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RICE UNIVERSITY

DISEASE, MEDICINE, AND SOCIAL CHANGE AMONG THE ABANYOLE
OF WESTERN KENYA, 1900-1963

by

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IN PARTIAL FULFILLMENT OF THE
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ABSTRACT

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Bunyore, like the rest of present-day Western Province of Kenya, came under British administration as part of the Eastern Province of the Uganda Protectorate between 1890 and 1895. In 1902 the area, then known as Kavirondo District, was hived off from the Uganda Protectorate and added to the East Africa Protectorate. These, basically geopolitical, developments went hand in hand with changes in communication networks, agricultural production, the introduction of taxes, and the rise of a labor-exporting peasantry, or what was called in the politics of conquest the opening-up of the East African interior. If these changes, for example, drew the Abaluyia into the world capitalist nexus, they also created conditions within which an expanding nineteenth-century social field of action was confronted with new diseases and ideas about these diseases that were extremely important in the making of a colonial medical social formation. Thus, if during the ‘Nyole-British encounter a colonial biomedical science came to define itself within and above a ‘Nyole cosmology as has been argued in this thesis, this was because to the British the AbaNyole were not only there to be perceived and felt as part of the experience of a Kenyan epidemiological landscape, but also because this definition was a normal requirement for colonial self-definition, cultural positioning, and boundary-marking between ‘science’ and ‘tradition’, ‘culture’ and ‘nature’. It was because of this perception, it has further been argued, that colonial discourses during the first twenty or so years of colonial rule revolved around the idea of nature, an idea that was a rendering of not just the physical, natural characteristics, of the colony, but also of the colony’s inhabitants whom
administrators like Sir Charles Eliot thought were both ‘primitive’ and ‘natural’ since they were not ‘cultured’. The conquest of disease was thus seen as a major aspect in the wider process of ‘reclaiming’ this nature through ‘taming’ it in both its physical and human attributes. From this perspective, it has been argued that from the very beginning Kenya was constituted into a ‘problem’ whose ‘solution’ demanded the application of the values and techniques of mastery, the mastery of ‘man’ over ‘nature’. This was a major discursive strategy not only in the logistics of political conquest but also in the constitution of a colonial state and a colonial civil society. Based on a bifocal address and the prevalence of argument by negative contrast, the image of the ‘natural’ like the all-embracing discourse on the ‘Native Problem’ constituted the intellectual domain in which the knowledge, strategies, policies, and justifications necessary to the maintenance of domination were fashioned.

Coterminous with this period’s colonial conquest/pacificationist stance, this approach was in Bunyore as elsewhere in Kenya characterized by an epistemic violence that, on the one hand, shaped the discursive practices of a colonial medical science as it attempted to expropriate AbaNyole’s capacity to narrate their own bodily experiences and, on the other, led the AbaNyole to draw a clear distinction between Ekilauni (the Crown) and Silikali (the Government). Brutality from ekilauni without redress from silikali, it has been argued, created fertile grounds in which all sorts of ideas about the two institutions, but also what these institutions were upto, could be planted, nurtured, and finally debated by the AbaNyole in all types of arenas.

But as a discourse-in-the-making, biomedical’s single-level authorization was in this period at a painful juncture of emergent self-definition. This became manifestly so when the outbreak of a plague epidemic between 1908 and 1930 not only provoked a crisis in this discourse, but also restated the centrality of disease to the colonial project. Because of its peculiar texture, plague forced a new explanatory paradigm that came to at once
perceive epidemic diseases as cognitive and emotional occurrences, and affirmed belief in rationalistic pathology that went a long way in strengthening the view that the African body and the conditions of its habitation were primary factors in the spread of these diseases. This was about differential or selective susceptibility and, in the interwar period, it became intertwined with an emergent discourse which saw the problem of health in Kenya from the point of view of the relationship between the African cultural environment, African psychology, and the problem of the uneducability of the African. It has been argued that though this discourse ostensibly undermined late nineteenth- and early twentieth-century European perceptions of Africa as a ‘patient’, it popularized race in its search for what was different and not similar between Africans and Europeans. Thus, though the colonial state and its medical experts in this period envisioned health reform as part of a larger scheme in the development of a numerous and healthy population, in its (state’s) second colonial assault it used this discourse to not only link problems of rural poverty, economic development, and education to a search for new directions in rural health-care provisions, but also to constitute the African rural world as a space in which a particular type of medical knowledge could be produced. The main dimension to this discourse was the construction of a new medical and disease language that categorized, or named, new disease entities not according to their biological, epidemiological, or pathological manifestations, but rather according to their geographical and/or racial incidence. As part of a wider ideology of systematizing and justifying the colonial state’s interventionist stance, health reform in the interwar period and beyond became a metaphor whose web of meanings included the incorporation of modernist and ‘scientific’ modes of discourse within the lexicon of the second colonial assault in the country. This is why, we have concluded, the period immediately after the end of the Second World War saw not only the rise and systematization of the Health Center as an arena in which a new object of knowledge, Bora Afya (Good Health), and field of intervention, the African home, but also the parameters
within which there was a transition from a conquest/pacificationist to an interventionist state, from preventive to curative medicine, from political to social medicine.
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PREFACE

In the human context of illness, experience is created out of the dialectic between cultural category and personal signification on the one side, and the brute materiality of disordered biological processes on the other. The recurrent effect of narrative on physiology, and of pathology on story, is the source of the shape and weight of lived experience. That felt world combines feeling, thought, and bodily process into a single vital structure underlying continuity and change in illness. Coming to terms with this human dialectic transforms our understanding of the difficult life problems that issue from chronic illness and of how they are best treated; it also alters our appreciation of what medicine and health care are all about (Kleinman, 1988: 55).

According to the editorial in the 1986 issue of the Review of African Political Economy, Africa is, perhaps more than any other part of the developing world, characterized by high death rates due to a myriad of diseases. The most common of these diseases are fever, measles, pneumonia, whooping cough, gastroenteritis, tuberculosis, anemia, poliomyelitis, tetanus, malaria, and all kinds of respiratory infections. This, coupled with food shortages and famines that have in recent years occasioned mass starvation and death in most parts of the continent, as well as the current AIDS pandemic, have turned Africa from the cradle to the grave of mankind. Because of the crisis these developments have occasioned, the need for social science research on diseases and medical practices has become urgent. Scholars and policy makers alike are beginning to take cognizance of the fact that social science research might give clues to, and guidelines for, new approaches to the solution of the problem. It is also hoped that such research will help in the understanding of changes in certain patterns of behavior -- for example in food preferences and consumption, sexuality, and the rural-urban continuum -- that are related to changes in health regimens in the continent.

What is perhaps most glaring in what has so far been done in this quest is the emphasis that has come to be put on how political and economic structures, both in the colonial and post-colonial periods, have been important factors in determining processes of
health and healing in the continent. However, in emphasizing regularities in the distribution of health care, as well as political institutions and economic production as determinants of health in Africa (Feierman and Janzen, 1992), the problematic interdependence of discourse and praxis, and the constant tension between them as represented in a complex colonial situation (Arnold, 1993) and the particularity of the African experience, is often lost to scholars. Indeed, as part of a current intellectual posture that has come to emphasize the themes of the ideology underlying tropical and colonial medicine, the preferences and politics of imperial medical research, and the dramatic effects of new sciences and technologies on the experience of Europeans overseas (Macleod and Lewis, 1988), this argument leads to one inescapable conclusion on the wider question of African historiography: that just like Eurocentric colonial histories of Africa, the history of biomedicine, at least from the point of view of this posture, is the history of Europeans and their medical sciences in the continent. By unnecessarily emphasizing this aspect of the history of biomedicine in Africa, the African voice is not only muted, but one is also left to wonder how the Africans, faced as they were by new diseases and therapeutic practices, both perceived and dealt with the situation. Diseases, but also famines, in the colonial period were episodes which in their singularity or nuanced simultaneity provided not only critical moments for reflection on social and political questions of the day; they also, for social historians, provide an opportunity to pose questions on the problematic of continuity, rupture, and transition in African history.

Through an examination of ideas about order and disorder in 'Nyole cosmology; 'Nyole experiences with new diseases and Western biomedical practices that were brought to bear on these diseases; and how these experiences and the meanings they produced transformed the peoples’ metaphors of disease, illness, and healing within that historical period called colonialism, this thesis posits the argument that just as colonialism was more than the mere quest for the construction of exploitative political and economic institutions,
so was biomedicine not merely a matter of scientific interest based on the principle of
benevolent neutrality. Colonialism, concerned as it was with both the physical being of the
colonized and the construction of its own authority, legitimacy, and control, also provided
the space within which a specifically colonial biomedical science was constituted. This was
a process in which this science, by defining itself within and above ‘Nyole society,
powerfully contributed to, first, the cultural and political construction of the AbaNyole and,
second, produced a particular type of medical knowledge with its own discursive practices.
Indeed, by setting the terms of discourse between the West and the African cultural
environment, and by insinuating itself at the center of contestation over knowledge between
a British science and African ways of knowing, this colonial biomedical science turned the
African body into a site of colonizing power and of contestation between the colonized and
the colonizers. Thus, it has been argued, because of its contribution to the political and
ideological articulation of the colonial order, biomedicine cannot meaningfully be abstracted
from the broader character of the colonial order since it remained integral to colonialism’s
political concerns, its economic intents, and its cultural preoccupations (Arnold, Ibid.). If,
as it has further been argued, colonial biomedical science in its early stages problematized
Africa as a ‘patient’, and its inhabitants as ‘half children and half devils’ (Prins, 1989), this
was because Africa as a landscape of fear was a major discursive metaphor in the politics of
subjugation which the West saw as a process of ‘pacification and normalization’. There
however was a shift in this perception in the post-Second World War period when a new
object of knowledge, public health, and field of intervention, the African home, came to
provide the parameters within which there was movement away from preventive to curative
medicine, from political to social medicine.

This thesis is also about how the AbaNyole perceived and problematized
biomedicine as both a cultural force and a tool of colonial domination. Through an
examination of ‘Nyole experiences with new diseases and biomedical practices that were
brought to bear on these diseases, as well as the multilayered meanings these experiences produced, this thesis has attempted to show that, first, narratives about the incidence of diseases like plague were in themselves experiences of suffering that open a window to how local knowledge about disease etiology and disease causation was produced among the AbaNyole during the colonial period. As Arthur Kleinman (1988: 25, 28) has recently argued, “culturally salient illness meanings disclose change as well as continuity over time and place.” This observation is antithetical to clinical and behavioral science research which “possess no category to describe suffering, no routine way of recording this most thickly human dimension of patients’ and families’ stories of experiencing illness.” Second, it is argued that AbaNyole perception and interpretation of new life-threatening diseases took place within an evolving repertoire of etiologic idioms that go a long way in showing that, instead of being passive victims of capitalistic forces of domination and exploitation, these people did confront biomedicine as its assemblage of practices inhabited, passed through, transformed, conserved, or escaped the terrain sketched by a pre-European ‘Nyole worldview (Comaroff, 1985). Encompassing resistance, accommodation, participation in, and/or appropriation of some of these practices, these repertoire of idioms were about ‘Nyole-British encounter, itself an idiom that at once expressed ‘Nyole cultural solidarity against the career of Western biomedicine, and captured moments in which attempts were made to reproduce traditional social relations or reaffirm pre-colonial notions of being, oneness, and belonging. It is from this perspective that rumors about these practices are in the thesis seen not as a malicious, or even ignorant vehicle for denigrating Western biomedicine but as an idiom for anxiety about and over traditional social relations as well as the social positioning of itinerary ‘doctors’, biomedical practitioners, and African therapeutic practitioners. If talk and elaboration on what went on in hospitals reduced anxiety over the disruption of pre-colonial ideas of continuity and completion at the community level, biomedical practitioners alleviated theirs by denigrating both itinerary
'doctors' and traditional healers. It is significant, therefore, to note that the importance of debates and contestations among the AbaNyole themselves over therapeutic choices lay as much in the arguments and justifications for the use of one or the other, as in the fact that these therapies were arenas in which negotiations over social transformation of the 'Nyole medical landscape took place. From this perspective, it has been suggested in the thesis that the whole notion of medical pluralism has in Bunyore been more about zones of activity between and within available therapies and less about therapeutic systems that have since the turn of the last century been fighting it out for dominance.

The approach taken in this thesis is thus different from that found in most histories of medical institutions, of the evolution of colonial medical policies, and of particular diseases which more often than not end up by excluding the patient and/or those around him/her from their narrativity. The thesis suggests that what the biomedical practitioner defines as disease is in fact a dynamic dialectic between its etiology, psychological states of both patients and their friends and relations, and the cultural environment. By narratives as experiences of suffering is meant all that that went into the categorization and explanation of, in commonsense ways accessible to the AbaNyole, the forms of distress caused by pathophysiological processes (Kleinman, 1988: 4-5), and practices brought to bear on these processes during the colonial era. The ways in which the AbaNyole learned to think and act about new diseases and biomedical practices are in the thesis seen as important discursive tropes through which ideas about colonialism and misfortune were organized: conventional expectations about disease as misfortunes were altered through negotiations in different social situations and in particular webs of relationships as colonialism came to be seen and experienced as a form of social death the AbaNyole had never encountered before.

But there is another, equally important, way in which the concept of experience is used in the thesis. Medical science during colonialism was a game of truth through which
the AbaNyole, as any other people who encountered it in Africa, were historically constructed as experience, as something that could and must be thought. The place of medical science in the social history of the colonized is in this thesis seen as a tool by which the colonizer proposed to think about the colonized African as a being occupying what Y. -F. Tuan (1979) has called the "landscape of fear," that unique space that was disease-ridden and degenerate. By directing his/her gaze on the colonized from this vintage point, the colonizer was perceiving the African as the epitome of the experience of disease.

This thesis is thus more than a history of behaviors (Janzen, 1978), of representations (Vaughan, 1991), or of political and economic structures of colonialism as determinants of health and healing in Africa (Feierman and Janzen, 1992) since the issues dealt with belong to a history of ideas, the movement of these ideas across various landscapes, and how these ideas help us in understanding processes of social change in Bunyore. The key question of the thesis has been, therefore, not why the AbaNyole suffered from certain diseases; rather our approach is one geared towards establishing why the AbaNyole thought they suffered from these diseases. In other words, it has not been the aim of the thesis to define the parameters of disease causation but rather the understanding of how the AbaNyole problematized life and death, Western biomedicine and its technologies, and the continuation of what they call Obulwaye bwe siafrika (African diseases) notwithstanding changes brought about by Western formal education, hospitals, and Christianity. This approach gives the thesis the levels of discourses that went into the explanation of disease causation among the AbaNyole and how this arranged, making and re-making, the 'Nyole medical landscape during the colonial era.

In arguing that 'Nyole perception and interpretation of diseases like libumba (plague), esirimba (yaws), and esihela (tuberculosis) took place within an evolving repertoire of etiologic idioms like the notion of esihia (newness), the significance of this study lies in its insistence on the importance of how the colonized, instead of being passive
victims of colonial institutions of dominance and exploitation, problematized biomedicine and its assemblage of practices. But as episodes that provided critical moments for reflection on social and political issues, this study has demonstrated that the shift in medical policy in Kenya after the First World War was partly due to the struggle between the conquest/pacification state and Christian missionaries over the colonization of African consciousness (Comaroff and Comaroff, 1991), and partly due to the importance of epidemic diseases to the colonial project. In restating the centrality of diseases to this project, it has been argued, the incidence of epidemics like plague in the interwar period brought to the fore certain counter-tendencies in colonial thinking that challenged, and sought to overturn, the conquest state's core assumptions about disease and how best to control it in the emergent post-First World War outfit. In this period medicine came to be seen as too powerful, too authoritative, a species of discourse and praxis to be left in the hands of Medical Missionaries. As one leading Medical Officer in this period put it, medicine was "the best form of advertisement" from which the state wanted to "reap the credit and the resulting influence." This conclusion has called into question the at times excessively generalized idea that the shift in medical policies in Kenya as elsewhere in British Africa after the end of the First World War was due to rampant epidemics that, in the first two decades of the twentieth century, threatened both European and African populations. Contrary to the conclusion by most scholars that Africa in this period was characterized by declining population trends due to these epidemics, evidence adduced in this study suggests that certain niches in the rural landscape as Bunyore witnessed population increase regardless of the epidemics.

It is on the basis of these arguments the study has concluded that as transitional markers in 'Nyole perceptions of the colonial state and Christian missionaries, diseases in the social history of Bunyore cannot be wholly understood within the framework of either European fear of contagion and the decimation of African populations, European guilt,
conscience, or public opinion; or purely from the point of view of social reform. Diseases must be understood in terms of the imperatives of the transition from a conquest/pacificationist to an interventionist colonial state, as well as from the point of view of the form and uses of medical knowledge in the constitution of a colonial order since their constituent domain was one of governance.

Data for the study was collected between the months of July 1992 and February 1993. The first three months of this period were devoted to the collection of archival data at the Kenya National Archives in Nairobi, the Western Kenya Regional Archives in Kakamega, and at the Kima (Church of God) and Maseno (Church Missionary Society) libraries. Apart from providing information on the establishment of Pax Britannica, demographic dynamics, labor and labor migration, and the establishment of forces of social change like schools, churches, and health centers in Western Kenya, data contained in files at the Kenya National Archives provided crucial insights into AbaNyole-British relations and occasionally into the 'Nyole community itself. These, together with information gleaned from annual and quarterly medical reports from the region for the period 1900-1960, colonial medical officers' researches on diseases and 'their relationship with African cultural environments,' recent scholarly research on 'Nyole oral literature, anthropology, and religion, and published reports on Luyia ethnographic studies, constitute the bulk of published primary data for the study.

Between September 1992 and February 1993 personal and often multiple interviews were carried out with a wide variety of informants who either experienced the events discussed in the thesis, or knew or were well conversant with relevant 'Nyole community traditions, names of diseases or famines and the years in which they occurred, and the measures either the community, the Christian missions, or the colonial government took to stem the crises. Life histories of retired biomedical practitioners (former employees with government and/or missionary medical institutions), African therapeutic practitioners,
as well as clients of these two therapeutic systems provided means through which to explore different areas of personal experiences. Through this, information was acquired on disease entities, on therapeutic choices, on the changing relationship between, for example, traditional healers and their clients, on the role of migrant labor in the expansion of therapeutic visions, and on the introduction and development of new diseases in Bunyore. Information gathered this way on the careers of biomedicine and Christianity in Bunyore provided additional insights into changing local ideas about disease and disease causation, as well as comparative data that assisted in the evaluation of attitudes toward healing. With the help of four research assistants, all AbaNyole and recent graduates of Moi University, these interviews were conducted primarily in Olunyole, the local language, or Kiswahili, the Kenya national language, in Bunyore. It is only on rare occasions that English was used.

The use of oral data, or testimonies, in the writing of history will always raise the question of objectivity. This is even the more so in the African situation where there has been that presumption that the use of such data belongs to the domain of the precolonial period. As Louis White (1990: 21) has pointed out, this presumption is pegged on the idea that “colonial historians had written records at their disposal.” This presumption, she cautions, not only “privileges written material over oral material,” but also forgets that “colonialists did not do such a good job understanding African social life that we can safely rely on their writings.” This is complicated by the fact that most colonial reports were at best generalizations on whole provinces or districts, or more focused on ‘trouble spots’ among the colonized so much so that it is rare to find information in the archives dealing in any detail with specific locations or sub-ethnic groups. Even so, it is always important for a researcher to be cautious in the way he or she interprets oral data. This is because, at least in the light of this study, of what Arthur Kleinman (1988: 50-51) has called “retrospective narration” in situations whereby the interviewee’s tale about illness had a catastrophic
ring to it. According to Kleinman, retrospective narratization acts, first, as "something like the recitation of myth in a ritual that reaffirms core cultural values under siege and reintegrates social relations whose structural tensions have been intensified" and, second, it "gives shape and finality to a loss." But, most important, it acts like "a political commentary pointing a finger of condemnation at perceived injustice and the personal experience of oppression [Taussig, 1980]. For these reasons, retrospective narratization can readily be shown to distort the actual happenings, since its raison d'être is not fidelity to historical circumstances but rather significance and validity in the creation of a life story."

The issue raised by Kleinman was apparent at two levels during fieldwork. First, to talk about disease necessarily meant talking about death and its causes: was such and such death from natural causes? If not what do you think caused it? Such questions were obviously painful to interviewees, more so if they were asked in a group situation. The apportioning of blame in issues related to death was something that could only be talked about in whispers since it touched group relationships, or involved the pointing of fingers. A similar problem was encountered in cases relating to the origins of certain clans or groups of people since this touched, directly or indirectly, on the question of whether an interviewee or group of interviewees considered themselves as 'bene liloba (the owners of the land), abamilikha (absorbed ones) abasumba (dependents), etc. In either case, it was always advisable to have individual instead of group interviews. But, as Louis White (1990: 24) asks in another context, how can one be sure that information acquired from either individual or multiple interviews is "accurate and reliable?"

Though information acquired from oral data can be cross-checked "against each other" for purposes of levelling inconsistances, one crucial thing that sets oral data apart from either the archival record or published secondary literature is the fact that inconsistances in the information given during an interview reveals something about
“commitments, concerns and strategies that might otherwise not be discernible to historians” (Ibid.: 26). Furthermore, in telling their “own stories in order to present a version of their lives” (Ibid.: 24) during the incidence of epidemics or famines, informants presented us with “the problem of suffering” articulated, as it was, as “both the question of meaning and the question of control [as] a fundamental crisis of society” (Kleinman, 1988: 29). The inconsistencies that emerged in the stories given by the informants were not only indicative of ruptures, limits, and chronological specificities in ‘Nyole society during colonialism; they also pointed to the interplay of subjectivities in their relationships to institutions, technologies, and changing social needs (Foucault, 1972:163). If, as has been argued in the thesis, rumor was for example more often than not the result of the absence of official explanation of the severity of epidemics and measures brought to bear on them, then it can be said that through it, “questions of the cultural significance of risk as bafflement [came] to the fore in spite of professional . . . attempts to expunge meaning and value from the equation of care. . . .“ (Kleinman, 1988: 30). Informants like Eliakimu Mutoka who ‘saw action’ in the First and Second World Wars and ‘lived’ the various diseases and famines that came in the wake of these two events, or Mahanga Mang’ong’o Odalo who are as old as the changes brought about by Ekilauni (the Crown) and Abakristaya (Christians) are, concerned as they were with the problem of social death, like the chronically ill, revisionist historians, refiguring past events in the light of recent changes. . . . Interpreting what has happened and why and prognosticating what might happen make the present a constant, self-reflective grappling with illness meanings. . . . [They are] interpreters of good and bad omens. They are archivists researching a disorganized file of past experiences. They are diarists recording the minute ingredients of current difficulties and triumphs. They are cartographers mapping old and new territories. And they are critics of the artifacts of disease. . . . (Ibid.: 48)

Thus, like the chronically ill, these informants, through the valorization of custom and the circulation of rumor, re-create meanings about disease and illness that both “make over a
wild, disordered natural occurrence into a more or less domesticated, mythological, ritually controlled, therefore cultural experience” (Ibid. Emphasis in original). From this perspective, it can be argued that personal narratives as experiences of suffering give the social historian of medicine a clue into how coherence to distinctive events as famines and diseases was created among the AbaNyole.

This study is divided into eight chapters. Chapter one is concerned with the question: how has medical knowledge been produced on and about Africa and its inhabitants in the last one hundred or so years? As part of the answer to this question, the chapter addresses itself to how, through the production of medical discourses as feats of discovery, potted biographies, and as accounts of the planning and manning of progressive medical institutions in the continent, imperialism constituted Africa as a ‘patient’ and its inhabitants as experience perceived and felt by the ‘self’. These discourses were acts of celebration as Western medicine came to be seen as being coterminous with the unfolding colonial story of scientific discovery and conquest of disease in Africa. In so doing biomedical science was privileged over local processes in the production of knowledge on health and healing in the continent. The chapter also looks at attempts by recent scholarship to not only challenge this view, but also this scholarship’s suggestions of new approaches to the writing of the history of medicine in Africa. Central to this enterprise, it has been suggested in the chapter, has been the argument that biomedicine was not an accident of Empire, nor can its particular forms be construed as accidental to the purposes of colonization. However, by emphasizing the dominant legacies of European occupation and less the experiences of the colonized, most of this literature fails to address itself to the role of Western biomedical ideas in the transformation of Africa’s social, political, and economic landscapes. It was with this criticism in mind that most Historians and Anthropologists working on Africa in the 1970s and 1980s sought to address themselves to, first, the political economy of medicine and, second, the place of medical pluralism in
the fast deteriorating means of health care provision in the continent. Though much ground
has since been covered in this enterprise, much more is yet to be done on, for example, the
contestation over the meaning and usefulness of traditional therapies, as well as the nature
of pluralism itself (Pool, 1994; Vaughan, 1994).

My point of entry into a discussion of some of the issues raised by this literature is,
in chapter two, the reconstruction of ‘Nyole history with particular emphasis on, first, the
constitution of community and identity and, second, geography as a major element not only
in this process but also in defining or bringing out the symbolism of solidarity among the
AbaNyole. The relationship between the individual, the corporate group, and the cosmos, it
has been argued, was expressed through the relationship the AbaNyole had during
migration and settlement established with their physical environment. To understand the
value and spectrum of ‘Nyole healing practices, it has been suggested, one has to first
establish these people’s group ethics, religion, and cosmology since health pertained to the
interactive spheres of physical, social, and spiritual life. This was expressed through a
framework of totality found in the symbolism of solidarity and the coherence between
body, group, and cosmos. If, as Jean Comaroff (1979) has argued, affliction is a
structurally configured dislocation of the self and its social and cosmic context, then healing
among the AbaNyole as among the Tshidi of Southern Africa involved the manipulation of
multivocal symbolic media that sought to reintegrate the physical, conceptual, and universe
of sufferers and community. The centrality of such physical features as Bunyore Hills and
Wekhomo in this process lay, therefore, in their importance as symbols of solidarity that
gave both form and meaning to illness, and defined how cultural constructions of the body
and social interactions were shaped by notions of harmony, purity, and wholeness.

These symbols, it has been argued in chapter three, were not timeless, static
pictures. Representing the principles of an essential whole that spoke to the idea of a primal
unity and harmony, they configured the meaning and management of affliction as, through
their articulation with personal experience, they expressed a more inclusive process of
cultural change. It is from this perspective, the chapter suggests, that as agencies of cultural
power by which social and subjective identities were formed, these symbols were as
important in ‘Nyole attempts to counter affliction, as they were in defining, through the
theme of disruption as grounding for a beginning and disorder as the moment in which the
conquest of a natural space foreshadowed order, the space within which the enlargement of
the social field of action took place before the colonial era.

Chapter four deals with the role of Christianity in the making of a biomedical social
formation in Bunyore. It has been argued that the move on the part of the AbaNyole, like
many other communities in Western Kenya, to ‘accept’ Christianity and Western
biomedicine in large numbers took place against the backdrop of a highly emotional period.
This was at the end of the First World War when diseases and famines, but also colonial
oppression, characterized the rural landscape. The theme of colonial oppression is
extensively covered in chapter five where it is argued that in its enthusiasm to consolidate
itself during the conquest and pacification period the colonial state not only alienated itself
but also delivered the colonized in places like Bunyore into the hands of missionaries.
Sanitary and medical measures it adopted -- the burning of houses and their contents,
quarantine, and the forcing of people to hunt for rats’ tails -- during anti-plague campaigns
only confirmed AbaNyole’s suspicions about its intentions. These developments were
however taking place against the backdrop of major social and economic changes within
Bunyore itself. There was, for example, a serious problem of land scarcity and
overpopulation that created a labor-exporting peasantry that in turn introduced irreversible
trends in kinship structures. The transformation in the latter affected decision-making
regarding both therapy-seeking behavior and therapy management. Furthermore, wage-
labor, together with formal education and Christian evangelization, became important
mitigating factors in the process of the expansion of therapeutic possibilities among the AbaNyole.

Chapter six addresses itself to, first, how the colonial state conceptualized and proposed to deal with health problems in the rural areas after twenty or so years of a disjointed, haphazardly executed, and often militaristic approach to the eradication of disease in these areas. Second, the chapter broaches the question of how the ideas produced in this process of 'state self-understanding,' as well as the articulation of these ideas, was a reflection of the changing exigencies of the political economy of colonialism. Central to this process, it has been argued, were arguments and counter-arguments on new disease entities called 'African'; the African cultural environment vis-a-vis the problem of disease causation; and on the question whether the African had the mental capacity to cope with the rapidly changing colonial situation. If the core of our analysis in chapter five were issues surrounding the problem of epidemics and their impact on the dynamics of African demography, and on the colonial state from the point of view of its self-perception and how the AbaNyole understood and saw it, the focus in chapter six is the process of the construction of a new medical discourse that, in its attempts to break with the pre-First World War period, came to focus on both education and economic development as techniques of subjectification and medical science as a divisive practice for exclusion and domination.

Chapter seven deals with the place or role of biomedicine in the constitution of the colonial order in Kenya. Emphasizing the dynamics of transition from a conquest to an interventionist colonial state in the post-Second World War period, the chapter argues that the career of Western biomedicine in Bunyore cannot be understood from a simplistic binary opposition between Same and Other. Second, it is argued that in reworking its medical policies in this period, the state fell back onto notions of differential or selective susceptibility of Africans to certain diseases, notions that, in the interwar period, were part
of an emergent discourse on the ‘disease-ridden native population.’ This discourse, on the one hand, ostensibly undermined earlier, nineteenth-century ‘non-scientific’ perceptions of Africa as a ‘patient’ and, on the other, popularized race in its search for diversificationism that emphasized aspects of human difference rather than similarity (Rich, 1990: 667). This discourse was used by the state and its medical ‘experts’ to not only perceive, interpret, and respond to epidemics like plague, but also, in varying degrees, to constitute the African rural world as a space in which a particular type of medical knowledge could be produced in the process of legitimating the second colonial occupation.

Central to chapter eight are two questions. First, what were ‘Nyole experiences with disease and Western biomedicine during colonialism? Second, how did these experiences and the meanings they produced transform ‘Nyole medical and etiologic landscapes in this period? The chapter argues, first, that resistance to Western medicine and its discursive practices among the AbaNyole was a central element in the dialectics of the constitution of a state-centered system of scientific knowledge and power. Second, the chapter, following David Arnold (1993), demonstrates how the career of biomedicine in Bunyore showed the importance of the African body as an object of colonial appropriation and as a site of contestation between the colonizer and the colonized. The search for control, it is argued, was not simply one of Same/Other opposition as the colonizers sought to consolidate their authority and legitimacy. Through an examination of African experiences with new diseases and biomedical therapies brought to bear on these diseases, as well as the meanings these experiences produced, the chapter has attempted to uncover different forms of ‘Nyole responses to biomedicine and its technologies. To therefore understand what direct medical intervention meant for the AbaNyole and how they reacted to this intervention, the notion of resistance has been recast in the chapter to encompass “the problematic interdependence of discourse and praxis, and the constant tension between them as represented in a complex colonial situation” (Arnold, 1993:7).
CHAPTER ONE
HEALTH AND HEALING IN AFRICAN HISTORY

1.1 Introduction

Out there in the colonies...sits wretched Lazarus....Albert Schweitzer (1948:1)

Sciences, and especially biological sciences, have since the dawn of Continental European Enlightenment epistemology occupied center stage in the constitution, demarcation, and naming of the world according to 'known' and 'knowable' landscapes of darkness and civilization. It was within the framework of this triple process that modern exploration was born and the invention of Africa as a dark continent systematized (Mudimbe, 1988; 1994). A unique space that was also re-presented as a repository of disease, degeneration, and death, the myth inscribed into the know-a-ility of Africa was one characterized by a set of recurring and simple dualisms: black and white, primitive and civilized, evil and good, dark and light (Vaughan, 1991:2). "The peculiar power of this myth", Felix Driver has observed, "lay in its fusion of a complex of images of race, science and religion; the iconography of light and darkness thus represented European penetration of Africa as simultaneously a process of domination, enlightenment and emancipation" (Driver, 1991:135. Emphasis in original). At the level of medical science, this myth has through time and space canonized certain truth-claims on Africa and its inhabitants, truth-claims that have bastardized local processes in the production of knowledge on health and healing in the continent.

Social science analysts have in the last ten or so years come to question the validity of these truth-claims. Arguing that these claims are at best representations of the African world, these scholars have come to see them as means through which the West has maintained a perceived difference between itself and the world it came into contact with since the fifteenth century. But these claims have, historically, served another, perhaps
more fundamental, purpose. By defining itself as civilized, and therefore racially superior to the ‘Other’ world, the West translated the perceived sources of difference between ‘self’ and ‘other’ into an article of faith for the West’s control over the ‘self’ and the world (Gilman, 1985; Figlio, 1976; Fabian, cited in Nerlich, 1987:179). It was the extension of the functions of these truth-claims into the poetics and rhetorics of late nineteenth-century and early twentieth-century medical discourses on Africa and its inhabitants, it has further been argued (Olumwullah, 1992a), that made the African body as social space and as cultural boundary a unique site of contestation between not only African and Western healing traditions, but also between these and other traditions that have made Africa their home since the turn of the last century.

The issues raised by Western medical discourses on Africa, and these discourses’ constitution of the African as *perceived* and *felt* experience by the ‘self’, are the subject matter of this chapter. Thus the chapter addresses itself to how these discourses and their production were acts of celebration as Western medicine increasingly came to be seen as being coterminous with the unfolding colonial story of scientific discovery and conquest of disease in Africa. But the chapter also looks at attempts made by recent scholarship to not only challenge this view, but also at suggesting new ways in which the history of health and healing in Africa should be approached and written. Through a survey of literature on health and disease in the former Anglophone Africa south of the Sahara, the central question the chapter attempts to answer is: how has, through time and space, medical knowledge been produced in Africa?

1.2 Imperialism and the constitution of Africa as a ‘patient’

During the nineteenth century, there developed in Europe a number of ‘scientific’ discourses that were to have far-reaching implications for Africa and its peoples. Informed by a scientific medical and epidemiological rupture as one of its major defining
characteristics, this period was also one in which Europe was increasingly beginning to grapple with the problem of its own being vis-a-vis that of the ‘Other’ world. It was during this period that there emerged, on the one hand, the discourse on black female sexuality and its realization in the figure of the “Hottentot Venus” and, on the other, the discourse on the “Great Chain of Being”. While the one was used to ‘scientifically’ invent and constitute a pathologized Africa through the tying up of blackness, sexual anatomy, and pathology, the other concretized this invention through the development of a schema of biological classification. Thus, while the discourse on black female sexuality argued that the black female was anatomically different from the white female and that what was different was impaired and diseased, the discourse on the Great Chain of Being spoke to and about the role of physiognomy and craniology in the constitution of personhood and agency. In either case the two discourses led not only to the rise of comparative anatomy, but also to the presentation and re-presentation of Africans as the extreme opposites of Europeans. The position the former occupied was that of the ‘link’ between man and beast (Curtin, 1964:42).

Since this period, and through most of the twentieth century, the popular European image of Sub-Saharan Africa has been one of a sick region that is also inhabited by sick and, more recently, starving people. According to this image, Africans are passive sufferers beneath the titanic and impersonal oppression of poor soils, hard and fickle climate, a myriad of tropical diseases, and the technical backwardness of the region’s cultures (Prins, 1989:159). This image has been a major discursive trope in African colonial discourses. More often than not, these discourses have been a celebration of the victories of ‘civilization’ over not only these pathetic conditions, but also over what was seen as African ‘primitive’ and ‘barbaric’ practices perpetrated in the name of solutions to diseases and famines.
Perhaps the most powerful portrayal of this image was the biblical metaphor employed by the famed and legendary Dr. Albert Schweitzer when talking about his "call" to serve in Colonial Africa. When Schweitzer saw the statue in Colmar of an African Negro he was challenged and felt that "Out there in the colonies sits wretched Lazarus..." (Schweitzer, 1948:1; 1992:77-78). This imagery 'appealed' to Medical Missionaries like Sir Clement Chesterman who, while working on the construction of Yakusu Hospital in the former Belgian Congo in the 1920s, sent Dr. Schweitzer "a card-index of the case of Lazarus":

**Name:** Lazarus  
**Age:** Unknown  
**Residence:** Doorstep  
**Occupation:** Beggar  
**Disposal:** Abraham's Bosom (Chesterman, 1979:360).

Diagnosis: Full of sores  
Treatment: Dog licks  
Diet: Crumbs  
Result: Died

It can be argued that both Dr. Albert Schweitzer and Sir Clement Chesterman were people imbued with the idea that they were "the true successors of Christ the Healer" (Ranger, 1992:257). This is indeed Chesterman's argument when he points out that as Medical Missionaries their mission to Africa lay not only in the urge "to convert the heathen or to save the perishing"; they went to Africa to also "show care and compassion" in the true "sense of Christian duty" (Chesterman, 1979:360). Even so, it is noteworthy that this position on the problems of pestilence and indigence in Africa before and after colonial conquest was taken with equal enthusiasm by many Europeans, including some historians.

Writing on East Africa in 1965, for example, it was W. O. Henderson's (1965:123) contention that before European conquest and colonization of the region tribal wars, depredations of the Ngoni raids, and Arab slave trade were the rule rather than the exception. In addition to this, the inhabitants of the region also "suffered from malaria, smallpox, typhus, sleeping sickness, and other diseases; their cattle were victims of the tsetse-fly and of rinderpest; their fields were stripped by locusts. Slave raids and epidemics increased recourse to witchcraft." Henderson's thesis, like that of P.C. Garnham (1968),
M. Gelfand (1953), P. Russell (1955), and G.S. Nelson (1978), is that the improvement in African health conditions in this century is owed entirely to colonialism and more particularly to Western medical science. Writing triumphantly on this issue just two years after Henderson had put forward his argument, Lewis Gann and P. Duignan (1967:292) declared that “Whatever political disadvantages colonialism might possess, from the biological standpoint its record is one of the great success stories of modern history.”

This argument has a long historical pedigree. It was Harold Scott, writing in the wake of the enthusiasm generated by the late nineteenth-century discoveries of Pasteur and Koch and the rise of “the new specialism of tropical medicine” (Vaughan, 1991:34), who set the pace for this argument in his two-volume *A History of Tropical Medicine*, published in London in 1939. Harold Scott wrote not only on almost all the tropical diseases Europe met with in the ‘Other’ world at the turn of the last century; his history of tropical medicine was also the story of Africa’s “diseased natives” and the role scientific discoveries had played by 1939 to eradicate most of these diseases. Describing when, where, and by whom significant discoveries were made, the essence of the story Scott and his successors tell is thus one of “triumph over diseases; the picture they portray is of ‘diseased natives’ made well by (the) white man’s medicine.” Thus, writing in the true tradition of the Whig interpretation of history, this story and “the triumphs of tropical medicine...almost (became) the last justification for imperialism” (Farley, 1991:1-2).

But if colonial apologists saw scientific discoveries as *force majeure* in the destruction of pestilence in Africa, they also, most naturally, came to link these discoveries to imperialism as an important element in the process of civilizing the ‘Other.’ It was Sir Charles Eliot (1905:4), that architect of White settlement in Kenya who, commenting on the colonizer as the harbinger of a “higher civilization” in Africa, observed that

*Man reclaims, disciplines, and trains nature. The surface of Europe, Asia and North America has submitted to this influence and discipline, but it still has to be applied to larger parts of South America and Africa. Marshes must*
be drained, forests skillfully thinned, rivers be taught to run in ordered
courses ... a way must be made across deserts and jungles, war must be
waged against fevers and other diseases ....

To Charles Eliot ‘Nature’ meant not just the physical characteristics of Africa; as a concept
the term also referred to the inhabitants of the continent who, to him, were not only
“primitive” but also “natural” since they were not “cultured” (Ibid.:143). It can be said,
using Eliot’s own logic, that if Africa was a mosaic whose distinguishing characteristics
were primitivity, disease, and naked death, its ‘reclamation’ had to have the ‘taming’ of
nature in both its physical and human attributes as an important item on the Imperialist
agenda. In other words, if the domestication of Nature is what distinguished the cultured,
civilized, and industrious West from Africa, the process of reclaiming, disciplining, and
training of Nature in Africa was also meant to bring the “savage” and “primitive” societies
of the continent into the realm of the visible (Olumwullah, 1992b:6).

The conquest of disease was central to this process. From this point of view, it can
be argued that Africa was from the very beginning constituted into a ‘problem’ whose
‘solution’ demanded the application of the values and techniques of mastery, the mastery of
‘Man’ over ‘Nature’(Ashforth, 1990:4). The image of Africa as a Lazarus was thus a very
important discursive strategy not only in the logistics of conquest, but also in the formation
of the colonial state and civil society. Like the all-embracing “Native Problem” in later-day
official discourses on the African, this image came to constitute the “intellectual domain in
which the knowledge, strategies, policies, and justifications necessary to the maintenance
of domination were fashioned” (Ibid.:1).

But the constitution of Africa as a ‘patient’ also meant the construction of the
continent’s inhabitants into an ‘Other’. As Gwyn Prins (1989:159-160) has observed, until
the last part of the nineteenth century, Europeans in Africa “trembled ignorant and
defenseless for the most part before the ghastly, invisible legions of African diseases which
struck them down with even greater ferocity than they did the native population.” The
question that disturbed the Europeans was: “Why should such primitives survive illness that so swiftly felled civilized whites?” The search for an answer to this question, coupled with the image of the continent as a ‘patient,’ contributed powerfully to the strongly drawn racial stereotyping that characterizes the European-African encounter: the African as half-devil and half-child. The combination of these two contradictory stereotypes completed the image-formation of Africa as a medical problem in that while the one represented Africans as disease-resistant demons, the other painted them as suffering, vulnerable, and child-like (Prins, 1989:160) whose state of hopelessness European protection and care. Thus Africa was named; whoever names, also controls.

Indeed, from the time of conquest to the constitution of the colonial state and civil society in Africa, Europeans always craved for the sensitivity of being different. This was partly because of their position as ‘protectors’ of the sick child Africa was supposed to be, but mainly because they thought they had the expert knowledge needed in getting rid of disease and death on the continent. The definition and operationalization, therefore, of this difference came to depend on the language and symbols of Western medicine. These were worked into a powerful ideology for the reproduction of the structures of racism and social domination. The main components of this ideology included the categorization, or naming, of ‘new’ disease entities -- African syphilis, African relapsing fever, African trypanosomiasis, African hernia, and so on -- not according to these diseases’ biological, epidemiological, or pathological manifestations, but rather according to their geographical and/or racial incidence. But, as both biological and epidemiological paradigms (Seidel, 1993:177), these categorizations resonated well with the idea of Africa as a ‘patient’ since they spoke to the location of new meanings of health and disease at a “particular site defined by the exteriority of its vicinity” (Foucault, 1972:17)

The constitution of Africa into a ‘patient’ was therefore meant to establish a prima facie case for a beginning upon which the grounding and application of Western medical
technical know-how could be based. To see Africa as a ‘patient’ thus resonated well with the idea of the ‘White-man’s burden’in Africa. This was an idea upon which Western civilization, as a universal referent, came to depend and it was an idea without which, so it seemed, both text and world would be devoid of orientation. It can, at this juncture, be contented that Western civilization and its handmaiden, modern science of which biomedicine was just a part, signified the quintessential Eurocentric gesture. This was the more so because, by privileging it, historians of medicine like Harold Scott and imperialists like Sir Charles Eliot imbued it with a foundational stability that was seen as a force prior to Africa. The naming of Africa as a ‘patient’ thus accomplished imperialism’s aim of justifying its presence in Africa; a justification that constantly harked back to the elementary beginning of universalized Western civilization as the pre-existent referent. Thus, to paraphrase Dorothy Nelkin and Sander L. Gilman (1988:323), disease, or sickness, was in popular colonial discourses associated with the African as an ‘Other.’ Inevitably, therefore, “the locus of blame (was) also tied to specific ideological, political, and social concerns. Blame (was) in effect a social construct, a reflection of the world views, social stereotypes, and political biases that prevail(ed)” during colonialism. It is no wonder, for example, that after so much recrimination within European countries over the causes and origins of syphilis, the increased encounter between Europe and Africa in the late nineteenth century provided the context in which a different explanation of the disease could be worked out. According to the new explanation, syphilis was not a disease introduced into Europe by Columbus’s sailors; it was a form of leprosy long present in Africa, and was introduced into Europe by blacks during the Middle Ages (Nelkin and Gilman, 1988:366). According to these two scholars, by frequently associating sickness with a specific group, “disease turns into a crusade against those who are feared as a threat to the established order.” Thus, the “drawing of boundaries not only defines the healthy and the sick; it is also an implicit
call ... to the destruction of the sources of the disease. Thus blame has justified persecution and destruction” throughout recent history (Ibid.:376, 376-377).

1.3 History of Biomedicine or a Social History of Health and Healing in Africa?

In the introduction to his *Bilharzia*, John Farley (1991:1), a professor of Biology at Dalhousie University, has argued that tropical medicine as an imperialist project arose as part of Western imperialism when explorers, military personnel, colonial administrators, businessmen, and finally settlers came face to face with a new set of diseases—tropical diseases, for which they had no answer and which were, at times, particularly virulent.

This notwithstanding, he avers, there is more to tropical medicine and its history than the discovery of pathogens, the unraveling of life cycles, and attempts to eradicate them. These and other medical and scientific events were and are influenced by political and social events beyond the narrowly defined sphere of medicine and parasitology. Founded as one aspect of European and American imperialism ...imperial policies and attitudes largely determined the nature of tropical medicine.

Farley’s concern is with the need to go beyond “narrative histories” that have only described when, where, and by whom significant discoveries were made to a history that incorporates the imperialist “sociopolitical component” to tropical medicine. Instead of confining ourselves to “the presentation of feats of discovery, potted biographies, and accounts of the planning and manning of progressive institutions” (Shortland, 1986:304), or simply looking at “the primary purpose of a social history of medicine” as the description of “how the practice of medicine has affected the health and development of people” (Cartwright, 1977:1), Farley’s plea is for a program that embraces within its framework of analysis the understanding of the role, authority, and influence of imperialist policies on biomedicine and its changing relationship with the people it was meant to serve. It is within this perspective that scholars like Roy MacLeod and Milton Lewis (1988) and David Arnold (1988) have sought to understand the relationship between disease, medicine, and the expansion of Europe overseas.
According to these scholars, biomedicine was not "an accident" of Empire, nor can its particular forms be construed as accidental to the purposes of colonization which at once embraced the survival of the white race and the social control of native populations. As Roy MacLeod and Milton Lewis (1988:x) have put it, European medicine served as tools of Empire, "of both symbolic and practical consequence, and as images representative of European commitments, variously to conquer, occupy or settle." Indeed, during the early years of colonialism, overcrowding, slums and slum development in emergent African cities, public health and safety -- problems often seen in the light of class and ethnic differences in the West -- were in Africa perceived largely in terms of color differences as urban race relations came to be conceived and dealt with in the imagery of infections and epidemics (Olumwullah, 1986:183-184). This "sanitation syndrome" as Maynard Swanson (1977) has called it, formed a major discursive trope in the creation of abysmal African living conditions. Imbued with the imagery of infectious disease as a societal metaphor, the European craving for difference was translated into the policy of control and segregation manifest in native locations in East Africa, cantons in West Africa, and bidonvilles in North Africa (Cell, 1986; Curtin, 1985; Olumwullah, 1986).

Central to these scholars' concern are the themes of tension between the 'medical occupier' and the colonized; the ideology underlying tropical and colonial medicine; the preferences and politics of imperial medical research; and the dramatic effects of new sciences and technologies on the experience of Europeans overseas. What emerges from this concern is the scope of work done on the political, racial, and military objectives during the medicalization of imperialism; the characteristics of biomedicine in the colonies; and the influence of epidemic diseases as well as theories of race on the posture and status of biomedicine.

Although in formulating their research agendas these scholars focused on the dominant legacies of European occupation and less on the experiences of the colonized,
their work opens up new avenues for the exploration of the role of medicine and Western medical ideas in the transformation of Africa's social, political, and economic landscapes in the last one hundred years or so. Explicitly drawn out in this literature, for example, is the fact that as a cultural force, biomedicine embodied within its manifestation and influence certain significant implications and contradictions. Thus, while on the one hand biomedicine spoke both to "imagery of a self-appointed civilizing vector, and to a degree of authority that transcend(ed) politics" (MacLeod and Lewis, 1988:x), it, on the other, assigned itself the responsibility of social engineering and, to a large extent, its discourse became coterminous with the unfolding colonial story of scientific discovery and declining death rates in Africa. But given that malaria, malnutrition, and other debilitating diseases are still endemic on the continent, and given that the AIDS scourge has only helped in confirming the image of Africa as a sick continent, the certainties of this victory of scientific success, are themselves problematic. This has become even more so considering the failure of post-colonial developmentalist discourses on health-care provision to come to grips with the situation and eradicate these maladies in the continent. Instead of the promised direction of considerable improvement in health-care provision, there has been, especially since the early 1970s, the confirmation of a collective situation that includes the worst of many worlds with a mixture of pestilence, the pathology of indigence, and affluence.

The increasing visibility of this problem since the early 1970s can be attributed to, first, the general collapse of African economies and, second, the search by scholarship for the answer to the question: what had gone wrong? From a position in the 1960s of unreserved support for the newly independent African governments in conquering poverty, illiteracy, and disease, social science researchers in the 1970s began questioning the role of the state as, to paraphrase Martin Doornbos (1990:184), the motor force behind social and economic development. "Noting the emergence and class behavior of the new bureaucratic elites," Doornbos writes, "questions were raised as to whose purposes and interests were
being served by their (researchers) ... efforts. By implication, question marks were placed on the priority of enhancing the state’s reach and control over local social and political networks, on its dominant role in the relations of production, on the dislocating effects of its interventions.”

This intellectual soul-searching might have had little to say about health and healing in Africa. But as an interrogation of the post-colonial state and its processual nature, it touched on questions that were crucial to the understanding of the relationship between the state and civil society, and to fundamental issues relating to political, economic, and social conditions shaping health and healing in the continent. From this perspective, it can be said that by questioning the role of the state in social and economic development, this scholarship was also questioning developmentalist discourses of the 1960s and their paternity, the colonial self-assuring and triumphalist discourses on Africa’s transformation.

In their attempts to interrogate this triumphalism from a specifically health point of view, historians like G.W. Hartwig and K. Patterson (1978:4), argued that “the unhealthiest period in all African history was undoubtedly between 1890 and 1930.” This was the more so because, in the process of conquest, colonialism created a completely new disease environment on the continent. This indictment is perhaps well brought out by John Ford (1971) who, writing on the problem of the tsetse fly and the incidence of trypanosomiasis in Africa, challenged the long-established truth-claim that the fly had always posed serious problems to the exploitation of Africa’s vast resources. Like Hartwig and Patterson (1978:14) who observed that the story of tropical medicine was not about the triumph of enlightened medicine over the useless and harmful practices of ‘ignorant natives’ but about the attempts made to control diseases colonialism had helped to create, John Ford (1971:9) writes:

It is a curious comment to make upon the effects of colonial scientists to control the trypanosomiasis, that they almost entirely overlooked the very considerable achievements of the indigenous peoples in overcoming the
obstacle of trypanosomiasis to tame and exploit the material ecosystem of
tropical Africa by cultural and physiological adjustment both in themselves
and their domestic animals.

According to Ford, it was largely because of this ignorance that the Germans in
Tanganyika, like their British neighbors in Ankole in Uganda, “looked upon themselves as
saviours of people sunk in centuries of barbaric misery.” However, few of them ever
“realized that they were the prime cause of the suffering they were trying to alleviate”
(Ibid.:143).

By therefore contending that European conquest of Africa destroyed the indigenous
peoples’ control of the ecosystem thereby letting loose diseases that had for a long time
been held in check, Ford, like Farley (1991), goes beyond the mere question of medical
innovation to suggest political and economic variables that altered the balance between
vegetation and human settlement patterns. This perturbation in the ecosystem altered the
relationship between man and the tsetse (Ibid.:190, 231). Ford thus puts much emphasis
on the epidemiological disasters that occurred in Africa in the last decade of the nineteenth
and first two decades of the twentieth centuries -- the rinderpest panzootic that wiped out
cattle and wildlife and smallpox that, together with famines, reduced the human population
-- as examples of colonial-induced problems that upset the ecological controls that had long
contained the threat of trypanosomiasis. Once this happened, tsetse belts never stopped
advancing. Colonial boundaries rigidified the *Grenzwildnisse* -- wilderness areas at the
borders of populated territory which in the pre-colonial period were maintained so that
people and cattle did not come into frequent contact with the tsetse flies -- and with this
death of both beast and man followed in rapid succession.4

From the foregoing, it can be argued that the move towards the recognition of
African therapeutic traditions by African governments in the 1970s, a move given a stamp
of approval by the World Health Organization in 1978, was partly a recognition of a
general crisis in the provision of health care services in African countries, and partly an
admission on the part of health planners that Western medicine was after all not the be-all and end-all in the maintenance of a healthy population. That biomedical practitioners were enraged by this development, and that the politics and rhetorics of independence could not be ruled out in the changes that were being proposed by African governments, was a powerful indication that the space occupied by Western medicine was not neutral: it was a thoroughly contested arena.

Murray Last (1986:10), writing on the issues that informed health and healing in Africa then, has observed that before the 1970s biomedical knowledge as a source of power and authority had led to the notion of ‘professional’ so much so that the recognition extended to other therapeutic traditions in the years that followed the ‘medical crisis’ constituted a threat to ingrained ideas about modern science. The period that came immediately before and after political independence witnessed an unsurpassed growth in the number of Africans trained in Western medical practice and working in government medical institutions. This, coupled with the rise of private practice outside government and/or mission medical institutions, made biomedicine a major source of empowerment for its newly arrived African practitioners. This development increasingly came to be seen both in government and public eyes as something that was part and parcel of the larger process of decolonization since it coincided with the Africanization of staff and curriculum; it was to prove, proudly, that the new independent states were not content with second best, with having only ‘sub-standard’ para-medicals as their doctors. In short, it accompanied the establishment of a middle-class whose legitimacy was based on educational attainments, a meritocracy to be open to all yet independent of commercial wealth or traditional power.

This routinization of biomedicine as a profession put further constraints on other therapeutic traditions. Whereas African therapeutic traditions preceded biomedicine in the development of a self-conscious profession, and whereas some of the earliest African Western-trained doctors wrote medical theses explaining and sometimes defending these
traditions (Lambo, 1955, 1956, 1960a, 1960b, 1960c, 1961, 1962, 1964, 1966), the late colonial and independent generation of biomedical practitioners tended largely to ignore them. This was compounded by the fact that the public began to take more eagerly to experimenting with the new, now more accessible, biomedical institutions in both urban and rural areas. Murray Last concludes that the official recognition of African therapeutic traditions just removed the lid that had for long suppressed their practitioners' will to power. Once this was done their reassertion became a matter of time, and it encompassed a conscious move to adapt methods and strategies that would help in meeting the competition and underhandedness posed by their nemesis, the biomedical practitioners.

The everyday activities of these African healers, now routinized in Traditional Healers Associations, however went beyond the mere question of the reassertion of their presence. They also sought to participate in ongoing debates within the arena of health policy formulation in their individual countries. To give a stamp of legitimacy to this quest, they started to award themselves, through their associations, professional medical degrees and titles. The result of these developments has been that practitioners of African therapeutics have been identifying, and addressing themselves, as doctors. Thus, just like in biomedicine, these titles have become symbols and guarantors of 'expert' knowledge and, again like in biomedicine, it is by their knowledge that these African therapeutic traditions as professions have ultimately come to define themselves (Last, 1978:8-9).

It can therefore be argued that the 'medical crisis' in Africa since the early 1970s was part of a larger crisis within the African political economy. But more specifically, it was about issues that revolved around the production of biomedical knowledge and the applicability or uses of this knowledge in Africa. The discursive world in which the rupture took place was one in which there was serious interrogation of the limitations of the scientific paradigm6 of Western medicine as the explanatory model for the collective patterns of health and healing in Africa. But it was also an interrogation of the capacity of
biomedical practice to transform meaningfully the health conditions of Africa’s ever increasing population. The issues at stake were therefore not just about the lack of appropriate funding for the expanding African health care services. Nor were they intransigently about the denial or confirmation of Africa’s health problems. These issues were also about the production, nature, and uses of biomedical knowledge; about biomedicine as the therapeutic system in and for Africa; and about the extent to which Western European perception and pathologization of Africa was guided by the European image of the continent.

Writing as early as 1955 on the role of cultural factors in paranoid psychoses among Africans, Dr. T. Adeoye Lambo (1955) for example argued that culture, and not race as most European psychiatrists working on Africa during colonialism had come to believe, was at the root of psychological differences between groups of people. This was an argument which Dr. Lambo revisited on many occasions during his long career first as a psychiatrist in his village of Aro in the Western region of Nigeria, and later as Deputy Director of the World Health Organization in Geneva. From his work at the Aro Village Psychiatrist Hospital, founded by him in 1954, Dr. Lambo concluded that in African traditional societies the understanding of medical problems like mental health had of necessity to go beyond Western concepts of disease causation and embrace African group ethics, religion, and cosmology. According to him (1960), disease and health were a continuum that brought into sharp relief the harmony that existed between the individual and his/her society as a whole. This was the more so because in Africa, unlike in the West where the treatment of mental health was considered a private transaction between the patient and the therapist (1978), health pertains to what Rene Devisch (1993:30) has called the “interactive spheres of physical, social, and spiritual life.” Treatment therefore depends on “a framework of totality” that must, of necessity, be based on the “underlying conceptual framework and the logic of ... symbolism with regard to solidarity and the
coherence between the body, group, and cosmos" (Janzen, 1989:229). Thus, the
rationality of "healing practices and symbolic imagery" and "condensed expressions of
beliefs and etiologies concerning man, descent, life, good and evil, and the resonance
between the various fields of experience" (Ibid.) are extremely crucial in understanding the
relationship between disease and health in Africa. It was on the basis of this understanding
that Dr. Lambo established the Aro village project in the Western region of Nigeria. Arguing
that colonialism led both to the establishment of lunatic asylums to control vagrant
psychotics and criminals and to the erosion of beliefs in African psychiatric methods, his
village system at Aro was a kind of middle way that was meant to reflect both Western and
African ways of treating mental health.

Explicitly or implicitly, these issues lead to a discussion of dis-ease at two
fundamental levels. Disease is not just a definite entity or syndrome, determined by rational
scientific thought. It is also, first, a construct determined by the way a particular culture
perceives and draws meaning from its relationship to the human body and the wider society
(Sontag, 1978).7 As will be demonstrated in chapters three and eight, dis-ease as a life-
threatening occurrence is in Africa not an abnormality since any normal situation must
contain an element of disease. Second, and flowing from the above definition, dis-ease is
an "encoded" moment whose language is culturally "embedded" (Prins, 1992:342).

It is the contention of this chapter, therefore, that the claim biomedicine has through
time and place arrogated itself as the epitome of such values as scientific enlightenment and
disinterested benevolence (Wright and Treacher, 1982), a claim that is supposedly at the
center of Western civilization's mission to Africa, needs to be re-examined. This is the more
so because the history of health and healing in Africa in the last one hundred years or so is
not only about the human and vector issues surrounding disease; it is also about the
changing images of therapeutic traditions8 as seen through the prism of African illness
experiences. Central to this is the question of how issues about health and healing were, in
this period, problematized by both intellectual constituencies, in their various ways, and Africans themselves.

1.4 Europe and Africa: Science against the Tyranny of Tradition?

In his now classic two-part article on African traditional thought and Western science, Robin Horton (1967:155) has argued that the “key difference” between “the traditional and the scientific outlook” is that

in traditional cultures there is no developed awareness of alternatives to the established body of theoretical tenets; whereas in scientifically oriented cultures, such an awareness is highly developed. It is this difference we refer to when we say that traditional cultures are ‘closed’ and scientifically oriented cultures ‘open’.

To Horton (1967:156) ‘closed’ cultures were “characterized by lack of awareness of alternatives, sacredness of beliefs, and anxiety about threats to them.” The latter, on the other hand, were characterized by “awareness of alternatives, diminished sacredness of beliefs, and diminished anxiety about threats to them.” It was Horton’s contention that while on the one hand the absence of any awareness of alternatives “makes for an absolute acceptance of the established theoretical tenets, and removes any possibility of questioning them” (emphasis added), it, on the other, makes any challenge to these tenets “a threat of chaos, of the cosmic abyss, and therefore evokes intense anxiety” in those who hold them. From these observations, he concluded (1967:156,180,183) that the transition from ‘closed’ to ‘open’ cultures lay in the development of awareness of alternatives.

