17). The implication of Young's argument is that in attempting to interpret say, the efficacy of ritual among Pokot, it is important that we consider what they expect to achieve through the performance of ritual during the health-seeking process. Lewis, in the above publication on the problems of interpreting ritual, makes the same point as Young but in a different way.

While not dismissing the significant role of the analyst in interpreting ritual, Lewis (op.cit) is very critical of the emphasis hitherto

given to the communication of meaning in code through symbols. He underscores the need to take seriously the actors' emotional and aesthetic responses to ritual and the reasons they give for ritual performance. He says that "we must find out what purpose or motives people give for their actions and what meanings they attach to them" (p.218). The message which Lewis conveys in his book seems to me to be that the cognitive or intellectual component of ritual should not be overstressed at the expense of the emotional, expressive and instrumental components. I therefore provide a few of the Pokot explanations of and responses to the rituals they perform in their health-seeking processes.

I attended a number of performances of healing ritual in various parts of Pokot. In response to my enquiry as to why the ritual was being performed, I got three sets of answers. The commonest answer was, as one informant put it, to "fulfil the requirements of therapy" - because it had always been the custom. It was implied that by performing appropriate ritual, the therapy managing group absolved itself from any responsibility for the illness. I have noted earlier in this chapter that to Pokot, failure to perform ritual can itself lead to further affliction with illness.

The second explanation Pokot gave for performing ritual when faced with illness was that through ritual, God is beseeched to activate the medicines given to the patient so that he can be cured of the physical symptoms. Though the potency of the medicines on their own is acknowledged by Pokot, they also say that their efficacy can be increased by God. Ancestors are also asked to plead with God to activate medicines. In fact many informants claimed that saapka is a form of acted prayer.

Pokot also give a third explanation of the rituals performed

during the health-seeking process. They say that the ritual removes the sins (ngoku) and the spirits which may be contributing to the illness. It is also said that though the liokin can deal with pan, some of it is so powerful that the elders have to order it out of the afflicted individual or family during a ritual performance. Pokot say that a community with sin, spirits and pan is bad. An illness reveals the presence of these unpropitious forces. They say further that it is only God who removes spirits and sin, but the elders can deal with pan without the assistance of God.

Pokot say that it is important that close relatives and neighbours of the patient should attend ritual. Failure to attend a ritual performance on the part of a relative or a neighbour is regarded a serious offence. Though jokes may be shared during certain parts of the ritual performance, it is usually a very solemn occasion. Food (and drink) eaten and drunk on such an occasion is shared out strictly according to the age and sex of the participants, with the elders getting their share first if they are the protagonists. Elderly women get their share first in the performance of ritual where they are the protagonists.

Like the Taita (Harris 1978) Pokot do not think that a ritual is ineffective if the patient fails to recover after its performance. When this happens, Pokot say that may be the right medicines for the illness have not been given the patient. They may also say that the right procedure was not followed during the ritual performance. Another explanation Pokot advance when a patient fails to recover is that there is a malicious individual who is using powerful forces to invalidate the ritual.

My reason for including the foregoing is to emphasize the points made by Young and Lewis, viz. that to judge the efficacy of the rituals

performed by Pokot, we must do so in the context of their medical paradigm, a summary of which I have given in the first half of this chapter. As I argue later, what is thought to be efficacious according to the biomedical frame may not appear so to Pokot, and vice versa.

Footnotes to Chapter Three

1 The novice's mother is assisted by other women to instruct her while she kneels down attentively.

2 I have discussed the concept of multiple causality in these societies in an unpublished M.Phi. dissertation (1979) Department of Social Anthropology, University of Cambridge.

3 Not all lineage members reside in one place. They may be scattered over several parts of Pokot country.

4 The mutin, kokomelkong and werkoyon can only come from specific clans.

5 Cf. Tanaka, J. 1981. Some of the commonest herbs used by Pokot in Chepareria are listed in the appendix.

6 Annual District Medical Report, 1980 Kapenguria Hospital, and Hospital In-patients records, Ortum 1980.

CHAPTER FOUR : INTRA-SOCIETAL VARIATION IN ILLNESS BEHAVIOUR

In this chapter I wish to discuss a number of factors which influence the choice of therapy among Pokot. The main purpose of the discussion is to explain the existence of variation in illness behaviour in spite of generally accepted concepts of health and illness in the society. In section one, the main arguments are stated and the general background to the problem provided. In section two I consider the intervening variables which account for variability in Pokot responses to illness and some case histories are presented to illustrate the arguments. In section three I carry the theme of variation further by showing the varied response to the introduction of rehydration as a therapy for infantile diarrhoea in Chepareria. Section four consists of an examination of the theory of illness and how it facilitates variation in illness behaviour and the assimilation of new elements into the Pokot health-seeking process.

4.1 My experience among Pokot showed that while the concepts of health and illness discussed in Chapter Three are generally accepted, the therapy utilized does not always match the perceived cause of an illness or the classification of medical conditions (into those which are treatable by traditional and Western forms of therapy respectively). Stated in another way, beliefs about the causation of illness are not deterministic in that given only the perceived causation of an illness, one cannot accurately predict the form of therapy that will be chosen. In several of the cases I observed, theory and practice were evidently incongruent. Pokot exhibit a high degree of pragmatism in their choosing of therapy. The overriding concern seems to be the expected or perceived efficacy of a form of therapy and not its theoretical correctness. In a

number of cases, principles relating to the treatment of an illness were manipulated to suit the specific socio-economic conditions in which an illness occurred. But though deviations from the norm occur repeatedly in illness behaviour, my informants insisted that what determines the form of therapy chosen is its perceived causation. When the therapy utilized does not seem to be appropriate according to the perceived causation, Pokot try to justify their actions by referring to some aspects of the theory of illness which supports what they have done. Such justification may be considered unnecessary where non-normative therapy has proved effective in curing the patient. These observations made it incumbent upon me to pay particular attention to the factors which lead to varied responses to illness whose perceived causation implies certain standard procedures of treatment. Before I discuss these factors in detail, I turn briefly to some studies of illness behaviour and assess their contribution to this discussion.

Most published literature on the management of illness in Africa reveals an over-emphasis on the role of notions of causation in illness behaviour at the expense of many other factors. For example, Buxton (1973); Harwood (1970); Imperato (1977) and Ngubane (1977), while they make useful contributions to the understanding of illness behaviour in Africa, depict a degree of uniformity in responding to illness in the societies they have studied which even some of their own material cannot support. This is mainly due to their interest in what these societies consider to be the ideal way of responding to illness. Not much attention has been paid, in these studies, to deviations from the prescribed procedures for dealing with illness. Because of the over-emphasis on ideal practices, other factors within and outside the societies which are important in influencing the choice of therapy have not received adequate attention, and because of this, intra-societal variation in

the management of illness in Africa is often assumed not to exist. A move in the right direction has however been made by Ademuwagun et al (1979); Janzen (1978) and VanEtten (1976) who have studied the role of factors other than the theory of illness which exert a lot of influence on the choice of forms of therapy. Van Etten, in a study of rural health development in Tanzania, shows how the varied utilization of traditional and Western medicine is influenced not only by notions of causality but also by the availability of health facilities and demographic aspects of society (ibid:83-87). Janzen, in a study of the health-seeking process among the Bakongo of Lower Zaire, shows that the variables which influence the choice of a form of therapy include: the therapy techniques deemed appropriate for the illness; the types and relationships of those who constitute the therapy managing group and the symptoms and signs of the illness. Though he shows an awareness of the role of resource limitations in the choice of forms of therapy, he does not discuss this in detail (p.221).

Increasingly, medical anthropological studies are showing that variation in illness behaviour is not restricted to complex, Western societies; it also occurs within even small, and apparently culturally homogenous societies whose members share similar concepts about health and illness. For example, Ahern shows that diversities observed in Taiwanese illness behaviour can be accounted for if demographic characteristics and the developmental stage in the life cycle of individuals are considered (in Kleinman et al 1978:101-111). Topley has identified some of the social and cultural determinants of variation in illness behaviour in a community in Hong Kong where both Chinese and Western forms of therapy exist (ibid:111-142). Hesler has rightly pointed out the need to focus on intra-societal variation in studying illness behaviour. He

states that:

> ...earlier research which explicitly or implicitly posits cultural or ethnic homogeneity in studying an ethnic group's illness behaviour appears to be problematic. Uniformitarianism of this order can lead to one's neglecting to appreciate and consider the complex network of independent variables and to which the dependent variable , illness behaviour, varies within a seemingly homogenous ethnic group (in Logan and Hunt 1978:362).

Chrisman (1977) makes the same point in connection with anthropological research in health-seeking among American subcultural groups. He suggests that such research should focus on both the similarities and diversities in illness behaviour at the intra-cultural level (p.351). Mechanic (1968) lists 10 factors which he says affect therapeutic actions (lay) in any society. Some of these factors include how symptoms are perceived, how they disrupt family work , needs competing with illness responses, competing possible interpretations and availability of treatment resources (p.130-31).

The need to focus on intra-societal variation in illness behaviour in Africa has become more urgent than ever because of the rapid socio-economic changes through which societies like the agricultural Pokot are going. These changes are being accelerated by the increasing presence of Western education, Christianity, cash crop farming and the National health care system. By making the basic assumption that variability in illness behaviour is a normal feature of the health-seeking process among Pokot, one is inevitably led to the identification of those factors within the Pokot physical and socio-economic environment and the Kenyan nation as a whole which interact with the society's theory of illness to determine what the people do in attempting to heal the patient. I posit therefore that though Pokot share common concepts about the causation of illness and how it should be treated, the response to the occurrence of any specific illness can vary in time and space. I further posit that

the varied response to illness perceived to have similar causation is due to factors whose presence (or absence) hinders the utilization of the therapy thought appropriate according to the perceived causation of the illness or the related classification of illness into those best treatable by traditional and Western medicine respectively. An analysis of several episodes of illness and informants' comments leads me to suggest that there are five major factors which contribute to the varied response to illness among Pokot. These factors include: the perceived efficacy and the practicability of a form of therapy, availability of health resources, social and moral constraints and individual judgement (interpretation) of an episode of illness.

In any episode of illness, one or all of these factors may exert influence on the therapy chosen. In the next section, I show how each of these factors may exert the critical influence in a specific episode of illness. Before I present various case histories illustrating the operation of the various factors, I wish to indicate in general terms, the nature of variation in illness behaviour I observed in Chepareria.

In principle, Pokot hold that when interpersonal or spiritual factors are thought to be operative in an illness, the appropriate ritual should be performed otherwise the illness will persist or the omission of ritual will become etiological. During my stay in the community of the core sample, there occurred a number of episodes of illness where socio-spiritual causation was implicated. However ritual was not performed for all these illnesses even when divination or discussions among kin had established the need for ritual therapy. In some of the cases, ritual was totally omitted while in others it was postponed until a later time. In some of the cases where ritual was performed, an element of substitution was discernible. Such substitution took one of two possible forms.

In some cases, one traditional ritual was substituted for another, and in most cases when this happened, a less costly but less appropriate ritual could be performed instead of a more costly one. For example, when Marko was unable to arrange for the performance of a required ritual because of a recent mishap in his family, a group of elders gathered in his compound and offered collective saghat (to God) to heal him, though it had been divined that moi was the appropriate ritual needed. Another form of substitution which is becoming increasingly common involves the offering of Christian prayers for illnesses thought to require a particular Pokot ritual. In fact, Christian prayers were offered even in some cases where the patient or those managing the case were not normally church people. It should be stressed here that even where omission, deferrement and substitution occurred in healing ritual, the relevance of the ritual itself was not necessarily disputed - usually attempts were made to justify the alternative actions taken by referring to the fluid concepts of causation. For example, where Christian ritual was performed instead of a specific traditional one, it was sometimes argued that the God who Pokot Christians pray to is the same one who is the objective of traditional ritual. When cases involving the omission, deferrement or substitution of ritual are examined, and though the actors themselves may not state so, the various factors listed above are seen to be operative to different degrees according to the context of the illness.

Intra-societal variation in illness behaviour is not restricted to illnesses thought to require ritual therapy, but occurs also in the management of illnesses thought to require only kitö sakt. Adult Pokot are expected to, and in most cases do, know which therapeutic options should be used on the occurrence of most common medical problems. For example, they should know which problems can be managed at the lay level

(lay therapy includes the utilization of both indigenous materia medica and techniques and Western drugs purchased from shops or obtainable from other sources). They should also know which problems require expert therapy of either the indigenous or Western types which have been described in the last two chapters. Most informants could list several common illnesses and the therapeutic options known to be appropriate to their management.

In actual episodes of illness however, the therapeutic actions taken do not necessarily correspond to those prescribed by custom. Before I discuss specific episodes of illness, I wish to show variation in the management of measles and malaria (whose causation and treatment is known to practically every Pokot) which I observed in Chepareria.

Measles (sonsar) is a disease that is dreaded by Pokot women because a single epidemic can claim the lives of several children. Elaborate regulations about the management of this disease have developed and mothers are expected to observe them when their children catch the illness. A child with measles should stay in the shade and not look directly at the sun's rays. The rash should be induced by smearing the child with a mixture of sorghum flour and water all over the face. The child should be given honey beer to sip now and again. The regulation stressed most in connection with the management of measles is that the child should not be injected before the rash erupts. For this reason, a child with measles should not be taken to a Western-type health facility.[1] It is believed that if a child is injected before the rash erupts, he will die.

While I was in Chepareria, two epidemics of measles occurred. During both epidemics, I was surprised at the number of children suspected by their mothers of having measles who were brought to the local dispensary

and given injections to prevent complications. When I enquired as to why the mothers were acting contrary to Pokot prescriptions regarding the treatment of measles, various answers were given. Some mothers claimed that in the past, some children who had not been brought to the dispensary when they were suspected of having measles had died any way. Others said that some children who had been injected while having measles had survived the attack. But some mothers kept their children away from the dispensary and applied the therapy prescribed traditionally.

Some mothers did not use either the treatment traditionally used for measles or dispensary treatment. They used a form of therapy which involves steaming the child by covering him with a blanket and seating him before a pot full of boiling water. It was claimed that the steaming helps the child to breathe easily. Pokot do not mention this form of managing measles when asked to say how the disease is treated, but I observed its use several times. Those mothers who used it said that they have found it effective in the management of the disease.

While most mothers kept children with measles in the shade, they rarely gave them honey beer. Some told me that the beer is too strong for children. Some protestant mothers said that it was wrong to give beer to young children, so they used soft drinks bought from the shops instead. One thing however, about which the mothers agreed was that measles is caused by wind.

In Chepareria, as elsewhere among Pokot, it is believed that the substance which produces malaria symptoms is a greenish-yellow liquid lodged in the stomach (bile). To cure the illness herbal purgatives and emetics should be used to expel the substance from the stomach, and to ensure that this has happens , the vomit and stools are examined to see if they have a greenish-yellow colour. Chloroquin is now perceived to be

effective in the treatment of malaria but Pokot say that it only subdues, but does not expel it from the patient. To prevent malaria from recurring, chloroquin should be complemented by the use of the indigenous emetics and purgatives. Even educated Pokot expressed their support for this double-therapy for malaria.

My observations indicated however, that while this double-therapy for malaria is the ideal treatment in practice as many Pokot as apply it do not carry it out. Most old folk in Chepareria still stick to the traditional emetics and purgatives, saying that chloroquin is not as effective as the medicines they have always used. But the majority use it and in most cases without using emetics and purgatives. Lukchu for example told me that he does not use purgatives and emetics because his body has been so weakened by the use of sugar and salt that it is too weak to withstand the effects of the traditional medicines. Some people said that since they had proved that chloroquin on its own cures malaria, there was no need to complement it with the indigenous drugs. Others said that they knew of people who had died after using purgatives and emetics, so they feared using them. Those in Chepareria who had access to the mass media said that it was the medicine recommended by the radio and newspapers, and must therefore be good. In spite of the different reasons given for using chloroquin for the treatment of malaria, informants were well aware of the fact that it is effective in curing the disease.

4.2 Episodes of Illness Illustrating Variation in the Management of Illness

In attempting to account for the varied responses to illness I observed among Pokot, I find it useful to use the case history approach which Janzen (1978) has used successfully in his study of the Bakongo. In this section therefore, I present a number of cases which illustrate

the role of various factors (listed above) in influencing the choice of therapy for the management of specific medical conditions.

It should be pointed out here that even where he is an adult, it is not necessarily the patient himself who takes decisions regarding appropriate therapy. As reported for a number of African societies, kinsmen or neighbours and friends take a keen interest in the illness of one of their members.[2] These are usually lay men as far as illness is concerned. The lay people participate in the illness by helping with definition, suggesting therapy, assisting with chores, giving material aid to cover the expenses of treatment and being involved in ritual. Though diviners are consulted, their advice is not followed in every case. It is now becoming increasingly common for teachers, shopkeepers or church leaders to be approached for advice regarding therapy instead of kinsmen and ordinary neighbours. This is mainly because teachers, shopkeepers and church leaders have more knowledge about Western forms of therapy than most other Pokot. By the time the patient reaches a medical practitioner, much discussion and decision-taking has occurred. In this aspect of their health-seeking process, Pokot do not depend as much for decisions about therapy on diviners as the Ndembu (Turner 1967) or the Azande (Evans-Pritchard 1937).

Case 1 : Lopes the herbalist

The first case involves Lopes, a herbalist. Lopes claims that he can cure most illnesses known to Pokot. He says that Pokot therapy goes further than mzungu[3] therapy because the latter does not consider all the forces which contribute to illness. Though he is a pleasant man of about sixty years of age, he has never attracted a large clientele. Lopes is a widower because he refused to marry after his wife died some years

ago. His three sons who are all married take care of him. In fact many of their children sleep in his hut. For a long time, Lopes and another healer, far younger than him, have not got on well though they both belong to the same clan. I came to learn that the problem started when the younger healer came back after a year's absence, claiming that he was a chepsaktian and that he had been trained by a Luo mganga.[4] Towards the end of 1980, Lopes started complaining of an eye problem. He applied some medicines which he concocted himself but the condition became worse. His sons suggested that he see an eye specialist in Kapenguria but he was reluctant because he had never been to the hospital before. He went and consulted a diviner who told him that the eye problem was due to pan which the younger healer was using to blind him so that the former could stop his practice. Lopes was instructed by the diviner to use the juice of a certain plant as eye drops. Though he tried the juice recommended by the diviner, his condition became worse, and by this time, there was a continuous discharge from both eyes. When he could hardly see, he called his eldest son and told him that he wanted to be taken to Kapenguria Hospital, but in strict privacy. Lopes and his son rose very early and walked the twenty kilometres to Kapenguria Hospital. He was given an appointment for the following week. He stayed with relatives near the hospital and after a month and a number of visits to the hospital, he had fully recovered. He came home and claimed that he had been to consult a famous healer (Pokot) in Chesegon. However, it was soon known to many people that he had been treated at Kapenguria.

Some more facts need to be stated before I make comments about the case. Eye infections, especially trachoma, have a very high incidence and prevalence in most of West Pokot. Traditional Pokot treatment is not very effective in curing eye diseases. There is a special opthalmological

unit at Kapenguria Hospital which has now become popular among Pokot who have been treated there and who have seen others cured after receiving treatment there. Most of Lopes' grandchildren had been successfully treated at the unit, as had a number of other children in the neighbourhood. His eldest son took time to point out to Lopes various people, and especially the grandchildren, whose eye problems had been treated successfully by mzungu medicine at the hospital.

Case 1 illustrates what I think is the crucial factor in the process of choosing treatment among Pokot; the perceived efficacy of therapeutic action. In many of the episodes of illness I witnessed, the overriding concern seemed to be the effectiveness of particular therapeutic actions in curing the patient. Perceptions about the effectiveness of a course of action are influenced greatly by experiences Pokot have had of particular illnesses and how they have responded to various forms of therapy. There is an element of cost-benefit analysis as it were, in choosing therapy. Lopes was aware of the fact that a number of his grandchildren had been successfully treated at the District Hospital when they had contracted eye infections. It is also interesting to note that though pan had been implicated in the illness, a year later when I left the field, no pütat had been performed by Lopes though he intimated to me many times that he felt threatened by the young healer who he believed was using medicines to eliminate him as a competitor.

Perceived efficacy of a treatment arises from repeated associations between a form of therapy and cure. The association may be due to a causal link between therapy and cure or pure chance - the latter is usually the case in some acute, self-limiting ailments like the common cold. What is important is not that the treatment should actually cure the illness, but that the cure should be perceived to follow from the

treatment. In their experience with illness and various forms of medicines and practitioners, individuals have come to associate such medicines and practitioners with the cure of specific illnesses. I found for example that different households prefer certain painkillers to others, though the painkillers only differ in name. There is also a belief that certain medical practitioners have "blood" which agrees with specific patients. Such healers need not be traditional ones only; particular nurses or clinical officers for example may be picked on by a certain household, and the same is also true for indigenous healers. A number of households for example claimed that certain bush doctors are very effective in handling family illnesses. This obviously does not depend solely on the drugs the bush doctors use, for in many cases a single drug is used for almost any of the illnesses referred to these "doctors". What is crucial here I think is that it is expected that a patient will recover and such expectation may prejudice the evaluation of the therapeutic efficacy of the bush-doctor's intervention.

The significance of perceived efficacy in influencing the choice of therapy can also be illustrated by referring to a cholera epidemic which occurred among Pokot when I was in the field. Traditionally, cholera, as other epidemics, is thought to be a punishment from Tororot because of sins committed by a community or the whole Pokot society. The first time the epidemic broke out (April-July 1980), various werkoi prescribed the sacrificing of oxen to stop patients with cholera from dying. The usual treatment for diarrhoea was also administered. Soon after the epidemic broke out, the government set up centres in various parts of the District to immunize people and treat those who contracted the disease. At first, most Pokot were doubtful of the efficacy of the immunization and treatment for cholera offered by the Ministry of Health.

However, it soon became apparent that the Western therapy offered was effective in preventing the death of patients with cholera - when in the following year another cholera epidemic occurred, patients were quickly taken to the treatment centres. There was also a corresponding decrease in the number of oxen sacrificed - though Pokot understanding of the causation of cholera had not changed.

The above two examples show the importance of perceived efficacy as a factor influencing the choosing of therapy. The perceived efficacy of a therapy may be unique to a single household or general to a whole community. It also changes over time. Lopes in case 1 did not decide to go to hsopital because of the beliefs about the causation of his eye problem, but in spite of them, because pan was thought to be involved, and Western medicine does not deal with pan. He was reluctant at first because he did not want to admit that he, as a healer, was incapable of treating his illness.

Pokot faced with an illness may consider a certain form of therapy to be efficacious in curing their patient but find that it is not practicable to utilize it. This is revealed in the following two cases.

Case 2 : Longorok's Daughter

Longorok's twelve year old daughter suffered from takat which in Pokot literally means "chest". The term is used to refer to infections in the chest area. The girl was treated at the local dispensary and later taken to Kapenguria Hospital. She had a chronic cough, fever and continuous loss of weight. At Kapenguria, the girl's phlegm was tested and she was pronounced as having tuberculosis of the lungs. She was given treatment and told to return frequently for more medicines. The father or mother accompanied the girl to the hospital to collect the required

drugs. After about five visits to the hospital, the family decided to discontinue the treatment. The girl, however, had not yet recovered, so she was taken by her father to a herbalist where she was to stay with a relative until she recovered.

Meanwhile at Kapenguria Hospital, the girl was considered to have defaulted when she had not appeared for two months to collect her drugs. The Public Health Technician of Chepareria was called to the Hospital and given details about the defaulter. He was able to contact the father who promised to take the girl to the Hospital to collect her drugs - but when the Technician asked to see the girl, he was told she was at the river. Weeks passed and Longorok's daughter did not report at the Hospital. The Technician was informed about the matter again and told to inform the Chief about it. The Chief sent a messenger to Longorok to tell him to take the sick girl to hospital. Longorok carried the girl on his shoulders to the Public Health Technician's house and left her there. It was there that I was told of the story. The girl was taken the following day by the Technician, while the father returned home. She was admitted, in a serious condition. I later went to Longorok's home to get details about his family.

The second case I wish to narrate before discussing practicability as a factor in the choice of therapy involves Lotee.

Case 3 : Lotee the herdsman's children

Lotee is employed as a herdsman in a farm near Kapenguria. His wife and their five children live in Chepareria. The land which Lotee lives on was bought from another Pokot several years ago. Lotee had moved from another part of the District to Chepareria because of a disagreement between him and his brothers. For all the time since he

settled in Chepareria, he and the original owner of the land were on very good terms, though the former had not completed paying for the land he had acquired. However, in mid 1980, a land demarcation and adjudication exercise began in the area. The exercise sparked off a controversy between Lotee and the land owner. The root problem was that the original owner of the land wanted to return the cattle he had given him so that the latter would not be registered as a land owner. When Lotee came home to see his wife and children, the land owner threatened him saying that unless he moved away, something serious was going to happen. Lotee did not take the threat seriously at the time so he went back to his place of work. After a few days, word reached him that three of his children had fallen sick. He received permission from his employer and walked home only to find that the children were very ill. The wife had taken them to the dispensary but the nurse had suggested that they be taken to hospital. He soon learned from his wife and neighbours that the land owner had made more threats and that the children had fallen sick after one of such threats. He instructed his wife to take the children to Jenet, a herbalist, and tell her that she would be paid later. Lotee himself went to consult a diviner. The diviner advised that a liokin should be called to treat the children, because an enemy was using pan to afflict them. Lotee reported the matter to the Chief so that a kokwa could be summoned to discuss the land issue. He never got to call a liokin to his home or take the children to Kapengirua as the diviner and the nurse had suggested respectively.

An important factor which must be considered when Pokot decide which therapy to use is its practicability.In Case 2 , I later collected evidence which shows that Longorok decided to discontinue his daughter's treatment at the hospital because he could no longer afford the fare. He had been spending over sixty shillings on the fare every two weeks, and sometimes he and the daughter had to sleep in Kapenguria when there were

no vehicles to take them home. Longorok is a very poor man, by Pokot standards, because he has only three cows, five goats and some chicken. He told me that he was soon to sell one of the cows to pay fees for his son who is in secondary school. He had borrowed money several times from some members of his sub-clan, but he told me that he could not go on borrowing for ever. Tuberculosis is one of those diseases which Pokot regard is best treatable with Western medicines, and Longorok confirmed to me that he held the same view. By taking the girl to a herbalist, Longorok was only doing what was practicable in the circumstances. Longorok's sister who lived near the herbalist (who was now treating the girl), was to feed her and ensure that she went to see the herbalist regularly. When the daughter was later admitted to hospital, Longorok was relieved of the problem of paying the double fare for the daughter and whoever accompanied her to hospital. He used to walk now to go and see her at the hospital and did not have to spend much money in the process.

Lotee (Case 3) was also faced with a problem of practicability. The threat by the land owner could be, and indeed was, understood to imply that he intended to use medicines to afflict Lotee's family, as this was confirmed by the diviner. The manipulation of medicines, "Kikipan" to afflict a person, is greatly feared by Pokot. The liokin is thought to be capable of countering the effect of kikipan. Lotee had spent most of his wealth buying the piece of land and was now employed as a herdsman, getting just enough money to enable his family to buy the necessary basic requirements. The liokin was never called, though there was no doubt that the children's illnesses were connected to the threats which the owner of the land had made. Instead, Lotee requested the Chief to summon a kokwa to discuss the dispute, so that the owner of the land

would revoke his pan - but the issue was never raised directly by Lotee in the kokwa which later took place. Ideally, Lotee should have called a liokin if he wanted the treatment to be private, or arranged for kikatat to be formed - but both alternatives would have involved a lot of expenses, which Lotee could not afford. An ox is required for the ritual, while the liokin has to be paid a reasonable amount of money or a live animal.