With developing awareness of alternatives (he writes), the established theoretical tenets come to seem less absolute in their validity, and loose something of their sacredness. At the same time, a challenge to these tenets is no longer a horrific threat of chaos. For just as the tenets of themselves have lost some of their absolute validity, a challenge to them is no longer a threat of absolute calamity. It can be seen as nothing more threatening than an intimation that new tenets might profitably be tried. Where these conditions begin to prevail, the stage is set for change from a traditional to a scientific outlook.
The medium for this transition lay in the development of literacy which Horton claimed radically transformed oral transmission of beliefs that were “one of the basic supports of the ‘closed’ predicament”; the rise of culturally heterogeneous communities that led to the encounter between not only “common sense” but also “basic theory where differences were striking”; and the development of the trade-travel-exploration complex.

Underlying Horton’s thesis was the assumption, long in vogue in Western post-Enlightenment epistemology but which he claims his fellow anthropologists in Africa failed to note in their writings, that knowledge can only be constituted in relationship to empirical reality. Part one of his article is therefore quite revealing. His approach to the understanding of African traditional thought is pegged on his criticism of Western social anthropology’s failures “to understand traditional religious thought” as its practitioners have, first, “been unfamiliar with the theoretical thinking of their own culture” and, second, those having any pretense to familiarity “have failed to recognize its African equivalents, simply because they have been blinded by a difference of idiom” (Ibid.:50). Emphasis added. In charting out a new approach, Horton therefore attempts what he calls “an exhaustive exploration of features common to modern Western and traditional African thought” before moving onto the enumeration of the differences between the two systems. Thus the second part of the article is devoted to the enumeration of these differences, or what he calls “the salient differences between traditional and scientific thinking” (Ibid.:50,154).

The implication of Horton’s thesis with regard to African healing traditions is quite clear. As Sindzingre and Zemplen (1992:319,333) have pointed out in their study of the Senufo of West Africa, Horton’s thesis implies that “the Senufo do not attribute given symptoms to causes, agents, or origins.” Though his postulates provide us with some important insights into how tenacious certain “core values” in a culture can be during moments of stress (Prins, 1992:342-343), the assumption that knowledge can only be
constituted in relationship to empirical reality poses problems for the understanding of processes of healing in Africa. As B.J. Good and Mary-Jo Del Vecchio Good (1981:181) have pointed out on this problem with particular reference to medical science,

Disease entities and normal and abnormal physiological functions are empirical realities that are essentially universal and independent of social and cultural context. Medical knowledge and disease theories are context independent reflections of the empirical order of reality, and a patient's discourse, while often grounded in faulty medical knowledge, is to be interpreted in relationship to empirical reality. From this perspective the rationality of medical knowledge and medical discourse is constituted in relationship to the biological order, and the logical integration of medical knowledge reflects the causal-functional integration of biological systems. Thus it is assumed that while medical care and the distribution of disease vary by social, cultural, and ecological context, medical knowledge does not.

I would like to argue, following Good and Good (1981), that by adopting an empiricist theory of meaning, Horton inscribed science with a particular view which he then compared with certain forms of knowledge and practice in Africa. Here, rationality was seen as manifesting itself in man's ability to transcend the tyranny of tradition as he embraced a 'scientific' explanation of his being. This was the more so because, to Horton, meaning was and could only be constituted within the ambit of scientific discourse because "although ... the gods and spirits do perform an important theoretical job in pointing to certain interesting forms of causal connexion (in Africa), they are probably not very useful as the basis of a wider view of the world" (Ibid.:57).

Like many writers on Africa during colonialism (Hichens,1928, 1930a, 1930b; Pentreath,1936; Perryman,1936; Keen,1963), Horton's attention was directed towards the rationality of thought and behavior in African cultures. In this exercise he was at pains to point out certain elements that he thought could easily and fruitfully be compared with Western science. He writes, for example, that

... there do seem to be a few cases in which the theoretical framework of which they (gods and spirits) are the basis may have something to contribute to the theoretical framework of modern medicine. To take an example, there are several points at which Western psycho-analytic theory,
with its apparatus of personalized mental entities, resembles traditional West African religious theory. More specifically ... there are striking resemblances between psycho-analytic ideas about the individual mind as a congeries of warring entities, and West African ideas about the body as a meeting place of multiple souls. In both systems of belief, one personal entity is identified with the stream of consciousness, whilst the others operate as 'unconscious', sometimes co-operating with consciousness and sometimes at war with it. Now the more flexible psycho-analysts have long suspected that Freud's allocation of particular desires and fears to particular agencies of the mind may well be appropriate to certain cultures only. Thus his allocation of a great load of sexual desires and fears to the unconscious may well have been appropriate to the Viennese sub-culture he so largely dealt with; but it may not be appropriate to many other cultures. A study of West African soul theories, and of their allocation of particular desires and emotions to particular agencies of the mind, may well help the psycho-analyst to reformulate his theories in terms more appropriate to the local scene (Ibid.:57).

This argument and conclusion raises crucial questions not least of them being Horton's understanding of the mode of transition from 'tradition' to 'science'. But they also speak to, and about, the problem of comparative historical and cross-cultural studies of medicine and society (Good and Good, 1981:183) in general, and the study of the social history of health and healing in Africa in particular. These questions are even more pertinent so when we consider that by formulating what amounts to a theory of the tyranny of tradition, Horton and others of his ilk started off by grounding the meaning of African healing traditions within the interstices of the relationship between these traditions and a Western-contrived empirical order. As Good and Good (Ibid.) have argued in their criticism of similar works on the Azande of Sudan, these scholars' analyses proceeded through the framing of African "beliefs as propositions and establishing their verifiability and deductive validity of their inferences. Since the meaningfulness of the discourse is constituted in relationship to empirical reality, and since we know that witches cannot exist empirically the rationality (of Azande) thought is fundamentally in doubt." This anomaly has led Good and Good to pose the following questions. How can a set of beliefs and institutions that are propositionally so obviously false "be maintained for such long periods of time by men who in much of their lives are so reasonable?" Is it possible, even feasible,
for medical beliefs and practices that are “obviously not in accord with objective reality” at the same time be “internally logical and even effective?” How should we approach the analysis of “religious or mystical rationality?” Can this be done in “completely different terms than we analyze scientific rationality?”

These questions have been central to recent historical and anthropological scholarship on Africa. Taking a critique of social anthropological works which in the 1950s and 1960s saw African therapeutic traditions as a conflation of cultural belief, psychotherapy, and trial-and-error medicine as her point of departure, Jean Comaroff (1978; 1982:52) has, for example, argued that to problematize the relationship between dis-ease and social processes from the Hortonian point of view has distorted the understanding of the social meaning of illness in Africa. According to Comaroff, the problem with ethnographers working in Africa has been the emphasis they have, *ad nauseam*, placed on “the importance of structurally determined ‘tensions’ in indigenous aetiologies.” The implication of this emphasis is that while on the one hand social structural issues within individual cultures were illuminated, traditional belief was on the other made to appear to exist in a near-vacuum of therapeutic efficacy. With an eye on colonialism as the harbinger of a “higher civilization”, and bearing in mind that Africa had in Western post-Enlightenment epistemology been invented as a ‘patient’, this approach served as an ideological trail-blazer for ‘rational’ Western medical knowledge which was supposed to supplant African ‘irrational’ therapeutic traditions. This ethnographic enterprise translated itself during the interwar period into the colonial official discourse that simultaneously contended that African beliefs in magic interfered with processes of modernization and privileged Western medicine as the tool for guiding the colonized “people to social betterment” (Beck, 1970:3). To the colonizer this was the more so because while the “*African’s unscientific mind ... searched for remedies against disease in his own way ... the sophisticated and trained mind of the scientific did by means of medicine*” (Ibid.:138).
The year Jean Comaroff's article, "Medicine and Culture", was published, a powerful book on African healing by John M. Janzen came off the press. A tour de force on medical pluralism in Africa, The Quest for Therapy in Lower Zaire (1978) emphasized two important aspects in ethnomedical therapy. First, Janzen argued that the 'patient' among the Kongo of Lower Zaire was seldom a single individual; s/he was a corporate kin-group such as a nuclear family or even an entire lineage. Second, he observed that a 'patient' whose illness lasts over a period of time moves through the broadest possible range of therapeutic alternatives: biomedicine was only but one of a range of options available to health-seekers in this community. According to Janzen, it is not the healer who controlled or made basic decisions on therapy management; on the contrary the critical decision-making body was the "therapy management group" (1978:134). By taking a Kongo perspective on the social construction of the category 'patient', Janzen thus broadened the scope of analysis of the relationship between patient/practitioner to include the social management of episodes of illness.

Perhaps the greatest contribution of this work's analytical insights was the erosion of the conceptual distance earlier, mostly colonial, anthropologists had established between African and Western healing traditions. It can be argued that in drawing our attention to how episodes of illness are socially managed, Janzen not only rescued the African body from biomedical impersonality; he also alerted us to new ways through which both old and new questions about social meaning, about social organization, and about the social construction of dis-ease and illness could be addressed. But this work had another, equally important, contribution to the understanding of health and healing in Africa. By identifying four contiguous therapeutic traditions among the Kongo -- the art of the nganga; kinship therapy; purification and initiation; and biomedicine (Ibid.:193) -- and by elaborating on the concept of "the therapy management group" (Ibid.:134), Janzen simultaneously historicized medical professionalization while at the same time pointing towards the fact that medicine
was a thoroughly contested phenomenon in the continent. As Steven Feierman (1986:206) was to note almost ten years later, the multiple therapeutic traditions Janzen had identified in Lower Zaire was a sign, indeed an eloquent testimony, to the state of medicine in Africa. “In a system without strong central control,” Feierman wrote, “a system in which many therapeutic options are available, and in which no one kind of therapy enjoys universal popular acceptance, the consumers of medicine must somehow find their way among the choices.”

These arguments pointed, at once, to the problem of continuity and change in health care provision in Africa, and to the viability of Western medicine as a scientifically oriented alternative to African ‘closed’ therapeutic traditions. Why was it, in Hortonian terms, that Kongo ways of ‘knowing and doing’ had not been replaced or overtaken by the scientifically oriented Western medicine? Was it because the trade-travel-exploration complex, formal education, and the development of culturally heterogeneous communities since the times of slavery through Belgian colonialism were not forces enough to lead to the development of awareness of alternatives and the collapse of the “‘closed’ predicament” (Horton, 1967:156) of the Kongo society? Murray Last (1986:12), writing from a presentism that did not bother to address these questions, argued in 1986 that so long as biomedical and African therapeutic knowledges continued to vie for power, the position of the lay therapeutic managers will eventually recede. Steven Feierman (1979:282-283) seems to have foreshadowed this assessment when he argued in 1979 that the emergence of capitalist relations of production in both the city and the countryside, the growth of population, and rapid urbanization had changed the social terrain upon which health care provision was based in Africa. According to Feierman, this had happened in two ways. First, “the kinship groups which tend to provide therapy management have diminished in inclusiveness, and have become less capable of unified action over the past hundred years.” Second, there had been in this same period a “reduction in the scope of the therapy
managing group’s control over the fundamental conditions of existence of its members.” To Feierman, this could be explained in terms of the changing spatial distribution of kinship groups or members thereof, and the changing scale and character of economic production. Industrialization and the commercialization of agriculture, two indices of change which are often seen as signs of man’s increasing mastery over the environment as well as his or her own fate, were developments in which in Africa the “managers of therapy lose some of their control over the social environment of health” (Ibid.:384)

As Murray Last was penning his conclusion that the position of lay therapeutic managers was bound to recede with time, Charles M.Good, a medical geographer, was finishing his research on the Akamba people of Kenya and his findings are worth examining here, albeit briefly. Good’s work on this Kenyan ethnic group found out that the evolving patterns of indigenous therapies in both rural and urban areas in Kenya had a lot to do with an almost unashamed dependence by Africans on these therapies.According to Good (1987:xiii), it no longer makes sense for “traditional medicine to remain compromised and discredited because the official health establishment denies its worth or scientific intelligibility.” Good’s plea is an understanding of “the locational dynamics of traditional medical systems” not only because the introduction of biomedicine has not destroyed them but also because their expansion is a significant trend in African urban areas where they fill a void for services that are in demand, are accessible, and offer culturally recognized responses to illness. In his case study of Nairobi, he shows that instead of crumbling, traditional medicine displays remarkable resilience and capacity to adapt to the needs of Nairobians. Traditional medical practitioners, he argues, are among the largest categories of self-employed persons in the vast informal urban economy and together with their patients they represent a significant dimension of the economy and social geography of the African city.
Developing on Janzen's concept of therapy management groups, Good thus argues that in any health care system there is always "the popular sphere of health care, which centers on self-treatment by the individual and family (and) is generally the first therapeutic choice for most people in most cultures." This sphere contains several levels, and includes individual, family, social networks, and community beliefs and activities (Ibid.:23). But if it is the popular sector that is typically the first line of resort for the Kenyan people, "as it is throughout the world", this is not all: "the practices adopted in the popular sector often directly influence the outcome of therapies that may be resorted to later -- for the same or a different illness -- in 'biomedical' and 'traditional' medicine" (Ibid.:60, 238, 247, 286).

Good identifies a series of therapeutic options in his area of study and makes the interesting observation that access to these options increases in direct proportion for those people who live out their lives in large urban areas. This is interesting because there has been the assumption that because it is in these areas that competition between traditional and Western therapies is most intense, it would be precisely here that the therapeutic management groups would disappear first. This assumption, clearly brought out in Last's and Feierman's arguments, is based on the idea that the concentration of the instruments of 'modernization' in urban areas is bound to automatically lead people towards choices that are anti-traditional. In fact Last's, but also Feierman's, argument that the position and power of lay therapy managers will recede as biomedical professionalism solidified the bases from which medical dispensers vied for power was pegged on the assumption that the consumers of traditional therapies will be either satisfied to surrender control, or can be forced to do so. But as Good's findings show, this seems unlikely. Even if all the therapeutic options were equally bureaucratized, there is enough evidence to suggest that the fundamental pluralism will remain.

Good's arguments find their most succinct resonance in Arthur Kleiman's (1980:50) thesis that health care is "a local cultural system composed of three overlapping
parts: the popular, professional, and folk sectors” (emphasis in original). Of these parts the most important is the popular sector as it is in “the lay, non-professional, non-specialist, popular culture arena ... illness is first defined and health care activities initiated.” Thus, Kleiman (Ibid.:51) has concluded, though customarily it is thought that professionals organize health care for lay people, typically lay people activate their health care by deciding when and whom to consult, whether to comply, when to switch between treatment alternatives, whether care is effective and whether they are satisfied with its quality. In this sense the popular sector functions as the chief source and most immediate determinant of care.

E.S. Atieno Odhiambo and David W. Cohen (1989) have, in their recent study of the Luo of Siaya District, Western Kenya, reached a similar conclusion. According to these two historians, Siaya has “a well-defined therapeutic economy” (1989:89). Characterized by “a distinctive landscape” in which considerable “expenditure is devoted to health care away from the national health stations”, the basic features of this economy include “a number of dukas (stores), where medicines, and medical advice, from various sources can be acquired”; “a range of specialists respected in the use of herbs and other treatments”; countryside “stations of daktari -- often former medical assistants” that are “organized into clinics and wards”; “the itinerant daktaris on their bicycls, traveling the countryside and equipped and ready to give injections”; and gifted women who in their compounds and homesteads “offer long-term therapy and hospitalization for specific, yet not otherwise treatable illnesses” (Ibid.:88-89). But, organized alongside or interspersed among nationally-recognized and regulated health institutions like hospitals, clinics, and dispensaries, this “economy of therapy” is also about traffic: the movement of the ill, concerned friends and kin, and the practitioners around the countryside and around Kenya in search of, respectively, effective treatment and more opportunities of practice. The taxi, the car, the bus, are significant elements of the long-distance economy of therapy as patients move back and forth along the highways seeking the best in specialized care. The traffic also marks the economy of therapy as substantially experimental ....[T]he landscape of therapy (is) an
experimental terrain across which one must travel to seek improved
diagnosis and effective treatment (Ibid.:89).

Encompassing as it were areas within and beyond Siaya in search of “more powerful
medicines and therapies” (Ibid.:91-92), this economy of therapy is, and has never, been
confined to either one therapeutic tradition or the dictates of one or a group of specialists
within any of these traditions. The movement to and from as well as between these
traditions in search of what is efficacious has since the turn of the last century when there
was what John Lonsdale (1977b) calls the “enlargement in the field of action” been defined
within the limits of the Luo popular culture arena.

1.5 In lieu of a conclusion: Questions and suggestions for a new approach

The foregoing review shows that the last fifteen years or so have been quite
eventful in the intellectual production of knowledge on health and healing in Africa. Apart
from challenging the colonial triumphalist and celebratory discourse on these two
phenomena, this enterprise has also shown that contrary to arguments that people in
African ‘traditional’ societies had few or no alternatives to established theoretical tenets,
“therapeutic practices formed an open set, one to which knowledge was added with great
regularity” (Feierman, 1990:105). Horton’s thesis, for example, was counter to this
diversity of visions since he held that though people in African ‘traditional’ societies had “a
coherent set of theories concerning the spiritual and material forces at work in their world,”
these “conceptions of causality could not easily be tested or proven false, because they
existed within a closed world without alternative theories of causation” (Feierman,
ibid.:101).

Be that as it may, the emphasis this critique has put on the concept of therapeutic
options in a plural medical situation has tended to obscure some crucial questions about, for
example, the nature of pluralism itself. This is more fundamentally so, as Steven Feierman
(1979:277) has pointed out, where the breadth of therapeutic pluralism has been obscured
by studies elucidating particular theories of causation, then assuming that one theory was equivalent to the thought of an entire society. Univocal and unilineal, this problem is compounded by another, equally important, assumption. To speak about therapeutic options is one thing; whether these options work, and what their consumers’ responses are, is another. Steven Feierman (1985:105) has on this problem posed the following questions: To what extent do these therapeutic choices act as independent sources of technical knowledge in society? To what extent do they act in concert with established political and economic power holders? Do they take socially effective action to promote health, and if so, what are the circumstances of this effectiveness? Finally, how can, from the point of view of history, pluralism be explained? On the last question, Steven Feierman (1990:102) has rightly pointed out that most of these accounts of plural healing traditions describe conceptions and practices as they exist in the twentieth century, for the most part after 1960. It is not yet completely clear whether therapeutic pluralism was common in precolonial days, or whether it was a consequence of either colonial intervention or increases in literacy.

This observation is important for a number of reasons. First, it throws into sharp relief the question of how, in the last one hundred years or so, biomedicine has attempted to affect the course of events either in the local intimate networks within which people organize therapy, or in the wider political arena where forces struggle to change the distribution of the social costs of health. Second, the observation raises the seemingly simple but complex question: how has dis-ease and its remedy been defined in different historical moments in Africa? In other words, how has, historically, the definition of dis-ease as a consequence of some behavior, the presence of some biological process, or as the manifestation of a particular set of symptoms, affected people’s social responses to the changing African aetiological landscape? Third, how have new technological advances in the science of epidemiology changed the perception of and response to dis-ease among Africans?
These questions are about, first, the relationship of experience to time in the cultural construction of illness. Second, they fundamentally touch on the question of how African therapies, including biomedicine, are organized within, and affected by, the processes that have and still restructure social relations. In his critique of John M. Janzen’s analysis of therapeutic choices in Lower Zaire, Steven Feierman (1985:82) has argued that Janzen, in reifying therapy management groups, failed to account for the implications of the series of events that surrounded both decision-making and the shuttling from one therapeutic choice to another. According to Feierman, these events as well as

the loose unity of the therapy managing group conceal a fundamental division between one set of people who have jural responsibility for the patient’s welfare in a given context, and others who offer voluntary assistance but have no rights or obligations in their particular transaction. Anyone can offer help, but ultimate authority rests in the hands of the person with the clearest claim to jural responsibility.

Feierman’s thesis is that, first, lay therapy does not have a distinctive institutional hierarchy since it is “fully embedded within general patterns of control over domestic and community affairs.” Second, “the values and assumptions communicated through therapy are usually the dominant local values -- in this case patriarchal ones” (Ibid.). This thesis has far-reaching implications for research on the social history of health and healing in Africa. By gravitating towards what he calls the core or dominant values of a community and their place in therapy management, Feierman historizes the latter as he simultaneously embeds the former within the framework of the impact on health and healing of the social, economic, and political changes of the last one hundred years or so. According to Feierman, since

the authority of lay therapy managers is not separate from generalized authority in the domestic and community sphere, all the factors which shape local communities affect healing. Change in transport, production techniques, marketing, or education profoundly affect the shape of the local society, and therefore also healing.
Thus, avers Feierman, though the strengths of Janzen’s work lies in Janzen’s establishment of the historical context within which types of healing and government control over medicine takes place, this is “merely one part of the framework within which people shape therapy.” The other part must be sought in the institutions of domestic and community life -- not separable in any way from those which manage the peasant economy, ritual, or peasant politics at the most local level. The most satisfying historical context for the evolution of Kongo therapeutics would be the total history of local organization and ideology. It is not the history of a transformation from ‘traditional’ to ‘scientific’ medicine ... nor is it a history of therapeutic pluralism. It is, instead, the history of the fundamental social institutions which control therapeutic choice.

Gwyn Prins (1992:342-344) recently arrived at a more or less similar conclusion when he argued that, contrary to Robin Horton’s empiricist notions of change in Africa, people can and do show awareness of alternative ways of explaining problems. According to Prins, these alternative ways are employed “without slipping through the looking-glass into a scientific worldview.” But, more importantly, Prins has convincingly demonstrated that “whereas in scientifically oriented cultures, the concentric physiological, social, and cosmological spheres of existence are sharply drawn and discrete so that activity in one need have no implication in others, in traditional societies the spheres are acutely interactive.” The implications of the latter are clear. First, “when the different spheres of society interact, it is possible that many more aspects of society are involved in supporting the accepted image of understanding and control in that environment.” Second, this interconnectedness makes a traditional society to possess “a wider and more insistent definition of ‘normality’ than a scientifically oriented society. This ‘normality’ is moral in that it defines the social order and is also cognitive in that by definition it requires no discussion” (emphasis in original). Third, and closely connected with the second implication, this interconnectedness points to the fact that “the criterion of truth is only one
among many, and which criterion dominates in a given circumstance depends above all on the circumstance.”

Looked at from this perspective, it can be said that both Prins and Feierman agree that the history of health and healing in Africa is not “the history of a transformation from ‘traditional’ to ‘scientific’ medicine ... nor is it a history of therapeutic pluralism” (Feierman, 1985:82). But unlike Feierman’s seemingly ordered, unidirectional process of change in “the total history of local social organization and ideology” (Ibid.), Prins posits the concept of “organized incoherence in patterns of ideas” (Prins, 1992:342). According to Prins (Ibid.:340-342), in any one given African society, there are “core concepts” that will “tend to persist and will tend to retain their form” in time and space. However, because of the “pervasive and therefore vulnerable” nature of these core concepts, part of their defense “may be their unpredictable location.” Thus, for the historian of an African society, the best entry point into the understanding of the role of these concepts is “a thorough working knowledge of the present-day form of the society” since the present-day and the past are “entwined in an inescapable dialectic.” One way of understanding these concepts lies in how “perceived physiological affliction was seen to have resonance in the social and cosmological spheres surrounding the patient. Potential disruption in the first was seen as a likely cause, and drawing on the orderliness and completeness of the second provided remedy, restoring ‘normality’.” Affliction and its remedy in any African society, Prins has concluded, shows that norms and beliefs “about illness are ... culturally ‘encoded’; the language of symptom and disease is culturally ‘embedded’.” It is during moments of stress as happened during colonialism, or whenever epidemics and/or famines challenge the very existence of society, that the importance of these core concepts in processes of social change become clear.

The concept of “organized incoherence in patterns of ideas”, read by Prins into John Janzen’s The Quest for Therapy in Lower Zaire but is neither defined nor elaborated
upon, seems extremely central to not only the understanding of epistemic breaks in African therapeutic traditions, but also to the definition and historicization of what we are in this thesis calling the problem of anxiety and uncertainty among the AbaNyole of Western Kenya during the colonial period. Raised to the level of concepts, we hope to show that anxiety and uncertainty were in periods of severe stress central to the definition and understanding of dis-ease. In their attempts to impose meaning on their daily lives during such periods of stress, the AbaNyole were characterized by heightened moments of these two phenomena as they negotiated various sites of contestation on the social terrain, a terrain they saw as the distance between their ways of knowing and those introduced by Europeans in the colonial period. We shall seek to further argue that it was these two phenomena, more than anything else, that defined the ever shifting boundaries in which both the composition of therapy management groups and therapy seeking patterns were embedded.

Periods of pestilential stress, like those of indigence, will thus be treated not as moments of catastrophe and erasure that also provided the medium for the transition from ‘tradition’ to ‘science’; these were moments of creativity. Benedict Anderson’s (1983:14-19) ideas, though developed to explain phenomena different from those of this study, are quite pertinent here. To paraphrase him, we shall want to posit that in the process of its constitution and reproduction as a community, the AbaNyole during times of stress saw an affinity between the community as it was and as it should be, on the one hand, and the spiritual imagination, on the other. Like in the days of old when in such moments a conscious link was drawn between the dead and the-yet-to-be-born, the two visions entwined in the above affinity mitigated death as misfortune by transforming catastrophe into continuity. This was the more so because to the AbaNyole what Prins describes as the state of ‘normality’ did not mean the absence of dis-ease; disease was an important element in the maintenance of social order since, during healing rituals to attain
physical normalcy and re-establish lost harmony, it brought to light and clarified a number of matters in cases where confessions were called for.

From the foregoing, and through attempts to make meaning out of the AbaNyole problematization of dis-ease and health care during the colonial period, we shall endeavor to show in the following chapters that first, because “medical knowledge and illness realities are produced discursively in social, political, and economic contexts”, they are “essentially social phenomena” (Good and Good, 1981:208). Second, we shall argue that while the way in which the AbaNyole in the colonial period problematized dis-ease and coped with it provided images that condensed “configurations of meanings and syndromes of experience to bring to light the underlying coherence or sense”, biomedical practitioners always tended towards the construction of illness realities that they used as objects of therapeutic endeavor (e.g. African syphilis) to define, demarcate, and inscribe the African body in terms of what was seen to be different. In this they employed “clinical models interpretively to abstract a particular reality from the wholistic phenomena of a sick patient (Ibid.). This tendency negated the idea of neutral benevolence in colonial medicine, confirming that the meaning of its discourse was “constituted not as a reflection of empirical phenomena, but in relationship to socially constructed illness realities” (Ibid.).
Endnotes

1 The term *invent* is used here to project not a denial of the fact that Africa ‘objectively’ is plagued by more serious diseases and ill-health than elsewhere. The term is employed for purposes of putting up a case for arguing that a pathologized Africa was in the post-Enlightenment European mind a metaphor for the interpretation and evaluation of continental European identity vis-a-vis that of Africa’s. By posing the question this way, we hope to move one step further in working out a meta-medical problem: Why did Europe assume that, more than any other place, Africa was a sick and dangerous place to live in? Thus, whether Africa was characterized by all sorts of diseases or not, of interest here is the almost universal prevalence of this assumption or belief.

2 For a detailed review and discussion of these two discourses and their place in Europe’s constitution and naming of Africa as a pathological landscape, see Jean and John Comaroff (1991: chapter 3); Sander L.Gilman (1985); Megan Vaughan (1991, especially the introductory chapter); Philip Curtain (1964); and Robert J.Gordon (1992).

3 Though elsewhere (1978) these two renowned scholars of the British Empire admit that “the effect of Western medicine on Africa as a whole is hard to assess” (p.308) since improvements in communications, labor migration, and wars of conquest introduced a variety of new afflictions” (p.309), they nonetheless are convinced that since the turn of the last century there was a “medical revolution” in British tropical Africa (p.297). Credit for this goes to colonialism which, they argue, led to “one of the most successful attacks on tropical diseases in the history of Africa” (pp.306-307) between 1890 and 1914 when “Westernization had clearly changed African conditions for the better” (p.309). This assessment is pegged on the argument that initially, “The colonial rulers faced formidable problems in trying to develop the continent. Men and animals were sickly and suffered from scores of debilitating and killing diseases. Little was known before 1900 about the parasites and insects that attacked men, plants, animals, and soils. Resources in manpower and money were lacking to do much scientific research. But there were some important beginnings: departments and institutes were started, and research teams were organized to study ways to make Africa a more productive and healthier place” (p.291).

4 This is the position Helge Kjekshus (1977) takes in his study of Tanzania. He has, for example, argued that the great rinderpest epidemic of the 1890s represented the “dividing line between initiative and apathy on the part of a large number of African peoples, particularly in the eastern and southern parts of the continent” (p.126). This epidemic was followed within a few years by smallpox epidemics, the sand-flea (jiggers) epidemic, famine, and sleeping sickness and they were “probably all seen by the contemporary Africans as the result of European machinations” (pp.131-132). He concludes that throughout the nineteenth century “man and beast combined to maintain an ecological control situation” (p.160) in which pre-colonial economies developed. This was “a relationship between man and his environment which had grown out of centuries of civilizing work of clearing the ground, introducing managed vegetations, and controlling the fauna” (p.181). This however changed in the last ten years or so of the century with the coming of colonialism that led not just to underdevelopment but also to “de-development.” John Iliffe (1979) has however taken the opposite view, arguing that pestilence and indigence were always rife in Tanzania hence they cannot be explained in terms of colonial conquest. To Iliffe the African environment had always been harsh and famines and
diseases had always been the main cause of under-population in this part of Africa (p.13). Juhani Koponen (1988) has taken a middle position in this debate, convincingly arguing that mid- to late-nineteenth century convulsions were due to "the Apocalyptic Horseman: famine, war, pestilence, and death" (p.126) and they were manifestations of "the build-up of the century's commercial system, and ... the conditions of those turbulent times cannot be automatically projected backwards to the normal and peaceful periods ..." (p.127).

5 In 1978 the World Health Organization (WHO, 1978) suggested that African governments could make use of traditional medical practitioners in primary health care in their attempts to alleviate the worsening health conditions on the continent. For a detailed discussion of the implications of this suggestion see Centre of African Studies, University of Edinburgh (1987) and Murray Last and Gordon L. Chavunduka (1986).

6 The term is employed here in its Kuhnian meaning, that science is a field of practices and not a network of statements. According to Thomas Kuhn (1970), science is a project in which the production of knowledge begins with an account of 'normal science' wherein its practitioners take an uncritical attitude towards the most fundamental concepts and theories accepted in their field. These theories and concepts are embodied in a paradigm or a set of theoretical doctrines constituting a worldview. To Kuhn this paradigmatic worldview serves two functions for those who engage in normal science. First, it prescribes some beliefs as essential and proscribes others. Second, it determines which facts it is important to know and provides some general expectations of what those facts will be. For further discussion on this point see Joseph Rouse (1987) and Michael Mulkay (1990).

7 According to Susan Sontag (1978), disease has always been enmeshed in metaphors and symbolic language which, when decoded reveal certain ingrained beliefs about the disease and its victims. She however in her positivistic mind-set strongly believes that these symbols and metaphors are bound to dissipate with the increased application of scientific knowledge.

8 The term is used here in the context used by Steven Feierman and John M. Janzen (1992:xvi). It is used to "describe historically continuous streams of interrelated theory and practice. Within each stream are sets of concepts concerning illness causation, anatomy, society, or self, as they relate to bodies of therapeutic practice, and also to the inherited occupational roles within which healers work."

9 For a detailed discussion on this argument see Steven Feierman (1990:69-119, 245-264); Jean Comaroff (1985); Jean and John Comaroff (1991, especially chapter 4); and Randall Packard (1989).
CHAPTER TWO

THE ABANYOLE OF WESTERN KENYA

2.1 Introduction

This study is about disease, medicine, and processes of social change among the AbaNyole of Western Kenya. It is an exploration of ideas about disease and medicine in 'Nyole cosmology; 'Nyole-European encounter; the AbaNyole experiences with illness and Western biomedical therapies; and how these experiences, and the meanings they produced arranged, making and re-making, the 'Nyole medical landscape during colonialism. But to speak about 'Nyole cosmology and a 'Nyole medical landscape is to also speak about a 'Nyole identity and "the possibility of reconstructing objective historical processes" (Binsbergen, 1992:xiii) in which illness experiences and the meanings these experiences produce can make sense. As Wim van Binsbergen has argued in the case of central western Zambia, the making of a group's identity, as well as the production of history, are inseparable processes (ibid.:3). It is from this perspective we take cognizance of the fact that an analysis of the recent (colonial) history of the AbaNyole is impossible without an assessment of the formation of their identity. The importance of this recognition, at least in the light of this study, lies in the need to establish whether one can speak of a 'Nyole episteme in which ideas about disease and its eradication can be embedded. In other words, the recognition constitutes the need for establishing the parameters in which we can say that indeed there was a 'Nyole worldview in which was embedded a clear-cut and well-defined conceptualization of disease and medicine before the AbaNyole came into contact with the West. The question for this chapter is, therefore: what went into the constitution of this identity?

2.2 Bunyore: Geographical and Political Location
Unlike Sabatia, Hamisi, and Vihiga divisions in the present-day Vihiga District of the Western Province of Kenya, Emuhaya (Bunyore) has hardly begun to receive the attention it deserves in social science studies.\(^1\) This neglect is surprising because, like the other three divisions in the district, Bunyore is located in that part of the Province that is arguably one of the most densely populated areas not only in Kenya but the whole of Tropical Africa.\(^2\) Ensnconced in a human settlement that is compact, and subject to the intense activities of the capitalist regimes of peasant commodity production, exchange, and labor recruitment, Bunyore has for nearly a century now been the site for state and missionary interventions, and for struggles over the control of the processes of production and reproduction. Indeed, land scarcity, as well as population 'explosion', are issues that have been central to the division for the most part of this century. These developments -- peasant commodity production, capitalist regimes of exchange, and labour recruitment -- are therefore not only about the way the 'Nyole social and economic landscape has been transformed in the last several years, but also about how the people have had to deal with the changes engendered by these forces, including the way misfortune is perceived and dealt with.

The ABA Nyole are one of the sixteen or so Luyia-speaking Bantu groups that are distributed throughout the Western Province of Kenya (Osogo, 1966; Were, 1967a, 1976b; Paterson, 1984: 35-6). Before Kenya's political independence from British colonialism in 1963, most of this province formed the northern part of Nyanza Province which, prior to its division into Elgon Nyanza and North Nyanza Districts, was called North Kavirondo District. When it became Western Province in 1963, Elgon Nyanza was split into two districts, Busia and Bungoma, while North Nyanza became Kakamega District (map 2.1). Kakamega was in 1990 split into two districts, Kakamega and Vihiga, with the southern divisions of Emuhaya, Vihiga and Hamisi forming the latter. Bunyore, administratively called Emuhaya Division, comprises four locations (map 2.2) -- North, South, East and
West -- and twenty-four sublocations whose demarcation and constitution follow clan lines or boundaries. In 1988 the division had a population of 153,451 people which, at an annual increase of 3.8%, was estimated to reach 182,610 people in 1993 (Government of Kenya, 1989).

Bunyore lies in the western part of Vihiga District. In the south in the plains surrounding Lake Victoria are the AbaNyole southern neighbours, the Nilotic Luo of Siaya and Kisumu Districts in Nyanza Province. Their northern, western and eastern neighbours are fellow Luyia-speaking Abidakho, Abakisa, and Abalogoli, respectively (map 2.3).

Although it lies some 375 kilometers (234.5 miles) to the west of Nairobi, Bunyore is "very well integrated into national lines of communication and transportation" (Paterson, 1984: 38-42). It lies roughly 30 kilometers to the northwest of the Lake Victoria port city of Kisumu, and is linked to all economically significant areas of Kenya by a transportation network that includes the all-weather road linking Mombasa on the East African coast with Busia on the Kenya-Uganda border; the all-weather road that begins in West Bunyore near Luanda and passes through East Bunyore and South Maragoli, meeting the Kisumu-Kakamega road at Majengo; and the railway line which passes through South and West Bunyore with stops near Maseno and at Luanda on its way from Kisumu to Butere (map 2.4).

Besides these major transportation lines, there are minor ones through which easy connections are made to points in the Rift Valley such as the tea-growing areas of Kericho and Nandi Districts, the agricultural areas of Uasin Gishu and Trans-Nzoia Districts, and the towns of Eldoret, Kapsabet, Kitale and Kakamega. On this integration into national transportation networks and its importance to Bunyore, Douglas Brian Paterson (Ibid.: 39) has noted:

While Bunyore is almost equidistant from Kakamega and Kisumu, most of its commercial contacts are directed towards Kisumu and Nairobi. Tracing the flow of goods originating along the Mombasa-Nairobi-Nakuru
transportation corridor, most products destined for Kakamega District will
almost invariably pass through Kisumu. Bunyore’s commercial orientation
towards Kisumu stands in interesting contrast to its lines of administrative
authority which emanate from Kakamega town, which serves as ...
Provincial and (until 1990) district government.

As already mentioned and dealt with in detail in chapters four and five, the process of this
integration has its roots in state and missionary interventions that go back to the dawn of
this century. But who are the AbaNyole? Put differently, is there such an entity called the
AbaNyole who are, say, different from their fellow Luyia-speaking neighbors in the north,
west, and east, or their southern Nilotic Luo neighbors of Siaya and Kisumu Districts?
This question is about the problem of 'Nyole identity, a problem that is not inseparable
from their history.

2.3 Bunyore: History and the Problem of Identity

Omuhika neingalukhano

Though historians of Western Kenya have for sometime now recognized the
intrinsic difficulties involved in taking an ethno-linguistic group as one's unit of study
it is still rare to find studies that concentrate exclusively on a single sub-ethnic group.

Writing on the Abaluyia as far back as 1967, the historian Gideon S. Were (1967a: 58-59)
noted that
to most writers the Abaluyia have seemed to be ethnically homogeneous -
homogeneous, that is, in origin. Having rightly perceived them as a people
with a common language and culture, some writers have hastily jumped to
the conclusion that the Abaluyia have had a common origin and a corporate
past. The proximity of Busoga, Bunyole, Samia, and Bugishu in Eastern
Uganda and the linguistic and cultural similarities between these
communities and the Abaluyia have further been readily used to prove that
the latter originally came from Eastern Uganda. Thus there is a
preconceived and highly misleading idea that there existed some tribal unity,
even at this early stage before the formation of the community itself.

Joseph Malusu, in his study of Isukha beliefs about death and the afterlife, agreed with

Were when he wrote that each of the Abaluyia sub-groups has its "own way of dancing and
singing, of initiation, marriage and burying its dead." According to Malusu, "[t]o write about death among the Abaluyia as [John] Mbiti ... has done, or label anything 'Luyia' is either to generalize about these diverse people or to perhaps just regard one group as a representative of the whole. As far as I can see such an approach can be quite misleading" (Malusu, 1978:xxii). And Helen Aswani (1972:1), writing on the oral literature of the ABA Nyole, has pointed out that the Abaluyia "do not have a homogeneous oral literature. Our literature does have common elements but there are other elements which are unique to certain parts of the tribe."

According to these writers, the Abaluyia are a hybrid community that, in reconstructing their history, "it is necessary to take as little notice as possible of their present Bantu identity ... T]he question as to whether the ancestors of the Abaluyia originally came from the 'West' or the 'South' becomes a false question. The early history of the Abaluyia can be examined by analyzing the origins of their various clans and sub-tribes within the wider context of inter-tribal movements in Eastern Uganda and Western Kenya" (Were, 1967a:60). Indeed, Were has argued, between c.1490-1706 Eastern Uganda and parts of Western Kenya were gradually being occupied by their present Bantu-speaking, Kalenjin, and Luo inhabitants. To these groups were added, sometimes between 1760-1868, the Teso who expanded from their settlements at Mbale and Tororo in Eastern Uganda. "All these developments," Were has concluded, "contributed to the emergence of the Abaluyia" (Ibid.).

Were identifies the period 1598-1733 as crucial in the immigration and settlement of Ebuluyia. It was during this period that "the majority of the present clans and sub-tribes of the Abaluyia seem to have been founded " (Ibid.: 64). Among the 'sub-tribes' that are said to have emerged in this period are the Abisukha, Abidakho, Abalogoli, AbaNyole, and Abatirichi of Southeastern locations of Ebuluyia. The ancestors of the Abalogoli, AbaNyole, and Abatirichi "seem to have originally come from the Bantu part of East
Uganda, and settled in the present Luo country of Central Nyanza. It was from there that they later moved northwards into their present settlements in Buluyia (Ibid.:73). According to John Osogo (1966:44), the first clans to arrive in Bunyore did so sometime after the Buongo-Luo Alego war of 1710 though some members of these clans, especially the Abasakami and Abamuli, had arrived far much earlier than this date.

Drawing evidence from the Evidence to Committee on Land Tenure in North Kavirondo (1945), Thomson (1883), and Gunter Wagner (1949), were argues that the ancestors of the AbaNyole "hived off from the Banyole of Eastern Uganda ... and wandered on to Kadimo, Sakwa Bondo, and Akala Gem before finally settling in their present country of Bunyore" (1967a: 73). But before their arrival in Bunyore sometime between 1571-1652, "a small column of Masai (sic)" entered the southeastern part of the country from the east and settled in the present location of Idakho (Ibid.:76). This factor is important. Its importance lies in the fact that though the AbaNyole "claim to be homogeneous,"

it is a matter of common knowledge in Southern Buluyia that the Abamuli of Bunyore, Tiriki, Gem, and Kisa are blood cousins of the Abashimuli of Idakho whose ancestors came from either the Masai country or Nandi. Furthermore, according to the accounts of the Babukusu, the Ababayi of Bunyore would appear to have hived off from the Babayi of Bukusu. It is also evident that the ancestors of a few of the clans of the Banyole, such as the Abalako, came from the present Luo country of Alego, though this does not necessarily mean that they were Luo. And, finally ... it is apparent that by the time the Luo came to Alego, most of the Bantu ancestors of the AbaNyole had migrated, leaving behind only a few remnants such as the Jousere (Ibid.: 73. Emphasis added).

Sometime between 1706-1760, the descendants of Nilotes who followed in the wake of the Bantu appear to have increased in population and expanded into surrounding areas of Bunyore, Kisa, and Tiriki. This expansion, "coupled with domestic disagreements and quarrels" which led to a split in the emergent Luo community, led to the founding of new clans in modern Kisa, Bunyore, and Gem locations (Ibid.: 77-78; Ogot, 1967:154).
From the foregoing, Were concludes that the Southern part of Buluyia "appears to have been peopled from four major sources". These are, first, "the category of the aboriginal inhabitants" who were of Bantu origin and "consisted of small quasi-sovereign communities." The second source comprised of immigrants of Kalenjin origin who "came into the country from the east and north-east of Mount Elgon" in the early part of the sixteenth century. By the beginning of the eighteenth century more immigrants of "Bantu origin had already arrived from Eastern Uganda, some directly, but the majority via the present Luo country of Central Nyanza. While the majority of this category originally came from modern southern Busoga, parts of the southern Uganda, Bunyole, Samia and Bugishu, a few of them would appear to have migrated from Western Uganda (Ankole and Bunyoro and the adjoining part of the Congo Republic) at some earlier time." The last source consisted of a "group of immigrants whose Masai (or Nandi) ancestors moved in, about the same time, either from the east or the south-east, and became Bantuised" (Ibid.: 79).

If we can go by Were's assessment, then it is clear that in writing the history of the AbaNyole or any one of the various groups that make up Luyialand, it is hard to start the argument by "a profoundly historical statement" (Binsbergen, 1992:3). This is mainly because, Were has argued, each and "every sub-tribe of the Abaluyia consists of a congeries of heterogeneous clans" whose history is more often than not "the history of the descendants of the . . . eponymous founders .... Consequently, it is (these founders) and their direct descendants who are best remembered and generally credited with the emergence of (these) communities" (Were, 1967a: 101, 89). Thus, it is partly because "various clans and sub-tribes were extremely jealous of their independence," and partly because there was no "coherent feeling of tribal unity or, for that matter, tribal consciousness" (Ibid.: 134), that the history of the Abaluyia, or the Luyia sub-tribes, must of necessity start with the history of various clans that compromise the 'tribe' or 'sub-
tribes'. Failure to take this into account, Were (1982, 1985) has argued elsewhere, has led to the overstating of the concept of 'tribe' and tribal cultural identity in historical, sociological and anthropological studies. Central to Were's argument has been the question: Are ethnic and cultural identities in African history mythical or real? In his attempts to answer this question Were has been at pains to debunk the concept of tribe, preferring instead to work with what he calls "a single cultural and linguistic unity" in the evolution of the Abaluyia. It is from this that he posits a model of identity-building based on "common linguistic and cultural links" (1967a: 134) because, first, the "ancestors of the great majority of their (Abaluyia) clans immediately moved into Western Kenya from one broad linguistic area comprising Busoga, Bunyole, parts of Buganda and Bugishu" (Ibid.: 151) and, second, the mobility of these groups before or even after settlement "facilitated . . . the mingling of peoples and development of a common language and culture" (Ibid.).

Other factors Were considers as being crucial though "less important" in this process are marriages, trade relations, and "other social contacts, especially the consultation of recognized medicine-men and other experts" who "created some kind of link within the wider country" (Ibid.) "Since every clan or sub-tribe did not have its own rain, circumcision, war-medicine, and divining experts", Were avers, "this meant that only a few people could be consulted all over the country and this had the effect of spreading culture" (Ibid.: 152). This argument has recently led him to conclude that cultural identity (the more generic), and not ethnic identity (the more specific and fluctuating), is more important in understanding identity formation in Western Kenya (1982: 1-11). This is the more so because "as a result of . . . frequent population movements across ethnic boundaries, diffusion and incorporation of many cultural traits among linguistically and socially different peoples seemed to have occurred in various degrees" (1985:6). Thus, . . . the contention is that since in the not-too-distant past our ancestors moved freely and widely, interacting with one another and with various environments, a lot of lending, borrowing and fusion have constantly been
taking place. As a result there are many common characteristics, particularly among neighbouring ethnic groups (1985:7).

Gideon S. Were's postulates raise crucial questions not the least being: How does one problematize identity and identity-formation, personhood and agency, and space and time in areas with peoples of diverse origins like in Western Kenya? This is even more pertinent in the light of his assertion that it is "apparent," and notwithstanding the "claim to be homogenous", that the AbaNyole are heterogenous; that it is "a matter of common knowledge" that clans like "the Abamuli of Bunyore, Tiriki, Gem and Kisa," for example, "are blood cousins of the Abashimuli of Idakho whose ancestors came from either the Masai country or Nandi" (1967a: 73). Most of the Abaluyia sub-ethnic groups' identification of 'Misri' or Egypt as their original homeland is equally dismissed by Were on the basis that the place "stands for (what) appears to belong to the realm of myth and the remote incomprehensible past" (1967a: 64, 68, 83 and 1967b: 15, 88-89). Against claims of sub-ethnic homogeneity and legends of common origin Were posits the clan as a self-contained entity. Because of the "common ancestor" factor, peoples' allegiance are said to have been to the clan since there was "a feeling of oneness, of common interest and purpose." What bound people together, therefore, was neither political nor economic considerations "for these were there as a necessary and logical consequence of the common (or supposed common) origin of the members of the clan" (1967a: 156). It is within these parameters that Were sees the clan as the fulcrum of corporate action or, as Atieno Odhiambo and David W. Cohen (1989:13) have put it with reference to identity-formation in Siaya, "the frame of interest articulation among individuals and households." Beyond clan corporate action was, according to Were, mostly inter-clan animosity since "by the middle of the 19th century the ancestors of the main communities had firmly established themselves in the country and therefore become either uneasy or indifferent neighbours since they had separate origins and interests" (1967a: 131). Indeed, "various clans and
sub-tribes were extremely jealous of their independence. And since every major clan was a
sovereign state, this meant that outside the borders of any such a clan all other communities
were regarded as foreigners . . . " (1967a: 133).

In their critique of historical and anthropological literature on the Luo past, Atieno
Odhiambo and David W. Cohen (1989: 13-14) have observed that in stressing "the
patrilineage as the fundamental organizing unit within Luo society, and segmentation as the
essential process of combination and separation", scholars have not only presented
"patrilineality as a timeless feature, and therefore as a central motor of Luo experience," but
also "consciously or unconsciously suppressed observations of the dynamics of other
forms of association and other possibilities of collective activity." Thus,

[by] giving prominence to patrilineality, powerful presumptions are
introduced into the study of the Luo past concerning the nature of action and
the explanation of event. The growth of community, the expansion of
population, the formation of the Luo "nation", and the construction of
political movements are comprehended in terms of segmentary kinship
processes writ large through endless repetition and agglomeration.

These sentiments can be brought to bear on what Were, but also John Osogo
(1966) and Gunter Wagner (1939, 1940, 1949, 1954, 1956), have had to say on the role
of the clan in Luyia social, political, and economic organization. It is noteworthy that
though Were, for example, gives prominence to the migration and settlement of clans; to
the importance of these clans as the loci of action in Luyia society; and to language and
culture as the two most important factors that give the Abaluyia their identity, his narrative
fails to explicate, first, what lay "beneath the surface of the details on horizontal mobility"
and, second, what the basis of his "language-culture homology" was (Odhiambo and
Cohen, 1989: 17). Thus, though Were's argument that the definition of the identity of the
people known as the Abaluya in general and the AbaNyole in particular goes beyond the
mere question of shared geographical spaces that demand serious attention. These are, first, his understanding of what is "apparent" and
"a matter of common knowledge" on 'Nyole claims that they are a homogenous people, and second, his definition of culture as a group's values, norms, traditions, customs, and language (1985). On the first issue what immediately comes to one's mind is: "apparent" and "a matter of common knowledge" to who? To the AbaNyole themselves or to Were the historian? Or is it a type of knowledge that emerges from the conversation between the historian and his informants?

It can be argued that Were's search for an essentialist definition of a language-culture homology forecloses the possibility of seeing 'Nyole claims to homogeneity for what they are: as discursive practices in which the construction of Nyole-ness is carried out. Quite contrary to Were's argument, common-sense, or common knowledge as Clifford Geertz (1983: 74) has called it, is "a relatively organized body of considered thought" and not "just what anyone clothed and in his right mind knows." It is an inherent characteristic of common-sense thought precisely to deny this and to affirm that its tenets are immediate deliverances of experience, not deliberated reflections upon it .... Religion rests its case on revelation, science on method, ideology on moral passion; but that is not a case at all, just life in a nutshell. The world is its authority (Ibid.: 75).

Seen from this perspective, we can say that Were was more concerned with the exercise of common knowledge, not its analysis. Thus, instead of working to re-establish the link "between the mere matter-of-fact apprehension of reality ... and down-to-earth, colloquial wisdom" (Geertz, Ibid.), he chose to separate the two, emphasizing the one while suppressing the other. We would therefore want to argue with Geertz (Ibid.: 76) that if common sense (read common knowledge) is as much an interpretation of the immediacies of experience, a gloss over them, as are myth, painting, epistemology, or whatever, then it is, like them, historically constructed and, like them, subjected to historically defined standards of judgment .... [It] is ...a cultural system, though not usually a very tightly integrated one, and it rests on the same basis that any other such system rests; the conviction by those whose possession it is of its value and validity (Ibid.).

As we are presently going to see, in the construction of their identity, the AbaNyole have always maintained facades of community and consensus that are erected at front stage level
but at the same time dismantled through commentaries made back stage (Goffmann, 1959 and 1974). 6

On the second issue, it is the contention of this study that culture and identity-formation are not just about peoples' movements across ethnic boundaries and the "lending, borrowing and fusion" of cultural traits this movement engenders (Were, 1985: 6); nor is identity and identity-formation a question of "common linguistic and cultural links" that can and should be experienced in terms of common origins (Were, 1967a: 134). Culture, John Fiske (1989:1) has observed, is "the constant process of producing meanings of and from our social experience, and such meanings necessarily produce a social identity for the people involved." To talk about the Abaluyia, or the AbaNyole for that matter, and how they came to occupy their present homeland, must of necessity embrace within its interstices the fact that present-day Western Province is more than a shared geographical space: it is a place where, through time, shared meanings have been produced, and identities constructed and modified. Constantly in the "process of coming to be" (Lonsdale, 1977b), the various sub-groups that compromise the Luyia 'nation' speak to a "multiplicity of forms of identity formation in innumerable contexts and at countless moments" (Odhiambo and Cohen, 1989: 36). But these processes, in their nuanced simultaneity, have involved other distinct though closely interwoven domains. There are, for example, the epistemic domain in which new forms of knowledge for dealing with inter-and intra-clan relations as well as the relationship between man and nature, have evolved; the discursive domain in which meanings about personhood, agency, space, and time, as well as the construction of 'Nyole-ness have historically been produced; and the aesthetic domain in which language and language use, rites of passage, as well as other cultural aspects about the AbaNyole have come to be defined. It is indeed within the ambit of the latter domain that cultural production has not only taken place, and within given historical contexts, but is also played back into identity-formation. Crucial to this process
are the questions: how do these cultural aspects move into features of everyday life where people make sense of their experiences? Is this sense-making activity a constituting element in the aesthetics of everyday life?

2.4 Community and Politics of Identity in Bunyore

The AbaNyole as demonstrated in the foregoing section have as neighbors the Luo-speaking Nilotes in the south and the Luyia-speaking Bantu of Kisa, Maragoli, and Idakho in the west, east, and north, respectively. A "loose congeries of peoples who occupied a mutually intelligible universe and a contiguous space on a terrain yet to be mapped" (Comaroff and Comaroff, 1991: 126) between the 16th and 19th centuries, the AbaNyole today see themselves as a people whose membership, while concentrated in Emuhaya Division of Vihiqa District, is dispersed: sizeable clusters are found in Seme and Sagam in Luoland, in Lugari Settlement Scheme of Kakamega District, (Apeli and Olasi v. Buluku in Eugene Cotran 1987: 231-236) and in urban areas that stretch from Busia in the West to Mombasa and Malindi in the East, Lodwar in the North and Isebani in the South. Expressed in 'Nyole everyday discourses as okuhila olubambwa Iwa'Nyole musibala (to spread Anyole's clan in the world), the reality of this dispersal is co-extensive with, and not contradictory to, notions like olayia Iwa'Nyole (Anyole's nation); abandu be'ingo (the people of/from home, home here meaning Bunyore); tsifwo or ebima bia'Nyole ('Nyole culture); abana ba'Nyole (Anyole's children) and nifwe baliho khandi nifwe balibaho (we are the ones there, today and tomorrow). The notions of dispersal and one-ness thus are important discursive tropes in the constitution of a 'Nyole identity: they are, as E.S. Atieno Odhiambo and David W. Cohen (1989: 25-42) point out in the case of the Luo of Siaya, about the construction of boundaries, and about the constitution of identity. The two notions - dispersal and one-ness - therefore direct our attention to crucial questions about how and when the AbaNyole as a community with its own shared social practices -- rituals,
beliefs, and community -- came into their own and what are the historical experiences that explain this constitution?

Posed this way, issues about the constitution of a 'Nyole identity become more than a question of whether these people are really an ancient lot with a common cradleland now struggling, in the 20th century, to reclaim this original unity. This is the picture the 'Nyole elite presents to the outside world, and it is probably this group Gideon S. Were had in mind when he pointed out that the AbaNyole have the tendency to "claim to be homogeneous". As a strategy in the fluid nature of politics in the Southeastern part of Western Province, this claim has always drawn upon certain terms in its definition of 'Nyole-ness: from every day speech and praise names like Anyole lichina (Anyole stone, literally meaning authentic Anyole), to claims that the AbaNyole are the only Luyia sub-ethnic group that speaks standard oluluyia. They have also described themselves as amajini ke'luanda (the genies of Luanda, literally meaning invincible); abajimbi (rainmakers); and abantu batinyu okhurula mimbi na mimbi (hardy people since time immemorial). Setting themselves apart from their southern Luo-speaking Nilotic neighbours because the latter don't practice circumcision, they have also, through the appropriation of the Church of God Mission as a 'Nyole church, described themselves as harbingers of 'civilization' since it was their sons and daughters who brought light' to such 'primitive' and 'backward' places like Kisa, Butsotso, Isukha, and Idakho. Some of these claims have been captured in popular songs, e.g.:

Bana befwe nimbwo khwallinji
Bana befwe injembe yalula
Abelukha omusevi batsie mumbo
Lelo inyanza esalamaa
Esalamanga niyenza obulalo
Sichila ingokho 'ndaafu nenyena okhwal'usia
Tsal'lusie mbikhe kholubambwa
Bulano oli tsimbeko tsio musiku.
The knife is painful
But those who run from the circumciser should go to the West
For today the lake surges
It surges as it looks for bridges
As I prepare to incubate my white hen
To put it in the open mainstream
Today you are the seeds of the hills]

But the AbaNyole have also been 'named' by their neighbors: as jamwa
(foreigners), or people from beyond the hills, by their southern Luo-speaking neighbors,
and abandu bo'musala (people of the tree, meaning bhang or cannabis sativa - users), or
Angola-Musumbiji (a rural banditry group that has, since the 1970s, been terrorizing the
Western Province countryside and is said can only come from, or be organized in,
Bunyore). Indeed, one enduring image of the AbaNyole among their Luhyia-speaking
neighbors is that they are, and have always been, very stubborn people: they are bhang-
users and traffickers; they are violent with tendencies that always border on the anti-social;
and they are intelligent but arrogant and proud.

These two constructions of 'Nyole identity, but especially that one by the AbaNyole
themselves, speak to a front stage discourse that give the impression that they are not only
homogeneous, but also an ancient people whose character and 'way of doing things' is
different from that of either the Luo, their southern neighbors, or their fellow Luhyia-
speaking Bantu in the east, west, and north. There however are internal or back-stage
discourses whose sites of production and articulation draw our attention to a myriad of
issues that range from sub-locational identities that more often than not are coterminous
with clan histories, to social and economic differentiation within Bunyore itself. Thus,
while on the one hand it is not uncommon to encounter situations whereby identity-
description encompasses both the administratively defined Division of Bunyore and sub-
locations within Bunyore, there is, on the other, glaring economic and social differences
that have led the AbaNyole to 'name' each other. An Omunyole doesn't just come from
Bunyore, but from, for example, Ebunyole Ebusamia, Ebunyole E bunangwe, or Ebunyole
Ebushiekwe. At the social and economic level, the AbaNyole of Em’mutete have been known to refer to themselves as Abangeleza as opposed to the AbaNyole from the north whom they call Abapokoti. In local 'Nyole discourses on development, Abangeleza means enlightened ones (though the word in Olunyole means the English) since they can, and do, speak olungeleza (English). Abapokoti, on the other hand, means the backward ones (though the word is derived from the name of another ethnic community in Kenya, the Pokot, who in some quarters are seen as 'backward' and 'primitive'). Though Abamutete's claims to 'civilization' is a reflection of social changes brought about by church-induced developments in education and health services within their locality (this is where the East African headquarters for the American-funded Church of God Mission is located), these have more often than not taken on political meanings. As we are presently going to see, through claims to being 'bene liloba (owners of the soil) as opposed to abamenyibwa or abasumba (tenants-at-will or dependents), Abamutete, but also other clans and groups of clans, have for the most part of this century seen themselves as the 'natural' rulers of Bunyaore.

These 'internal' and external definitions of 'nyole-ness point to webs of existence and signification that at once speak to, and about, the "enmeshing of ideology, identity, and material concerns" (Odhiambo and Cohen, 1989: 29); social identities that are rooted in concrete historical experiences and social practices; and to a set of symbols that, although subject to constant negotiation, keeps constructing and modifying a 'Nyole identity. Thus, and like any other community in Africa, the 'Nyole community is based primarily on shared social practices. These practices do not, however, constitute community per se: this requires the symbolic 'processing' of these practices (Bierschenk, 1992: 515). We would like to argue after Thomas Bierschenk, but also Benedict Anderson (1983) and A. P. Cohen (1985), that the constitution of the 'Nyole identity has been a simultaneous social and ideological process in which the politics and poetics of everyday existence are
constituted and legitimized through forms of knowledge 'Nyole peasant intellectuals (Steven Feierman, 1991) and 'Nyole elites create and organize to both weigh 'Nyole-ness and reproduce community as the natural embodiment of history, territory, and society. This argument is significant. Its significance lies in the fact that as a 'loose congeries of peoples,' there has always been an economy of access to the community's symbolic domains. These are, as Thomas Bierschenk (1992: 515) has noted in the case of the Fulani of Benin, West Africa,

> Important political resources and the ability to manipulate, or to use a less negative concept 'arrange' them is part of the classical repertory of political strategies. Thus, as with all other types of political resources, the capacity to manipulate symbols is unequally distributed. Symbols and rituals do not represent community in a socially undifferentiated sense. Instead, they represent interpretations of social situations proposed by certain actors in their strategies to attain power; these actors can also be identified as 'symbolic entrepreneurs'. Rituals represent an attempt to establish the general acceptance of specific definitions of social reality.

However, "no elite," Bierschenk continues through a reiteration of the importance of A. Giddens's (1984) notion of urgency,

> possesses limitless powers to change symbolic domains and create communities. The limits here consist mainly in the necessity to root symbols in both the historical and contemporary experience and practices of the actors concerned. The possibilities for manipulation by the elite are above all restricted by the power to act and the the discursive awareness of the other actors who are merely the victims of the strategies, but are active and conscious participants in the process of negotiating social and ethnic identities.

Contrary to Gideon S. Were's notions of identity-formation in Western Kenya, it can therefore be argued that the 'Nyole community, or any other sub-ethnic community in the region, is not taxonomic. Subject to the ebbs and flows that characterized the conquest and settlement of the region by both Bantu- and Nilotic-speaking peoples between the 16th and 19th centuries, Bunyore is the product of, to use Jean and John Comaroff's (1991: 128) words, a "historical transformation of a dynamic social world." The source of these ebbs and flows, as well as their "historical motor," lay partly in the internal workings or
symbolic processing of certain aspects of culture and society since the settlement of the area between the middle of the 16th and early 17th centuries by pioneering clans, and partly in the external relations between these clans, their neighbors, and the original occupants of this environment. These dynamics have in time and space played themselves out in a variety of forms and registers; the spatial anatomy of the landscape and its expanding frontier, mythic and ritual representations of the cosmos; interaction with the non-human realm; the social ecology of production; and kinship ties and marriage arrangements. These were and have been complex 'Nyole worlds, and the role of peasant intellectuals in the interpretation and representation of these worlds must be seen to be rooted in both the social reality and in the historical experiences of all the members of the 'Nyole community. As Thomas Bierschenk (1992: 517) has cautioned, the "plasticity of the arrangement of symbols used to construct" this community must ultimately "do justice to this social and historical reality."

2.5 Of Identity, Community, and Sacred Landscapes

In his analysis of the emergence of a Luyia identity in Western Kenya, Gideon S. Were (1967a: 131) has argued that the question of 'otherness', especially at the level of the social and political constitution of clans, became critical by the middle of the 19th century. This was because "the ancestors of the main communities had firmly established themselves in the country and therefore become either uneasy or indifferent neighbours since they had separate origins and interests." According to Were, this was even more pertinently so because "various clans and sub-tribes were extremely jealous of their independence. And since every major clan was a sovereign state, this meant that outside the borders of any such a clan all other communities were regarded as foreigners" (Ibid.: 133). This however does not mean that there were no friendly relations between these clans, or between Abaluya and non-Abaluya clans. Such was the case in the later part of
the 19th century when "chief Nganyi of the Abanyole sub-tribe ... and chief Odera Ulalo of the Luo of Gem" struck a long-standing alliance (Ibid.: 134). Thus, despite the hostilities that existed between the southern Abaluyia and the Luo when the latter immigrated into Gem and embarked on a process of conquest and expansion, they (especially the Luo of Kisumu) avoided hostilities with the AbaNyole on account of the AbaNyole's famous role as rainmakers and, therefore, "important benefactors who must be placated" (Ibid.). Before the alliance between Odera and Nganyi, "the Luo of Gem were not bothered by this (knowledge of rainmaking) and so continued to harass the southwestern part of Bunyore" (Ibid.: 140; Ogot, 1967: 154, 224).

Gideon S. Were, and later John M. Lonsdale (1977a: 847), attribute these hostilities to the struggle over land though Were, unlike Lonsdale, intimates at differences in modes of production between the Abaluyia and the Luo as one of, if not the main, factors that made land of crucial importance in the shaping of the dynamics of this relationship. According to Were, the Luo were basically pastoralists and hence mobility was an inbuilt mechanism in the constitution of society and polity. The Abaluyia, on the other hand, were agriculturalists and had long discarded mobility and settled down as tillers of land (Were, 1967a: 134, 149). But of crucial importance, which Were doesn't mention, and Lonsdale touches only in passing (1977a: 850), is that by the 19th century and certainly from the middle of the century, 'Luyia' and 'Luo' cosmologies were in the process of "being adapted to explain and therefore give a measure of control over the changes of the times, especially the enlargement of the social field of action." Lonsdale articulates this position for purposes of understanding the processual nature of the imposition of colonial rule, and how the indigenous people responded to it, at the turn of the century. Thus, he places this change within the ambit of British conquest and imposition of Pax Britannica in Western Kenya.
But if there was "enlargement of the social field of action," and the terrain upon which this took place was Western Kenya as a physical entity, the dynamics of the process must, at least in the case of the AbaNyole, be sought from the contradictory if necessarily dialectical nature of frontier relations during this period. The emerging boundary between the people who in the 20th century came to be known as Luo and Abaluyia was, on the one hand, "fluid, highly adaptable, and capable of absorbing outsiders easily" (Waller, 1985: 348-349) and, on the other, constricting. Though the precise nature of the Luo/AbaNyole frontier can only be conjectural, there is reason to believe that land was extremely important for pioneering groups and individuals in defining who they thought they were.

Though no precise figures are given, a number of writers, among them early travellers in this part of East Africa, have noted and extensively commented on both land use patterns and population concentration in the southern parts of what was later to become Kavirond District. Harry Johnston (1902: 738-739), travelling through this area during the last decade of the 19th century, has for example noted not only the high population density in this area, but also what he thought was the "destructive" nature of these peoples' agricultural practices. According to Johnston,

The Kavirondo are essentially an agricultural people. Both men and women work in the fields with large iron hoes. As usual, their agriculture, being of the negro order, has been destructive to forests. The whole of Kavirondo was once covered with dense forest of a rather West African character but trees are now scarcely even seen except in the river valleys. The people would hew down all the trees they could fell, and burn the branches and trunks, mixing the ashes with the soil as manure. These fires would often kill the bigger trees less easily to bring down by the native axes, and in time these would die, decay, and fall. After the land had borne two or three good crops it was abandoned and a fresh piece opened up. The country, therefore, outside the plantations is mainly rolling downs covered with thick grass (1902: Ibid. Emphasis in the original).

The historian John Osogo (1966: 36) has pointed out that at the time of the arrival of some of the pioneering groups, that is from 1650 onwards, the present Maseno-Luanda area
extending into Bunyore and Seme locations in Luoland was one of a number of densely populated 'pockets' in Western Kenya.

If these observations are anything to go by, then Richard Waller's (1985: 347-349) argument in a general statement on the "processes of expansion and ... adaptation to the environment" by the various East African peoples in the 19th century must be taken with a lot of caution. According to Waller, it was "labour, rather than land, (that) was the scarce resource" which placed a "high premium on the ability of pioneering groups or individuals to contract and manipulate effectively a wide range of kinship and other ties in order to mobilize the social and political resources necessary for colonization." It is on the basis of this 19th century 'paradigm of colonization' that Waller reaches the conclusion that due to the "need for mobility, there were few barriers to the flow of population from one small-scale unit to another and definitions of identity tended to be inclusive rather than exclusive". We would like to argue that, contrary to Waller's paradigm, from the time of settlement in the middle of the 16th century to the end of the 19th century, the notion of difference between the people who came to be known as the AbaNyole and their southern neighbours was shaped partly by anxieties over the fear of 'being hemmed in,' partly by the environment they came to occupy, and partly by the surging Luo-frontier which constricted their mobility, making their definition of identity both an inclusive and exclusive affair. It was inclusive in the sense that Bunyore as a geographical entity was populated by people from diverse origins; exclusive because with time these people came to see themselves as being different from their southern neighbours, the Luo. The most important question here is, therefore, how does this conglomerate category of diverse groups of people come to define itself exclusively? The answer to this question lies partly in the nature of the relationship between this conglomerate and what it came to call Abakami (present-day Luo), and partly in the relationship the conglomerate established with the environment it came to occupy.
According to Bethwell A. Ogut (1967: 154), Luo expansion into Alego, Sakwa, Asembo, and Uyoma from "the small area around Ramogi Hill" took place between 1560-1640. But, between "six and seven generations ago, South Nyanza was invaded; and the process was completed when the Luo finally abandoned their traditional habitat and invaded the higher areas of Gem, North Ugenya, Kisumu and North Seme about two to three generations ago", or sometimes between the second half of the 19th century and the first decade of the 20th century. This last wave of invasion brought the Luo into direct confrontation with the Luyia-speaking Bantu of Maragoli, Kisa, and Bunyore. On this, W. E. Owen (1923: 67), drawing on oral data, has pointed out that pressure on the AbaNyole at this time invoked ill-feelings as, only a few generations back, the Luo had driven them, or at least the original settler groups, out of lands "they occupied ... away to the West of their present holdings, land now in the possession of the Kavirondo Nilotes." According to Owen, the Nyole "traditional founder, by name Omwa, lived 45 miles to the West of their present location".

The struggle which goes on in the mind of the Bantu narrator (Owen continues) is amusing at times, for he is obviously unwilling to admit any superiority of prowess on the part of the Nilotes, and yet resentful that lands formerly in the possession of his tribe have been wrested from them, and are now in the possession of their old-time enemies. So though they have lost much land it is never because they were not as good and as brave men as their conquerors. They generally attribute their defeat to "frightfulness" and "ruthlessness" on the part of their enemies which they themselves were too humane to resort to (Ibid.: 67-68).

This observation, especially on the methods the Luo used in dealing with the AbaNyole, is corroborated by oral evidence I collected during fieldwork. According to one of my informants Omukambi Glaid Namweya, in their acquisition of land belonging to the AbaNyole, the Abakami (Luos) used a type of medicine called Laluthi. They used to light a fire using this medicine and "deliberately make the smoke from the fire to blow towards the AbaNyole. The smoke stung the eyes, making the AbaNyole to run away. The smoke was also a sign that abasuku - enemies - were on their way to kill the AbaNyole. As they
ran the AbaNyole left their land to the Luo, though they argued that they were giving
shelter to Omukamii (the one who seeks shelter). When the AbaNyole later claimed their
land back the Omukamii used an imitation of omurundo (gun) to scare them away.8

The differences these observations intimate at do not however mean that there
always were hostilities between the AbaNyole and the Luo. As Gideon S. Were has
pointed out, these differences were more often than not between not whole ethnic groups
but between neighboring Luo and 'Nyole clans. There is evidence to suggest that some
'Nyole clans used to call upon their Luo counterparts to help settle differences with other
fellow 'Nyole clans. This indeed seems to have been the case in the Nganyi-Odera alliance
towards the end of the last century. Furthermore, just as much as certain Luo clans came to
respect the AbaNyole for their rainmaking knowledge, there were others who came to
depend on 'Nyole magic and medicines in settling their own clan disputes in Luoland
(Whisson and Lonsdale, 1975). In addition to this, there was not only trade between the
Luo and the AbaNyole, but also cordial relationships between families as well as whole
clans that were made even stronger through marriage arrangements. These relations were
further cemented by the fact that during their escape from their former lands, some
AbaNyole remained behind, or went back after the conflict not to expel the Luo but to settle
down and live peacefully with them. Such groups are the Kasagam (related to the
Abasakami), Enyamwalo (related to the Abalielo), Otombolo or Abatombolo (related to
the Abatongoi), and Kachuka (related to the Aberanyi).9 The nature, and ramifications, of
these relations led Archdeacon W. E. Owen (1923: 68) to make the all too important an
observation that the 'Nyole retreat "before the Luo was not a retreat, lock, stock and
barrel."

What emerges from the foregoing is the fact that by at least the beginning of the
19th century there is a group of people that starts identifying itself as the AbaNyole. This
stands in direct contradiction to our earlier observation that what we know today as
Bunyore comprises a congeries of people who cannot claim to be an ancient people struggling in the 20th century to reclaim some original unity. How do we resolve this contradiction? To argue that a 'Nyole identity is an invention of this century is to throw into doubt the question of language, or culture, as a major defining characteristic in the constitution of this identity. While it is true that the linguistic boundary on their southern border is sharp, and cultural practices like circumcisions are quite distinct among them as opposed to the Luo, these cease to hold any force when it comes to their fellow Luyia-speaking northern, eastern and western neighbours. Language and culture as bases for identity-formation are further complicated by a number of factors. First, the full history, or histories, of the many clans that are now said to comprise the AbaNyole, as well as their interrelatedness, is largely unknown. Second, there is the problem of the tendency towards a pan-Luyia unification as an aspect in the overall ethnic process in modern Kenya. Third, it is difficult to unravel the different strands of linguistic, cultural, and political traits which contemporary ethnic chauvinists see as but one, holistically integrated package but which in fact may have been less coinciding.10

Be that as it may, it seems that it still is linguistic and cultural affinities between the 'Nyole clans that unite them under a common ethnonym that, far from being merely situational, points to an original shared identity. As far as the internal composition of these clans is concerned, they have, historically, ceased being localized since their members live side by side: the ethnonym has acquired such hegemonic qualities as to obscure the fact that the AbaNyole are not so much a people, but rather a historically heterogenous group. It is from this perspective that their self-definitions, hence their idea of being one people, should be looked at. The dynamics of these self-definitions should thus be sought from Bunyore itself because the AbaNyole, whether as a group or as a collection of individual clans, were from the 16th century onwards caught up in complex regional relations and subtle social and political discourses with their neighbors and with each other. These were
processes which, as John and Jean Comaroff (1991: 126) have pointed out in the case of the Tswana of South Africa, "gave historical notion to the construction of economy and society."

Perhaps the best point of departure in comprehending these processes is the concept of 'bene liloba (the owners of the soil), and the articulation of this concept with notions of abameniyibwa (tenants-at-will), abarende (neighbours but can also mean enemies from within), and abasumba (dependents). The centrality of these concepts lies, in part, in the fact that instead of kinship or dialect groups, identity lay in membership of the polity in which families and individuals moved freely, settling as citizens in particular clans "membership of which then constituted their prime collective identity" (Ranger, 1993: 225) and, in part, in the relationship pioneering groups established with their environment. It can from this perspective be argued that as a recent "expansive, enlarging identity," a culturally and linguistically-constituted Luyia 'tribe' overlaps with, rather than prevents, "the simultaneous imagination" of a 'Nyole polity that has constantly redefined itself within the parameters of competition over land in the southeastern region of the Luyia-speaking Bantu of Western Kenya. Thus, instead of a conglomeration of "face-to-face, microcosmic communities encrusted in tradition, tied to one spot" (Ranger, ibid.: 225-226) and jealous of their sovereignty as Were would like us to believe, clans and the relations between these clans were dynamic rather than givens. The motor force of this dynamism (in the widest networks of human interaction and identity) were a repertoire of symbols around which social idioms proved to be adaptive and innovating, "answering to the needs of ('Nyole) re-imagination" of community and identity (Ranger, ibid.).

As Wim van Binsbergen (1992: 18-19) has argued in the case of the Nkoya people of Central Western Zambia, "(i)entity formation goes hand in hand with the construction of a common past." This indeed is the case with the AbaNyole who, when asked who they are, seek to state their unity by tracing historical links between the various clans that
constitute their polity. The commonest way to claim such links has been through the
genealogy of Anyole, the eponymous founder of Bunyore. According to oral traditions,
some thirteen to fourteen generations ago (between 1487-1522) a group of ten brothers
named Muhindila, Muhando, Ngome, Andimi, Wekhomo, Mugusi, Etende, Ekongo,
Musali, and Tarime arrived at a place called Etiencyele which was near the present city of
Kisumu. This place was in a valley therefore the group was anxious to "see and know"
what lay beyond. They decided to disperse: one group of five decided to go round the
Inyanza (Lake) and the other -- Muhindila, Muhando, Musali, Ngome, Wekhomo -- moved
in the opposite direction towards present-day Bunyore Hills "to discover for themselves
what lay in the distance beyond the valley."11 When they reached a hill called Esia Nganyi
in present-day Lela, they discovered land that was fertile and full of pumpkins, fruits,
water melons, and potatoes. They moved further on, coming to Ebuando hills where they
found the Abarua living in Mulwangaywa (cave). These Abarua attacked the strangers,
killing Musali and forcing the remaining four to retreat back to Lela. They did some
investigations after which, one night, they smoked most of the Abarua in the cave to death.
Those who managed to escape left a child, whom the strangers called Amaatsi, behind.

It is in this area, the Ebuando Hills (after Muhando) and its environs, these
invaders settled. It is here that Muhando gave rise to the Abahando, and Ngome to
Abamachinaa. Muhindila and Wekhomo moved on further to the west and settled at
Wekhomo, a place named after one of them. Muhindila gave rise to Mwenje who in turn
gave rise to Munyole. Munyole died before his wife, who was pregnant, gave birth to a
son whom she named Anyole. Anyole in turn gave rise to three sons: Amuli, Siratsi, and
Amutete. These are the founders of the Abamuli,12 Abasiratsi, and Abamutete group of
clans that are considered to be the "typical AbaNyole since they are the descendants of
Anyole" and, together with their cousins Muhando's descendants, are considered as 'bene
liloba'.13
According to 'Nyole oral traditions collected by Gideon S. Were (1967: 10) in the 1960s, there are twelve clans of the AbaNyole "all of which were founded by Anyole and his sons." These are the Abamutete, Abasirinsi, Abamang'ale, Abatongoi, Abasiekwe, Abasakami, Abasikhale, Aberanyi, Abamuli, Ababayi, Abamuhaya, and Abahando (Abalako). The earliest ancestor of the AbaNyole was Omwa. Omwa was the father of Muhindira who was father of Anyole, the founder of the AbaNyole sub-tribe. It is said that all these ancestors died at Wekhomo. Three things emerge from these genealogies. First, there are not twelve (even in the 1960s) but twenty-four major clans that comprise the AbaNyole sub-nation. Second, Asakami, Mwiranyi, Ambayi, Asikhale, Amang'ali, Tongoyi, etc. who are founders of clans that bear their names were relatively late-comers. Third, and this is important for the purpose of our argument, all these clans claim to have a common ancient toponym, Bunyuli in Uganda, though their cradleland like all the other Abaluyia sub-nations is in the oral traditions called Misri. The ethnonym Bunyore thus comes from both the name of one of the forefathers of the AbaNyole, and the name of the newly invented overall group - the AbaNyole. Somehow, in the process of this invention Wekhomo, one of the original four men, and the ancestor of the Abamachinaa, Ngome, disappear from the narrative. Is this an aspect of the treachery of memory in the reconstruction of Africa's past? This seems to be hardly the case because Anyole's children adopted the name Wekhomo for their ancestral homestead and Abamachinaa (Ngome's descendants) became the praise name for these pioneer clans. Ngome died and was buried in Ebuhandu (also called Bunyore) Hills and his descendants, Abamachinaa, were called not after him but after the physical characteristics of these hills. That Wekhomo and Amachina, geographical spaces, are central to the definition of who the AbaNyole think they are, is therefore crucially important.

The importance of these spaces lies in the fact that, first, the Luo, especially the Seme and Kisumu groups, came in their dealings with the AbaNyole to define them as
"those people from the other side of the hill". Environmentally this was a "situational identity" (Waller, 1985: 349) defined for the AbaNyole by the Luo. But the AbaNyole had, from the time of settlement, defined themselves geographically in relation to Bunyore Hills as the place where their forefathers settled first, but also as a protective entity they so effectively used in their confrontation with the first inhabitants of the place. Furthermore, in their identity-definition, these hills symbolized the need for "blood closeness" and hence the unity needed in confronting both hostile neighbors and the new environment they were occupying. This was the place where the blood of one of theirs had first been shed and, like the "circumcision blood" that binds the 'Nyole man with his soil/land, it became at once a reference point for belonging and a point of departure in their quest to colonize the "land beyond". It can, from this perspective, be argued that Bunyore Hills, among other things, came to define, first, the boundary between friends and enemies and, second, a will to power on the part of these pioneers.

Thus, if Wekhomo came to represent the ancestral homestead for Anyole's children, and Bunyore Hills (as the birthplace of Abamachinaa, literally 'of the stones') hardiness and resilience, in their complementarity they represented "principles of an essential whole" that spoke to the "idea of a primal unity and harmony" (Tuan, 1974: 20) among the AbaNyole themselves. But as open geographical spaces these were "mental worlds" constructed by pioneer settlers to not only "mediate between themselves and external reality" (Ibid.: 13), but also to symbolically cojoin them "and social facts with those of nature" (Tuan, 1993: 172). As we are going to see in the next chapter, this link between the individual, the corporate group, and the life-world (Devisch, 1993: 30-31; Kleinman, 1988: 4-5) found its most immediate resonance and expression in the Ebukwe-Mumbo (East-West) continuum that at once and at large established the parameters within which good and evil, but also life and death, could be talked about. It was within the framework of this link that was to be found not just the 'Nyole idea of "solidarity and the
coherence between the body, group, and cosmos," but also their notions of sickness, illness, and misfortune. Indeed, the latter were related to the former's "integrative notion of personhood and health" (Devisch, 1993: 30, 31). This is poignantly brought out by the fact that while the sun rose from the east, bringing with it all that meant well for the polity it set in the West where lay Inyanza (later called Lake Victoria in a colonial cosmology), a visual marvel that intrigued the AbaNyole not so much for its expansive majesty as for its location in Mumbo. In short, while the East signified life, Inyanza, and by extension the West, provided a space of reflection that had the capacity to reveal both evil and the otherness of death (Lattas, 1993). Thus it was that in 'Nyole every-day activities the prayer was esibi sitite 'khukwa mumbo (let evil go to the west) as the sun arrives where Matwasi yekhul'la nyina (Matwasi wept over the mother's death).

It is arguable that, and notwithstanding some historians' uncritical acceptance of the AbaNyole's claim to an external, ancient and unitary toponym called Bunyuli, the ideational value of Wek homo and Bunyore Hills as representations of being and oneness draws our attention to an internal process of becoming that spoke at once to the ideology of 'bene liloba; the rules of incorporation or exclusion into an emergent polity; and the relationship between members of this polity and nature. In this process "the appeal to the grave sites of their (pioneers) forefathers" (Owen, 1923: 73) or to the notion of habakuka bakoona (where our forefathers slept) became important, while those who arrived later did so either as abamenyihwa, abarende, or abasumba. To belong to any one of these three categories was to be esiekenye (naked) since your forefathers' tsing'ani (graves), and your tsingobii (placenta) lay somewhere else. This meant that until they had passed away, and their offsprings had gone through "three or four generations" to become abamilikhaa (absorbed or merged ones) with their own graves to look at, they were "confined in (their) choice mainly to seeking a tenancy on land" that belonged to 'bene liloba (Owen, 1923: 74).
2.6 Conclusion: Community and Cosmos.

From the foregoing, it seems that for one to understand the various strands that have gone into the definition and constitution of a 'Nyole identity, one must of necessity begin by taking cognizance of factors that go beyond a cultural-linguistic homology. It is our argument that this beginning lies at the intersection of the social and the political, and also in the meanings the AbaNyole have through time and space inscribed into their physical landscape. The implications of this argument are quite clear. First, if Wekhomo and Bunyore Hills were, and still are, used to speak about the AbaNyole in their early period of settlement, this does not in the least mean that there indeed was such a group whom we must historically trace to some cradleland outside Bunyore itself. As ideational spaces and mental worlds in the establishment of "relative positions on the cognitive map of (an) expanding frontier" (Waller, 1985: 349) in Western Kenya, the symbolic representations with which these features are invested alert us to the need for discarding the assumption of "continuity of social groups through time" and establishing "the continuity of certain types of identify through which different groups may 'pass' and to examine the factors which make this possible" (Waller, Ibid.).

Thus, and this brings us to our second point, to argue against unilineal and unidirectional tendencies explicit in the notion of the continuity of social groups through time and space while at the same time privileging the processual nature of identity formation is to do two things at the same time. First, the argument anticipates in the following chapters questions about the resilience of what John M. Janzen (1989: 227, and 1992: 57-84) has called African civilizational traditions in the face of aggressive and often destructive religious and medical forces emanating from outside the continent.16 Second, to deny the notion of the continuity of social groups through time and space is to suggest, contra Eurocentric developmentalist and scientific discourses, that "(i)n order to understand and value the spectrum of Bantu healing practices in their own right, it is necessary to study
their group ethics, religion, and cosmology" (Devisch, Ibid). This is the more so because, and unlike in the bio-medical traditions where emphasis is on a person's physical well-being, in African societies health pertains to the "interactive spheres of physical, social, and spiritual life" (Ibid.: 30). Thus, to look for "a framework of totality" (Janzen, 1989: 229) is to both seek for the "underlying conceptual framework and the logic of ... symbolism with regard to solidarity and the coherence between body, group, and cosmos" and establish the rationality of "healing practices and symbolic imagery ... as condensed expressions of beliefs and etiologies concerning man, descent, life, good and evil, and the resonance between the various fields of experience" (Ibid.).

Thus, as crucial elements in the process of coming to be, the issues involved in the production of a health culture in Bunyore before the 20th century went beyond the individual's physical well-being to embrace the entire spectrum of the essence of belonging and one-ness. Problems of health were also social and political problems since their incidence obstructed, disconnected, or deflated the "legitimate bonds connecting body, group, and life-world into one single vital unity" (Devisch, 1993: 31). The comprehension of these bonds is therefore significant. Its significance lies in the fact that in the AbaNyole's "unfinished process of coming to be" (Lonsdale, 1977a), the "problem of symbolic mediation" (Comaroff, 1985: 5) had by the 19th century come to command such an overwhelming position that ideas about polity and its constitution went beyond society to encompass transcendental cosmic elements that were used to explain or answer questions about life and death, the relationship between man and nature, and between the living, the dead, and the yet-to-be-born. This became even more fundamentally so sometimes in the first half of the 19th century when there arose what at first sight seemed to be an alternative center of power based on the art of rain-making and located not in Bunyore Hills or at Wekhomo but in Esibila Hills in Ebusiekwe, some eight miles to the southwest.
It is true that if Wekhomo continued, throughout the 19th century, to hold onto the idea that it was the center around which the forces of incorporation into, and expansion of, the 'Nyole polity gravitated, the rainmaking shrines which also claimed to shelter the 'Nyole god of fertility, Malondole, lay neither at Wekhomo nor in Bunyore Hills. This, it can be argued, pointed to two, and not one, centers of the circulation of power in Bunyore from the 19th century onwards. This is indeed what W. C. Hobley (1896), and the historian G. S. Were (1967a), had in mind when, while recognizing the importance of Wekhomo in Bunyore politics, saw the high priest at the rain shrines in Ebusiekwe as the chief of the AbaNyole in the 19th century. This is also what Aggrey Anduru, the 'official' historian of the Abasiekwe rainmaking clan, intimates at when he argues:

The first chief of the AbaNyole this century would have been Munala. He is the one (Nabongo) Mumia knew because he was a rainmaker. Nabongo Mumia picked on him to be chief but on the day he was to be crowned, the Abamutete tricked him by giving him a lot of alcohol so that he was senselessly drunk on this day. The crowning ceremony was to be held at Ebukhuka, now in Maragoli. So Otieno wa Ndali, an Om' mutete, was crowned chief as Munala had failed to turn up.17

Implicit in this argument is the question of conflict between Abamutete (Anyole's descendants) and Abasiekwe (offsprings of Abamenyibwa) over power. As to whether this also meant resistance on the part of Abasiekwe that can be traced back to the time of settlement is not clear. What is clear, however, is that Asieche, the eponymous founder of the Abasiekwe, Abakanga, and Ababayi group of clans, is said to have been an Omunyala (Navakholo) who on arrival in Bunyore settled at Emuhaya on the outskirts of Wekhomo. It is here that he begat Nerungo who in turn begat Amukhobo and Achetsi. Achetsi gave rise to Abakanga and Amukhobo to Ambayi and Asiekwe, the founders of the Ababayi and Abasiekwe group of clans, respectively. Tradition has it that it is here, in the land of the Abamutete, that Nganyi, Asiekwe's descendant, received his rainmaking knowledge.18

The woman who brought this knowledge, the tradition goes, told his husband and former
apprentice: "Nganyi, we better go near the hill, there we might find a chance of making rain."19 The most pertinent question here is: Why did they move to Esibila Hills, and not Bunyore Hills in whose shadow, as a matter of fact, they were staying? Can this be construed as conflict, even resistance?

Seen from the point of view of an expanding polity, this question touches not only the efficacious nature of Wekhomo and Bunyore Hills in the constitution of this polity, but also how, as symbols that shaped social relations, they provided the parameters in which the forms of power and knowledge they exuded constituted "the critical conditions of social reproduction and change" (Apter, 1993: 7). If migration and settlement were both event and process, and both spoke to different levels and networks to which they belonged, the reconstitution of the lines along which they were connected and engendered each other (Foucault, 1980: 1140) alerts us to, first, the fact that as legitimating symbols of one-ness and belonging Wekhomo and Bunyore Hills were neither static nor strictly determinate. Second, to understand the 'critical conditions of social reproduction and change' embodied in these symbols we must move from "the symbolic field or the domain of signifying structures" to an analysis of "the genealogy of relations of force, strategic developments, and tactics" (Ibid.) that must have gone into the making of the 'Nyole polity. This is the more so because as essential as they were "to the general functioning of the wheels of power" (Ibid.: 116), their role in the constitution of a 'Nyole identity did not take place outside history. Thus, at the level of history, they must be understood in terms of how they help us account for the constitution of knowledge, discourse, or domains of objects "without having to make reference to a subject which is either transcendental in relation to the field of events or runs in its empty sameness throughout the course of history" (Ibid.: 117). Thus, if Wekhomo and Bunyore Hills shaped social relations during and after the time of settlement, they did so not in "a strictly determinate sense, but dialectically, under historical conditions of political and economic competition and transformation" (Apter,
1993: 6). This, at least at the level of the ordinary contexts of everyday life, reminds us that as the *standi loci* for acceptance and incorporation into a 'Nyole polity, these symbols were sooner or later bound to be contested "either openly, in heated debate, or implicitly, in deeper interpretations" (Ibid.) of what they meant for *bene liloba, abamenyibwa, abarende*, and *abasumba*. They were thus not "simply fixed" by *bene liloba*, but shifted "between deep and official levels to index the powers which render(ed) them efficacious and dangerous or the authority which establish(ed) them as orthodox and safe" (Apter, 1993: Ibid. emphasis in original).

It is on the basis of this we would like to argue after Jean and John Comaroff (1991: 23) that as the embodiment of an emergent hegemony, Wek homo and Bunyore Hills as discursive tropes in a totalizing vision were marked for what they silenced, what they prevented either *abamenyibwa, abarende*, or *abasumba* from "thinking and saying", what they put "beyond the limits of the rational and the credible". From this perspective, it can be said that the acquisition of rain making knowledge by an *omumenyibwa* exposed these tropes's hegemonic "hidden and axiomatic terms ... to discursive articulation and negotiation," turning them into objects of not only symbolic, but also, ideological struggle (Ibid.: 24). If by ideology is meant the fusion of "the conscious management of ideation" and "the practical constitution of the everyday life" (Comaroff, 1985: 4-5), the symbolic and ideological struggle in which Wek homo and Bunyore Hills came to be embroiled in was one that took place at the level of "contestation of the given world and ... the revision and revaluation of its most essential forms" (Apter, 1993: 22). It thus follows that the acquisition of rain-making knowledge by Nganyi and his move to Esibila Hills represented not resistance, *per se*, to the hegemonic tendencies of *bene liloba*, or even a binary opposition within the emergent 'Nyole polity; its acquisition and move to Esibila Hills took place within the framework of "the ends of a continuum" (Comaroff and Comaroff, 1991: 28) that, at one level, alerted *bene liloba* to the needs of re-emphasizing the rules of
incorporation into a 'Nyole polity, thus transforming hegemony into an ideology and, at another level, represented a dispersal of power and "an enlargement of the social field of action" (Lonsdale, 1977a: 850) that incorporated elements of the natural and the supernatural to provide "an organizing scheme for collective symbolic production" (Comaroff and Comaroff, 1991: 24). Hegemony and ideology, in this case, came to exist "in reciprocal interdependence" (Ibid.: 25) in that if hegemony represented ideology naturalized, ideology represented hegemony conceptualized.

But at the cosmological level, the move to Esibila Hills by Nganyi symbolically represented a vertical element in the 'Nyole landscape that came to link rain with the fire that was supposedly located in these hills. According to 'Nyole oral discourses Malondo, the god of rain, clouds, and hail, lives in Esibila Hills and anyone "who went (there) to collect firewood ... and failed to take delicious food to (him) never came back, or if she went with a child, the child would be left behind. The god enjoyed children's flesh and children were never allowed to go to the hills alone" (Aswani, 1972: 5). Malondo was also god of fertility and rainmakers "were and are still (his) prophets and they share his powers when they cause rain" (sic) (Ibid.). A cross-section of those interviewed on this point argued that before Nganyi's move to Esibila, the place was only known for its 'everlasting fire' whose owner, Malondo, lived in a sacred spot in the hills called Esilemba siomu. It is here, from a dead wood called omukomari, the AbaNyole got fire whenever their hearths went out. When Nganyi moved to the hills, he set up his ebijimbilo (rain-making shrines) at esilemba siomu though, with time, he established a second esijimbilo at a place called Andatsa not far from Esilemba Siomu. Now, in 'Nyole cosmology, fire and rain represent maleness and femaleness, respectively, so much so that while the one directs our attention to a striving consciousness as opposed to Wekhomo (the horizontal element) that brings to mind the notion of acceptance and rest as captured in the idea of habakuka bakoonu (where our forefathers slept), the other evokes ideas about
femaleness, fertility, and potential power. In other words, Esibila Hills as a place where both fire and rain could be obtained came to symbolize, on the one hand, a feminine side of 'Nyole personality as well as wisdom and regeneration and, on the other, a sense of striving consciousness. The juxtaposition of these two elements therefore came to represent the 'Nyole conscious striving for whole-ness (which had hitherto only hegemonically been expressed in terms of what Wekhomo and Bunyore Hills stood for). It is this juxtaposition which renders possible our comprehension of the cosmological link between, on the one side, 'bene liloba and habakuka bakoona as a hegemonizing cultural tenet and, on the other, the expansion of the 'Nyole landscape that lay in the abilities of new arrivals — abamenyibwa. It is within this perspective that, first, the AbaNyole sought to resolve the contradictions they encountered in life of which the most fundamental and painful was the antinomic pair in their experience of life and death and, second, the myth of a single origin and the idea of 'bene liloba together became partly an attempt to resolve the dilemma of heterogeneity and partly a tool for envisioning a state in which the forefathers were dead yet alive, mediating in the everyday life. Thus mythical thought came to transfigure death into a constant process of "coming to be". What is the place of health and healing in this worldview? To this question, in the next chapter, we now turn.
1 The Abatirichi of Hamisi division have extensively been studied by Walter H. Sangree (1962, 1960a, 1966b) and Walter H. Sangree and Robert A. LeVine (1962). The Abalogoli (Sabatia and Vihiga divisions), were, alongside the Bukuusu of Bungoma District, the subject of Gunter Wagner's anthropological studies in the 1930s and 1940s. They have extensively been treated in The Bantu of North Kivirondo (1949 and 1956) and a series of articles e.g. Gunter Wagner (1939, 1940, 1954). The Abalogoli have also been studied by among others, Robert F. Stevenson (1968); Andrew N. Ligale (1966); Joseph W. Ssenyonga (1978); and Judith M. Abwunza (1990, 1993). Recent research on the AbaNyole include Helen Aswani (1972); Jane Nandwa (1976); Douglas Brian Paterson (1984); and Mary Nyangweso (1992).

2 Douglas Brian Paterson's (1984: 50, 54, 58-59, 63) analysis of the 1969 Kenya National Census shows that with 530 people per square Kilometer (just about 1,370 people per square mile), Bunyore had "about one third higher than the theoretical maximum (number of people) the area could support at the subsistence standard." This density had by 1979 risen to 665 people per square kilometer, or about 1,729 people per square mile, making Bunyore "one of the highest (densely populated) in Kenya for a rural agricultural area." From the 1969 and 1979 censuses, Paterson concluded that the scarcity of land in Bunyore had since the 1960s been quite severe. This was even the more so because the figures given in the two censuses represented the de facto population since the AbaNyole who lived outside the area viewed their absence as temporary: they maintained strong social and economic ties with their homes. They participated in "the major decisions" and "flow of goods and cash between migrants and their village homesteads" and they remained, in most instances, "an integral part of the household as an economic unit." Thus, while some men and women left for work or to look for work, others, having been dissatisfied with their employment, or having retired, or having been terminated or dismissed, returned home "for a rest" or to pursue other income generating activities within their villages. On the role these migrants play in maintaining their villages economically and socially, see also Douglas Brian Paterson (1980 and 1981).

3 This is a 'Nyole saying which literally translates as "the year is permanently in a state of flux" and is used to at once convey a sense of change, indeterminacy, and, as one elder put it, "the need for one to always turn his head after at least every three minutes lest he found himself caught unawares by the constantly changing world."

4 This issue has recently acquired new dimensions in both historical and anthropological discussions relating to, first, the relationship between micro- and macro-level processes of change and, second, whether this relationship can be subjected to the rigours of theory. Starting with the interrogation of the concept of 'tribe,' recent scholarship seems to be agreed on the fact that as a unit of study this is at best contradictory. It is contradictory because, on the one hand, it speaks to the dangers of totalization, thus obscuring the importance of local social and cultural processes which might point to "differential response to macro-processes of political economy" and, on the other, it re-presents African communities as entities that have endured forever (Sharp, 1985:67-71). At the level of theory, this discussion has focussed on the problem of 'grand' theory in disentangling issues relating to specific historical instance. The central question here has been how does one discuss the effects of local and at times mundane happenings on larger regional or national economic and political processes? Doesn't grand theory obscure regional variation in historical process and local response? It is precisely on the basis of this interrogation that
modernisation, center-periphery, and modes of production analyses have been critiqued in African studies. While modernisation theory has been criticised for tending towards the rendering of "all undeveloped" societies equally backward in the sense of being enmeshed in stultifying cultural inhibitions which prevented progress, and the role of spreading bourgeois values was everywhere the same - to overcome such barriers" to progress, dependency theory has come in for a beating because of its "overly centrist perspective". The Althusserian (revisionist) Marxist mode of production analysis wasn't spared, either, because, the argument goes, it "tended towards abstract and ethereal analysis of pre-capitalist social formations and of the process of their articulation with the capitalist mode of production" (Ibid.:72). The result of this critique has been, on the one hand, the insistence on the part of certain scholars (Prins, 1978, 1979) to jettison grand theory and return to local-level empiricism and, on the other, a plea for grounding the understanding of twentieth-century African communities within the framework of a widening universe whose dynamics were and are not given (John Comaroff, 1982; Jean Comaroff, 1985; Feierman, 1991). The kind of approach advocated in the latter view and which this study adopts has well been summarized by John Sharp (1985:81) who argues that it allows one to "conceptualize the relationship between the unit of observation and its context in a way which reifies neither, which makes the internal organization of the former a consequence of historical process and, at the same time, a system of meaning for the people who experience it. The focus on meaning as well as history in the unit of study implies, of course, a rejection of the simplifications of functionalist or economistic explanation. But the focus on meaning as the outcome of historical process indicates a like questioning of the basis of much anthropological discussion of culture."

Thus, and as Jean Comaroff (1985:3) has put it, instead of emphasizing the "stubborn dichotomies in the legacy of modern social analysis -- the division between global and local perspectives; between materialist and semantic interpretations; between structuralist and processual models; and between subjectivist and normative methodologies," it is possible, and more fruitful, to explore the viability of a dialectical approach to the life of a single social system at whose center is the understanding of the "reciprocal interplay of human practice, social structure, and symbolic mediation, an interplay contained within the process of articulation between a peripheral community and a set of encompassing sociocultural forces. (This is the more so because) ... (i)n Africa ... the relationship between local social orders and the agencies of the world system shows clearly the inadequacy of synchronic models that presuppose the "perpetuation" or "reproduction" of existing sociocultural structures. But they also believe the assumptions of teleological models of transformation (whether of "modernization" or "dependency") which beg all the key questions about the nature and direction of historical processes. Both local and global systems are at once systematic and contradictory and they became engaged with one another in relations characterized by symbiosis as well as struggle."

5Though implicitly his definition of geographical space lies within the realm of modern administrative boundaries, it raises the question, out of the logic of his own argument, whether these boundaries can be said to have any meaning in and for the past.

6This is done through a kind of 'front stage' and 'back stage' discourse in the constitution of their identity. On this question see also W.P. Murphy (1990) and J. Scott (1991).
The Luo and Abaluyia as concrete ethnic groups are twentieth-century inventions. Thus there is an asymmetrical relationship between these entities and their nineteenth-century counterparts.


Interview, Nyonje Atieli, Es'saba Sub-Location, West Bunyore, December 10th, 1992.

I owe these observations and much of what follows in the next paragraph to the work of Wim Van Binsbergen (1991:17-18).


Other oral data point to the fact the Abamuli are not Anyole's offsprings. It is argued that they are of Maasai origin but it is not clear as to whether they are related to Amaatsi, the child the Abarua left behind when they fled on the arrival of Muhindila and his brothers. G.S.Were, but also John Osogo, point to the fact that they are cousins to the Maasai.

Oral Interview, Aggrey Anduru, op.cit.

ibid.

Yi-Fu Tuan (1993: 172) argues that space becomes symbolic when "it intimately conjoins human and social facts with those of nature." Thus it becomes "a mental artifact, necessary to the ordering of life, and so in this sense it is a practical venture." But symbolic space is also "infused throughout with the aesthetic value of balance, rhythm, and affect."

According to John M. Janzen, African civilizational traditions are those "integrative patterns, assumptions, and values in African cultures, which have over the centuries been confronted by, yet have often absorbed, external medical and religious influence."

Historically deep and environmentally adapted, these traditions are "agricultural, technological, social, political, religious, and therapeutic institutions bearing rich linguistic, ritual, and artistic expressions". Indeed, "(F)or the past thousand years these civilizational forms have shaped African life, slowly and surely evolving sets of their own distinctive therapeutic ideas, practices, and institutions and adapting to local environmental dictates. It has often been these distinctive features that have determined how therapeutic and religious notions would be received .... In therapeutics there has been found much mutual shaping and a forging of syntheses. Many themes and features of the classical civilizations continue, fused with or alongside themes of scientific-industrial civilization: wage-labor alongside kinship and community cooperation, localized place spirits together with Christianity and Islam, laboratory tests side by side with divination, mass-produced pills and hand-made herbal treatment." Janzen's contention which we would like to adopt for this study is that to talk about African civilizations and traditions or, to be more specific, what Rene' Devisch (1993: 25) calls "African health cultures," is to look at things from "a
framework of totality that encompasses the combined analytical and substantive scope of pertinent ideas, assumptions, and institutions represented in society" (Janzen, 1989:229).

17 Oral Interview, Aggrey Anduru, Ebusiratsi Ekamanji, North Bunyore, December 29, 1929. G.S. Were’s (1967a), and also Hobley’s (1896) idea that Nganyi was the chief of the AbaNyole in the 19th century comes from the confusion of the Nyole word omuruki for ruler. Though this word has in this century increasingly come to be used interchangeably with omwami, in the nineteenth century, or even earlier, it was used to refer to a person with emiruko (many domesticated animals). From evidence collected by Gunter Wagner (1949:144-159) among the Abaluyia, it seems that Nganyi’s riches derived from tribute or presents from people who came to him for rain. As Wagner points out (p.145), "In the southern part of the North Kavirondo District there is only one family of reputed rainmakers which belongs to the Nyole tribe. The sphere of their influence is not restricted to the Nyole but extends to the Logoli, Tiriki, Kisa, Idaxo (sic.), Isuxa (sic.), and some of the Nilotic Luo as well. Delegations from all these tribes come to consult the Nyole rain magician if they are in need of rain .... (In an area populated by a third of a million people there are only seven or eight rain-magicians each of whom is consulted by people belonging to different and (formerly) even hostile clans .... The Nyole family of rain-magicians enjoys by far the highest reputation in the whole of Bantu Kavirondo .... According to my informants, the Nyole rain-magician owes his high reputation to the fact that he has repeatedly given startling proof of his ability both to cause the rain to fall and to withhold it ...." As Wagner correctly points out, the Nyole rain-maker also received "the most substantial tribute or presents" and could not be "approached privately by ordinary people but only publicly by a delegation of the highest clan-heads of the tribe" (p. 157). It was said that "formerly people would never have dared to challenge the omugimba (rainmaker) for withholding the rain, but they would have increased the number of their petitions and the value of their tribute" (p.158). Wagner concludes that inspite of "the greater or lesser prestige which the rainmaker enjoys everywhere among the Bantu Kavirondo, his status has remained that of a departmental expert and has not been linked with that of a 'chief' exercising political authority" (p.159. Emphasis added).

It can be argued that beyond tribute-paying, rain-making was territorially significant in the constitution of a ‘Nyole identity. Apart from Bunyore Hills and their granite boulders as signifiers of ‘Nyole solidarity (the notion of Anyole lichina), the rain cult came, in the nineteenth century, to symbolize not only the regenerative/productive power of the AbaNyole but also, in its transcendence of local disparities and hostilities, to signify the macrocosm, the unbounded order beyond that of the ‘Nyole community. From this perspective, it can be said that the cult mediated a moral and social order shared by all the AbaNyole and those beyond the ‘Nyole boundaries. The embeddedness of this order was respect for the earth as the essence of being and becoming, and for the neighbours whose constant ‘investment’ in the regenerative and productive capacity of this earth was reflected in the nature of presents given to the rain-maker. Thus, the cult simultaneously stood for the construction of a ‘Nyole identity (ifwe khuli abajimbi/AbaNyole na’abajimbi: we are rain-makers/the AbaNyole are rain-makers), and the wider regional social and economic order that was agricultural, or increasingly becoming so. In other words, though part of the intense local pride arose from an imaginative reality codified from the possession of this knowledge ‘by one of us’, the idea of possession vis-a-vis ‘those others’ without paradoxically came to less and less represent the local community and more and more concern itself with the representation of a trans-tribal social and moral order.
18Cited in one of the oral texts collected by Gunter Wagner (1949:154). For a full account of the origins of rain making knowledge in Bunyore see Gunter Wagner (1949:152-157).
CHAPTER THREE
HEALTH IN 'NYOLE COSMOLOGY

3.1 Introduction: Structure or Practice?

In an attempt to establish whether there is a 'Nyole epistemic domain in which ideas about health and healing can be situated, we have in the preceding chapter argued that in the constitution of their identity, the AbaNyole have always had recourse to a repertoire of symbols around which social idioms for answering to the needs of, and imagining about, community are constructed. It is on the basis of this we argued after Yi-Fu Tuan (1974:20) that two of these symbols, Wekhomo and Bunyore Hills, in their complementarity, represented the "principles of an essential whole" that spoke to the "idea of a primal unity and harmony" among the AbaNyole. It was further argued, again after Yi-Fu Tuan, that these were "mental worlds," constructed by pioneer settlers for purposes of not only mediating between themselves and external reality (Ibid.:13), but also to symbolically conjoin them "and social facts with those of nature" (Tuan,1993:172). From this, we concluded that to understand the various strands that have gone into the constitution of a 'Nyole identity, we must go beyond a cultural-linguistic homology and embrace the meanings these people have through time and space inscribed into their physical landscape.

But, as the embodiment of an emergent hegemony, these geographical spaces were in their totalizing vision marked for what they silenced or prevented later settlers from "thinking and saying," what they put "beyond the limits of the rational and the credible" (Comaroff and Comaroff, 1991: 23). It was not until the acquisition of rain-making knowledge sometimes in the early part of the nineteenth century that there occurred a dispersal of power that represented what John Lonsdale (1977a:850) has called the "enlargement of the social field of action." This, for the first time since settlement, introduced within the 'Nyole polity a discontinuity between, on the one hand, Wekhomo
and Bunyore Hills as elements of incorporation into an expanding social structural field and, on the other, the not undifferentiated cultural field brought in by different groups of people. Thus, the acquisition of rain-making knowledge, but particularly the natural and supernatural powers that were thought to inhere in this knowledge, led not to the social and cultural disintegration of this polity; it instead led to "social and cultural conflict" (Geertz, 1973: 164) which underpinned the search "for new, more generalized, and flexible patterns of belief and value" (Ibid.:150) that found their meaning in a new "organizing scheme for collective symbolic production" (Comaroff and Comaroff, 1991:24). Thus, the symbolic complexes that rain and fire came to bear onto the hitherto existing social structural field posed challenges that did not throw the community into disarray but rather gave bearings to a nascent worldview in which rain came to represent femaleness, fertility, and potential power and fire maleness and striving consciousness. It is on the basis of this we concluded that migration and settlement as event and process were about the quest for coming-to-be, and that the enlargement in the social field of action found its full expression in Esibila Hills which, as the place where both fire and rain could be obtained, symbolized the two emergent sides of the 'Nyole polity -- striving consciousness and regeneration.

It might be argued, and quite correctly, that this structuration gives the impression that the AbaNyole either had only one epistemological position, or that premium was placed on the collectivity and not on personhood and agency. This is indeed the position one finds in much of structural-functionalist analyses of African cosmologies during much of the colonial period, or in social anthropological studies that, in varying degrees, concerned themselves with either an individual's powers and obligations in society or the role of the individual and the allocation of responsibility within the wider community.¹ An off-shoot of the late nineteenth-century "dominant theoretical prism through which all non-European peoples were perceived" (Moore, 1993:4) as evolving towards 'civilized' standards already attained in the West, and refined by social anthropologists like Bronislaw Malinowski
(1948) and A.R. Radcliffe-Brown (1952), structural-functionalist "central showpiece" in Africa was the "system" around which notions about "tribe" and "tradition" were organized and articulated (Moore, 1993:6).

According to this analytical framework, "all of the contemporaneous cultural and social features of a stable society" formed "part of a coherent and interdependent system." The role of the anthropologist as interpreter of such systems was that of only inferring the connections (Moore, 1993:8). Thus, for theoreticians like Malinowski "the small-scale society was not just the physical unit of study for practical reasons, it was the theoretically defined totality in which the functions of institutions and their integration within a cultural whole could be demonstrated" (Ibid.:10). This postulation was given much clarity and new impetus by Radcliffe-Brown's "emphasis on the importance of groups and of the way group solidarity was both constituted by and represented in a common stock of cultural norms" (Ibid.:11). Malinowski's functionalism was social-psychological, Radcliffe-Brown's sociological. Thus, though Malinowski emphasized how, for example, religion satisfied both the individual's "cognitive and affective demands for a stable, comprehensible, and coercible world, and how it enable(d) him to maintain an inner security in the face of natural contingency," Radcliffe-Brown placed premium on "the manner in which belief and particularly ritual reinforce(d) the traditional social ties between individuals," stressing as it were "the way in which the social structure of a group (was) strengthened and perpetuated through the ritualistic or mythic symbolization of the underlying social values upon which it rest(ed)" (Geertz, 1973:142-143). Be that as it may, both scholars were in agreement on at least two things. First, their approaches provided the theoretical basis upon which "the functional aspects of a people's social usages and customs" in the production of stable societies could be grounded. Second, because of their emphasis on "systems in balance, on social homeostasis, and on timeless structural pictures" (Ibid.), they provided the basis upon which the African as an exotic other could
simultaneously be the object of "scholarly investigation" and missionary/colonial "civilizing efforts" (Moore, 1993:4; Stocking, 1987:237).

Though this approach began to come under severe scrutiny in the late 1930s in works that concerned themselves with the "historical moment at which the fieldwork was done, and (which) provided data on everything" from rural-urban migration, urban life and work, to what was described as "detribalization" due to the impact of colonial institutions (Moore, 1993:13-16), it was not until the late 1940s and 1950s that "an actor-centered anthropology" (Ibid.) began to emerge. Since then, but more so during the 1970s and 1980s, structural-functionalist concern with "timeless abstractions" (Ibid.) or what Geertz (1973:143) has called "timeless structural pictures" was increasingly pushed from center-stage as emphasis came to be placed on "the feelings and actions of individual human beings or the centrality of phenomena in the interpretation of meaning" (Jacobson-Widding, 1991:21). Based on the assumption that "space is constituted by the consciousness we have about it" (Ibid.:22), meaning and its interpretation has since come to denote not "the ultimate signification which a society-subject attaches to its practices (its ineffable, and more important, untranslatable, nuances) but as a signification bound to the ordered diversity of the social sphere and the irreducible reality of the suffering body" (Auge, 1985:1).

Does this theoretical development mean that symbolic complexes and subjective experience, structure and practice, are asymmetrical in African societies? In a recent collection of essays on the body and space in African cosmology and experience (Jacobson-Widding, 1991), a clear distinction has been drawn between "spatial models" that are "predominantly concerned with the division of social and cosmological categories as general principles," and the human body which, when employed as a symbolic-vehicle, helps in comprehending "the complementarity and interconnectedness of human beings or the fusion of otherwise separate categories" (Ibid.:15). According to Anita Jacobson-
Widding, while the former focuses on "spatial symbolism, and is mainly concerned with how dual divisions of the world are spatially represented," the latter grapples with the "problem of how dual divisions are overcome." In either way, both "focus on body symbols, or on triadic models that are applied in the mediation of opposed categories" (Ibid.:16). Thus, Jacobson-Widding has concluded, there is no fundamental contradiction between the two since they both "treat a common issue, viewed from two different angles" (Ibid.:16).

Taking our cue from Jacobson-Widding, we would like to argue after Jean Comaroff (1980) that shared symbolic categories don't necessarily negate subjective experience.³ As demonstrated in chapter two, Wekomo and Bunyore Hills as important political resources did not, and have never, represented the 'Nyole polity in "a socially undifferentiated sense" (Bierschenk, 1992:515). That there has always been an economy of access to these symbolic domains leads to the conclusion that they represented, as they do now, an "attempt to establish the general acceptance of specific definitions of social reality" (Ibid.). To take cognizance of this is to also accept the undeniable fact that in their migration into, and settlement of Bunyore, the various clans that came to make up this community were brought into relations that subjected them to a double-bind. This, in its simultaneity, at once spoke to the hegemonizing idea of 'bene iloiba (the owners of the land) and to the need for individual clans to keep or maintain their ways of 'knowing'. Thus if, at the level of health, these symbolic categories in their totalizing vision configured "the meaning and management of affliction," their articulation with subjective experience was, on the other, "an expression of a more inclusive process of cultural change" (Comaroff, 1980:637). Indeed, it can be argued that if what we have outlined above forms the epistemic domain in which knowledge about inter- and intra-clan relations as well as the relationship between man and nature was produced, this, of necessity, cannot be divorced from both the discursive and aesthetic domains in which meanings about personhood and
agency, rites of passage, order and disorder, and therapeutic rituals were produced and fed into the aesthetics of the everyday. Thus, though the spatial anatomy of the 'Nyole landscape was in its (community) constituting processes silent on questions about personhood, its 'reading', and also a 'reading' of the strong emphasis people put on the active construction of the social and material world vis-a-vis this anatomy, had profound implications for prevailing notions of time, person, and practice (Comaroff and Comaroff, 1991:129).

It is the thesis of this chapter, therefore, that a study of 'Nyole notions of health provides one with not only an appropriate locus for more general inquiry into the role of both culture and social action in historical processes but also, because "systematic attempts to counter affliction tend to merge thought and action" (Comaroff, 1980:637), an opportunity to demonstrate that structure and practice are not necessarily opposed absolutes in a culture-historical context. To advance this thesis, our epistemological point of departure lies in our understanding of the 'Nyole world as "structured yet negotiable, regulated by conventional rules and practices yet enigmatic," structured yet fluid and full of internal tensions (Comaroff and Comaroff, 1991:128). Thus the issues raised above, when brought to bear on questions about health in 'Nyole cosmology, are as much about, on the one hand, 'Nyole perceptions of order and disorder as they are, on the other, about affliction as a "structurally configured dislocation of the self and its social and cosmic context," and healing as "the manipulation of multivocal symbolic media, seeking to reintegrate the physical, conceptual, and social universe of sufferers and community" (Comaroff, 1980:637). But they are also about how form and meaning are given to illness and about how cultural construction of body, subjectivity, and social interactions are shaped by notions of harmony, purity and wholeness, notions that are "articulated less through explicit artistic or philosophic tenets and embodied more in the visceral experience of cultural actors" (Desjarlais, 1992:1105). They are therefore about "local ways of being
and doing which lend specific styles, configurations and felt qualities to experiences of body and social life" (Ibid.).

3.2 History, Cosmology, and the 'Nyole Social Order before the Twentieth Century

It seems that within the bipolarity of the sets of ideas about formlessness, fertility, and potential power (rain) on the one hand, and striving consciousness (fire), on the other, lay the critical dimension in which questions about man's place in the universe were raised and answered. This dimension had as its "spatial frame" (Tuan, 1993:172) the social and the cosmic, while physical health, moral integrity, and spiritual wholeness, all at once, were about man's well-being in terms of the attainment of a state of equilibrium. Our point of entry into the understanding of this dimension is a folkloric text which, we hope, will help us in establishing how the issues raised above were related to ideas about health among the AbaNyole.

Once upon a time, long long time ago, amañani (ogres) ate all the people in the world. There remained only two children in a certain village, a boy and a girl. These two children tried all they could to hide from the ogres. They stayed hidden until the ogres became few. Since they could see no other human beings, they said, "We are now alone in the world; let us marry one another. If we don't, who knows what shall become of us?" They did not argue over this, for they both knew the kind of position they were in.

One night, when they were asleep, there broke out a fire and by the time they got up it was too late to escape. They were both burned to death.

During the rainy season, many years after the fire, the world again began to be covered with grass and trees. Where the boy and girl had burnt to death there sprouted two plants. One of the plants was libokoi, a type of spinach. The other plant was olusaka. Libokoi, the healthier, thicker and more fleshy of the two, sprouted where the girl's body lay when the fire struck. Where the boy's body was burnt sprouted Olusaka, the less fleshy of the two and the slower one to grow. The rainy season ended and drought was ushered in. Now in a far far away village, in another land, amañani had reduced the population to only one man and his wives. One of the wives did not have any children. She was barren. Since the drought had destroyed everything, this woman traveled far and wide in search for food, though the most she hoped to get were wild vegetables that could still be found growing in river-beds. It was on one of these occasions she came across two lovely plants. Her heart danced with joy for she had at last found some
vegetables. When she moved closer and saw the two luscious plants growing in the ruins of what obviously was a house, she felt pity overwhelm her. Thus, despite the urge to pluck them and take them home with her, she left them for that day. When she came back the following day determined to pluck them, she noticed that the two plants had grown round at the tips. Nevertheless, she pulled them up and took them home.

After getting the vegetables ready, the barren woman cooked them. After sometime she tasted them and found that they were very bitter. She added some water into the pot and continued cooking. A few minutes later, she again tasted them, but they were still bitter. "They must be cooked by now," she thought. "But why are they still bitter? What shall I do?" She asked herself. At that moment a thought struck her, that in such situations the vegetables would be eaten the following day when the bitterness would have dissipated naturally.

When the following day she went to check whether they now tasted better, she noticed two human beings, a boy and a girl. What had been Libokyoi was now a little girl while Olusaka had turned into a boy. "Uuul! Have my ancestors revisited me?" She exclaimed.

She did not tell anyone what had happened. She feared that her co-wives would at best laugh at her, and at worst say that she was only being repaid for being secretive about the vegetables. So she took the pot and went to hide it in the barn. When the following day she went to check on them, she found that babies had grown too big for the pot. So she took them out and fetched two bigger pots, while at the same time thinking to herself: "Andae (God) and Eliuba (Sun) have done this to remove shame from me." The following day she again went to check, and this time she found the children had outgrown the pots. Her heart beat fast, and she had a great longing to take them out of the barn and hold them in her lap. She waited until dark before removing them from the barn and taking them into hiding in the house. Here she arranged how to bathe and feed them without attracting attention. This way the children grew bigger till they began doing these things by themselves. They bathed themselves in the evening behind the house, and all this time the man of the house did not know about their existence.

That is until one evening when Linani, passing by behind the house, saw them. Linani admired the girl and said to himself: "So there is such a beautiful girl in this home. I shall come to propose to her one of these days." He went home and changed into a human being. Then he came back to the girl's home to ask for her hand in marriage. When he arrived he was welcomed well for the people in the home did not know that he, Linani, was an ogre and not a human being. When he made the reason for his visit known, all the girls in the home were called to come and see him. After examining them all he said: "The girl I want is not among these." When he was told that there was no other girl apart from those before him, he insisted that his hosts were lying. He went away but came back repeatedly, till he was asked to say in which house he had seen the girl he was talking about. When he pointed at the barren woman's house, the owner of the homestead
assured him that there were no children in that house. When he insisted and his hosts said they didn’t know what he was talking about, he got annoyed, but not until an idea occurred to him that he could get the girl whether they liked it or not. He said to himself: "If I went and lived in the sea and ordered all the rivers and lakes to dry up and then stopped the rain, there would be a great drought. This might force them to give me the girl." So he went and did as he planned. All the lakes dried up, and all the rivers too and there was no rain. Then the grass dried up and the cattle had nothing to eat and no water to drink.