Because of their low level of income and especially the problem of getting ready cash (see Chapter Two), few Pokot can afford to utilize all forms of therapy they think necessary for an illness. In most cases therefore, alternative treatment may be chosen - and this of course will depend on the economic conditions in the particular household in which the illness occurs or the possibility of getting assistance from kin or neighbours. What is practicable for one household may be impracticable for another, so that the occurrence of an illness perceived to be due to a specific causation does not necessarily elicit the same response from different Pokot. Since Pokot may find it impracticable to perform the form of ritual considered appropriate, a substitute can be found, and such substitution is becoming increasingly common, because most agricultural Pokot have fewer animals than before, and most of the cash they get from selling crops is used for fees and the purchasing of basic necessities. In most cases because of unaffordable costs, curative ritual may be omitted from the health-seeking process, as case 3 shows. As noted earlier in this chapter, a number of Pokot who do not necessarily take Christianity seriously may arrange for the performance of Christian ritual where normally a traditional one would be performed, mainly because the former involves fewer expenses.

Because of the problems of affordability, Pokot find it convenient

to perform saghat or kisoyonet instead of, say, moi chepkompis or kilokat, because the first two involve fewer expenses than the last two. Considerations of costs to be incurred may also prevent Pokot from choosing Western type therapy even if it is perceived to be better in handling a medical problem than traditional therapy as case 2 shows. It has been reported that in some societies, custom requires at least some expenditure on all forms of therapy (Foster and Anderson 1978:246). This custom does not exist among Pokot. I found it interesting, therefore that one of the missionaries working in the District should suggest that Pokot seem to prefer health services that are paid for to those provided free of charge.[5] In support of his argument, he said that he had given lifts to several people from Chepareria who wanted to receive treatment at the private clinic in Makutano, instead of at the Government Hospital nearby where services are free. It is true those Pokot who can afford it, prefer mission and private health services to free government ones. The reason, however, is not because there is a custom which enjoins payment for health services, but because there are usually shorter queues where services are paid for and also because patients are handled quite well there. That this is the case was confirmed to me by informants and visits to a number of facilities of either type.

I also learned of cases where Pokot decided to utilize self-care because it was not possible to afford the services of an expert, even though the illness was regarded serious enough to need the services of a medical practitioner.

In summary it is possible from the foregoing to argue that since Pokot are not uniformly endowed with economic resources, some forms of therapy may be practicable for some households and not for others. This

inevitably leads to varied responses to even those illnesses thought to have similar causation but occurring in different economic contexts. The practicability factor has been given little attention in studies of the management of illness in Kenya though it has been briefly touched on by Ndeti (1972), Van Etten (1976) and Mburu (1979).

Before discussing the significance of the availability of health resources in influencing the choosing of therapy, I narrate case 4 to illustrate some of the points I wish to make.

Case 4 : Mwalimu's Pregnant Wife[6]

Mwalimu teaches in Mwino location, one of the least accessible areas of West Pokot. A narrow dirt road winds up the mountain sides from Sigor to the location but hardly any vehicles pass through it. Mwalimu's wife lives in Kapenguria and rarely goes to Mwino. It is Mwalimu who goes to Kapenguria at the end of the month. Since Mwalimu had not come as usual, his wife decided to travel to Mwino and find out what was happening. Fortunately, she was able to get a lift in a government vehicle right to Mwino. Mwalimu had been a bit sick and therefore unable to walk to Sigor, about twenty kilometres away, to catch a vehicle to Kapenguria. By the time the wife arrived, he had recovered fully and was ready to go home, but she wanted to stay on with him at the school because she had never been there.

During the second day of her stay at Mwino, Mwalimu's wife fell sick. It started as constipation but in a few hours, she had swollen all over the body and felt nauseous. As she was pregnant, Mwalimu became quite concerned with the condition. She said that she had had such symptoms before while at home and had been treated at the Maternal and Child Health Clinic in Kapenguria Hospital. Mwalimu sent two school

boys to Sigor Health Centre, so that the Centre's landrover could come to take the patient for treatment.[7] Unfortunately, it had broken down weeks before. As it was already late, the boys slept at Sigor and returned the following morning. By this time, Mwalimu's wife was quite ill. Since there was no way of getting her to a Maternal and Child Health Clinic, Mwalimu consulted the School Committee Chairman about a chepsaktian who could treat his wife. The wife did not particularly like the idea of being treated by a traditional healer, because she had been forbidden to do this at the Clinic. Her husband had to do a lot of persuading before she finally gave in. The chepsaktian was called and gave her a herbal laxative which proved effective in dealing with the constipation. Some of the teachers at the school later told me that they thought Mwalimu's wife fell sick because Mwalimu had been moving about with another man's wife, but this suggestion was put to Mwalimu only after the wife had left.

Mwalimu's wife's case shows the influence of the availability,, or more accurately, the accessibility, of health resources in the health-seeking process. The chepsaktian was called, not because the illness was thought to be treatable better by traditional than Western therapy, but because the former was the form of therapy to which there was easy access. The wife later went to Kapenguria Hospital for further attention. Health resources in this context refer to medical practitioners (whether these are indigenous or Western), herbal and shop medicines and physical facilities like dispensaries and hospitals. Such health resources are not evenly distributed among Pokot, and it is here argued that the unequal distribution of health resources is important in explaining the regional variation in the use made of various types of therapy.

The access Pokot have to a particular form of therapy exerts an

important influence when they choose treatment. This factor relates closely to the two factors so far discussed - efficacy and practicability. When Western medicine for example, is easily accessible, people will soon discover those aspects of it that are effective; if it is easily accessible, the problems of fares and unavailability of vehicles may not be hindrances, and it will be practicable to use it. I think one can demonstrate that if a form of therapy is more accessible to Pokot than another, it will be used more than other forms of therapy which are not so easily accessible - hence leading to varied responses to illness on a regional basis. I now proceed to illustrate this point by showing the use made of traditional and Western medicine respectively in two areas where there is differential access to either type of therapy. The two areas I wish to compare are Tamkal and Kapenguria, both inhabited by agricultural Pokot.

Tamkal is situated in the Cherangany Mountains (the scene of case 4) and as yet there is not a single Western-type health facility within a distance of twenty kilometres (1981). Public transport is non-existent in the area. Sigor Health Centre, the nearest such facility, runs a Mobile Clinic in Tamkal, whenever their landrover is working and the roads are passable. Pokot who live in the Kapenguria area have easy access to a number of Western-type health facilities. The District hospital is situated here and a Kenya Prisons dispensary and a private clinic are nearby. The area is linked by a tarmac road to Kitale and several other towns where more facilities are available. The number of traditional health workers in both areas is given in Table 2.of Chapter 3). Tamkal has more of these workers than Kapenguria - the reverse is the case for modern health workers. I interviewed 75 household heads each in both Tamkal and Kapenguria about the therapies they had used

during the previous two months. The results are shown in Table 1. The results seem to confirm the postulate that the more access Pokot have to Western health facilities, the more the number of medical cases they refer to these facilities and vice versa. Pokot in both areas share the same basic concepts about health and disease, and therefore the differential utilization of traditional and Western medicine is due mainly to the differential access to either type of therapy.

Table 1

Therapy Used Per Region

	Tamkal			Kapenguria		
	Traditional	Western	Total	Traditional	Western	Total
Lay therapy	24	6	30	9	12	21
Expert therapy	10	5	15	6	11	17
Total	34 (76%)	11 (24%)	45	15 (39%)	23 (61%)	38

Differential access to Western facilities is especially important in explaining the fact that most of the women who are admitted to deliver babies in both Kapenguria and Ortum Hospitals come from within a short distance of either health facility - because it is often very difficult to get a woman in labour to hospital in the absence of motor transport. Indeed my informants said that the most serious health problem in the area is the lack of sufficient Western health facilities. The problem was also raised several times in the District Development Committee meetings. This problem is discussed further in Chapters Five and Six.

I interviewed all the patients (or their guardians if they were children) who visited Chepareria dispensary during a one week period in May 1981. There were 547 patients and of these, only 12 had come by car transport. I asked each patient or guardian to state where they had come from. Table 2 shows the distances travelled to the dispensary and the percentage of patients involved.

Table 2

Distance Travelled to Dispensary (on foot)

Distance in Kilometres	No. of Patients	%
0 - 5	261	49
6 - 10	192	36
11 - 15	44	8
over 15	38	7
	535	100

The regional variations in the utilization of Western medicine are a result of external forces over which Pokot have little control. It cannot be blamed on their notions of causation per se, because these are uniform among agricultural Pokot.

I now turn to a discussion of the way social and moral considerations can influence the therapy selected for the management of medical problems and thus contribute to variation in illness behaviour. First, I narrate a set of three cases which illustrate the process.

Case 5 : Longorereng's barren wife

Longorereng is about thirty years old, and a primary school teacher. His first wife is illiterate and for a long time he had been contemplating marrying a second one who had some schooling. Two years before I went to the field, Longorereng had married the second wife but though she had

stayed with him at school for the two years, she had not conceived. Longorereng had taken her to Kenyatta National Hospital where she was attended by a gynaecologist but to no avail. When I was in the field, a controversy developed between Longorereng's family and that of his second wife. The controversy revolved around what should be done to enable the second wife to conceive. Most Pokot say that infertility is caused by spirits or a curse which can be removed by performing the ritual called kikatat. Longorereng and his family arranged to have it performed but the barren wife's father said he wouldn't participate in it. He and his kin claimed that their daughter had been made infertile by the teacher's parents and his first wife because they had opposed her being married into the family. So the barren wife's kin wanted to have pütat performed, because they said pan had been used. A performance of pütat would have implicated the teacher's family in the wife's illness, so he refused to have it performed, and he was supported by his parents. In response to this refusal, the wife was recalled to her natal home allegedly because the bridewealth payments had not been completed. Some people claimed that the woman's father wanted her to marry another man and have children, thus proving that the teacher's family were to blame for her condition, but she refused. At last a compromise was reached between the two families and kisoyonet was carried out for the woman. Representatives from both families attended, but the animosities between them were clearly revealed in the speeches made and the way the families sat in different parts of the teacher's compound during the ritual. To date the woman has not conceived.

Case 6 : Chepkemoi, the birth-attendant's daughter

Chepkemoi is married to a primary school teacher and they have

three children. She and her husband, unlike many Pokot couples, reside uxorilocally. She teaches at the village Polytechnic and is the regional leader of Maendeleo Ya Wanawake clubs. Her mother is a well-known traditional birth attendant cum herbalist. Chepkemoi is being trained by her mother so that she can succeed her eventually. Chepkemoi's mother is regarded very highly by many mothers because she can tell in advance which cases are likely to develop complications and refer them to hospital. Chepkemoi's third child was born while I was still in the field but interestingly, especially because she had not shown any initial signs of a complicated delivery, she had gone to Ortum Hospital. While she was still in hospital, her mother delivered two mothers. When I went to see the baby, I brought up the subject of the role played by traditional birth attendants in Pokot. Chepkemoi stated the general attitude Pokot women have, i.e. they prefer giving birth with the assistance of traditional midwives to hospital delivery. She said that what the traditional birth attendants needed was some knowledge of hygiene. She then went on to say that her going to hospital to deliver was due to her wish to set an example to other maendeleo women about "modern ways". Even her boss, the District Community Development Officer, expected her to set a good example. She confirmed to me, however, that she wished to master all the techniques needed to be a birth attendant and later succeed her mother.

Case 7 : Paralysis in Lokwo's family

Lokwo,a man of about thirty-five, is married and has three children. He is a devout Christian (Protestant). His young daughter went down with what at first was thought to be an ordinary cold but with fever and vomiting. She was taken to the local dispensary where she was treated

and returned home. After a few days she became quite ill. Lokwo hired a van and took the child to Makutano private clinic where she received out-patient treatment. After the initial symptoms disappeared, the girl started limping in one leg. The limping sparked off a lot of consultation among members of Lokwo's sub-clan living nearby. Funds were collected to enable the girl to receive further treatment, but there was some disagreement between the kin about what should be done. The majority of them felt that ritual should be performed to get rid of the oi which were tormenting the girl. Lokwo, his wife and a minority of kin said that the girl should be taken to the Provincial Hospital at Nakuru. The smaller group eventually succeeded in convincing the others to let the child be taken to Nakuru. At the Provincial Hospital, Lokwa was told that his child had had an attack of poliomyelitis and that this had completely paralysed one of the girl's legs and that nothing could be done to correct her limping.

Back home, Lokwo's kin would not accept that nothing could be done for the girl. The two groups emerged again. The majority said that a diviner should be consulted. Though Lokwo resisted the suggestion initially, he later gave in when a brother offered himself to consult the diviner on his behalf. The brother, who went to consult the diviner brought back the information that Lokwo's ancestors wanted the parpara ritual performed.[8] Lokwo could not concede to such a demand, because it would have led to his excommunication from his church. However, Lokwo did not want to be accused by his kin of having neglected his daughter's illness. Secret arrangements were made and the girl was taken to a Luo healer in Kitale who claimed to be capable of treating all illnesses connected with ancestor spirits. The last time I visited the family, the girl was back home - on crutches. Lokwo remarked bitterly that he

had done all he could but the illness was an act of the devil.

Only rarely is an episode of illness among Pokot a private matter, and even when it is, the potential consequences of carrying out certain therapeutic actions are considered carefully. Stated differently, some therapeutic actions may be carried out or omitted because of consideration for the impact they are likely to have on social relations and public opinion. Public opinion evaluates the actions according to the traditional moral code or Christian principles and sometimes both. Cases 5, 6 and 7 show some of the ways in which public opinion and social relationships are brought to bear on the process of choosing therapy. In Case 5 (the barren wife) because Longorereng's father-in-law wouldn't attend the kilokat ritual which the teacher had intended to perform, it had to be cancelled. Later, pütat was also cancelled, because its performance would have led to Longorereng's accepting that his parents and first wife had connived to use medicines to afflict his second wife with infertility; this would have been a difficult step to take and would have resulted in permanent cleavages within the family.

Case 6 reveals the influence of considerations of public opinion on the action taken. Chepkemoi's leadership position in maendeleo and as a teacher was important in her decision to deliver her baby in hospital, though Pokot women generally prefer home to hospital delivery (an attitude which Chepkemoi shared) and her mother is a birth attendant and Chepkemoi is training to be one. With regard to the use of Western medicine among Pokot today, a person's position in society is important. Teachers, civil servants, shopkeepers and community development leaders are expected to use Western-type health services more (where these are available) than the rest of Pokot. Such people, in line with the philosophy of "development" as preached by the government

and understood by Kenya's rural population, are supposed to set examples of modernity to the rest of society. I return to this issue in the next chapter.

Case 7 also illustrates how Pokot may accept the carrying out of a therapeutic action because of pressure exerted by kin and sometimes neighbours. Lokwo wouldn't normally, as a Christian, consult a diviner, but his kin prevailed on him. Christian Pokot are in a particularly difficult position when they have to decide which therapy to use for a medical problem. The majority of these Christians still perceive illness in traditional terms, which means that they cannot ignore interpersonal and spiritual forces involved in illness. At the same time, they know that the indigenous rituals performed to deal with the secondary causes of illness are condemned by their churches. Some are able to ignore the performance of appropriate ritual by offering prayers as a substitute, but these are a minority.

Most Christians find it necessary to compromise their Christian principles and perform rituals appropriate to episodes of illness, and here the pressure of kin and neighbours is very important. Protestant Christian tend to resist such pressures more than Catholics, who tend to have a more liberal attitude to traditional practices. Members of Dini Ya Msambwa perform rituals which combine both traditional and Christian elements.

Sometimes ritual is omitted from the health-seeking process if it is thought that its performance may lead to adverse legal consequences for the protagonist or some other person. This could have been a factor in Case 5 above. The barren wife's parents would have had to make a public accusation against their in-laws if pütat had been formed. If divination reveals that an illness involves an oath, the therapy managing

group may omit the relevant ritual because its performance will lead to some restitution being made. Cases 8 and 9 below illustrate the role played by fear of litigation in influencing the therapy selected for the treatment of a pasticular illness.

Though the various factors so far discussed are important in influencing which actions are taken or not taken in the attempt to heal a patient, their significance will be appreciated variously by different individuals as cases 8 and 9 show.

Case 8 : The trader

X, a livestock trader, was suspected of having stolen Rege's goat. In fact somebody had even claimed to have seen him taking the goat away. It was alleged that X had later sold the goat at Makutano market. Though no direct accusation was made against X, he reported the matter to the Subchief because many people in his korok kept avoiding him. The Sub-chief summoned a kokwa where it was decided that X should take a muma if he claimed he was being accused falsely. He took the muma and the matter was forgotten for some years. In mid 1981, X's wife fell sick, and she was soon followed by two of her children. X took her to Kapenguria Hospital where she was admitted. She was soon discharged and the doctor said that there was nothing physiologically wrong with her. She came home still complaining of pain all over the body. X's father and brothers approached him, intending to convince him to have the muma revoked - but X said that the illnesses in his household were a result of someone using medicines against him because of his success as a trader. X's wife was taken to a private clinic in Kitale where she stayed for two weeks and came home fully recovered. The matter cooled when the wife and children recovered. Informants claimed that X had

been warned of more trouble to come.

Case 9 : Chesempai's daughter

Chesempai is the eldest among five brothers. His father is dead but the mother is alive. Chesempai is about forty years old and has two wives and seven children. When his father died, Chesempai fenced off a large piece of land for himself, leaving only a small portion for his four brothers. His mother had tried several times to convince Chesempai to relinquish part of the land but all in vain. So when his ten year old daughter failed to respond to treatment by a herbalist and at the dispensary, his brothers attributed the illness to their late father's spirit, and saw the illness as a punishment to Chesempai for fencing off the land which should have been shared well among all of them. Chesempai on the other hand claimed that the brothers were using pan against him because he was a successful cash crop farmer. The mother intimated to me that the illness was eywei, because people were not happy with Chesempai's fencing off the father's land. So, though divination also suggested the involvement of ancestor spirits in the girl's illness, Chesempai decided to carry out an amoros for himself. This involved the slaughtering of a goat near the river, helped by a friend. Ideally, moi chepkompis should have been performed - but if Chesempai had accepted to do this, he would have had to admit publicly that his father's spirit was displeased with his having fenced off the land.

Cases 8 and 9 show that individual judgement or interpretation is important in the management of illness. Though kin, neighbours and friends may be involved in an illness, the household head, or at times the extended family head, kuko, ultimately shoulders the responsibility of deciding which therapy is to be utilized in managing an episode of

illness. The advice given by kin, friends, neighbours or a diviner is not always accepted. An element of self-interest is involved as the course of action taken may lead to adverse social, moral and financial consequences for the household or extended family head. Whoever eventually makes the final decision about the treatment to be used is a conscious individual, with idiosyncratic characteristics depending on life experiences, and especially with a unique exposure to various types of therapy. The decision such an individual makes will depend on his appreciation of the effectiveness of a form of treatment, its costs and likely social and moral repercussions. The trader for example did not wish to accept the interpretation of the illnesses in his family which suggested that he was guilty of theft - accepting this interpretation would have led to dire legal and moral, and eventually economic, consequences. Should a person accept that an illness is due to a muma, he has to effect restitution of whatever damage or loss was involved. More expenses will have to be incurred in ritual to spiritual forces to stop them from afflicting the victim further - and of course a person has to face public opinion. It is a task for those managing an illness, and especially the protagonist, to evaluate the social, economic and moral environment in which the illness occurs and reach a decision about therapy which is likely to be effected with minimum disruption. Because of such considerations, the treatment chosen may not match the perceived causation of an illness. The way their theory of illness is constituted allows individual Pokot to adopt different and at times contradictory interpretations and subsequent treatment of an illness, and still justify their actions - this is mainly possible because of the processual multiple causality principle in their theory of the causation of illness to which I return later.

4.3 Case 10 : Infantile diarrhoea in Chepareria

This case is somewhat different from all the other cases in that I examine how mothers in the sample households (30) responded to the introduction of a new therapy for the management of infantile diarrhoea. The "case" started some time before I arrived in Chepareria but I was able to reconstruct the background and make observations of various episodes of diarrhoea in children under three years of age.[9]

The socio-economic context of the sample households is given in Chapter Two so I need not repeat it here. I only wish to stress that the mothers I observed in these households for a period of six months shared the same concepts about the causation of infantile diarrhoea which I discuss below. I ascertained that the beliefs and practices I observed in Chepareria during episodes of infantile diarrhoea are general to Pokot by observing such cases and interviewing mothers in other parts of the District.

In many parts of Africa, it is believed that infantile diarrhoea is caused by the development of "false teeth" in the gums of the child, usually before the milk teeth appear. This belief is very widespread and several examples can be given. For example, in most of Uganda, this phenomenon is called gindok or telak among Luo speakers and ebinnyo among Bantu speakers (Parma 1979). Among Gusii in Kenya, the phenomenon is called ebisara lit. "sticks". Among Kikuyu of Muranga, it is referred to as iriti while Luo in Kenya call it omuot or gimo. This belief in "false teeth" has several implications on the management of infantile diarrhoea as I show presently with reference to Pokot.

In Pokot, diarrhoea has a general name kayitan, but in children, sometimes it is referred to as kelapooi lit. "spirit teeth". The term kelapooi is used when referring to infantile diarrhoea because Pokot, like other societies in Kenya, believe that it is caused by abnormal

teeth which are likened to spirits. According to informants, the false teeth are soft and appear in the mouth before or with the milk teeth. They are said to grow in the position where normal canine teeth later grow. The presence of false teeth is detected by feeling the gums with the first finger. If they are detected, any diarrhoea affecting the child will be attributed to them.

To prevent false teeth from causing diarrhoea, the gums are rubbed with medicines. Alternatively, and this is the more common practice, they are removed physically by an expert. All the 30 mothers in Chepareria I interviewed (except three who were not sure) were unanimous in saying that the commonest cause of infantile diarrhoea is false teeth. Regarding false teeth, Ongom (in Owor 1975) writing on the problem in Uganda says that false teeth are:

> Normally developing canine teeth, as the specimens extracted during one of the operative procedures were identified by a dentist as being normal canines. Ignorance about infantile diarrhoea, vomiting and febrile episodes has led many people in this country to believe that it is a disease. Complications - septicaemia and osteomyelitis - following the operative manoeuvres often result in high infant mortality (p.305).

Though the mothers in Chepareria now believe in false teeth phenomenon, I show later that this concept has been borrowed from immigrants in the District.

It is now generally agreed that diarrhoea, a major cause of morbidity and mortality in children in developing countries, can be managed effectively in the home even by lay mothers. It is now thought that what is important is not that the diarrhoea should be stopped, but that the fluids and electrolytes lost should be replaced by giving the child a rehydration mixture. This mixture can be made at home with water, sugar and an orange (Morley 1973:185-189). Rehydration as a method of managing diarrhoea is now being introduced in many parts of Kenya. Below

I examine how the method was introduced to mothers in Chepareria and how they responded to it.

My observations of episodes of diarrhoea were focused on two behaviours - the removal of false teeth and use of rehydration. Rehydration as a method of managing diarrhoea had been taught to all but three of the mothers I observed. The teaching had been done in the Maternal and Child Health Clinics conducted once in a while at the dispensary. Sugar and salt are available in most of the households or can be bought at short notice. Oranges are grown in several homes in Chepareria and are therefore easily obtainable.

False teeth are removed by a number of experts who charge very little (usually a shilling). If the mother cannot afford to pay the shilling, the teeth can be removed free of charge. For both the behaviours I chose to observe, the problems of costs and acccessibility are not crucial, because both could easily be carried out in any household when necessary. During the six months when I observed the management of diarrhoea in infants, there were 47 such cases. The results of the observations were quite interesting.

False teeth removal occurred 17 times only, though they were given as a cause of diarrhoea in 39 of the 47 cases. Several reasons were given why false teeth removal was not used in the management of diarrhoea. In most of the cases where they were not removed, it was claimed that other forms of therapy were more effective than false teeth removal - for example ashton powder (tincture of matricaria and lactose) sold in the shops was said to be very effective. Other mothers said that they knew children whose gums had been infected and even died after the removal of false teeth. Some mothers said that the removal of false teeth can prevent the appearance of normal teeth. Whether false teeth

were removed or not in the management of diarrhoea did not seem to depend on the demographic characteristics of the household; what seemed to be important was the various experiences that mothers had had of the removal of false teeth.[10]

The utilization of rehydration in the management of infantile diarrhoea was not evenly distributed in the group of women I observed. As with the false teeth removal, the demographic factors of the household were not crucial here. What seemed to be the most important factor in influencing the use of rehydration was membership in a Maendeleo Club. There were 12 (of the 30 mothers) who belonged to the Chepareria Maendeleo Club. These twelve accounted for about 70% of the 24 cases where rehydration was used for the management of diarrhoea. As already indicated, nearly all the women in the sample have been exposed to rehydration through the Mother and Child Health Clinics. Why was it that maendeleo women tended to use rehydration more than those who were not members of such a club? Detailed discussions with the Maendeleo women, their leader and a home economist working in Chepareria helped me understand the different responses to the introduction of rehydration.

When rehydration was introduced to women in Chepareria about three years ago, many of them found it difficult to see why it should be recommended. In the first place, they argued, it does not stop the diarrhoea. Secondly, it does not make sense with regard to false teeth as a cause of the problem in young children. These two issues were raised by the Maendeleo women to a home economist who was working with them. The home economist decided to show the maendeleo women that rehydration is useful in managing diarrhoea in children. She visited individual homes and made the mixture for children who had diarrhoea to demonstrate the right way to make it. She then told the mother to give it to the

child as appropriate and later report the results. The results were discussed in several meetings. Many mothers soon realized that a child who is given the rehydration drink remains strong throughout the attack. Finally, the women unanimously decided (in a meeting) to adopt the method. After this decision, all maendeleo women almost invariably used rehydration whenever episodes of diarrhoea occurred in their homes. The maendeleo leader in Chepareria, who is herself Pokot, endorses the method and is willing to explain it to those mothers who do not understand yet how it works.

An interesting observation that I should make here is that maendeleo women still think that infantile diarrhoea is caused by "false teeth". I found that the nurses and midwives who run the Maternal and Child Health Clinics in Chepareria had never taught the mothers that the false teeth operation can contribute to infection. In fact none of them admitted knowing that the operation was carried out. The same ignorance was shown by the home economist. She was very surprised when I put the question to her. The mothers had not asked questions regarding false teeth at the Clinic because, as informants put it to me, they feared that the nurses would call them "wajinga" , the Swahili for "ignorant".

Some of the women who now use rehydration regularly have never had any schooling. For example, Jenet Loyongo, the herbalist, is over fifty years old and illiterate. She is a staunch supporter of rehydration and uses it when her grandchildren have diarrhoea. Some of the non-maendeleo women who do not use rehydration have had up to seven years of education. Case 10 illustrates most of the principles already discussed in the nine cases so far discussed.

Rehydration has been introduced to almost all the mothers I observed.

However, it is only among the maendeleo members that the efficacy of the method has been demonstrated, thanks to the efforts of the home economist. It is not sufficient that a new therapy be introduced - it should be shown to work. In the next chapter, I discuss further the problems of demonstrating the efficacy of Western therapy among Pokot.

Another factor which is important in case 10 is that the new therapy is reasonably practicable because it does not require much expenditure to utilize as most of the ingredients are easily obtainable. There are no problems of accessibility in using rehydration - if a mother cannot make the mixture herself, she can consult other maendeleo members or their leader at short notice.

Another important factor about the therapy that makes it a good choice among maendeleo members is that there are few, if any, social or moral constraints to its use, once a mother has accepted it. In fact there is a lot of motivation for her to use it from other members, because it is now regarded to be one of the signs of modernity. There is actually group pressure which encourages individual maendeleo members to use rehydration.

Indirectly, individual judgement plays a part in the process because the very decision to join a maendeleo club entails a certain outlook on life. Those women who join the clubs have aspirations about changing their living conditions by adopting innovations which are regarded in a rural Kenyan context as "modern".

In summary, case 10 shows that even within a small community with similar socio-economic conditions, it is possible to have different responses to health innovation. The factors that are involved have been stated, but of equal importance, is the role of the change agents, in this case the home economist and maendeleo clubs, in promoting or

hindering the process of change. I explore this theme further in the next two chapters. The case also shows that the notions of causality are not always crucial in influencing the response to new therapy - both those women who use rehydration regularly and those who do not share similar beliefs about how infantile diarrhoea is caused.

4.4 The View of Illness and How it Facilitates Variation in the Health-seeking Process

I now wish to demonstrate that the element of processual multiple causality, an important facet of the Pokot view of illness, enables them to justify various responses to any illness. Because of the principle of processual multiple causality, redefinition of an episode of illness is possible. As already stated, the physical symptoms of an illness are given a specific name. If the symptoms do not respond to the therapy regarded appropriate to their treatment, a new name can be ascribed to them. This will allow another course of treatment to be followed. The process of re-naming the physical symptoms can go on until the illness is cured. There is no limit as to how many times a re-definition of the symptoms can occur.

When an illness is thought to involve inter-personal and/or spiritual causation, the practicability of the ritual thought appropriate, social and moral constraints may necessitate several interpretations of the illness. The causal agent(s) which is given emphasis will depend on the economic, social and moral consequences of performing the relevant ritual. Hence, different causes will be emphasized at different phases of an illness by different people. Case 5 illustrates the process of redefining one illness several times.

Because of the diffuseness of therapy at the secondary level, Pokot who cannot afford more expensive ritual can opt for simpler ritual and still claim to have carried out the appropriate therapy according to the perceived causation of an illness. The theory is also fluid enough to account for the failure of therapeutic action to effect the hoped for results.

The flexibility of the theory of illness enables different categories of people to give different interpretations and responses to an illness without any category being considered to be entirely wrong or correct. I wish to show how different, and apparently contradictory, interpretations and responses to a single illness can occur by narrating Case 11.

Case 11 : Powon the technician

Powon, a young man in his early twenties, works as a technician in Kapenguria Hospital. Some time before my arrival in Pokot, he had purchased a plot of land from N. He had already harvested one crop of maize and was getting ready to plant another. He was therefore surprised to find that while he had been away in Kapenguria, his plot of land had been ploughed and planted with beans. His attempts to get N to explain what was happening proved abortive. However, Powon discovered from other sources that N had resold the land to a third party.

Powon approached the third party but the latter refused to negotiate. He went back to his place of work but found it difficult to concentrate. He returned home, very confused and began drinking heavily. His speech became incoherent. He walked anyhowly, even at night, shouting abuses at N, and calling people to support him regain his land. People said that he had become kepil which can be glossed as "half-mad". Kepil is used to refer to a person who is mentally confused who however retains

some degree of normality.

Powon's father conferred with members of his sub-clan living nearby and it was decided that a goat should be sacrificed (as an amoros). Powon did not recover after the amoros had been offered. People began saying that N had used pan to confuse Powon, so that he could not refer the land case to court. He became very violent, shouting at and sometimes beating up those who disagreed with him.

Powon's sisters, who are "saved" Christians, organized a night-long prayer session for Powon. One of them told me that they saw in his illness the work of demons, onyetei, which could be cured only by the intervention of Jesus. The sisters were supported by their friends who also participated in the prayer session. Even his parents who are not Christians, took part in the prayers.

During a lull in his illness, Powon took a bus and went to Mathare Mental Hospital in Nairobi to see a psychiatrist. He was told that there was nothing wrong with his mental state. He was given a written statement to prove that he was normal. When he returned home, he showed the chit to everyone he met, and emphasized that he was not chepiyu "mad", as people were now calling him. Finally the land case was settled and by the time I left the field, Powon had fully recovered and returned to his job in Kapenguria.

Case 11 raises a number of interesting points. It shows how different interpretations of, and responses to, an illness can occur without any apparent contradictions. It is also important in showing that an illness perceived in traditional terms can be managed by non-traditional therapies. Pokot classify mental illnesses among those conditions needing traditional therapy only, but this did not prevent Powon from visiting a Western-trained psychiatrist.

Pokot argue that what is done during an illness depends on its causation. This would imply that the theory of causation imposes a limitation on the therapeutic responses. The above examples show however that the theory actually facilitates the utilization of several therapeutic alternatives for any episode of illness. I am here suggesting that one cannot accurately predict which therapeutic option will be taken, given only the perceived causation of an illness. This does not mean that the theory of illness is not important in the health-seeking process; I turn to this issue later.

The Pokot theory of illness does not only allow varied interpretations and responses to illness - it also draws upon this variability by incorporating new concepts of causation and related therapies. Examples of the process of incorporating new ideas and related practices whose assimilation could be remembered by informants e.g. "false teeth" (kelapooi) Yomat, Christian ritual and certain Western notions of disease.

Oral historical evidence suggests that the belief in false teeth as a cause of infantile diarrhoea did not exist among Pokot before the thirties. Its acceptance into their theory of illness occurred only in the forties by which time the practice of extracting false teeth had become widespread as a therapy for infantile diarrhoea. At first, only a few Pokot, especially those near Kapenguria and in close contact with Bantu immigrants, used to extract false teeth. During this period as informants could remember, some men forbade their wives to teach their daughters that kelapooi was one of the causes of diarrhoea in children. When the removal of teeth became widespread in the treatment of infantile diarrhoea, even the men who had initially not accepted that kelapooi could cause diarrhoea, began to accept the new idea. Today all adult

Pokot give it as the commonest cause of infantile diarrhoea. A change in ideas followed a change in practice. Rehydration is now becoming widespread as a treatment for diarrhoea, and it is likely that if it becomes firmly established, Pokot notions regarding diarrhoea will change. There are signs that this will take place.[11]

The concept of Yomat is a relatively newcomer into the Pokot theory of illness. Informants said that most of the ideas relating to Yomat have been borrowed from Karimojong. The sequence was similar to that of the assimilation of kelapooi. According to my informants kilokat, the therapy regarded appropriate for Yomat, was accepted before the concept. It was only when the therapy became widespread in the fifties that the concept itself was refined and assimilated into the Pokot medical paradigm. It is now considered by them to be a basic component of their theory of illness.

I have already said that sometimes Christian ritual may be performed when an illness is thought to require traditional ritual. Christian concepts of illness, especially those which suggest that sins, Satan and demons can contribute to illness, are very attractive to Pokot. Informants said that the same God who is prayed to in traditional ritual is the same one Christians pray to when they need help. It is however too early to predict what nature the syncretization of Pokot and Christian notions of illness will take. Most Pokot have not had contact with Christian ideas for any reasonable length of time. Wilson (1963) discusses how among Nyakyusa traditional concepts of causation have been "Christianized" (p.127-132).

Gradually, Western biomedical notions of causation are being accepted by Pokot, especially those who have had some education. But what is more significant is the fact that Western health services are

used before Pokot have changed their ideas of causation, as some of the cases I have discussed show.

Though Pokot would say that the raison d'etre for their theory of illness is to provide guidelines for therapeutic action, it is recognized by anthropologists that a theory of illness can have several other functions in a society. For example, it has been shown that a theory of illness can be an important instrument in social control (cf. Dyson-Hudson 1966 and Middleton 1970). It may also be used in the control of aggression as Foster and Anderson argue (1978:45). A theory of illness, as an important feature of a people's culture, can also be used in the expression of nationalistic sentiments. This happened in India during the years leading to Independence as Sigerist reports (cf. Roemer 1960:276-77 cited in ibid:46-47).

I stated in Chapter Three that the oath, the curse and eywei, all of which still play an important role in social control among Pokot, are important elements of the Pokot theory of illness. However, the theory also plays another important but less visible function - enabling them to make sense of the physically, socially and psychologically painful, often traumatic, experiences occasioned by illness and the metaphysical questions raised by such experiences.

Having observed several responses to different medical problems among Pokot, it has now become clear to me that their theory of illness enables them to feel a sense of being in control of the situation by providing a paradigm within which to relate meaningfully to illness, an experience that is not only painful to the patient, but also to those around him. The theory enables Pokot to place a medical problem in the context of natural, social and spiritual phenomena. Without the theory of illness, a medical problem would appear arbitrary and thus cause a

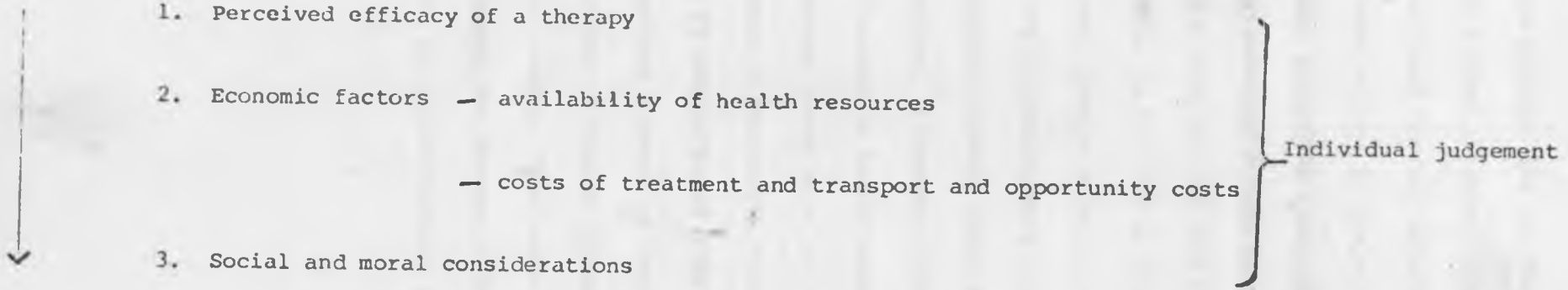
lot of anxiety and frustration. By defining a medical problem in familiar terms, Pokot feel that they know what is happening. This brings a sense of security which is necessary if normal life has to go on. That this is so is revealed by the fact that the illness which causes most anxiety among Pokot is that which is not easily definable using existing labels and categories of medical phenomena.

The quest for meaning in life experiences is a fundamental human problem; it is especially important in societies like the Pokot where, because of technological limitations, it is difficult to establish one-to-one causal relationships between phenomena relating to health and illness. The plasticity of the Pokot theory of illness is of fundamental significance therefore, because it enables different individuals to ascribe diverse interpretations to illnesses occurring in various physical, social and spiritual milieux. Because the theory deals with such a fundamental problem, it is one of the basic social and cultural forms of Pokot society which change only slowly over time—in most cases long after related behaviours have been modified.

Before closing this chapter, I wish to make brief remarks in connection with the relative significance of each of the variables mentioned above in specific episodes of illness and also the therapy managing group introduced in Chapter Three. An accurate weighting of the factors discussed above in the health-seeking process among Pokot necessitates quantitative data of a nature not collected in this research. But having observed several episodes of illness, I suggest that the factors can be ranked as below, according to their importance in influencing initial decisions about treatment. It should be stressed however that in most episodes of illness, the factors are operative in combination. It should also be noted that individual judgement runs

Figure 1

Factors Influencing Therapeutic Decisions



through the whole process and is therefore in a category of its own.

As already stated (Chapter Three) Pokot emphasize the importance of forming a kin-based therapy managing group (or) when a major illness occurs. In my observations at Chepareria, I encountered few such groups. Of the 10 episodes presented (excluding case 10) in this chapter, enduring therapy managing groups were observable only in cases 5, 7 and 11. It may be that most of the cases presented did not involve serious illnesses. But this is not, in my opinion, the main reason. According to informants, such groups should have been formed in cases 2, 3, 8 and 9, because the illnesses were long and serious. This, once again, shows the discrepancy between ideal norms regarding the health-seeking process and practice. Informants claimed that most Pokot nowadays like to deal with illnesses in their households privately. Some suggested that this is because there is a lot of hatred and suspicion in Chepareria because of economic differences. Therapy-seeking is tending to become individualized. In remote areas like Tamkal, the therapy managing group is still an important element of health-seeking. Pokot in Chepareria are increasingly turning to church elders, teachers and shopkeepers for advice regarding therapy. This seems to be a general trend in East Africa as for example among the Zaramo of Tanzania (Swantz 1973) where individualization in health-seeking is reported to be on the increase.

Footnotes to Chapter Four

[1]The assumption that a child with measles is likely to die if injected is found in many other societies in Africa, for example the Gusii, Luo, Marakwet and Luhyia of Kenya. Imperato (1977) gives other societies which have the same belief.

[2]See for example (Dean 1978; Janzen 1978; Middleton 1963; Turner 1966,67).

[3]Mzungu literally means "European" in Kiswahili. It is also used as an adjective to refer to things which have Western origins.

[4]Mganga is the Kiswahili term for "medical practitioner but it is nowadays used almost exclusively when referring to indigenous health specialists.

[5]The remarks were made by one of the delegates at a meeting held on 26.8.80 at Kapenguria Hospital and at which I was present, to discuss the operation of Mobile Health Clinics in West Pokot.

[6]Mwalimu means "teacher" in Swahili; the term is used widely in Kenya. In some cases it is used not as a title but as a personal name for particular teachers.

[7]The landrover is hired by those who want to use it as an ambulance.

[8]Parpara was necessary because Lokwo had married from a clan which had killed a member of his clan some years before. It is a public ritual whose performance could have been easily noted by Lokwo's fellow church members.

[9]Pokot say that "false teeth" affect children of up to three years of age.

[10]Pokot men show little interest in the management of infantile illnesses. Such problems are almost entirely under the control of women.

[11]One of the programmes underway among Chepareria maendeleo women is to learn about the common causes of childhood diseases. Those who will teach them intend to introduce the germ theory of illness.

CHAPTER FIVE : THE RELATIONSHIP BETWEEN TRADITIONAL AND WESTERN MEDICINE

In this chapter, I continue the discussion started in the last chapter, i.e. how various factors influence decisions about therapy and therefore contribute to variation in the health-seeking process. However, in this chapter, I restrict the discussion to a single aspect of the health-seeking process viz. the relationship between traditional and Western medicine. The first section puts the discussion in its theoretical context while the second deals with the cognitive response to Western medicine. The third section looks at the organizational (physical) aspects of the relationship while the fourth deals with the varied interaction between traditional and Western medicine in relation to certain curative and preventive therapies. Section five looks at the response to both types of medicine by different categories of people in Pokot and the final section is devoted to some general remarks.

5.1 Studies of the relationship between traditional and Western medicine

in developing countries until recently have been based on two basic assumptions: firstly, that contact between the two inevitably leads to conflict, secondly, Western medicine is resisted because of "cognitive dissonance". Kunstadter summarizes these assumptions quite aptly: "...when Western practice applies treatment which is perceived or classified as inappropriate in the local system for the category in which the disease is locally placed, treatment will be rejected because of the 'cultural conflict' or cognitive dissonance..." (in Kleinman et al. 1978:210). As I argue below, these assumptions hinder a fuller understanding of the complex relationship which ensues with the introduction of Western medicine in non-Western societies. In the first place, the

two types of medicine can be seen to relate to each other variously depending on the medical conditions or categories of persons being considered. The second assumption places undue emphasis on the role of concepts of causation in the differential relationship between Western and traditional medicine, sometimes to the exclusion of other factors, dealt with below, which are just as important, and sometimes more, than notions of causality. It has now become increasingly clear that concepts of causality are crucial in determining the relationship between the two types of medicine in the initial stages of contact (Foster and Anderson 1978:227). As time goes on and people come to perceive the benefits of using Western medicine, other factors become relevant in influencing how they relate to Western medicine and its practitioners. As I show later, the nature of the relationship between traditional and Western medicine may be influenced significantly by forces which emanate from outside Pokot society and culture and over which they may have little control. Before I discuss the complex interaction between the two types of medicine among Pokot, I make brief reference to studies which show the role of indigenous medical concepts in the way people relate to Western medicine.

Several studies have revealed that non-Western societies dichotomize illness between those which can be treated by Western and traditional therapies respectively (Barker 1959; Foster 1952; Gould 1957). Among the Zulus for example, Barker found that some illnesses were regarded as uniquely African and therefore not treatable by Western medicine. Such illnesses were not taken to hospital (1959:88-89). Schwartz reports that among the Manus, the situation was

> Quite different from other areas where the Indigenous and Western medical system find some points of complementarity and contact; in the Manus, the two systems actively compete and which system is chosen depends more upon the natives' classification of the moral component of the specific illnesses than upon their perception of what each medical system can do. (Romanucci-Ross 1969 quoted in Landy et all 1977:481)[1]

Conflicts between Western-trained medical practitioners and their non-Western clients have been reported for the Mexican-Americans (Clark 1959a:250) and the Abron of the Ivory Coast (Alland 1964). Among the Abron, Alland reports that people had more confidence in Western drugs but not so much in the doctors (ibid. reproduced in Ademuwagun 1979:171-175). Several studies report that preventive medicine has often proved more difficult to be accepted by various non-Western societies than curative medicine (Khare 1962 and Paul 1958). The Karks report a case from South Africa where belief in witchcraft made it difficult for the Zulus to construct pit latrines (Kark and Kark 1962). Several other studies have been devoted to the understanding of the contact between Western and indigenous types of therapy and how medical concepts held by a society contribute to the acceptance or rejection of the former. Medical anthropologists are however increasingly turning to the identification of other factors which, together with concepts of health and illness, explain the complex interaction patterns which have been observed in many areas where new forms of therapy have been introduced. In the last section of this chapter, I shall cite some of these studies.

I think it is important from the outset to distinguish between the cognitive, organizational and behavioural aspects of the relationship between traditional and Western medicine. There are two main reasons for this distinction. In the first place, though Pokot dichotomize illness between those that should be treated by traditional and Western therapies respectively, in practice the dichotomization is not always

maintained. Moreover though the two types of therapy are provided at different health facilities, Pokot in most cases utilize both Western and traditional services for the same episode of illness. The distinction therefore secondarily makes it easier to discuss the varied and dynamic relationships between the two types of therapy. The main arguments which I develop in the following sections are:

(i) that Western medicine is often used while the concepts of causation and illness remain largely traditional, therefore it is necessary to identify factors besides notions of causation which can account for the varied relationship between traditional and Western medicine.

(ii) that the relationship between the two types of medicine is not simply one of rejection or acceptance, but a complex one involving competition, complementarity and supplementarity.

(iii) that different categories of people in the Pokot environment relate variously to either types of therapy and that this is due to social and moral factors arising out of their roles in society.

5.2 The Cognitive Response to Western Medicine

Since the introduction of Western medicine into Pokot about fifty years ago, some aspects of the germ theory of disease are being grasped and included in their general perception of illness. For example, some Pokot understand that mosquitoes and contaminated food and water can transmit malaria and infective diarrhoea respectively. But to a very large extent the indigenous understanding of the causation of illness still persists. This is especially so for their general concepts of illness where illness is thought to involve different planes in a processual manner. Even those Pokot who have acquired some knowledge of Western ideas about the causation of a number of diseases do not usually

reject the traditional perception of illness as involving different planes of causation. Of the 65 episodes of illness which occurred in the core sample in Chepareria, it was only in 19 of them that non-traditional causes were used to explain the illness. Even most of the patients I interviewed at the local dispensary did not seem to have changed their understanding of the causation of illness. In fact it was from such patients that I came to learn about most of the Pokot understanding of illness, because most Pokot talk about illness only when they are sick or involved in seeking therapy for a kinsman or a friend.

I was able to witness a number of ritual performances for patients by following cases from the dispensary to their homes. In fact most of the patients used to invite me to attend such performances because they came to realize that though I worked closely with the Western health workers, I never despised these rituals. Atudo even gave me "a special message" for the District Medical Officer of Health (to tell him that I had confirmed that the rituals were "just prayers to Tororot" and not uganga "). I passed the message to Doctor Alube. I was on several occasions asked to give some medicine to a patient for whom some ritual was being performed - I had a large supply of aspirin which I carried around. This once again confirms my argument that Pokot are more concerned with the effectiveness of a treatment than its theoretical correctness. It also shows that as has been shown for other societies (Erasmus 1952) behaviour change often precedes change of beliefs when Western medicine is introduced into non-Western communities.[2] Traditional concepts about the causation of illness are still taught to young Pokot who are undergoing initiation in the fashion described in Chapter Three, and it is unlikely that this will stop in the near future.

I now turn to the more pertinent question of the level at which Western medical practitioners and their practices are thought to be capable of intervening in the health-seeking process. I should first of all stress the fact that Pokot do not regard Western medicine as superior or inferior to traditional medicine. For example, in the three planes of causation introduced in Chapter Three, Western medical practices are placed in the same category as the work of herbalists, birth attendants, tooth extractors and physiotherapists who deal only with the first plane of causation. This is only one of the spheres of intervention, involving the biological aspects of illness, which Pokot recognize. Diviners, prophets and ritual experts intervene on the more complex phases of illness. Christian ritual is considered to be in the same category as the traditional healing rituals. Western medicine is not perceived to have a separate sphere of intervention; on the contrary, it has been slotted into an already existing scheme. According to Pokot, there are now more options for intervention at the how level of illness with the introduction of Mzungu medicine.

Table 1

Spheres of Intervention by Traditional and Western Practitioners

Spiritual	Prophets diviners Christian daktari ritual leaders	Saapken (Curative ritual) + Christian prayers
Inter-personal	herbalists + daktari	
Biological	birth attendants tooth extractors bone setters	Kitö sak t (materia medica)

Pokot nowadays use a single Swahili term daktarion when referring to Western-type doctors, nurses, midwives etc. However, daktarion falls under the generic term Chepsaktian which Pokot use to refer to medical practitioners in general, traditional or Western. Even the traditional Chepsaktis have individual names as has been shown in Chapter Three. In the Pokot cognitive map (medical) the distinction which matters is not that between traditional and Western medicine, but that between the two spheres of intervention - kitö sak tand saapken - intervention with materia medica and healing ritual respectively. According to this distinction, the herbalists, Western health workers, traditional birth attendants, tooth extractors and bone setters belong to one category, while the ritual leaders, diviners and prophets belong to another. Christian daktari are sometimes placed at the same level with the latter category of medical experts.

Not all Pokot accept this. Some informants claimed that since Christian daktari offer prayers before treatment, these are closer to the diviners and ritual leaders than to herbalists. Christian daktari are seen to combine both kitö sak t and saapken, but Pokot have not developed this idea to the extent the Abron of Ivory Coast have. Among the Abron, the Christian doctor is regarded as the indigenous kparese who combines both herbal and ritual therapy. Alland (1970) says that the missionary doctor among the Abron is seen to cater for both the religious and biological aspects of disease - he treats cause (sin) as well as symptoms (p.176). Pokot see a single hierarchy of therapeutic options, and not parallel systems of medicine. Schwartz calls the therapeutic options "a hierarchy of resort" among the manus but among them there seems to be a rigid distinction between Western medical practitioners and traditional healers in general. The two types of

practitioners are thought to operate on two distinct categories of illnesses, while among Pokot, an illness can be treated by both traditional and Western medical experts. Hence it can be justifiably argued that Western medicine is not perceived as being a completely different type of therapy, rather, it is a special form of therapeutic intervention which is not new to Pokot. At the perceptual level, therefore, a syncretization has taken place to accommodate the practices introduced through Western medicine. This cognitive syncratization gives Pokot a sense of stability in a rapidly changing environment by regarding new forms of therapy as aspects of the old. New explanations about the causation of illness can be accepted without necessarily altering the basic structure of the Pokot theory of illness. Of course, in spite of the cognitive accommodation of Western medicine in the traditional scheme, there are some illnesses which are classified as treatable better by traditional than Western therapy and vice versa. I now turn to this dichotomization.

I have already referred to the fact that the dichotomization of illnesses into those thought to be treatable by indigenous and Western therapy respectively obtains in many societies. Pokot also make this distinction, because conditions requiring medical intervention are classified into two categories namely Pojon and Mzungu (Pojon simply means "of Pokot"). In the category pojon Pokot place those conditions which they say should be handled by traditional therapies while in the Mzungu category are placed medical conditions which Pokot say are best treatable by Western therapy. This classification is shown in Table 2 below. I shall show presently that the criteria for this classification are varied, and that this categorization is not always maintained in practice. Some informants said that this classification has not been

fixed since the introduction of Western medicine because some conditions have moved from the pojon category to the Mzungu one. I give some examples of this process later on.

Table 2

Pokot Classification of Conditions Requiring Medical Intervention[5]

Pojon

A. Epilepsy
Sterility
Impotence
Mental Illness

B. Bone setting
Constipation
Trephining

C. Curse (chupo)
(pan)
Ancestor spirits (onyetei)
Evil spirits - (oohi)
Oath - (muma)
Wind - (yomat)

D. Circumcision and Cliteridectomy
Cosmetic scarification and tooth removal
Ear piercing
False teeth removal and uvula excision

E. Mzungu

Mainly acute ailments and conditions requiring surgical operations but also the following:

Venereal disease
Kala-azar
Tuberculosis

As seen from the table, the classification is not based simply on the distinction, reported for other societies, between acute and chronic conditions, with conditions of the former description being regarded as treatable better by Western medicine and the latter by traditional medicine. In order to examine what does distinguish the two major categories I have subdivided the medical conditions in Table 2 into five sub-groups (A-E) according to the kinds of response Pokot make to the

different conditions. I discuss the broad basis of the sub-grouping first and will return later to consider detailed responses and the reasons for them.

In sub-group A I have placed illnesses which, irrespective of their preceived causality, Pokot regard as not easily treatable by Western medicine. These are conditions where it is possible for Pokot to relate therapy and cure, if it occurs, quite easily. Informants claimed that impotence and mental illnesses are both treatable by traditional medicine, but they thought Western medicine is not capable of curing such conditions. I was also told of several cases of women who had been cured of their sterility by indigenous medicine but verification of such claims is not easy in the circumstances of field-work. Pokot say that epilepsy is not curable even by traditional medicine but it is classified as a pojon illness because, as I show later, traditional medicine has excuses for failure in therapy, though these are not extended to Western medicine.

Sub-group B includes those illnesses which traditional healers can deal with successfully, even though they can also be effectively dealt with by Western therapy. Sub-group C includes not any specific illnesses per se (primary definition) but rather phases of illness (the secondary definition). There is no single illness for example called a curse (chupo) - several illnesses may be seen to include the curse in their causation. But informants were agreed that illnesses thought to include any of the forces in C belong to the pojon category because Western medicine does not understand this phase of illness. But as I show later, this does not mean that the biological phase of an illness thought to include any of the forces in C is not referred to Western medicine. From the way Pokot talk about the matter, it may appear as

though any illness defined as chupo or pan (for example), is not referred to Western medicine during the course of its treatment. Sub-group D contains those medical interventions which are not part of the domain of Western medicine. Circumcision, clitoridectomy, cosmetic scarification and ear piercing are carried out for cultural reasons, or more specifically, the main purpose stated for their performance is cultural (though Pokot sometimes give "medical" reasons for circumcision and clitoridectomy).[4] In sub-group E are those illnesses where the efficacy of Western therapy has been clearly demonstrated to Pokot. The foregoing shows that Pokot classify conditions into pojon and Mzungu for many different reasons, and that in this classification, notions of causality are only crucial for those conditions in sub-group C. The most important criterion for this classification (except for conditions in D) is the perceived efficacy of Western medicine. I should add here that there are many other illnesses which are not classified as either pojon or Mzungu. The classification of conditions as pojon or Mzungu is an ongoing process because conditions which were once in the pojon category have been moved to the Mzungu category. For example, cholera used to be regarded as a pojon disease before the efficacy of Western medicine was demonstrated to Pokot. In the last few years, the Ministry of Health has dealt successfully with a number of cholera epidemics. Pokot still think that cholera, as any other epidemic, is a punishment from Tororot for moral offences for which the whole society is to blame. Venereal diseases were in the past regarded as pojon conditions, because the efficacy of Western medicine to cure tham has only recently been demonstrated. In the past Pokot were very fearful of going to hospital to receive treatment for VD because of the fear that they would be reprimanded by Western-trained health workers who blamed them for care-

less moral behaviour. In the past, few Pokot returned to complete the course of injections if they had been reprimanded during the first visit for contracting VD. For a long time therefore few received the full course and therefore the efficacy of antibiotics was not demonstrated. Private clinics do not reprimand patients for their illnesses and it is through these that Pokot have come to perceive that Western medicine can deal with VD effectively. I should stress here that the classification of medical conditions as either pojon or Mzungu is not determined solely by their perceived causality, because there is no special reason why for example VDs should have been regarded as belonging to the pojon category, because Pokot do not associate their causation with any inter-personal or spiritual forces. Later on, I discuss how Pokot respond to the occurrence of conditions belonging to any of the sub-groups A-E, and it will be clear that the dichotomization of medical conditions at the cognitive level is not always maintained when it comes to illness behaviour. It is my impression that the mzungu category of medical conditions is expanding while the pojon one is decreasing for conditions requiring intervention on the biological plane.