People began wondering why all the lakes, rivers, and streams had dried up and why there was such a great drought. They investigated this strange happening and discovered that it was Linani who had caused the catastrophe. They also found out that the reason this had happened was that one day, Linani was passing near a certain house and he saw a very beautiful girl. When he went to ask for the girl’s hand in marriage, the man of the homestead refused to give him the girl. That is why he went and dried all the water in the land. The people got together and went to the home of the man whom they urged to take out the girl he was hiding and give her to Linani so that they may get water. The man did not know what to do. When he was tired of their frequent visits he decided to take all his daughters, one at a time, to the sea where Linani was staying. On each occasion Linani refused saying that these were his sisters-in-law. When the man took his sons, again one at a time, Linani refused saying that these were his brothers-in-law. He only wanted Nabwende and nobody else.

The drought continued and cattle began dying. The people having seen this man offering all his children to Linani and Linani refusing, said: "We are just bothering this fellow for nothing. He is not the one who is causing the drought. He does not have a daughter called Nabwende." But others objected, saying: "No. Let us keep on urging him to produce Nabwende. Our people are dying one by one. Will the whole village perish because of only one girl?" They decided to search his home and, at last, they found the two children in the house of the barren woman. They were all amazed and said: "Oooo! What is the matter with you? You have caused so many deaths because you hid your daughter away. Take her to Linani, now!" But the girl's brother said: "You are not taking her now. You will take her tomorrow. Go and tell Linani that tomorrow he should come and take the girl from the cliff by the sea. She will not go into the water." They took the message to Linani. The following day it started to rain. The rivers were filled with water and all the lakes and streams as well. The girl, hearing that she would be given to Linani the following day, wept the whole night. But her brother kept on comforting her, saying: "Don't weep. Whatever will eat you will eat me as well!"

The boy forged two types of spears. Some were as straight as a stick and others forked. At dawn, the girl was taken to the appointed cliff. Her brother accompanied her and when they got there the girl was put at the very top of the cliff. Her brother hid himself in the hollow of the cliff, with his weapons. The man then went to shore of the sea and told Linani that he had brought Nabwende. When Linani heard that he had been given Nabwende
he ran out of the water with great haste, his tail high up in the air and danced for joy. As soon as he got out of the water, it began raining heavily. He did not mind the rain. He made for the cliff. When he got there, he began climbing quickly but before he got half-way Nabwende's brother pierced him at the side. He fell off and said, "What has pierced me?" All this time the girl was screaming desperately, terrified.

Once more he tried to climb. Again Nabwende's brother pierced him with a spear. Once more he fell off and exclaimed, "This thing that is piercing me, where is it hiding?" Nabwende went on screaming. Linani tried to climb again for the third time. Once more the boy pierced him with a spear and he fell off heavily and was unable to get up. The boy then pierced him repeatedly till he died. The boy climbed the cliff and brought his sister down and took her home. They found their mother dying with grief. They left that village and went to stay elsewhere, and the boy built for his mother a house and they lived there the three of them happily.6

Though a number of interpretations can be brought to bear on this text, of fundamental importance, at least in the light of this study, is the idea of disruption and renaissance (Aswani, 1972:9) which draws our attention to not only meanings encoded in the relationship between man and amanani, but also to the importance of such moments of destruction and chaos as occasioned by fire and droughts in the constitution of social and cultural experience. Organized around the theme of a before-and-then and an after-and-now, the text is for example loaded with primordial symbolic meanings that constitute a corpus of some authentic knowledge of a sacred order. Indeed, by conveying the meaning of man's life through vicissitudes of mythic time, the text in its multilayered texture on the one hand expresses the essence of a particular social and cultural experience and, on the other, serves as a paradigmatic axis around which this social and cultural experience can be both pegged and understood. The text thus invites a consideration of the primordial link between the theme of disruption as the grounding of a beginning, and disorder as a cosmogonic moment in which the conquest of a natural space foreshadows order. In this sense the narrative "sanctifies the definitive triumph of life over death, of the pure over the impure, of order over disorder" while it, at the same time, directs our attention to a
consideration of the "forces that determine the architecture of the world and the meaning of the universe at the conjuncture of the timeless and concrete time" (Sow, 1980: 132).

But if this text is about that space between a before-and-then and an after-and-now, in its interstices are suggested the origins of some sorts of the panstructuration of the 'Nyole universe in which are to be found the necessary correspondence between social and cosmic order, and the mechanisms that were at the core of the operation of this universe. A three-tiered space, this universe comprised of emakombe (the macrocosm), the place or abode for the spirits of the chosen dead; musitsimi or esitsimi (mesocosm), a no-man's land; and oluhiya (microcosm), the place of practical everyday life. There were constant interactions between these levels, making esibala (the world) appear as "an architectonic structure in which each element (was) necessary to the whole, and a vast network of interconnections unite(d) man with the universe, the living with the dead and with the spirits" (Sow, 1980:134). At the core of this network of interconnections were basic elements (complementary or contradictory) whose ordering brought about cosmic and social equilibrium to life (Ibid.:133).

Perhaps of greatest interest here was the interaction between esitsimi (the mesocosm) and oluhiya (the microcosm). While the one was the place where chance reigned "with the disquieting strangeness of natural laws," and was the scene for the nocturnal activities of abafila (witches) and aboroli (sorcerers), the other was the socialized space of practical everyday life (Ibid.:134). The special preserve of esitsimi was that it was a "space of the individual and collective imaginary," and it began at the edge of oluhiya to encompass, as it were, "the bush and the forest, that is, natural uncultivated space" (Ibid.). As the "realm of violent but also peaceable doubles" like amanani, it was the abode of "aggressive forces" but also those that gratified everyday wishes. From this perspective, esitsimi was "a parallel nocturnal world, structured and organized like a replica of the microcosmic diurnal society" (Ibid.:48-49,135). This structuration was encompassed by emakombe
(the macrocosmos), and it leads to the conclusion that the 'Nyole universe was interwoven rather than layered since "each element of the composite (was) an image of the totality ... the whole appear(ed) to have a unity: the cosmos (was) both hominized and humanized" (Ibid.:136).

From the foregoing, it can be said that the essence of the text lies in its attempt to express and interpret the order of the 'Nyole world. This is brought out by the fact that, first, suffering through misfortune is an original feature of 'Nyole history. This is so because the image of disruptive and chaotic forces like fire, droughts, and ogres testify to a rupture which reminds us that forces (good or evil) that tradition locates in the individual nevertheless express a basic human drama. This is "a drama of a relational conflict evoking the primordial symbolism of rupture" (Sow, 1980:181). Second, the period in which the text is located, that is the before-and-then, is an era of incompleteness in which rudimentary humans walked about in quest of an ontological status. Third and most crucially, there is in the text the equation of the forces of destruction with confusion due to the nondifferentiation of beings and things. The need to draw boundaries between beings and things, people and animals, was in this world of fundamental importance because, it was thought, their (boundaries) dissolution engendered a threat to man and society. This is indeed why the idea of marriage between Linani, a monstrous double, and Libokoyi, portended the "blurring of the frontiers, contaminating one with the other" (Sow, 1980:201). Here fear lay as much in what Linani’s proposal meant for society from a relational point of view, as in the interpenetration between Oluhia and esitsimi. Thus, if the proposal brings out a relational conflict between, on the one hand, the barren woman and her co-wives, and, on the other, the man's homestead and the larger society, the presence of Linani as the main character in this drama speaks to the primordial symbolism of rupture that is both about boundary maintenance and the dialectics between before-and-then and after-and-now. At the core of this is, therefore, the question of prescribed practices,
customs, prohibitions, and codes of conduct that not only convey the idea that cultural
cohesion and order among the AbaNyole rested on a subtle and delicate system of
differential identification, but also the urgency with which the observance of this system
was seen to underpin the process of avoiding misfortune.

But what do we, at the level of history, make of the relationship between before-
and-then and after-and-now? It can be argued that as a series of events, famines, droughts,
and the menace of ogres in the text are about collective memory in whose interstices are
embedded the problem of remembering and forgetting. This is the more so because, by
anchoring these events in space for their re-enactment, the text encodes several strata of
Nyole history. These strata provide, first, a link between the symbolic and imaginary
bases of social and cosmic order and, second, autochthony and ancestrality as key concepts
in the social handling of temporality and historicity. Three of these strata can be identified
in the text. First, there is that earliest period generally referred to as mutsinyinga tsia
'manani' (the days of man-eating monsters or ogres) in Nyole traditional lore. This stratum
corresponds to the wild and untamed period of conquest and settlement, and it conjures up
images of the struggle between man and wild animals and man and the environment. Thus,
if the text is about a struggle in which a definitive triumph of life over death, of purity over
impurity, and of order over disorder was achieved (the killing of Linani), it also suggests
that the invention of a repertoire of oppositions or differential identifications in the name of
social and cosmic order marked off this period as the time in which a Nyole geocentricism
was born and the spatialization of collective memory began giving meaning to notions of
being, belonging and social continuity. As demonstrated in chapter two, the AbaNyole
have in their identity-constitution and definition always looked to Bunyore Hills not just as
a place where their forefathers settled first, but also as a space that symbolized 'blood
closeness' since it was here that the blood of one of the pioneers was first shed. Like
'circumcision blood' that binds the AbaNyole with their land, Musali's blood imbued this
period with an urgency that made the hills both a reference point for being and belonging and a point of departure in these early settlers' quest to hominize and humanize the environment around them.

The second stratum of history in the text flows from the first and it is about the laying of the basis for imprinting the all-encompassing and totalizing idea of 'bene liloba (the owner of the land) after the sixteenth century. This period which runs up to the end of the eighteenth century revolved around the processes of consolidation in which Bunyore Hills and Wekhomo as ideational arenas in the construction of being and one-ness were central. These processes at once spoke to the ideology of 'bene liloba, rules of incorporation or exclusion for new migrants, and the relationship between Emakombe (macrocosm), Esitsimi (mesocosm), and Oluhia (microcosm). As representations of the "principles of an essential whole" (Tuan, 1974:20), Bunyore Hills and Wekhomo were thus in this second stratum of 'Nyole history mental worlds constructed by pioneer groups of clans for the purposes of both mediating between themselves and external reality and symbolically conjoining them, and social facts with those of nature. This was a link between, on the one hand, the individual, the corporate group, and the life-world and, on the other, personhood and health, and it gravitated around the appeal to tsing'ani tsia 'bakuka (the grave sites of the pioneer forefathers) or the notion of habakuka bakoonaa (where our forefathers slept or were buried).

By the end of the eighteenth century there was a clear move away from, but not complete disengagement with, Wekhomo and Bunyore Hills as signifying structures in the constitution of social and cosmic reality. This not only threw into sharp relief the at times suffocating totalizing vision of 'bene liloba, but also pointed towards the fact that as the embodiment of an emergent hegemony, these structures were discursive formations that were marked for what they silenced or prevented the abamenyibwa (tenants-at-will), abarende (neighbors from within) and abasumba (dependents) from "thinking and saying"
(Comaroff and Comaroff, 1991:23). Thus if the text alerts us to the fact that reference to primordial signifiers permitted pioneer settlers and their offsprings to become aware of their identity through time, it also reminds us of a form of collective memory that manipulated history through the appropriation of these signifiers as markers of human destiny between the sixteenth and eighteenth centuries. In other words, primordial signifiers of order and disorder were in this period used by pioneer settlers as metaphors for introducing into the flow of events an abstract, all encompassing history that ignored the plurality of collective memories that corresponded to the many groups that comprised Bunyore. Thus in choosing to remember only what was emphasized in terms of the triumph of order over disorder 'Nyole history in this period is not only constructed as universal memory; it is also, from the point of view of identity, pushed to the limits where a general representation of humanization process is equated to the evolution of community.

Remembering and forgetting was essential to the "general functioning of the wheels of power" (Foucault, 1980:116). But this was a process that took shape against the backdrop of different levels and networks of social relations engendered in the different times of arrival of new groups of clans; the essence and being of abamenyibwa, abarende, and abasumba; and the reconstitution of the times and conditions under which these groups were incorporated into Bunyore. Oral data is full of anecdotes about groups of people who arrived, initially, as abasumba or abamenyibwa but the terms and conditions under which they were incorporated into Bunyore were mitigated by the knowledge they had, singularly or collectively, in one aspect or another of social life. A good example here are the Abamuchina who, brought into Bunyore as abasumba (dependents) by 'bene liloba (owners of the land) sometimes in the eighteenth century, are said to have been the custodians of the ritual drums that were used to signal that olubi (misfortune) or olumbe (death) were about to strike. Found in Mwitua, Ekatsombelo, and Ebusiloli Mwilonje in present-day North Bunyore location, this group of clans is said to have been till recently
experts in detecting impending danger to which they responded, as a warning sign to the entire community, by drumming in a ritualistic performance to dispatch the danger to Mumbo (the West). According to oral data, the settlement of this group of clans in the eastern direction in Bunyore was significant. Its significance lay not in the mere fact that they could initiate the process of ritually ‘chasing’ misfortune from the East to the West; it can be argued that as an element newly introduced in the finite events of sacred history, ritual drumming and its link to the detection of danger helped in putting into focus a once vaguely defined two-fold horizontal discrimination of space that at once did two things. First, it gave new meaning to the three-tiered vertical division of the ‘Nyole universe into Emakombe, Esitsimi and Oluhia. Second, this ritual performance came to not only link rhythms of the everyday to the processes of production and reproduction but also, through counterposing the trinity of Emakombe, Esitsimi, and Oluhia, to Likulu (sky) and its deities, established a central region in which vertical order was articulated and horizontal discrimination centered.

According to ‘Nyole cosmogonic and cosmological ideas, in the beginning of time when Esibala (world) came to be, two large stars called Etsiyasulwe (sing.:Eyasulwe) appeared in the sky. One eyasulwe was to shine in the East before dawn and the other in the west after dusk. While these two stars always signaled the beginning and end of day, rain which before Nganyi “fell on its own” was controlled by two rainbows: one male and narrow, the other female and wide. The male rainbow alone could not prevent the rain from falling; it needed to combine efforts with the female rainbow to do this. But it was the male rainbow which always appeared first only to be followed later by the female one.9

The sun, on the other hand, rose from the east and it provided light so that people could work in their fields and also go about their daily tasks. Traveling “from east to west across the sky” (Wagner, ibid.:30), it helped them to divide the day into the various activities they had to perform. From a ritual point of view it featured in a number of
activities like in morning prayers which were done while spitting in its direction. But the sun, "in accordance with the 'normal order of things'" (Ibid.), not only brought milk and health with it as it moved across the sky; it set in the west taking evil along with it. However, the AbaNyole believed that "the sun could also be a source of evil. Shining at the precise time when it was about to rain, its rays brought the female and male rainbows together and if this continued day in and day out, drought was bound to follow."\textsuperscript{10} Its journey back to the east was also fraught with danger. This was because "it traveled at night and this was not across the sky but underneath. On this journey it carried with it a lot of things: milk, cattle, food, honey, blood, etc." If one happened to see it on this return journey, he or she expected to get anything. Thus, "if it gave you grains then you would have full granaries during the next harvest. But if it gave your blood, then you would die."\textsuperscript{11}

The moon on its part was not only seen as a close relative to the sun but also as a major element in both sickness rites and a woman's rhythms of fertility. As Gunter Wagner (1954:32) has pointed out in the case of the Abalagoli, improvement in some children's illnesses as well as stutterers' ability to talk were among the AbaNyole predicated on the waxing and waning of the moon. Furthermore, it was also believed that the moon not only shined upon people at night to help them make love; it also enabled women to know when they were going to have their menstrual periods or, if they had failed to come, how long it was going to take for them to be delivered of child (Ibid.)

The sun's rise from the east entailed both a propitious moral quality and a diurnal character that gave meaning to the chores and necessities of everyday living. But this quality and character lay in the delimitation of the boundary between day and night, a delimitation which in turn defined dawn and dusk as in-between times. Preceded by the east \textit{eyasuulwe (star)} at dawn and followed by the west \textit{eyasuulwe (star)} after dusk, this delimitation generated a form of anomie or feelings of awe, danger, and potency that
inherited in the break or crack between the socially constructed cosmologies of day and night. As discontinuous spheres, day and night were separate social worlds in which the AbaNyole not only related to ultimate cosmic reality but also, because of the break or crack in the two spheres, experienced a momentary loss of self. These in-between times have been well summarized by Mary Douglas (1966:116) who has written that as transitional zones dawn and dusk were domains of danger "simply because transition is neither one state or the next, it is undefinable. The person who must pass from one to another is himself in danger and emanates danger to others."

This notion of transition is probably well brought out in the opposite pairings that are so prominently manifest in the solar elements mentioned above. While at the general universal level there was the earth-sky and low-high pairing, at the solar level there was the sun-moon, east-west stars, and male-female rainbow pairings. These pairings both about the alternation or complementarity necessary to the functioning of the universe, and kinship terminology that evoked some of the most complex symbolism (Sow, 1978:138) that can be seen, for example, in the Olusaka and Libokoyi pairing in the folkloric tale above. Thus, while the sun-moon pairing expressed the opposition between the sun's stability and permanence and the moon's changeability and transformation, the zones of transition both elements delimited revolved around the east-west axis that was a major signifier in 'Nyole conceptions of health and disease. From this perspective, it seems that like the sun in its delimitation of dawn and dusk as in-between times, the moon and its association with the rhythm's of a woman's fertility entailed marginal situations that encoded ideas about the dialectics between pollution and fertility and also between feelings of anomie and pure ecstasy. Indeed, to be 'in the moon' or to fail 'to see the moon' as the AbaNyole put it was to at once stand at the edge of organized reality that led to feelings of uncertainty, caution, and confusion, on the one hand, and joyful longing and ecstasy, on the other. In a word, the moment evoked primordial notions of order and disorder, purity and impurity, life and
death, and also the quintessential necessity to "classify, to distinguish, to separate-in short, to identify special preserves without confounding them and to isolate potentially explosive points in the community edifice" (Sow, 1980:202). This was about first, 'Nyole understanding of the body and its continuity with both the environment and other bodies of the social unit and, second, notions of pollution and contagion which found their full expression in certain prohibitions.

From the foregoing, it can be said that if the arrival of Abamuchina gave definitive form to the East-West axis and to notions that threats of olumbe or olubi (death or misfortune) could be detected early enough, this development was to be inextricably linked to the three-tiered vertical division of the 'Nyole universe whose association with sky elements came to constitute the complementary halves of an essential unit. This unit with all that it entailed restored a primordial relationship on whose fundamental conditions rested fertility, potential power, and striving consciousness, on the one hand, and, on the other, the conditions of possibility for the inculcation of new ideas in 'Nyole cosmology. Indeed, it can be argued that by claiming to be experts in early detection of misfortune, the Abamuchina introduced in Bunyore not only the medical notion of 'prevention is better than cure', but also the element of individual or group expertise that was to be followed in rapid succession by rain-making knowledge and therapeutic visions associated with Long Distance Trade from mid-nineteenth century onwards. According to oral data, some families for example acquired in the nineteenth century a form of okhufruitula (divination) known as ebikanda or ebichooyela. Though various places ranging from Kano in Luoland, Samia in Southwestern Luyialand, and Bunyuli in Uganda are mentioned as the possible sites this divinational knowledge was acquired from, it is not possible to say with any certainty which places were involved in this development. What is certain however is that this development was the result of individual or group initiative and it involved going very far beyond 'Nyole borders. This becomes even more so because this acquisition coincided
with a more general development in the opening up of Western Kenya to people who were looking for elephant tusks "to take to Mumia"\textsuperscript{12} or give to Khamati (Ahmed) and Khamisi who had established camps at Ebukhuka in present-day South Maragoli and Hamisi in Tiriki, respectively, in exchange for cowrie shells.\textsuperscript{13}

\textit{Ebikanda} were types of genies (jinns) which "talked but could not be seen by the diviner's client."\textsuperscript{14} According to this informant, "to directly see them meant instant death. They could only be seen by means of water in a trough, behind the door at the back of the house."\textsuperscript{15} They were used by the owners to \textit{Okhulakula} (to 'name') a client's enemies and they were kept in \textit{ebimuka} (gourds) or \textit{orurabu} (small pots). It is said that \textit{ebikanda}, fed only on \textit{ebinolu} (fatty foods) in order to tame them, could make a member of the family that owned them to run mad if they were not fed well.\textsuperscript{16} The owners, like the \textit{abafumu} (diviners) who manipulated animal entrails to detect the source of misfortune, were consulted mostly in cases that involved personal misfortune. The most unique aspect of this that is also a testimony to rapidly changing times was that unlike in other forms of divination where misfortune was attributed to the violation of "the moral universe of kinship" (Whyte, 1991:155) through \textit{esilamo} (curse) or \textit{emisanswba} (ancestral retribution), \textit{ebikanda} divination dealt only in foreign spirits. This therapeutic tradition was not unlike \textit{okhupa ebisanda} (gourd rattling) that operated on "a working relationship with teams of spirits who possessed them and spoke through them to reveal the causes of a client's misfortune" or \textit{okhufuba tsisimbi} (the throwing of cowrie shells) which "manipulated the same etiological model of misfortune" (Ibid.:156).

\textit{Ebikanda}, or cowrie shell throwing as a form of divination was Arabic in origin and spirit and it found, as it were, an increasingly expanding arena of acceptability as population pressure, inter- and intra-clan strifes,\textsuperscript{17} and individual endeavor buoyed by both Regional and Long Distance Trade became major factors in the transformation of Western Kenya during the second half of the nineteenth century. Oral data is resplendent
with stories about people going to Eburebe (E bunyala Wa Ndombi) *m'mayenga,18* or consulting with more powerful *abafumu* (diviners) who used mirrors to 'name' and kill their clients' enemies, or carrying *etsirisi* (protective charms) acquired from as far as Pemba, an island in the Indian Ocean, and Tanga in Tanganyika (Tanzania).

But these were also times when people embarked on what Steven Feierman (1991:103) has called "journeys of discovery" on which healers not only "learned new medicines, thus opening the therapies ... to many new influences from the outside," but also "tested themselves against one another, when they came to know competition abroad." Thus, it can be argued that instead of just following the vision of *bene liloba, AbaNyole* in the nineteenth century "used varied approaches and assessed the consequences of therapy on a practical basis" (Ibid.:102). Oral data suggests that like Feierman's Usambara, in Bunyore, at least at the level of personal health,

patterns in the training of healers tended to open up healing to borrowing and innovation, for they combined extended training ... with long periods of travel and learning throughout the surrounding region. Healers in training were either the sons of practitioners, or younger men (or women) who apprenticed themselves to recognized healers for extended periods (Ibid.)

According to this same data, these developments in the search for new therapies took place against the backdrop of serious famines the most important in recent memory being *inzala ya esileta abakhaye,19* which occurred in 1884, and epidemics like *mongoyi* (sleeping sickness) and *inundu* (smallpox).20 This was the time when *esibala siali 'khunia* (when the world shut)21 and, it led to all sorts of quarrels and fights between individuals and between clans and sub-clans. For example,

If someone came from a village which was infested with any serious *obulweye bwo 'khuhambania* (contagious disease) and the village he visited got infected, he/she would be blamed for bringing the *esibi* (misfortune) to the people of that village. Most people who were singled out for blame were *abamenyi* like Ab'biba who had moved from their home in Eb'biba at Emuhaya to live among the Abamukunzi, Abamuli and Abakhaya. People like these were always blamed for any serious disease outbreak in their adopted homes.22
The anxiety which these crises occasioned became in itself diagnostic of a world in serious flux. Diseases like *inundu* and *mongoyi* led many people to ask themselves: why me, my family, or my clan? The answers that emerged ranged from locating causes and finding treatment, and they were deeply embedded in all sorts of stories: about such and such a clan, recently arrived in Bunyore, had been thrown out of its original home because of *oluswa* (ritual impurity); about A from so-and-so's home having visited Ebuyoyo (Luoland) several times for nobody knows what; and about so-and-so's elder brother having brought in an *omufumu* the previous season from Ebukitosi (Bukuwelland) and that was why his children or neighbors were dying one by one. These stories not only rendered these crises meaningful but also proposed powerful explanatory frameworks from which emerged important organizing paradigms. Among these paradigms was the master trope *abakuka* or *abatsia hasi basuye* (our forefathers or the departed are not happy with our ways) -- that harked back to the foundational stability that inhered in such symbolic complexes like Bunyore Hills and Wekhomo and what these entailed in terms of the totalizing vision of *'bene liloba*. That the crises were seen as emanating, collectively, from ancestral retribution meant that the Nyole idea of belonging and one-ness was reinforced. But, paradoxically, this conceptualization of oneness came to force questions about the way clans related to each other that is, the way they shared this idea of oneness. It was on the basis of this questioning, deeply embedded as it were in emergent inter-and intra-clan strifes, that other explanatory frameworks were worked out to understand the rupture occasioned by these crises. Explanations led to the search for remedies, and enemies were sought and named accordingly.

As the nineteenth century drew to a close, these concerns became deeply interwoven with the realities of *etsirotsa* (famines), *mongoyi* (sleeping sickness), and *inundu* (smallpox), and they contributed powerfully to the social construction of new and
exotic diseases during colonialism. It can thus be argued that if in the nineteenth century and earlier the idea of oneness and belonging underpinned the essence of being an Omunyole, the incidence of famines and diseases in this century and later not only brought to the fore the fragility of this idea but also stretched "institutionalized behavior to its limits" (Torry, 1984:229) among these people. History is resplendent with examples showing that in situations where there is a crisis in a society's corporate identity or collective existence, the crossing or interpenetration of boundaries is suspected. This suspicion leads to either attempts to reset lines and categories through ritual action, and/or the accusation and persecution of those thought to be deviant and anti-system, or the movement of boundaries. In the latter case it is not people who are suspected of having violated rules; rather rules are moved to reclassify people as deviant, unclean, or simply 'those others.' This is even more pertinently so if those who are affected by boundary reaffirmation or reclassified as deviant are inside outsiders like abarende, abasumba, and abamenyibwa in the case of Bunyore.

There is evidence to suggest that side by side with individual accumulation of wealth during the development of Regional and Long Distance Trade in the nineteenth century, there was a persistence in ideas and accusations about the use of destructive medicines acquired by individuals from Ebukami (Luoland), and the need to look for more powerful counter-measures from Eburebe Ebutirichi and Ebusamia by those who felt threatened. This was a persistence that was accompanied by a rapid process of expansion and colonization of land in the northern, eastern, and western parts of present-day Bunyore. There was also, in this period, the acquisition of rain-making knowledge by the Abasiekwe who were, as we saw in chapter two, abamenyibwa. It can thus be argued that if rain-making knowledge created in the south some amount of respectability for the AbaNyole (Were, 1967a: 134), the expansion and colonization of land in the northern, eastern, and western parts of Bunyore saw to not only the invitation of whole clans like
Abashikunga and Abakwelo to settle as buffer zones between the AbaNyole and their fellow Luyia-speaking Abakisa, Abalogoli, and Abidakho, but also the emergence of such warlords as Omutoko and Omuyumba among the Abasiratsi; Anabwani and Mwangala among the Abamang'ali; Mukhwana among the Abatongoi; and Otieno among the Abamutete. At the turn of the last century, Otieno nominally allied himself with the Abamang'ali (Hobley, 1902:50). These people were mostly from the abarende, abasumba, and abamenyibwa groups of clans and they had, by either moving away from Wekhomo and Bunyore Hills or acquiring wealth through trade, liberated themselves from their 'dual existence' as inside outsiders. Though many members of the 'bene liloba' group of clans also participated in trade they feared that the opening up of Bunyore had exposed them to powerful medicines in the hands of those their forefathers had welcomed. Be that as it may, it seems that it was mostly members of the abarende, abamenyibwa, and abasumba group of clans who pointed accusing fingers at 'bene liloba' as they traversed the length and breadth of Western Kenya and beyond in search of new medicines to either augment their wealth or protect themselves from what they saw as their enemies. This was, as Michael Taussig (1980:117) has pointed out, was "tantamount to fear of having more than others, and having more indicate(d) failure to share. Sorcery (was) evil. But its roots (were) embedded in legitimate concerns in areas in which competition pitted individualism and communalism against each other." But this had another side to it. As Sally Falk Moore (1975:137) has pointed out in the case of the Chagga of Tanzania, "poverty may lead the community to suspect (the poor man) of malice, and consequently he or his wife may be accused of sorcery or witchcraft when misfortunes befall his more fortunate kinsman."

Thus, if 'bene liloba' accused abarende, abasumba, and abamenyibwa of sorcery or witchcraft, this was because the latter were 'those others' bent on the destruction of the 'Nyole corporate spirit. But, alternately, the abarende, abasumba, and the abamenyibwa pointed accusing fingers at 'bene liloba' because they were seen as a hindrance to the
formers' development, but also because the gesture was a subversion of their own failure to share. In either case, medicines were involved and this (at the level of competition and the expansion of both the social and cultural field) threw into sharp relief any notion that Bunyore was by the turn of the century a self-contained group of people with set rules for the reproduction and maintenance of society and economy in time and space.

What can we make of these examples? First, they serve to underscore the dangers of seeing Anyole's genealogy both as "transcendental in relation to the field of events" and as one that "runs in its empty sameness" (Foucault, 1980:117) throughout the making of the 'Nyole polity before the twentieth century. Suggested in these examples is the fact that the role of Bunyore Hills and Wekhomo as signifying structures were from the eighteenth century onwards subjected to historical conditions of social transformation necessitated by not only new emigrant groups but also new therapeutic visions linked to the changing economic and social conditions in Western Kenya. Second, these examples are suggesting that while in the period before the nineteenth century forgetting was a strategizing force both in the conscious management of ideation and the practical constitution of everyday life, the "incorporation of symbolic elements from external cultural sources" (Comaroff, 1980:638) from this century onwards brought into play an expansion in the arena of therapeutic possibility. It can thus be argued that if conquest and the rise of the ideology of 'bene liloba is prefigured in the wild and untamed world of libokoyi and Olusaka, at the cosmic level the fire that destroyed the two brings into play the symbolism of striving consciousness that foreshadows, indeed anticipates, the idea of fertility and regeneration encapsulated in the incorporation of rain-making knowledge and the shift of cosmic attention from Wekhomo/Bunyore Hills to Esibila Hills in Ebisiekwe.24 This, together with changes brought by Long Distance Trade from the middle of the nineteenth century onwards, introduced into 'Nyole history a multivocal dimension that brought out, first, a
new form of sociability and, second, several sites at which the weaving of a mesh of partial or specialized memories of life and death cris-crossed as they confirmed or negated each other.

Third, and perhaps most crucially, these examples raise important questions about the relationship between historico-structural transformations and individual action, between structure and practice. For example, does practice reproduce the system? If it does, how can "the system be changed by practice" (Ortner, 1994:398)? In other words, does practice embody, and hence reproduce, "the assumptions of the system"? Are "divergent or nonnormative practices ... simply variations upon basic cultural themes, or (do) they actually imply alternative models of social and cultural being" (Ibid.:398-399)? These questions are pegged on two considerations: "how practice reproduces the system, and how the system may be changed by practice" (Ibid.:398). These considerations have, especially with reference to those people without history (Wolf, 1982), attracted all sorts of analyses and conclusions. Thus, writing as recently as the early and mid-eighties on the Sandwich Islands in Hawaii, Marshall Sahlins (1981, 1985) has through his emphasis on group 'interests' reached the conclusion that conscious individual efforts had little if any contribution to historico-structural transformations in these Islands in the post-Cook period. This is more or less the position reached by Robin Horton (1967) who, in his attempt to advance a neo-rationalist view of culture change in African societies, denied not only the category of person but also individual persons as conscious intentional agents in processes of social change in these societies. How do we, in the light of these questions and conclusions, explain the situation in Bunyore before the twentieth century?

One theme that runs through the history of Bunyore between the sixteenth and nineteenth centuries is the idea of one-ness and belonging. Predicated on feelings of immutability and stability, and also on constant reference to primordial notions of the
triumph of order over disorder and life over death, this theme encoded ideas which permitted 'bene liloba to imagine the AbaNyole as a collectivity. The theme took shape within a physical environment which provided, first, a social setting in which the individual was rehabilitated as the place for conserving and transmitting ideas about this collectivity. Second, this environment perpetuated processes of silencing or muting alternative ways of thinking and knowing. Thus, if order was something latent, and manifested itself in the never-ending process of coming-to-be, it was also about its antithesis, disorder, whose taming was not only about the maintenance of the collectivity but also a clear indication that need for coherence presupposed "inconsistent cultural stuff and inconsistent like experience" (Dirks, et al., 1994:18). Coming-to-be as the constitution of order dealt in the maintenance of structures noted for what they prevented either abameniyibwa, abarende, or abasumba from "thinking and saying" (Comaroff and Comaroff, 1991:24) while disorder, on the other hand, was disobedience or desecration of the idea of the collectivity. If the idea of 'bene liloba through its master trope, habakuba bakoona (where our forefathers slept), constructed abameniyibwa, abarende, and abasumba as objects of power, it also, willy-nilly, made them active agents seeking ways out of their 'subjection' (Dirks, et al., 1994:18). From this perspective, it can be argued that the understanding of disorder not only "opens ways to confront the ambivalent relationship of discourse and event ... in which the twin processes of containment and dispersal are always in conflict" (Ibid.:21), but also invites consideration of sites of disruption as places where knowledge is produced and new discourses about order and disorder generated.

It thus follows that if the parameters within which subjects were culturally and historically constructed emanated from the universalizing vision of 'bene liloba these were, of necessity, closed and open. They were closed in the sense that they were totalizing in their definition and shaping of what Raymond Williams (1994:585-608) has called
"structures of feeling." But, in masking prior divisions as were reflected in 'Nyole heterogeneity, these parameters were also open since they not only left the actor not wholly subjected but also provided "residual" and "emergent" arenas of practice in which individual actions as reflected in the organization of space and time did not fully articulate with notions like oluyia lwa'Nyole (Anyole's nation) or abana ba'Nyole (Anyole's children). This openness was most critically manifested in periods of crisis when, by forcing questions about the way clans related to each other, latent feelings of "different belonging" led not only to a sense of clan histories (akabakuka befwe) or family genealogies (akolubambwa lwa lebe) but also to "a politics of desire". As Nicholas Dirks, et.al. (1994:17) have pointed out, it was in such conditions of "daily experience ... settings of ordinary desire and the trials of making it through, that the given power relations (were) contested or secured, in an always-incomplete process of negotiation." Crisis as disorder in this case came to embody a "multiple foci and forms" which made the need for restoration through, for example, ritual not just "a sociological mechanism for the production of order, but also a cosmological and symbolic site for the containment of chaos and the regeneration of the world" (Dirks, 1994:487). Thus, if the individual, per se, was not "the ultimate locus and transmitter of historical change" as Raymond Fogelson (1989:135) has argued, it seems, at least from the nineteenth century onwards, that the conscious production of ideas about transformative change took place at sites of disruption in a socially constituted and unequally distributed power structure.

But given the configuration of nineteenth-century 'Nyole society where notions about management of dis-ease precipitously and continually went beyond ideas about the collectivity to encompass independent and more often than not foreign sources of causation, the category of person as the force behind every act of consciousness becomes relevant. The relevance of this category lay as much in the intertwining character of power
and knowledge, as in the interrogation of, and struggle over, meanings encoded in collective symbols and the place of these meanings in shaping the future (Feierman, 1991:107). It can indeed be argued that as the nineteenth century drew to a close individual agency as captured in the comings and goings of the nouveaux riches was more or less diagnostic of self-conscious personhood whose role in processes of social and cultural change became increasingly manifest in both the interpretation of, and search of remedies for, the crises that were besetting society. This is the more so because nineteenth-century famines and diseases were both processes and events. As processes they shaped, and in turn were continually shaped by, the contestation over ideas about belonging and one-ness. But as events famines and diseases were, on the one hand, "the empirical form" of the nineteenth century 'Nyole world and, on the other, the relational expression of "a certain happening and a given symbolic system" (Sahlins, 1985:153) that spoke to, and about, the cumulative actions and interpretations of individuals who took part in them as protagonists, as observers, and as meaning-makers. The role of individual agency as understood from this perspective draws attention to the fact that, first, it does not take place outside or above structure. Second, it alerts us to the fact that because of their very nature as open and closed, structures assure both a "constructed and limited subject" (Dirks, et al., 1994:14) whose role in social and cultural change can only be comprehended from the point of view of an ongoing, simultaneous, process of positional negotiation and cultural change.

At the center of the unfolding drama in Bunyore were, on the one hand, the totalizing visions inscribed in such symbols as Bunyore Hills and Wekhomo and, on the other, the notion of habakuka bakoona (where our forefathers slept) which in its contradictions referred to both Anyole's genealogy as 'bene liloba and those clans or groups of clans that arrived later either as abarende, abamenyibwa and abasumba. As argued in chapter two, for one to become an omwene liloba (the owner of the soil)
required, first, the lapse of three to four generations from the time of his clan's arrival and, second, the establishment of recognizable tsing'ani tsia'bakuka (our forefathers' graves) of his own that entitled him to be known as om'milikha (one that has been absorbed). The fulfillment of these two conditions made abamilikha (those who had been absorbed) as much entitled to being 'bene liloba (the owners of the soil) as the members of Anyole's genealogy and, by extension, they looked to Bunyore Hills and Wekhomo as symbols that sanctified this claim. If these symbols and the meanings they encoded came to be contested by both groups as the nineteenth century unfolded, then the inextricable link between structure and individual agency, between material and cultural life, in processes of social and historical change cannot be gainsaid (Ortner, 1994:372-411). But, more fundamentally, the contestation over these symbols and the meanings they conveyed draws our attention not only to the intertwining character of power and knowledge, but also to the complexities involved in the relationship between the production of order and the problematics of power. As Steven Feierman (1991:107) has noted in the case of the Shambaa of Tanzania, in a situation where there is an "ensemble of social relations within which intellectual activities find their place, "symbolic complexes of general scope and abstract reference cannot be shown to serve one side or the other in a struggle to shape the future." According to Feierman, if a "set of symbols can be subtly reconfigured to support one position or another," then the "principles of order in a configuration of symbols may have more to do with the logic of the symbols than with any issues of power." If Feierman's insightful observation is anything to go by, then it can be argued that as important as the 'Nyole geocentric notion of belonging and one-ness may have been in defining and shaping both individual and group identity, it was not, at least in the nineteenth century, the only one. To struggle over the idea of 'bene liloba meant that, ultimately, peasant intellectuals25 were bound to take positions in the unfolding drama. It is through the study of these positions as Feierman has cogently argued, as well as the sites
where the positions were constituted, that we can begin to understand how discourses on
dis-eases and their management were produced "within a configuration of power" (ibid.)
before the twentieth century. In this process ideas other than, or together with, the notion
of 'bene liloba -- ideas that were contingent, random, or habitus-inspired -- were crucial
both in embodying assumptions about how the world was and ought to be, and in the
simultaneous process of constructing and constituting notions about health.

3.3 Cosmology, the Body, and Metaphors of Causation

Mulala khubekhobe Okhumusikha (noho okhuyabira) yabukulanga lisaqfu
elala lielilombwe nende elindi liomuruba niyekha ninako mushilindwa mana
abukule lisaqfu elala are khushirwi shiompfu nasunga ari: 'olekala amarwi
mwiloba ta niwiyambakhana okhukhonya abaanabo nende abekhobo.
Witembelisie mushilindwa shino. Shioli owambeli okhufwa tawe.
Okhufwa khwabarulira bosi' (Wako,1965:38).

[One of his relatives assisting in burying him took a leaf from libombwe and
another from omuruba after which he descended with them into the grave
where he took one leaf and placed it on the deceased's ear saying: 'Don't be
deaf in the grave, you should not refuse to help your children and your
relatives. Be calm in this grave. You are not the first to die. Death is meant
for all.]

* * * * *

Yindi 'nyama yarula mundangu

Echendanga neyaha 'mako

Ngoyanile nirula ebukwe

Sabanga obukalani

Akhunza 'mwe ne ngoyanile

Aaah ngoyanile

Nirula ebukwe ngoyanile

Aaah ngoyanile

Akkunza wefwe orabelelanga

Aaah orabelelanga

A strange animal came from the west

Digging holes as it moved on

Confused I come from the east

Asking for obukalani

Akhunza truly I'm confused

Aaah confused

I come from the east confused

Aaah confused

But don't be sad, Akhunza

Aaah don't be sad
Orabelelanga amayingo kosi
Don't be sad for even to loved ones

Kasebulanga abakosi
Death must bid farewell

Aaah orabelelanga
Aaah don't be sad

'Lumbe silwamulala
Death is not for one person

Mama lekhanga okhulila
Mother don't cry

'Lumbe silwamulala
Death is not for one person

Papa lekhanga okhulila
Father don't cry

'Lumbe silwamulala.26
Death is not for one person.

The first conscious act by the AbaNyole in shaping their social and cultural order before the twentieth century was borne out of, first, the need for internal order and, second, the fear of being 'hemmed in' by a resurgent Nilotic-speaking Luo nation in the South and the southward movement of fellow Bantu-speaking groups in the North (Were, 1967a:76-79,140; Ogot, 1967:154,224; Owen, 1923:67). These two factors, coupled with the vicissitudes which accompanied the enlargement in scale of polity and economy, made this era one long period of flux, experimentation, and anxiety. These were external and internal factors that were not a once-and-for-all demarcation in the shaping of the 'Nyole social and cultural landscape. In their nuanced simultaneity they were at once about a long-drawn process of defining 'Nyole-ness vis-a-vis 'those others,' and the quest for internal coherence. How do these factors help us in understanding 'Nyole notions of causality as well as the principles upon which the domain of healing was based and organized?

Any answer to this question must begin with appreciating the fact that as a long drawn-out process of coming-to-be the constitution of the 'Nyole social and cultural order was a dynamic one. This fact lies as much in the knowledge that Bunyore comprised of clans or groups of people with different origins and backgrounds as in the dialectics of the
need for order, and it points to the naivety of notions like 'bene liloba' as the be-all and end-all in matters to do with health and healing. Indeed, as symbols of general scope and abstract reference Bunyore Hills and Wekhomo overlapped with, and were in turn overlapped by, networks of relations that emanated from patron-client relationships, marriage, linkages of agnation, patrilaterality, and affinity. These networks of relations not only throw into sharp relief any notions of clan autonomy and the hegemonic pretension of 'bene liloba'; they also point towards what Kris L.Hardin (1993:18-19) has in another, albeit recent, context called "the constant struggle between two dimensions of personhood -- the objectively or culturally defined expectations of others and the subjective interpretations of self that are idiosyncratic to each individual." These dimensions are about what Jean Comaroff (1980:639), referring to the Tshidi of Southern Africa, has called the "ambiguity surrounding personal identity," and are clearly brought out in proverbs and 'sayings of the wise' in 'Nyole everyday discourses. Clearly counter-posed against notions of the collectivity as contained in proverbs like omusala mulala sikulombanga omutsuru tawe (one tree does not make a forest); okhubol'la yilukha niye owolubekalwo (he who tells you to run is the one on your side); and tsinyinga tsiyomba obuswa bwe ing'ombe (time is more than the hair on a cow's skin) are proverbs like obulwayne bwowasio sibukhukaya okhukona (your neighbor's disease cannot deny you sleep); bulikhasiele nobufila bwakho (each old woman with her own witchcraft); and linyonyi lie'hale libotsanga nililekhela (a bird from a distance does not finish its food on one visit). Thus, while the first set of proverbs is about the collectivity and time-honored notions of one-ness as opposed to kinship ties, the second set is outrightly individualistic.

This ambiguity raises a number of fundamental questions. Among these are: What kind of conceptual generalizations did the AbaNyole have about disease and disease causation? How did they link these generalizations to facts of everyday existence? How did
they combine premises based on their cosmic understanding of order and disorder with a body of knowledge that dealt with what cultural and medical anthropologists have called naturalistic and personalistic ailments. These questions are about "a wider conceptual field" that can be understood only "when they are placed in the context of the other concepts which make up that field" (Pool, 1994:16). Thus, they are as much about the 'Nyole cultural order and the management of affliction as they are about processes of cultural change. Embedded within their wider interstices are issues that speak to spatial arrangements whose social and productive co-ordinates entailed a classification of beings and forces, things and actions, and time and space (Comaroff and Comaroff, 1991:152).

Our point of entry into the understanding of these issues are two texts, set at the beginning of this section. In these texts are suggested two broad themes: the idea of continuity but also dichotomy between life and death, and the opposition between Ebukwe (East) and Mumbo (West). These themes bring into play highly symbolic entities that are used for purposes of recounting "a prototypic or primordial event," death (Sow, 1980:181) and, apart from describing the reality of living, convey meanings that are meant to justify death as "the inevitable 'compliment' of life" (Ibid.:185). If the first theme brings out the 'Nyole view of society, it also draws our attention to these peoples' notions of bereavement; the relationship between the dead, the living, and the yet-to-be-born; and to the "concept of the natural and social order and the forces that are believed to threaten its maintenance" (Wagner, 1954:42). It is thus about the essence of death, but also how death is not such "a radical severance" that can be understood from the point of view of some "cyclical, biological episode" which explains "cosmic renewal and circular time" (Ibid.:191). As Sow (1980:192) has observed with respect to the conceptualization of the relationship between death as an event and time in most African societies, to the AbaNyole circular time was not 'humanized' time. This was the more so because the corollary of
circular time, periodic rejuvenation, was seen as both a travesty against generational boundaries and a sure way of dissolving these boundaries. The consequence of this dissolution was a violent "diachronic chaos" since the process negated the principles upon which society was based. It was on the basis of this that another temporality that saw time as lived experience was worked out. This was:

- time lived by the elders, time lived by those ... younger, distinguishing the successive generations and hence making for a highly social temporality.
- Interruption by a third party result(ed) in disrupting the order of things, that is, in confounding those two scales of vertical time and jumbling them together in a linear (horizontal) time, spatializing time and therefore depriving it of meaning. Thus there (was) no purely 'natural', biological time without a base of concrete human groups to give it substance and reality (Ibid.:192).

A prototypic or primordial event, death was among the AbaNyole just as much a "horrifying event" (Nyangweso, 1992: 19) as it was an inevitable compliment of life. One conspicuous feature about its nature was the lack of a myth explaining its origins. Thus, as a 'strange animal' associated with mumbo, its comprehension lay more with its causes and the daily experiences it occasioned, as well as with the relationship between it, as an event, and the problem of disruption or undifferentiation of cultural relations and signifiers that led to disorder in the 'Nyole world. This observation is captured in certain expressions, eight of which Mary Nyangweso (Ibid.:19-20) has identified. These are utsiye emakombe m'mbafu (s/he has gone to the spirit world); ulangilwe (s/he has been called [by the departed to join the spirit world]); ufiye (s/he is dead, referring to all deaths, generally); lumulambisiye (death has finally 'stretched' her/him); ukon'ne tsindolo (s/he has fallen asleep); ukor're (s/he is lost); utsiye okhuraka amabwoni (s/he has gone to plant potatoes); and ukhurangiliye (s/he has preceded us). Though, at face-value, these expressions confirm our earlier observation that death among the AbaNyole was treated as an accepted reality, they raise a very important question: does this mean that it was natural? It would seem, from the face of it, that man was a passive victim of death and therefore innocent
with regard to its origination. Indeed, the absence of a myth explaining the origins of death seems to confirm this conclusion.31

A deeper analysis of these expressions however shows that though death was an accepted reality, it was "received differently" (Nyangweso, 1992:21). Thus, while utsiye emakombe m'mbafu (s/he has gone to the spirit world), ulangilwe (s/he has been called), utsiye okhuraka amabwoni (s/he has gone to plant potatoes), and ukhurangiliye (s/he has preceded us) draw our attention to the fact that death as a decisive break did not exist, that "life after physical death (went) on in a sense that (was) much more realistic and immediate than ... the Christian idea of immortality" (Wagner, 1949:90), ukor're (s/he is lost) expressed both the idea of the loss "a family experience(d) of the death of a relative, and the immediacy with which this loss was associated with the coming to "a standstill" of the "good deeds" of the deceased (Nyangweso, 1992:20). This was different from the expressions ukon'ne tsindolo (s/he has fallen asleep) and lumulambsiye (death has finally 'stretched' him/her). While ukon'ne tsindolo draws our attention to sleep as a symbol for "alternation and duration" (Sow, 1980:190), lumulambsiye in 'Nyole everyday discourses on death refers to the demise of those who had been wicked and thought they were immortal, or "killed others as if they themselves would never die" (Nyangweso, 1992:20). Both expressions are about the two opposing pairs of wakefulness-immortality and sleep-death in that while immortality, on the one hand, "follows a continuous line (connoting perpetual wakefulness)," mortality on the other "appears as a rhythmic succession of alternating wakefulness and unconsciousness. By blotting out consciousness and memory, sleep removes man from immediate social life, just as death removes him from organic life" (Sow, 1980:189-190). According to the AbaNyole, while ukon'ne tsindolo denies the basis for a complete break between the dead and the living, and thus is a good death, lumulambsiye is bad death that is justly earned.32
The significance of these expressions lies in what could be described as the symbolic themes used in 'talking' about life and death, and in issues that attempt to give form to the crucial questions of man's origins and destiny (Sow, 1980:179). From what we can learn from our two texts as well as the above expressions, the various thematic representations of life and death are not only "always indissolubly linked"; they are also "animated by the complex play of dialectic complementarity" (Ibid.) giving, as it were, a firm basis upon which notions about misfortune and disease can be understood. This, however, leads us to a paradox. There is in our two representative texts, on the one hand, the problem of the symbolic significance of the suggestion that death being inevitable, it was meant for all since "even to loved ones (it) must bid farewell." On the other hand, there is the all powerful representation of death as a "strange animal" that not only confounds but also leads to "confusion" in man's chosen journey of life from the east to emakombe (the land of the living dead). It seems that apart from the link between the living and the dead this paradox attempts to establish, there is a hint at what I.Sow (1980:180) has correctly seen as the reason why death in most African societies is "interpreted more than it is really explained." Itself seen as a symbol referring to "something other than itself," and because of the absence of any explanation of human suffering in the various ways it manifests itself, it only succeeds in leading to the telling of how and not in explaining why (Ibid.). It might be argued that what this paradox suggests is that, since there was no myth explaining it origins among the AbaNyole, death was a chance occurrence. If this is so, then why, to use I.Sow's words, is it that disease and death among these people were always "thematically portrayed as a relational conflict, a breakdown of communication, an aggressive assault, always evoking the most fundamental symbol of rupture"? This question cannot be answered apart from the understanding of the second theme in our representative texts, the oppositional relationship between Ebukwe (East) and Mumbo (West). Suffice it to say here that the essence of misfortune among the AbaNyole revolved
around the fear, real or potential, diffuse but fundamental, of "a resurgence of the state of primordial violence" (Ibid.:181) that could be found in the violation of what Gunter Wagner (1954) has described as the neutral ritual status of these people. This had to do, to quote Sow (Ibid.:181) again, with "a lack of distinction ... undifferentiation ... the absence of stable and well-defined bonds" that could give rise to, or account for, "the symbolic practices and manipulations aimed at restoring ties in the cultural order."

Notions about life and death among the AbaNyole were not only inscribed in the layout of homesteads and in the physical environment, but were also captured and articulated in what Michel Izard (1991) has in reference to the cosmology of the Mossi of Burkina Faso called "the axis of human destiny", that is, the oppositional relationship between Ebukwe (East) and Mumbo (West). Gunter Wagner (1954:33), writing on the Abaluyia generally, has noted that "the north and the south (in Luyia cosmology) are treated with indifference, whereas the east is in various ways identified with life, health, and wealth, and the west with illness, evil magic, misfortune, and death." Among the Abaluyia, "not only does the sun rise in the east, bringing 'milk and health' with it, but the rain, too, comes from that direction, and all major streams flow from the east or north-east. The symbolic meaning attached to the east and west thus receives support from the nature of the local environment." Though Wagner denies the ritual significance of such physical features as "the broad massif of mount Elgon" and the Kavirondo Gulf of Lake Victoria among the Abaluyia, he nonetheless acknowledges that among the Abalogoli "the waters of Lake Victoria serve as a dumping-ground for witchcraft medicine." According to Wagner, "a person who believes he has been infected with elilogo (witchcraft) must immediately set out for the lake and throw all his clothes into the water, as this is thought to be the only effective means of getting rid of the elilogo" (Ibid.:33-34). Needless to say, the AbaNyole had a similar belief because the Lake not only lay in the west (mumbo) where the sun was
thought to take all the vicissitudes of everyday life in its trip from the east, but also because its expansiveness reflected the otherness of death. But the Lake, perhaps because of its supposed calmness, or perhaps because of the divinational qualities that were attributed to the calmness of water after the arrival of ebikanda sometimes in the nineteenth century, was thought to be endowed with prophylactic properties that went into the management of a myriad of ailments among the AbaNyole. This ambiguous status of the Lake was to become, in the twentieth century, a major point of contention over the question of whether it was morally right for the AbaNyole to continue with an eighteenth-century practice of drumming and ritually dispatching esibi okhutsia okhukwa munyanza or mumbo (evil into the lake or in the west generally) since they had become avid consumers of fish from this same Lake.

Within its wider conspectus, the opposition between the East and the West brings out the notion of boundaries, tsitsakho (sing. olwakho): between day and night, bush and homestead, and, as we have seen in the case of generational differences, between life and death. To just take one example, the day in 'Nyole cosmology is like that space between the before-and-then and the after-and-now since it lies between the east, the source of life, and the west, the harbinger of death. The day in this case was a microcosm of the 'Nyole world as it represented that space in which the needs for survival and the forces of destruction were confronted and negotiated. The importance of the day thus lay as much in the fact that it provided that space in which cosmology became "a consciously perceived order" that stressed, as it were, "the human and largely individual negotiation and control of ritual and temporal power," as in the appreciation of affliction as "the symbolic expression of structurally ordered competition" (Comaroff, 1980:640).

According to oral data,
the head of every 'Nyole homestead used to wake up very early in the morning before any other person in the compound. He would then survey the homestead to find out whether there had been any bad goings-on during the night. If he satisfied himself that everything was in order he went back to the house. At Obukwe nibuseba (break of dawn), he again left the house to begin okhwekayakaya (lit. to deny himself) before the rising sun. This was in front of the house, on olusambwa (the homestead shrine).  

To the rising sun these words were said: "Eliuba (sun), when you come from ebukwe (east), bring us milk, wealth, honey, and health and take esibi (misfortune) to Mumbo (west)." These two points on the horizon represented by the East and West, respectively, can be seen as, on the one hand, the beginning of life and, on the other, the end of life. Their importance was reflected in the layout of homesteads which, well fenced, had two entrances: the main, front gates called esilibwa sie'bulunj (lit. the gate of the straight forward), and esibil'li which was on the left side of the homestead and was used mainly by women when they went to fetch water and collect firewood. According to my informants, "all people entering the homestead had to use the main gate. Those who did otherwise, especially men, were 'named' and even songs composed about them to tell the world what kind of people they were. Any person who failed to use any one of these gates when entering the homestead was referred to as one who went through musibanga meaning such a person was potentially dangerous. 

The comprehension of this world is perhaps well brought out in the spatial arrangement of the homestead, on the one hand, and the discontinuity between oluhia (the microcosm) and esitsimi (the mesocosm). Oluhia referred to that socialized space of practical everyday life and esitsimi, which began at the edge of the village, encompassed, in large part, "the bush and the forest, that is, natural uncultivated space" (Sow, 1980:134). But Oluhia was also about amatala (homesteads; sing.:litala) which, as ritual constituencies encompassed residential clusters and their periphery of emikunda (cultivated lands) and
*ebiayo* (grazing grounds) as it excluded *esitsimi*. This distinction was implicit in the way the house was organized, and also in the aesthetics of everyday life, in ritual forms, and in gender relations. If *oluhia* was therefore about everything domesticated, *esitsimi* was about everything wild. Indeed the word *esitsimi* is etymologically related to the word *tsimaa*, meaning put off the light. In other words, it was related to darkness with all its attendant dangers including witches' palavers, the activities of sorcerers, and the coming out of *ebisieno* (evil spirits) from their hiding places in hilly areas, forests, *tsikhombe* (caves), valleys, and lakes. 38

Thus, while on the one hand the contrast between *oluhia* and *esitsimi* intimated at the idea of cultural control and ranked nature, the spatial organization of the centralized, enclosed *litala* encoded the gendered nature of the axis of human destiny (Comaroff, 1980:640), viz., BACKYARD:WOMEN::FRONTYARD:MEN. The front part of the homestead was always the male domain and this is where the *olusambwa* (homestead shrine) and *omukitsi* (courtyard but also place of the homestead head) were located. This was in contrast to *ekwandiangu* (backyard) or *esibil’li* (lit. worldly) where domestic pursuits, but also the process of nurturing "associated with matrilateral solidarity and moral unity" (Comaroff, Ibid.), were organized. Thus, if *omukitsi* was "associated with maleness and agnatic interaction," and it fronted onto "the communal space beyond," *ekwandiangu* mediated between "the cultural centrum ... and the wild" (Ibid.). But, from a wider conspectus, *emukitsi* (in-front), also referred to as either *ebulunji* (lit. of the straight forward) or *ebulafu* (in the light), stood contradistinctively to *ekwandiangu* (backyard), *tsikheya* (banana groves), *emikunda* (cultivated fields), and *ebiayo* (grazing fields). The latter were spheres of production and reproduction and, by their very nature, they formed not only the peripheral margins to the former but also the point of exit where the social gave way to
nature "over which control (was) tenuous" (Comaroff, Ibid.). It can be argued that if in the
former, basically male domain, social action 39 centered on questions of what esitsimi
portended for society, in the latter domain it revolved around concerns with fertility in
women, livestock, and fields as well as with issues about rites of regeneration and renewal.
It was enukitsi, a ritual space but also an arena of public discourses on what was and what
ought to be where olusambwa (homestead shrine) was located. Like rkisi among the
Kongo (Sow, 1980:90-91), olusambwa was an artifact designed to subdue the invisible
creatures of the mesocosmos since the finished products it was made of -- the three stones
and the olusioda stick -- were directly taken from nature to constitute "a veritable distillation
of the laws" of this nature. But olusambwa was, as a homestead's sacrificial site (Wagner,
1949:282), also both a point of conjunction, a place of contact between oluhia
(microcosm), esitsimi(mesocosm), and emakombe (the macrocosm) as represented in the
three forking points on the olusioda stick and the three stones around the stick, and a system
of constraint in the business of maintaining balance and order in society.40 It was here that
homestead enisango (sing.:omusango) or okhwetisaa (sacrificial rituals) like okhubita
obuwanga (the spitting of a mixture of millet flour and water as a way of cleansing
members of the homestead) were carried out by the omusalisi (sacrificial priest). These
were rituals for dealing with misfortune whether this had been brought on by sorcery,
witchcraft, ancestral retribution, murder by a member of the homestead, or any other agent
of disorder.