5.3 Physical Organization

Among Pokot today as among all the other societies in Kenya, Western health facilities and practitioners are separated physically from traditional practitioners. This separation has existed since the introduction of Western health services in Kenya and there are few signs, if any, that the two will be brought together. Legally and politically, traditional health services have little recognition and no financial support from the Government. This stems mainly from the fact that right from the beginning, traditional medicine was regarded as

inferior to Western medicine and therefore it had to be supplanted by the latter. I examine the historical background to this separation in detail in the next chapter.

In spite of government (past and present) and church opposition, traditional healers still practise among Pokot and though their numbers are not known, they outnumber Western health workers by far. So far, there are no professional associations of indigenous healers as have been reported for other areas. No single administration of the indigenous services exists to date and there is no control about entry. But there are several people occupying the role of traditional healers as discussed in Chapter Three. The traditional healers form a hierarchy starting from the herbalists (and other practitioners who deal with the biological aspects of illness), right up to the prophet who deals with social and spiritual aspects of illness at the highest level. Most of these traditional healers live with the people and share the same concepts of health and illness. They can, in most (but not all) cases be reached easily when they are needed. The major problem with them is that they are not in one place so that if a patient needs to consult two or more of them at the same time, it is not always easy.

Western health facilities among Pokot are provided by the facilities described in Chapter Two and a few other stations sporadically visited by Mobile Clinics. Over three quarters of these facilities are run by churches, one by a private doctor and the rest by the government. Though there are thus three versions of Western medicine, their approach to health problems follows the same pattern so that they can be regarded as a unit in contrast to the traditional practitioners. Western services are recognized and supported financially (except the Private Clinic) by the government. These services are all

provided by a group of practitioners who are usually stationed in one place and most are non-Pokot. There are tremendous problems of accessibility because of a poor transport network.

That the two types of medicine are so far apart physically is not a problem of the Pokot's own making. This is a situation which has been thrust upon them. When I asked Pokot whether they were happy with the situation, the response was usually to the effect that the two types of health services should be brought closer so as to lessen the need to cover vast distances in the process of seeking therapy from both traditional and Western medicine.

Though the two types of medicine are parallel in the sense of physical facilities and administration, Pokot oscillate from one to the other, in some cases for a single illness. There are certain implications for the health-seeking process among Pokot which derive from the physical separation between the two types of health services. Pokot sometimes take patients from hospital so that healing ritual can be performed before treatment by Western medicine can continue. There are several instances when those managing the illness of a kinsman have clashed with hospital authorities because of attempting to smuggle a patient out of hospital. Such clashes have also occurred when Pokot attempt to carry out indigenous treatment in hospital. There is also a problem of delayed referral. It is sometimes discovered that traditional therapy is not being effective in the treatment of an illness - it then becomes necessary to transfer the patient to a Western practitioner but it is often too late by the time the latter is reached. Perhaps the most significant consequence is that Pokot in different regions have differential access to both types of therapy and this is crucial when decisions about the management of an illness have to be made.

As shown in the previous chapter, those who have been exposed to Western medicine for a long period tend to utilize it more than those who have little and recent access to Western medicine. In trying to account for the nature of the interaction between the two types of medicine, it should be remembered therefore that external forces are important in structuring this relationship. The existence of physically separated health structures has not been determined by Pokot, but by both the Colonial and Post-colonial governments. It is important, therefore, that attention should be paid to the ways through which Western medicine has been introduced to Pokot, because this has a bearing on its current relationship with traditional medicine, especially at the organizational level.

5.4 Pokot Behaviour in Relation to Western Medicine : Curative Services

Most ordinary Pokot are of the opinion that at the biological level of illness, both Western and traditional treatment are effective. But my observations in the sample households and elsewhere revealed that where Western medicine is available and if the people involved find it practicable to do so, Western therapy is used almost exclusively for most acute and self-limiting illnesses, minor pains and aches (Sub-group E). Other conditions which may not necessarily be acute or self-limiting like venereal diseases, tuberculosis, eye infections, ulcers and conditions requiring surgical operations are also in most cases treatable by Western medicine. Pokot I asked about the reason for preferring Western to traditional therapy for these conditions often said that Western medicine had proved more effective in curing them than indigenous therapy. Pain killers for example, bought in the shops or obtained from Western health facilities, were in use in

all the sample households. Atudo, an elderly and illiterate Pokot for example, always reminded me to buy pain killers for his family whenever I left for Nairobi. He told me that Pokot medicines do not remove pain in the short-run, like when someone has a headache. "Mzungu medicine can remove pain quickly, Algon[5] for example is very good when you have a headache", he said. Most Pokot keep a number of analgesics to be used when necessary. Some of these drugs have now become household names.

However, some conditions (Sub-group B) like sprains, dislocations, bone fractures and constipation are dealt with almost exclusively by Pokot medical experts. Informants told me that Pokot bone setters ar able to deal with most muscle pulls and fractures. I witnessed a number of such treatments and was shown several people who claimed to have been treated by traditional experts. Marakwet experts can effectively deal with head injuries by complicated trephining. When head injuries occur among Pokot, Marakwet experts are called.[6] For some medical conditions, Pokot have come to associate particular therapy with the cure of a given condition. Case 1 of Lopes the healer illustrates the significance of perceived efficacy in choosing therapy. Over time, some routine becomes established whereby a specific illness is always referred to either Western or traditional therapy. This has happened with conditions in subgroups B and E in Table 2 though the problems of accessibility and practicality may hinder the pattern.

In evaluating the efficacy of either types of medicine, Pokot maintain double standards. For Western medicine, efficacy of a cure means the disappearance of physical symptoms within a relatively short time of the application of the treatment - because this is what this particular therapy is thought and indeed expected, to be capable of

doing. As far as traditional therapy is concerned, the disappearance of symptoms is sometimes not the only criterion used when assessing the efficacy of a treatment. This is because excuses, or rather reasons, can always be found for the failure of a traditional therapy - the presence of inter-personal and/or spiritual forces. This means that a traditional treatment can fail to cure a patient and still be resorted to in future; not so for Western treatment. Therefore, when it is not easy to link Western therapy with immediate (or nearly immediate) cure, Pokot say that Western medicine has failed to work. It is therefore understandable that chronic illnesses in which it is usually difficult to achieve cure with therapy (sub-group A) are categorized as pojon. Informants, however, confessed that most of these illnesses are in fact not easily treatable by traditional therapy. Why are they then classified as pojon? The answer seems to lie in the fact that for these illnesses, Western therapy has not demonstrated any obvious advantages over traditional medicine.

My observations involving conditions from the sub-groups A, B and E, revealed that it does not follow that conditions of sub-groups A and B are inevitably referred to traditional therapy and E to Western, according to their categorization as pojon and Mzungu respectively. Cases 5 and 11 for example show that though infertility and mental illness are regarded as pojon conditions, they were in these cases treated by Western therapy. That this should happen is explainable by the fact that besides the perceived efficacy of either Western or traditional therapy for any particular illness, other significant factors affecting choice are the accessibility of the therapy, whether it can be afforded and whether any social or moral considerations hinder the utilization of the therapy thought otherwise to be appropriate.

And of course individual judgement is crucial in determining the therapy eventually chosen. I have discussed these factors in the last chapter, so I only need to reiterate a few major points here. Cases 2 and 3 show how, even when Western therapy was thought to be efficacious, it was not possible to continue using it because of problems of accessibility and affordability. Chèpkemoi's daughter's case (6) shows the significance of social pressures in influencing the decision to use Western medicine. Once again, Pokot pragmatism in responding to illness is revealed in their response to Western medicine.

One can justifiably argue that for conditions in the sub-groups A, B, E and others not specifically placed in either the Pojon or Mzungu categories, traditional and Western medicine compete, in the sense that either can be utilized when these conditions occur. This competition, I should stress, occurs for the biological phase of illness.

Competition never occurs, however, between traditional and Western medicine for conditions in sub-groups D and C. D includes conditions requiring expert medical intervention which Western medical experts do not concern themselves with. Uvula excision and false teeth extraction are performed for "medical" reasons not accepted by Western medicine that is, to cure the cough and infantile diarrhoea respectively. Pokot know that in Western medicine, these operations cannot be carried out for the same reasons, so they are only referred to indigenous experts. Circumcision, cliteridectomy, cosmetic scarification and removal of two incisors on the lower jaw are carried out for cultural reasons, though the people who perform the operations are numbered among the Chepsakitis, medical experts. These operations

usually are part of wider processes marking various stages in social development and maturity. A specific socio-cultural environment is usually needed for each one of these operations, and this makes difficult their being carried out by Western medical experts in a hospital environment. For these conditions, traditional medicine performs a function that is supplementary to Western medicine. In this case social and moral constraints necessitate the utilization of traditional therapy. Though in some other Kenyan societies like the Luhyia, Kikuyu and Gusii circumcision is sometimes performed by Western trained medical experts, among Pokot it is largely the work of the mutin and the kokomelkong.

I now turn to a discussion of how traditional and Western medicine relate to each other with regard to cases thought to involve any of the forces in sub-group C. Anthropologists have usually argued that illnesses thought to involve inter-personal and/or spiritual forces like those in C above are treated only by indigenous therapy. I suggest that this argument is not wholly correct. According to Pokot, such aetiological agents do not in themselves constitute any particular illness as such; rather, they are perceived as phases in the identification of illness. C refers to conditions which are part of a complex process of illness which usually starts on the biological plane. On this plane, therapy can be sought in either traditional or Western medicine. When, however, an illness has been perceived to involve any of the agents in C, Pokot will then treat this feature of the illness by traditional healing ritual only. It is therefore not correct to assume that any illness thought to involve the curse, for example, is only treated by pojon therapy, because it is possible that during its initial phase, this illness might have been treated by Western therapy. In ordinary conversation with Pokot, it is possible to assume that

illnesses thought to involve agents in sub-group C are treated only by traditional medicine, but it is worth remembering here that they are talking about the secondary phase of illness involving the inter-personal and spiritual planes, but not the physiological plane. Even when Western medicine has been used for the treatment of illness, Pokot may consider some psycho-social (traditional) therapy necessary to complete this treatment, if any, of the forces in C are thought to be involved. Here then, it can be said that traditional and Western medicine complement each other. This complementarity implies that Pokot are cognizant of the fact that the inter-personal and spiritual aspects of illness are not part of the domain of Western medicine. There is no conflict here, because the two types of therapy are aimed at different phases of illness. It is thus clear that belief in inter-personal and spiritual forces in the causation of illness need not be a hindrance to the utilization of Western medicine because Western medicine is actually used when available but for the physiological aspects of illness, which it is thought to be capable of dealing with. I have observed this complementarity also among the Samia, Gusii and Kuria. The Samia and Gusii nowadays utilize Western medicine for the biological phase of most illnesses. However, the same illnesses are usually treated at another level by ritual therapy to remove the inter-personal and spiritual forces which may be seen to be involved in the illnesses. But this complementary treatment among Kuria, Samia and Gusii is not considered enough. Considerations of efficacy are important here because an illness is said to be cured entirely when any of the forces which may cause it to recur have been removed.

Another form of complementarity also exists between Western and traditional medicine. Even when a patient is treated in a Western-type

health facility, the psycho-social support offered to him is along traditional medical lines. For example, an adult is supposed to spit in his hands before greeting a patient. The person should also utter a short prayer beseeching Tororot to heal the sick person. Visiting the patient and spending time with him is regarded as an important part of treatment, be it Western or traditional. It is also considered important that kin, friends and meighbours should take a break from their daily activities if a patient is undergoing surgery, be it at home or in hospital. To continue working especially when an adult is very sick in hospital is tantamount to saying, according to informants, that his life is less important than the work being done. Utilization of Western medicine is thus supported by modes of behaviour which are part of the indigenous Pokot understanding of therapy.

Gould-Martin (in Kleinman et al. 1978:41-64) reports a similar complementarity between Western and traditional medicine. Referring to the Ong-ia-kong in Taiwan, she says that this healer's dealing with the social and spiritual aspects of a patient's illness does not interfere with Western medicine, rather, it "patches" it by handling the conditions underlying illness such as fate or loss of harmony (p.61). Janzen's study of the Bakongo quest for therapy also illustrates the same point. Not much attention has so far been paid by medical anthropologists to the complementarity that can exist between traditional and Western medicine in developing countries. I think this failure to unravel the complicated nature of the relationship between the two types of medicine has contributed to the over-statement of the role played by indigenous medical concepts as constraints in the attempt to extend Western health services in developing countries. I shall look at this in detail in the next chapter.

I conclude this section by stating there is little pre-determination of the sequence in which traditional or Western medicine is used for conditions thought to be caused on the biological plane only, as has been argued for some societies (Asuni 1979). What seems to be predetermined in the health-seeking process among Pokot is the sequence in which kitö sak t and saapken are carried out. In most cases, the former usually precedes the latter, though at times they may be concurrent.

5.5 Pokot behaviour in Relation to Western Medicine : Prevention

Having examined how traditional and Western medicine relate to each other in terms of curative health care, I now wish to discuss how Pokot relate to Western medicine as far as preventive health care is concerned. Many researchers have reported that preventive medicine usually is not accepted by non-Western societies as much as curative medicine. This observation holds true for Pokot, because though they use as much of curative health services as is practicable, few of them carry out measures which are considered necessary in Western medicine in order to prevent a number of diseases. Medical anthropologists have advanced a number of explanations as to why preventive measures are less readily accepted than curative Western medicine. Most of these explanations lay the blame on the recipient populations' medical beliefs and practices.[7] Foster and Anderson (1978) have summarized a view regarding the reason why non-Western societies practise few preventive measures that is held by many social scientists and health planners:

> In this premise about health, traditional peoples - probably all pre-industrial peoples - reflect a much wider world view: maintenance, Western style is little valued ... Lacking basic agreement that maintenance is essential to a smoothly running society, it is not surprising that pre-industrial peoples are less receptive to maintenance of the human body through preventive medical activities than are people whose ancestors began the practice generations ago. Major forms of preventive medicine are not consistent with the wide world view of traditional peoples, and they will not accept it with the same alacrity with which Europeans and Americans have done so (p.232-3).

This statement does not quite apply to all non-Western societies, because Pokot for example, have clear principles regarding prevention, and this is an important aspect of their theory of illness. For example, in the sample households, almost invariably all mothers with young children mixed kromwo (Ficus sp.) with milk and water before these were fed to the children (to prevent diarrhoea). For the prevention of malaria, a routine use of emetics and purgatives is very strictly followed. There is not a single adult Pokot who does not know nyermen or kapkop both of which are used as prophylaxis against malaria. I have already referred to ighat (Chapter Three) which is an occasion when a whole family is given a mixture of about ten different herbs with goats' soup. When a member of a household is sick, usually the rest of the members are given medicines to prevent contagion. Pregnant women take certain medicines to prevent sickness and do not eat the meat of a sickly animal or one which has died due to sickness. Such women should drink from a spring set aside for them, and do not drink from the common streams from where Pokot say the pregnant women may catch disease. It is one of the major duties of the household head to perform saghat (prayers) and amoros (sacrifice) so that Tororot can protect the household from sickness. At the communal

level, once a year the punyon ritual is performed, to ensure good health for man, crops and animals.

The argument I wish to develop in the following paragraphs is that among Pokot, preventive measures based on Western medicine are practised less than Western curative medicine is used because of lack of proper knowledge about the measures, difficulties of perceiving the efficacy of the measures, the impracticability of some of the measures and the way the measures are introduced, and not because they lack an understanding of the principle of prevention as such.

Lack of proper knowledge about prevention as understood in Western medicine is widespread among Pokot, and this is mainly due to the fact that not much has been done to teach them about it. Since few adults can read it is not possible for them to acquire this knowledge from the scanty literature that is available. In the sample households, there were only three radios which means that the people do not have access to the health programmes broadcast on radio. Until very recently, Western health workers dealt only with the curative aspects of Western medicine. In schools, health education is given little emphasis because it is not one of the subjects that are examined in the Certificate of Primary Education. In any case, adults are not likely to listen to their children telling them about the health education they may acquire at school. It is therefore not surprising that little is done to prevent preventable diseases like malaria and diarrhoea.

Some measures to prevent diarrhoea for example could be carried out in the Pokot environment, but the need to carry them out must be revealed to Pokot.[8] In the core sample for example, there are only six privies (for 30 households). In eight of the households, goats,

sheep and chickens share the same room with human beings. Pokot mothers faithfully mix several traditional medicines with milk and water for new-born babies and the practice goes on for several months. Weaning of babies is usually very sudden and the breasts may be smeared with bitter substances and dirt to prevent the child from suckling. The feeding bottle has now become very popular, not only for artificial feeds, but for water and porridge, but it is difficult to keep it clean and thus prevent infection. All these practices are carried out because Pokot are not aware of the danger of infecting children through them. The few mothers who have learned about the prevention of childhood diarrhoea are now trying as much as possible to carry out the preventive measures they have learned. But these are only a minority in areas like Kapenguria and Chepareria where the Mother and Child Health Clinics and maendeleo clubs are more active. In areas like Mwino, mothers continue with the practices they have learned in the traditional setting.

Malaria is another disease that could be prevented, but again, as with diarrhoea in children, there is lack of proper knowledge about its prevention. Chloroquin is used widely for curing the disease but few people know about its prophylactic properties. The traditional preventive measures are still carried out by most Pokot. But the lack of knowledge means that prophylactic use of chloroquin is hardly understood. Pools of water near homesteads are not drained to prevent Mosquito breeding because the insects are not thought to be connected with water. As shown below, however, even the few who understand that malaria can be prevented by various measures find it highly impracticable to carry out the measures. The only preventive measure which most Pokot know about well is that of spraying houses with

insecticides, thanks to the shopkeepers who have done much to tell Pokot about it (the motive being to increase their sales). Though insecticides are available in most shops in the area, spraying is expensive and uneconomical and is therefore hardly ever used. The above examples on the lack of knowledge about the prevention of diarrhoea and malaria could be extended to include many other diseases but they give an indication of the problem.

Closely related to the lack of understanding about proper preventive measures is the difficulty in perceiving the connection between the preventive measures and reduction of the incidence of specific diseases. Preventive measures in most cases have a long term effect and it is not therefore easy to relate them to their outcome. It was remarked severally by informants that though shopkeepers praised the effectiveness of insecticides that kill mosquitoes, many people had used them for a while, only to stop when the cases of malaria did not go down. The maendeleo women were especially concerned that though they kept their babies clean and boiled water, this did not prevent the children from getting diarrhoea. It was also remarked that even children born in households with privies contracted diarrhoea and other diseases as much as those in households without the privies. Since the introduction of the Mother and Child Health Clinics, Pokot mothers in Chepareria have now proved that measles, tuberculosis and polio can be prevented by immunization. This is why many women attend the clinics and the queues are especially long when immunizations are taking place. Immunizations are regarded as ighat and as one mother put it "The medicines they give our children strengthen them. Their blood is made powerful so that diseases cannot weaken them. Those women who do not take their children to the clinic

are foolish". But immunization is not so popular in remote areas like Tamkal and Sook where its efficacy has not been demonstrated because few children have ever been vaccinated. I have indicated above that the efficacy of Western-type health measures is assessed according to whether the measures remove physical symptoms of an illness (or prevent their onset in case of preventive measures) or not. To reduce diarrhoea or malaria in any significant degree necessitates the carrying out of many types of measures at the communal level. Individual households may try to control either disease but they normally meet with little success because their neighbours can be a source of infection. Soon such a household discovers that the preventive measures they take are not effective and therefore give them up.

Even when Western medical preventive measures are known and their efficacy perceived, it may prove, in the Pokot environment, impracticable to carry out the appropriate measures. This can be illustrated by a consideration of the problems encountered by Pokot who attempt to control diarrhoea and malaria. These problems stem from the low level of socio-economic development in the area. The incidence and prevalence of diarrhoea is greatly affected by the house type, availability of water and some indigenous practices. Though individual mothers may make attempts to keep their children clean, this measure in itself cannot reduce the chances of the child being infected. The dirt-floored houses, lack of privies and the presence of chickens make the physical environment easily contaminated. Further, infected children share the same utensils and sleep with the healthy ones. Water shortage in an area with only seasonal rainfall is an acute problem. There is evidence which suggests that some diarrhoea can be reduced when plenty of water is available and used around the home -

but the quality of water must be good. In Chepareria for example during the dry season (December-March) water is only available in one or two permanent streams, and the rest of the streams dry up completely. I estimated that during this period, a family of about seven uses no more than twenty litres of water in twelve hours. The problem is compounded by shortage of storage facilities. In such an environment, piece-meal measures like washing the baby do not help, because the baby easily picks up and puts in his mouth objects which may contain pathogens. Most mothers are aware that the incidence of diarrhoea in their children increases during the weaning period. Some of this increase is due to contaminated food prepared in unhygienic surroundings. The recently introduced feeding bottle is a major source of infection because it is extremely difficult to sterilize, given the home environment. There is no special food for weaning children and the food they eat is prepared for adults. Such food can in itself cause digestion problems. To improve the situation, better housing and plenty of water are essential - but these two are out of the reach of many Pokot because of their physical environment and low economic development. It is not possible for many households to provide for their children an environment which reduces chances of infection with diarrhoea.

The control measures for malaria also present many insurmountable practical problems for those Pokot who may have knowledge of them. Of the thirty household heads in the sample, at least ten revealed knowledge of at least one way of preventing malaria according to the principles of Western medicine. But not a single household among the thirty was involved in regular control measures to prevent malaria. Spraying of houses to kill adult mosquitoes has been tried but soon

left because it is both expensive and uneconomical. A small can of the insecticide spray costs about twenty Kenya shillings, but this is only enough to ward off or kill mosquitoes in one house for about two nights. Most Pokot houses contain many openings so that the insecticide quickly diffuses to the outside. To use the insecticide everyday will cost well above the average monthly income of most people in Chepareria. Using larvicides in stagnant pools of water is equally expensive and less desirable because such pools in most cases provide much needed water for livestock. The netting of beds at night is out of the question because of the expenses involved and also because many Pokot sleep on the ground and therefore it is difficult to provide a mosquito-proof chamber by netting. Prophylaxis seems to be the only viable preventive measure, but the weekly dose of chloroquin is not yet popular enough among Pokot. Children find the drug unpleasant and when the syrup form is obtainable it is usually drunk with little consideration about dosage. In any case there are few areas in Kenya where prophylactic control of malaria has proved successful. Two households only in the core sample took chloroquin to prevent malaria, but not on a regular basis.

The way preventive measures are introduced to Pokot is crucial in determining their reception. This can be illustrated by attempts by the Ministry of Health in West Pokot District to introduce the construction of latrines to the people. I watched these attempts in Chepareria Sub-location during the course of my fieldwork. By the time I left the area, only 33 latrines existed in an area with about five thousand people[9]; only seven of these were a result of the special efforts by the Public Health Department - the rest had been dug before. In 1979 and 1980, severe epidemics of cholera broke out among Pokot.

These epidemics aroused a lot of concern because health authorities toured the area and found it to be very unsanitary. Public health technicians were therefore told that they should teach Pokot about the necessity of latrines in order to prevent further outbreaks of the disease. In Chepareria Sub-location, the campaign was launched at the District Officer's meeting in July 1980. Pokot were told that latrines would, if constructed, reduce the risks of a cholera outbreak. It was then made clear that those who did not dig the latrines would be reported to the Chief for prosecution. The Public Health Technician for Chepareria toured individual homesteads and, by himself, selected the area where the latrine should be put up. He then gave the homestead two weeks within which to complete the latrine construction.

The results were very disappointing because, by the time I left the field (towards the end of 1981) only seven new latrines had been constructed. A number of people were reported to the Chief but the reasons they gave (rather, excuses) for not putting up the toilets were convincing. I was present when some of them explained why they had not complied with the instructions from the health authorities. Some argued that the area selected by the health technician for the latrine did not belong to them - he should have consulted them. Others said that they did not know how to do it, so they were looking for people who knew how to do it for money. Yet others said that it was too expensive to pay for the construction of a latrine - it could cost up to two hundred Kenyan shillings. Others claimed that they lived on very rocky land, so it was not possible to dig the latrine. A letter I received recently stated that to date, there are not more than fifty latrines in the sub-location, (excluding those in institutions). I had raised the matter with the District Public Health Officer: his

opinion was that Pokot are still too primitive to understand the importance of having privies.

This unsuccessful experiment is typical of many attempts to introduce innovations in health to non-Western societies. There is no doubt about the importance of privies as a preventive measure. The problem revealed here is one of approach. No attempt was made to teach Pokot about the relevance of latrines in their environment - it was assumed that since latrines are an important facet of preventive medicine, Pokot would automatically dig them and within a matter of weeks. It can be argued that the Public Health Technician in this particular place made a mistake - I found out, however, that the same failure had occurred in other areas of the District. Since the introduction of modern medicine among Pokot, there has never been any systematic programme aimed at enabling Pokot to understand how the construction of latrines contributes to the prevention of various diseases. It is also surprising that indigenous structures such as the kokwa, were not involved in the attempt to make Pokot construct latrines. Those Pokot who have latrines are the ones who understand that they are important for the prevention of diseases - usually people who have travelled out of the District. During the cholera epidemics in 1979 and 1980, village committees were selected by the people and paid by the Ministry of Health to ensure that people maintained high standards of hygiene. The committees were quite successful, according to the Ministry of Health officials - but the committees were disbanded when the epidemic was eradicated. Such committees would have been very useful in the campaign to get Pokot to build latrines. It should also have occurred to those concerned that digging a pit latrine is a complicated and often hazardous exercise. Arrangements were not made

to demonstrate the techniques to Pokot who are not used to latrine construction. Lacking proper skills about their construction, Pokot who decided to construct them had to rely on a team of non-Pokot to do the work at a very high price. Most Pokot found it difficult to justify the expenditure of money on a venture whose benefits were not yet demonstrated. The endeavour to introduce latrines contrasts sharply with the introduction of rehydration for the management of infantile diarrhoea in the same area. The latter was largely successful because of the approach of the change agent, and of course because it did not involve the expenditure of large sums of money.

The discussion in the last three sections can be summarized in the following words. At the organizational level, two independent structures, one for traditional and another for Western medicine, exist. At the cognitive level, in spite of the dichotomization of some medical conditions as either Pojon or Mzungu, Pokot conceive of both traditional and Western health workers in a single hierarchy, depending on the plane on which a particular practitioner intervenes during therapy. According to this scheme, the Western health workers, daktari, are placed alongside herbalists, while the diviners and prophets are at a higher level. At the behavioural level, however, traditional and Western therapy interact closely, in several cases both being used for the same episode of illness, but there is also competition and supplementation between the two types of medicine. Pokot do not see Western medicine and its traditional counterpart as two parallel systems, but rather as different parts of one system.

5.6 Categories of Pokot and How They Relate to Western Medicine

Having discussed the relationship between traditional and Western medicine in terms of certain curative and preventive measures, I now wish to discuss the relationship from the perspective of specific categories of people in the Pokot environment. The purpose of doing this is to show how, impelled by social or moral considerations, people of various social categories relate to traditional and Western medicine differently so that it is not correct to label the relationship simply as one of conflict. It will be shown that some people actively oppose Western medicine; others just accept it as another option in their hierarchy of therapeutic alternatives, others actively support it and some, especially categories of indigenous healers, incorporate Western elements in their practice. The categories that I discuss are the indigenous medical practitioners, community leaders, Christians, administrative officials and Western-trained health workers.

I have already pointed out that there is not one, but several types of Pokot traditional medical experts. The traditional experts respond to Western medicine in diverse ways, for as Landy (1977) aptly states:

> The challenges of change and powerful competing systems often result in the near-submergence of traditional healers and medical systems. But just as often they afford opportunities as much as threats, and indigenous systems and personnel respond in adaptive and not infrequently innovative ways (p.467).

Among Pokot, the first category of healers I deal with, comprising the Werkoyon, Kapolokion and Liokin, is totally opposed to Western medicine. The main reason for this opposition seems to be because these experts stand to lose much economically and to some extent politically if Western medicine becomes fully established. These

healers traditionally earn their living almost entirely from their practices -·other medical experts usually engage fully in economic activities such as agriculture and trading. The fees charged by these three types of healers are relatively high compared with the rest of the others. Any of these three can charge up to the equivalent of an ox and sometimes more, for their services. In their dress, speech and mannerisms, they are expected to live as authentic Pokot. They may not, for example, become Christians or attend adult literacy classes. No case could be remembered when a Werkoyon, a Kapolokion or a Liokin had been admitted in a Western hospital. They see Western culture as the cause of the famines and epidemics which have recently plagued Pokot. The Werkoyon is the most vocal in opposing Western medicine. In the last few years when epidemics of cholera and rabies broke out among Pokot, Werkoi exhorted Pokot to slaughter oxen and even donkeys so that the epidemics could come to an end. The Werkoi claimed that the Western treatment offered at various centres for cholera could not work, unless accompanied with appropriate ritual, because the epidemic was a punishment from Tororot. Though most Pokot ignored the warnings, some, especially in the remoter parts of the District, heeded their advice, much to their dismay because it soon became clear that the Western treatment indeed worked. These healers do not refer their patients to Western medical practitioners, though the patients may later decide to visit the hospital. The three types of healers have not incorporated any Western techniques in their practices. In Kapenguria and Chepareria, these types of healers are no longer resorted to as much as before. But in some of the remoter areas of the District, they are still regularly consulted. A further reason for the Werkoyon, Kapolokion and Liokin being opposed to Western

medicine is because its introduction has contributed partly to their losing the political influence they held in the past. The Werkoyon for example was consulted about seasonal migrations, raids and any fighting Pokot carried out with their neighbours. The Kapolokion was usually approached by elders to afflict offenders with illness as punishment for social wrongs. The Liokin could also be approached by a whole community, to rid the country of illness and punish those who used pan to molest others. Because of their power over mystical forces, these experts were usually consulted whenever there were important matters to be decided upon. Their political influence derived from their knowledge about mystical powers. This power has now been greatly eroded, not least because not all Pokot now think that the experts are the only authorities as far as misfortune and in particular, illness, is concerned. The experts know that their power has declined because of Western education, the national government - in short, because of maendeleo development. It is worth noting therefore that these experts are also opposed to Western education, Christianity, Western medicine and the administration. Western medicine to them is part of the maendeleo which has robbed them of the ritual, political and economic benefits which they enjoyed in the past. Their response can be regarded as part of a Pokot "nationalism" which the experts express rather covertly because they know the strength of the maendeleo they are contending with.

The diviners (Pkwanyan, Pkweghion, Chepsogoyon) and the ritual leaders (such as the Parparin) are not as opposed to Western medicine as the healers discussed above. Western medicine is seen as just another alternative which the diviners can advise their clients to use. The presence of Western medicine has not led to any marked reduction

in the number of rituals which the ritual leaders conduct for patients. This is because among agricultural Pokot, the increase of trading activities, cash crop farming and Western education has led to many inter-personal relations worsening and as a result of this, diviners have a lot more work to do than before and this inevitably means that the ritual leaders have many saapken to perform. The roles of the diviners and ritual leaders in any case need not necessarily conflict with Western medicine, because they intervene on different planes of illness. I interviewed four diviners, two in Chepareria, and one in Kapenguria and Mwino respectively. They seemed unanimous in thinking that they complement the work done by Western medical practitioners. Kongelai, one of the diviners, put it this way:

> Awoi, mzungu sindano[10] medicine is powerful, My eyes had troubled me for a very long time, but they gave me good medicine in Kapenguria. It is Tororot who gives them their medicines as he gives us. Our medicine is also good. The daktarion does not know about oi and onyeti which trouble our people. But we can see them and advise people to remove them by performing the appropriate saapken. I help my patients to understand the need to follow kirurut (moral rules). If I see that a client is to blame for his illness, I do not hide it - I tell him frankly that he must reform his ways or he will lead his family to misery. There is now much hatred in our community. People want to take other people's land. So they accuse one another of pan. I rebuke them when they come to me (interview at Ortum, September, 1980).

Angar, a ritual leader, remarked "The daktarion's medicine is powerful, like our sak t, but he does not know about our rituals of healing". The diviners and ritual leaders maintain a peaceful co-existence with Western medicine, because its weaknesses are their strengths. Diviners do not rebuke their clients for consulting Western medical practitioners before or after seeing them. In many cases nowadays they advise them to visit a Western health facility for treatment of the biological aspects of an illness.

The diviners do not seem to have changed their methods of divination in the recent past, but they now advise their clients on a wider range of problems than before. Success in education, trade, cash crop farming and salaried job-seeking are now part of their concern. Unlike before diviners now accept cash in return for their services instead of grain and livestock. Ritual leaders nowadays can accept shorter versions of a ritual and they are usually instrumental in arranging the substitution of one healing ritual for another as stated in the last chapter. Some patients nowadays may reject certain requirements of a ritual, (for example the removal of clothes) and the ritual leaders do not insist on following the prescriptions of the ritual to the letter as informants claimed they did in the past.

The traditional medical practitioners I have so far dealt with are concerned with the inter-personal and spiritual phases of illness. I now turn to those practitioners who deal with the biological aspects of illness. I have split this category into two groups; the first group includes the herbalists, the traditional birth attendants, bone setters and tooth extractors, while the second consists of those experts who deal with medical operations which are mainly of a cultural nature - the circumcision and clitoridectomy experts, scarification experts, and those who fit the lip plugs. I deal with each group in turn. The herbalists, birth attendants, bone setters and tooth extractors are grouped together here because they deal with medical problems which are also dealt with by Western health workers. Except in areas like Tamkal, Lomut and Sook where Western medicine is still out of the reach of many Pokot, this group is having to face the challenge of Western medicine among agricultural Pokot. This challenge comes in the form of shop medicines, mobile clinics (especially the

Mother and Child Health Clinics), and the dispensaries and hospitals. The factors which are considered when Pokot have to decide between traditional and Western medical experts have been outlined in the last chapter. I only need to reiterate here that sometimes it is more practicable to use traditional rather than Western medical experts and further that to most Pokot, traditional healers are still more accessible than Western health workers. Where Western medicine is easily accessible and when it is not easy to decide whether an illness is amenable to treatment by a traditional or Western practitioner, a situation of "perfect competition" exists. My informants seemed to suggest, however, that Western medical practitioners are in a better position in this competition because they have government recognition and support and are all usually available in one place. The traditional healers revealed a clear knowledge of the fact that they are competing with Western type healers, I visited several herbalists, birth attendants, bone setters and tooth extractors and watched some in practice. There was not one of those I talked with who said that Western medicine was inferior to traditional medicine or vice versa. One herbalist in Chepareria put it very clearly

> Whether a patient consults a daktarion or is treated by a pojon chepsaktian, it is the "hand" of the healer and his "heart" which matter. All medicines are the same. If my medicines do not cure a patient, I tell him to see a daktarion.

Some herbalists, however, claimed that there are some diseases which they can deal with better than Western practitioners. Kokolima, for example, said that chepskut, an inflammation of the mouth in young babies, responds better to her medicines than to Western medicines - but she noted that when her child had sustained severe burns, she had

rushed him to the dispensary. Traditional birth attendants feel the challenge from Western medicine very acutely. They realize that their techniques are not effective when complications develop when their clients are in labour. But they still know that many mothers have little access to Western health facilities; even when they do, they may choose to be delivered by traditional birth attendants. Jenet Loyong, the leading birth attendant in the Sub-location, had this to say regarding her role as a midwife:

> The daktarion can deliver a woman, but he does not see her until she is in labour. We stay with and advise our clients from the time they conceive. When they have delivered, they come to us and we advise them about the food they should eat and how to care for their babies. In hospital, they allow men to come to the labour room. Young girls abuse the woman in labour - girls who have not had children. They do not allow other women to support the woman in labour and to sing when she has done it. (July 1981, Propoi).

But Jenet advises some of her patients to be taken to hospital to deliver. (Her own daughter delivered in hospital (case 6) though she had had no complications.)

The bone-setters and tooth extractors also face stiff competition from Western practitioners and so are looking for ways to attract more clients. The herbalists, traditional birth attendants, bone-setters and tooth extractors are meeting the challenge from Western medicine by trying to modernize their practices. Hygienic measures such as boiling and washing are now widely used, especially by the birth attendants. Medicines are now packaged in paper bags, bottles and cans. Dosage is given in terms of cups and glasses. Some Western drugs such as gentian violet and potassium permanganate are now used - I witnessed a case where after extracting a client's tooth, the expert told the client to gurgle a mixture of water and salt and the wound was then covered with gentian violet. As already noted, some cases are referred

to Western healers when it is realized that a case is too complicated; such referral is increasing because the healers fear prosecution if a patient dies in their hands. In the past, few of these healers could admit that they could not deal with some cases brought to them. Some of the healers are trying to enhance their prestige by joining adult literacy classes or becoming Christians. Most of the traditional birth attendants are strong members of the Maendeleo ya Wanawake clubs and attend the Maternal and Child Health Clinics. Informants claimed that the fees charged by these healers have decreased drastically so that many clients find it cheaper to consult them than to visit a Western-type health facility. Let me illustrate these adjustments by describing how Jenet Loyongo, a leading herbalist-cum-birth attendant has reacted to the challenge of Western medicine.

Jenet is about fifty years old and lives in Chepareria. She used to carry out clitoridectomy but stopped in 1961 when she became a Christian (Anglican). She was then trained as a herbalist by a friend and also learned to do midwifery. She told me that when a dispensary was built near her home (1966) the number of patients who visited her began decreasing. She decided to build a number of huts so that those patients who came from far could stay as in-patients. Instead of demanding cash payment after treating her patients, she allowed them to pay later - and the patient decided how much. Those who could not pay her worked in her gardens. A patient can return as many times as it is necessary until he recovers. If a patient does not respond to Jenet's medicines, she can refer him to another herbalist or to the dispensary. At present she has four wards used by in-patients. Some of the patients sleep in her own two houses and share her food. When the Mother and Child Health Clinics began at the dispensary, Jenet

became one of the first regular attendants. The Maendeleo clubs which encourage women to engage in development activities also impressed her, so that she joined the Chepareria branch, where her daughter is the leader. Before and after she treats her patients, she prays to Tororot to heal them. Her homestead is kept very tidy and she has now put up a corrugated iron-roofed house with plenty of room for her consultation. She dresses very smartly, is extremely friendly and reassuring to all her patients. Most of her clients are pregnant women and children. She gives them very detailed advice about how to care for themselves and their young children. Because of these adjustments, she has a constant stream of clients - especially Christians and younger Pokot women. Her adjustments to changing conditions show that she is cognizant of the challenge offered by Western health workers. Those herbalists and traditional birth attendants who have not adjusted to the changing conditions tend to lose many of their clients to enterprising ones like Jenet and Western health workers. These adjustments by traditional healers is most marked in those areas where Western medicine is accessible. As already pointed out, in areas far removed from Western medicine, no threat is felt and consequently few adjustments have been made by the traditional medical experts.

The last category of traditional medical practitioners I wish to discuss consists of experts who carry out various operations mainly for cultural reasons, circumcision, cliteridectomy, removal of two lower incisors and piercing the lower lip to insert the aponoi "lip plug". As noted in previous sections of this chapter, these operations are not carried out by Western medical practitioners, and the traditional experts therefore do not feel threatened from this angle. The practices are however condemned by missionaries and government

officials. These experts still use traditional techniques and have made few adjustments. Since they do not experience any challenge from Western medical practitioners, they maintain a peaceful co-existence with the latter.

A development which shows the competition between indigenous and Western medical practitioners is the emergence of a new type of practitioner (for whom Pokot have not found a name) who combines both traditional and Western type elements. He is referred to simply as chepsaktian which means healer in general, though some Pokot refer to him as daktarion, a term used for Western health workers. This new type of healer uses the hypodermic needle, antibiotics, chloroquine, and a whole range of other drugs obtainable from various sources.[11] However, he behaves like the traditional herbalist in the therapeutic interview. He does not have an office and can consult with his clients anywhere. On most occasions he is called to treat the patient at his home. The atmosphere is very informal and he explains the illness to the patient according to the indigenous paradigm of illness. Herbal concoctions are dispensed and food prohibitions imposed. Some of these practitioners keep written records and others do not. Their approach is aimed at preserving the best in the traditional approach while incorporating elements from Western medical practices but adapting them to the local conditions.

As can be seen from the foregoing, the relationship which traditional healers maintain with Western medicine depends very much on the challenges which the latter is perceived to present, since the category implies the relationship which may involve direct opposition (e.g. Werkoyon, Kapolokion and Liokin), competition (e.g. herbalists, birth attendants, bone setters and tooth extractors) complementarity

(e.g. diviners and ritual leaders) supplementarity (e.g. the circumcisors and related specialists).

Some of the traditional practitioners have adjusted their practices in a number of ways so as to meet the challenge of Western medicine. Landy (1977) has discussed these adjustments by traditional healers quite usefully by using the concept of role. He gives several examples of role adaptation by traditional healers faced by Western medicine. He also says that some traditional healers' roles become attenuated, for example when a healer accepts diminished prestige and loss of clients because of competition from new types of practitioners. In the Pokot context, the Werkoyon, Kapolokion and Liokin realize this danger as Western medicine spreads - they have therefore adopted a hostile attitude to the new type of therapy. The prestige formerly accorded to them is diminishing due to the influence of Western education and religion. To survive they are starting to accept greatly attenuated roles. Landy's "emergent role" concept seems to be an apt description for the new type of healer among Pokot who combines the old and the new in the health-seeking process (p.475). This type of practitioner contrasts very sharply with the normal Western-trained health workers who are not prepared to utilize any traditional principles or medicines in their practice. He acts as "a bridge" between the two types of therapy and his practice seems to be attractive to most Pokot. In a way, most herbalists and midwives are tending to assimilate more and more modern methods as a strategy of retaining clients whose perceptions of the role of a medical practitioner have been influenced by their contact with hospital medicine.

Pokot who are teachers, civil servants, councillors (and politicians in general) and church leaders are looked up to by other

Pokot, as pace setters in the process of maendeleo. They form a category called viongonzi lit. "leaders". This is a Swahili term which is commonly applied to community leaders in Kenya. Viongonzi are expected to set examples to the rest of Pokot regarding the need to participate in development activities. Though development according to the National objectives means an improvement in the socio-economic conditions of the people, in Pokot, as in the rest of rural Kenya, development (maendeleo) is interpreted to mean the process of becoming "modernized". Implicit in this concept of development also is the assumption that indigenous ways of doing things should be abandoned. Though their stance is mainly rhetorical and not necessarily related to practice, it is significant that these community leaders tend to speak highly in favour of Western medicine in public meetings. In most of the chiefs' meetings I attended, the chiefs and their assistants repeatedly exhorted their fellow Pokot to stop going to traditional healers and to use the dispensaries and hospitals more. The councillor of Kipkomo Location in a speech on Madaraka Day[12] was very uncompromising in his support for Western medicine:

> My people, why should we remain backward? Why should we continue consulting our healers, who cannot read? Mzungu medicine is good. We must all do what other people in Kenya are doing. People in Kitale, Kisumu and Nairobi go to hospital when they are sick, but we keep our patients at home for too long and only take them to hospital when they are dying (June 1st, 1981)

At the same meeting, Pokot pupils sang a tune (composed by Pokot teachers) which more or less echoed the councillor's words. Community leaders actively support more use of Western medicine, though of course they sometimes use traditional healers (cf. cases 4 and 5). Leaders of the newly instituted maendeleo clubs belong to this category because they also render active support for Western medicine (see Chepkemoi's

daughter in case 6). Church leaders especially are expected to discourage Pokot from participating in indigenous ritual and utilize Western health facilities more. I attended services in the various (6) Christian churches and listened to sermons which condemned traditional medical practices. I also interviewed various Pokot church leaders and they seemed to be unanimous in thinking that traditional medical beliefs and practices were hindering maendeleo. However, the church leaders were agreed that the herbalists, birth attendants, bone setters and tooth extractors are doing a good job. The church leaders' support for Western medicine has sometimes though not always, a strong influence on church members who often consult them regarding appropriate therapy. The stance taken by Community Leaders among Pokot shows the importance of external influences, in this case the National concepts of development and Christianity in structuring how they relate to Western medicine and therefore traditional, medicine. Concepts regarding development are part of the general policies that government administrators in West Pokot communicate to the people. I shall deal with this in detail in the next chapter, so suffice it to say that the administration does not in theory and practice, clearly recognize or support traditional medicine. This is sometimes communicated to Pokot in no uncertain terms. An incident I recorded at a District Officer's meeting in Chepareria reveals the position taken by the Administration, one which Western-trained health workers, discussed next, are very much aware of.

A large crowd of people, including all government officials in the area, had gathered to hear an address by the District Officer. The meeting had been called, among others, to discuss the progress of a piped water project for Kipkomo Location. The District Officer began

his address by noting the increase of illnesses in the area which he attributed to the heavy rains and lack of food. I could not believe my ears when all of a sudden, I was requested to stand up and greet the people. The Officer then went on to say:

> For many months now I have been telling you that your uganga[13] is causing a lot of problems. When you are sick, you know there is a dispensary here and hospitals everywhere. Yet patients are rarely taken to these places. I am happy that Mr. Myanwaya (standing in front) has been sent here to study your uganga and write a book about how terrible it is. If I am told of a case where a patient is not taken to hospital but treated by your waganga, I will treat that as a criminal offence (DO's Baraza Chepareria 27.8.80).

I was then told to go back to my seat though I had become almost petrified. It took me many weeks to reassure Pokot that I had not been sent by anybody and that my aim was not to discourage their utilization of traditional medicine. I had presented papers to the District Officer in question and briefed him about my research project. What he said about me at the meeting was definitely his interpretation, not mine of what the project entailed but the words are representative of the administrative attitudes and responses to Pokot medicine.

In the last chapter, I indicated that Christian Pokot usually do not participate in traditional healing rituals. On the whole I found that they tend to keep their homes and bodies cleaner than the rest of Pokot, but it is difficult to say whether this is done with a view to preventing disease or not. All I was able to ascertain was that it is part of the Christian experience to be physically clean. I now turn to an examination of the role played by Western-trained health workers in influencing the relationship between traditional and Western medicine.

In the first place, I should note that nearly all Western health workers among Pokot are people who come from outside the District. All the six doctors in the District are non-Pokot - one African, four Europeans and one Asian. Most of the nurses, clinical officers, and

midwives are also non-Pokot. The few Pokot who are in the Western health system are mainly subordinate staff. The main reason for the paucity of Pokot in this, as in other parts of the civil service, is the fact that until very recently, few of them had the requisite academic qualifications to join the health service. In their attitudes and behaviour Western health workers reveal a lot of hostility to those patients who they think have had recourse to traditional medicine before coming to the hospital. I observed several cases of the interaction between Western health workers and Pokot patients and also carried out a number of informal interviews with both. Before I discuss the findings of these observations and interviews, I should note that the medical doctors, unlike their junior staff, are more sympathetic to some indigenous medical beliefs and practices - at least they indicated so during the interviews - but they are only an insignificant number and are not in as frequent contact with patients as the junior staff, (the clinical officers, midwives, nurses, physiotherapists, who perform tasks which in Western countries are performed by medical doctors such as diagnosis and prescription. These are usually people with "O" level education and three or four years of medical training). Most of the following discussion is restricted to these junior staff (cf Table 2, Chapter 2).

On the whole, the attitudes of the Western health workers to traditional medical practitioners and practices are very negative, and these are expressed not infrequently in their words and actions. In my interviews with them, I managed to gather a lot of their expressions about Pokot patients. An extract of answers given by four of the staff of the Mother and Child Health Unit in Kapenguria Hospital to questions I put to them about the major obstacles to health develop-

ment among Pokot are quite representative of the opinion of Western health workers in the area. Since the remarks were made in English, I reproduce them verbatim:

> The main reason for the poor state of the health of Pokot is their belief in witchcraft. They do not bring patients to hospital until they are too ill. They trust their witchdoctors more than they trust us. Most of their medicines are very strong and some may be poisonous. They give their children these medicines and some die. When we ask them if they have taken any of their medicines before coming to hospital, they say no. Some of them bring their medicines to the wards to give to in-patients. When we find them we send them away. Some even take away patients from wards to perform their magic on them. (27.8.80, Kapenguria Hospital).

In a meeting of all the agencies involved in providing Western health services in the District, several delegates said that something should be done to enable Pokot understand the dangers of their indigenous medical practices. Many of the health workers present claimed that Mobile Health Work could be more successful if the traditional healers were eliminated. The Senior Nursing Officer, Rift Valley Province, however, remarked that the traditional birth attendants were still needed because of the shortage of Western-trained midwives. Dr. Alube cautioned that not all traditional medical practitioners were magicians.[14]

The negative attitudes Western health workers hold regarding Pokot traditional medicine were revealed several times when they were dealing with patients. Patients were given no explanation about their illness. Most health workers claimed that Pokot did not understand any such explanations. In many cases, Swahili was used - yet few Pokot, especially women, can speak it. Pokot are used to suggesting that they be given injections instead of tablets - but such suggestions were always met with abuses and they were told to respect the health workers. Many of the health workers told me that Pokot never deferred to them

at all; Pokot patients on the other hand claimed that "young children" (most of the health workers are young) treated them with contempt without realizing that they were their seniors. I witnessed several arguments between the health workers and Pokot mothers regarding charms and marks on children's bodies. Mothers were asked what the charms or marks were for - many said they were decorative - the health workers often claimed they were magical. I never witnessed a single case of a patient accepting having used traditional medicine before coming to hospital when asked by a health worker. Most arguments between Pokot and Western health workers occurred in the labour wards. As one of the midwives put it, "Pokot mothers are very unco-operative when in labour. Sometimes they do not obey what they are told to do." Pokot mothers on the other hand find it difficult to obey young nurses who have not had children. I have alluded to this problem in the last chapter, so I should only say here that the misunderstanding between Western health workers and Pokot is a result mainly of misconceptions about Pokot medical beliefs and practices; the health workers see these beliefs as mainly based on superstition and are therefore irrelevant in the health-seeking process.

The misconceptions the health workers have regarding traditional medicine were revealed in my informal interviews with them in various health facilities and Mobile Clinics. The health workers for example revealed inadequate knowledge regarding the variety of traditional healers that exist. The term mganga, which English speakers in Kenya translate as "witchdoctor" was used for all Pokot traditional healers including the herbalists and midwives. They assumed that there is a single type of medical practitioner who combines both empirical and magical elements in his practice. The health workers revealed an

equally insufficient understanding of Pokot concepts of causality. It was thought for example that Pokot see all illnesses as due to "witch-craft". The English term was used in an extremely fluid and confusing sense. The behaviour of the Western health workers is also influenced by the fact that most of the in-patients they encounter are usually in critical condition, sometimes because it may have been difficult to reach the hospital for any of the reasons described in the last chapter. The delayed referral to hospital is however attributed to the "beliefs" of the patients or their kin. Individual health workers are however judged on their own merit by Pokot. There are some who have nicknames depicting their behaviour when dealing with patients.

Though some Western-trained health workers said that aspects of traditional medicine are effective, especially in dealing with the social and psychological aspects of illness, I did not learn of any case of them referring a patient they had treated to a traditional healer. Even the medical doctors in the district did not admit to having referred patients to traditional healers. The Western health workers in Pokot are not alone in not referring patients to indigenous healers - this is the practice in most of Kenya. But patients and their kin, as already explained, do not hesitate to use both traditional and Western medical practitioners for one and the same illness when they see it fit. To the Western-trained medical practitioners, Pokot medicine is inferior, and mainly magical. They see little sense, therefore, in referring patients to the indigenous healers. In fact many of them openly told their clients not to utilize indigenous therapy at all.

Most Western health workers especially in the past and significant numbers today, are Christian - both Pokot and non-Pokot (cf. Chapter

Two). Christian Western health workers are especially antagonistic to traditional medicine. This is mainly because of the apparent incompatibility between some Christian doctrines and Pokot medical concepts, and especially their belief in ancestor spirits, the curse, oath and pan. On the whole, however, my informants tended to speak very favourably about Christian health workers, who, while opposed to the indigenous concepts of health, were more sympathetic in their interaction with Pokot patients. The maternity ward in Ortum Mission Hospital usually has more women than that of the District Hospital at Kapenguria.

In summary it can be said with justification that while most Pokot who have access to Western medicine are usually favourably disposed to it, Western health workers, in their attitudes and behaviour relating to traditional medicine, are not quite so accepting. Government health workers are markedly less tolerant than those in private and mission dispensaries and clinics. Because of this, sometimes Pokot decide to go to mission and private clinics rather than government ones, though the last are free.

5.7 How Many Systems?

Anthropologists and other social scientists are fond of making a distinction between the "modern" and the traditional when discussing developing societies. However, it should be stressed that such a distinction may not be regarded as important by the actors. The actors rarely think in terms of the separate "systems" which researchers are fond of identifying. This may be said of the distinction made between traditional and Western health care: I therefore wish to make a few remarks regarding the concept of "Medical System" in the context of

the therapeutic alternatives available to Pokot today. In Medical Anthropology, the concept is sometimes used in a very confusing manner. When discussing the health-seeking process in non-Western societies, it is often assumed that Western medicine always forms a different "system" from traditional medicine. I wish to argue that though in terms of health facilities, personnel and administration traditional and Western medicine are separate entities, it is possible to regard them as aspects of a single medical system. According to Kleinman, a Medical System represents a total cultural organization of medically-relevant experiences, an integrated system of social (and personal) perception, use and evaluation (1978:413-14). In other words, a medical system can be regarded as being much more than particular kinds of medical facilities, practitioners, and practices. It is then the cognitive, affective and behavioural environment in which an illness occurs and therapy is sought. This view of a medical system implies that from the perspective of Pokot, there is a single system which includes both traditional and Western medicine. It can be argued further that in Kenya, because of the differences in the perceptions, availability and utilization of medical resources by different societies, there is not a single but a multiplicity of medical systems because the different societies perceive, evaluate and utilize medical resources variously. When I therefore use the phrase "Kenyan medical system" I do so only for analytical purposes.

I have already stated that Pokot think of a hierarchy of alternatives, rather than of traditional and Western medicine. However, Western health workers and the administration would like to think of two separate medical systems, one legitimate (Western) and the other (traditional) not so. In earlier chapters I have made reference to

aspects of assimilation of medical concepts and practices by Pokot from their neighbours especially the Karimojong, Turkana and Marakwet. Even today, use is made of practices and medical experts from these neighbours. With the introduction of Western medicine, the Pokot medical environment has become more heterogeneous but they have responded to the new situation by perceiving Western medicine as an element of the old (section 2 of this chapter). It is therefore not correct to talk of "parallel" medical systems among Pokot, unless of course "medical system" is restricted in meaning to refer only to the facilities and personnel of pojon or Mzungu therapy.