Ekwandiangu (backyard), tsikheya (banana groves), emikunda (cultivated fields),
and ebiayo (grazing fields), though belonging to the domesticated realm of litala
(homestead), were asymmetrically related to enukitsi (in-front). These spaces spoke to,
and about, the relationship between good and evil, the individual and society, and life and
death. This brought out 'Nyole notions of health as the expression of man's harmony with
the universe, but also the understanding that what caused dis-ease could also bring about
the failure of crops, ill-luck in hunting, or incompetence in the completion of an important
task in the homestead. It was in these spaces that ideas about libaa mwowo (beingness),
onimbili (body), amakani (mind), ebikhole (activities), tsinganakani (thoughts), and
obuhul'lisani (social relations), on the one hand, and the secretions and effluvia of the body
like feces, lochial blood, saliva, urine, sperm, etc. on the other, were thought to be
simultaneously confounding and regenerative. Two examples will suffice here. First is
how the words tsimbeko (offshoots/ seeds. sing.: imbeko) and tsimwo (seeds. sing.: imwo)
were used to talk about the paradoxical or ambiguous condition of life and death. Tsimbeko
were those seeds that had carefully been chosen from a previous harvest to be used during
the next planting season. But the word was also used to mean either products of these
seeds which could be plucked and planted elsewhere, or an offspring as in the father
referring to a child he was proud of as imbeko yanje (my seed/offshoot). Tsimwo, on the
other hand, was mostly used to talk about seeds in the literal sense. But when used
metaphorically, it meant sperms whose correct word was obutsiva. Now obutsiva also
meant poison especially the type transmitted through a snake bite or the sting of a bee.
While the patterning of meaning in tsimbeko and tsimwo is straight forward, that in
obutsiva draws our attention to a moment of synthesis of life and death. How do we
explain this synthesis? Can man be seen as the embodiment of order and disorder,
primordial elements that were transmitted to a woman, through sexual intercourse, in form
of pregnancy? Indeed, in 'Nyole everyday discourses, to impregnate a woman is referred
to as paralyzing the woman through okhurema esilenje sie (to cut her foot). The answer to
this question lies as much in our understanding of disorder as deviance in whose interstices
were to be found the essence of life -- conception, growth, and maturity -- as in 'Nyole
notions of the body. Conception, growth, maturity and all that these stages entailed were all
processes that bordered on disorder.
The body in 'Nyole cosmology was not only continuous with the environment where such bodily secretions like feces of potent men was thought to pass to the soil the potency of these men's bodies, or a woman's lochial blood was thought to be harmful to ripening crops in the field; it was also continuous with other bodies in the social unit, a continuity that brought out the strength or weakness of the unit as when the body was healthy or sick. In sickness the body exposed the whole unit to danger and, unlike biomedicine which recognizes this as contagion and explains it scientifically, the AbaNyole recognized a different order of contagion pollution and acted according to a different conception. Thus esiluchi or okhuratsia esitsahi (murder) by a member of a community exposed the whole unit, as well as its land, to dangers of pollution. There was also amatsahi mahiu (hot blood) which, like a woman's lochial effluvia, was dangerous to both the land and other members of the community. Blood was hot immediately after sex, or in a woman's later stages of pregnancy. Bereaved spouses who were parents exuded hot blood, just as a new born baby was considered to be 'dirty', because of hot blood, until a purification ceremony was carried out. In short, hot blood led to paralysis, or sterility, or even death to a sexual partner.

This conception of continuity also provided the framework in which the image of the body was defined and understood. At one level, the material and non-material dimensions of society were so inextricably enmeshed so that ideas about mwoyo (meaning life as opposed to omwoyo meaning heart) and om'mbili (body) tended for example to subsume both physical and social identity. As among the Tshidi of Southern Africa (Comaroff, 1980:643) the self among the AbaNyole was "not perceived as confined within visible limits of the body; it extend(ed) to encompass the more general sphere of personal influence upon the environment, inhering in words, footprints, and personal possessions." While words were dangerous tools in retributive dealings between elders and juniors, or
between parents and children, footprints and personal possessions like pieces of cloth, food leftovers, hair, or nails were the province of omuroli (sorcerer) who could use these items to cause dis-ease or even death. At another level, the body did not have sharp boundaries since its different parts were stressed in forming the link of continuity: just as lineal continuity with a descendant was envisioned as a continuity of the internal organs as in a father talking about his most loved child in terms of so-and-so nomwoyo kwanje (is my heart), so was a lateral relationship which was one of blood as in the expression my brother or sister namatsahi kanje (is my blood). Evil like ebikhokho and obusula (bad-eye) was thought to flow through the eyes when an individual become covetous.

But the body was never complete at birth. It had to be added to for purposes of increasing it either in maleness or femaleness or in potency and effectiveness. Thus, to be truly male, one had to go through circumcision which marked the transition from the uterine domestic sphere to the male domain, otherwise the body on its own accord was not completely potent: the blood shed during circumcision signified continuity with the land just as the removal of the foreskin enhanced personhood and maleness. The woman was scarified on the lower abdomen and across the forehead (tsimochelo) not just for aesthetic purposes but also for enhancing her femaleness as the grounding of sexual and reproductive maturity within the domestic sphere. This completion was not just for the body: it also symbolized the continuity with the social unit. The introduction of ear-piercing and the plaiting of the hair among 'Nyole women in this century, for example, is not only a departure in meaning from the idea of completion, but has also come to symbolize the tension between the younger and older generations and the break from what defined womanhood in this society. Thus the word owakatula which literally means "the one who has severed" has increasingly come to be used both in reference to a prostitute and in the construction of a woman with independent means of livelihood.
If these spheres were, as we have seen in the foregoing narrative, simultaneously confounding and regenerative, they were, from a Turnerian perspective, liminal spaces in which specific relationships between symbolic processes and social dynamics took place. These were relationships fraught with, and enmeshed in, ambiguous conditions (Turner, 1967:97) and they alert us to, first, the question of ritual action and its focus on the body not just as "a sociological mechanism for the production of order, but also a cosmological and symbolic site for the containment of chaos and the regeneration of the world" (Dirks, 1994:487). To suggest this raises the question of the relationship between emukitsi, the public and basically male domain, and ekwandiangu, the domestic female domain and the supposed domination of the former over the latter (Wagner, 1949:40-54; 1956:1). This, needless to say, is about knowledge and how this knowledge was related to power. But, more fundamentally, we are reminded of the fact that as antistucture, as a liminal space, ekwandiangu must have provided emukitsi with powerful preconditions for controlling it. It might be argued that because rituals like female scarification constituted "a tremendously important arena for the construction of authority and the dramatic display of the social lineaments of power" (Dirks, 1994:487), they were not only about disorder but also the conservation and transmission of ideas about the 'Nyole collectivity. It is indeed Dirks's argument that rituals not only provide "critical moments for the definition of collectivities and the articulation of rank and power;" they also "often occasion more conflict than consensus, and ... each consensus is provisional, as much a social moment of liminality in which all relations of power (and powerless) are up for grabs as a time for the reconstitution and celebration of a highly political (and thus disorderly) ritual order" (Ibid.:488, emphasis added).

Though Dirks was writing about the festival of Aiyantar, a political ritual that inaugurated "all other village rituals" in the Kingdom of Pudukkottai in the Tamil-speaking
region of southern India (Ibid.), his postulation, when broadly applied, seems to suggest that the reconstitution of power/knowledge does not necessarily have to take place within the logic of the reconfiguration of known and therefore given structures. The understanding of this process lies, as Steven Feierman (1991:107) has suggested, in the positions taken by peasant intellectuals during what Dirks himself has called "the struggle between discourse and event" (Dirks, 1994:494). This point is worth belaboring if only for the reason, and this brings us to our second point, that the domestic sphere's conditions of possibility lay as much in its confounding ambiguities as in ritual power as critical reflection. As Victor Turner (1967:97) has argued, "Liminality may perhaps be regarded as the Nay to all positive structural assertions, but as in some sense the source of them all, and more than that, as a realm of pure possibility whence novel configurations of ideas and relations may arise." It was in this sphere that the universalizing visions of 'bene liloba were not only contested and even negated, but also new ideas about health were formulated and reformulated as the body, as cultural space, was fought over. As the point of exit where the social gave way to nature, "undoing, dissolution, decomposition" in this sphere were "accompanied by processes of growth, transformation, and the reformulation of old elements in new patterns" (Ibid.:99). Thus, if liminality was partly "a stage of reflection" in which "neophytes (were) alternately forced and encouraged to think about their society, their cosmos, and the powers that generated and sustain(ed) them" (Ibid.:105), it was, unlike the more stable public male sphere, more prone to receptivity and experimentation with new ideas. This was the more so because, always in a state of disruption, the domestic sphere was not just about "claims about authority and struggles against (and within) it" (Dirks, 1994:488). It was also an arena in which new knowledge about the body, not necessarily for or against 'bene liloba's hegemonic stance, or even for the male domain, was produced and propagated.
This observation points to the homestead, as *habitus*, for the understanding of
Nyole notions of causality not only because of what Jean Comaroff (1980:642) has
elsewhere called rites of prohibition "governing the interaction between men and women
and their environment," rites which both "minutely reproduced the ordered categorization
of this symbolic universe: relations between men and women, private and public, and
things domestic and wild," and subjected these categorizations to careful control. As much
as the mediation between these "categorical oppositions was the basis of potency and
creativity; and their confused mingling unleashed polluting destruction (which was) a
significant component in indigenous notions of affliction and distress," they were also
about new knowledge, the exercise of this knowledge, and the relative position its owners
-- diviners, herbalists, and sacrificial priests -- occupied in a constantly changing cultural
order. Thus if affliction was "the dislocation of self and context" and healing "the
objectification and restructuring of such dislocation" (Ibid.:644), the identification and
management of affliction lay as much within "specific contexts of practical experience
where it serve(d) to impose meaning upon the flow of everyday events" (Ibid.:643) as in
the acquisition of, and experimentation with, new ideas as could be found within an ever
expanding terrain of therapeutic possibilities.
Endnotes

1 For an extensive review of some of these works see Paul Riesman (1986).


3 The relationship between structure and practice has for sometime now been the object of debate and analysis for many social science theorists. In outlining a 'theory of practice' Pierre Bourdieu (1977) has, for example, drawn our attention to the distinction between, on the hand, observing and analysing social events and, on the other, participating in activities. According to Bourdieu, while structuralism allows an observer to see how pattern is generated, it does not help him or her to see the utility structures are put to in constantly changing situations. Bourdieu, not unlike Anthony Giddens (1979, 1981), is therefore concerned with the development of theories of practice or social action in which there is a recursive relationship between structure and practice. Of particular importance here is his notion of Habitus which he situates between structure and practice in relation to the use of space. Habitus, defined as the "strategy-generating principle (or structure of social practice) enabling agents to cope with the unforeseen and ever-changing situations" (1977:72), is socially constituted and materially continuous. The home is such a principle since it is a place where not only such coping knowledge and understanding is generated, but also social relations are played out within the house: "through the intermediacy of the divisions and hierarchies it sets up between things, persons and practices, this tangible classifying system continuously inculcates and reinforces the taxonomic principles underlying all the arbitrary provisions of this culture" (1977:89). Thus, echoing M. Merleau-Ponty who in 1962 observed that "space is not the setting (real or logical) in which things are arranged, but means whereby the positing of things becomes possible" (1962:243), Bourdieu has posited the all important argument which this study adopts: that the "meaning objectified in things or places is fully revealed only in the practices structured according to the same schemes which are organized in relation to them (and vice versa)" (1977:90). But Bourdieu's theory has another, equally important, relevance for this study. His areas of practical knowledge -- the use of the body as a map or framework by which people 'live through' their Habitus -- helps us to see how its symmetry naturalizes contradictions in society, for example between social control by lineage heads and socialized production. The theory thus invites us to understand the principles behind both 'Nyole involvement in objects arranged in space and in contexts of use when dealing with the meaning and management of affliction. It is on the basis of this that we would want to argue after Bourdieu that it is through practical enculturation that "a whole cosmology, an ethic, a metaphysic, a political philosophy, through injunctions as 'stand up straight' or 'don't hold your knife in your left hand'" (1977:94) that the social world is formed.

4 One such reading is provided by Rhys Isaac, perhaps one of the finest historians of cultural geography in the U.S.A. today. In an attempt to elicit patterns of life in Virginia, U.S.A., during the second quarter of the eighteenth century, Rhys Isaac (1982, 1988:19) has through a 'reading' of the arrangement of social space cogently argued that "(s)haping environment for use in accordance with ideas of well-being is a universal trait of human behavior." According to Isaac, "A society necessarily leaves marks of use upon the terrain it occupies. These marks are meaningful signs not only of particular relations of a people to the environment but also of the distribution and control of access to essential
resources. *Incised upon a society's living space appears a text for the inhabitants -- which he who runs may read -- of social relations in their world.* Moving more slowly, anthropologists for present societies, and historical ethnographers for past ones, must seek to interpret such texts -- both to understand the relations of production inscribed upon the land and to decipher as much as they can of the meanings that such relations assumed for those who were part of them." In the last part of the book (Discourse on Method), Isaac qualifies this important argument by observing that "society is not primarily a material entity. It is rather to be understood as a dynamic product of the activities of its members -- a product profoundly shaped by the images the participants have of their own and others' performances" (P.324). This is the more so because, "consisting of more than words (culture) also comprises gesture, demeanor, dress, architecture, and all the codes by which those who share in the culture convey meanings and significance to each other. Through a process of elucidating contexts, structures, and meanings, we can learn to reconstruct something of the participants' worlds as they experienced them" (p. 325). Following Isaac, it can be argued that "the generally available, public symbols" like Wekhomo and Bunyore Hills, as well as shared meanings these symbols generated, were mediums through which actors related to, and communicated with, one another. From this perspective, culture is a composite of "interlocking sets of paradigms, or metaphors, that shape participants' perceptions by locating diverse forms of action on more or less coherent maps of experience" (p. 347)

5 In his criticism of structural-functionalist theory, Clifford Geertz (1973:143) has through a reading of P. Sorokin (1937) cogently argued that one of the major reasons for the inability of this theory to cope with change lies in its "failure to treat sociological and cultural processes on equal terms." For the concepts of this theory to effectively deal with historical material, he has further argued, they should distinguish "analytically the cultural and social aspects of human life" while at the same time treating these aspects "as independently variable yet mutually interdependent factors." Thus, he sees culture as the "framework of beliefs, expressive symbols, and values in terms of which individuals define their world, express their feelings and make their judgements." Geertz in this case is not far from Rhys Isaac's ([1983],1988) definition of culture when he says that it is "the fabric of meaning in terms of which human beings interpret their experience and guide their action" since its basic characteristic, a "logico-meaningful integration," directs our attention to the fact that it is "a unity of style, of logical implication, of meaning and value." But unlike Isaac, Geertz is more explicit in drawing a distinction between culture and social system. While the one is "an ordered system of meaning and of symbols" where "social interaction takes place," the other is "the pattern of social interaction itself." Thus, the social system is the domain of ongoing processes of interactive behaviour "whose persistent form we call social structure" or "the form action takes, the actually existing network of social relations." Geertz thus concludes that "culture and social structure are then but different abstractions from the same phenomena. The one considers social action in respect of its meaning for those who carry it out, the other considers it in terms of its contribution to the functioning of some social system." The basic characteristic of the social system is its "causal-functional integration," that is, "the kind of integration one finds in an organism, where all the parts are united in a single causal web .... And because these two types of integration (the logico-meaningful and the causal-functional) are not identical, because the particular form one of them takes does not directly imply the form the other will take, there is an inherent incongruity and tension between the two and between both of them and a third element, the pattern of motivational integration with the individual which we usually
call personality structure." The contradictions between these three types of integration
define the contours of the historical processes of culture change.

6 This is a reworked version of a combination of the original text as recorded by Helen
Aswani (1972:10) and Jane Nandwa (1985:15-22).

7 See also Gunter Wagner (1954:35) who, writing on the Abaluyia generally about this
point, has pointed out that in folktales "the land of the dead is always described as an exact
replica of the land of the living." He could as well have been talking about esitsimi because
emakombe as the home of the chosen dead as Mary Ngwangweso (1992) has pointed out
was not the same as the valleys, hills, forests, or bushes around villages whence ebisieno
or spirits of possession hid always waiting to strike at night or in the dark.

8 Oral Interview, Hosea Khayanje, Ebulisoli Mwilonje, North Bunyore Location, 30/12/92
and 31/12/92. According to this informant, the Abamuchina kept these ritual drums in the
roofs of their houses. When the ropes that held them in place snapped, "the Abamuchina
would pick up the drums and start beating them. This would spread to other parts of
Bunyore, ending in a general progression in Munyanza (Lake)."

9 Oral Interview, Mang'ong'o Mahanga Odalo, Ebuhando, Karateng'i Sub-Location, Ojola
Village, Nyanza Province, 20/11/92. Nganyi is the reputed first high priest of the rain-
shrines in Esibila Hills, Ebusieke. Gunter Wagner (1954:29) records a similar myth
among the Bukusu of Bungoma District, Western Province, though he sees this as part and
parcel of the wider scheme of the Bukusu myth of creation.

10 Oral Interview, Imbale Kutai, Emuchula Village, Essaba Sub-Location, West Bunyore
Location, 8/11/92.

11 Ibid.

12 Oral Interview, Esitambale Anabwani, Ebusamia sub-location, North Bunyore
Location, 16/11/92.

13 Oral Interview, Mang'ong'o Mahanga Odalo, 20/11/92.

14 Oral Interview, Joshua, Esibambala, Emmukunzi Emakunda, North Bunyore Location,
15/11/92.

15 Ibid.

16 Oral Interview, Mr. and Mrs. George Malema, Em'mukunzi Emakunda, North Bunyore
Location, 24/11/92.

17 Early colonial reports are full of episodes of inter- and intra-clan fights over land.
Writing on these fights in 1910, D.R. Crampton for example points out that the AbaNyole
were "numerous and their country none too large." Otieno, in the same report, points out
that "people of Bunyore have been fighting among themselves." D.R. Crampton comes to
the crux of the matter when, in 1913, he says that about "20 years ago the Wawai
(Ab'bayi), a clan of Unyore (Bunyore), drove the Wasiroli (Abasiloli), another clan in

18 This is a descriptive term referring to the process whereby a person who had acquired wealth and feared that his neighbor or kinsman was trying to destroy him or his family, went to Bunyala where experts could 'cook him' in a huge container of water. After this, now immuned, he would go back to his home and, during one night, would go to his 'enemy's' homestead and call him. If the 'enemy' responded at the first call, he/she would certainly die.

19 So-called because it is said to have affected even women who were 'known' never to suffer from famines.

20 Oral Interview, Aggrey Anduru, Ebusiratsi Ekamanji, East Bunyore Location, 4/1/93. It is important to note here that one of these epidemics, inundu, was so serious that it in later years became a metaphor for explaining all types of epidemics in Bunyore. In the twentieth century inundu was not just smallpox; it was used to talk about all sorts of life-threatening diseases.

21 Oral Interview, Taisi Mukabi, Ebulielo Village, West Bunyore Location, 15/11/92; Mang'ong'o Mahanga Odalo, 20/11/92; Walter Odera, Ebulako Village, Esibembe SubLocation, South Bunyore Location, 18/11/92.

22 Oral Interview, Aggrey Anduru, 4/1/93

23 Oral Interview, Mangongo Mahanga Odalo, 20/11/92; Walter Odera, 18/11/92.

24 On this development, see chapter two, section 2-6, above.

25 As defined by Steven Feierman (1991:17-18, 22-24, 105-112, 123-124), these were men and women who, because of their "place in the unfolding social process ... engaged in socially recognized organizational, directive, educative, or expressive activities." In other words, these were people who "earned their daily livelihood by farming" but, at crucial historical moments, elaborated new and often dissenting discourses without losing their "valued occupations" as farmers.

26 Recorded by myself during fieldwork. Though it might appear as one song, these are in fact a series of short songs that can be sung either individually or in a group. They are fairly common and popular and, alongside Christian singing and drumming, cannot be missed at almost all 'Nyole funeral wakes.

27 To be admitted, or welcomed to settle, in 'Nyole society needed sponsorship from a respected member of the society.

28 According to G.S. Were (1967a:131, 133), by the middle of the nineteenth century the social and political constitution of clans was a foregone conclusion since "the ancestors of
the main communities had (by this time) firmly established themselves in the country and therefore become either uneasy or indifferent neighbours since they had separate origins and interests. "This was the more so because "various clans and sub-tribes were extremely jealous of their independence. And since every major clan was a sovereign state, this meant that outside the borders of any such a clan all other communities were regarded as foreigners."

29 According to Jean Comaroff (1980:639), "where relations with kin are also potential ties of affinity, personal identity and location within a basic unit of relations are not 'given': they become the subject of explicit definition and management." This ambiguity of individual ties, as well as "the absence of discrete corporate units", are not only importat to the symbolic order of "the Tshidi cosmos, to moral categories, and to the perception of causality in disorder and affliction", but also to the rise of "an explicit ideology of utilitarianism ... and self-consciousness as to the person's engagement in the encompassing world." This has fundamental relevance to "Tshidi perceptions of well-being and affliction."

30 Perhaps the most comprehensive definition of these two concepts is that given by G.M. Foster (1976:775). According to Foster, a "personalistic medical system is one in which disease is explained as due to the active and purposeful intervention of an agent, who may be human (a witch or sorcerer), non-human (a ghost, an ancestor, an evil spirit) or supernatural (a deity or other very powerful being). The sick person is literally a victim, the object of aggression or punishment directed specifically against him, for reasons that concern him alone. Personalistic causality allows little room for accident or chance ... naturalistic systems explain illness in impersonal, systematic terms. Disease is thought to stem, not from the machinations of an angry being, but rather from such natural forces or conditions as cold, heat, winds, durness, and, above all, by an upset in the balance of the basic body elements" (Emphasis in the original). For a critique of this conceptualization see, for example, M. Fortes (1976), P.S. Yoder (1982), and Marc Auge (1985).

31 For a myth explaining the origins of death among the Bukusu, see Gunter Wagner (1949:169-70).

32 M. Bloch and J. Parry (1982:15) have suggested that the contrast between 'good' death and 'bad' death has to do with the extent to which death is seen and controlled. "The 'good' death is ... the one which suggests some degree of mastery over the arbitrariness of the biological occurrence by replicating a prototype to which all such deaths conform, and which can therefore be seen as an instance of a general pattern necessary for the reproduction of life. By contrast ... those deaths which most clearly demonstrate the absence of control and those which are represented as 'bad' deaths and which do not result in regeneration." Such bad deaths, which also point at the dissolution of ritual boundaries, causing ritual impurity, include homicide, suicide, and death by drowning. On the Abaluyia, generally, see Paul Bohannan (1967). From this perspective, death among the AbaNyole was not just about causes and blame-apportion; more fundamentally, death provided the opportunity for explicating 'Nyole notions of order and disorder and on the one hand, and, on the other, personhood and agency. Death was, above all, about the margins of social life which created a variety of experiences since it occasioned breaks in the continuity of social reality which in turn created feelings of anomie or identity crisis, as well as breakdowns in the organization of interaction.
33 Oral Interview, Mang'ong'o Mahanga Odalo, 20/11/92. For the nautical symbolism of Lake Victoria among the peoples of its eastern shores in Kenya and the Baganda in Uganda, see Michael G. Kenny (1977).

34 Oral Interview, Njeli Atieli, Emuchula Village, Essaba Sub-Location, West Bunyore Location, 4/12/92.

35 Oral Interview, John Oluchina, Ebusiratsi Ematsuli, Mundoli Village, North Bunyore Location, 19/11/92.

36 Oral Interview, Johnstone Achul'Iu Atieli, Ebutongoi Es'saba, West Bunyore Location, 22/12/92. According to this informant, the homestead was fenced using amarobo shrubs, or an olwakhi (ditch) was dug around the entire homestead.

37 Ibid.

38 Oral Interview, Sylvester Andai Njeche and Nyonje Atieli, Emuchula village, Es'saba Sub-Location, West Bunyore Location, 5/11/92.

39 Social action is here seen as being predicated on an already well-articulated cosmology. Put another way, cosmology is prior to social action since "all communities implicitly accept a cosmology, a certain concept of the universe and the place of man within it" and which provides "the ultimate conditions of action" (W. MacGaffey, 1986:3).

40 Olusambwa was a three-thronged stick which was erected on the right hand side of the first wife's house. The stick was surrounded by three stones collected from a mountain or hill by a special person. These stones were "considered pure as no person was thought to have stepped on them." Oral Interview, Imbale Kutai, Emuchula Village, Essaba Sub-Location, West Bunyore Location, 8/11/92. The stick was carved from an olusiola tree and it was about 5 to 7 centimeters in radius. Oral Interview, Aggrey Anduru, Ebusirati Ekamanji, North Bunyore Location, 4/1/93. Gunter Wagner (1949:282) describes olusambwa among the Abalogoli, Abatirichi, AbaNyole, Abamarama, and Abatsosato thus: it "consists of a set of three (sometimes also of four or more) stones ... arranged in a triangular shape like the hearth stones and erected in the yard in front of the living-hut. Each of these stones is about 3 or 4 inches high, and the sides of the triangle formed by them vary between 10 to 15 inches in length. A sprig of the olwovo-tree (sic!), thought to be a favourite abode of the ancestral spirits, is placed in the centre of this stone setting. Sometimes a circular arbour is erected above it, so that the sacrificial shrine looks like a miniature native hut without walls." This olusambwa was only erected at the homestead of men who enjoyed the full social status of a family head (pp.283-284).

CHAPTER FOUR
HEALTH AND HEALING IN BUNYORE: CHRISTIANITY AND THE
MAKING OF A BIOMEDICAL SOCIAL FORMATION

4.1 Introduction

Esikhumala sikhuchakanga butoro

In a picturesque, symbol-laden, and vivid description of Bunyore Hills in 1956,
Elizabeth Richards (1956:47) captured the tensions between African and Western
(British) knowledges on health and healing in Africa when she wrote:

In the shelter of the low-flying Bunyore Hills lies Maseno Hospital - a
concentration of red-brick buildings not unlike a dolls' tow so compact are
the missionaries' houses, the dwellings of the African dressers and the line
of the hospital itself - on the shelf of ground beneath them. The early
morning sun topping their rounded crests lights up the plots at "Sunrise",
Maseno School and the offices, long before its rays reach the dolls' town
warming it and dispelling the sombre shadow cast over it by those hills.
And now as the light grows stronger the boulders - large and square as
houses - stand out clearly, their geometry thoroughly well-etched on the
hill-sides, the tall maize plants that sprout from each patch of soil between
them almost visible, the queer stunted trees and bushes hiding, we are
sure, the huts of rock-dwellers as secret and mysterious as the hills which
give them their sustenance. At this hour it is not hard to believe that the
witch-doctor exerts his sway on their summits and that at times sacrifices
are offered where the rocks are most hidden.

Here too is the tall boulder against which Dr. Green placed his
ladder when he took his guests for a morning climb to show them a
particularly fine view of Kavirondo country. The ladder made accessible
the perfect spot for a picnic breakfast while still leaving rock upon rock
for the adventurous to break their necks on. In front of the dolls' town is
the levelled flatness of the Sports Ground where on Boxing Day
competitions, tugs-of-war, football matches were held regularly and where
afterwards Dr. Green would assemble spectators and competitors alike for
evening prayers complete with sermon.

What the spirits on the hills would think at these invasions of their
territory one cannot conjecture. Perhaps they fled; perhaps they were
transformed and took the shape of the silvery-cheeked hornbills that roost
on the Grevilleas bordering the hospital road. If so they still haunt the
mission grounds, for haverings (sic!) of hornbills occupy the copses,
making the air loud with their harsh cry or flying with a heavy swish of
their black and white bodies to the clumps of microcarpa and eucalyptus
which grow near the school swimming pool (Emphasis added).
In its multi-layered texture, this text reveals, and directs our attention to, the problems of the relationship between 'science' and 'culture' in Africa, whether the two are complementary or diametrically opposed absolutes, and to that too important a question: to what extent, in the half-century presence of Western 'civilizing' forces, was the 'Nyole social and cultural landscape transformed? The text, in an attempt to address this question broaches, simultaneously, the dynamics of the making of a new social formation in Bunyore and the definition of, on the one hand, the space between Maseno Medical Mission and the 'Nyole World, and, on the other, the Medical Mission's symbol system and social practice. In this we are invited to direct our gaze at the importance of this space as the arena within which both the 'Nyole and Missionary activities were acknowledged, reflected upon, negotiated, defined, and invested with social and personal significance.

But the text also hints at a set of problems encountered in the process of making a colonial medical social formation. The profile to which our gaze is drawn is one that defines the normal requirements for self-definition: resistance and/or accommodation, boundary-marking, practices and views, rituals, and rites of entry and/or exclusion. It therefore opens up a perspective on the gap between what Medical Missions have, since their arrival in Bunyore, done and what actually is. This allows us, to paraphrase Frederick Cooper and Ann Stoler (1989: 609-610), to see how categories about diseases and disease profiles as well as these diseases' victims were constructed; how cultural boundaries were marked and maintained in the process of self-definition; how competing agendas of the Medical Missions, on the one hand, and those of the AbaNyole, on the other, were defined and invested with meaning as ideas about health shifted; and how contestations in and between these processes engendered a varied and variegated landscape in which ideas about pestilential affliction and its relief were produced. In these processes the otherness of the AbaNyole as felt and perceived experience by the
same was neither "inherent nor stable" since "social boundaries that were at one point clear (did) not necessarily remain so". This was so because, in the process of pursuing a concerted line of biomedicalization, the Christian Missions like the Colonial State "opened up a discourse on the question of whether still more 'civilizing' would make" the AbaNyole into still more healthier Africans "hence a less distinctive category" of beings. Looked at from this perspective, Gunter Wagner's (1949: 32) conclusion that the coming of colonialism among the Abaluyia (of which the AbaNyole are a part) led to "a steady process of Westernization" not only begs the question but also, in its unilineal understanding of Westernization as a transformational force, fails to address itself to autochthonous transformations among the Abaluyia.

4.2 Christian Missions and the Introduction of Biomedicine in Bunyore.

The missionary doctors have not only a natural concern for the welfare of their people, but a peculiar interest in gaining their confidence, if not a special aptitude for doing so. Macmillan, 1949: 230.

The establishment of Christian Mission Stations in North Kavirondo District goes back to the first decade of this century. By 1905 the Friends African Mission (originally the Friends Industrial Mission), the Church of God Mission in East Africa (originally the South African Interior and Mission Compound), and the Mill Hill Mission had been established at Kaimosi among the Tiriki, Musikomoli (Kima) in Bunyore, and at Mumias among the Wanga, respectively. Though the Church Missionary Society in 1906 claimed for itself 'a sphere of influence' among the Luo of Central Kavirondo, its presence at Maseno which lay just on the southeastern tip of North Kavirondo District assured it of followers first among the AbaNyole of present-day South Bunyore Location and later the Abakisa and Abamarama where it established outposts at Namasoli and Butere. These Mission Societies were followed in close succession by either their branches, or by wholly new ones so much so that by 1938 there was a total of six such
societies operating in the district and claiming between them over 56, 611 adherants or 15.6% of the district's estimated population of 354, 505 people (Wagner, 1949: 17, 21, 35, 37).

Of these Mission societies it was the Church Missionary Society, based at Maseno, and the Church of God Mission, headquartered at Kima, that were to play a major role in both the evangelization and bio-medicalization of the 'Nyole society. Though there is no evidence, oral or written, to suggest that the locational choice of these two Missionary Societies was dictated by the presence of diseases which they felt called upon to combat, the time of their arrival, consequent development, and spatial expansion in this region took place against the backdrop of pestilential and famine afflictions. Maseno, unlike Kima or Kaimosi whose historical foundations lie deeply embedded in ling'ana lio'nwami -- the Lord's word -- was started by two brothers, Mr. Hugh Savile and Bwana Fred, as a sisal plantation. According to Walter Odera, a lay preacher with the Church Province of Kenya, North Maseno diocese,

The European who brought white medicine to us settled at Emuseno. His name was Bwana Sabili and he was a farmer who planted mainly sisal. He took land belonging to the Abalako (Abahando), Abasakami, and Abamutsa so that his sisal plantation extended as far as Luanda... Bwana Sabili was nick-named Ogore because he now and then used to tell his labourers 'Ogore' which in Dholuo means 'pigana na kazi'. He built a sisal factory and he also built a grass-thatched house where his wife treated labourers suffering from emirengo (fevers), injuries, anakhwaku (wounds), and other minor diseases. The children and wives of these labourers were also treated here. Initially this hut was used for supplying posho (maize meal) to labourers but it later became a dispensary...

Though Elizabeth Richards (1956: 47-49) is silent on the fact that missionary work at Maseno was started not by missionaries but by a farmer, what she says about the beginnings of medical work in Nyanza Province is borne out by the above piece of oral information. From her we learn that Maseno CMS station was not founded until 1906, and it was not until 1922 that the Missionary Hospital was built. According to Richards,
Mrs. Savile "ran a dispensary in the grass banda in the shade of a large fig-tree" in 1905 and 1906. In this banda she dispensed daily "chiefly in the way of dressings which require less explanation than drugs and are therefore safer." Mrs. Savile is further quoted by Richards admitting that she was not a qualified bio-medical dispenser, but that she did her work in the hope that it "will give a good prestige to the white man's medicine".

According to Mrs. Savile,

The native medicine in Uganda and Maragoli consists of leaves largely, hence their name for medicine is the word for leaves. Here (in Central Kavirondo) they use bits of wood, and the word for medicine is "yath", meaning "a tree", and it is quite a common thing to see people going about with small logs of wood tied round their necks or arms. . . . We hope and pray that they may be attracted by the white man's "yath" and, finding it more beneficial than their own, may be led further to test that of the Great Physician of Souls and so find life everlasting.

Explicitly or implicitly, there is no hint in this text that there were any life-threatening diseases around Maseno. What was sick, and crucial, was the African's soul, and the place of the whiteman's medicine in the situation confronted by the Saviles lay in its importance as a mitigating factor in the African's acceptance of Christianity. This position is well brought out by B.A. Ohanga's foreword to Elizabeth Richards' book (1956: i,ii). In this foreword Ohanga has written:

When the first missionaries arrived they found the inhabitants of this part of Africa to be truly raw. Tribe fought against tribe and clan against clan. People wore and cared to wear pretty little. The human needs were confined to the basic necessities of life. Life was everywhere simple. The Africans, simple and cheerful, lived much according to the customs and traditions of their forefathers. Not only were their material wants limited, but so, too, was their vision and experience. With severely limited means of communication at their disposal knowledge and experience to be gained could only be of a local or tribal nature. . . . The immediate result of the work of the first missionaries who were, in fact, the spearhead and forerunners of western civilization and culture, can be likened to the eating of the fruit in the Garden of Eden but with more beneficial effects. The people ate the fruit, their eyes were opened and they began to see. For the first time the fact of their nakedness and simplicity was revealed to them. Not only did they try to remedy the short term and immediate defects in their way of life, but also really started on their way towards becoming "like the gods". With the coming of the first rays of the Christian Gospel
away went stark nakedness, excessive fear of evil spirits and fear of and practice of witchcraft. So also did many of the more superstitious forms of customs and beliefs which were now found not to be supported by the new knowledge and understanding....

This text sums up quite well the missionary construction of the African: a raw, war-ravaged, excessively superstitious being whose customs and traditions, coupled with an "excessive fear of evil spirits and fear and practice of witchcraft," formed a pathological continuum that lay at the heart of "the short term and immediate defects in (his) way of life". Christianity to Ohanga, and by extension the missionaries, was one mighty dose which helped the African "remedy" this pathological condition. It was the Venerable Archdeacon W. E. Owen of Maseno who, in his 'diagnosis' of this condition, declared in 1924 that the Kavirondo, "both of the Bantu and of the Nilotic tribes, are animists" since they did not have the "ability to discover true causes" for "the phenomena of daily life." This had led them to develop "a series of theories which assign to unseen discarnate spirits a large place in the causation of disease, and as discarnate spirits cause disease, so they have developed a theory that the disease can be cured by placating or removing the malignant discarnate spirit" (Oweno, 1924: 138).

But to say that the establishment of these Mission Stations had nothing to do with the presence of diseases, real or potential, in their environs does not suggest that Bunyore was free from disease. Mr. Hugh Savile is said to have done really "valuable work among the sick visiting the people in their homes as far away as Luanda" and his brother, Bwana Fred, who had "a rough practical knowledge of dispensing... would make up medicines for those who came to his store" (Richards, 1956: 48). Be that as it may, what emerges from available data suggests that while curiosity took Africans to Fred's store, Hugh Savile's visits to people's homes was driven by a desire to win friends in this strange land and labourers for his sisal plantations. In either case, both Savile's and Fred's efforts, just like those of the Europeans who came after them, were viewed by Africans
with a lot of suspicion. This was the more so because, first, the AbaNyole thought that these strangers were using their medicine to poison them so that more land could be taken away for more plantations. Second, mission stations, once they had been established, came to be associated with places where "the theft of young boys was planned and girls died". While the idea that the stations were places where the theft of boys was planned gained credence when chiefs, instead of taking their sons to Maseno school, turned to poor homes, the latter grew out of a rumour that all the girls who had joined Sunrise School, opened in 1914, had been poisoned and secretly buried by the missionaries. The truth of the matter was that when the school opened its doors to its first intake - ten girls - plague struck in the first term, claiming one girl [Richards, 1956: 27]. Though the reasons for the school's abandonment in 1919 are not clear, it seems reasonable to argue with one of our informants that it was largely because of this 'rumour' that people resisted any attempts to have their daughters go to the school to stay with strangers.

The third reason why the AbaNyole viewed the newcomers with suspicion was that these Europeans "all the time did funny things." According to Mzee Mang’ong’o Mahanga Odalo, the people living around Maseno responded negatively when Sabili, Fred, and four or five Ugandans -- Saisi, Oyugi, Elisha Sirula, and Mukibi (who died and "was burned at Maseno") -- arrived in the area. "They kept their distance but feared to attack the strangers because their colour gave them away as ebisieno. We thought the Ugandans who came along with these whites had had their bodies -- emibili -- captured by these ebisieno. Many people therefore decided to keep their distance." It was this suspicion, mixed with curiosity, that Sir Albert Cook (cited in Richards, 1959: 49) mistook for "intense interest" when "enjoying a typical busman's (sic!) holiday at Maseno in January 1914". According to Cook, who saw "a good many patients" during this holiday,

... the Kavirondo crowded round the windows of the house we had turned into an operating theatre, and watched with intense interest the painless
removal under chloroform of disfiguring tumours from the foreheads of two of their number. These were, I suppose, the first operations performed under an anaesthetic in Kavirondo, for the days of the splendidly equipped Mission and Government hospitals had not yet come. The second patient, who was a chief, watched proceedings in the case of No. 1 with grave stoicism, and the latter recovering from the anaesthetic, before the operation was finished on No. 2 came and looked on with great interest. Afterwards, proud of their bandaged heads, they came up and warmly thanked us.

If, as the foregoing evidence suggests, the AbaNyole like the other communities in this region kept their distance from the goings-on at the Missions, we can conclude that biomedicine as a cultural tool for winning their souls for Christ was a dismal failure. This is borne out of the fact that by 1914 not many Africans had chosen to 'follow' Jesus Christ. The Reverend Byram Makokha (1980: 2), writing on the early years of the activities of the Church of God Mission in Bunyore, has pointed out that though this Mission's first missionaries, Wilson and his wife, did "magnificent work" to convert the AbaNyole to Christianity, this "produced no confirmed convees and they left after two - and - a half years of labour". This was despite the fact that the sponsors of this work had in 1906 dispatched three more missionaries - Benson, a Norwegian, Richardson, an Australian, and John Bila, a Zulu - from South Africa "to strengthen the nascent church work". The reality of the situation forced the missionaries, both at Kima and at Maseno, to employ other means, in addition to biomedicine, to draw the Africans to their faith. As a worldview external to Bunyore but seeking to define itself simultaneously within and above the 'Nyole cultural traditions, to argue for Christ's acceptance as the Great Physician of Souls demanded a re-examination of the space between the symbol system the missionaries had chosen to use in their bid to convert of the AbaNyole, and the methods adopted for putting this across. These missionaries were quite clear in their minds about what they wanted, and this could be attained not only through the use of biomedicine but also by manipulating conventional values, rhetorical patterns of persuasion, and symbols gleaned from 'Nyole culture. It is thus that "Wilson acquired a
huge drum from Uganda which he used to summon his inquirers. He also employed
drum beating and traditional dance (in addition to) the distribution of salt, groundnuts and
even money to gain and hold the people’s interest in what he was preaching” (Makokha,
1980: 2). An oral informant added that the missionaries also went out of their camps “to
participate in ‘Nyole dances and thereafter invited the AbaNyole to their churches so that
they could also listen and dance to their songs.”15

Reflecting on this strategy, Archbishop Festus Olang’ has observed that had the
missionaries abandoned the idea that they were preaching among a people without a god,
“Christianity would have been a failure in this part of the world. In fact it was after this
realization that they started joining ‘Nyole ceremonies and beer-drinking parties. Though
they were not drinking, they held onto their tsinzekhe -- drinking straws -- and they fully
participated in all manner of discussions. They would then in turn invite the AbaNyole to
listen and dance to their music. Some even joined the AbaNyole in smoking enasole --
opium. Through such activities they gained African confidence....” This is how such
CMS parishes like Ebuyalu, pioneered by Khamadi; Esiandumba; and Mungoye were
established in Bunyore, and this is also how people like Sila Okiya, Elly Kabochi,
Zakayo Mukaka from Emmuli, Samson Atwota, and Enock Monya were ‘won over’ and
later spread the church’s ideas outside Maseno.16 Yohana Owenga, Matayo Sikalo, Jairo
Opetsi, Yusuf Okwemba, Miriam Atetwe, Stefano Khayebala, and Phoebe Muchilwa
from around Kima, and Daniel Malala, Fulipu Esitiang’a and Nicodemus Amuchuku from
around Emusire came to be converted by the Church of God Mission in a similar manner
(Makokha, 1980: 2).

These individuals, or their sons and daughters, were ‘won over’ after the
missionaries had learned ‘Nyole idioms of the everyday, and their numbers were boosted
by Sabili’s labourers, servants in missionary households, and gardeners in missionary
compounds. This latter group which included people like Chrispo Nyabogo, remembered
as having played a prominent role in the building of Maseno hospital; Luka Okore from Ebulako and a prominent mason who went on to become a famous 'doctor' in his retirement; and Ondieki from Ebwiranyi who is remembered as "a good builder", comprised the pillars of what came to be known as amatala -- Christian villages -- around these Missions. It was from here that they went out into Bunyore to speak about the white men, their god, and their medicine.\textsuperscript{17} Taken in either as destitute children or young boys who were looking for adventure by the missionaries, some of them went on to become clerks or teachers after moving through the ranks from labourers or servants, and thus became abandu abakhongo -- big people -- in the community. After Maseno Joash Ogutu became a clerk to the chief before joining the Uganda Railway as "the big man who paid salaries to workers". Dishon Asilutwa, a Maseno-trained carpenter who also joined the Railways, also belonged to this category.\textsuperscript{18} There was also Zakayo Ojuok who moved from the position of house servant to nurse assistant at Maseno hospital before "it was discovered that Bunyore needed a chief. The missionaries recommended him for the position because he had been a good boy throughout his tenure at Maseno."\textsuperscript{19} Zakayo Kwendo, the father to the first Omunyole in the Colonial Legislative Council, Edward Eric Khasakhala, too was an Omundu Omukhongo having who was trained and worked as a nurse assistant at Maseno.\textsuperscript{20} There were others, like Kefa Ndaria from Ebulako, Isaya Osome from Ebusikhale, and Munala Godia, who started off as either labourers or house servants but because the missionaries thought they had "proved to be faithful and hardworking, and had refused to remove their six-lower teeth because it spoiled spoken English", were later to become prominent 'doctors' in Bunyore.\textsuperscript{21}

The centrality of these individuals lay not only in the spread of Christianity, and therefore Western civilization, in Bunyore; as the first products of a Christian discourse-in-the-making, they talked about everything - from the virtues of monogamy; taking children to school; 'eating' balanced diet; Jesus as the healer of all diseases; the
backwardness of 'Nyole magico-religious ideas; and the virtues of going to hospital instead of herbalists or abafumu (diviners) when someone in the family became sick. This discourse was carried out at various sites: in houses of relatives and friends; in markets or at the emergent but popular m'mikawa (tea rooms) at these market places; and in church compounds. As one of our informants has put it, as labourers or servants at mission stations, these people "were lured into accepting the whiteman's medicines and they in turn lured their fellow AbaNyole into following them." 22

There is no evidence to suggest that these activities, in themselves, met with any major successes in these early years. It is true that developments in the establishment of Christian missions went hand in hand with developments in educational and medical fields. During the Kramer period (1914-1929) at Kima, for example, the Church of God Mission "grew and expanded rapidly." It was during this period that the Es'songolo, Esalwa, Ematsuli, Ebunangwe and Mumboha ebikweng'u -- parishes -- were established. It was also during this period that "baptismal classes or centres" were established at Ematsuli, Kilingili, Emusire, and Kima Mission Station itself "to identify the new convettees in Bunyore" and the neighbouring sub-ethnic communities of Kisa, Butsotso, and Kakamega (Makokha, 1980: 4). This process involved not only the spread of the word of God but also training in reading and writing since Mrs. Baker had in 1906 'discovered' that when Africans, "first realized that the little notes they were given by Mr. and Mrs. Wilson to take to one another were really messages, and talking or saying something, they were utterly amazed that the paper could talk". 23 This development had by 1937 materialized into seventy-eight schools run by the Mission. 24

In the medical field, the Friends' African Mission and the Church Missionary society maintained a dispensary and a maternity ward each, at Kaimosi (started in 1903) and Maseno (started in 1905), respectively, and the Church of God Mission a maternity home at Kima that developed into a dispensary after 1914. Though located in the
Central Kavirondo District, the Church Missionary society health facilities were so near the border with North Kavirondo District that a great deal of patients came from here (Wagner, 1949: 38; Richards, 195: 47-55; Adalja, 1962: 113). The utility of these institutions by the indigenous people can be gleaned from the number of child deliveries they handled. Between 1929 and 1934 the Friends African Mission Hospital at Kaimosi delivered 812 babies, 442 males and 370 female. Between 1935 and 1938 (January-April), the Mission delivered 207 male and 186 female babies. This represented 52.6% and 47.4% of live births, respectively. The Church of God Mission maternity home at Kima on its part registered 99 male and 69 female births between 1936 and 1937 (Wagner, 1949: 18). A cross section of those interviewed on this development pointed out that these maternity homes had tremendously increased the number of live births in Bunyore and that this was one of the reasons that led the AbaNyole to start looking at mission activities in a different light.

Though data on either in-patient or out-patient utilization of these institutions is hard to come by, there is reason to believe that their services were becoming popular with the indigenous people. This however is a development that began to manifest itself with greater intensity after 1918. The first clientele of these institutions were members of the church community or amatala, and converts who started off "as labourers and servants in wazungu's home."25 It was these converts who later went out to spread the virtues of the whiteman's medicine.26 It seems that the most important mitigating factors in this development were the famines and epidemic diseases that struck Bunyore at this time. Christianity became a serious issue when "the hissing of the world" had become a common occurrence.27 These were the times of inundu -- smallpox -- a term which in the pre-European days had been used to generally refer to any kind of indwasi or natural disease of epidemic proportions; esiherekere (measles); indwasi ye'libombo (stomach ulcers); and olwangala (tropical ulcers). Our informants pointed out that
though some of these diseases were not new, their intensity coincided with the coming of *obwami bwe'kilauni* -- the crown's overlordship. This was compounded by wholly new diseases like *esirimba* (yaws) which entered Bunyore from Ebuhami (Gum) and made people affected to stink before their death; *etakanyi* (gonorrhea) which "once a man acquired it had problems in urinating and pus came out of the penis" while women with it walked "as if a stake had been driven between their legs;"\(^{28}\) *Libumba* (plague) which was "brought by rats from India;"\(^{29}\) and *esihela* (tuberculosis). These diseases posed serious problems and if it were not for the Missions at Maseno and Kima, inoculations against *Libumba* by *silikali* (the government), and 'drinking medicine' for *emirengo* (fevers), "we all could have been wiped out."\(^{30}\) The famines our informants say ravaged this area in this period were the 1907 *inzala yo'Pande* (the Oponde famine), which was followed by the more severe *inzala ya Keya* (the Keya famine) of 1918.\(^{31}\)

From the foregoing, it can be argued that the period between 1900 and 1918 was one of experimentation in which Christianity made, and remade, in a process of self-definition, the boundaries that separated it from the 'Nyole world. Though it was helped in this process by the first crop of African converts, it was not until new diseases and famines hit Bunyore, as they did most of Nyanza Province, that Africans in large numbers began to turn to the church. That this took place against the backdrop of pestilential and famine afflictions is therefore important. Writing on the situation in the southern locations of North Kavirondo after the First World War, Richards C. G. (1947: 13-14) has noted that

> When the Owens went to Kavirondo (in February 1918) the country had suffered much from the war and other disasters. Many of the younger men had been recruited as carriers for the army fighting in German East Africa ... and as a result much land had gone out of cultivation, with the natural consequence of reduced crops and depleted stores of the staple foods, maize and millet. In 1917 to 1918 the rains failed, rinderpest killed most of the cattle, and an epidemic of smallpox broke out among the half-starved people. Many who had gone to the war died of dysentery or malaria. In those days the methods which now exist of tracing a man's
identity and place of birth had not been devised, and news of deaths did not reach the villages until some returning comrade brought word. The countryside daily resounded with the wailing of women for their sons...

In those days, in the whole of Nyanza Province there was only one Government doctor; there were no hospitals for Africans, Europeans or Indians; no dispensaries, except the small ones on Mission stations. When, in 1919, influenza of the virulent type which had caused so many deaths in Europe swept through Kavirondo, all races suffered it... Later in 1919 bubonic plague appeared and spread through the district. (Archdeacon) Owen used to go on his motorcycle to Kisumu, 40 miles away, to fetch serum and would go with it from village to village where cases of plague had been reported, inspecting the dead and inoculating those who had been near to them. It is estimated that in less than 4 months he inoculated 11,000 persons in this way.

This observation is made against the backdrop of the fact that in the immediate post-World War I period, missionaries were experiencing a serious problem of overcrowding in the few churches that had been built since the Church Missionary Society set foot in North Kavirondo. In a 1917-1919 report on the Butere district, Owen states that "the Sunday congregations have steadily increased in numbers, so that when a year ago one building sufficed two are now well filled" (cited in Richards C..G..1947: 15). This phenomenon is well brought out in Mrs. Owen's eye-witness description of her and her husband's experiences in these early days of their tenure in North Kavirondo.

According to Mrs. Owen as summarized by C. G. Richards, the returnee soldiers, many of them recently baptized and others still under instruction, were in 1918 and 1919 teaching members of their clans so much so that

When the work in the maize and millet fields was over for the day, they would collect the young men and girls... under the shade of some big tree, and teach them a hymn, or the Lord's prayer or how to read in a copy of the Gospel. They were a great sight, these tree congregations, composed of anything from 50 to 100 people, with perhaps two or three copies of the Gospel, or a few alphabet or word sheets among them. They and the teacher would lie face downwards in a packed circle, each learner equipped with a grass stalk for the purpose of pointing out words or letters as instructed....

On Sundays the church would be crammed, young men sitting on the floor in tightly packed rows, and encircling the building outside where
they would join in the service, though only visible from inside as they pressed around the doors and windows (C. G. Richards, 1947: 12).

Yet just before the Owens arrived in Kavirondo, C. G. Richards (1947: 11) admits the Church was not "of only comparatively few years' standing;" it also had only two ordained missionaries, few trained evangelists from Uganda, and "only a small number of Africans had become communicant members of the church." To what can this upsurge in interest be attributed? Can we argue with C. G. Richards that it was the returning soldiers who incalculated a sense of christian Godliness among the young boys and girls who comprised the "tree congregations" and "crammed" Sunday church services? If so, where were the elders - men and women - of these villages?

That the above-mentioned famines and epidemics took place at the time they did meant many things, singly or in combination, for the main actors in the unfolding drama. Taking place concurrently, they made the southern locations of North Kavirondo District and indeed other parts of the country in these early years of colonilism into a crucible in which ideas about death and life - whether by missionaries, colonial administrators, or the colonized - were formulated, reformulated, implemented or discarded. While to the colonial state these crises confirmed Britain's argument that Africa was a 'patient' whose resuscitation depended on the applicability of Western science in the mastery over nature by man, to the missionary these were tests whose grounding found both meaning and realization in the belief that "what won the hearts of men was the sign of God's love in action" (W. E. Owen, cited in Richards C. G. 1947: 8). Thus to the latter group the events offered both a challenge to God's love which Africans could only experience through their acceptance of Christianity, and an opportunity for driving this message home. But for the AbaNyole, as for the other Abaluyia communities in this region, the occurrence of these events at the time they did proved devastating. This was the more so because, quite unlike in earlier times when famines could be staved or put in check
through the time - honoured practice of *okhusuma* (dependence on distance kin in times of famines), the concurrence of famines and epidemics meant, first, the throwing of this practice into sharp relief and, second, the denial of its practice side by side traditional means of isolation and inoculation that had hitherto been used in dealing with *olufu* -- death. This dilemma is captured by one informant who has observed that

During the times of our grandfathers and fathers, famine was not as bad a thing as it came to be when *Abakurisitayo* (Christians) and *silikali* (Colonial Government) appeared in Bunyore. Though there were inter-clan and inter-ethnic conflicts, people could still count during famines on networks established through marriage or friendships. If for example there was famine in Ekamanji people from here could go looking for food as far as Ebuakami, Yala, or Eburwa where girls from the village had been married. This is what was called *Okhusuma*. But when disease and famine occurred at the same time the way it happened during *inzala ya Keya*, it was hard for people to fall back onto this practice. This was because during epidemics the AbaNyole had rules that restricted the movement of people from infected areas to healthy ones. Victims were isolated and the sharing of food, the use of common grazing grounds, and the sharing of utensils was prohibited. In the case of *inundu* or *Libumba* it was not just individuals who were sick; entire villages were clouded in *olufu* -- death -- hence *okhusuma* or the sharing of the little food that could still be found in the villages was difficult. The early years of *silikali* compounded this problem in another way. While in the days of our forefathers *olufu* could lead to whole villages migrating, in the days of *ekilauni* (crown) this was impossible as people had come to be confined to their clan lands. The only way open to people was the church because it gave out food and also treated the sick.

From the foregoing, it can be argued that the move on the part of the AbaNyole, like other communities in the region, to 'accept' Christianity in large numbers took place against the backdrop of "a highly emotional period" (Elizabeth Elbourne, 1990: cited in Ranger, 1992: 262). Thus while to the AbaNyole the church became something of a 'savior' in an otherwise hopeless situation, to the church the crises following the end of World War I provided, on the one hand, an ideal moment in which God's love for his people could be demonstrated, and, on the other, a practical lesson in how people could avoid the occurrence of similar crises in the future. This was the more so because, in its "characteristic mixture of providentialism and modernizing calculation" (Ranger,
1992: 263), the church sought to appropriate the famines and epidemics as societal
metaphors for advancing the idea that first, "Time can never change the necessity for men
to repent of their sins and to work out their own salvation with fear and trembling" and,
second, that these were times in which moral hygiene, spearheaded by the ordained
pastor, should be promoted. This was to be done through "cleanliness in person and
home, and accessibility and a willingness (on the part of the pastor) to advice his people
in all matters pertaining to the difficulties of their daily life . . ." (Archdeacon W. E.
Owen, cited in Richards C. G. 1947: 17, 19). In either way, as responses to the
immediate post-World War I crises, these two perspectives, so it was assumed, "revealed
the superiority of christian 'science' over African 'superstition'" (Ranger, 1992: 264). This
cultural positioning, elaborated in the next chapter, set the church on a collision path with
the colonial state during the interwar period over the question of the role of biomedicine
in the social and political control of the countryside.
Endnotes

1 'Nyole proverb: That which finishes you start working on you early. This proverb was used by most of our informants to underscore how christianity succeeded in Bunyore only after the missionaries started employing 'Nyole idioms in their relationships with the AbaNyole.

2 By a colonial medical social formation is meant the emerging medical landscape in which ideas about health and healing are necessarily contested as common ground for social self-definitions, boundary-marking, attitude formation, ritualization, and the enunciation of rites of entry and/or exclusion is sought by both the AbaNyole and the makers of the new biomedical discourses. Central to this is the notion of 'articulation' which in this study is seen from the point of the emergent ideas on health and healing in Bunyore as resulting simultaneously from as many angles as there are therapeutic traditions. From this we can have the theoretical language to speak about the relationship between different therapeutic traditions, and about how individuals or groups of individuals experienced these multiple therapeutic traditions simultaneously. Furthermore, these insights allow a far more sophisticated relationship between biomedicine as an ideological tool and the Kenyan colonial social formation that might not be fully comprehended if looked at from the point of view of deterministic base/superstructure analogies and/or concepts of hegemony which see dominant ideologies as products of single dominating classes. Finally, we hope to use the concept to understand the complexities of what has been described as medical pluralism in Africa. Our reworking of these formulations borrows heavily from Eric R. Wolf (1983).

3 In developing this perspective we have used Michel Foucault's (1963 [1975: 16]) notion of space. Though he delineates three different spaces - the parameters in which diseases are classified hence the theory of medicine; the human body; and social space - it is the third type we are interested in since it introduces us to the problematic of medicine and to the question as to whether medical 'crises' are epistemological or political problems. As he has pointed out, the third type of space "is not intended to imply a derivative, less essential structure than the preceding ones; it brings into play a system of options that reveals the way in which a group, in order to protect itself, practices exclusions, establishes the forms of assistance, and reacts to poverty and to the fear of death. . . . In it a whole corpus of medical practices and institutions confronts the primary and secondary specializations with forms of a social space whose genesis, structure, and laws are of a different nature." Thus, "...for this very reason, it is the point of origin for the most radical questionings. It so happened that it was on the basis of this tertiary specialization, that the whole of medical experience was overturned and defined for its most concrete perceptions, new dimensions, and a new foundation."

4 The Friends' African Mission was the first to arrive. It was started among the Abaluyia in 1902 by Chilson, a minister; Hole, a businessman and architect; and Hotchkiss, "a minister and the person with the needed experience to lead the industrial department, which he had planned. These were practical men; knowing forming,
building, and brickmaking." The three began building the Mission at Kaimosi "as soon as the government gave them a grant of land. One thousand acres it was" (N. Grace Donohew, 1963: 22). The Friends mission was followed by the South African Inland Mission Compound whose agent, Wilson, arrived in Kenya in 1904 "in order to look into the possibilities of starting a mission in North Nyanza (sic!)". When he arrived at Kisumu by train "he started out on foot to Kaimosi, the headquarters of the Friends' African Industrial Mission . . . . The Friends received Mr. Wilson very cordially, and . . . very kindly offered to allow him to use their station as a base of operations until he was settled on his own" (Mabel A. Baker, 1955: 1-2). After a few months of reconnaissance Wilson returned to South Africa, but in 1905 came back with his wife and two young sons. Chief Otieno of the Abamute clan of Bunyore offered him thirty acres of land on which to build his mission station (mabel A. Baker, Ibid.: 5-6; Rev. Byram Makokha, 1980: 1-2).

5 When Bishop James Hannington was murdered at Busoga in 1885, Bishop Alfred Tucker arrived in 1892 to continue with his work. Tucker stayed at Mumias on his way to Buganda, but was eager to explore other parts of The Anglican Diocese of Eastern Equatorial (which embraced present-day Kenya, Uganda, and Tanzania) over which he had come to preside. He pressed Missionaries to start work in Kavirondo. In 1904, accompanied by Messrs. Willis and Purvis, he visited the Kavirondo area "to find a suitable site for a mission station. It was then that Mr. Willis volunteered to open up work at Maseno" [Elisabeth Richards, 1956: 10]. According to Archbishop (retired) Festus Olang', the first black Archbishop of the Anglican church in Kenya, "the missionaries who first landed at Maseno agreed that the Friends would remain at Kaimosi to evangelize among the Maragoli and the Tiriki, the Church Missionary Society (CMS) would base itself at Maseno and do work among the Luo, and the South Africa Inland Mission Compound (later Church of God in East Africa) should establish itself at Kima to evangelize among the AbaNyole. As to where the leaders of these missions met and reached this agreement the Archbishop doesn't say. According to Olang' Maseno, because of its unique geographical location, did however stray beyond the boundaries and brought into its fold AbaNyole clans like Abahando (Abalako) and Abasakami "who naturally fell under the C. M. S. sphere". Oral Interview, Archbishop Festus Olang, 76, Ebukakami, South Bunyore, 7th December, 1992.

6 Charles M. Good has in a fascinating article on medical missions in Africa suggested that one of the themes and questions to be investigated during research on the impact of these missions "on the health, lives and lands of colonial Africans" should be the "combination of location decision factors (sociopolitical, epidemiological, demographic, environmental, economic or other)" that "most influenced the selection of a specific place for the MM" (Charles M. Good, 1991: 2, 6).

7 Oral Interview, Walter Odera, 85, Ebulako Village, Esibembe Sub-Location, South Bunyore Location, 18th November, 1992.

8 Oral Interview, Màng'ong'o Mahanga Odalo, Ebuhandó Village, Karateng'i Sub-Location, Ojola Location (in Nyanza Province), 20th November, 1992. Mzee
Odalo, who claims to be about 110 years old, "saw when they came and ... was among the first people in the locality to work at the Mission when it was established in 1906. I was then a young man and my first job was to water seedlings. I later on became a watchman and that is the work I did till my retirement."