In this chapter, I have tried to show that there are several other factors which besides the concepts of health and illness, account for the varied ways in which Pokot relate to Western medical practices and personnel. I do not wish, however, to convey the impression that Pokot medical beliefs are irrelevant in their response to Western medicine. In certain cases, these beliefs are quite important, as I argue in the next chapter. I have had to deal with these "other factors" in detail so as to reveal the need to include considerations of the broader socio-economic and political contexts in the study of illness behaviour in non-Western society. Pokot are quite pragmatic in the health-seeking process, and have a great capacity for accepting new ideas and related practices. This has been shown by the fact that the few who have had contact with Western health education have not found it difficult to accept the germ theory of disease.

Such "other factors" have been identified in a number of studies in other non-Western societies. As early as 1952, Erasmus (1952:418) reported that in Ecuador, "folk beliefs in themselves are offering no

resistance to modern medical practices insofar as those practices may be judged by the folk on an empirical basis. Among people of North India Banerji (1974) reports that

> Among those who suffer from major illnesses, only a tiny fraction preferentially adopt those practices by positively rejecting facilities of the Western system of medicine which are more efficacious and which are easily available and accessible to them (quoted in Logan and Hunt 1978:305).

Zeller reports that among Baganda, traditional medicine is used more widely than Western medicine because the former is more accessible; where the latter is also accessible, it is used as much (in Ademuwagun 1979:251-55). Bryant (1969) and Alland (op.cit. pp.171-75) show that in Senegal and among the Abron (Ivory Coast) respectively, the people, though with strong indigenous medical concepts, are favourably disposed to Western medicine, but resent the Western doctors' attitudes. In Kenya, not many studies have been carried out to identify the "other factors" but two studies by Thomas (1970) and Ndeti (1972) point to the role played by financial costs, transport problems, and perceived efficacy in influencing how the Kamba relate to Western medicine. This study, hopefully, should contribute to the stimulation of interest in carrying investigations into the complex process of the interaction between indigenous and Western medicine further than the examination of traditional beliefs and practices.

Footnotes to Chapter Five

[1] In the original article "The Hierarchy of Resort in Curative Practices the Admirality Islands, Melanesia", Journal of Health and Social Behaviour 10:201-209 the author is referred to as Lola Romanucci Schwarts.

[2] Gould (1965:201-208) found that in an Indian community, the acceptance of Western therapy for critical, incapacitating illness was not related to any understanding of scientific etiologies or the germ theory (quoted in Foster and Anderson 1978:251).

[3] The table is not meant to be exhaustive. In it I only give a few examples of medical conditions the reasons for whose categorization as Pojon or Mzungu I discuss below. The sub-categories A-E can be expanded by adding more medical problems.

[4] Some informants claimed that circumcision and clitoridectomy are carried out not only to express Pokotness, but also to facilitate physical maturity of the initiates which is necessary for sexual reproduction. The operations let out "bad blood" which may hinder the initiates from achieving this maturity. It was also stated that the piercing of the lower lip and the insertion of a metal or wooden plug though not common now, was done so that the opening could be used for feeding a person suffering from tetanus with liquid foods. Some informants, however, said that the piercing of the lip was done so as to maintain, rather show, Pokot distinctiveness, though other neighbouring peoples like the Marakwet and Turkana also have the same operation.

[5] Algon is a popular brand of analgesic in most parts of Kenya.

[6] In Kenya, the Meru, Gusii and Kuria also carry out trephining. Marakwet, Luhyia or other African healers, are also thought to be capable of dealing with conditions of the Pojon category.

[7] Cf. for example S. and E. Kark in Kark and Stuart (1962:1-30).

[8] In this section I refer mainly to infective diarrhoea.

[9] This figure (33) excludes about forty latrines in schools, churches and government offices in the area.

[10] Sindano is a Swahili term used to refer to the hypodermic needle. It is sometimes used by Pokot to mean Western medicine in general. Awoi means "yes" in Pokot.

[11] Most of the drugs used by the new type of healer are smuggled out of government and mission hospitals, or from chemists in towns. Some of the medicines so obtained are diluted so that more profit can be made by injecting more patients than if the medicine were to be used in its concentrated form.

[12] Madaraka Day is the commemoration of internal self-government for Kenya on 1st June.

[13] Uganga is the Swahili term for medicine in general.

[14] Meeting in Kapenguria District Hospital (26.8.80) with delegates from government and mission health institutions in the District, chaired by Dr. Alube, then Medical Officer of Health, Pokot District.

CHAPTER SIX : ISSUES IN RURAL HEALTH DEVELOPMENT : THE POKOT CASE

I have been prompted to write this chapter because of two considerations. Firstly, I share the same opinion with Frankenberg who suggests that "...the medical anthropologist has to situate his/her work in the context of three processes - development, the making social of disease and the more general concepts of anthropological analysis" (1980:197). The management of illness among Pokot today is affected by the whole process of socio-economic development, and I think that the anthropological approach enables one to contribute to the understanding of the processes involved in socio-economic development and how these affect health conditions. But secondly and more importantly, this chapter constitutes my response to claims made by most of the Western-trained health workers I met during my fieldwork in Pokot - that the main cause of the poor health conditions among Pokot is their traditional beliefs and practices related to health and illness. It was argued that these beliefs and practices led to under-utilization of available Western health services and also contributed to the incidence and prevalence of certain diseases. Cholera epidemics in the area were given as an example to support this argument.

International health planners, social scientsts and governments in developing countries have usually assumed that the best way to effect health development in these countries is through the introduction of the Western model of health services. Because of this assumption, anthropologists interested in health in non-Western societies have, with only a few exceptions,usually advanced two main explanations to account for the poor state of the health of people in these societies. Indigenous beliefs and practices have been seen to be major hindrances to the extension of Western health services. This explanation implies that to improve people's health conditions, some form of acculturation

has to take place to enable them to accept Western health services and thereby improve their health. It has also been suggested that poverty is a hindrance to health development because it prevents people in developing countries from having all the Western health services they need. Van Etten (1976) presents these arguments very well in a recent study of rural health services in Tanzania. While there is evidence to suggest that both the "cultural obstacles" and poverty explanations for the poor health conditions in societies of the developing world have some substance, I wish to show that some of the policies, approaches and the personnel of the Western health care system can also obstruct the health development process. I shall also go further by suggesting that health development should not be seen to depend only upon the promotion of Western medicine, but that indigenous medical resources should be tapped as well, to offset the financial and manpower limitations imposed by a low level of socio-economic development. I am suggesting that the failure to exploit indigenous resources for health development is in itself a major constraint.

In the first section I examine the role of indigenous beliefs and practices as a constraint to health development. In Section Two I discuss how the low level of socio-economic development affects health. In the third section, I argue that there are certain policies and approaches in the Kenyan health care system which prevent better distribution and utilization of available health resources. In the fourth section, I discuss the potential contribution of indigenous health resources to health development among Pokot. I draw extensively on literature by health planners both at the international and national (Kenyan) levels.

6.1 Indigenous Beliefs and Practices and Health Development

By claiming that Pokot indigenous beliefs and practices are the major constraints to the improvement of health among them, Western health workers raise two important but separate questions: the contribution of these beliefs and practices to the incidence and prevalence of certain diseases and their role in preventing the acceptance of Western curative and preventive medicine. I deal with each of these issues in turn. Van Luijuk, a medical sociologist with considerable experience in Kenya summarizes both issues thus:

> Social and cultural factors have an impact upon the pattern of health and disease in the community and they play a role in the etiology of certain diseases. These factors also play an important role in the organization and utilization of modern and traditional medical care. The pattern of interaction between health workers and their clients is influenced by their social and cultural background. The success of preventive and promotive actions ... is related to cultural norms and values (in Vogel 1974:63).

There is evidence to suggest that certain beliefs and practices among Pokot contribute to the occurrence and prevalence of certain diseases. Let me give specific examples. Pokot think flies around the home are a sign of wealth. This of course derives from the association of flies with cattle. The more cattle a person has, the more flies there are around the home. Traditionally, a wealthy man is a person with many cattle. Though wealth is no longer thought to derive solely from cattle, most Pokot do not worry about flies landing on utensils, food or any part of the body. It is known that flies are involved in the transmission of, for example, trachoma. This is one of the commonest diseases among Pokot, affecting especially children and very old people. My informants expressed surprise when I enquired about their apparently easy relationship with flies. "Flies are cattle" said an informant. "Have you seen a homestead without them? If you have seen

one, I am sure you agree with me that the owner was very poor" he added. Most Pokot do not boil milk before use.[1] They say that boiling milk will cause cows to reduce their output of milk. Such unboiled milk is an easy source of infection, because the milking is usually done in an environment full of dirt and flies. Brucellosis is thought to be on the increase among Pokot today, and its transmission is usually associated with unboiled milk (Oomen and Wegener in op.cit. p.221-3). Some practices among Pokot may contribute to diarrhoea in children. To prevent a child from suckling the breast during weaning, a mother smears them with dirt. Some children will ignore the presence of the dirt and just suckle. I have already referred to the operation which Pokot perform on young children to extract "false teeth". I watched a number of these operations and found that the nail used for the purpose is obviously not sterilized. The expert who performs the operation uses her bare hands to feel the gums and then to prevent the bleeding, crushes some medicine in her hands. After the operation many children usually pick up any objects from the ground to rub the gums with because of the pain. As Pokot do not use latrines, it is possible that some of these objects will be contaminated. It is therefore understandable that Pokot mothers claimed that diarrhoes seems to increase with the removal of false teeth. All I wish to show is that some of these practices do indeed prevent the improvement of health among the people. But it should be remembered that they do not know that these practices are harmful. Few of the Western health workers there know about these practices in detail. Fewer still take time to teach Pokot about the dangers inherent in some of their practices.

I now turn to the other issue raised by the claim that indigenous beliefs and practices are a hindrance to the acceptance of Western

medicine and therefore health development. This argument has usually fascinated anthropologists studying illness behaviour in non-Western societies. I have already referred to the "adversary" model used frequently by them (see Chapter Five, 5.1). Anthropologists have been encouraged to locate constraints to the extension of Western health services in non-Western societies in target populations (their culture) because, as Foster and Anderson argue

> Public health and other medical personnel generally have been receptive to what anthropologists have told them about the customs and beliefs of the people with whom they work. After all, the problem is identified as being "out there" among the patients (1978:233).

Imperato (1977) and Read (1966) have shown that certain social and cultural forms in a number of African societies prevent full utilization of Western health services. In Kenya, cultural factors have been shown to be important in keeping some medical cases away from hospital, tuberculosis among Kamba (Ndeti 1972), leprosy among Luos (Van Luijuk 1971) and functional disorders among Luos (Whisson 1964). Among Pokot I have already stated that children with measles may sometimes be kept away from the dispensary because it is feared an injection may kill them. Mental illnesses, impotence, sterility, fractures and constipation are usually treated by indigenous healers. As already discussed in the last chapter, few Pokot practise the preventive measures advocated by Western medicine. In the current District Development Plan for West Pokot, it is claimed that patients are usually brought to hospital in very critical condition because of "cultural factors" (p.74). I have already argued that the decision to use Western curative therapy or practise preventive measures depends mainly on the demonstrated efficacy of the therapy (or preventive measure) and whether it is accessible and can be afforded. Western therapy, as I have shown, can be used even when an illness is understood in

traditional terms - for example rehydration is carried out while Pokot think infantile diarrhoea is caused by false teeth. In the last chapter I showed that measures to prevent both malaria and diarrhoea are not usually carried out by Pokot because of lack of knowledge about the measures, because the efficacy of these measures has not been demonstrated and also due to the fact that most people simply cannot afford to do so.

There is no necessary contradiction between Pokot concepts of health and illness and Western medicine, because the Pokot view of illness recognizes biological causality. The fact that Pokot see the involvement of inter-personal and spiritual agencies in some illnesses does not mean that when such illnesses occur they will necessarily be kept away from Western therapy; this has been shown in the last two chapters. The suggestion of Foster (in Logan and Hunt 1979:304) that indigenous beliefs are a major constraint to the acceptance of Western health services during the initial stages of contact seems to be true in the Pokot case. Going through the District Commissioner's annual reports for the area, one reads of initial opposition to immunization for example. But as Pokot came to appreciate the effectiveness of Western therapy, the problem, since the fifties, has been one of trying to meet Pokot demands for Western health services. According to my informants, the major health need they feel is the lack of adequate Western health services. So while I accept that certain beliefs and practices among Pokot hinder the process of health development, I think at the same time, that the role of Pokot concepts of health and illness in obstructing the utilization of Western health services has been overstated. The few Western health services available in the area are usually used at full capacity. A visit to the two

hospitals in the area may surprise someone who is not expecting to see two patients on every bed, and a lot more on the ward floor. Western health workers in the District however, would like to absolve themselves from any responsibility for the poor health conditions in the area, most of which are due to the low level of socio-economic development.

As evidence for the argument that Pokot beliefs are not the main constraint to the utilization of Western health services, one only needs to point to the cases in Chapter Four, especially 1, 3, 5 and 10, where Western health care was utilized even when the illness was understood in traditional terms. It should also be noted that in spite of their dissatisfaction with certain elements of Western health care, Pokot are demanding more of these services.

6.2 Economic Development and Health

Poverty as an obstacle in the process of health development in developing countries has received much attention from social scientists, international agencies concerned with health development and, of course, national governments. The main argument seems to revolve around the fact that most of the major causes of mortality and morbidity in the developing countries are not very important in developed countries where their effects have greatly been reduced. During the decade between 1960-1970, one of the guiding principles for international agencies and governments was that economic growth in the developing countries would automatically lead to better health standards (Berthet 1979 and Mahler 1979). Carlson (1975) and Illich (1977) argue convincingly that the improvement in health conditions in developed countries is due mainly to better living conditions and not just the

advances in the medical field. Bryant (1969) states that in developing countries, medical problems are in essence problems of poverty, manpower and finance. Economists predict that in the year 2000, the expenditure per head on health in the developing countries will be only $3 compared to £250 in the developed countries. (In the seventies the figures were estimated as $1 and $200 respectively) Morley (1973:3,16) In Kenya in 1978-79 the government spent about $25 per head on health.[2] Health expenditure in Kenya has declined slightly from 7% (1976-77) to 6% of total government expenditure due to the constraints brought about by a decrease in the economic growth rate and rapid increase in population. The current Development Plan rates financial shortages with inadequate medical personnel as the major constraints to health development (p.126). Because of financial constraints, it is estimated that 75% of Kenya's population are still out of the reach of proper health facilities (UNICEF 1981:10). The constraint imposed by insufficient economic resources for health development is greatly accentuated by a very high rate of population growth (4%) which puts very high pressure on already existing health services, which in any case have to compete with other services like education and community development. The problem of scarce economic resources is also amplified due to the fact that most of the existing health services are concentrated in urban areas. While it is true, therefore, that levels of health and nutrition have improved and life expectancy has increased by 10% in the last ten years, and infant mortality has dropped by 30% (ibid:2), this does not give any indication of the imbalances between (urban/rural region and region) different parts of the country. These imbalances have been discussed in detail by Bigsten (1980) and I return to them briefly in the next section.

Among Pokot, poverty is a major constraint on health development, because, as already pointed out in Chapter Two, it is one of the poorest districts in Kenya. The present poor economic conditions in the District result partly from the approach to development in Kenya which was initiated during the Colonial period viz: concentrating on assisting those areas of the country which were economically productive. Migot-Adhola (1980) and Nkinyangi (1980) have shown that this approach has not changed very much after Independence. The implications for health among Pokot of this approach have been quite negative. They have few government health facilities, and accessibility to those few in existence is hampered by the poor transport system. 75% of all the health facilities among Pokot are church sponsored or private and fees are paid for treatment in such places. In the last chapter I discussed how low income levels affect the management of malaria and infantile diarrhoea, mainly because Pokot have no clean water and the type of housing that facilitates the maintenance of hygiene standards. Table 1 shows that most of the common diseases treated at Kapenguria Hospital are both preventable and related to poverty. Measles, one of the major causes of infant mortality, is not ranked among the top ten because it usually comes in epidemics and not many of the cases are referred to Western-type health facilities because of the reason already mentioned. Granting that the low level of economic development among Pokot and in Kenya in general contributes to the poor health state among Pokot, this effect could be mitigated if the available resources could be more equitably distributed in the country. West Pokot has one of the lowest levels of earning from labour in the country (Statistical Abstract, 1981:257). Income from agriculture is also quite low (see Chapter Two), this situation, coupled with the lack of basic infra-

structure in the area and a harsh environment, has led to the District being designated "a hardship District". Employees of the government

Table 1

Top Ten Causes of Morbidity in West Pokot[3]

Acute respiratory infections
Malaria
Diarrhoeal diseases
Skin infections
Acute eye infections
Intestinal worms
Gonorrhoea
Accidents (fractures, burns etc.)
Rheumatism, joint pains etc.
Pneumonia

and other agencies are accorded a 33% allowance for hardship, but this has not attracted enough health workers for instance, into the area. Lomut Dispensary for example has had no health worker for a long time because of its location - yet Kenya has experienced a remarkable growth in GNP for most of the years since Independence.

I am suggesting here, therefore, that the assumption that economic growth will automatically lead to overall health development is only partly correct. One can, with justification, argue that like in many other developing countries, in Kenya, there is less than optimum utilization of the available health resources and further that this is mainly due to problems of the approach to health development and pitfalls in the health delivery system (some of which even the current five-year Development Plan admits).[4] In the following section I consider some of these pitfalls in the policies and delivery of Western health services in Kenya and how they affect Pokot.

6.3 Policies and Approaches of Western Health Services as Constraints to Health Development

It is becoming increasingly accepted that even with low income levels, it is still possible to achieve a reasonable improvement of health standards in developing countries. This is the thinking now guiding the policies of agencies like the World Health Organization and UNICEF. This is because experience has shown that the existing policies and organization of health services in developing countries along models of their counterparts in developed nations, are in themselves constraints to health development. There is a lot of literature now available regarding this issue. International health experts think that a lot of the present rates of morbidity and mortality could be reduced considerably by a re-organization of the existing health services. Bryant (1969); Logan and Hunt (1978); Morley (1973) and Rifkin (1973) have discussed the major problems of transplanting health care delivery systems suited to developed countries to countries with very different socio-economic conditions (the developing countries). Rifkin asks some fundamental questions regarding the adoption of Western models of health care in the less-developed countries. He is critical of the assumptions which underlie this transplantation of health care models such as the belief that increased facilities imply improved health, that highly trained manpower is the only method by which to deliver health care, that medical care is exclusive of health education and preventive activities, and that disease and hospital-based systems are the most appropriate to meet health care needs (1973:249-257). Dubois (1968) goes along with Rifkin by arguing that

> the extent of health improvement to be expected from building ultramodern hospitals with highly trained staffs and up-to-date equipment is probably trivial compared with results from the much lower cost of

> providing infants and children with well-balanced food, sanitary conditions and a stimulating environment (p.138).

In Kenya today, the Western model of health care is legally sanctioned and enjoys many prerogatives. However, various studies of the system have shown that it contains certain features which are major obstacles to health development in the country. In the light of current thinking regarding health development in non-industrial countries, the major problems in the Kenyan health care system include: separation of preventive from curative services, with undue emphasis on the latter; concentration on the development of huge, urban-based facilities at the expense of smaller units in rural areas; emphasis on high level manpower training, the end products of which are unsuitable to provide services in most of the country and the failure to link health development closely with related sectors like education, agriculture, water development and other social services. As some of these problems have been discussed at the national level (Bigstein 1980; Ghai 1979; Mburu 1979; Onyango 1974) in the following, therefore, I give specific examples of the impact of these problems on the health development process among Pokot.

I have already shown (Chapter Five section 5.4) that knowledge about the prevention of malaria and diarrhoea among Pokot is limited. The same can be said of many other diseases. Except for the recently introduced Mother and Child Health Clinics, most Pokot have had little exposure to preventive health education. I made several observations of Western-trained health workers at Kapenguria Hospital and Chepareria Dispensary, treating patients and afterwards interviewed them regarding whether they considered preventive health education to be part of their job. The results were quite interesting. My observations revealed that

the health workers never told the patients what actions they could carry out to prevent preventable conditions such as trachoma and diarrhoea which are quite common in the area. In my informal interviews with them, the health workers indicated their opinion that they were trained to cure disease, not to teach health education. One Clinical Officer told me that Pokot could not understand health education because they are "primitive". The Medical Officer of Health claimed that he did not include health education in his practice because he did not have enough time, and this may well be true, because there are only six doctors in the District. The District Health Education Officer felt that it is the public health technicians who should undertake to educate Pokot about preventive medicine. One of these technicians, based at Chepareria, claimed that some Pokot wondered why he told them to dig pit latrines, while the daktarion never told them that these were necessary. In the eyes of most Pokot, the Public Health technicians are superfluous in the health development process because they do not operate from health centres, dispensaries and hospitals, where disease is dealt with. This cadre of health workers is not included in the category daktarion, which includes all other Western-type health workers. Their advice regarding health matters is not taken seriously. As informants put it, their work is just to inspect meat at slaughter houses and food and drinks in hotels. Many experts feel that preventive education should be given more emphasis especially in rural areas (Scotney 1979). Preventive health education provided during hospital visits would be quite useful as it would be connected with the cure which follows the treatment. The separation of curative and preventive medicine is the rule in the Kenyan health system, in spite of mounting evidence that this separation is not very useful.

As in the rest of Kenya, preventive medicine is left almost entirely to a few Public Health technicians and recently, the Mother and Child Health Clinics. Many Pokot still think that Western preventive medicine is not as important as curative medicine, because as one primary teacher stated "If preventive medicine is important, why is it not offered in hospitals and dispensaries, where the daktari are, and only left to technicians and nurses?" The health workers in Pokot cannot be blamed for the separation between curative and preventive medicine, because this is a matter emanating from National policies and inculcated during their training. The failure by Pokot to carry out preventive measures cannot be attributed mainly to their "beliefs" alone - most of the simplest of preventive measures have not been taught to them, as I have already shown for diarrhoea and malaria in the last chapter. Although it is now known that prevention is not only better, but cheaper than cure, the fact that prevention is given little emphasis in the Kenyan health system is a constraint to health development which, if rectified, can lead to more benefits than the present over-emphasis on curative services.

Another constraint in the Kenyan health system which has a negative effect on the improvement of health among Pokot is the training of health personnel. Because of economic limitations, Kenya cannot afford to train as many health workers as she needs. Table 2 shows that in 1980 for example, the doctor-patient ratio in the country was 1:10,000. In West Pokot this ratio was roughly 1:27,000 (see also Table 2 Chapter Two).

In view of the economic limitations facing health services in Kenya, many experts feel that the emphasis should be placed on training middle-level health workers with less emphasis on the training of

Table 2

Medical Personnel (1980)

	No.	No. per 100 000 people
Doctors	1541	10
Dentists	141	1
Clinical officers	1750	11
Pharmacists	245	2
Registered nurses	6388	43
Enrolled nurses	7908	54

Source: Ministry of Health

medical doctors, many of whom tend to aspire to highly specialized further education and are usually unwilling to work in the rural areas - more than half of all doctors in Kenya work in urban areas. The curricula for training medical doctors, according to experts, are not suitable for developing countries (Bryant 1969; King 1966; Morley 1973). I shall later deal with initiatives by World Health Organization to get developing countries to concentrate on middle and low level cadres of health workers because they are cheaper to train and quite capable of dealing with most of the medical problems in these countries while referring complicated cases to the few medical doctors available.

There is another problem which also stems from the type of training which Western-type health workers in Kenya receive; the training prepares them for service among an educated, "modernized" population. In the last chapter, I referred to some of the problems of communication between the junior medical staff and Pokot patients. Some experts in Kenya feel that even medical doctors in the country are not trained so as to serve a largely rural, and illiterate, population, with notions of illness which are largely indigenous. Informants

claimed that even the few doctors in the District sometimes adopt a take-it-or-leave-it attitude when treating their clients and even reprimanded them for asking "unnecessary questions" during the therapeutic interview. Professor Mungai, who has been involved in the training of medical doctors in Kenya for many years feels that

> From the point of view of curriculum development, the apparent question still remains therefore as to whether or not the programmes of the medical school are relevant in the business of delivering effective health care.... The medical school programmes need to be reviewed by all those who are in the business of medical education and health service to insure that they are training competent doctors who will be motivated to, and capable of, giving relevant health care according to the observed health needs of the country (in Vogel et al. 1974:144-5).

The few medical doctors and also the junior staff in rural areas like Pokot could become more efficient if they took into consideration the cultural constructions of illness among their patients. It has been argued that due consideration for the patient's view of health and disease by Western (or other) health workers leads to increased compliance in the prescribed therapy (Becker 1974 and Eisenberg 1981). Kleinman (1978) suggests that medical training as a whole should be restructured so as to get medical students to

> ...integrate into their viewpoint the viewpoints of clinical reality held by patients and families. That change holds important implications for clinical care. It suggests a way of humanizing care by opening it up to the personal and social realities of illness and treatment. It suggests that the perspective of the clinician...must hold together quite different concepts of reality - biological, psychosocial and cultural (p.370).

Pokot would be happy if such a change were effected in the training of Western health workers who work in their area.

One of the features of the Kenyan health care system which affects West Pokot District adversely is the inequitable distribution

of available health services. This inequitable distribution of health services (like other social services) began during the Colonial period when the policy was to concentrate development in those areas which were considered economically productive, but the situation has not been rectified since Independence. This problem is stated in the current Development Plan thus

> However, the distribution of health centres amongst the population varies from district to district, for instance, there is one health centre per 166 000 in Turkana but one health centre per 1000 in Lamu and the average for the whole country is one health centre per 72 000 (p.128).

As I argue later, areas like West Pokot which have low population densities and a poor communication network are the most affected by this unequal distribution of health services. The urban areas seem to benefit most from this situation. It is usually very easy to move about in urban areas and most people can afford private health services anyway. Ghai (1979) summarizes the inequitable distribution of Kenya's health services very graphically:

> ...the distribution of health facilities remains regionally inequitable. Nairobi of course dominates; with 5 per cent of the population it has 67 per cent of the doctors and 18 per cent of hospital beds. Distribution of facilities between rural areas is more equitable although Rift Valley Province with 21 per cent of the relevant population has 28 per cent of the Government health centres, Central Province (16 per cent of population) has 19 per cent and Western Province (13 per cent) has 16 per cent)(p.36).

Ghai is referring to government health facilities in rural areas, that is why he says that there are few inequalities there. The implications of these inequalities can only be made clear when I have argued below that total population alone as a criterion for locating health facilities in insufficient.

The policy of deciding the location of health facilities in rural areas on the basis of total population, and not the population density inevitably leads to differential access to such facilities in areas with high and low densities of population respectively. Table 3 gives the type of health facility and population catchment areas at District level as stipulated by the Ministry of Health.

Table 3

Health Facility Per Population

Facility	Population Catchment Area
District Hospital	250,000
Health Centre	50,000 - 70,000
Health Sub-centre	50,000 - 70,000
Dispensary	10,000

Source: Ministry of Health

The actual location of health facilities is determined by the existing service centres - urban centres, rural centres, market centres and local centres. Such centres have usually developed unplanned. This means that facilities tend to be located in areas where it may be difficult for most people to have access to them. In areas with sparse population like West Pokot (with 17 people/sq.km.) the problem of access to health facilities is magnified. In places which are densely populated (like Kisii and Maragoli), the location of a Health Centre, say, for every 50,000 people means that, because of the high population density, the people do not need to travel large distances to reach the centre. Among Pokot, besides the sparseness of the population, the lack of a public transport system makes the problem even worse. According to this policy of basing the location of health facilities on

population figures alone, the three health centres in the District are adequate for the population, and so is the District Hospital - but there are Pokot who have never visited these facilities because of the large distances involved. Table 4 gives an indication of the distances Pokot have to travel to get to health centres and dispensaries. Though financial limitations are partly responsible for this situation, the locationing of the facilities could be improved; the District Hospital for example has been placed in the extreme south western tip of the District, and out of the reach of most Pokot. Mobile health services would seem to be one solution to the unequal distribution of health services among Pokot, in spite of the fact that many

Table 4

Health Centres and Dispensaries in West Pokot (1980)

	Distance from Kapenguria Hospital	Distance from Nearest Other Facility
Kacheliba Health Centre	22 miles	22 miles
Sigor Health Centre	50	28
Kanyerus Dispensary	42	20
Nauyapong Dispensary	100	80
Nasolot Dispensary	80	60
Ptoyo Dispensary	60	45
Kaibichbich Health Centre	30	30
Chepareria Dispensary	15	17
Kainuk Dispensary	60	10
Lomut Dispensary	70	20

Source: District Development Plan 1979-83.

Western health workers find it unattractive to have to travel on rough and at times dangerous roads to reach some remote parts of the District.

It would be more economical, however, for such mobile services to take health care to the people, instead of a whole population having to travel several miles in search of medical personnel and services.

The limited financial resources available for the improvement of health in rural areas like Pokot could produce better results if the Ministry of Health worked in collaboration with other Ministries which are concerned with activities which have a bearing on health. Indeed this collaboration is stated as a matter of priority in the planning, and implementation of health programmes (Development Plan op.cit.:133,138). In practice, however, very little co-operation occurs between the Ministries of Health, Culture and Social Services, Agriculture, Education, Information and Broadcasting, all of which can enhance health development among Pokot especially through health and nutritional education. The lack of an integrated approach to health development has recurrently led to undesirable results. Let me give two examples to illustrate this. The Ministry of Culture and Social Services has been involved ina project to provide the people of Chepareria with piped water. By 1981, the pipes had been laid and storage tanks constructed, the Ministry having secured a large grant from an American aid agency. The community provided the labour and some of the materials for the project, which is now ready to supply about five thousand people in the area. Because of the cholera epidemics which have hit Pokot for the last few years, the Ministry of Health also initiated a plan in 1981 to dig bore-holes and fit them with hand pumps to provide the people with clean water and thus reduce the risk of further outbreaks of cholera. By the time I left Chepareria at the end of 1981, about ten of these bore-holes had been dug in the same area where the Ministry of Culture and Social Services

had laid pipes for water. There had been no consultation between the two Ministries so as to avoid such wasteful duplication of capital which has now occurred in Chepareria, while several other areas of the District have no access to clean water. Since water is essential to health development, both Ministries should adopt a concerted approach to its provision, and in collaboration with the Ministry of Water Development.

Malnutrition was not a serious problem among Pokot before the seventies.[5] This has been attributed to the abundance of livestock products, and wild fruits and vegetables. However, the tendency has now become established whereby the Ministry of Agriculture emphasizes farming mainly for cash. As a result of this policy, Pokot today in the agricultural areas have very few cattle and concentrate on crops such as sunflower, maize and sheep (for wool). Finger millet and sorghum, which have high food value, are hardly grown now. The formerly important wild fruits and vegetables have been cleared to provide space for cash crops, which the Ministry of Agriculture encourages. The results of this policy of encouraging cash crops at the expense of traditional food crops are not yet well documented, but a few recent observations reveal that protein-calorie malnutrition in children is on the increase among agricultural Pokot.

The increase in cases of malnutrition in areas with much cash cropping was stated by the officers in charge at Chepareria Dispensary and the Family Life Training Centre at Kapenguria. Before the seventies, most of the cases of malnutrition reported in the District were usually non-Pokot immigrants such as Kikuyu, Luo and Luhyia. The increase of malnutrition as a result of intensive cash cropping in other areas of Kenya has been referred to by Parry (1976:20). It is

possible that the increase in cases of malnutrition could have been forestalled if the Ministry of Agriculture had co-operated with the Ministry of Health to consider the impact of cash cropping on the health of the people.

I have already referred to the useful results due to the complementarity between the maendeleo ya wanawake clubs in Chepareria sponsored by the Ministry of Culture and Social Services, and the Mother and Child Health Clinic, sponsored by the Ministry of Health. This has been achieved through individual efforts and already there seem to be problems in the experiment now that the home economist has left the area. Such co-operation could be institutionalized and be extended to cover all Pokot, to hasten the process of improving their health conditions. I shall discuss some of the possible ways of doing this in a later section of this chapter.

6.4 Indigenous Resources in Health Development

Up to this point in this chapter, it has been assumed that the improvement of health conditions among Pokot depends entirely on the provision of more Western-type health facilities and their utilization. No doubt Western health services are essential to health development, but I wish to question the assumption that they are the only factor. Firstly, with rapid increase in population growth, declining aid from developed countries and low levels of income, it is not possible for Kenya to provide the required Western health services for all Kenyans. Secondly, health experts now recognize that indigenous medical resources can be tapped to make a positive contribution to health development especially in poor countries (WHO 1976, Dunlop, Harrison, Janzen, in Ademuwagun et al. (1979)). There is now increasing emphasis on community

based health services, with local populations playing a major role in their own health care. Because of the realization that orthodox Western health services are inadequate in improving the state of health of the majority of the people in developing countries, a new approach to health care has now become generally accepted. This approach is called primary health care. The approach emphasizes the important role that indigenous health resources can play in the health care of developing countries.

As a background to the examination of potential contribution of indigenous resources to the improvement of health among Pokot, I trace in outline the developments in international health planning which have led to the recognition of the need to tap indigenous resources for health development. In 1975, the 28th World Health Assembly passed a resolution that the concept of primary health care become official WHO policy. Three years later, September 1978, Declaration Alma Ata was passed and a programme of implementation with 22 recommendations was adopted for all member countries. Primary health care is an integrated approach to health development. The approach has two major objectives; to inform every individual how to enjoy good health and to assist him to achieve this aim. Primary health care emphasizes low-cost efficient services based on simple techniques and organization. Health services should be accessible, acceptable and affordable (Mahler, WHO Director General 1979:38). The major principles of primary health care are that it should:

(i) consider the customs of the population for which it is designed;

(ii) be an integral part of the national health system;

(iii) be fully integrated into work in other development sectors;

(iv) arouse the support and active participation of the community and lead to a continual dialogue with the services concerned;

(v) correspond to local resources, the cost of this service should not exceed the economic resources of the community served.

In interpreting the relevance of primary health care in Africa, Bennett (1979) states that it has been firmly established as the avenue which most developing countries will explore in the next twenty years, in order to improve the quality of life and health of every individual in the community. He goes on to say that primary health care may make possible the achievements of health for all by the year 2000 (pp.505,513).

For the purposes of this discussion, the significance of the new strategy of primary health care lies in its recognition of the potential role that indigenous health techniques and personnel can play in national health systems. This recognition is stated in recommendation 9 of the Alma-Ata Conference and section 7 of Article 8 of the Alma-Ata Declaration. The latter reads that primary health care should rely:

> at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community (WHO Chronicle 1978:429).

One may however, wish to be sceptical of the increasing attention which international agencies are now paying to indigenous resources in health development in developing countries. It can be argued that to these agencies, indigenous resources provide an easy way out of the difficult situation in which the agencies find themselves i.e. rapidly

increasing costs of extending Western health care. Indigenous health personnel and techniques cannot wholly substitute for some of the effective therapy now possible in biomedical health care. My view is that traditional medicine should play a supportive role. As I show later, indigenous resources can only contribute to health development if they are promoted side by side with Western health services, and the emphasis should be placed on promoting the role of indigenous resources in preventive and promotive, rather than curative, health care.

As a member of the World Health Organization, Kenya endorses this declaration though in practice not much has been done.[5] Kenya is not alone, however, in lacking a clear-cut policy regarding the role of indigenous medicine in health development in Africa. In recent years, some moves have been made at the Continental level to encourage individual countries to consider utilizing traditional medical resources in health care. The Organization of African Unity (OAU) has created the Commission on African Medicinal Plants and Traditional Pharmacopoeia. The Commission is entrusted with stimulating and assisting research in various laboratories in Africa with a view to discovering the therapeutic value of traditional medicines. Unfortunately, the Commission translates traditional medicine in terms of materia medica thus excluding the concepts and manpower of traditional medicine.

Under the auspices of the WHO, a conference was held in Kampala with delegates from the African region of the Organization (1976). A document was produced to guide member countries regarding the role of traditional medicine in modern health care services. This document adopted a broader definition of traditional medicine than that of the OAU. Traditional medicine is defined so as to include materia medica,

concepts of health and illness and practitioners. I have already referred to the intensification of efforts by the WHO to make African countries re-organize their health services along lines suited to local situations and this re-organization includes the utilization of traditional medical practitioners and other resources. However, many member countries have not responded enthusiastically to the idea of utilizing traditional medicine in their official health care systems. This is mainly because of the prejudices which have been built up for many years regarding the role of indigenous resources in general in the development process because for many planners, development is coterminous with westernization (Fanon 1966).

So far, African governments have adopted one of three policies regarding traditional medicine - illegalization, legalization and informal recognition (Dunlop in Ademuwagun 1978:191-196). Illegalization of traditional medicine was the policy adopted especially during the Colonial period in Zaire for example, though Janzen indicates that such a position is no longer seriously invoked, especially at the local government level (1974:105). Legalization of certain traditional practitioners especially herbalists, has occurred in countries like Ghana, Mali, Nigeria, Botswana and Zaire. But this does not mean that traditional medicine is given an equal footing with Western medicine. There are few countries which devote adequate finances for the promotion of traditional healers, and there is little evidence to suggest that traditional healers are on the payroll of any central government in Africa. Because of recent developments in health thinking, a number of African countries have tended to opt for a policy of some form of tacit recognition. For example, in Liberia and Tanzania, some types of indigenous healers are retrained by the government.

Research into various aspects of traditional medicine is now being carried out in many parts of Africa, while in Nigeria, Liberia, Tanzania, Mali and Uganda, some referral occurs between traditional and Western practitioners, especially for psychiatric patients. It is within this general context that I wish to examine the position of traditional medicine in Kenya in general and illustrate this with ethnographic material from Pokot.

When the Foreign Office in London took over the administration of Kenya from the Imperial British East Africa Company (1895) a few Western medical personnel were brought to the colony to take care of the health of Administrative Officials in various parts of the country. By 1910, there were only 77 of these workers, with the population of the country being about three million. Christian missionaries, who had begun coming to Kenya at the end of the last century often combined medical work with pastoral ministration, but because of their small numbers, most of the health of the Kenyans was in the hands of traditional practitioners. Especially with the introduction of dispensaries into different parts of the country, problems started to develop when Western health workers were confronted with the work of traditional practitioners.[7] Throughout the Colonial period, there was little distinction between the useful medical practitioners operating in Kenyan societies and the so-called witches - the term "witchdoctor" was applied wholesale to all indigenous healers. The Colonial laws said little about herbalists or other healers except what were termed as "witchdoctors". For example, the Witchcraft Ordinance (1925) does not say anything about the legality of herbalists or other traditional healers, but was aimed at punishing the "witchdoctors". An excerpt from the ordinance pertaining to traditional healers makes clear the attitudes of the Colonial Government to them.

> Any person who holds himself out as a witchdoctor able to cause fear, annoyance or injury to another in mind, person or property, or who pretends to exercise any kind of supernatural power, witchcraft, sorcery or enchantment calculated to cause such fear, annoyance or injury shall be guilty of an offence and shall be liable to imprisonment of either description for a term not exceeding five years (Witchcraft Ordinance, 1925).

The missionaries, who ran the majority of health services in Kenya during the Colonial period and continue to do so, were even more opposed to traditional medicine than the government, the best example of this opposition being the circumcision crisis among Kikuyus (Beck in Vogel et al. 1974:100). Among Pokot, few direct conflicts occurred between them and the government over the issue, because no Pokot was ready to report the traditional healers to the government. However, the presence of these healers was often regarded as a major hindrance to health development among Pokot in spite of the fact that there were only a handful of Western-type health facilities in the area throughout the period, with less than a hundred workers (Annual Reports 1955-64). In any case, Pokot killed anybody who was thought to be afflicting the community with pan. In the 1950s, as informants recalled, a number of Pokot were reported to the government as "witches" but it turned out to be that these "witches" were actually people who were thought to be government informers. A few of such people were killed but the government was usually at a loss in trying to find the culprits. Here Pokot used the Witchcraft Ordinance to their own advantage by accusing friends of the Colonial Government of being involved with witchcraft, outlawed by the same Government. Well-meaning traditional healers never faced this dilemma. The people accused of witchcraft were in fact those Pokot who were opposed to Yomat, a quasi-political movement which emphasized indigenous concepts of misfortune.[8]

After Independence, the position of indigenous healers did not improve automatically. Development Plans before the current one hardly ever mentioned traditional medical practitioners - health development was understood to mean the extension of Western-type health facilities. However, because of international developments already outlined, there is now a slight change of policy, tending towards some recognition of certain types of traditional medical practitioners in Kenya, but in practice, not much has been done to utilize them fully in the official health services. But this initial step of recognizing the traditional healers is an important one, because there was fear among consumers, Pokot included, that the Government would systematically eliminate the healers by refusing to recognize and support them. The clause referring to this recognition in the Current Development Plan shows that health planners are moving very cautionsly:

> Traditional medicine and health care are an important part of the life of the people in the rural areas. However, more information is needed and will be collected during this Plan period with regard to both its substantive aspects and its potential link with Government institutions..... Further, consideration will be given to the manpower aspects of the traditional sector, for instance, the extent to which certain cadres of selected traditional sector practitioners, such as the midwives, might be encouraged to serve in Government health institutions in the rural areas (Development Plan 1979-83:136).

In the last chapter, I have shown how among Pokot, in spite of this positive statement, Western health workers and government administrators regard traditional medicine as irrelevant to the health development exercise in the area. This has led to the adoption of various strategies for survival by different categories of healer. What I now wish to do is to discuss the need for a clear policy and

effective action regarding traditional medicine and my arguments are based on my experience among Pokot.

One of the resources in Pokot traditional medicine which can be exploited with positive effect is the emphasis which this medicine places on self-care. Traditionally, the acquisition of basic knowledge about illness, its causation and treatment, is a major aspect of social development among Pokot. As already discussed in Chapters Two and Three the community had the responsibility of dealing with any threats to the health of individuals and the whole society at large, under the direction of the council of elders. It was a system of health for and by the people. With the introduction of Western medicine, the emphasis has been laid on the provision of health for the people by Western-trained experts. As in most other parts of Kenya, Pokot have not been encouraged to participate fully in Western health care and thus the communal responsibility for the health of individuals has waned, almost entirely disappeared. But this is not necessarily a useful development, for expert opinion now suggests that the participation of the community in their own health care, now called self-care, is crucial to the improvement of health conditions in developing countries. It has now become generally accepted that target communities in health programmes should be involved in the planning, implementation and evaluation of health projects, in order to achieve their full support for the project. This approach is clearly spelled out in a joint WHO/UNICEF document.

> There are many ways in which the community can participate in every stage of primary health care. It must first be involved in the assessment of the situation, the definition of problems and the setting of priorities. Then, it helps to plan primary health care activities and subsequently it cooperates fully when these activities are carried out. Such cooperation includes the acceptance by individuals of a high degree of responsibility for their own health care - for

> example, by adopting a healthy life style, by applying principles of good nutrition and hygiene, or by making use of immunization services (WHO/UNICEF 1978:21).

This community participation is not a new idea for Pokot. In fact it was exploited usefully during the cholera epidemics to which I have already referred. The experience of Maendeleo women has also shown that better results can be achieved when people participate fully in their health care. I have already referred to the numerous traditional preventive measures which Pokot carry out at both the individual and community levels because it is expected of them to do so. The kokwa, kiyech and sikom described in Chapter Two can be used to mobilize communities to participate in health programmes, if stimulated by the relevant departments. Western medicine unfortunately, has come to be seen by Pokot as something to be provided by the government, and that they simply have to accept it. This is because the concept of self-care, which exists in Pokot traditional medicine, has been lacking in Western health services introduced in the area. It has now become clear that to accelerate the process of health development in the poorer countries of the world, lay people have to be involved more in health promotion, prevention, disease detection and treatment. The general argument is that since it is impossible to train and pay all the health workers needed in areas like Pokot due to financial limitations, it is reasonable for individuals to perform for themselves many aspects of health care, leaving only those tasks which cannot be done by untrained lay persons to professionals. A greater emphasis is placed on personal responsibility for illness which is then extended to the community level. The main proponents of selfcare are Habicht (1979), Illich (1976), Kronenfeld (1979) among others. Kielmann and McCord (1977) have shown that self-care can greatly improve health

conditions even in societies with low income levels.

It has been estimated that from 25 to 50 percent of non-Western pharmacopoeia is empirically effective (Hughes in Logan and Hunt 1978:154). Though some work has been done on medicinal plants in Africa (Ayensu 1978; Githens 1948; Kokwaro 1976; Nerdcourt 1969; Watt and Breyer-Brandwijk 1962), most of this work has not been carried further than a mere identification of active principles in the medicinal plants. It is not even known which of the pharmacopoeia Pokot use may be clinically harmful. The climate at the international level is now ripe so that a national programme of research into the efficacy of traditional pharmacopoeia should be considered seriously. Such a programme is mentioned in the current Development Plan and one hopes that the envisaged unit can start by researching into those medicines which are now in use in various societies in Kenya.

Pokot themselves have much faith in the drugs they use, but this in itself is not sufficient to promote their utilization. The efficacy of some of the pharmacopoeia is however unquestionable and this is true for example for those used for the treatment of worm infestation and various abortificients.

Obviously it would be quite useful for Kenya to co-operate with other countries in the endeavour to develop indigenous pharmacopoeia. There already exists a useful example of official recognition and support for indigenous pharmacopoeia in China (Wilenski 1976). The development of a locally-based drug industry will go a long way in reducing the expenditure on imported drugs, but this is likely to be a venture for the future, given the fact that Kenya does not as yet possess all the financial and manpower resources needed for advanced pharmacology.

Perhaps the most critical issue regarding possible official recognition and utilization of indigenous medical resources in Kenya's national health services is that relating to the practitioners of the former. As I have already indicated in the last chapter, many of the assumptions held by administrators and Western health workers about the indigenous healers are not based on facts. In the next few paragraphs, I summarize the reasons why there is need to recognize and/or support these healers as appropriate. Most of the arguments I present are applicable not only to Pokot, but to many other societies in Kenya. The general premiss on which the following discussion is based is that there are not sufficient financial and manpower resources in the present Kenyan health care system to satisfy all the health requirements of Pokot.

One of the major reasons for suggesting that indigenous healers among Pokot should receive government recognition and/or support is that they are capable of dealing with a number of medical problems quite effectively. For example, I have already indicated that over 75% of all births which occurred in the area in 1980 were conducted by the traditional birth attendants (TBAS). The effectiveness of the skills of TBAS among Pokot was attested to by Dr.Alube though he felt that they could be made even better equipped for their work if they received some re-training.[9] From an emic perspective, the various traditional healers satisfy their consumers' felt health needs. This is especially so for those healers who deal with inter-personal and spiritual aspects of illness which are not dealt with in Western medicine. I look at this point in detail later on. I need to stress that the healers should be supported not just because they are available but because their work is of therapeutic value. Further, I have

shown that most of them are willing to acquire new skills and paraphernalia which enable them to serve their clients better.

The indigenous healers are affordable given the economic resources available to Pokot. Most healers as already stated, are usually involved in other aspects of the community such as agriculture, animal husbandry and trade. Few of them depend entirely on the earnings from their medical practice for a livelihood. The community can sustain them and therefore the Government does not need to spend a lot of money employing them.

Since the healers share the same concepts of health and illness with their clients, there are few barriers to communication.[10] This encourages compliance in treatment which is a serious problem in Western medicine in the area. More importantly, most healers are opinion leaders in their own communities and this is an advantage if they are to be used as pace-setters in health education. Their being respectable and acceptable to ordinary Pokot makes it easy for them to demonstrate the efficacy of new ideas in health.

I do not wish to imply that all traditional medical practitioners should be supported and/or retrained. The prophets, diviners and ritual leaders need little, if any, official support in order to perform their functions effectively. For these practitioners, what is needed is that they should be made to understand that they are under no threat of prosecution. Their domain involves psychosocial therapy of a nature which few non-Pokot, even if they be medically trained, understand.

It is the birth attendants, herbalists bone setters, tooth extractors and "bush doctors" who need not only recognition, but some retraining to make them more effective in their work. Basic principles about hygiene,

anatomy, proper dosage and preventive education should be made available to them. Those specialists who perform "cultural surgery" (circumcision, clitoridectomy and scarification) should also be given basic principles about sterilization so that they can prevent infection. Where possible a medical kit should be prepared for specific types of healers. The need to refer complicated cases should be taught to these practitioners.

Since in every community there are several indigenous healers, some criteria should be developed for choosing some of them to receive training and support. Ways have to be found to remunerate them for their service to the community. The criteria for selecting healers and ways of remunerating them will depend on the economic environment and educational stiuation in a community - but it has been shown that highly educated individuals are not necessarily the best choice for community health work (Habicht 1979); the willingness of the individual to serve his or her community is a crucial factor. I should stress here that the community should play a major role in the selection of indigenous healers. It should also be reiterated that indigenous healers can only succeed if they are part of a comprehensive primary health care programme. Appropriate supervision of the indigenous practitioners by qualified medical personnel and administrators is an essential feature of any such programme.

I see the role of the bone setters, tooth extractors, herbalists and birth attendants not only in their own specialities, but also as teachers of preventive medicine. Given appropriate training, they can guide their fellow Pokot to participate fully in their own health care and especially by taking appropriate preventive measures.

There are certain problems which will have to be faced before

indigenous practitioners can participate fully in Kenya's health care services. I have already indicated that most healers are suspicious of government officials because of reasons already stated. The first problem to be solved is that of winning the confidence of the practitioners. Recognition and support can change the attitudes of the indigenous practitioners regarding the government and related agencies.

Some informants felt that there are not as many indigenous healers as there used to be in the past. Younger Pokot with some education do not seem to be very keen on being trained as healers. The main reason for this is that without government recognition, the future of indigenous healers is uncertain; in any case, school education raises the expectations of young Pokot regarding employment after school. Such young people expect to get jobs where they are assured of a study income and some status. Government recognition and active support for Pokot healers will make it more attractive even for educated Pokot to become healers. Educated Pokot as healers will have some advantages over the illiterate ones, especially for the purposes of health education.

Pokot now complain that some healers are just charlatans . In the past, informants claimed, the kokwa would ensure that only genuine healers could deal with patients. The kokwa does not have much power nowadays and therefore some Pokot practise medicine just to make money. Christian Pokot, as I have already pointed out in Chapters Four and Five, do not consult healers like the kapolok and the werkoi. I think both of these problems can be dealt with at the community level. In Zimbambwe, the problem of charlatanism among traditional medical practitioners has been dealt with by the formation of healers' associations which issue certificates to those who have proved their

competence in healing (Chavundika 1978). Such associations do not as yet exist among Pokot.

The above problems are surmountable if the health planners co-operate with the communities involved in deciding which course of action to be taken. This brings me to another important issue regarding the utilization of traditional health workers in national health services viz: should the healers be incorporated fully in the existing health structure or should they be given support while they are left outside the existing structure? It may be argued that the healers should be incorporated fully into the Western health services so as to facilitate planning and control of health development. This seems to be the opinion of several writers on the subject in Africa (Ademuwagun 1979:151-251). But it is arguable that since Western health services are dominated by personnel with academic and professional training, and emphasize strict control over entry and codes of practice, it is unlikely that these personnel will be willing to work with traditional healers who have few academic certificates, are mainly illiterate and with no written codes of practice. In any case, as it has already been argued, the two types of medical practitioners have quite different concepts of health and illness. Incorporation may lead to the traditional healers being overshadowed by their Western counterparts.

I think what would seem to be workable at least for the present time is to encourage co-operation at the official level, between traditional and Western medical practitioners. There should be a clear policy and action on traditional healers, because many of them feel alienated and are still suspicious of the Administration. Some of the healers should receive appropriate re-training so that they grasp the basic principles regarding infection and its prevention especially

through the maintenance of hygienic environment when they practise. Healers' associations should also be encouraged so that professional ethics can be kept.

Another important indigenousresource which Pokot can offer to Western medicine and which is now regarded as a significant component in health development in developing countries is the holistic approach to therapy. Though Western health workers among Pokot do succeed in dealing with the physical symptoms of an illness, this in itself does not satisfy Pokot expectations regarding treatment. There is need for Western health workers to pay attention to the psychosocial aspects of illness which to Pokot are no less important than physical symptoms.

By focusing on the biomedical aspects of treatment alone, Western health workers fail to satisfy Pokot expectations regarding treatment. This is because the former are trained to deal with disease, and not illness, in the sense these terms are defined at the beginning of Chapter Three. I have shown in previous chapters that Pokot regard both disease and illness as the object of therapeutic intervention. This has the important implication that for treatment to be considered efficacious, it should have succeeded in dealing effectively with both the primary and secondary aspects of illness. Kleinman (1980) makes an observation which seems to hold for non-Western societies in general. Writing about Taiwan, he says that while Western doctors aim at providing symptom relief, from the perspective of the patient

> ...disease and illness are usually not distinguished. Most of the time patients are concerned with symptom relief together with treatment of psychosocial problems produced by the stress of illness. For most patients this includes a need for explanations of their health problems that are personally and socially meaningful and that usually requires that the practitioner explain the illness (p.356).

My experience in a number of other Kenyan societies, especially Gusii, Samia, Kuria and Marakwet suggests that most of these societies expect Western health workers to explain to them the meaning of cases of illness in terms they understand. This is what the indigenous medical practitioners do, and Western health workers are expected to do the same. In most cases, the latter do not do what their clients expect of them, and this is a cause of much dissatisfaction.

There is need for Western health workers to change the methods they use during the therapeutic interview, if they are to satisfy fully the expectations of their clients. The practitioners should learn from the methods used by Pokot (and other) practitioners. A total re-orientation is needed here, and this should start right from the time that Western health workers are undergoing training. This re-orientation has been suggested even for medical personnel in Western countries.[11]

In trying to effect a re-orientation in the approach to treatment, health planners should draw upon the rich experiences of Pokot health practitioners, and even involve them in the training of Western health workers. This calls for more research to discover what constitutes clinical reality from an emic perspective, and why indigenous practitioners are more successful in satisfying consumer needs regarding treatment than their Western counterparts. In stressing the need for the tapping of indigenous resources - institutions, pharmacopoeia, practitioners and the holistic approach to health - for health development among Pokot and other societies in Kenya, I am agreeing with a statement by the World Health Organization (1976) which says that

> Modern medicine, to which we owe crucial discoveries during the 20th century is ill-adapted to the provision of health care for rural populations in countries in the process of installing their infrastructure. African traditional medicine is one of the pillars of the cultural heritage of the Region and has the potential capacity for finding a remedy for that inadequacy. An integration of the two systems, without compromise of principle, yet with full understanding on both sides, should enable sorely underprivileged populations to benefit from one of the fundamental human rights; the right to health (Agenda 10).

Footnotes to Chapter Six

[1]Only seven of the 30 sample households had their milk boiled regularly.

[2]Kf 249 040 000 was spent on health in 1978/79 (Development Plan 79-83 p.116) and the population was estimated at 15,327,061 in 1979 (Statistical Abstract 1981). This of course does not include all expenditure on health because some of it is met by churches and international organizations.

[3]Compiled from Annual Reports at Kapenguria Hospital 1975-1981.

[4]It is stated in the Plan that one of the major constraints to health development is due to inefficient management and organization (op.cit.:125-26).

[5]A study of all the Annual Medical Reports in the District Hospital shows that up to the late sixties, there were very few cases of malnutrition. In the seventies, such cases have been on the increase, especially among agricultural Pokot.

[6]The government is at present involved directly in three Primary Health Care Projects - at Kakamega, Sio Port and Chulaimbo. The University of Nairobi is involved in Primary Health Care in Saradidi (South Nyanza) and Kitui. Christian Missions have similar projects in Kisii, Nandi, Kerio Valley, Yalta, Rangala, Nangina, Pokot, Baringo, Mt. Kenya, Meru, Chogoria and Maseno South. The African Medical and Research Foundation runs a support unit for community health workers and has its own project at Kibwezi (UNICEF 1981:10).