9 Oral Interview, Sylvester Andai Njeche, 79, Es'saba sub-location, West Bunyore Location, 18th November 1992.


12 Oral Interview, Felestus Hoka Chapia, 60, Ebusikhale Ebusiralo, West Bunyore, 14th November, 1992.


14 Ibid. Ebisieno (Es'ieno, sing.): Means evil spirit in Olunyole (the 'Nyole language).

15 Oral Interview, Imbale Kutai, 68, Emuchula Village, Es'saba Sub-Location, West Bunyore Location, 8th November, 1992.

16 Oral Interview, Archbishop Festus Olang', Ebusakami, South Bunyore, 7th December, 1992; David Okwamba Ngola, 80, Mungoye Village, Ebusiakwe Sub-Location, West Bunyore Location, 21st December, 1992. Many informants noted that the relationship between Maseno and Kima was not always a good one. Among the reasons contributing to bad blood between the two mission stations were, first, the fight over the AbaNyole in the battle for souls and, second, the Church of God Mission disproved of the smoking habits of Maseno missionaries. Missionaries at Kima argued that Maseno was using smoking as a strategy to lure the AbaNyole into accepting the Anglican Church. This conflict became increasingly pronounced when H. C. Kramer (Kulema) and his wife Gertrude were in charge of the Kima mission between 1914 and 1929.


18 Ibid.

19 Oral Interview, Sylvester Andai Njeche, 18th November, 1992.

20 Ibid.

21 Oral Interview, Mang'ong'o Mahanga Odalo, 2th November, 1992.

23 Mable A Baker, untitled, typewritten notes on the beginnings of the Kima Mission, N.d. Kima, Church of God Mission Station.

24 Though this figure includes schools that were later established in Kisa, Butsotsoso, Kakamega, and Idakho, Bunyore had the largest share by virtue of the fact that the mission's headquarters were located there. By this year the Church Missionary Society, the Friends' African Mission, the Catholic Mill Hill Mission, the Salvation Army, and the Pentecostal Assembly Mission had 103, 294, 41, 19, and 14 schools, respectively, in the district (Wagner, 1949: 37).


27 Oral Interview, Taisi Mukabi, 15th November, 1992; Mang'ong'o Mahanga Odalo, 20th November, 1992; and Walter Odera, 18th November, 1992. In 'Nyole worldview, esibala - the world - is held in balance by a huge snake that lives somewhere in the bowls of the earth. Occurances like earth tremors are attributed to either the turning in position of this snake or when it hisses. Either of these actions portends esibi - evil - or generally the coming of catastrophes like droughts, famines, and epidemics.


32 Oral Interview, Johnstone Otukwa, 57, Ebusiralo village, Ebusikhole Sub-Location, West Bunyore Location, 29th December, 1992; Mr. Francis and Mrs. Felestus Chapia, Ebusiekwe village, Ebusiekwe Sub-Location, West Bunyore Location, 24th December, 1992; and Mr. and Mrs. George Malema Em'mukunzi village, Emakunda Sub-Location, North Bunyore Location, 10th November, 1992 and 19th November, 1992.

CHAPTER FIVE

HEALTH AND HEALING IN BUNYORE: THE COLONIAL STATE, 
THE AFFRICAN COUNTRYSIDE, AND THE MAKING OF A 
BIOMEDICAL SOCIAL FORMATION

5.1 Introduction

Health reform... could never be imposed by fiat from without, 
but in this sphere there is little that is African to build on... Our 
duty to apply our Western knowledge to the mitigation of African 
suffering and the betterment of African health is perhaps a crucial 
test for 'trusteeship' W. M. Macmillan, 1949: 228.

North Kavirondo District (map 5.1) came under British administration as part of 
the Eastern Province of the Uganda Protectorate between 1890-1895 (Lonsdale, 1964, 
1977; Wagner, 1949: 32). Apart from the institution of completely new ground rules for 
the political regulation of the hitherto self-governing Abaluyia, other developments that 
were to have an immediate impact on these people were the introduction of a hut tax and 
an increase in agricultural production for the market. While the one was meant to force 
Africans into wage labour,¹ the other, ironically, gained momentum as demands for 
colonial taxation intensified.² But there was also the development of communication 
networks along and through which the Abaluyia were both drawn into the world capitalist 
nexus and acquired new ideas either from their recently arrived rulers, or from fellow 
Africans they met with on settler farms, in towns, and at Mombasa where they went to 
look for work as stevedores (Cooper, 1987). For example, the Slater Road, built for ox-
carts, reached Mumias, the British administrative boma in the district, in 1896. In 1901 
the Uganda Railway reached Kisumu, its terminus on the Kavirondo Gulf and, thirty 
years later, it was extended to Butere. In a geopolitical and economic reorganization the 
district was hived off in 1902 from the Uganda Protectorate and added to the East Africa 
Protectorate. Two years later there was the construction of a new road to Yala, and
extensive public works were carried out in the district so much so that by 1911 hundreds of miles of roads for bicycles and mules had been constructed with the potential for further development to cater for the ever-growing agricultural surpluses in the district. The first all-weather road in the district, the Kisumu-Kakamega road, was completed in 1936 [Wagner, 1949: 32-35].

But if these developments, referred to in early colonial discourses as the opening-up of the African interior, introduced the Abaluyia to new ideas and notions about themselves vis-a-vis those they came into contact with, and about money and what it could buy, they also exposed them to new diseases and ideas about these diseases that were an important component in the making of a colonial medical social formation. Thus if the railway took the AbaNyole to Ukambani or Mombasa, and the Kisumu-Kakamega road made their journeys to and from Eburebe (Bunyala) in search of more potent medicines to deal with their enemies and/or improve on their fortunes, Libumba (plague), etakanyi (gonorrhea), or esihela (tuberculosis) are known to have entered Bunyore along these same communication lines. That this two-way traffic was a product of colonialism was not lost to them, but the way ekilauni (the crown) thought it created the one as it destroyed the other forms not one, but many moments in the history of biomedicine in Bunyore. With an emphasis on the production of medical knowledge by the colonial state personnel, but also on the connection of ideas on disease, medicine, and the AbaNyole as the state sought to make sense of the world it was fashioning, this chapter and the next attempt to understand how, first, colonialism understood and proposed to deal with health and healing in the African countryside. Second, the chapters will examine how the ideas produced, and the mode of their articulation, were reflections of not only the changing nature of the political economy of colonialism, but also of debates that arose over, and discourses generated on, new disease entities called 'African', the African cultural environment vis-a-vis the problem of disease causation, and the question
of the educability of the African. Thus, through a focus on the actors (medical and administrative) within two specific periods - the pre-World War I and the interwar periods - rather than on these actors and periods themselves, we shall attempt to argue that first, after an era of indecision that more often than not bordered on indifference towards African health, the interwar period witnessed the construction of a new medical and disease language that was used to designate 'newly discovered illnesses', cures, and other biological facts. Second, there was in this period a rupture that led to the break with the pre-World War I paradigm of the 'diseased native' to one that emphasized the development of both preventive and curative medicine in the African countryside.

5.2 The Colonial State, Epidemics, Demography, and the African Countryside.

Perhaps the best entry point in this drama are the views of J. L. Gilks, the Principal Medical Officer for the Protectorate and Colony of Kenya during the interwar period and the man credited with the laying of the foundation for a Western medical system in the country. Starting with Gilks draws our attention to the fact that though a medical department was established in the country in 1901, it was not until 1920 that policy began shifting away from an urban-focused medical system towards one that emphasized the development of government-sponsored and maintained health facilities in the rural areas. This point is well brought out by J. L. Gilks, quoted here at length if only for the clarity of the issues involved when he took over as the PMO. According to Gilks,

In the early days of the East Africa Protectorate, now the Colony and Protectorate of Kenya, the energies of the Medical Officers attached to the administration were chiefly directed towards the maintenance in health of the European and native employees of Government. The practice either of curative or preventive medicine among the general native population was, on account of the paucity of the medical staff, the difficulties and dangers of transport and the backwardness of the native population, largely impossible, while the preventive work which these officers were called on to perform was limited to such as was necessary for the maintenance in a sanitary condition of small administrative stations, the population of which would not, as a rule, exceed a dozen Europeans and fifty or a hundred native troops or police. The practice of medical officers was, therefore,
for the most part clinical, since there was but little other scope for their
activities, and as the directions in which the country might develop were
not then realized, they were not required to be specially experienced in
those branches of preventive medicine and public health work, which are
more particularly concerned with the avoidance of the insanitary
conditions which were apt to be concomitants of urban and industrial
development.4

The need for a shift "towards a new sphere of work" that had increasingly become "of a
specialized nature" had, according to Gilks, been necessitated by "the development of
urban conditions and the breakdown of natural quarantine which resulted from the
opening of the Uganda Railway and the development of the road system." This awareness
became apparent before the outbreak of World War I and, because of the urgency with
which urban conditions and the need to prevent epidemics called for attention, provisions
were made in the 1913-1914 estimates for the appointment of two full-time Medical
Officers of Health and "four European Sanitary Inspectors, in addition to the appointment
of (a) Medical Officer of Health, Mombasa."5 These changes however did not provide for
the stationing of Medical Officers in 'Native Reserves'. This had to wait till four years later
when, in 1918, "provision was made in the estimates for the appointment of 10 more
Sanitary Inspectors to the Sanitation Division with intention that these additional officers
should work in Native Reserves, and accompanied by travelling dispensaries should
undertake the treatment of disease and the control of epidemics." These appointments
were never made "on account of circumstances resulting from the war".6 Nonetheless,

... the provision was not removed from the estimates, as every year it was
becoming more fully realized, not only by Government, but by the
European section of the public that the institution and establishment of
facilities for medical treatment and the control of epidemic diseases
among the native population was a matter to be undertaken at the earliest
opportunity.7

Three things stand out clearly from Gilks's assessment of the colonial
government's medical performance in the first two decades of this century. First, medical
work in this period was urban-oriented and its clientele comprised of the European
population in particular and government employees in general. Second, medical emphasis was on curative and not preventive medicine. Third, the realization that there was a serious medical problem in the countryside was late in coming and when it came, the approach to its remedy was to be both preventive and curative. What led to this realization and why at this particular time in the colony's history?

Much recent literature on the introduction of a Western therapeutic tradition in Africa is in general agreement that while in the initial years of colonialism governments were plagued with scant resources and lack of medical manpower, the shift in policies that took place in the interwar years was mainly due to the fact that the epidemics that had been laying waste the countryside began from 1918 onwards to threaten first, the European populations and, second, African labour. In the second case, the argument goes, it was feared that the depletion of the African population by these epidemics posed serious problems to the labour required for plantations and/or mines. Megan Vaughan (1991: 39) has, for example, written that

> Early colonial administrators...frequently faced a major epidemic of one sort or another. Most often the fear was that European populations would be affected. Africans were regarded as a 'reservoir' of disease and...this often provided a medical rationale for racial segregation (in urban areas). Settler economies were...much more prone to this particular formulation than were peasant-based economies...where the consequences of depletion of the African producing population was a focus of another kind of concern. In either case, there were only scant resources at the disposal of the colonial state to deal with epidemic diseases. This was not, at this stage, because of the triumph of the 'individual pathology' model of disease and a resulting bias towards curative medicine. Rather it was because the early colonial state was generally impoverished, and in any case did not conceive of its role as providing health (or education) services on any scale, except to white minorities. The problem of epidemic disease threw this issue into sharp relief for, though epidemics affected the poor severely, they also showed an alarming tendency to cross race and class barriers. If one was going to protect the health of the European population, then the health status of Africans would have to be addressed, at least in a minimal way.

The issues Megan Vaughan raises with regard to the threats posed by epidemics to both African labour and European health are not new as early liberal critics of the
colonial system in Africa, as well as colonial medical experts, saw things precisely in this light and extensively commented on them. This is indeed what W. M. Macmillan, one of these critics, had in mind when he commented, forty-two years before Vaughan articulated her argument, that "Rural Africa is after all the crux of the health problem" (1949: 230) and that a health policy geared towards urban areas was bound to be counter-productive as Africans kept on flocking into these towns, thus constantly reinfecting them. With regard to threats to African labour, it was, at least in the case of Kenya, the colonial medical department which noted with grave concern in 1926 that due to a combination of factors ranging from famines to epidemic diseases in the rural areas, there was a serious population shortfall and that there was an urgent need for active measures to promote its increase.\(^9\)

The evidence with regard to North Kavirondo District appeared different to contemporary observers. According to Joseph Thomson (1885:491), C. W Hobley (1898:362), and Harry Johnstone (1904), the most densely populated part of the district at the turn of the last century was the Nzoia River-Wanga area.\(^{10}\) There however was a shift in the density node from this area to Bunyore and Maragoli locations in the southeastern part of the district following the imposition of Pax-Britannica and a "postcontact process involving acute aculturative pressures upon Bantu Kavirondo" (Stevenson, 1968:150). Though the Nzoia River-Wanga area, like what became during colonialism the Maragoli and Bunyore locations, was blessed with abundant and reliable rainfall coupled with fertile soils, the precontact population concentration here was mainly due to political developments that revolved around the Wanga Kingdom's "strategic position on the east-west trade route" from the East Africa Coast to Buganda (Stevenson, 1968: 151). Joseph Thomson (1885:481-82, 487), Harry Johnstone (1904:208), C. W. Hobley (1929:88), and Gunter Wagner (1956:162) are in agreement.
that because of good rains and fertile soils in both areas, agricultural productivity was high and what the two areas did not produce was obtained through a highly developed and well-organised local and regional trade in sheep, goats, iron and salt. How, then, do we explain the shift in population concentration from the former to the latter area?

As is later demonstrated in chapter seven, it appears that the first dynamic in this shift revolved around the relocation of the nerve center of communication networks from Mumias to Kisumu; the introduction of maize as a cash crop; and the growth in labor migration from the rural areas to towns and plantations in the 'White Highlands'. This, coupled with the rise of Kisumu as a major port city, assured an automatic shift in population concentration from the Nzoia River-Wanga area to the district's southeastern locations of Bunyore, Maragoli, Kisa, and Tiriki (Fearn, 1961; Stevenson, 1968; Kitching, 1980). The other crucial factor which explains the dynamics of population growth in the southern locations of North Kavirondo District before World War II is that both Bunyore and Maragoli formed a wedge in that part of the district with fertile soils and reliable rainfall, and which also was the closest to Kisumu, the major port city and the communications center in the region. Thus, while the city on the one hand served as a magnet, including a more southeasterly concentration of population in North Kavirondo, the recently created boundary between the Abaluyia (North Kavirondo) and the Luo (Central Kavirondo), on the other, served as a dam that tended to bottle this concentration within Bunyore and Maragoli.

This situation was compounded by the establishment and expansion of missionary stations. As seen in chapter four, Maseno Mission Station for example had its beginnings not in missionary but agricultural activities. The need for land by Hugh Savile to expand his sisal plantation, and by the missionaries from 1906 onwards to establish their institutions, led to the removal of the Abasakami, Abamutsa, and Abalako
(Abamusikulu/Abahando) from their ancestral lands to areas that were already settled by other clans. Though land acquisition for both Maseno and Kima Missions was initially through negotiation, in later years cunning and force were used. As Andai Njeche, one of our informants has noted, "Chiefs Otieno and Sangolo offered their land for the building of Kima Mission. Missionaries were to later use these same chiefs to force local people to give land for the expansion of this mission. Chief Zakayo Ojuok in the 1920s forced the Abasakami to vacate their ancestral lands for his clan after he had given away its land for the building of Maseno Hospital. Chief Otieno used force to snatch Ababiba's land for the establishment of the Emuhaya administrative boma and the Emuhaya health centre." 14

Gunter Wagner, visiting these locations in the late 1930s, noted that

There is a consensus of African opinion that the southern locations of the District (Maragoli, Kisa, Bunyore, Tiriki) are far more densely populated today than they used to be. In 1932, Maragoli (North and South) had a population of 45,800, in an area of 95 square miles, the average density per square mile being 591 persons in North Maragoli and 391 in South Maragoli. As far as the available data indicate, the annual increase in population averages somewhere between 0.7% and 1.2% for the whole district. It probably lies well above the district average in the comparatively healthy, prosperous, economically progressive and largely Christianized southern locations. Moreover, in addition to the natural increase in population, the very fertile soil of the southern part of the district attracted an influx of both clans from neighbouring tribes and of individuals. It seems, therefore, quite probable that the population of Maragoli has doubled during the last fifty years. (Wagner, 1956:92)

On the population situation in Bunyore, he observed:

As we approach the south-western corner of the district the density of the population steadily increases. In the chiefancy of Bunyore it reached the remarkable figure of 1,137 persons to the square mile. In these parts the native homesteads stand close together; every inch of arable soil is exploited to the utmost, and pasture land is so scarce that not only sheep but also cattle are tethered while grazing or even stable-fed. But even the extraordinary fertility of the soil and the two full crops which it yields every year cannot sustain such a dense population. Clear symptoms of overpopulation begin to show: not only do adults take up labour-contracts in European employment, but to an increasing extent children also, who work chiefly as tea-pickers in the Kericho tea plantations. But whereas
some of the people have to look for work outside the reserve to buy foods out of the money, which they earn, others grow maize for export even here in Bunyore. (Wagner, 1949:15).

Population growth vis-a-vis land utilization in Bunyore had by the early 1930s become a major concern for the political establishment. In 1935, for example, the District Commissioner, E. L. B. Anderson, not only defined the relationship between the AbaNyole and their land as one of utter "confusion"; he also strongly recommended that the way out of this confusion was a dual process of soil conservation and emigration of the AbaNyole out of the location. Twelve years later, in 1947, Lambert (1947: 1) was of the opinion that the Abaluyia were "on the border line of destitution" and, "if the present trend" was left unchecked, "distress" was "certain to prevail". Norman Humphrey (1947: 8-9) put this concern into perspective when he wrote that

... the stage is set for the same drama as has been enacted elsewhere: increase of arable cultivation at the expense of a proper balance between crop and stock and with its concomitant of an ever-quickening tempo of soil deterioration. Already, indeed, the play is well advanced in Maragoli and Bunyore and only swift remedial action is likely to stop its repetition throughout the whole district... (W)e are faced... with the all too familiar picture of the fertility of the soil being drawn upon without respite, only to give results that are quite inadequate to meet the needs of the people.

These shifts in population settlement patterns highlight the connection between epidemic diseases and population growth in the interwar years. As already noted, the European missionaries and colonial administrators had long realized that disease had no respect for class and/or racial boundaries. Secondly, specific area studies indicate that certain niches in the rural landscape witnessed population increases regardless of the epidemic diseases and famines of the late nineteenth and early twentieth centuries. North Kavirondo was such an area. Indeed, from the evidence we have adduced above, and bearing in mind that this district, like the whole of Nyanza Province, increasingly became a major source for cheap labour on settler farms before the Second World War, it can
be argued that for colonial authorities the problem with the southern locations in North Kavirondo District was not one of the danger posed by epidemic diseases to African labour. The politics of the time revolved around the role the commodification of peasant agriculture was playing in the denial of settler economic enterprises of the much needed Luyia labour. 16 This observation, coupled with the foregoing argument, draws our attention to reasons for the shift in medical policies that go beyond the mere question of European anxiety over contagion and the rhetorics surrounding arguments about decline in African populations.

It is the argument of this chapter that the Kenya colonial government's move towards the introduction of health facilities in the rural areas was the result of not just the need to protect the health of the European population from the epidemic diseases that were destroying the subjects of the colonial state. Neither was this wholly due to anxieties settlerdom had over the potential shortage in African labour. supplies That these were genuine concerns cannot be gainsaid. However, to leave the argument at this level is to suggest that the efforts that went into the establishment of these institutions were at best expedient and, at worst, selfish.

There is evidence to suggest that this development in Kenya was the result of at least two not so mutually exclusive factors. First, during the recruitment of African manpower for service during the First World War, both colonial administrators and settlers were shocked at how in poor health and physique the African really was (Adalja, 1962: 107-108). This sobering revelation led to efforts to improve on the situation in subsequent years when, in its interventionist status, coupled with increased settler demands for African labour, the state openly admitted that there indeed was a serious health problem in the 'native reserves'. Attributing this to factors ranging from constant famines 17 to the incidence of epidemic disease in these 'reserves', the state could in 1926
declare that Kenya had a serious population shortfall and there was an urgent need for active measures to promote its increase.18

Second, in the early part of the interwar period, the colonial state was genuinely becoming alarmed by the activities of Missionary Societies operating in various parts of the country.19 This is poignantly brought out by J. L. Gilks who, as the architect of and presiding officer over, medical reforms during much of the interwar period, argued in 1921 that though these societies were doing a good job in alleviating the poor health conditions in the 'reserves', there was

the desirability of Government itself undertaking the medical work in the reserves rather than subsidizing missions to do it for them. The work in Government units can be standardized and kept to a high level, and politically it is important to show the native that he is something more than a mere taxpayer. A Government hospital is a tangible sign of Government activities which is understood by every native, but it is doubtful whether a subsidized Mission hospital is in any way connected in the minds of the majority of the patients as being anything more than a token of the benevolence of the missionaries who therefore reap the credit and the resulting influence. It is a fact which cannot be gainsaid, that the provision of medical attendance, even of the crudest and most primitive description, is the best form of advertisement for any form of activity among natives, from labour recruiting to missionary work, and therefore every penny of Government money which is available for medical work should be spent by Government rather than by any independent body, and the resulting kudos would thereby be obtained by Government (emphasis added).20

Implicit in this text are several issues, two of which are of immediate relevance to our argument. First is the struggle between the state and the church over the colonization of African consciousness(Comaroff and Comaroff, 1991), and the centrality of biomedicine as an ideological apparatus in this struggle. As J. L. Gilks rightly points out, government medical services were belated in coming to the rural areas. This however does not in the least suggest that between 1895 and 1920 Africans in these areas remained unaffected by what was going on either in Nairobi or, for that matter, in any other administrative boma where medical facilities had been established. It can indeed be argued that apart from
taxation, the only other activities which directly impinged on African lives were inoculation and vaccination campaigns against such epidemic diseases like smallpox, plague, and yaws mounted by the Government (Dawson, 1983). Perhaps the most poignant clue to medical work in the rural areas was the incongruity of the task that confronted those who had been assigned the task of administering colonial Kenya. These were government officers who, "whatever their training and background, once they were in East Africa . . . had to do more than practice their professions" (Beck, 1974:103) The duties of a Medical Officer of Health were, for example, of a "multifarious character" since he "was a clinician, a lecturer in eugenics, a Medical Officer of Health, an educationalist and an amateur agriculturalist" (Carman, 1976: 40).

Of necessity, the nature of the government provision of medical services in the rural areas was characterized by "the growing co-operation between the medical departments and the other social agencies" (Beck, 1974: 103). John A. Carman (1976: 35) writes in his personal memoir that when Africans "saw the Agriculture Officer working hand-in-glove with the Veterinary Officer, and the Education Officer consulting with the MO . . . they believed that all these people had the interests of their tribe at heart." Carman is nonetheless convinced that the system of central control had, especially after the establishment of locational and district councils, "a most beneficial effect on the public health and on the control and treatment of disease" (1976, 35) What impact did this conflation of duties have on events and everyday experiences among the AbaNyole?

Whatever the merits of this co-operation between government officers in the execution of their duties, in the eyes of the colonized 'Nyole there was a clear distinction between ekilauni (the crown) and silikali (the government, which in the local dialect also translated as hot/fierce secret). Ekilauni is what was present, constantly trying to be part and parcel of the everyday lives of the AbaNyole but, because of its brutality, was not
only despised but also associated with the pestilence and indigence that had since the turn of the century become the rule rather than the exception. *Silikali*, on the other hand, was what was distant and therefore invisible. This invisibility was enhanced by the fact that it was also *hot*, or *fierce* and, therefore, if *ekilauni* brutalized the people in the name of *silikali*, the people could not take their grievances to the latter because its unknowability, coupled with its state of secrecy/hotness, made it not only mysterious but also dangerous. To understand the relationship between the State and the 'Nyole peasantry in time and space, there is need to comprehend how these people have, generally, perceived the whole notion of "social control vis-a-vis their need for survival" (Olmwullah, 1991:12, 14-15). During moments of societal crisis such as brought on by disease or drought, there seems to have been, even at this early period of colonialism, what Ranajit Guha (1981: 76-108) has called a "twilight phase" in which the peasants' "threshold of . . . tolerance" was lowered and clear boundary lines drawn between 'those others' and 'us'. It is indeed during the anti-plague campaigns that there began to be a clear change in terms of how leadership and social control were perceived among the AbaNyole. Thus, for example, instead of *abamii* (rulers), we begin to have *obwamii bwabwe* (their rulership); instead of talking about *silikali yefwe* (our government), there is talk about *silikali yabwe* (their government); *Omwami*, the recognized ethnic ruler, disappears and is replaced with *esilauni* or *ekilauni* (the crown whose manifest presence was symbolized by the pith helmet won by government administrators mostly but also by any civil servant on tour of the 'native reserves'). The inversion of the concept of *omwami* as a popularly recognized ruler to *esilauni* or *ekilauni* as an authoritarian leadership that spoke to and about representing a faceless *silikali* came to not only emphasize AbaNyole's negative reaction to the colonial state's activities, including anti-epidemic disease campaigns; it also subjected the state's agents to a process of othering that drew very clear distinctions
between the AbaNyole themselves on the one hand, and the colonial state presence on the other.

From this perspective, we can argue that if the Medical Officer of Health could be *everything* in his effort to improve the lot of the 'diseased native', his role by training and by employment was not immediately manifest among the AbaNyole. Medical personnel like J. H. Thompson, investigating the incidence of plague in the neighbouring Maragoli location, could with amusement report that "one man, after I had painted the iodine on and picked up the syringe, bolted, (and) I saw him still running over a mile away". Or John A Carman (1976: 36), a government medical doctor on an anti-plague campaign in North Ugenya Location, would argue that "in spite of its faults the vaccine was effective and the epidemic was stopped". But while this was the case as understood from a government officers point of view, to the African *silikali* was up to something more sinister. It is John A Carman (*Ibid.*) who, his qualifier notwithstanding, gives us an insight into this view when he writes that "when we had been at it for a week, all the roads and fields began to be deserted, for the brand of Haffkine plague vaccine put out by the Medical Research Laboratory looked rather like pea soup and gave rise to such formidable reactions that by the time our campaign was finished all the people lay groaning in their huts, wondering which was worse, bubonic plague or the *sirkali's dawa* (Government medicine) . . .". Though a cross section of those interviewed gave varying reasons for the AbaNyole's negative reaction to these campaigns, there was a general feeling that *abatakiti bo'muchui Emuhaya* (literally translates as doctors in duty at Emuhaya Chief's camp) were not different from "those others" who authorized the "counting of our children, the capture of our animals because we could not pay *obusuru* or *ekotii* (tax) . . . the burning of our houses because *ekilauni* wanted to finish *puleki* (plague) . . . the draining of marshes and the digging of *etsihonyo* (terracing in soil conservation) . . .". Furthermore, "if the chiefs and their *askaris* were not chasing
people all over the village to get them inoculated, they were engaged in house-burning because, so they said, this would help in chasing away or destroying the rats that had brought plague. And all this time the white man was at the marketplace, running after people and trying to inoculate them against a disease that had not fully been explained to them."

Thus, while on the one hand most men disappeared into the bush only to re-emerge at nightfall, "their reason being that silikali wanted to humiliate them in front of women and children," those the chiefs or the dakitari caught up with and inoculated, on the other, wondered whether the treatment they were being given "was meant for the disease or to kill them."

From the foregoing, it can be argued that the Colonial State's medical policy in the rural areas in the first two decades of colonialism was both disjointed and haphazardly executed. This however was not unique to the Medical Department. The militaristic gusto with which campaigns against epidemic disease were carried out resonated quite well with this period's colonial state's status as a conquest and pacificationist construct (Lonsdale, 1977, 1986). This was even the more so because, as a tool of empire, "of both symbolic and practical consequence, and as (an image) representative of European commitments, variously to conquer, occupy or settle", biomedicine was neither an accident nor accidental to the processes of a colonial state formation in Kenya (MacLeod and Lewis, 1988: x). Thus, while in this period in urban areas the rise of slums came to be perceived largely in terms of colour differences as race relations came to be dealt with in the imagery of epidemics and infection (Olumwullah, 1986: 183-184), in the rural areas this "sanitation syndrome" as Maynard Swanston (1977: 387-410) has called it came to be understood in terms of a "problem" whose solution demanded the application of the values and techniques of man's mastery over nature (Ashforth, 1990: 4). This mastery spoke both to the Kenyan rural society as a 'patient', and to the application of "our Western knowledge to the mitigation" of suffering brought by disease and therefore "the
betterment of African health" (Macmillan 1949: 228). Thus, as a trajectory of early
twentieth-century imperialism in Africa the notion of the 'diseased native' was a powerful
discursive strategy in both the logistics of conquest and pacification and in the formation
of the colonial state and civil society in Kenya. This image, like the all-embracing
'Native Problem' of the interwar period (Buell, 1928), came to constitute the "intellectual
domain in which the knowledge, strategies, policies, and justifications necessary to the
maintenance of domination were fashioned" (Ashforth, 1990: 1).

The main actors in this unfolding drama were the AbaNyole, the Church, and the
Colonial State. The effects of epidemic campaigns tended, with increasing intensity, to
alienate the AbaNyole from the state's presence and activities and to drive them into the
embrace of the church. As we have seen, to the AbaNyole these campaigns were not
different, though they could be worse than, the means used in either hut or poll tax
collection. Thus instead of continuing with their earlier stance of suspicion and mistrust
of the missionary presence, they increasingly moved into the Christian fold because
missionaries came to be seen not only as kind people "who were always with us, either
listening to our problems or participating in our singing and dancing,"26 but also had
hospitals in which "there was no cruelty, treatment was good, and doctors could go to
homes to see how their patients were doing. This was unlike silikali which had no
hospital or clinic in the location and whose doctors mishandled people."27 Be that as it
may, perhaps the most critical aspect of silikali's cruelty lay not in the manner in which it
rounded up the AbaNyole for inoculation, or in the pain the patients felt after the
administration of the Haffkine plague vaccine. As most informants pointed out, the
government's agents went too far when they started burning houses. This was the more
so not because this exercise rendered many people homeless, but rather because in 'Nyole
Worldview - the burning of a house was taboo and, like in cases of incest - the perpetrator
of such an act was an outcast who could be re-integrated into society only after a series of
The questions that became pertinent to the AbaNyole at this time were: how could chiefs, though recruited from amongst them, or from their ebilibwa (gates), be allowed to be part and parcel of the community after participating in house-burning? For ekilauni to claim that it was carrying out orders from silikali was one thing; how to get hold of this faceless construct for cleansing was another. Was it surprising when in popular, most of the 'Nyole colonial chiefs either died after a short while in office, or ran mad while still in office, or that their families never did well in life?

What is at issue here is not so much the authenticity of the information but the idea the information is trying to convey: that though chiefs were members of the 'Nyole society, they had in the course of their employment breached the taboos and put themselves outside the community. Thus, at one level, ekilauni of which the chiefs were the most immediate representatives came to symbolize a form of leadership that was not necessarily foreign or belonged to another ethnic group; it was of them but not for them. But at another, equally fundamental level, ekilauni and therefore colonialism came to be seen as a form of pollution that was dislocating the 'Nyole social and moral order. If this perception of the state, coupled with droughts, famines, and epidemics that occurred during or immediately after the First World War drove the AbaNyole to see Christianity in a different light, then the second issue in J. L. Gilks's text on biomedicine on the one hand, and the state-church relationship, on the other, becomes apparent.

According to J. L. Gilks, one of the most crucial issues in the making of a colonial medical social formation in Kenya was the lack of a 'centre' in the formulation and implementation of a medical policy for the rural areas. Though he blames this on lack of enough personnel, money, and the general backwardness of the rural areas, what is conspicuous in its silence is the methods used in the pre-war period to fight epidemics, and how these methods had polarized the relationship between the colonizer and the colonized in rural areas. It seems that at the time Gilks took over as the colony's PMO,
the question that urgently needed answers was not as to who should be but who was in charge of medical services in the rural areas. This was the more so because, first, notification of an epidemic outbreak more often than not came not from the state's auxilliary in these areas but from the church's medical corps. The Medical Department's position in this issue was compounded by the fact that the fight against such an epidemic was coordinated, at the level of mobilization of medical personnel and the excution of remedial measures, by the Provincial administration. That the period between 1902 and 1920 was characterized by what K.V. Adalja (1961: 106-107) has respectively called the periods of "beginning and groping" (1902-1912) and "unplanned progress" (1913-1920) cannot therefore be gainsaid. In its enthusiasm to consolidate itself during conquest and pacification the state had not only alienated itself but also had delivered the colonized in places like Bunyore into the hands of the Church. Thus, if it was through the anti-epidemic campaign methods that this development had taken place, it had to be through disease as a societal metaphor that the state was to re-assert its presence. It is within the parameters of this vision we have to, first, appreciate the fact that as an event and as process the state, through its articulation with society, was by the end of the First World War on the verge of transforming itself from its conquest and pacificationist stance to a status that was at once interventionist and mediatory as issues about land, the relationship between Settlerdom and the Indian Question, and the position of the African within the colonial set-up became paramount. Second and most crucially, it is within the framework of this "realization" as J. L. Gilks has called it we have to both understand his definitive statement on the place of a government health institution in re-capturing the imagination and consciousness of the African in rural areas, and the need for constituting a new domain of knowledge in which a new paradigm about biomedical health and healing in these areas could be embedded. Central to this second point were debates and discourses on new disease entities called 'African', the status of nutrition and hygiene in
the rural areas, and the educability of the African. To these debates and discourses, we now turn.
Endnotes

1 KNA: NZA/1/7, North Kavirondo District Report for 1912, included in the Annual Report for Nyanza Province, P. 26. In the 1905-1906 Annual Report for Kisumu Province, renamed Nyanza Province in 1910, the Provincial Commissioner notes that revenue for the province for 1904-1905 was Rs 293,000 and Rs 244,000 for 1905-1906. The hut tax for these years was Rs 187,740 and Rs 201,534 respectively. The Provincial Commissioner also notes how difficult it was to get labour from the province especially in the months of January-March and September-October because, according to the report, the province was producing surplus millet and wimbi. KNA: PC/NZA/1/1, Annual Report for Kisumu Province, 1905-06.

2 The British administration introduced taxation for purposes of increasing labour supplies to recently established settler farms and for public works like the construction and ditching of roads. That this instead intensified African agriculture leads to the conclusion that taxation created conditions for resisting migrant labour. Trends in this development can be seen from the number of hoes imported into the province, the tonnage of produce from the province, and the rise of the trading center as a place where foreign consumer goods were bought and some of the produce sold. In 1909, for example, 240,000 tons of sesame seed, 2,500 tons of maize, and a substantial tonnage of cotton were exported from North Kavirondo. By 1910 twelve trading centers had been established in Nyanza Province. See KNA: NZA/1/4, Annual Report for Kisumu Province, 1909, P. 30; KNA: NZA/1/6, Annual Report for Nyanza Province 1910-1911, P. 36; KNA: NZA/1/7, North Kavirondo District Report, 1912 (included in Annual Report for Nyanza Province, P. 17); KNA: NZA/1/5, Annual Report for Nyanza Province, 1910-1911; and KNA: NZA/1/6, Annual Report for Nyanza Province, 1910-1911.

3 KNA: NZA/1/8, Annual Report for Nyanza Province, 1913, P 64. In September 1948, in a further reorganization of the Provincial Administration, North Kavirondo became North Nyanza and, in 1953, the district was divided into two, North and Elgon Nyanza Districts.

4 Colony and Protectorate of Kenya, Annual Medical Report for the year ending 31st December, 1921, pp. 16-17.

5 Ibid., p. 17.

6 Ibid., p. 18.

7 Ibid.

8 For a summary of this literature see Steven Feierman (1985) and Gwyn Prins (1989).

Plate IV (map showing density of African population and European settlements) in Harry Johnston (1904) shows that the area stretching from Port Victoria to Ugowe Bay and falling just south of Lake Gangu as well as the area around Mumias and Kisumu (government administrative *bomas*) had the highest population density in the region at the turn of the last century (100+ people per square mile). This was followed by the area between Ugowe Bay and Kisumu but just below the Equator, the area just above Port Victoria and Guas, and the area along River Yala between Ugada's and Kakamega (between 60 and 100 people per square mile). Lastly, there is the area between River Nzoia in the west and present-day Maseno stretching through the corridor between Bunyore Hills and Nandi Hills to the western fringe of Nyando Valley and Kakamega in the north (45 to 60 people per square mile). Bunyore lies in the third zone.

KNA: DC/NN3/3/14, Political Record Book (Bunyore), 1935.

Official colonial reports are resplendent with stories about inter-clan and inter-ethnic conflict over land, land disputes and litigation, and the movement of people out of the location. In his report for 1930-1935 on Bunyore, the District Commissioner for Kakamega, E.L.B. Anderson, for example notes that because of land scarcity, many AbaNyole were seeking outlets in Seme, Sagam, and Kano "where very many are already settled and have been for years. . . . In North Kavirondo there has been a mild movement into Teriki (sic!), but there is a distinct disinclination to go to such places as Kabras where there is ample room. They have frequently been advised to give it a trial." KNA: DC/NN3/3/14, Political Record Book (Bunyore), 1935, p. 2. In the same report the D.C. reports that prior to 1925, clan jealousies had hampered chiefs' performance hence, "being unable to agree on an individual as their Headman, they had chosen the alternative of being put under Chief Mulama. . . . Incidentally it was then hoped, a vain hope as it turns out, that being under one chief the surplus population of Bunyore would find an outlet in Kisa and Marama" (Ibid., P. 1).

Conflicts between the AbaNyole and the Abakisa over land are also reported for the years 1910-1911 ad 1913-1914. See KNA: DC/NN3/2/14, Political Record Book, Bunyore 1910-11, 1913-14. This same file contains a report on the conflict between the AbaNyole and the Luo of Gem. See KNA: DC/NN3/2/14, Minutes of meeting held at the Honourable Provincial Commissioner's Office with the chiefs and elders of the Gem and Bunyore Locations on the subject of the Gem-Bunyore boundary on 19/5/20.

Claims and counter-claims over whose land Maseno was built between the AbaNyole and the Luo are legion. In his 1930-1935 report the D.C. for Kakamega, E.L.B. Anderson for example notes that "the Bunyer (sic!) contend that the Mission and Estate is really their land (so do Sagaam and Seme) and much disappointment was caused by the decision of the Kenya Land Commission that it should be kept and developed as a social service Centre. It was then requested that North Kavirondo apprentices should be accepted at the Veterinary Centre and that tree seedlings etc. should be issued from the Agricultural Farm. This was by way of keeping alive a claim for what it was worth. Both these requests were arranged by giving a local Native Council grant to each institution". KNA: DC/NN3/3/14, Political Record Book (Bunyore), 1935, P. 2.
Oral Interview, Sylvester Andai Njeche, 80, Es'saba Sub-Location, West Bunyore Location, 18th November, 1992. By the 1920s land litigation in Bunyore was the rule rather than the exception. As E.L.B. Anderson notes, "some 10 to 12 years ago the idea of individual rights had not by any means reached the same pitch as it has now, and many of the clashes between one sub-headman and another were due to disputes over clan lands. Possibly now they would have been considered as civil suits between individuals". Though this was beginning to happen," only a small proportion are taken to the Appeal Tribunal, and when this does happen the Appeal elders are often treated with scant respect. Steps have been taken to stop this and in several cases parties have been punished". KNA: DC/NN3/3/14, Political Record Book (Bunyore), 1935, P. 2. Perhaps the most famous dispute was that between Assistant Chief Zakayo and M. M. Atolua which is recorded as "Shamba Dispute, Bunyore: Assistant Chief Zakayo vs Ex M. M. Atolua, Revision for Kakamega Appeal Baraza Case No. 36/33 "included in DC/NN3/3/14, Political Record Book (Bunyore), 1935. Zakayo gave away his ancestral land to the CMS missionaries for building the Maseno Hospital. After this seemingly benevolent gesture, he simply moved, in 1926, and claimed land belonging to Atolua's clan.

The health centre the above informant mentions was never built until 1963-1966. This was because the people around Emuhaya refused to give more land for its construction. In 1934-1935, and in 1958, further attempts were made by the colonial government to have the health center built but, on both occasions, the people again refused to give land for the project. The project was in 1953-1954 taken to Kilingili by Chief Francis Kulali. After the 1958 refusal Chief Elijah Enane relocated the money for the building of the Ebvisrirati Elukongo Dispensary in 1959-1960. Kima Mission experienced a similar problem when it wanted to expand the maternity home on the Mission Station into a fully-fledged hospital. Due to lack of space the hospital was later built at Mwihiila, Kisa Location.

It is estimated that in 1932 about 20% and in 1937 about 30% of the adult male population of the district, and probably an even higher percentage from the southern locations, was out of the Reserve at any given time of the year (Gunter Wagner, 1956: 94). Labour migrancy from Western Kenya had in fact by 1910 become a major issue over its effects on social and economic organization in the area. See KNA: DC/CN1/5/1, Kisumu Quarterly Reports for December, 1910, P. 24 and for March, 1910, P. 24.

See footnote 2, above.

Colony and Protectorate of Kenya, Annual Medical Department Report for 1923, P. 64.

Colony and Protectorate of Kenya, Annual Medical Department Report for 1926, P. 15.

In Nyanza Province, for example, the activities of The Venerable Archdeacon Walter E. Owen had in the 1920s brought him into direct conflict with the settler community over the question of Church Missionary Society pastors "engaging, at
the request of their people, in activities of a civic nature". Against the
government and settler opposition to these activities Owen posed: "I personally
am of the opinion that if we were to attempt to forbid our padres from
participating in Local Government we would be cutting the ground from under
our own feet, and would be depriving the community from benefitting from a
service to the community which our padres are desired by their people to perform
... It should be remembered that the teachings of our Saviour have a community
as well as an individual application. ..." (cited in Richards, 1947: 20).
In 1922, after his return from a visit to the United States where he had been
invited by Dr. Jesse Jones "to study the position of the coloured people there",
Owen attempted to establish a "Christian view of the British nation's duty to
backward races". He advocated reforms in such matters as Hut Tax collection,
forced labour on roads, and unpaid labour in government camps. He also stressed
the need for consultation with Africans in "order that they might be given an
opportunity to voice their opinions as to where the laws and regulations were
harsh or resulted in unnecessary limitations to their freedom". This was a direct
challenge to the tenets of the colonial conquest state, and was seen in many
quarters of the settler community as a move to shift the center of social control in
the countryside from the State to the church. On June 16th, 1922, he preached a
sermon in All Saints' Cathedral, Nairobi, urging the application of the Golden
Rule: "Do unto others as you would they should do unto you" to 'native' policy in
Kenya. This earned him the title 'Archdeacon' of Kavirondo (Ibid.: 31-32). For
an analysis of the role of Mission Societies in the social and political development
of Nyanza province, and Archdeacon W. E. Owen's ambivalent position with
regard to his understanding of the place of colonialism in this development, see J.
M. Lonsdale, "Political Associations in Western Kenya" in Robert I. Rotberg and
unpublished Ph.D. dissertation, University of Cambridge, 1964, and F. B.
Wellbourn and B. A. Ogot, A Place to Feel at Home, a Study of Two Independent

20 Colony and Protectorate of Kenya, Annual Medical Department Report for 1921, P.
23.


22 Oral Interview, Daudi Omoka Afwaba, Ebushikale Emayoka, West Bunyore Location,
25th November, 1992; Dishon Aywa, Ebusiekwe Sub-Location, Ebukoloow
Village, West Bunyore Location, 16th December, 1992; Mang'ong'o Mahanga
Odalo, Ebuhanzo Village, Karateng'i Sub-Location, Ojola Location (Nyanza

23 Oral Interview, Archbishop (retired) Festus Olang', Ebusakami, South Bunyore
Location, 7th December, 1992.

24 Oral Interview, Mrs. Malema, Em'mukunzi Village, Emakunda Sub-Location, North
Bunyore Location, 10th and 19th November, 1992.

26 Oral Interview, Nikanoli Khakali Imbote, 84, Em'mukunzi Village, North Bunyore Location, 11th November, 1992.


30 Oral Interview, Hosea Khayanje, Mwilonje Village, Ebusiloli Sub-Location, North Bunyore Location, 30th December, 992 Of course upon cross-checking of this last point it was found that madness or death in office never occurred, although most chiefly families never did well in terms of educational or material achievement during colonialism.

31 Colony and Protectorate of Kenya, Annual Medical Department Report for 1921, P. 16.

32 It seems that the basis of the realization on the part of the 'faceless' "European section of the public" Gilks talks about that health in the rural areas was in bad shape lay partly in the reasons Megan Vaughan advances but mainly in the struggle between the colonial government and the missionaritores over the colonization of African consciousness (John and Jean Comaroff, 1991). The Kenyan colonial state, though basically a conquest one (Lonsdale, 1977, 1986), was both an event and a process. As an event, it was a revolutionary construct which came into its own through physical and ideological means (Odhiambo, 1987, 180). But as process it was an apparatus that transformed, but in turn was itself transformed, by the societies which it came into contact with at the turn of the last century. Thus while in its transforming capacity it created a colonial economy (Sorrenson, 1967; Brett, 1973) and a colonial society (Munro, 1975, Tignor, 1976), in the process of its transformation it changed from its conquest and pacificationist stance between 1902 and 1920 to a status that at once talked about the mediation between settler, Indian, and African interests on the one hand, and the protection of the African native populations under the vaguely - defined notion of trusteeship, on the other. It was in the interwar period, that it moved in quick succession from its self-appointed role of
mediator, to a settler-dominated construct/social formation that was also interventionist in stance when it came to the social and economic changes that were taking place in the rural areas. Thus, starting from the premise that the realities of state performance in colonial Kenya must ultimately lead to a closer consideration of the non-state sphere...
VOLUME II

DISEASE, MEDICINE, AND SOCIAL CHANGE AMONG THE ABANYOLE OF WESTERN KENYA, 1900-1963

by

OSAAK A. OLUMWULLAH
CHAPTER SIX

HEALTH AND THE AFRICAN RURAL WORLD:
BIOMEDICAL VISIONS AND RE-VISIONS DURING THE INTERWAR PERIOD

6.1 Introduction


"If you look for a disease in Africa, you will find it," has often been impressed on me. When I first went to Africa, I was told that certain diseases did not occur, but it only wanted a little investigation to find the cases. Dr. H. S. Stannus, 1923: 286.

In 1926 the Annual Medical Report of the Kenya Colony summarized the medical problem in the country thus:

The sanitary problem of Africa is how to improve the standard of living among a population of some millions of persons; in many cases poorly developed physically; at a low stage of civilization and comparatively uneducated; living under primitive and fundamentally insanitary conditions, with, in most cases, a high birth rate, a high death rate, and a high infantile mortality rate; suffering from preventable diseases; in occupation of fertile land, but without the ability to use that land to the best advantage.1

Going into the specifics of the African rural living conditions and the relationship between these conditions and organisms causing these diseases, the 1928 Annual Report was more succinct:

Almost every African native is infested with some type of intestinal worm. A large proportion suffer at one time or another from malaria. Over large areas plague and yaws are endemic. Syphilis appears to be becoming increasingly prevalent in certain districts. Pneumonia, broncho-pneumonia, and tuberculosis take a large toll of life.

The circumstances of the people are such that they live under conditions which are admirably suitable for the existence and spread of the causal agents of disease or of their animal hosts. Even where huts and villages are not overcrowded with humans, they are always overcrowded with the causative organisms of disease or the carriers of these organisms, so that escape from infection is for the great majority of people impossible.2
A number of writers have used these and many other official texts to conclude that Kenya was indeed an epidemiological landscape where "the human race" before the arrival and applicability of Western medicine "continued to exist" only because of "the very high fertility of the African woman" (Adalja, 1961: 105). Western medicine, the argument goes, had by the end of the colonial period led to the "virtual" elimination or control of these diseases. In fact, from a position of anxiety in the 1920s over the fears that the African population was threatened with extinction, there were, at the beginning of the 1960s, anxieties over population explosion which, if left unchecked, threatened to outstrip the resources of the country. According to K.V. Adalja, the foundations of this success story were laid by Dr. J. L. Gilks who, as "a man of vision, of understanding and of considerable ability", had at the beginning of the 1920s foreshadowed the 1925 East African Commission's contention that to increase or even maintain "the native population" there was need to reorientate medical policy and planning towards "hygiene, sanitation and midwifery" (Adalja, 1961: 106, 108).

Though this triumphalist discourse directs our attention to the data needed to ascertain its claim-truths, as a trajectory of the official colonial discourse on the 'diseased native' and the role of Britain in 'modernizing' Kenya, it also alerts us to the fact that it is a representation of the winning side, a selection from what must have been a thoroughly experimental period whose hallmark was not one, but several discourses. It thus raises questions not just about the issues that led to its constitution, but also about the quality of life it speaks to, and how this life was constituted into an object of knowledge for the eradication of disease in Kenya. Thus, since it has everything to do with how biomedicine talked to and about Kenya and its indigenous populations, the ideas generated in the course of its production -- on the African, on disease and its relationship with the African cultural environment, and on the making of a new medical social formation -- become crucial in understanding both how the colonial state medical
'experts' conceptualized the problem of health and healing, and sought solutions to it. But, more crucially, it directs our attention to the fact that as a new social formation seeking to define itself within and above African therapeutic traditions, it had to first define a space for its constitution. Both this space and its definition lay, this chapter argues, in "the modes of inquiry" which attempted "to give themselves the status of sciences", and at that point where the African was "objectified by a process of division" from the European and categorized by bestowing on him/her a perceived and felt inferior identity (Foucault, 1982: 208).


To argue for a biomedical tradition, and to place this tradition in a privileged position, the makers of the Kenyan colonial society had of necessity to start by rejecting African therapeutic traditions. This was necessary, so it was argued, because Kenya as a decidedly landscape of fear had "little that is African to build on" (Macmillan, 1949: 228). Starting from the premise that African therapeutic traditions were magical practices, the colonial state, through its medical "experts" but after appropriating missionary and early administrators' delimitation of what these therapies were thought to involve, sought to define new parameters in which the idea of 'development' as 'civilization' could be embedded. It was The Venerable Archdeacon W.E. Owen (1924: 138) who in the early 1920s declared, after what he thought was a detailed study of the Abaluyia and Luo notions of disease causation, that the "Kavirondo, both of the Bantu and of the Nilotic tribes, are animists". Mrs. R. Pentreath (1936: 318) took a similar position when she argued that "The natives here, in North Kavirondo District, are so filled with the fear of what bad spirits and the M'ganga (witch-doctor) will do, that their lives are often a burden, and they are kept back from the benefits of civilization". The
colonial administration's position was well summarized in 1928 by Captain W. Hichens of the Native Administrative Service in East Africa when he argued that

Witchcraft and superstition loom so large in the daily life of the African savage, that science, in offering the native the benefits of her discoveries, often finds herself repulsed and dismayed by the barriers set up by witch-doctors, and by the apathy and fear behind which the kraalsfolk entrench themselves (1928: 229).

This position received impetus in the second half of the 1920s when an upsurge in Kikuyu cultural nationalism pushed to center-stage the debate over the merits and demerits of the practice of clitoridectomy. Missionaries, administrators, and medical doctors came to look at this practice with horror. Central to these "experts" argument was not an inquiry into the surgical and educational, as well as psychological, aspects of the operation, but what they interpreted as the absence of sterilization and anaesthetics in African medical practice. At the level of ideas, this perception revolved around Western biomedical notions as to what constituted cleanliness, and as to how this was the crux of the health problem in rural Kenya. Thus, from the missionary and early colonial administrators' discourse on African therapeutic traditions as magical practices, there was, towards the end of the 1920s, a conscious move to not only link this discourse with a developing one on hygiene and cleanliness, but also to reconceptualize the health problem in rural Kenya in terms of a conflation of socio-economic, cultural/environmental, and scientific/medical ideas. This developing perception was in its embryonic form brought out as early as 1923 by a British medical doctor, J.F.C. Johnstone, who observed that

considering the morbidity tables of statistics as a whole, the popular belief that the native living in his own natural surrounding is full of health and vigour is largely disproved . . . . The native huts are without light or ventilation, and harbour every sort of insect and vermin; the surroundings are persistently fouled with excrement; cattle are housed in their immediate vicinity. The water supply is often inadequate, and always liable to contamination. . . . The only rational method of tackling the problem of disease in Native Reserves is to raise the sanitary standards of
the population, rather than to attempt curative measures against specific diseases. *The peculiar mentality by his lack of the sense of responsibility for public health, and his attitude of pessimistic fatalism towards questions of life, disease and death, is the great obstacle* (emphasis added).7

Among diseases observed by J. F. C. Johnstone in Central Kairondo District were yaws which had "evidently been present . . . for a very long time" and was acquired "by direct contact with an infected case, and flies by conveying the infection from person to person, clothes, chairs, cooking utensils, etc." ([Ibid.]: 372); umbilical hernia which was rampant among children and resulted from "possibly . . . septic conditions of the umbilical cord"; scabies whose cause was scratching and which led to "septic conditions" supervening; smallpox; syphilis; malaria; and pneumonia which "accounts for a large number of deaths at all ages" ([Ibid.]: 372-373). Pneumonia, Dr. Johnstone averred, was, the result of "the tendency to adopt European clothing" which rendered "the native more susceptible to diseases of the chest. Clothing, for the most part, is not worn for the sake of warmth, but for ornamental effect. It is worn largely during the heat of the day, and is often discarded during the colder hours of the evening when the native returns to his own domestic circle" ([Ibid.]). The authority upon which these conclusions were based was not any rigorously carried out medical examination or research. Indeed, as he points out in the text, these were observations borne out of information "obtained as carefully as possible by means of an interpreter and in the presence of the chief or other responsible person" as "no attempt at an exhaustive medical examination was made" ([Ibid.]: 370) (emphasis added).

J.F.C. Johnstone's position is not different from that taken by J.L. Gilks (1923) and A.R. Paterson (1931) on the relationship between disease causation and hygiene in African homes. J. L. Gilks, for example, had this to say on the incidence of yaws in the same district of Central Kavirondo: "Native evidence as to the incidence of the disease, where it is now prevalent, is to the effect that such has existed among them for as long as
they can remember" (1923: 278) and though there was "a certain amount of evidence that
temperature and climate have a bearing" on its incidence (Ibid.), "It is, of course, not
impossible that conveyance . . . may occur through the agency of blood-sucking insects,
but so far there is no evidence of this, and the conditions under which the native lives in
the reserves afford excellent opportunities for the spread of disease by simple
transmission. The huts are dark, warm, unventilated, and dirty, and overcrowding is
prevalent" (Ibid.: 279). Dr. Gilks was to re-affirm this position twelve years later when,
starting from the assumption that "the principles which govern public health are
fundamentally simple and they operate universally, in towns or in rural districts, in
England or in Africa" (1935: 31), he argued that "the ordinary round hut in use as a
habitation by most of the tribes" in Africa was

unventilated, unlighted, impossible to keep clean, and affords excellent
harbourage for every kind of vermin; it is insanitary to a degree and would
be condemned as such in England if it were used to house cattle. . . . it . . .
offends against every sanitary
canon . . . (Ibid.: 33)

Some of the most important features of this emergent discourse on the 'crux' of the
health problem in rural Kenya in the interwar period are, therefore, the conscious
attempts by medical 'experts' to draw ready connections between the disease environment
and African culture with little or no effort to appreciate what the indigenous people
thought constituted public health; the recognition of the incidence of new diseases with
the tendency on the part of these 'experts' to place African cultural practices at the centre
of their incidency, thus setting up "the terms of discourse between the West, with its new
diseases and its new prophylactics on the one hand", and the African cultural
environment on the other (Odhiambo, 1992: 7); and the attempts to insert biomedical
science at the centre of contestations over knowledge between a British colonial science
and African ways of knowing. At the core of the latter feature was a kind of 'eyewitness
observation' which, when translated into a 'scientific know-a-ility' of rural Kenya,
provided the terms in which a new disease language and a new domain of knowledge for
dealing with rural health were constituted. While on the one hand the authors of these
texts called for further scientific research into what they already knew to be the
difference between African and Western experiences of disease, they, on the other, went
ahead and "quickly constructed theories to explain peculiarities of the African disease
experience". Thus,

> Given the deficiencies in medical and social knowledge that existed at the
time, these theories were inevitably influenced by cultural assumptions
about Africa and Africans, and tended to focus on the peculiarities of
African behaviour . . . Once these theories were constructed, they shaped
the course of subsequent research, privileging certain lines of inquiry
while largely excluding from vision or marginalizing other potentially
important areas of research (Packard and Epstein, 1991: 771)

Thus a key dimension in this emergent discourse was the categorization, or
naming, of 'new' disease entities not according to their biological, epidemiological, or
pathological manifestations but according to their geographical and/or racial incidences.
Among these 'new' disease entities were African syphilis, African relapsing fever, African
trypanosomiasis, and African hernia. Resonating well with the late nineteenth and early
twentieth centuries' European construction of Africa as a 'patient,' these categorizations
were epidemiological and biological paradigms (Seidel, 1993: 177), in the construction of
Africans as disease-ridden beings. But as discursive formations these categorizations
constituted the domain in which knowledge, strategies, and medical policies as tools of
control and domination were systematized in the interwar period. As part of the wider
ideology of systematizing and justifying the colonial state's interventionist stance in this
period, health reform was thus not just about anxiety over contagion in the European
section of the population and about threats posed by epidemics to African labour; it was
also a metaphor whose web of meanings included the incorporation of modern or
'scientific' modes of discourse within the interventionist lexicon. It is within these
parameters that health reform became in this period an important arena in which ideas
about race, about Western science, and about the African cultural environment could be debated.

Important players in the Kenyan debate—J. L. Gilks, A. R. Paterson, H. C. Trowell, H. L. Gordon, and Drs. Vint and Oliver—were biomedical 'experts' on rural Kenya, as well as senior members of the colonial administrative hierarchy. The debate revolved around African cleanliness and hygiene; African educability; and African nutrition. The main features of the debate were, first, its evidentially thin base and, second, because of the first feature, its tendency to plead for more research while at the same time falling back onto well-worn stereotypes about the African society. As Paul Rich (1990: 667) has noted in the case of South Africa, though this new interest from "ostensibly neutral 'experts' who appeared to be gaining allies from within a new professional intelligentsia in efforts to influence policy at the level of the state" undermined earlier 'non-scientific' perceptions on Africans,

The newer scientific discourse in many cases ended up perpetuating older conceptions of African society—inaugurated from nineteenth-century travellers and missionaries in a new guise. The scientific popularizers of race looked for tendencies described by Philip Curtin as 'diversificationism' that emphasized aspects of human difference rather than similarity. Behind much of their thinking was the assumption that there was some form of order and hierarchy in human races in which the white, Anglo-Saxon race occupied the topmost position.

The appeal of this development lay partly in the rapidly growing connections established, but also coordinated, by such international scientific communities as the Royal Society of Tropical Medicine and Hygiene, the British Medical Association (which had branches in the colonies), and the International Eugenics Society, and partly in the 'scientific' researches that had been going on in the U.S.A. on the educability and psychology of the Negro race. In a series of lectures delivered under the auspices of the Academic Council of the University of London in 1923, members of the Royal Society of Tropical Medicine and Hygiene for example brought to the attention of the international
scientific community the anxiety the society was having over tropical food or food prepared under tropical conditions and the danger this posed with regard to "the capacity of the white race to people the tropics" (Belfour, 1923: 151). At the heart of this concern was the "tragedies (that) might happen in European households" where food consumed by Europeans was prepared by very unhygienic 'native' hands (Ibid.: 157-159). This anxiety was in the 1920s in Kenya to 'scientifically' lead to the definition and categorization of the African as a person whose attitude towards life, disease, and death was the result of a "peculiar psychology" and an overly "indolent fatalistic disposition" (Johnstone, 1923: 374). This point was poignantly brought out in Percy W. Bassett-Smith's presidential address to the Royal Society in 1923 on the relationship between food and disease causation in the tropics. According to Bassett-Smith (1923: 227-228), diet choice in the tropics was made "under instinctive guidance". That is why, compared to the "inhabitants of cooler climates", people in the tropics were less energetic and had low mental capacity. "A rich diet in proteins", Bassett-Smith concluded, "makes for physical and mental energy, and it is animal not vegetable protein that is most wanted. It is animal protein which is the true food of the brain and nerves, hence all the more energetic races of the world have been meat eaters".

It was this developing line of thought that A. R. Paterson (1931) and J.L. Gilks (1935) built upon when they argued that the poor and unhygienic conditions obtaining in rural areas in Kenya were more often than not the outcome of dietary deficiency caused by "local resources (which), though sufficient in quantity, may not be varied enough to provide all the essential constituents of a diet . . ." (Gilks, 1935: 33). In an address to the Centenary Meeting of the British Association for the Advancement of Science held in London in 1931, A.R. Paterson, the Deputy Director of Sanitary Services in Kenya, argued that the nature of African economies before colonialism assured that people "were ill-fed both mentally and physically" (Paterson, 1931: 303). Colonialism, Paterson
added, had not initiated the desired changes in Africa: instead it had led to the acquisition of new knowledge which was not always complete and where contact with new methods was greatest the changes which took place in domestic life and habits were not always for the best". For example,

Clothes were introduced before soap and a kind of house which required water for its cleansing began to be built before water supplies had been improved, and there was no small disruption of domestic life. And all the while though here and there epidemic diseases such as smallpox might be controlled the old sicknesses of Africa which stood in the way of increased production remained rife (Ibid.: 304. Emphasis added).

To Paterson, like to Gilks and Johnstone, these "sicknesses of Africa" lay in "the huts or houses of the people, their clothes, their cooking pots, their food and their water supplies" (Ibid.).

To these 'experts' the solution to this problem in Kenya lay in economic development, education, and in the initiation of new programs in the sphere of public health. As Paterson (1931: 302) put it, education was the only means of enabling "backward people . . . to function efficiently under the very different conditions which are resulting from the removal of (primitive conditions of isolation) and from their incorporation in a world community, and how to enable them to bear effectively the responsibilities which that incorporation involves". J.L. Gilks (1935: 36-37), in linking housing, diet, and education to the improvement of health in the rural areas, argued that attempts to promote both curative and preventive medicine had to go hand in hand with economic development in these areas. This was the more so because the lone efforts of the most devoted and skillful medical staff equipped with a hospital and every modern facility would be barren of permanent results, because there are few important diseases whose incidence can be permanently reduced merely by the treatment of individuals. The majority of the patients who might be cured would inevitably again be exposed to the infections whose results originally caused them to seek medical aid, and public health propaganda, backed by all the influence obtained by the successful treatment of individuals, would be futile, for the population would not be in an economic position which would allow them to act on the truths contained in the sermons preached to them.
But if these 'experts' identified and defined the health problem in rural Kenya as one of poor diet and unhygienic living conditions, the question that needed answering was one of how to proceed in both finding solutions and implementing them. Through a reading of similar conditions in India, Paterson was of the opinion that "The hygienist and the statesman both in India and in Africa" were faced with, first, a psychological problem which was also a solution: "how to induce a will" in the colonized "to live better." This, Paterson felt, was the heart of the matter since the will to live better was the motor force "without which improvements in agriculture and commerce will not give an adequate return". The best approach to the problem, he concluded, lay in "the instruction of the peasant in the technique of living" (Paterson, 1931: 310). Thus, if the health problem in rural Kenya lay in the African cultural environment, its remedy lay in a simultaneous process of the destruction of this environment and the introduction of new ways and means through which a new species of Africans could be socially produced. This point is significant. Its significance lies in the fact that while biomedical sciences could, on the one hand, function as "dividing practices" in the service of exclusion and domination, education and economic development were to function as means or techniques through which the 'native', under colonial guidance, was to initiate an active process of his/her own self-formation. and development. In other words, as techniques of "subjectification" (Foucault, 1982: 208), education and economic development were processes of 'native' self-understanding which, understood from the point of view of the vaguely-defined interwar notions of imperial trusteeship and native paramountcy in the colony, were to be mediated through the 'benevolent' hand of biomedicine. Thus, though Paterson and J.L. Gilks constantly criticized earlier notions of racial difference between the 'native' and the Anglo-Saxon they in this period still harked back to Western civilization as a universal referent without which the understanding and destruction of disease in Kenya was lost both to "the hygienist and the statesman". The indices of this
dual approach were well brought out in these 'experts' simultaneous re-affirmation of the
rejection of African therapeutic traditions and the appeals they made for what they called
a sympathetic understanding of "not only the people but the environment of the particular
people with whom we may be dealing with a view to discovering in which direction
alteration of custom or environment is required" (Paterson, 1931: 311).

From the foregoing, it can be argued that both A.R. Paterson and J.L. Gilks spoke
to the need for re-directing the focus of medical policy from urban to rural areas. This, of
necessity, required a shift in the semantics and lexicon of colonial domination. The
change in the terms used to address the African from 'native' to 'peasant' in Paterson's and
Gilks's writings in this period is therefore quite significant. This, needless to say, was a
reflection of their philosophy that the problem in Africa was one of culture and not race.
Though both are silent on just how the the imbalance between urban and rural areas was a
major mitigating factor in the need to re-focus medical policies from the the former to the
latter, the dynamic in this shift was the anxiety generated by rural-urban migration and
the problem this posed for social control and 'moral hygiene' in towns. This was the more
so because the First World War had brought into sharp focus the relationship between
African labor, living conditions, and the incidence of epidemic diseases in
towns( Olumwullah, 1986). To initiate any meaningful reforms in towns, it was felt, the
dynamics of rural society and the role education and economic development was to play
in these dynamics had to be addressed. It was Paterson, that ever present force in the
systematization of the state's interventionist stance in the interwar period, who summed
up this position when he argued that

A feature of modern life in many countries is lack of interest in the
country and the consequent drift to the town. To a certain extent a similar
tendency is manifest among the native peoples of Africa today. Can this
tendency be counteracted? That it should be the aim of all policy to
counteract any undue development of this tendency there can be no doubt;
equally there can be no doubt that the correct policy is to make life on the
land attractive and to show the peasant that such life is well worth while.
To this end he must be given something to do which is worth doing and worth doing well. It would appear to follow that any educational scheme for the development of backward peoples in an agricultural country must recognize the need for the full exercise of the potentialities of the peasant.... Today health, and the welfare of future generations in Africa, depend on efficiency in agriculture, on a ratio of production per acre and per person.... That is the outlook which we have to give the African if we would have him healthy. If he achieves it hygiene follows almost as a matter of course, and a public health conscience, for that after all is no more and no less than self-respect on the part of all members of the community (1931: 314-315. Emphasis added).

Explicit in this assessment of the relationship between economic development and health in the rural areas are a number of issues. First is the link drawn between rural economic conditions and labour migrancy. The concern here was with the African urban dweller as a 'problem' that in this period increasingly came to be articulated in terms of social discipline and control. As has been argued elsewhere (Olumwullah, 1986), and as Paul Rich (1990: 666) notes for South Africa, the sanitation syndrome that informed urban city fathers was an extension of Victorian fears over 'dangerous classes' in emergent towns. Imbued with the fear of contagion, "social order as well as social and moral hygiene" became powerful metaphors for articulating arguments for rural health and economic development. Thus these arguments became quite important in systematizing and justifying the colonial state's interwar interventionist policies in the rural areas. Second, there was a clear if not conscious move to drop such terms as 'native' and to articulate ideas about change not in terms of racial difference but in terms of an appeal for the appreciation of the fact that "the African is essentially an enthusiast and the tradition which sufficed and fitted when the communities were isolated, and the needs of war provided principles of hygiene can, if we will, be developed and altered to meet the needs of peace" (Paterson, 1931: 314).

6.3 African Educability, Psychology, and the problem of Health
If at the core of the arguments outlined above were discourses on African therapeutic traditions as magical practices; the African cultural environment as an unhygienic edifice; and education and economic development as civilizing projects, these were by no means the last word on how changes could be brought about in Kenya. In developing a counter-discourse, Drs. Gordon (1930, 1932, 1933, 1934), Oliver (1932), Vint (1932, 1934), and Trowell 1935), not only drew direct links between the African cultural environment and what they called 'the uneducability of the African', but also sought to draw upon both British social Darwinism and ideas already in vogue in the U.S.A. on the psychology and mental capacity of the Negro race to 'scientifically' prove that the difference between Kenyan Africans and Anglo-saxons was indeed one of race. The terms of this counter-discourse were set by Dr. H.L. Gordon who, in a letter to the Editor of The East African Medical Journal, argued that the causes of African backwardness were not to be explained wholly in terms of lack of "scholastic and social education" (1932: 212). The argument that African backwardness was "a matter only of lack of education" was, to Gordon, founded on "misconceptions contained in innumerable definitions by educationists, from Milton, Mill, and Herbert Spenser, to Charlotte Mason, Signora Montessori, and the pedagogic shibboleth that education is character-formation, to be attained it seems by scholastic variations of that which Montaigne was the first to ridicule". To insist upon scholastic education as panacea to African backwardness was to not only ignore that there was not one, "but possibly many causes" of the problem that could "be classifiable as either nurtural or natural (environmental or inborn)"; to Gordon it also meant that the Education Department in the colony was oblivious to the fact that "its practical application for many generations by industrious believers has not cured African backwardness" (Ibid.: 210).

African backwardness was pathological, and its understanding lay in the ideas of Rousseau, Voltaire, and Darwin who, in their own different ways, had proved that
"education begins with the infant's first breath", or that "nature is more powerful than education," or that "scholastic education is far from being the whole of education" (Ibid.). According to Gordon, these positions had been scientifically proven: "Neurology has told us that . . . real education depends upon the cerebro-spinal system and its stimulation through the twenty special senses. System and stimulations vary with race, individual, and environment, sufficiently to produce countless variations in behaviour, 'intelligence', and character." To Gordon, therefore, the understanding of African backwardness lay in "the fascinating and incomparable value of biology" which provided any educator with insights into "ideas of growth, development, heredity, variation, and evolution" (Ibid.: 211).

It is on the basis of this "biologist's definition of real education" that H.L. Gordon and F.W. Vint had, between December 1931 and March 1932, published "some preliminary objective evidence of the possible share of nature in the causation of African backwardness." The aim of the project was to show how European "nurtural efforts for the African" could "be made to induce the best possible development of hereditary African nature" (Ibid.: 211). Dr. F.W. Vint undertook an anatomical investigation of the 'native' brain, Dr. H.L. Gordon 'native' mental deficiency or Amentia. But both investigations were based on attempts to determine the brain weights and the cranial capacity of Africans. These drew heavily on the work of nineteenth-century European anatomists and histologists and early twentieth-century American scientists who had advanced the argument that first, there were fundamental differences in the cranial capacities of various races and, second, the Negroid brain was smaller and lighter especially in the frontal lobe than that of the Caucasoid brain. This argument had, by 1906, found its way into the study of the African brain from Africa by, first, Karl Pearson (1906) and, later, Karl Pearson and Bennington (1911) who argued that crania collected from the Congo and Gabon showed that the Negroid skull was smaller in size than that of
the Caucasoid skull. It seems that it was on the basis of these ideas that Dr. Vint in 1934 published the results of an investigation of 389 Nairobi "native brains". His findings were that, first, the brain of an adult Kenyan African was 1,276 grammes or 152 grammes (10.6%) less than the average weight of the European male adult brain. Second, the "native brain" attained its maximum weight at the age of between fifteen and eighteen years after which it began to gradually decline. This was in contrast to the European brain which did not attain its maximum weight until adult life and declined when old age set in. Third, from a naked eye examination of a series of one hundred brains of "normal natives," Dr. Vint found a very high prevalence of the simplicity associated with primitive brain and a most unexpected prevalence of definite simian features, especially the lunate sulcus, which were rare in Europeans. Fourth, through a microscopic measurement of cortical layers or the grey matter which was believed to be the seat of intelligence and intellect, Dr. Vint found out that there was a 15% quantitative deficiency of the 'native' cortex as compared to that of the European. Lastly, he found a number of immature, underdeveloped, and undifferentiated cells.

The year before Dr. Vint published his findings, Dr. Gordon (1933) had, in a paper presented at the Eugenic Society in London, pointed out that from an investigation of 3,444 living Africans, he had found out the brain capacity of the African adult to be 1,316 C.C. as compared to that of the European which was 1,481 c.c. According to Gordon (1934: 236), while the average annual rate of increase of the European brain from the age of ten up to twenty was 17.7 c.c., "that of the series of 3,444 natives was only 8.5 c.c." If the difference between the European and African "average final cubic capacity" in adult life was 165 c.c., it followed that there was not only an "unmistakable relationship" between the African cubic capacity to "some common origin" but also that "the problem of that common origin contains to my mind the key secret to the cause of racial backwardness."
What was the significance of these investigations? This lay in attempts to correlate Dr. F.W. Vint's findings on the weight of 'native' brains and quality of the 'native' cortex, on the one hand, and Dr. H.L. Gordon's findings on the 'native' brain weight on the other, to determine the African mental capacity. Though Dr. Vint refrained from drawing any conclusions to that end, and Dr. Oliver (1932) had pleaded for caution in any attempts to determine African mental capacity on the basis of the relationship between the size of the head and brain weights alone, Dr. Gordon used his and Vint's findings to argue that they conclusively pointed "to the cortex or grey matter as the site of a biological deficiency which would account for the biological actions on a lower level... [T]his opens the way to study of racial backwardness from the biological approach" (1934: 239). Dr. H.C. Trowell (1935: 343) agreed with Gordon when he argued that though in the "present state of our knowledge we are unable to relate these findings to the problem of native education," the fact that "the cortical measurements of the East African have been recorded (and) are now ascertained facts of neurology and psychology" will one "day... be built into a scientific conception of the capabilities of the Africans." In other words, what mattered to Trowell was not the lack of a scientific conceptualization of the racial inferiority of the Kenyan; to him what Drs. Vint, Gordon, and Oliver had done in terms of re-enacting "within the compass of a few years... the history of racial comparison in North America" had "never failed to record racial standards, it has always failed to record valid racial comparisons" (Ibid.: 345).

It was on the basis of these three 'experts' formulations - on the measurement of cranial capacity, brain weights and brain structure; anthropometric measurements having significance for mental ability; and intelligence tests - that Dr. Trowell concluded that the training of Africans in the medical field would henceforth be "conditioned by the material to be trained, the physical health and the mental ability of the recruit and the degree to which these endowments of heredity have been modified by environment" (Ibid: 340).
To him an African could not be trained in the intricacies of curative medicine because first, he was "not really adequate to any condition where he cannot be frequently supervised" (Ibid.: 346). This made him only fit to work in the field of preventive medicine (Ibid.: 349). Second, the closest Africans could come in terms of training was as compounders, laboratory assistants, midwives and nurses, the last category being women because, as he rhetorically posed, "for is not a nurse a woman, and nursing a sublimation of the maternal instinct?" (Ibid.: 349). Third, and apart from low physique and doubts about his "mental ability to receive training", the African was characterized by three other "mental barriers": he was incapable of grasping ideas in English or the country's Lingua franca, Kiswalili; philosophically he did not "move in a world of cause and effect explained in scientific laws, a world whose history is known, whose evolution is gradual, where at the moment the ideas of Humanism supplement the strong edifice of materialism;" he did not have character since "all the failures that have occurred during or after training, have been due to character. If the old African failed for want of knowledge the modern African fails for want of character . . . Without character, sanitation is a verbose preaching, and medicine mere quackery" (Ibid.: 350-352).

6.4 Conclusion

In chapters five and six, two themes have informed the analysis of the colonial state and medical practices in Kenya. First, an attempt has been made to understand how the colonial state conceptualized and proposed to deal with questions about health in the rural areas after twenty years or so of a disjointed, haphazardly executed, and often militaristic approach to the eradication of disease. Second, the two not so mutually exclusive chapters also broached the question of how the ideas produced in this process of 'state self-understanding', and the mode of their articulation, was a reflection of the changing exigencies of the political economy of colonialism. Central to this process, it
has been argued, were arguments and counter-arguments on new disease entities called 'African'; the African cultural environment vis-a-vis the problem of disease causation; and on the question as to whether the African had the mental capacity to cope with the rapidly changing colonial situation. At the core of the analysis in chapter five were issues surrounding the problem of epidemics and their impact on the dynamics of African demography, and on the colonial state from the point of view of both its self-perception and how the AbaNyole understood and saw it. The focus in chapter six has been on the process of the construction of a new medical discourse that, in its attempts to break with the pre-World War I period, came to focus on both education and economic development as techniques of "subjectification" and medical sciences as "divisive practices" for exclusion and domination.

What effects did these developments have on the processes of health and healing in Bunyore in subsequent years? As demonstrated in the next chapter, the answer to this question lies partly in an appreciation of the role of the protagonists in the operationalization of this emergent discourse, and partly in the definition of the type of African 'medical hand' Dr. Trowell's training scheme produced. This is the more so not just because the ideas espoused by J.L. Gilks and A.R. Paterson, on the one hand, and H.L. Gordon, H.C. Trowell, and F.W. Vint, on the other, were crucial in the shaping of a biomedical social formation in the interwar years and beyond, but also because some these 'experts' were intimately involved in the implementation of their ideas. Paterson and Gordon were, for example, at the center of this process, one as the colony's Director of Medical Services after J.L. Gilks, and other as the Director of Mathari Mental Hospital in Nairobi. In fact, quite revealing about Gordon's place in the modern medical history of Kenya is what he says about his entry into government service, facilitated by none other than Dr. A.R. Paterson: he moved to Nairobi in the late 1920s from "the hybrid occupation of a medical farmer" in Koru, Nyanza Province; this was a time when no
"scientific effort" had been made "to investigate racial backwardness"; that "the hand of science has not yet been held out with all her will and strength to help the rise of the native" though it was common knowledge that colonialism was a "huge traditional social experiment" that needed science to succeed; and that it was the desire to bring science in that "turned me into a public agitator and something of a nuisance to the Kenya Government." Despite all the misgivings, Gordon tells us, research on his project began in 1929, "the same date the Government placed me in a position to acquire knowledge pertinent to the subject of backwardness" (Gordon, 1934: 226, 227). As a man who had "had some psychiatric experience" and had been picked upon "because there was literally no one else available" (Carman, 1976: 74), Gordon turned Mathari Mental Hospital into a laboratory for testing and proving mental deficiency, or Amentia, among Africans.

If Paterson's and Gordon's views on the problem of health in rural areas differed, this was mostly at the level of how to find solutions to it. Otherwise both spoke to a particular idea, the Western (European) conception of public health, and both saw rural areas of Kenya as insanitary, hence unhygienic, 'danger zones'. Though their language of defining the problem differed, they both saw the colonized African as somebody who needed guidance. This was emphatically brought out by Trowell, but also repeated on several occasions by Paterson, in his understanding of the African universe of reference with respect to disease causation. According to Dr. Trowell (1935: 350-351), apart from the fact that the African "primitive mind works a long lines unmoulded by logic, that it cannot be influenced by words of reason or scientific proof,"

The African child is reared in a culture so totally different that it is difficult to conceive of it... [H]e is reared in a world in the control of the spirits of the dead. Magical conceptions and magical causation are the only facts of his philosophy. The pleasure or anger of the spirits are the cause of all disease, famine, death, and the whole range of natural science. That being so, to discuss any phenomenon in terms of observation and deduction, is to follow a path of thought which to their minds can only be described as insane. The world is full of dreadful forces, the spirits are lurking everywhere, one's attitude to all phenomena is not one of curiosity,
observation and deduction, the answer can never lie that way. For the seen is never explained by the seen, always by the unseen.

This being so his attitude to the world is one of cringing fear. He moves in fear, this fact becomes more obvious the longer one studies him. A strange nameless fear will make him hate windows, lest he should be seen, or open his windows if he has them. His wife cannot use a kitchen that is separated from his house, for his wife might be attacked. There is the fear prompted by sympathetic magic, that forbids him to touch or handle any excreta, the urine, faeces, bedpans and urine bottles, and everything connected with the dead.....

But, more fundamentally, Paterson’s and Gilks’s ideas, on the one hand, and those of Gordon, Vint, Oliver, and Trowell, on the other, met over what was to be done, and how this could be done: the promotion of preventive medicine through the creation of a category of ‘native’ health ‘expert’ as well as the popularization of the concept of bora afya (good health)... In other words, the difference between the two groups lay not entirely in their visions of the African world but, most crucially, in how planned social change could be made into a major component in the process of subjectification.
Endnotes


3 This concept was developed by E.N. Pavlovsky (1966) and M. Meade, J. Florin and W. Gesler (1988).

4 The concept is Y.-F. Tua's (1978: 87-104).


7 Kenya Medical Journal vol. 1, No. 1, June 1923 adaptation of an address entitled "Biology and Pathology of the Central Kavirondo District" by Dr. J.F. Carlyle Johnstone to the Nairobi Division of the British Medical Association held on July 19th 1923 and later published in revised form under the title "The Biology and Pathology of the Natives of the Central kavirondo District, Kenya Colony", in Transactions of the Royal Society of Tropical Medicine and Hygiene vol. 17, Nos. 6 and 7, 1923: 369-377. Further reference is based on this publication.

8 Dr. A. Powell, a self-proclaimed authority on the treatment of yaws in the British Empire, criticized Dr. Gilks's, and by extension Dr. Johnstone's, methods of obtaining information on "native treatment" in a discussion that followed the presentation of Gilks's paper. According to Dr. Powell, Gilks's information was flawed because the diagnosis in many of the cases "was based on the statement of his negro patients, who were probably as illiterate as mine, and their dermatological qualifications no greater . . . [H]aving been a medical jurist most of my life, I may require more legal evidence than other medical men. Dr. Spittel (an authority on yaws) . . . says that it is on the personal history we must rely for a diagnosis of tertiary yaws. When we reflect that these histories are given by uneducated adult coolies or negroes, and that their alleged attack of yaws took place when they were babes or young children, I think all lawyers will agree with me that 'what the coolies said is not evidence'" (J.L. Gilks, 1923: 284).
9 A cursory look at the sources used in advancing the Kenyan argument is quite revealing. Works constantly used were drawn from the United States on the racial peculiarities of the negro brain; the study of the negro skull; the relationship of intelligence to the size and shape of the head among negroes; the physical constitution of the American negro; the cerebral convolutions of the negro brain; and the physical and mental abilities of the American Negro. Other works referred to were from continental Europe on the histological basis of Amentia and Dementia; the human cerebral cortex, and temperament and race.


12 This was an obvious reference to the work of American scientists on what was described as the "negro mental capacity". See footnote 9 above.

13 Much of our understanding of F.W. Vint is based on H.C. Trowell's (1935: 342-343) and H.L. Gordon's (1934: 238-239) simplification of the technical terms involved.
CHAPTER SEVEN

BIOMEDICINE AND THE SECOND COLONIAL ASSAULT IN NORTH KAVIRONDO

7.1 Introduction

The place or role of biomedicine in the constitution of the colonial order in Africa has in the last ten years or so been the subject of heated debates among historians and anthropologists working on Africa. In a recent collection of essays on African therapeutics and the social conditions shaping health in the continent, Steven Feierman and John Janzen have, for example, argued that contrary to earlier analyses fostered by Western scholarship, African therapies were diverse and dynamic and not necessarily ethnically based and static. Though they admit that appropriate "research on change and continuity in African therapeutics has barely begun" (1993:165), they believe that before the turn of the last century Africans had developed therapeutic traditions that included "empirical therapies based on careful -- although not necessarily 'experimental'-- observations of sickness...'ritual therapies'...with an extensive symbolic framework...; collective therapeutic rites; divination rites...; and general cultural values" (Ibid.:171). The two scholars argue that the people responsible for the introduction of Western medicine in Africa had been trained in a "narrowly focused allo(counter) pathic(disease) paradigm of medicine." This is the paradigm that "was brought to Africa to wage the battle against the famous scourges: sleeping sickness, malaria, smallpox, typhus, cholera, and others...." (Ibid.:168). This battle, however, was a failure so much so that when it came time for departure colonial powers left Africa with a legacy of "medical pluralism...a de facto result of the continuation of social and religious traditions and of the lack of resources for the achievement of health through...public health measures" (Ibid.:173).

Following this argument, the two scholars have posited the thesis that "health in Africa over the past century is inseparable from the history of change in control over
political institutions and change in the organization of economic production" (Ibid.:5). This is pertinently so because, during the colonial period and beyond, states of health were affected through the "simplification of the food crop regime, a weakening of kinship-based support mechanism, and the emergence of profound health consequences growing out of inequalities in the payment of social costs for competing groups of workers" (Ibid.:7-8).

The results of these inequalities were, the two scholars aver, "regularities in the distribution of health and ill health in twentieth-century Africa. Most colonial health care systems provided...services to White people in the early days, and next to African men in the working place (reaching) African women and children and...the rural population (after World War II)" (Ibid.:9).

In emphasizing regularities in the distribution of health care, and stressing political institutions and economic production as determinants of health and disease in Africa, the two scholars lose track of their other key concept, diversity. What happened to the diverse and dynamic nature of African therapies during the colonial period? If medical pluralism was "the result of the continuation of (African) social and religious traditions and of the lack of resources for the achievement of health" during colonialism, then it was more about the survival of African therapeutics as a system and less about their diverse nature during the pre-colonial period. Be that as it may, it is true that among the "social conditions shaping health in Africa"(Ibid.:xv) were "changes in population distribution and movement in the colonial period (and that) urbanization, the building of roads and railways, labor migration, and the movement of armies all increased the possibilities of transmitting communicable diseases" (Ibid.:26). It is also true that colonial conquest was "a political event that deprived Africans of the capacity to control their own environment" (Ibid.).

These two factors, among others, led to a decline in African population and when it started to grow in the interwar period this was against "a background of poor health, and cannot (the growth) be taken...as a sign of generally improved conditions" (Ibid.:31).
One important issue can be raised about this assessment. This is what David Arnold, writing on India, has called the "problematic interdependence of discourse and praxis, and the constant tension between them as represented in a complex colonial situation" (1993:7). This problematic alerts us not only to the dangers inherent in a simplistic Same/Other opposition but also, most crucially, to the "notion of resistance, of an ineradicable otherness, at times opposing from without, at times resurfacing within," and the discursive domain of Western medicine itself, "often condemned but repeatedly summoned up as an active and not altogether unwelcome principle of negation" (Ibid.). It seems that by emphasizing political institutions and economic production as determinants of health and illness in Africa, Feierman and Janzen are in effect suggesting that therapy-seeking behavior is predicated on social class which, during colonialism, was also a Same/Other or racial divide. This not only draws a rigid line between African and Western therapeutics, but also makes nonsense of John M. Janzen's (1978) observations that therapy-seeking behavior transcended class as people always used various therapies either concurrently or serially. If Feierman's and Janzen's thesis is correct, then how do we, for example, explain African healing systems' continued invention and re-invention of "new practices, new medicines, sometimes directly incorporating elements of biomedical practice and often creating for them totally new meanings" (Vaughan, 1994:290)? The answer to this question lies not in the obvious fact that medical pluralism in Africa is predicated upon the forces of capitalism which are its conditions of possibility. Neither does it lie in the why of medical pluralism. It must be sought in the zones of activity between the two therapeutic traditions

7.2 Biomedicine and the Reconstitution of the Colonial Order: The case of Plague

Human plague, first experienced as an urban disease in Nairobi in March 1902 (Smart, 1950; Wilkinson, 1957; Myers, 1973; Olumwullah, 1986), arrived in Western Kenya
in 1904 and, in 1908, had registered its first demographic impact in the port city of Kisumu and the surrounding 'Native Reserve'. In 1909, rat plague and a devastating epidemic of human plague were reported in Maragoli 3, a location bordering Bunyore to the east. Kisumu, on the other hand, was only seventeen miles to the southeast, and its rural environs bordered those of Bunyore. But, most importantly, the arrival of plague in Kisumu took place almost immediately after the establishment of a British administration over much of what was to become North Kavirondo District, and the completion of the Uganda Railway which reached Kisumu in 1901. These developments meant several things of which two are important here.

First, it meant that the position of Mumias which in previous years had been the focus of caravan routes plying between the East African Coast and the kingdom of Buganda, and which had been enhanced by the building of Slater Road in 1896, was economically rendered obsolete. This was further dented in 1920 when Kenya became a Crown Colony and the administrative headquarters for North Kavirondo was moved to Kakamega, a place deemed by the British to have "a more healthy climate" (Donhew, 1963:14). Second, and because of further geographical and administrative adjustments in the region -- the severing of Kavirondo from the Uganda Protectorate in 1902; the creation of 'Native Reserves'; and the establishment of the Nyanza Provincial headquarters at Kisumu -- meant that Kisumu, and not Mumias, became the new center of focus in the region (Wagner, 1949:7,32; Hill, 1949:473; Stevenson, 1968:151-152; Olumwullah, 1991:7-8). Indeed, the development of Kisumu in these early years as the political seat of Nyanza Province, a major railroad head and port for the transshipment of goods to and from Uganda, and as a place where Africans could go in search for wage labor, meant that the town was not only a ready market for African produce from the surrounding areas, but
also a major transit zone for all types of people, European-produced merchandize for the fast-changing countryside, and pathogens.

Kisumu, observed M. Aline Buxton (1927:127) in an eye-witness account, was in the 1920s a town full of "shouting, jostling, and laughing people" who, at the railway station, crowded "into the long native carriages". This "continued stream of outgoing and returning labourers" included policemen, half of whom were "Kavirondo", and "a large percentage of the King's African Rifles". In another eye-witness account which gives us a glimpse into the changes that were taking place among the Abaluyia, as well as the importance of Kisumu for these changes, Gunter Wagner (1949:8-9) had the following to say:

"On narrow paths which frequently cross the winding highway we meet hundreds of Africans. They are mostly women and children carrying their produce - maize, sorghum, bananas, vegetables - to Kisumu market or balancing on their heads the heavy boxes or suitcases which their husbands want to take on their way to a labour contract in the 'European Highlands', or the Coast...."

This was in the 1930s, and the produce which the women carried to the Kisumu market came from mostly Bunyore and Maragoli locations which, "with about 590, and in some areas far more, inhabitants per square mile," still had "maize-, sorghum-, and eleusine-fields, interspersed with ground-nut, simsim, and beans." Dotted over the Bunyore and Maragoli landscape were also "patches of...the banana-groves" that surrounded "almost every hut or homestead in a semicircle." According to Wagner, Kisumu, in turn, provided most of the merchandise sold at "the crossroads native dukas or stores" which were operated by "enterprising Africans who have learned from their Indian tutors." This merchandise included "'king stock' cigarettes, soap, matches, sugar, salt, tea, kerosene in bottles, safety-pins, glass beads, thread, and similar commodities of European manufacture that have come to form part of the present-day native standard of living."
Though Buxton and Wagner were writing in the 1920s and 1930s, their observations are reflections of the social and economic changes that had been taking place in the region since the imposition of Pax Britannica in 1895. As Marc H. Dawson (1983:101) has argued, these changes, especially those brought about by colonial cash crop policies and the increased demand for food-stuffs in the towns and on plantations, coupled with expanding trade networks and a new transportation system, created favorable conditions for both the growth in rat populations, particularly the hosts of plague, and the means for the spread of these infected rats and fleas. Thus, though Buxton's, but mainly Wagner's, observations were made long after the eradication of the disease, they underscore the importance of both the changes brought about by colonialism, and the place of Kisumu in these changes. Furthermore, they help us appreciate how Bunyore, a 'native reserve' location, got ensnared in the spread and devastating effects of the plague epidemic of 1908-1930 in Nyanza Province.

Since its first serious manifestation in Kisumu in June 1908 until the colonial state's concerted efforts to try and eradicate it in 1921, Bunyore went through harrowing social, economic, and demographic experiences for almost every month of the year. Though mortality figures for the location, or even for the entire North Kavirondo District, are imprecise and not easily forthcoming, the pages of the Nyanza Province and North Kavirondo District Annual Reports bear witness to this. Like Maragoli and Tiriki, the other two locations in the southeastern corner of the district, Bunyore was hit first and suffered longest before the plague started to seriously threaten other parts of North Kavirondo. For example, between March 1912 and February 1914, the hard hit areas with both rat and human plague were those parts of Maragoli and Bunyore that bordered Kisumu rural areas. In the following year, 1915, plague was reported near the Uganda border but, as the year drew to a close, Yala River Valley, Bunyore, Sagam, and Seme were reported to have severe mortality from the outbreak. Though various public health methods were deployed
in attempts to contain the outbreak, little was achieved since there was no Medical Officer in the district to either check on the intensity of the disease, or provide logistics for its containment. Thus, by May 1916, the plague was reported as continuing to ravage Yala River Valley, Maragoli, Bunyore, Gem, Maseno, and Sagam. Between February and May 1917 the plague hit Tiriki, Maseno Boarding School and its environs and, by 1919 and in the subsequent two years, mortality in these areas was reported to be not only severe, but also worsening. It was in the light of these latest developments that the administration, for the first time, admitted that the situation was severe and getting out of hand. According to the government, the situation in North Kavirondo District was due to the fact that the area had neither a Medical Officer nor sufficient staff to deal with the epidemic. However, though the government went ahead and appointed a Medical Officer for the district in 1920, the epidemic continued to claim lives. Between the months of April and December in this year, as many as 1,500 deaths from the epidemic were reported for the district though the District Commissioner estimated that 2,000 people may have died in that period alone (Symes, 1930:350). In the following year small local outbreaks were reported in Bunyore (with 46 and 53 deaths in February and April, respectively) and, between January and February, the plague on its northward march was said to have hit Mumias, Marama, Kakamega, and Bukusuland with the Wanga reporting numerous deaths. In these two months alone, deaths from the epidemic in the district totaled in excess of 1,000.

It might be said that without proper and well documented statistics on the demographic impact of plague in Bunyore we cannot fully appreciate its significance for the people and their history. But if we cannot lay our hands on the whole story as told in figures, we can still find within explanations given for, and responses to, the incidence of disease certain ideas and their articulation that go beyond the seemingly objective and cold realities statistics are supposed to give. As T.O. Ranger (1992:241) has pointed out, explanations for and responses to disease have always had their own history in Eastern and
Southern Africa and, pegged as they are on competing ideological traditions -- Christian, Colonial, and African -- they raise fundamental questions that cannot be answered through the mere counting of dead bodies. In Bunyore, as in any part of Eastern and Southern Africa, these questions are as much about the dynamics of church and state activities in the development of a Western biomedical tradition in these two regions, as they are about how Africans, the colonized, perceived and experienced these activities.

Both the Christian and Colonial traditions erected what Ranger (Ibid.:242) has called orthodox and official structures of public health that sought "to control and domesticate" diseases and which, in so doing, brought to bear upon this goal the power and knowledge that was to significantly legitimize wider claims for either political or social authority. As a "mixture of providentialism and modernizing calculation"(Ibid.:263), the Christian approach to epidemics like plague and famines in Bunyore was for example based on the appropriation of these disasters as societal metaphors through which notions of salvation and of moral hygiene could be driven home among the 'heathen' Africans.12 This approach worked well before and during the First World War since state activities in this period were more or less confined to what in official circles was considered as a pacification exercise meant to bring the so-called African 'recalcitrant tribes' under the aegis of Western civilization. There seems to have been a tacit agreement between the Conquest State and Christian missions in this period that while the former concentrated on matters political, the latter were to handle matters spiritual that also included the development of educational and health facilities in the rural countryside. This 'gentlemanly' agreement however came up for review, and consequently serious debate, during the period of adjustment to postwar life in the colony. This was in the light of debates on the place of the African in the colonial set-up, on the social, economic, and political impact of the war on the colony, and on what role, if any, should the Missions play in a program of
reconstruction. Since the Government and the Missions were in agreement on the first two issues, it was the third that was to dominate debate throughout the interwar period.

At the level of health, both the Government and the Missions agreed that the war had had far-reaching consequences for the African populations. For example, of the 350,000 African men recruited for the war effort in the Carrier Corps, 46,618, or 12.7%, never lived to see their families at the end of the war. The major killer of these men was not enemy fire power, or even war-related accidents, which in their own right claimed 4,300 Africans, or a mere 9.2% of the total dead (Rosberg and Nottingham, 1966:30-31), but diseases like malaria, typhoid, enteric fever, and other nutrition-related maladies. Apart from these numbers of the dead, there was a large percentage of those accepted for duty in British and German East Africa but because of poor health were repatriated back to their homes before the end of the war. These "returned diseased" as Ann Beck calls them were at the end of the war joined by survivors and, together, the two groups became important in the spread of diseases hitherto unheard of in the rural countryside (Beck, 1970:76-77).

The most affected areas were the Kenia (Central) and Nyanza Provinces which, prior to the war, had had their own share of debilitating diseases like yaws, a condition which was discovered through general health surveys enforced by the Compulsory Military Service Ordinance of 1917 which demanded a systematic medical examination of all drafted carriers.13

It was on the basis of these developments that both the Government and the Christian missions called for immediate action to remedy the situation. The best approach to this, both sides felt, was through the technical training of qualified African personnel to take on the work of building a hygienic tradition in the countryside. Was it not true, after all, that most diseases Africans suffered from were self-inflicted through "centuries-old manners and customs" that perpetrated poor hygiene and irregular habits? To Dr. A.D.Milne, the Principal Medical Officer in the Protectorate, one of the greatest, in fact the
greatest, impact of the "eruption of war" on these manners and customs lay in the role it was to play in its aftermath "on the colonizing ideas of peaceful permeation of Western civilization" in Kenya.\textsuperscript{14} Dr. J.L. Gilks, the man who took over from Dr. Milne, saw this process as taking place through the building of medical centers in 'reserves' as a humanitarian project.\textsuperscript{15} In 1921, he promised that the system of government medical units in these areas would be extended considerably since "with proper selection of candidates and a systematic course, it would be quite possible to train Africans to the necessary standard." \textsuperscript{16}

If the Christian missions were in agreement with these plans, what was their role to be in their implementation? As Ann Beck has correctly pointed out, the Missions' role in this endeavor would have seemed only natural, bearing in mind that they had a long tradition of dealing with rural social and spiritual problems, and were better established in these areas than the government was. However, a new postwar government health policy based on direct intervention in the rural areas was bound to lead to "an ambivalent situation. Any means by which the medical departments (in East Africa) could reach out to populated and diseased native areas were welcome. On the other hand, a new awareness of the postwar tasks of the medical departments made medical administrators often reluctant to continue their subsidies to Missions" (Beck, 1970:81). Indeed, in the debates that dominated the early 1920s on how best to approach rural health a major problem for the medical department in Nairobi was the clarification of the relationship between government medical authorities and medical missions in the country. As Beck has sanctity put it, "[b]efore the war, Officials had been content to let the missions take care of native reserves. After the war, the situation had changed" (Ibid.:85) so much so that though practical deliberations continued on the need for the technical training of Africans for work in the medical profession, this had, by 1926, not produced any tangible results. The sense of urgency with which the deliberations on this issue had been mooted virtually dissipated as
the decade moved into its second half. According to Ann Beck, this was due to "other issues of more immediate political concern" as well as an "interplay of political, economic, and administrative factors" that increasingly affected health reform plans (Ibid.:78-79).

Whatever the strength of both political and economic arguments in this struggle, it seems that reasons for the strained relationship between the government and the Christian medical missions lay partly in what Charles E. Rosenberg (1992:280) has called the "peculiar texture" of epidemics like plague and other life-threatening maladies, and partly in these epidemics and maladies as raison d'être for a second colonial assault in Kenya. While the one reflected "continuing interaction among incident, perception, interpretation, and response" (Ibid.) when it came to these pestilential crises, the other was about the state's transition from its pre-war conquest and pacification ideals to a position that spoke variously about the mediation between Indian, African, and European races; postwar reconstruction and adjustment; and the 'protection' of Africans under the vaguely-defined and often contradictory notions of African paramountcy and trusteeship. It can be argued that, apart from their perceived and real demographic impact before and after the war, epidemics like plague provoked an unparalleled crisis in the history of state medicine in Kenya since they not only dramatically restated the centrality of epidemic disease to colonial hegemony, but also emphasized the enormous differences that existed in the perceptions of, and response to, disease between state and mission medical authorities. As David Arnold (1993:202) has argued in the case of nineteenth-century India, this was about the significance of epidemics like plague for "political epidemiology", for "the place of medical science and authority of medical practitioners in the colonial order", and for "the political constraints on medical and sanitary intervention". But, most crucially, the struggle between the government and the medical missionaries powerfully restated the fact that "medicine did not stand alone but occupied a place within a more expansive ideological order and a wider empirical domain" (Ibid.:8). To paraphrase David Arnold (Ibid.:10),
medicine was too powerful, too authoritative a species of discourse and praxis to be left in the hands of medical missions in Kenya.

This is well brought out by, first, the Native Commissioner's presentations in 1919 on the need for a centrally (meaning government) coordinated "native policy" and, second, the exchanges between Dr. J. L. Gilks, the first postwar Principal Medical Officer, and Dr. John W. Arthur, the missionary in charge of medical services at the Church of Scotland Mission in Kikuyu. According to the Native Commissioner, developments in the country since the end of the war had made it imperative that a system be worked out whereby, through a centrally coordinated native policy, broad rules should be brought to bear on native education and medical services. This was the more so because, the Commissioner argued, the British, American, French, and German Missions had different programs for and approaches to "native education". The danger in this was that, apart from there being a lot of room for disagreements between these programs and approaches on the needs of Africans in particular and the country in general, the scope for confusing the "native mind" was very high. Left to their own devices, these missionaries could very easily retard development in the country. 17 If the Native Commissioner's presentation clearly brings out the importance of education and medicine in the struggle over the colonization of African consciousness, the exchange between Gilks and Arthur goes straight to the heart of the matter. It was Gilks's position that

A Government hospital is a tangible sign of Government activities which is understood by every native, but it is doubtful whether a subsidised mission hospital is in any way connected in the minds of the majority of the patients as being anything more than a token of benevolence of the missionaries who therefore reap the credit and the resulting influence. It is a fact which cannot be gainsaid, that the provision of medical attendance, even of the crudest and most primitive description, is the best form of advertisement for any form of activity among natives... and therefore every penny of Government money which is available for medical work should be spent by Government rather than by any independent body. 18
Gilks's position was based on the question as to whether or not the government should continue subsidizing medical missions, a practice stopped in 1919, in the country. To him, this was, if allowed to continue, a sure way of undermining government authority. Directly linking the importance of medicine to the broader character of the colonial order, he, together with the Native Commissioner, went ahead and proposed to lay down definitive medical standards for all medical services, including medical missions, in the country.

On the other hand, Dr. John W. Arthur of the Church of Scotland Mission in Kikuyu was of the opinion that since Missionaries had been working with Africans in the rural areas for over twenty years, they were the only individuals who had both the experience of rural medical needs and the knowledge required to provide them. According to Dr. Arthur, it was only mission doctors who knew the "efficiency and power of spiritual healing as a direct therapeutic agent in special cases and as creating the right atmosphere for all healing". Thus, he averred, if there was to be any change in policy and the government wanted to help in "uplifting the natives of the reserves, public health would demand morality in its agents as a primary condition." Though it is not clear as to what Dr. Arthur meant by this last statement, its providentialism cannot be mistaken. Be that as it may, the comment in the margins of Dr. Arthur's presentation, written probably by Dr. Gilks himself, is a very good indication of just how far complicated the struggle between the colonial state and the missionaires over the colonization of African consciousness was. The comment in the margins states that "[t]his shows that propaganda comes first and doctoring after." After much debate and recrimination between the two institutions, an agreement, finally arrived at in 1927, saw the state emerge as the sole decision-making authority in matters to do with health-care provision in the colony (Beck, 1970:90).

This development was significant. If to colonial medical officers like Gilks "the provision of medical attendance, even of the crudest and most primitive description", was
"the best form of advertisement for any form of (government) activity among natives," 21 the debate between Medical Missionaries and the State was less about which agency was best suited to provide health-care to Africans and more about the crisis in the latter's self-perception as a conquest construct. But, taking place in the immediate post-World War I period, this crisis was also about self-doubt in this construct's collective representation of the colonial order in Kenya as "the greatest philanthropic achievement of the later nineteenth century." 22 It can indeed be argued that the state's victory over claims by Medical Missionaries to social authority in the African countryside was a victory which, once translated into state claims over concern for the future of Kenya, also meant a conscious move away from a purely conquest and pacificationist stance to a position that called for the state's direct intervention in the countryside's social and economic processes.

Once won, how did the colonial state propose to use this victory in the provision of health-care to Africans in the rural countryside? The answer to this question lies partly in the state medical authorities' perception and interpretation of the nature of diseases in the countryside, and partly in the medical and sanitary measures adopted to deal with these diseases. If in the pre-World War I period medical services were urban-oriented, and notions of health and illness were premised upon the state's emphasis on curative rather than preventive medicine, the incidence of plague in the rural countryside provoked a crisis whose importance went beyond Church-State differences in their struggle over the control of these areas of the colony. In restating the centrality of diseases to the colonial project, plague also brought to the fore certain counter-tendencies in colonial thinking that challenged, and sought to overturn, the conquest state's core assumptions about disease and how best to control it in the emergent postwar colonial outfit. As has already been demonstrated, this was as much about medicine as "the best form of advertisement" from which the state wanted to "reap the credit and the resulting influence (and) kudos", as it
was about the importance of medicine in showing "the native that he is something more than a mere tax-payer." 23

How does this seemingly contradictory situation help in understanding why the state took, at precisely this point in the history of the colony, the position it did in both curtailing subsidies to medical missions and emphasizing its 'personal presence' in the rural countryside? How, in other words, do we explain the state's conspicuous failure to come to terms with the fact that for eighteen years, that is between 1902 and 1920, plague had been ravaging not just Nairobi but also the rural areas? According to Marc H.Dawson (1983:99), this failure should be explained in terms of the fact that medical and sanitary measures like quarantine were "predicated on an incorrect understanding of the endemic pattern of the disease" in the country. When state authorities, for example, set up roadblocks outside Kisumu in 1912 and 1913, the argument, officially held until 1920, was that plague was basically an urban disease. According to this argument, the disease was carried into the rural areas by the constant movement of African laborers between these two worlds. It was on the basis of this position that other anti-plague measures like the bathing of Africans in the Jey's fluid, a disinfectant, at this and other similar roadblocks before they were allowed to continue on with their journeys; the inoculation of contract migrant laborers and military recruits; and the building of large isolation camps for the screening of newly recruited laborers; were predicated. There however was another group of 'experts' who were of the opinion that though Kisumu was an endemic focus for the disease, this was reinforced by "rats brought from Lake Steamers carrying cotton from Uganda....In either case since Kisumu Town was the presumed focus, British health efforts were aimed at preventing the spread of the disease from the township to the rest of Nyanza Province" (Ibid.:100) 24.

The central issue in this 'misunderstanding' was whether, indeed, plague transmission radiated from the towns to the rural areas. Officially maintained until 1920
when Dr. J. L. Gilks, the new P.M.O., pointed out that plague in Nairobi in that year had been brought in from the rural areas \(^{25}\), this position was held against the backdrop of mounting evidence that plague was indeed endemic in the colony's rural countryside. In 1910, for example, the Medical Officer for Nyanza Province reported that there had been an unusually high rat mortality and human plague deaths in Kisumu District though "most of the latter escaped the notice of the medical authorities" while, on the other hand, "the administration was not cognisant" of the deaths.\(^{26}\) In 1917 Dr Paterson, the Medical Officer of Health for Kisumu District, wrote a letter to the P.M.O. in Nairobi in which he pointed out that contrary to what was believed and held with regard to the transmission and spread of plague, the disease had a local endemic focus in the district. The disease's eradication, Paterson argued in the letter, largely depended on the local population's cooperation with state and medical authorities in their campaigns to destroy the rat population in the district.\(^{27}\) Why, then, did both medical and state authorities take so long in recognizing the value of this information for the eradication of plague in Nyanza Province? In other words, why, in the light of this evidence, did the state authorities continue to insist that plague was an urban phenomenon?

According to Ann Beck (1970:25), though the cause of plague was well known when it first appeared in Nairobi in 1902, Charles Eliot, the first Commissioner for the East Africa Protectorate, did not see the disease as "a serious threat to the development of Nairobi....The disease seemed to him a nuisance rather than a problem." This however proved not to be the case since the disease, with recurring outbreaks in the city in 1902, 1905, 1906, 1911, 1912, and 1913 came to reflect "merely the government's inability to exercise control over the economic and political life of the city" (Ibid.:27). Beck concludes that this was an indication that "the control of plague was not primarily a medical problem but rather a task which depended upon environmental factors and sanitation, \((issues) which were outside the reach of government during the early colonial period\). Plague control
could succeed only when it was coupled simultaneously with attempts at education and social planning" (Ibid. Emphasis added).

Though Beck admits that the incidence of plague led to the isolation of Indian and African quarters in the city, her conclusion betrays a serious lack of understanding of what Maynard Swanson (1979) has called the 'Sanitation Syndrome'in early colonial urban planning policies in Africa. As we have argued elsewhere (Olumwullah, 1986:181), the outbreak of plague in Nairobi was very quickly turned by the city fathers into a question of law and order around which arguments about the control of Africans revolved for most of the interwar period. Culminating in the creation of the infamous African Locations along 'reserve' lines in 1919, this question was about control and, its law and order pretensions notwithstanding, it spoke to the fact that the colonial state was not ready to "voluntarily pay for the reproduction of labour power which was regarded as 'natural' among non-whites" (Ibid.:183). But, more fundamentally, there was in this period among colonial medical authorities the view that improvements in the technology of health were too important to be given to the colonized: these improvements were a resource to be allocated for specific gains for both colonial and metropolitan economies.28 Thus, as a medical problem as well as a question of law and order, plague in Nairobi provided the framework within which segregation as a policy of political and economic control of non-white populations in the city was articulated in the early colonial and interwar periods. It was therefore not by mere coincidence that the organization of labor in the city in these years fell strictly in the hands of the colony's Principal Medical Officer, the Medical Officer of Health for Nairobi, and the Municipal Native Affairs Officer.29

But if Ann Beck was more concerned with the manifestation of plague and the government's inability to eradicate it in towns, Marc H.Dawson, writing on the countrywide incidence and spread of the disease, has argued that the reason why control and eradication in the rural countryside was difficult lay in the distribution of medical
personnel in the colony. According to Dawson, the naive belief that plague was an urban disease, coupled with the concentration of most European physicians in the cities and towns, made urban plague "more familiar" and reduced events in the countryside to something these physicians "only heard about" (Dawson, 1983: 88-100).

It can be argued, and Dawson acknowledges this in his thesis, that Western medical knowledge about disease in Africa was sparse and that, being heirs to the knowledge produced about plague in their own countries of origin and training, these physicians could not be faulted for seeing it as an urban phenomenon in Kenya. However, considering that between 1902 when there was the first outbreak of the disease in Nairobi and 1920 when Dr. Gilks pointed out that plague in the city in that year had been brought in from rural areas, and considering that there had been an accumulation of evidence by men on the spot that the disease was endemic in the rural areas, the state's failure should be explained in terms other than the mere and obvious fact of urban bias in physicians' distribution or, indeed, that there was limited knowledge about the disease's endemicity in the rural countryside. There could have been controversy as to which species of rat was responsible for the disease's transmission, but plague's aetiology in both rural and urban areas was not different. As has already been mentioned, the reason for the state's failure to take cognizance of the seriousness of the disease in the countryside lay in what Charles E. Rosenberg (1992: 280) has called the "peculiar texture" of any epidemic that reflects "continuing interaction among incident, perception, interpretation, and response".

According to Rosenberg, during an epidemic there is always "the increasingly steep curve of case incidence, the exhaustion of susceptible individuals, and the gradual decline in mortality and morbidity". This corresponds to "the social pattern of gradual recognition, negotiated response, and gradual decline" (Ibid.: 281, fn.3). Put another way, there is always "an important parallel...between the biologically determined chronology of an epidemic and its social chronology" (Ibid.: 280). The Kenyan colonial state was slow in
accepting and acknowledging the independent incidence of plague in rural areas partly because, as demonstrated in chapter five, of its essentially conquest and pacificationist stance before the 1920s; partly because it was feared that the acknowledgment would disrupt African labor supplies to the plantations in the 'White Highlands'; partly because of the fear that an acknowledgment would lead to the quarantining of grain exports from Kenya by importing countries or "simply not purchased for fear of the disease" (Dawson, 1983:68); and partly because, unlike in Western societies where presentations against epidemics stimulated pre-existing social reform movements and tended to enhance governmental assumption of responsibility for social conditions, the voice of the victim of plague in Kenya was an affirmation of British conceptions of the place of disease and illness among Africans.

North Kavirondo District, like its counterparts in Nyanza Province, was an important district in the colonial economy. It was a major supplier of labor to the 'White Highlands' and to the cities and towns of the colony. But it also produced grains for both export and the maintenance of urban and plantation populations. Though the plague epidemic, exacerbated in 1918-1919 by an influenza outbreak, posed a serious threat to this importance as Marc H. Dawson (1983:69) rightly points out, they met only with a gradual recognition from state authorities. This was because the state wanted to give both traders in African produce and consumers of African labor some form of "emotional assurance and complacency" (Rosenberg, 1992:281). As a conscious act, this move was as much a failure to confront the realities of the epidemic in North Kavirondo District as it was a form of action. In other words, the action not to act was in itself a form of action which, as a policy choice, constituted "the best and most available verdict" on the plague's social and economic impact (Ibid.:285). This becomes even more so in the light of the fact that this action was taken against the backdrop of William J. Simpson's 1913 sanitation report which clearly intimated at a link between the growth in African agricultural production,
grain trade, transportation networks, and the spread of plague. Reporting on the spread of the disease in the district in 1921, J.L. Gilks, the Principal Medical Officer, observed that the "extension of the disease which has recently taken place in North Kavirondo has only occurred subsequent to a natural spread of the black rat over an area where it was previously unknown." 31 Written eight years after Simpson's report, the silences on the ecological transformation, as well as on the expansion in grain production in the district, are quite revealing. By noting that "practically no information is available with regard to the factors which govern the movements or migrations of rats either in the presence of the infection, or its absence", 32 Gilks was simultaneously echoing the state's unenthusiastic response in terms of refusing to publicly acknowledge "the presence of so dangerous a disease" (Rosenberg, 1992:281), and admitting to its existence as a preamble for "the creation of a framework within which its dismaying arbitrariness (could) be managed" (Ibid.:282). This framework readily availed itself in an explanatory paradigm that harked back to notions of differential susceptibility of particular races that talked about risk factors, styles of life, and environmental determinism. As Rosenberg has argued, if "susceptibility was not to be seen as a random accident or as the result of constitutional idiosyncrasy alone, it had to be understood in terms of physiological mechanisms suggesting the physical -- and risk-enhancing -- effects of behavior, style of life, and environment. Such hypothetical schemes constituted a framework within which moral or social assumptions could be at once expressed and legitimated" (Ibid.:283).

But if this explanatory paradigm was a set of "public rituals" which reflected the way the authorities perceived plague, as "cognitive and emotional elements" in the unfolding drama they were a form of affirmation of belief in "rationalistic pathology" that at once promised "a measure of control over an intractable reality" (Ibid.:285), and strengthened the view that the "human body and the conditions of human habitation and sanitation (were) primary factors" in the spread of the plague epidemic (Arnold, 1993:210).
Thus, if the one (rationalistic pathology) was about ill-health as a biological phenomenon whose mitigation could only be achieved through the intervention of Western medicine, the other (human body) was about human agency in the transmission of plague. In Bunyore, as in other parts of the country that suffered from this epidemic, these two positions resonated well with notions of differential susceptibility as the distribution and habitat of *Rattus rattus* came to be directly linked to the African social, cultural, and environmental habitats. Writing on this link in 1921, Dr. J.L. Gilks pointed out that it was

> In grass huts (that the rat) lives and nests almost entirely in the roof, or in the grass bed if there is one. It may also be found in native grass stores; in towns it is to be found nesting and living among boxes, crates, hides, etc. etc., in stores and go-downs, in roofs of houses, behind match-boarding, and in defective plinths and under wooden floors, i.e., it takes advantage of existing spaces (Emphasis in original).³³

To Gilks the conditions under which 'natives' lived -- "in wattle and daub huts thatched with grass and with grain stores of similar construction in the immediate neighbourhood" -- were ideal for the spread of plague since each hut in the countryside was said to harbor five to fifteen rats.³⁴ Though empirical evidence more often than not supported these assumptions, and the administration went ahead and burned such huts, 'knowledge' of the African as an Other as well as ideology enforced the association between 'natives', rat habitat and distribution, and the spread of the plague. Thus, even if Gilks was willing to concede that no information on the movements or migrations of rats and their association with the spread of the disease was available, "selective susceptibility still demanded explanation" (Rosenberg, 1992: 284).

As demonstrated in chapter six, differential or selective susceptibility was in the interwar period part of an emergent discourse on the 'disease-ridden native population'. This discourse, on the one hand, ostensibly undermined earlier, nineteenth-century 'non-scientific' perceptions of Africa as 'a patient' and, on the other, popularized race in its search "for tendencies described by Philip Curtin as 'diversificationism' that emphasized
aspects of human difference rather than similarity" (Rich, 1990:667). Though the state in this period saw the reforms envisioned by Gilks as part of a wider scheme to appreciate "the fact that the economic welfare and progress of the country is at bottom dependent on a numerous and healthy population"\(^{35}\), it in its second colonial assault used this discourse to link problems of rural poverty, economic development, and education to a search for new directions in rural health-care provision. Medical/Health 'experts' on their part went further and used this discourse to consciously draw ready connections between African culture, African psychology and its supposed role in the uneducability of the African, and 'African diseases' as the concomitant results of African backwardness.

In either case, both the state and the medical 'experts' used this discourse in this period to not only perceive, interpret, and respond to diseases like plague, but also, in varying degrees, to constitute the African rural world as a space in which a particular type of medical knowledge could be produced in the process of the making of a colonial order. This was premised on two factors. First, there were conscious attempts to exclude from this process what the indigenous people thought constituted disease and disease causation. Second, African cultural practices were located at the center of the incidence of 'new' diseases. This was an undertaking which set up the terms of the discourse "between the West, with its new diseases and its new prophylactics on the one hand", and the African cultural environment, on the other (Odhiambo,1992:7). The net result of these factors was the insertion of biomedical science at the center of contestations over knowledge between a British colonial science and African ways of knowing. Central to these processes was a form of scientific know-a-ability that (its 'eye-witness observation' method notwithstanding) went ahead to provide the parameters within which a new disease language was constituted. Indeed, while on the one hand State and Medical/Health 'experts' called for further research into what they already knew to be the difference between African and Western experiences of disease, they, on the other, "quickly

The main dimension to this discourse was therefore the categorization, or naming, of new disease entities -- African syphilis, African relapsing fever, African hernia, for example -- not according to their biological, epidemiological, or pathological manifestations, but rather according to their geographical and/or racial incidence. Resonating well with the late nineteenth-century European construction of Africa as a 'patient', and as both epidemiological and biological paradigms (Seidel, 1993:177), these categorizations were about the location of new meanings at a "particular site defined by the exteriority of its vicinity" (Foucault, 1972:17). These were powerful discursive formations in which Africans as an Other were marked, counted, disciplined, and discoursed upon. But they were also powerful discursive formations in that they formed the domain in which knowledge, strategies, and medical policies meant for the rural African world were constituted and systematized. As part of a wider ideology of systematizing and justifying the colonial state's interventionist stance, health reform was thus a metaphor whose web of meanings included the incorporation of modernist or 'scientific' modes of discourse within the lexicon of the second colonial assault in the country. As is going to be demonstrated in the next section, this came out quite well in the rise of the Health Center Concept around which ideas about rural health in Kenya were organized for the rest of the colonial period.

From the foregoing, it can be argued that plague was a dramaturgic event which, from the progressive recognition of its incidence through the management of randomness to the negotiation of public response (Rosenberg, 1992:280-286), encapsulated within its interstices the political ecology of race. Embedded as it were within the changes occasioned by the First World War and in the rhetoric of the State's transition from a conquest and pacificationist status to an interventionist stance, the knowledge produced during this event reflected shifts in boundary-markers in the State's self-perception, in sites
of disease and disease-transmission, and in the definition of the place of the African in the 'new' colonial order. But as a chronological specificity and as a site of rupture in colonial political and medical thinking, the importance of plague lay in its singularity as a constitutive moment in which autochthonous transformations provided the limits within which texts and discursive practices on Kenya and its rural inhabitants were produced and executed. Thus, and most crucially, the epidemic provided an arena in which the African cultural environment, as well as the African body, were elevated to a position of both source and vehicle in the transmission and spread of the disease.

This last point meant two things. First, just as colonialism was more than the mere quest for the construction of exploitative political and economic institutions, so was medicine not merely a matter of scientific interest based on the principle of benevolent neutrality. Colonialism, concerned as it were with both the physical being of the colonized and the "construction of its own authority, legitimacy, and control", also provided the space within which a specifically colonial biomedical science was constituted. This was a dual process which led to the production of a particular type of medical knowledge with its own discursive practices. In defining itself within and above African societies, this uniquely colonial biomedical science powerfully contributed to the cultural and political construction of the colonized (Arnold, 1993:8). Second and flowing from the first, by setting the terms of discourse between the West and the African cultural environment, and by inserting itself at the center of contestations over knowledge between a British science and African ways of knowing, this colonial biomedical science turned the African body into "a site of colonizing power and of contestation between the colonized and the colonizers" (Ibid.:7-8). From this perspective, it can be argued along with David Arnold that by contributing to the political evolution and ideological articulation of the colonial order, biomedicine "cannot meaningfully be abstracted from the broader character of the colonial order" since "it remained integral to colonialism's political concerns, its economic intents,
and its cultural preoccupations" (Ibid.:8). What were the results of this new way of thinking for both policy development and for North Kavirondo?