[7]Dispensaries began to be built in Kenya in the twenties but the process was quite slow - by 1932 there were only 14 Western-type health units in the African areas (Beck (1974) and Carman (1976)).

[8]Yomat was interpreted as a form of "witchcraft" by the Administration, and the killing of "witches" came as a surprise to the Administration, because some of those killed were quite progressive people. The reports state that Pokot were not co-operative in investigations into the death of witches (District Annual Report 1955:2).

[9]Personal communication August 1980.

[10]Pokot do not have little and greater traditions in their medicine as has been reported for Asian societies.

[11]Eisenberg and Kleinman (1981) for example, underscore the need for social science to provide medical personnel with information regarding the sociocultural aspects of illness which they need in order to satisfy their clients' needs during consultation. They say that this is needed in both the developed and non-Western countries.

CHAPTER SEVEN : SUMMARY AND CONCLUSIONS

7.1 Summary of Chapters

In the first chapter, the research problem was stated and the relevant literature reviewed. It was pointed out that while there is no single theory which dominates medical anthropological research, there are two main orientations in this sub-discipline, namely the ecological and sociocultural models. It was also stressed that medical anthropological research today lays emphasis on both theoretical and practical issues and pays close attention to socioeconomic changes, especially in developing countries and how these changes affect responses to illness. These general trends in the sub-discipline are reflected in various parts of this dissertation.

The second chapter was devoted to an examination of the research setting. It was stated that relative to other areas in Kenya, Pokot country is economically little developed. This was attributed to the harsh physical environment and development policy during the Colonial government which concentrated development assistance in areas of high economic potential.

The role of Christian missions in the introduction of Western education and medicine among Pokot was discussed. It was stressed that while initially Pokot did not seem to be very interested in Christianity and schooling, Western medicine appealed to them in as much as its efficacy could be demonstrated. Demand for Western health services has always exceeded supply right from the fifties.

Pokot perception of the relationships between man, the physical and spiritual worlds was described. Pokot think human actions can affect physical phenomena such as rain and disease. Tororot can affect man's life both negatively and positively. Ancestor spirits care for

their descendants but can punish them as well. Various malignant spirits can afflict man with misfortunes. Man should keep the moral law to avoid such affliction. God can control the spiritual and physical forces but sometimes he does not.

In Chapter Three, I argued that Pokot have a theory of illness which contains both naturalistic and personalistic elements. It was also stressed that though they say that interpersonal and spiritual forces can contribute to the causation of illness, they recognize disease as a biological process. In this chapter the idea of planes of causation of illness was explored. The main feature of the Pokot view of illness, I suggested, is that illness is perceived as a condition always biological but potentially also interpersonal and spiritual. Therapy as a process, it was argued, allows for several and at times contradictory, interpretations of a single episode of illness. The major distinction I made was that between primary and secondary definitions of illness and the subsequent treatment with material medicines (or physical manipulations of the body) and ritual therapy respectively. According to the Pokot view of illness, health is fully restored when both the physical symptoms and the interpersonal and spiritual factors thought to be involved in illness have been removed.

The specificity of treatment on the biological plane was contrasted with the diffuseness of therapeutic intervention on the interpersonal and spiritual planes.

In the same chapter various roles in the health-seeking process were described with emphasis being placed on the role of lay people and especially that of the household head in health-seeking. Different categories of indigenous medical practitioners were described and it

was noted that it is difficult to apply terms like shaman or witch-doctor to all of them as a collectivity.

The various preventive and curative practices carried out by Pokot were examined e.g. herbal treatment, physiotherapy, surgery, midwifery and healing rituals. I suggested that in assessing the efficacy of ritual therapy, the biomedical paradigm should not form the basis for such assessment. The basis for evaluating the therapeutic efficacy of ritual should be what Pokot consider to constitute clinical reality and therefore what they expect to achieve by ritual performance.

In the fourth chapter, I argued that there has been too rigid a view of how therapy was derived from theories about the causation of illness in studies of the health-seeking process in African societies. It was argued that among Pokot, variation in the health-seeking process is the rule rather than the exception. It was stressed that because of the nature of their view of illness, theoretical correctness is not their overriding concern in the health-seeking process. It was also argued that variation in illness behaviour can be accounted for by considering a number of intervening variables whose influence leads to the utilization of forms of therapy which to an observer appear theoretically incorrect, considering the causation perceived to underlie a specific illness.

It was stated that though more than one intervening variable may be operative in a single episode of illness, it is possible in most cases to identify the factor which exerts critical influence. To illustrate this argument, it was shown for example how perceived efficacy of a form of treatment exerted a crucial influence in Case 1 of Lopes the herbalist. Financial, transport and treatment costs may lead to a different therapy being utilized instead of the one considered

most appropriate as Cases 2 and 3 illustrate. Alternative therapy may also be resorted to because of poor access to particular health facilities as Case 4 of Mwalimu's pregnant wife shows. Social and moral pressures may also lead to the choice of one therapy and not others as Cases 5, 6 and 7 illustrate. Individual interpretation of the likely consequences of a therapy is also an important factor in health-seeking, as Cases 8 and 9 show. It was also shown how different people can respond variously to a single episode of illness and justify their actions by referring to the same but differently interpreted concepts of the causation of illness (Case 11).

In concluding Chapter Four, I referred to the different functions which a theory of illness can play in a society. It was pointed out that various writers have emphasized the role of theories of illness in social control, the management of aggression and the expression of nationalism. Though Pokot say that the raison d'etre for their theory of illness is to provide guidelines for therapeutic action, I stressed the role of the theory in enabling them to give meaning to the painful experiences occasioned by illness. I also showed how the theory allows for experimentation with new forms of therapy and how when the new forms of therapy become widely accepted, they are assimilated into the theory of illness.

In the fifth chapter, I examined the role of various factors in structuring the relationship between traditional Pokot medicine and Western medicine. A distinction was made between the organizational, cognitive and behavioural aspects of the relationship. It was noted that at the organizational level, the two types of medicine are two separate entities. At the cognitive level, both traditional and Western therapeutic interventions are perceived as forming a single hierarchy

of alternatives. It was argued that there are different reasons why various subgroups of conditions are categorized as pojon or mzungu. At the behavioural level, I stated that the cognitive dichotomization of medical conditions is sometimes ignored, leading to the management of pojon conditions by mzungu therapy and vice versa.

I duscussed in some detail why Western medical curative measures are used more widely than preventive ones. I argued that this is due mainly to the fact that the efficacy of the former is more easily demonstrated than that of the latter. I showed that contrary to some anthropologists' suggestions, not all non-industrial societies lack the maintenance concept in their view of health - prevention among Pokot is taken very seriously. I showed that most Pokot do not possess the appropriate knowledge regarding the prevention of malaria and infective infantile diarrhoea and in most cases even those who know what should be done to prevent the two diseases, find it difficult to practise the preventive measures because of the low level of socio-economic development.

I also argued that various categories of Pokot respond to Western medicine diversely. The response varies from direct opposition as exhibited by the werkoyon, kapolokion and liokin, to competition as shown for example by the herbalists and midwives; complementarity as shown for example by the diviners; supplementarity and peaceful co-existence as shown by for example the circumcision and clitoridectomy experts and active support by community leaders. The description of the relationship as simply one of conflict, I suggested, does not portray the correct picture of the complex and dynamic relationship between the two types of medicine.

I concluded the chapter by arguing that though at the organizational

level traditional and Western medicine exist as separate structures and although the former is not fully recognized and supported by the Government, from an emic perspective, there is only one medical system, according to Kleinman's definition of medical system as a total cultural organization of medically-relevant experiences, an integrated system of social (and personal) perception, use and evaluation (1978:413-14).

In the sixth chapter, I examined various issues relating to rural health development with special reference to the Pokot situation. I contended that contrary to popular views of most anthropologists and Western health workers, indigenous beliefs and practices are not necessarily the main obstacles to rural health development. While showing how certain beliefs and practices can contribute to the incidence and prevalence of certain diseases, I stated that the Pokot view of health and illness is quite accommodating to new forms of therapy and should not be seen as a major obstacle to the extension of Western health services.

In the same chapter I stated that the low level of socio-economic development and certain policies in the national health care system hinder not only the extension of Western health services but the whole exercise of health development, which, as I suggested, does not depend solely on the introduction of more and more Western health services. Some of the problems in the Kenyan health care system which I examined include the separation between curative and preventive services; overemphasis on high level manpower training; failure to adopt an integrated approach to health development and the use of total population figures in locating health facilities without due regard for population density.

In the rest of the sixth chapter, I questioned the assumption that health development in societies in the developing world should be seen to depend on Western medical models. I suggested that indigenous health resources should be harnessed for health development, in line with the new approach called primary health care, which all member countries of the World Health Organization have endorsed as especially appropriate for developing countries. The harnessing of indigenous resources for health development includes measures such as community participation, utilization of indigenous pharmacopoeia and medical practitioners and the adoption of a holistic approach to health problems.

Having summarized the main issues discussed in this dissertation, I now wish to make some general remarks regarding (a) the appropriateness of the methodology used, (b) societal responses to new (medical) ideas and practices and (c) implications of the study for health development in Kenya.

7.2 The Approach to the Subject

Disease and the beliefs and practices relating to its management are closely interrelated with the social, economic and physical environments in which it occurs. To understand the health-seeking process in a society, it is necessary to unravel this intricate interrelatedness. Anthropological research is specially equipped for this task because, firstly, it is holistic and secondly, it gives emphasis not only to people's ideas but also how these ideas influence behaviour and vice versa.

By observing the responses to a number of medical problems among Pokot, I have been able to show that while Pokot have articulated

principles regarded therapy, ideal norms are not always actualized in real life. Though their concepts of health and disease do influence illness behaviour, the two are not related in a deterministic way. By focusing on both principle and practice, it has been possible to identify a number of factors other than the theory of illness (which Pokot say is the sole determinant of illness behaviour) which affect the way they respond to the occurrence of various medical problems, given their indigenous medicine and Western health services. Participant observations made it possible to perceive the process of optation in illness behaviour, and to show that Pokot can manipulate ideal principles to suit specific socio-economic contexts within which an illness occurs.

Cognizant of the fact that the major task of an anthropologist is to find out how data from various facets of a society fit together, I have endeavoured to relate the Pokot view of therapy to their economy, religion and morality, social relationships and national policies and programmes. Without observing this complex interaction in a real life situation, the picture of what constitutes the management of illness among Pokot would have been incomplete.

Though it is common in anthropological research (especially in the structural-functional orientation) to emphasize normative behaviour, I found it necessary to pay close attention to deviations from the norm. In seeking to account for these deviations, I managed to identify the already mentioned variables which influence illness behaviour. This was possible mainly because I used the extended case history method which has proved useful in studies such as the judicial processes among the Lozi (Gluckman 1967) and social control among the Arusha (Gulliver 1955).

7.3 The Process of Socio-economic Change

This study brings out some interesting points about societal responses to new ideas and practices. Variation in responses to new medical practices has been shown to occur even in an apparently homogenous society like Pokot. Different categories of people in the society have been shown to respond differently to Western medical technology. This indicates that the sharing of similar basic cosmological ideas does not necessarily lead to similar responses to Western medicine. The example of the response to the introduction of rehydration shows that the way an innovation is introduced to a society is important in influencing the way it is responded to. In this case, a major factor responsible for the varied response to the new therapy was the nature of exposure various mothers had had to it. The most positive response was achieved among those mothers to whom the effectiveness of the therapy had been demonstrated repeatedly.

The study also shows that contrary to the postulates of proponents of conflict models, cognitive dissonance may be occasioned by the introduction of new medical practices without necessarily preventing the adoption of the new practices. In other words, new medical practices can be accepted while fundamental concepts relating to such practices remain largely traditional. This study supports the findings of others which show that behaviour change in most cases precedes change in ideas (cf. Foster and Anderson 1978:243-262). It has already been shown for example that the utilization of rehydration for the management of infantile diarrhoea is inconsistent with what Pokot say causes the illness and therefore what treatment should be applied.

It has been observed, most notably by Van Velsen (1967) that inconsistency and contradiction in behaviour (relative to theory) are

a feature of all societies. In connection with behaviour related to illness, I suggest, contradictions are sustained because, as already noted, concepts of illness may serve a number of other purposes besides providing guidelines for therapeutic action. The concepts are only a part of a world view which changes only slowly. Among Pokot, the theory of illness still has a special role in social control still (cf. the curse, oath and eywei). This is why they can accept new therapy which contradicts their theory of illness. Such a contradiction should, from an observer's view, lead to change in the theory, but such a change may occasion serious repercussions for social control and order in the society. That this is so once again reveals the fundamental weakness of the conflict model in the study of the interaction between traditional and Western therapy. The conflict model presupposes that for a medical innovation to be accepted, it should be such that it occasions no dissonance in the people's view of illness. In my view, non-Western societies need not be acculturated along lines of Western civilization in order to accept biomedical health care as the conflict model implies.

This study reveals an important feature of the process of social change i.e. the indigenization of Western ideas and practices. This indigenization involves the accommodation of new ideas and practices in already existing cognitive categories and relating to them accordingly: for example, though the Western health workers are referred to as daktarion, Pokot think of them as a type of their traditional chepsaktis and are therefore puzzled when the former do not behave as chepsaktis are expected to do. I have also stated that Western preventive medicine is regarded as a form of the traditional ighat (cf. Alland 1970).

This study also shows that certain responses in the process of social change among Pokot are made necessary by developments taking place outside their society. For example, the fact that they use more Western curative medicine than they practise the related preventive measures is due mainly to what until recently was the generally accepted approach to health development (emphasis on curative medicine) and which until recently, most developing countries like Kenya adopted and implemented enthusiastically. The same can be said of the organizational separation between traditional and Western medicine and lack of official support for the former. In the past, anthropological studies of health-seeking processes could be limited to a particular society as an isolated entity. Now that most societies are effectively part of larger entities, i.e. nations, such processes can best be understood by viewing particular societies within the context of the larger and more complex processes of national development which in turn are engulfed in international developments, in this case, the endeavour by non-Western nations to "modernize" their respective societies and the uncritical adoption of Western technology and structures thought to constitute development. This in effect implies that population-centred studies on their own are not adequate for a proper understanding of the process of socio-economic change.

7.4 Implications for the Provision of Health Care

This study shows that although Pokot use as much Western medicine as is available to them, they still hold views of health and illness which go beyond the physical realm of existence, and that consequently they expect therapeutic intervention to be holistic. The belief that interpersonal and spiritual forces can cause or exacerbate illness is

widespread in Africa. It has been reported for the Abron, Azande, Bambarra, Lugbara, Mandari, Ndembu, Nyakyusa and Zulu, to name only a few, the relevant literature of which has already been cited in this dissertation. The biomedical view of disease, upon which Western medicine is based, emphasizes mainly the prevention or removal of biological and sometimes psychological symptoms only. I suggest that Western health workers in African societies like Pokot should regard as part of their work, the treatment of interpersonal and spiritual components of even those conditions which appear primarily biological.

It is now becoming increasingly recognized that social and spiritual causation of illness is as important as is biological causation. Kleinman (1980) argues convincingly that for Western medicine to be psychologically and culturally appropriate, Western medical personnel must take seriously a society's construction of clinical reality, which for African societies like Pokot, includes interpersonal and spiritual components. I am not suggesting that interpersonal and spiritual forces should be dealt with by Western medical personnel just because several societies believe in these phenomena; there is another, and I think more important reason. A number of researchers are convinced that the various "mystical" social and spiritual forces can actually cause disease or exacerbate an already existing condition (see for example Alland 1970; Fabrega 1974; and Horton 1967). Horton (1967) for example thinks that a number of ailments marked by bodily changes may be touched off or exacerbated by mental stress resulting from interpersonal and spiritual conditions (p.56). The possibility that certain ailments may be caused or exacerbated by disturbances in an individual's social life has an

important implication for the provision of Western health services in African societies. Western-trained health personnel should therefore go beyond biomedical problems when diagnosing illness. As Horton suggests, Western medical personnel will eventually have to include some sort of diagnosis of and attempt to combat stress-producing disturbances in the individual's social life (p.56). I take it that stress-producing disturbances in an individual Pokot's social life include things like the violation of muma invocation of the curse, eywei and pan. To be able to deal with such problems, Western health workers need to receive the kind of training suggested in Chapter Six which will enable them to understand the complex process of the causation of illness in societies like the Pokot. When or where these health workers find it impossible to deal with all the factors which are involved in an illness, they should be willing to refer such cases to the appropriate type of indigenous healer.

At the same time, through a comprehensive programme of health education, Pokot should be introduced to the basic biomedical concepts so as to enhance proper communication between them and Western-trained health workers. Such enhanced communication will not only increase compliance (Becker 1974) but can also contribute to more consumer satisfaction (Linder-Pelz 1982).

In the light of the findings of this research, I wish to suggest that there is an urgent need to re-assess the overall strategy for health development in Kenya. Hitherto, the emphasis has been on the provision of as many Western-type health facilities, equipment and highly-trained personnel as possible. There is evidence to suggest that merely increasing such facilities is not only expensive but may not necessarily contribute to any substantial improvement of health

conditions (Bryant 1969). It is here suggested therefore, that it may be more economical, as some have argued (Dubos 1968), to aim at improving health conditions through the increased production and better distribution of food, education and the improvement of communication. This implies that health development should be seen as integral to the wider process of socio-economic development. Of course one is aware that such an approach may seem unattractive, especially to politicians who want to show tangible rewards (such as ultra-modern hospitals) in the short run to their constituents; however, this is an issue which will sooner or later have to be faced, given the population explosion in the country and insufficient resources for development programmes.

The change to an integrated approach to health development should include an attempt to arrest a recent, but increasing tendency among Pokot and other people in Kenya viz.: reliance on the government and other agencies to provide all health care for the community. In many parts of rural Kenya today, both individual and community participation in health care is very low. People's responsibility for their own health care is being gradually and systematically shifted to outside agencies. This is not a positive development because the importance of involving target populations in the planning, implementation and evaluation of development projects has now become generally recognized (Berthet 1979). An important element of such a process should be the promotion of the traditional psychosocial supportive systems, because most anthropologists are unanimous regarding the effectiveness of this supportive dimension in therapy (Foster and Anderson 1979:128).

Finally, having written this dissertation, I am convinced more than ever before that it is difficult to carry out research on phenomena

relating to illness in human society without touching on matters of practical relevance. Some may think that the interest medical anthropologists take in practical (applied) issues is a hindrance to the development of theory in the sub-discipline. This study like many others, shows that practical issues can yield much material for theoretical analysis and vice versa. In expressing the opinion that one can hardly ignore the practical aspects of medical anthropological research, I am perhaps echoing what many Pokot feel about the matter. While they accept that Western education is important in preparing young Kenyans to participate profitably in their society, my informants refused to accept my reasoning that one could study their health beliefs and practices without making recommendations to the Government in the end about what should be done to help them lead healthier lives.

Appendix I

Medicinal plants commonly used in Chepareria by Lay people for the treatment of various medical conditions. Identified at the Kenya Herbarium, Nairobi Ref. KNU/H173/81

Plant	Uses
Chepkopil Cassia Singuena (caesalpiniaceaea)	Bark chewed for constipation.
Chepkresmeywon Fagaropsis, angolensis (Rutaceae)	Panacea for all minor ailments.
Chepopet Clerodendrum, myriacoides (Verbenaceae)	Roots boiled in water for indigestion.
Cheptinonwo Ficus, thonningii (Moraceae)	Fruit - children given to eat for general health.
Cheptugen Pavetta crassipes (Rubiaceae)	For general malaise - prepared variously.
Chowou Acacia, seyal (Mimosaceae)	For headache and dizziness.
Chuchwen Dovyalis macrocalyx (Flacourtiaceae)	For gonorrhoea.
Iwak Sansevieria sp. (material sterile) (Aga vaceae)	Roots boiled and fed to person with high fever with convulsions.
Ket pokata Pachycarpus schweinfurthii (Asclepiadaceae).	Roots mixed with water for worms (general).
Ketpotaswo Piper capense (Piperaceae)	Routinely given to babies - mixed with milk for prevention of sickness.
Knyotwo Ximenia americana (olacaceae)	Juice used for eye infections, ulcers and mouth inflammation in babies.
Koloswo Terminalia brownii (Combretaceae)	For jaundice.
Konoll Combretum molle (Combretaceae)	Used for ighat (Prevention)
Korendus Pittosporum vindifolium (Pittosporaceae)	Roots boiled and given to weak and thin children.
Koworio Pergularia daemia (Asclepiadaceae)	Leaves and bark boiled in water for colds.
Kromwo Ozoroa insignis (Anacardiaceae)	Bark mixed with water and milk for diarrhoea.
Kuanditos Clausena anisata (Rutaceae)	Juice for eye infections.

Kukugho Strychnos spinosa (Loganiaceae)	Bark crushed and mixed with water : emetic.
Kukughoonyet Oncoba spinosa (Flacourtiaceae)	Roots boiled in water and drunk for gonorrhoea.
Kunyan Indigofera sp. (material sterile) (Papilianaceae)	Eaten with goat soup for prevention of sickness.
Kutkutia Spilanthes mauritania (Compositae)	Crushed and mixed with water for mouth infections in babies.
Lokotetwo Carissa edulis (Apocynaceae)	Roots boiled in water for headache and dizziness.
Mononguyon Lantana trifolia (Verbenaceae)	Sap squeezed into infected ears and old wounds.
Melkachei Asparagus deflexus (Liliaceae)	Stem burned and ashes rubbed on gums to assist the eruption of milk teeth.
Ongurwo Plectranthus barbatus (Labiatae)	Sap used for cuts and wounds.
Pirirwo Fuerstia africana (Labiatae)	Leaves crushed and mixed with water for ear infections.
Priokwo Pappea Capensis (Sapindaceae)	Bark crushed and boiled for liver swelling.
Reberwo Syzygium cordatum (Myrtaceae)	Plant crushed and mixed with water for swellings in abdomen region - especially liver.
Sarkach Crassocephalum bojeri (Compositae)	For diarrhoea.
Sinetwo Cassia didymobotrya (Caesal piniaceae)	Roots boiled as an emetic (for malaria)
Siriowo Rhus natalensis (Anacardiaceae)	Bark mixed with water for diarrhoea.
Sioyoywo Ficus sp. (material sterile) (Moraceae)	Bark boiled in water or mile for diarrhoea.
Songowo Zanthoxylum chalybeum (Rutaceae)	Leaves chewed for common cold. Stem boiled for thrush in babies. Also for dizziness and headache.
Soroktwo Sansevieria sp. (Agavaceae)	Sap squeezed into infected ears.
Süpko Ocium Kilimandscharicum (Labiatae)	Leaves chewed for common colds.

Tingoswo Flacourtia indica (Flacourtiaceae)	Plant crushed and boiled for gonorrhoea.
Toprirbirwo Vangueria epiculata (Rubiaceae)	Fruit for strength.
Torokwo Ziziphus abyssinica (Rhamnaceae)	Fruit for strength.

Appendix II

Summary of Major Episodes of Illness

Problem(s)	Afflicted	Therapeutic Actions[1] Taken	Actors	Critical Factor(s) Illustrated	Outcome
P - Lochongo eye trouble S - Pan	Widower (healer) lay T. (herbal) hospital T.(G.D)	diviner consulted	Patient and adult sons	Perceived efficacy	Eye problem cured. Secondary causation ignored in the end.
P - takat tuberculosis	Twelve year old daughter	lay T (shop medicine) dispensary T.M. herbalist T. hospital T(GD)	Household head Wife Chief Health Technician	(Affordability)	Patient not cured when I left.
P - Kayitan diarrhoea, fever & vomiting	Three young children	lay T (herbal) dispensary T.M. herbalists T.	Household head and wife	(Affordability)	Patients cured Secondary causation not dealt with but considered serious.
P - sickness incidental to pregnancy s - ngoku	Teacher's pregnant wife	herbalists T. visit to Maternal Clinic (GD)	Household head school chairman	Accessibility to health facilities	Patient cured ngoku not accepted as important
P - barrenness S - Onyetei - Pan	Teacher's wife	hospital T(GN) Kisoyonet performed	Household head Household's parents and other wife afflicted parents (TMG)	Social and moral considerations	Patient not cured, but secondary causation considered removed.
P - birth	Birth attendant's married daughter	hospital M.	Patient and mother	Social status considerations	Successful delivery.
P - Kawitwit paralysis S - oi	Young daughter	lay T (shop medicine) dispensary T(M) hospital T(GP) diviner consulted non-Pokot healer consulted	Household head wife and close kin (TMG)	Social and moral constraints	Patient not cured. Secondary causation only partly dealt with. Kin still wanted Parpara performed.
P - no clear definition Semeu S - Muma (oath) effects Pan	Wife and children of trader	lay T (shop medicines) hospital T(GD) clinic T(P)	Household head his father and brothers	Individual judgement legal consequences feared	Patient cured. Secondary causation not dealt with
P - no clear definition S - Pan	Ten year old daughter	lay T (herbal) herbalists T. dispensary T(M) diviner consulted amoros offered	Household head mother and brothers	Individual judgement economic consequences feared	Patient cured. While brothers thought otherwise Protagonist considered Secondary causation eliminated.
P - Kepil mental illness S - Onyetei Pan	Unmarried son (technician)	- Christian prayers - Amoros offered - hospital (psychiatric) visited (N)	Patient and close kin - sisters, father and uncles (TMG)	Plasticity of theory of illness	Patient cured. Secondary causation considered eliminated

contd/....

12	P - dysentry	Three year old son	lay T (herbal) dispensaryT(M)	Mother and her father-in-law	Perceived efficacy	Patient died.
13	P - ear infection	Eight year old daughter	lay T (shop clinic T(P)	Father and mother	Perceived efficacy	Patient fully cured.
14	P - abortion	17 year old daughter	Indigenous specialist T	Mother and her two women friends (TMG)	Legal constraints availability of resources	Patient died.
15	P - Impotence S - Pan	Husband of 2 wives	Indigenous masseurs T. Putat performed.	Patient, 3 brothers and 2 male neighbours.	Perceived efficacy	Patient not cured but pan considered annulled.
16	P - Infertility S - oi	2nd wife with one child	Herbalists T diviner consulted	Patient and husband	Affordability	Patient not cured - appropriate therapy not completed.
17	P - Miscarriage S - Eywei	Widow	hospital T(M) diviner consulted herbalists T	Patient and her parents and parents-in-law (TMG)	Social and moral pressures	Patient cured but parents-in-law considered eywei still operative.
18	P - Semeu	Newly married woman	lay T. (shop medicines) clinic T(P)	Husband	Perceived efficacy	Patient cured.
19	P - Chronic abdominal pains S - muma	Divorced woman staying with her parents	lay T (several shop and herbal medicines). herbalists T. diviner consulted	Father and brothers (TMG)	Social and moral constraints. (Family refused to accept muma as cause	Patient died. muma allegation not solved.
20	P - Semeu	Adult man employed as wage labourer	lay T (shop medicine) hospital T(M)	Employer	Perceived efficacy	Patient cured.
	P - Spear wound	Unmarried son	hospital T(M)	Friends and father.	Legal considera-tions (evidence for Court case needed)	Patient cured.

Key

[1] support activities are not included.

* referred to in dissertation.

TMG - cases where a therapy managing group was formed.

P = primary definition.

S = secondary definition.

T = treatment.

G = Government (N - national, P - Provincial, D - District).

M = mission.

P = private.

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	1956		File DC/WP.1/7
	1957		File DC/WP.1/8
	1958		File DC/WP.1/9
	1960		File DC/WP.1/11
	1961		File DC/WP.1/12
Medical Annual Reports	1955 - 1964		File DC/KNRIA/13/1
Monthly Reports West Pokot	1962 - 71		File DC/KPNRIA/14/1
Political Record	1923 - 47		File DC/WP.3/15