7.3 State Medicine and the Reconstitution of Response to Epidemic Diseases: The Rise of the Health Center Concept

During the interwar period, policy towards rural health in Kenya emphasized both curative and preventive approaches to health-care provisions. This policy established the parameters within which, for the next several years before political independence, colonial biomedical science defined itself as it pushed aside rival or preferential claims of abafunu (diviners), abalesi (healers), and what John M.Janzen (1978) has called therapy-management groups in African societies.

It can be argued that by emphasizing on a curative and preventive approach to disease after the First World War, state and medical authorities had finally realized the folly of seeing medical problems in the colony from a purely preventive point of view. It can further be argued that it was on the basis of this realization that the Public Health Ordinance of 1921 was promulgated. Largely founded in the Public Health Act of the Union of South Africa, No.36 of 1919, this Ordinance delimited the functions of the Medical Department to include the prevention of the introduction of infectious diseases in the Colony and Protectorate; the promotion of "public health and the prevention, limitation or suppression of infectious, communicable or preventable diseases within the Colony and Protectorate"; and the provision of medical advise and leadership to the local authorities in the Colony and Protectorate. The Ordinance also called for, under the supervision of the Principal Medical Officer, the promotion of "researches and investigations in connection with the prevention or treatment of human diseases"; the preparation and publication of "reports and statistical or other information relative to the public health, and generally to carry out in accordance with directions the powers and duties in relation to the public health conferred or imposed by this Ordinance." 36 Though emphasis here was still on preventive rather than curative
measures, Dr.J.L.Gilks, the first postwar Principal Medical Officer, was of the opinion that both the government and the "European section of the public" had, after the war, come to the realization that "the institution and establishment of facilities for medical treatment and the control of epidemic diseases among the native population was a matter to be undertaken at the earliest opportunity." 37 That in 1921 fifteen Medical Officers and Senior Medical Officers of Health were added to a 1918 proposed provision of ten more Medical Officers of Health to work in "Native Reserves" is significant. Its significance lies in the fact that while in the 1918 proposals eight more Sanitary Inspectors were supposed to be added to the Sanitation Division, the 1921 additions "were made to the Medical rather than to the Sanitation Division". According to Gilks, this was because "it was now more fully realized that in order to carry out preventive measures in the Reserves the confidence of the people must be obtained, and that such confidence could best be obtained by Medical Officers engaged primarily in the successful practice of curative medicine." 38

It was Dr.Gilks's feeling, however, that the success of such a policy combining curative and preventive measures in fighting diseases in the rural countryside depended on the efforts of both the Medical Officer and the District Commissioner. The role of the two was important because, he argued, it was their responsibility to safeguard "the health of the native population." 39 What did he mean by this? The answer lies partly in the wording of the Public Health Ordinance of 1921, and partly in the emergent discourse on the difference between African and European disease experiences. The emphasis in the Ordinance was on, first, the "prevention, limitation or suppression of infectious, communicable or preventable diseases" and, second, the preparation and publication of "reports and statistical or other information relative to the public health." These two factors alert us to, first, the importance of categorizing and discoursing on African bodies and, second, the place of these bodies in the production of a uniquely colonial biomedical science. The terms and conditions under which this science was to operate had, of necessity, to be
different from those obtaining in the 'Mother Country'. Thus, though Dr. Gilks gave a purely administrative argument why the District Commissioner, a coercive arm of the state, and the Medical Officer, were to jointly bear the responsibility for rural health, his observation after the above cited policy statement is quite revealing. According to Gilks, the "arrangement whereby the Medical Officer is a member of an executive authority" was "somewhat unusual, and on the whole foreign to English custom." This arrangement, however, represented "probably the most satisfactory solution of certain difficulties which in the past stood in the way of efficiency in underdeveloped countries." 40 What Gilks was in effect calling for was the continuation of at least some aspects of the pre-World War I approaches to the problem of health in the rural areas.

This, needless to say, was paradoxical. While the new policy called for, on the one hand, the continuation of pre-World War I medical and sanitary measures, it, on the other, sought to obtain the confidence of the rural folk through the work of Medical Officers who "engaged primarily in the successful practice of curative medicine." 41 If preventive measures were, in the pre-war period, premised on coercion, their success or failure largely depended on the role of ekilauni (the Crown/State). But, as argued in chapter five, and reiterated in the foregoing section of this chapter, the struggle between the Missionaries and the State over the colonization of African consciousness was partly the result of this approach. Coercive methods in dealing with epidemics like plague had alienated the colonized and driven them into the hands of the Church in places like Bunyore and, therefore, for the State to lay claim to social authority in these areas it had become necessary to abandon these methods. From this perspective, it can be argued that Gilks's proposed approach -- a combination of curative and preventive medicine -- was driven by a tension between his desire to continue with both prewar methods of disease eradication and medical authorities' dependence on the state for their execution, and his attempts to recast the image these measures had already created among the colonized. This was, as David
Arnold (1993:203) has pointed out in the case of India, a clear indication that the transition state medicine was undergoing from a "defensive preoccupation with European interest and physical well-being to a broader, and as yet poorly defined, notion of public health", was not an easy one.

But the adoption of a dual approach -- curative and preventive -- to public health was also a reflection of the elevation of the importance of the (African) human body and its cultural environment to the position of source and vehicle in the transmission and spread of diseases like plague. The human body was, through the premium placed on curative medicine, given further emphasis by the difficulty experienced in identifying plague (Arnold,1993:211). Once transmitted from *Rattus rattus* to fleas and thence to man, where exactly was the disease located in the human body? As Arnold has explained in the case of India, the answer to this question called for the physical examination of the body to find the characteristic buboes or swellings though, as it so often happened, symptoms like high temperature and glandular swellings did not provide conclusive proof of the presence of the disease in the body. It was therefore necessary to have postmortems as recommended by many experts, especially in Britain, as the only reliable guide. The physical examinations and postmortem operations the body was subjected to turned it into "both the presumed vector of the disease and the bearer of its essential diagnostic signs" (Ibid.). How was this new policy carried out in North Kavirondo?

A cursory look at subsequent developments in the provision of health services in North Kavirondo District shows that the colonial government's response to the vagaries of epidemics like plague from the end of the First World War to the end of colonialism involved the reorientation of policy towards the provision of medical institutions staffed with qualified medical personnel. Compared to the first twenty years or so of colonialism, the developments that took place between 1920 and 1950 were quite impressive. From the position of skeletal medical personnel at government *bomas* mounting militaristic,
haphazardly-organized, and often ill-advised campaigns against epidemics in the surrounding areas, there was a conscious move towards the building of dispensaries from where medical care for the rural folk could be provided. In 1924 three such dispensaries were established in the district. It was however not until 1928 that the first permanent structures meant to house such services were erected, reaching ten in number in 1929, the year a regular ambulance service was introduced. By the eve of the Second World War, there were fourteen such dispensaries in operation and the Medical Department in the district now comprised of two Medical Officers, one Sanitation Officer, and several European nurses. These European medical personnel were assisted by a staff of 'native orderlies' "whose task was to carry out or supervise the execution in the native locations of the various measures passed by the Government" (Wagner, 1949:37).

In addition to these dispensaries, there was one 'native hospital' at Kakamega where in 1937 11,677 in- and out-patients received treatment, compared to the 71,439 who were attended to at the dispensaries in the same year (Wagner,1949:37). By 1949 this hospital had expanded to a capacity of 255 beds with two Medical Officers, one Wardmaster, two nursing sisters, one Asian clerk, six hospital assistants, two compounders, one laboratory assistant, two African clerks, and eighty-seven "other African staff." 42 In addition to this was a Leper Camp with 130 beds 43 as part of the 'native hospital', and a subsidiary hospital at Bungoma with 76 beds (Fendall, 1955:125). By 1960, the bed capacity at the 'native hospital' (including a maternity section) had risen to 286 (Roberts, 1960:187). In this same year, the 'native hospital' at Kisumu which lay some seventeen miles to the southeast of Bunyore treated 4,901 in-patients and 26, 556 out-patients while all Kakamega Out-dispensaries treated 126, 936 patients (Ibid.:22, 23). Maseno Medical Mission had, meanwhile, expanded its bed capacity to 89 and, in 1949, handled 1, 261 in-patients, 13, 748 out-patients, 7, 713 Out-dispensary patients, and 69 confinements (Ibid.:28). By 1960, there were six Mission hospitals in the district, now
renamed North Nyanza, which provided "a high standard of curative medicine" (Roberts, 1960: 187).

These policy trends were initially focused on the development of dispensaries in appropriate government bomas like Chiefs' Centers in the district. As the Director of Medical Services, Dr. Norman M. MacLennan, pointed out in his annual report for 1949, this focus was not in tandem with what was required to fully live to the medical needs of the people in the rural countryside. This was the more so because, by the end of the 1940s there were, for example, no "full cadre of African Assistant Medical Officers"; no locatoidal health centers though "a good beginning was made with the construction of one in the Nyanza and another in the Rift Valley Provinces"; and no training of African girls as nurses. On the first point, MacLennan noted that by 1949 Kenya had only ten, compared to Uganda which had sixty, African assistant medical officers. Given the rate of expansion in the number of officers in this category, he observed, the country "would provide a total of 15 over a period of 14 years."

The training of Africans in medical work started in earnest in this year (1949) with the enrollment of nineteen students to be trained as health inspectors. Otherwise most work in the district hospitals and dispensaries was carried out by African dressers whose training had started in 1920 (Adalja, 1961:107) and "nurses...who had hitherto been given no systematic training." This latter category was the product of J.L.Gilks's program of training Africans as vaccinators, dressers, assistant sanitary inspectors, dispensers, laboratory assistants, and hospital assistants, which was started in 1932.

Though the slow pace in both the expansion of medical services in the rural areas and the training of African medical personnel was officially blamed on lack of funds, Dr. MacLennan was of the opinion that the real reason lay in the "lower educational standards" of those Africans who could have been trained, and in the fact that since 1920 "the medical services in the colony had grown up in an uneven fashion." This does not
mean to suggest people like MacLennan were unaware that the 1930s and 1940s were difficult decades because of the Depression and the Second World War. In the early 1930s, only 3% of the colony's population could see a qualified medical person in a year, and there was one medical officer to 300,000 people. The situation was made even worse by these two events. During the Depression, for example, the Expenditure Advisory Committee, a select committee of the Legislative Council, recommended a cut of £50,000 in medical estimates for 1933. This led to a reduction in medical staff as well as the abolition of the posts of Deputy Director of Medical Services and of Sanitary Services (Adalja, 1961:110). The move towards the training of Africans was thus a break with interwar training policies which, as demonstrated in chapter six, were governed by the argument that Africans were, mentally and physically, incapable of being trained as workers in the field of curative medicine.

From this perspective, it can be said that by pointing at lower standards of education among Africans and the haphazard nature of growth in medical services since 1920, Dr. MacLennan was in essence questioning conventional wisdom that lack of progress in these two areas was due to lack of funds. As outcomes of the interwar period discourse on the uneducability of the African and the African cultural environment as source of disease, the two aspects were part and parcel of the debates that raged in this period on the role of education and economic development in the improvement of African health. As argued in chapter six, the central question here was whether the African was capable of grasping the intricacies of a scientific discipline like medicine, given that he had an acute lack of "mental ability to receive training" (Trowell, 1935:350). It was because of this perception that medical work in the years between 1920 and 1939 was characterized by two extremes. At one extreme, "there was a strong organization for the institutional treatment of disease, whilst at the other there was also a well-organized system for the control of environmental hygiene," all manned and supervised by the white colonial
establishment. According to MacLennan, this was "a working hypothesis" which assumed that

the Central Government should be responsible for the control of the more formidable and widespread communicable diseases such as the conventional diseases, tuberculosis and venereal diseases, whilst the local authority should cater for the diseases associated with the locality or conditions occurring there ... e.g. typhoid, relapsing fever and malaria.  

This however did not work for the simple reason that these two extremes were based on a center whose "arrangements for domiciliary treatment of illness and home personal hygiene were very deficient."  

Though it had been the assumption of the state "that the colony's health center scheme would fill the breach and weld the two extremes...into a solid unit, strongest at the center", and that financial arrangements made between the Central Government and the Local Authorities would guarantee this, "the division of responsibility for the promotion of health had not been properly defined."  

This was apparent in the failure of medical services to stem epidemic diseases that, together with increased cases of famine, led the state to declare in 1926 that the African population in the colony was threatened with extinction unless urgent measures were taken to promote it.  

These concerns were a reflection of the contention by the East African Commission in 1925 that the threat facing the "native population" in the colony was the result of the failure for the authorities responsible to reorientate medical policy towards "hygiene, sanitation and midwifery" (cited in Adalja, 1961:106, 108).  

The establishment in Bunyore of such institutions as dispensaries was first mooted in the early 1930s, but it was not until the 1950s that the government through the District Council began to get fully involved, institutionally, in the area through the building of Health and sub-Health Centers. This can be explained partly in terms of the assumption on the part of the government that Bunyore, being so close to Kisumu, was well catered for by
the 'Native Hospital' there, and that Kima and Maseno Mission Hospitals were virtually in
the reach of each and every Omunyole. There were other reasons, amongst which were the
haphazard nature of the development of medical services in the colony after 1920, and
AbaNyole's reluctance to provide land on which such institutions could be built. The
reasons for this reluctance were many, though scarcity of land, as well as 'Nyole
suspicions of government intentions, were supreme. For example, when the building of a
dispensary at Emuhaya was proposed in the mid 1930s, the Abamutete refused to have
anything to do with it because they feared that its establishment was a stepping stone for the
government to take more land from them.\textsuperscript{56} In the early years of colonial rule, they
argued, Chief Otieno and later Chief Zakayo Ojuok had used force to acquire the land on
which the government built Emuhaya Chief's \textit{Boma}. Later, this was used to drive the
Ab'biba from their lands which were adjacent to the \textit{Boma}.\textsuperscript{57} The Abamutete remained
adamant on this question forcing Chief Francis Kulali to finally take the project to Kilingili
in 1953-54. When the question of having a Health Center at Emuhaya came up again in
1958, the Abamutete still insisted that they did not have any land to spare. This led Chief
Elijah Enane to use the funds the Local government had set aside for the project to build the
Ebusiratsi Elukongo Health Center in 1959-1960. Emuhaya Health Center, along with
Ipali, was finally built between 1963 and 1966 when Edward Eric Khasakhala, an
Om'mutete, was Member of Parliament for Bunyore in independent Kenya.\textsuperscript{58}

\section{Conclusion}

By interrogating interwar state medical policies, MacLennan was questioning the
wisdom behind the continuation of the pre-1920 militaristic approach which, in the name of
reform, Gilks had given a human face in the 1920s. But Dr. MacLennan's criticism had
another, equally important, aspect to it. His plea for "a solid unit, strongest at the center",
was an attempt to rescue early twentieth-century British ideas on the importance of the
domestic sphere in social engineering that had worked so well in Britain itself, and in other
parts of the Empire. The urgency with which he called for these reforms, as well as the
language he used in doing so, made the idea of the centrality of a health center in the
development of medical services in rural Kenya appear quite novel. This is the impression
created by members of MacLennan's staff who, writing in the fifties and early sixties, saw
the period of MacLennan's tenure as Director of Medical Services in Kenya as truly
revolutionary. As one of them put it, MacLennan's call was for a medical system whose
co-ordinates embraced "an intimate and personal approach to the medical and health needs
of the rural inhabitants and (had) been developed to suit local needs" (Roberts, 1960:186).
According to Roberts, but also N.R.E.Fendall (1955), a new era had dawned in the
immediate post-First World War period which demanded "a fundamental change in
approach ... to the rural African in relation to health and disease; and to the economic value
of his land in terms of agricultural practice and animal husbandry" (Roberts, Ibid.). It was
progression of "thought in this direction", Roberts has concluded, that "resulted in the
application and development of the rural health centre concept, to bring to bear curative,
preventive and promotive aspects of health to the individual and the community" (Ibid.).
What Dr. MacLennan called for, and implemented, was therefore the "devolution and
decentralisation of curative services," and the establishment of "rural or bush dispensaries"
in the rural areas that went a long way to redress the hitherto urban/homa bias in health-care
provision in the colony (Fendall, 1955:125).

As is going to be demonstrated in the next chapter, the health center concept had its
origins in 'panel doctoring' in Britain in the first two decades of this century. Just like in
Britain in the early part of this century, in Kenya in the post-Second World War period this
concept emphasized personal health services as provided through school-canteens, school
medical examinations, maternity and child-welfare clinics, and venereal disease clinics. The
concept also emphasized domiciliary services by nurses, midwives, and other health
personnel. From this point of view, the health center in Kenya was, as a matter of fact, an institution geared towards the bringing of "medical aid and the forces of preventive hygiene completely into touch with the home through the medium of African Assistants" (Walker, 1950). It was on the basis of this concept that the building of health institutions, called Health Centers, on a locational basis commenced in earnest in North (Kavirondo) Nyanza in 1949. Within the next ten years the local government authority, the African District Council, financed the building, staffing, and maintenance of eight locational health centers. This development went hand in hand with a program for the integration of existing medical services, called dispensaries during Gilks's tenure, within the pattern of the health center outfit. In addition to these health centers, the local government also provided for a mobile health unit whose duties were to cover remote areas, areas needing particular attention, and areas where important development projects were under way (Fendall, 1955:125).
Endnotes

1 For a recent review of some of these issues and how they have been handled in both Historical and Anthropological scholarship see Megan Vaughan (1994) and Robert Pool (1994).

2 This is a disease caused by an “accidental infection and entanglement of man in the usual transmission cycle of rodents, fleas, and plague bacilli” (Marc H.Dawson, 1983:70). There are two distinct models of plague transmission and endemicity: an urban model which in most parts of the world is associated with two species of rats, Rattus rattus (the black rat) and Rattus norvegicus (the brown sewer rat), and the sylvatic model which occurs when “the main animal reservoir of plague is not the domestic rat but another rodent” (Ibid.:70-71). The two types of fleas involved in plague transmission in East Africa were Xenopsylla cheopis and Xenopsylla braasiensis and the bacillus responsible for plague was Yersina pestis, though three strains of plague bacilli: orientalis, antiqua, and mediaevalis, differentiated according to their ability to ferment glycerine and reduce nitrates to nitrates, can be identified. Though both orientalis and antiqua strains have been found in Kenya, only antiqua is known to be widespread (Ibid.:71-72). Though R.norvegicus is an important host in most of the world, this was strictly confined to the coastal areas in East Africa. The transmission and spread of plague in the interior of Kenya was associated with R.rattus though, as Dawson (Ibid.:86) points out, the arrival of plague and R.rattus were “probably two separate events.” According to Dawson (Ibid.:72,87), though the history of this disease in East Africa is yet to be written, there is evidence to suggest that its presence, “characterized by local epidemics of low morbidity and mortality” in East Africa and certainly in Western Kenya in the nineteenth century cannot be ruled out; that it was “clearly endemic in wide areas around Kisumu long before Rattus rattus arrived.” In the course of my fieldwork, I did not come across such evidence in Nyole oral traditions.


4 This not to suggest that there were no state attempts at containing the epidemic. What is meant here is that as devastating as the disease was, it was not until 1920 that North Kavirondo’s first ever Medical Officer, a Dr.Nunan, was appointed. This was at the height of the epidemic which in Bunyore alone in this year claimed 99 deaths. This was also the year in which the medical authorities carried out the first major survey of Kenya’s rat population. See KNA: Colony and Protectorate of Kenya, Annual Medical Department Report for the Year ending 31st. December,1921, pp.30,36..

5 For reasons that will fully be explored in the next chapter, the deaths that were recorded are those that mostly took place where colonial and missionary medical authorities were in a position to record. Otherwise most deaths in most villages went unreported as there was much concealment to evade what David Arnold (1993:202) has called “intrusive state medical and sanitary measures.”
6 See C.B. Symes, “Note on the Epidemicity of Plague,” East African Medical Journal 6 (1930), pp.347-50. In a report on Sanitary Matters in the East Africa Protectorate [African, No.1, .025], Professor W.J. Simpson makes the following statement: “In some of the Kavirondo districts the more intelligent natives associate the appearance of plague with the advent of a new species of rat which they call the Kisumu rat, which they declare is the only one which suffers from epidemics of rat disease. They have always had the field rat and the small black house rat, but the rarely dark brown rat which is found in the houses in Kisumu, they assert, a new importation. It has reached as far as Yala in the north, but not Mumias, and Yala appears at present to be the northern limit of the prevalence of plague in the district.” Report on Sanitary Matters in the East Africa Protectorate [African, No.1, .025], p.26. Cited in KNA: Colony and Protectorate of Kenya, Annual Medical Department Report for the year ending 31st. December, 1921, p.35. Simpson made this report in 1913. Bunyore, especially the southernmost part, lies astride the land between Yala and Kisumu. The fact that people like the Wanga called the black rat panya ya jerumani (Kiswahili for the german rat) indicates that it reached them, and thus plague, during or after the First World War. See KNA: Colony and Protectorate of Kenya, Ibid.,p.67. During the first ever survey of Kenya’s rat population in 1920, the northeastern part of North Kavirondo District, especially the area around Mt. Elgon, was found to be free of both Rattus ratus and plague. The remainder of the district, the survey showed, had been taken over by Rattus which had replaced P. natalensis as the domestic rat. The latter was now living as a wild rat in the surrounding countryside. KNA: Colony and Protectorate of Kenya, Ibid.:36-37. Rattus ratus reached the southern slopes of Mt. Elgon on its northward march in 1929 (Hobley, 1929:123).


8 C.B. Symes, pp.347-350.


11 Ibid. pp.14, 28-30, 32-33, 44, 46, and 49; C.B. Symes, pp.347-350. By 1922, Rattus ratus had reached Malakisi. The rat was also found to be spreading north from the southwest corner of Nandi District where it had been introduced in 1919. The northward spread of the rat accompanied the spread of grain trade, though it is probable that the shift in the cultivation of maize from the southwestern corner of Kavirondo to the northern parts also contributed to this development. For developments in agriculture in the district, see, for example, Gavin Kitching (19:22-32) and C.C. Wrigley (1965:222-227). Yala was an important African grains trading town in this period. On this aspect, see P.A. Memon (1975:136). The relationship between the development of trading centers like Yala and their link with emergent transportation networks in Western Kenya, see Ibid., pp.132-137.

14 Ibid., p.25.


20 Ibid.


22 Charles Eliot.


27 KNA: Medical Department, TC 268 MH1/18642. Letter to PMO from A.R. Paterson, M.O.H, Kisumu, 9 May, 1917.

28 Dr. A.R. Paterson to Chief Secretary, Nairobi, 11/12/1939, “Ref.: Colonial Development Fund: Medical Work in the Masai, Particularly a Campaign for the Treatment of Venereal Disease.” In KNA: MD 28/1420/15, and *Venereal Disease in Kenya*, KNA: MD 28/854, Vol. IV.
29 See, for example, Dr.A.R.Paterson to Director, Medical Services, "Ref.: Proposed New Native Housing Scheme," 23/3/1940 in KNA: MD 40/1131/HOU.20/40.

30 Marc H.Dawson (1983:67-68), however, sees this importance, alongside the fear that grain exports from Kenya might be quarantined by the importing countries or "simply not purchased for fear of the disease," as constituting a major reason for quick action in dealing with the plague. But available evidence suggests that fear of quarantine by importers was a major factor in the State’s refusal to publicly acknowledge the presence of the disease in its early years.

31 Emphasis in the original. KNA: Colony and Protectorate of Kenya, Annual Medical Department Report for the Year ending 31st December, 1921, p.43. Part of Professor Simpson's Report is found in this reference.

32 Ibid.

33 Ibid., pp.14, 34, 44, 46.

34 KNA: Medical Department TC 268 MH1/18642. Letter to Principal Medical Officer from Dr.A.R.Paterson, Medical Officer of Health, Kisumu, 9 May, 1917; KNA: Medical Department TC 250 MH1/17643, "Plague Report on South Nyanza District," 13 July, 1922.


36 KNA: Colony and Protectorate of Kenya, Annual Medical Department Report for the Year ending 31st December 1921, p.38.

37 Ibid. p.42.

38 Ibid. p.18.

39 Ibid. p.19.

40 Ibid. p.18.

41 Ibid.

42 Ibid. p.20.

43 Ibid.

44 KNA: Colony and Protectorate of Kenya, Medical Department Annual Report, 1949, pp.3-4, 29.
Ibid. p.5.

Ibid. p.6.

Ibid. p.29.

Ibid. p.4.


Ibid.

Ibid.

Ibid.


Oral Interview, Sylvester Andai Njeche, Es’ saba Sub-Location, West Bunyore Location, 18/11/92.

Oral Interview, George Malema, Emakunda Sub-Location, Em’mukunzi Village, North Bunyore Location, 10/11/92.

Ibid. For the distribution of health facilities in Kakamega District in the 1970s and 1980s, see map 7.1
CHAPTER EIGHT
HEALTH AND HEALING IN BUNYORE: EXPERIENCE AND MEANING

8.1 Introduction

_Obutsilili'ii no'lufu._¹

_Abachesi lelo besinganga ne'tsingubo._²

During the 1980s a political and economic gloom settled over Kenya. The Kenyans' response to the ramifications of this development was aptly summed up in the words of one 'Nyole elder: _abatsia hasi basuye._³ This phrase, commonly used by the AbaNyole during periods of crisis, is a powerful retention of not only the mood of the people, but also their efforts at both explanation and will to meaning.

Starting with _inzala yo'mukolokolo,_⁴ and followed by political accusations and counter-accusations over what had happened to the country's food production and distribution, this decade closed with a series of earth tremors that rocked most parts of Western Kenya.⁵ As the 1990s opened and Kenyans braced themselves for major political changes in the country, there erupted a wave of witchcraft accusations among the Mijikenda at the Coast, the Kikuyu of Kiambu District, the Gusii, and the Abaluyia of Western Kenya.⁶ Then, in 1992, there was a major malaria epidemic in Northern and Northeastern Kenya. This was followed in early 1993 by an outbreak of yellow fever in the Rift Valley.

Parallel to these developments were anxieties over the incidence of AIDS.⁷ This was even more pertinently so in the wake of the disintegration of hopes raised by the Kenya Medical Research Institute (KEMRI) that researchers there had discovered a drug that would go a long way in combatting the scourge. At the center of this was, on one side, the squabbles between herbo- and bio-medical practitioners over who should be credited with the discovery of the drug, code-named Kemron and, on the other, the politicization and internationalization of KEMRI's claims.⁸
It was within the parameters of these developments that the elder declared *abatsia hasi basuye*. But this kind of upheavals were not, at least for the AabNyole, unique: in a tone that betrayed anger and despair, but which was also incisive, almost clinical, Eliakimu Mutoka had the following to say:

Young man. Tell me this. What *Oluhia* (nation) worth its name can continue to believe that *omusungu yaleraa obulafu* (the white man brought light)? *Abasomi* (Christians) told us that our ways were bad, and together with *Ekilauni* (the Crown) they built schools. *Ekilauni* (the Crown) forced us to build roads and to plant maize and to go to school for this was the only way to get *obutsilili* (development). We fought *mwiheee lio'Mujelumani* (the German war) and *mwiheee lio Keya* (the King's African Rifles war). But what did we get? *Etsirots'o* (Famines). There was in 1908 *inzala ya Demesi* (the Demesi famine); *inzala ya Keya* (the Keya famine) in 1918; *inzala ye Liboyi* (the Liboyi famine) in 1927; *inzala ya'Makomia* (the banana famine) in 1941; *inzala ye'Sikombe* (the Cup famine) in 1943; *inzala ya Mau Mau* (the Mau Mau famine) in 1953. And because of *obutsilili* we were fed on *amafwi ke’tongu* (yellow maize) during the famines of 1961 and 1983 and we can no longer plant the foods that made us men. *Esekiita* (the Sector) took us away and *etisikulu* took our children and grandchildren. You have asked me about diseases and I will tell you this: *Lihee lio Keya* brought us influenza and *etakanyi* (sexually transmitted diseases). Webuye brought us Nylon. *Amatulela* (Trailors) from Uganda have now brought us *eiti* (AIDS). *Etsisikulu* (Schools) and *Abasomi* (Christians) told us our ways were bad and roads took away our children and grandchildren. And they came back in boxes, just lying there, never to be seen again. *Busina abachesi bessinganga ne’tsingudo* (Why is it that the clever ones should bathe with their clothes on)? *Oh! Tawe! Obutsilili no’lufu.* (Oh! No! Development is death).9

This text speaks to and about disease not merely as a natural occurrence, a way of life. To Mutoka disease in modern Kenya is a perverse experience of development that at once puts Western biomedical triumphalist discourses on Africa under severe scrutiny, and interrogates claims that Christianity, Western formal education, and general economic projects have transformed the African social and economic landscapes for the better.

Mutoka’s concerns are about anxieties over children’s -- both in and out of Bunyore -- welfare, and about new diseases and devastating famines that are thought to have come in the wake of colonialism. In other words, these are anxieties that have taken form and shape in an historical space, variously called reserve, rural, peasant, and backward. The
comprehension of these anxieties therefore invites us to understand, first, how colonial biomedical therapies intruded upon this world and, second, how the AbaNyole perceived and reacted to them. But we are also invited to consider, on the one hand, the problem of continuity and/or change in African therapies during their encounter with biomedicine as well as the interpretative framework within which this took place and, on the other, the idea of narrative as the experience of suffering. Thus, the link between disease and forces of 'development' in Mutoka's text should not be taken to mean that development *is the cause of all the suffering* one can think of in Bunyore. *Obutsili'il' no'l'ufu* is in this chapter treated as a metaphorical statement in whose structure inheres "two thoughts of different things active together and supported by a single word", disease, "whose meaning is a resultant of their *interaction*" (Richards, 1939: cited in Turner, 1974:29. Emphasis in the original). It does not mean comparing, or for that matter likening *development to death*. Nor does it mean substituting development for death. As Victor Turner (1974:29) has argued, what is at stake in such statements is the emphasis put on "the dynamics inherent in the metaphor, rather than limply comparing the two thoughts in it, or regarding one as 'substituting' for the other. The two thoughts are active together, they 'engender' thought in their coactivity." Development *and* death are thus used here as "multivocal symbols...which bring into relation a number of ideas, images, sentiments, values, and stereotypes" (Ibid.). Since components of "one system enter into dynamic relations with components of the other," and since the metaphor is charged with irony (Ibid.:30), it provokes a rethinking of the roles of development and disease in 'Nyole society through a consideration of questions like: What were 'Nyole experiences with disease and Western medicine during colonialism? How did these experiences and the meanings they produced transform 'Nyole medical and aetiological landscapes in this period?

This chapter argues, first, that resistance to Western medicine and its discursive practices among the AbaNyole was a central element in the dialectics of the constitution of
"a state-centered system of scientific knowledge and power" (Ibid.:7). This was the more so because colonialism was not just about political institutions and economic production that were to later prove to be important determinants of health and disease. Though these factors were important in terms of the conditions they created for the increased "possibilities of transmitting communicable diseases" (Feierman and Janzen, 1993:26), the quintessential import of colonialism lay in the building of "an enormous battery of texts and discursive practices" (Arnold, 1993:8) which concerned themselves with, on the one hand, the "construction of its (colonialism's) own authority, legitimacy, and control" and, on the other, the physical being of the colonized (Ibid.:8). It is the argument of this chapter, therefore, that it was the accumulation of knowledge thus produced, and not the other way round, that "contributed to the political evolution and ideological articulation of the colonial system" (Ibid.). So long as biomedicine remained embedded within the wider interstices of this process, and so long as it remained "integral to colonialism's political concerns, its intents, and its cultural preoccupations," its presence in the colonial world ceased to be merely "a matter of scientific interest" (Ibid.) which could be called upon whenever the colonizers wanted to refocus their political and economic interests. As already demonstrated in chapters five and six, the essence of discourses on the 'diseased native', on a whole array of diseases called 'African', and on the 'inferior, uneducable African' lay as much in the 'African pestilential scourges' colonial medicine concerned itself with, as in "the more general nature of colonial power and knowledge" (Ibid.). That is why, as a discourse-in-the-making, this system of knowledge sought both to define itself within and above 'Nyole (and for that matter Kenyan) society and to, through ideological and administrative mechanisms, engage in the counting, categorizing, disciplining, and discoursing upon, the African body. It was, indeed, colonial medicine's "battery of texts and discursive practices" produced first during the plague years and later through the
institution of the Health Center that made it a very important tool in the "cultural and political construction" of colonial subjects (Ibid.).

Second, the chapter will, following David Arnold, attempt to demonstrate how the career of Western medicine in Bunyore showed the importance of the African body as an object of colonial appropriation and as a site of contestation between the colonized and the colonizers. The search for control, it is argued, was not simply one of Same/Other opposition as the colonizers sought to consolidate their authority and legitimacy. Through an examination of African experiences with new diseases and biomedical therapies brought to bear on these diseases, as well as the meanings these experiences produced, an attempt is made to "uncover different forms of ... responses, to peel apart the onion layers of resistance, accommodation, participation, and appropriation" (Arnold, 1993:10). The chapter thus goes beyond an account of colonial power and knowledge, or the answer to the what and why questions of the career of Western medicine in Bunyore, to attempt an understanding of how the AbaNyole perceptions of new diseases and biomedicine led to autochthonous transformations of, and shifts in boundary-markers in, Nyole medical and aetiological landscapes. It is further argued that by emphasizing both curative and preventive approaches to health-care provision immediately after the end of the First World War, the State established the framework within which, for the next several years before political independence, colonial biomedical science defined itself as it pushed aside rival or preferential claims of abafum (diviners), abalesi (healers), and what John M. Janzen (1978) has called therapy-management groups in African societies. Like in India in the late nineteenth and early twentieth centuries, this development increasingly led the State and Medical authorities to see the African body as "a secular object, almost as state property, not as sacred territory; as an individual entity, not as an integral part of a wider community. The body, moreover, was exposed not just to the 'gaze' of the Western medical practitioner" (Arnold, 1993:7), but also to the scalpel during postmortem and other surgical
operations. These, especially the latter, were invasions of the sanctity of the body and, therefore, a violation of the idea of continuity and completion as demonstrated in chapter three. These practices were central to the patterns resistance to, accommodation of, and/or appropriation of what this science meant for both the individual and the community as a whole. To therefore understand what direct medical intervention meant for the AbaNyole, and how they reacted to it, the notion of resistance is recast to encompass "the problematic interdependence of discourse and praxis, and the constant tension between them as represented in a complex colonial situation" (Ibid.). This is the more so because questions concerning the career of Western biomedicine in Bunyore or any other colonial situation were as much about the creation of "a state-centered system of scientific knowledge and power," as they were about the resilience of indigenous therapeutic ideas. This resistance was an "essential element in the evolution and articulation of a particular system of medical thought and action" (Ibid.).

8.2 AbaNyole's Encounter with Colonial Medicine

Between 1895 and 1963, Bunyore went through a series of devastating diseases and famines. Among these diseases were smallpox, yaws, tuberculosis, typhoid, influenza, plague, measles, whooping cough, and sexually transmitted diseases like syphilis and gonorrhea. Major famines, on the other hand, included Opande (otherwise known as Demesi) in 1907-1908; Keya in 1917-1918; Liboyi in 1927; Nyangweso in 1932; Esikombe in 1943; Mau Mau in 1953; and Esipindi (Yellow) in 1962-1963.

Just like any other major catastrophes in history, the causes of these diseases and famines have been a subject of much debate. Explanations as to why they occurred have been as varied, and controversial, as the various shades -- religious, administrative, victim, academic -- of interpreters who have cared to look at the twin phenomena. The debates and controversies surrounding these phenomena have more often than not obscured the fact that
in their occurrence and people's response to them, rare opportunities avail themselves for setting and testing theories of social change. But as William I. Torry has reminded us, catastrophe always stretches "institutionalized behavior to its limits, revealing the extent of receptivity of social organizations to new ideas and exposing the strengths and weaknesses of moral and legal controls of society over individuals and groups under a full range of conditions of risks and stress" (Torry, 1984:229).

But to say that Bunyore during colonialism went through devastating diseases and famines does not, in the least, mean to suggest that all these were entirely new phenomena. Diseases like smallpox, malaria, and typhoid were well known and the AbaNyole had local idioms in which they explained their experiences with these diseases. There was, for example, a strong belief that omurengo (fever) was a seasonal disease brought about by "walking in rain, stagnant water after rain, or generally by eating ebiokhulia 'bihia (first foods in season) like green maize." The incidence of inundu (smallpox), on the other hand, was predicated upon a disturbance in nature. A highly contagious disease, its treatment involved a combination of methods like the removal of pus from an infected person and rubbing it into scarified bodies of healthy individuals; the use of herbal medicine; the isolation of infected people during treatment; the general restriction of movement within the community; prohibition of the sharing of food and of common grazing grounds; and "singing and making noise to chase the epidemic to the West."  

These diseases occasionally led to serious tensions within and between homesteads and/or clans. As demonstrated in chapter three in the case of inundu (smallpox) and mongoyi (sleeping sickness) during the nineteenth century, whenever these diseases reached epidemic proportions people tended to blame others for their incidence, and all sorts of explanations including the practice of witchcraft and sorcery were put forward. This was the case if some homesteads or clans were affected more than others and, if the toll was particularly high within a single homestead, enisambwa (ancestral retribution)
and/or emisilo (the breaching of custom) were suspected alongside witchcraft and sorcery. Be that as it may, perhaps one of the most common responses to such moments of crisis was wholesale migration of families, homesteads, or clans. These migrations were either due to the tensions occasioned by epidemics, a general move away from what was considered to be an unhealthy environment, or the fear that ancestral spirits were not happy with the present settlement.

Though most of those interviewed are agreed that whenever similar crises occurred during colonialism (as in the 1908 smallpox epidemic) 'Nyole methods of dealing with them got a boost from Church and State campaigns, newly created locational boundaries caused more harm than good. This was because migrations as a way of diffusing tensions between families, homesteads, and clans were no longer possible. This hemming-in was made even worse during the incidence of new epidemics the AbaNyole had neither the knowledge of dealing with, nor the space in which they could refer to their materia medica, or tap from past experiences to understand them. Such new epidemics were the influenza outbreak of 1918-1919, and the plague epidemic of 1908-1930. Perhaps because diseases like smallpox, malaria, typhoid, and measles were well known, and the influenza outbreak short-lived though devastating, the most remembered and talked about epidemic is libumba or puleki (plague). This can be partly be explained in terms of the time it took to eradicate it, and partly because of public health measures adopted by the colonial state to carry out this eradication.

As argued in chapter five, government medical work in the first twenty years or so of colonialism was in Bunyore as elsewhere in Kenya characterized by a sense of ambiguity with regard to what duties each and every officer of the Crown was supposed to perform. The duties of the Medical Officer of Health were, for example, of a "multifarious character" since he "was a clinician, a lecturer in eugenics, a medical officer of health, an educationalist and an amateur agriculturalist" (Carman, 1976:40). The nature of these duties
of necessity demanded "the growing cooperation between the medical departments and the other social agencies" of colonial administration (Beck, 1974:103). This led medical officers like John A. Carman (1976:32,35) to not only think that whenever Africans "saw the Agriculture Officer working hand-in-glove with the Veterinary Officer, and the Education Officer consulting with the M O ... they believed that all these people had the interest of their tribe at heart," but also credit the system of central control with having "a most beneficial effect on the public health and on the control and treatment of disease." Of interest here is John Carman's caveat: that administrative officers "'clothed with a little brief authority' behaved like little tin gods as did also their wives" (Ibid.:32). It was more often than not this 'little brief authority' that led the AbaNyole as early as the 1910s to draw a clear distinction between ekilauni (the crown) and silikali (the government). The one was what was constantly trying to transform the everyday lives of the AbaNyole but, because of its brutality, was not only despised but also associated with the pestilence and indigence that had since the turn of the century become the rule rather than the exception in Bunyore. Silikali, on the other hand, was what was distant and therefore invisible. Enhanced by the fact that it was also hot or fierce, its unknow-a-bility made it mysterious and dangerous. Brutality from ekilauni without redress from silikali created fertile grounds in which all sorts of ideas about the two institutions, but also what these institutions were upto, could be planted, nurtured, and finally debated by the AbaNyole in all types of arenas.

For example, the smallpox and influenza outbreaks, as well as the droughts and famines, that occurred immediately after the end of the First World War, were blamed by the AbaNyole on the arrest, incarceration, and death of Nganyi. Nganyi was the high priest at the shrines of Malondole the god of rain, fertility, fire, clouds, and hail. According to one informant, "he (Nganyi) was arrested by ekilauni for failing to make rain during the droughts of 1918-1919, and was taken to prison in Kisumu where he died after being fed on sand and mud." 13 The lack of understanding of 'Nyole institutions, as well as
ekilauni's insensitivity to 'Nyole feelings, was reflected in C.W. Hobley's (1934:247) comments on this issue when he wrote that rain-making was a "manifestation of the play of magical beliefs, and those who practiced this profession (were) often a nuisance." This is how he described Nganyi and the latter's arrest:

I once had a struggle with a famous old rainmaker in Kavirondo, who persisted in mulcting villages for cattle every season on the plea of with-holding the rain until all had paid. He was a truculent old man, so early one morning I paid him a visit, and told him to accompany me to the Government Station, 30 miles. He refused, so his own people carried him; he cursed us heartily, and prophesied our speedy decease, but a stay of a few weeks at the station changed his attitude if not his heart, and what was more important, his prestige was shattered and his remunerative practice destroyed.

Of course Hobley does not tell us who was involved in carrying Nganyi to the government station in Kisumu. Who were Nganyi's people? Neither does he mention the fact that Nganyi died in detention at Kisumu, and was not brought home for burial. As high priest at the rain and fire shrines in Esibila Hills, Nganyi was not only Malondole's representative and mediator between the latter and the AbaNyole; his clan was, since the early nineteenth century, central in the enlargement of the social field of action in what was to become Western Kenya in the twentieth century. If, as argued in chapter two, fire and rain in 'Nyole cosmology symbolized maleness and femaleness, and the two elements evoked notions of striving consciousness and potential power, respectively, then the arrest and incarceration of Nganyi was a brutal assault on 'Nyole ideas of being, belonging, and regeneration. But, at another level, ekilauni's actions were a reflection of the nascent colonial authorities' failure to imaginatively manipulate 'Nyole stock of images as they sought, in their social and political experiments, to ground what they saw as 'civilization' in recently anchored Western symbols. This failure was most crucially brought out in, first, a bifocal address and the prevalence of argument by negative contrast as in all the arguments that came to inform the debate on the differences between 'science' and 'tradition', or the contrast between African 'supernatural' and Western 'natural' bases of
disease causation. Symptomatic of the othering process of 'Nyole cultural vehicles, the arrest and incarceration of Nganyi symbolically played itself out at three levels. First, it symbolized the British violent approach to social self-definition in a colonial situation. Second, it reflected the British idea of Africa as experience to be perceived and felt. Third, it was, as necessary rationalization, an important index in the early stages of a colonial medical social formation. Based as it was on the logic of Britain's own fundamental persuasion about its role in Kenya, and defined by a nineteenth century pattern of thinking and perception of an imagined community of diseased natives, this bifocal address -- and this is our second point -- developed into the discourse that came to not only shape the discursive practices of colonial medicine but also, in the process, attempted to expropriate AbaNyole's personhood, of their capacity to narrate their own bodily experiences.

From this perspective, the social issues lurking in the background are not difficult to discern. Indeed, as part of the master narrative, the discourse on the 'diseased native' was a normal requirement for self-definition, cultural positioning, boundary-marking, and for working out the tenets upon which the rites of entry and exclusion were based during the 'Nyole-British encounter. This encounter was marked by an acute lack of historical examples drawn, by the new rulers, from the 'Nyole world. AbaNyole knew and believed in heroes; the new colonial ethos had no heroes of Nganyi's stature to offer. Thus, whenever positive examples were needed, the early colonial administrators struggled in the cross-currents of two cultures that strongly disagreed on just about everything, including disease aetiology. From this perspective, it can be said that the arrest, incarceration, and death of Nganyi "m'makhono ke 'kilauni" (in ekilauni's hands)\(^4\) signalled, on the one hand, continuous suspicion among the AbaNyole over what ekilauni was doing and, on the other, the difficult terrain the colonial administrator, medical officer, or even agriculturalist, had to traverse in trying to fill the vacant space left by Nganyi.
But if the treatment of Nganyi is evidence enough to suggest both a vigorous process in the politics of cultural positioning and the medicalization of Bunyore through the denial of the people of themselves, it does not say much about why the AbaNyole, in varying degrees, remained attracted\textsuperscript{15} to this social formation. Furthermore, if the AbaNyole were suspicious about the intentions of ekilauni and silikali, then there is reason to argue that even the reasons set forth in official and Christian discourses on the need to 'civilize the native' lack the power to have generated the interest AbaNyole showed in this novel social formation. Then what attracted the AbaNyole to this social experimentation?

The answer to this question lies partly in AbaNyole's perception of ekilauni and silikali, and partly in the attraction of the social formation itself. As demonstrated in chapter four, AbaNyole's first experience with Western biomedicine was through the work of the Kima and Maseno medical missions. The two missions, like Pax-Britannica, arrived in the southeastern part of North Kavirondo District at a time when the relationship between 'bene liloba, on the one hand, and abamenyibwa, abarende, and abasumba, on the other, was under stress due to the expansion in scale of the social field of action, and the changes brought about by the Long Distance Trade. Evidence from oral narratives suggests that the amatala (villages) that arose around these missions in the first decade of this century initially comprised of the underprivileged and/or their children in 'Nyole society. As an impulse behind the constitution of these villages, and therefore the first cadre of Christian converts and consumers of Western biomedicine, the lack of obunyollo (means of livelihood) on the part of some members of society was indicative of how fluid certain notions of the 'Nyole social fabric were at the turn of the last century. It can be argued that evangelization as well as the incalculation of the virtues of Western biomedicine among the AbaNyole must have been, initially, encouraged rather than prescribed behavior.

The other, equally important, factor which made the AbaNyole to become attracted to Western medicine was intimately connected with the events of the immediate post-First
World War period. As demonstrated in chapter four, the popularity of Medical Missions among the AbaNyole began manifesting itself with greater intensity after 1918. According to C.G. Richards (1947:13-14), 1918 was a year characterized by much suffering in the southern locations of North Kavirondo District due to "war and other disasters." These disasters included "rinderpest which killed most of the cattle, and an epidemic of smallpox" which "broke out among the half-starved people." In these locations, the "countryside daily resounded with the wailing of women for their sons ...." These disasters were followed in 1919 by "influenza of the virulent type which had caused so many deaths in Europe .... Later in 1919 bubonic plague appeared and spread through the district." To the AbaNyole, this was a time when "the hissing of the world" had become a common occurrence due to the incidence of inundu (smallpox), indwasi ye’libombo (stomach ulcers), esiherekere (measles), and olwangala (tropical ulcers). 16

Though well known among the AbaNyole, the incidence and intensity of these diseases in this period coincided with the establishment of obwami bwe 'kilauni (the crown's overlordship), as well as the incidence of wholly new diseases like esirimba (yaws), etakanyi (sexually transmitted diseases), libumba (plague), and esihela (tuberculosis) which the AbaNyole had no knowledge of. 17 In addition to these diseases, there was inzala ya Keya (the Keya famine) of 1918-919 which was far more severe and devastating than the inzala yo 'Pande (the Opanse famine) of 1907. 18 If it were not for the Missions at Kima and Maseno, most informants pointed out, "we could have been wiped out." 19 Before the war, there was a relatively small number of Africans who had become "communicant members of the church." This position changed between 1918 and 1919 as more and more people "crammed" churches or held "tree congregations" on Sundays as Rechards (1947:11-12) has pointed out. Thus famines and diseases, both old and new, were major mitigating factors.
It can be argued that like in the period following the arrival of Christian missions, AbaNyole's attraction to both Christianity and Western medicine after the First World War took place within the framework of a highly fluid situation characterized by pestilence, indigence, and want. But, unlike the earlier period whereby those affected were people from underprivileged groups in society, the 1918-1919 development was emotionally charged since it was characterized by the diseases and famines mentioned above, and the arrest, incarceration, and death of Nganyi. As already pointed out, these two factors were not mutually exclusive. If pestilence and indigence were in the period after the end of the First World War attributed to the way ekilauni treated Nganyi, and Christianity came to receive acceptability in the eyes of the AbaNyole as a caring institution, later developments especially sanitary and medical measures adopted by ekilauni to eradicate epidemics like plague only confirmed AbaNyole's suspicions about the State's intentions. Characterized by the wholesale burning of houses and their contents, and the forcing of people to hunt for rats' tails "like little spoilt children," 20 these measures met with great disapproval in Bunyore. As some informants pointed out, the "abatakitari bo'muchuti Emuhaya (the doctors on duty at Emuhaya Chief's camp) were not different from either the Chief or his askari kanga (Chief's police)." This was because "they all participated in the counting of our children, the capture of our animals because we could not pay obusuru/ekotii (tax) ... the burning of our houses because Abekilauni (of the crown) said they wanted to finish puleki (plague)." 21

All these developments were taking place against the backdrop of major social and economic changes within Nyole society. For example, due to the recently created locational boundaries, there was, from as early as 1910, a serious problem of land scarcity and overpopulation. A quick review of available literature and oral data reveals that though AbaNyole's attraction to Christianity and Western medicine in the first two decades of colonialism lay in the factors outlined above, erosion in the means of survival as well as
wage labor migrancy had one or both of the following results. First, the creation of locational boundaries removed the prospects of wholesale migration as a form of diffusing societal tensions. This led not only to pressure on land which in one way or another deprived the people of the only source of paying for their therapeutic needs, but also to the creation of a labor-exporting peasantry that introduced irreversible trends in kinship structures. The transformation within the latter in turn affected decision-making with regard to both therapy-seeking behavior and therapy management. Second, wage-labor, together with formal schooling and Christian evangelization, became important mitigating factors in the process of the expansion of what we called in chapter three the arena of therapeutic possibilities. These, coupled with campaigns mounted by both missionsaries and the colonial government to discredit what was described as African fatalistic beliefs in witchcraft, magic, and ancestral spirits, either drove underground, or marginalized, African therapeutic experts. The net result of this was not the annihilation of these experts, but rather the rise of a power that either challenged the myth of the superiority of Western medicine, or consciously competed with it.

Drawing its constituency from the recently converted Africans, Western medicine could, by 1920, boast of its own cluster of authoritative conventions and could venture forth as a self-sustaining culture living above 'Nyole therapeutic traditions. Indeed, at this early stage of its development it could claim to have subsumed 'Nyole therapies through a narrative that combined Christian, medical, and the colonial state's convictions in a single-level authorization. Everything in this discourse-in-the-making -- the categorization, counting of, and discoursing on, the 'Nyole body -- were read off with an aura of inaugural address attached. But this was only up to a point. As a discourse-in-the-making, this single-level authorization was during the early period of colonialism at a painful juncture of emergent self-definition. Thus, as a social formation it had within itself challenges to its triumphalist, non-negotiable, claims to authority, as well as to the very
notion that Western medicine was an essential grounding and guide to a better life for Africans. The reassertion of the 'Nyole presence between the 1920s and the 1940s, and the outbreak of a plague epidemic between 1908 and 1930, challenged this self-congratulatory and triumphalist cultural positioning.

Two incidents of cultural conflict are illustrative of how tenuous the relationship between the Missionaries and the AbaNyole over spiritual matters could be. Mr. Kramer, a missionary seconded to the African Institute Mission (later Church of God) at Kima by the American Mission Board between 1912 and 1927, once had "a serious confrontation with Chief Zakayo Ojuok leading to Chief Ojuok's slapping of Kramer in public. Also evangelist Philip Omuchelu from Emusire was publicly whipped at Chief Kuta's Baraza in Kisa because he preached against smoking, drinking and traditional ceremonies which the administrators seemed to condone" (Makokha, 1982:2). And, sometime in 1943, there was a serious conflict between young mission-educated Africans of the Church of God and the white establishment at Kima over the contribution, since 1905, of some Sh.25,000 yearly to the church coffers. These African faithfuls, mainly from the E bunangwe Parish, wanted Mr. J.S. Ludwig, the head of the Mission, to give them a percentage of these moneys "to pay for our children's higher education." According to these individuals, Mr. Ludwig refused the request, saying "we Africans are Sinners and cannot be given money for educating our children. He added that, money was God's money and could not be given to bad spirited (sic) people." 22 The following year, in 1944, these elders declared that "we shall remain Christians in our church, but shall keep our own money (Offerings)" to which Mr. Ludwig answered: "if that is the case' Never appear at my Mission station anymore." 23 This led these faithfuls to declare to be "intirely (sic) and absolutely independent," establishing the African Interior Church. In 1948 they were demanding for what they called an African baptism. 24 On May 12th, 1951, at a special meeting called to discuss E bunangwe Primary School which had been taken over by A.I.C,
the Education Committee of the Church of God mission decided to completely withdraw from the management of the school. 25

These two examples are indicative of how the cultural space Christianity came to occupy in Bunyore was contested from within and without the so-called 'civilizing mission.' But the slapping of Mr. Kramer, a missionary, by Chief Ojuok, and the whipping of Philip Omuchelule, an evangelist, at a Chief's baraza (palaver), were public spectacles, or rituals, that demanded what David R. Shumway (1992:115) has aptly described as "an exercise in defamiliarization." Kramer was both a whiteman and a missionary, two characteristics which in colonial Kenya were markers of both power and invincibility. Philip Omuchelule was an evangelist from Kramer's mission. But both were representatives of a supposedly self-sustaining, superior culture that had come to assume that it had peripheralized 'Nyole culture.

Indeed, unlike the pre-First World War period when missionaries manipulated 'Nyole conventional values, rhetorical patterns of persuasion, and symbols to win followers, the period after 1920 increasingly came to be characterized by combative language by missionaries condemning African traditions as the devil's way. Things seem to have reached breaking point when, during the plague years, the missionary and government insistence that ritual sacrifices be done away with was seen by most AbaNyole as a direct challenge to their very existence as a people. Though missionaries had previously insisted on this, and participants in such rituals were more often than not excommunicated from the church, these were in the pre-war period seen as individual acts that did not threaten the community's corporate relationship with the supernatural. For missionaries to use the same language as the government in calling for a total ban on ritual sacrifices was a development that was both a betrayal of the trust the 'Nyole had in these missionaries, and a threat to the principles upon which the community's social harmony and equilibrium depended. That this threat became manifest, immediate, and more
compelling during the plague years cannot therefore be gainsaid. As public rituals the
slapping of Kramer and the whipping of Omuchelule were therefore manifestations of the
anxieties and uncertainty plague had caused. But these acts were for the AbaNyole also a
symbolic call "to experience at once the alterity of another historical reality, and thus to be
unable to 'recognize'" themselves in it (Shumway, 1992: 115).

These two examples have been chosen both for their striking similarities with the
career of biomedicine in Bunyore, and for the simple fact that Christianity as a cultural
force was implicated from the beginning in the way processes of social change during
colonialism were perceived by the AbaNyole. If Christianity was, at least initially,
'accepted' in Bunyore without much questioning, the career of Western medicine as
propagated by the colonial state was, to use David Arnold's (1993: 211) words, "almost
paradigmatically, a tale of alienation and resistance." While missionaries from the start led
most AbaNyole to believe that medical dispensation was an extension of the love of God
for mankind, colonial administrative and medical authorities did not provide the people with
any explanation why they thought their services were necessary. This difference in
perception on the part of the AbaNyole became manifestly clear during moments of crisis
like the one unleashed by the plague epidemic of 1908-1930.

8.3 Health and Healing in Bunyore: Experience and Meaning

Unlike in the nineteenth century when mongoyi (sleeping sickness) and inundu
(smallpox) epidemics led to the location of questions about causation and remedy within the
framework of kinship and clan relations, the interpretation and comprehension of life-
threatening diseases during colonialism lay within the parameters of state operations. A
simple reason for this was that such new diseases like yaws, influenza, and plague
coincided with ekilauni's invasion of a very important sacred space, but also because of the
sanitary and medical measures ekilauni adopted to eradicate these diseases. But, more
fundamentally, kinship or clan relations were powerful organizing paradigms *only* in cases of diseases whose aetiology was *known* and *understood*. Plague, for example, was a new disease that could not be explained in terms of such tropes as *habakuka bakoono* (where our forefathers slept), tropes which harked back to the foundational stability that was thought to inhere in such symbolic complexes as Bunyore Hills and Wekhomo, and entailed the totalizing vision of *bene liloba* (the owners of the land). These were notions which tied the idea of one-ness to belonging, and they logically, in the event of an epidemic, forced questions about the way clans related to each other. There is no denying that such questions were raised during plague. Indeed, oral narratives indicate that beside the conspiracy theory, plague also brought to the fore debates that, before colonialism, had underlain concepts of disruption and chaos which were always linked to a primordial existence where misfortune consisted in "the threat of a resurgence of the old chaos, prior to creation, and hence to culture and socio-cultural bonds" (Sow, 1980: 206). However, since the quest was for the location of the site of disruption and chaos, and plague had no precedence in terms of aetiology, there was a subversion of incidence and occurrence. While in the past concepts of disruption and chaos were seen from the point of view of a primordial antithesis to one-ness and belonging, in the colonial period diseases like plague forced a link between these concepts and what was new -- *esihia*.

*Esihia* -- newness -- was not such a novel concept in *Nyole* aetiology.

Etymologically connected to *hia* (burn), it was central in such ontological expressions as *amatsahi mahiu* (hot blood, meaning dangerously pollutive), and *ebiokhulie bihiia* (first crops in season which were thought to cause temporary madness unless their consumption was ritually authorized). Its novelty in the case of new diseases, however, lay within an evolving repertoire of aetiological idioms that were used to perceive and interpret life-threatening crises during colonialism. Articulated in a form of language that was elaborated upon vis-a-vis an assemblage of state and Christian practices, this repertoire encompassed
resistance, accommodation, participation, and appropriation as biomedical practices inhabited, passed through, transformed, conserved, or escaped the terrain sketched by a pre-European 'Nyole worldview. Thus, and as can be read in Mutoka's text, this concept came to be captured during colonialism and beyond in such man-made features like hospitals, factories, bituminized roads, and in the heavy traffic on the Kisumu-Busia road. Aetiologically, the importance of these features lay in the association the AbaNyole drew between their establishment and the arrival of such potent snake poisons like imbilikong’o, dangerous diseases like syphilis and gonorrhea and, most recently, AIDS. But these features, especially transportation networks, were also associated with travel, if only to look for new and more potent medicines to either increase one's fortunes or deal with enemies.

Indicative of this development was how widely and intensely discussions on the origins and meaning of these diseases were carried out. Characterized by anxiety and uncertainty over "what this world was coming to," 26 these discussions revolved around, among other things, questions about the meaning of public health as preached by state medical authorities; hospitals and what was done there to bodies; female doctors undressing men to examine them; inoculations as a prophylactic and, later, why injections were better than em'pi (M&B tablets). The point of departure in these discussions was the 'Nyole conception of the body as a unit that encompassed notions of olubi (misfortune) and oll'ahi (good), and the relationship between the individual and the social unit and the universe. Based on the harmony between oluhia (the microcosm), emakombe (the macrocosm), and esitsimi (the mesocosm), notions about olubi and oll'ahi expressed, on the one hand, ideas about life and death and, on the other, linked these ideas to concerns about harmony that could be disrupted through the breaching of emisilo (taboos), ebilamo (curses), emisambwa (ancestral retribution), or the uncritical acceptance of ebihia (new things) in society. If hygiene comprised in telling people what they should do to prevent the spread of
diseases, and missionary and government campaigns amounted to just this, then what the AbaNyole were being asked to do was to abandon their ideas about *continuity* between the body, the social unit, and the environment; *composition* without which holistic treatment was meaningless; and *completion* which symbolized continuity with the social unit, the environment, and the universe. To insist that the AbaNyole should abandon these time-honored ways of seeing and knowing amounted to the creation of grounds for disharmonious situations that could and did lead to dis-ease. But this, in itself, was not so alarming since disharmony through, for example, the breaching of *omusilo* (taboo) or the desecration of sacred spaces by a member of the community, made dis-ease an important factor in the maintenance of social order. Healing rituals involved both the attainment of a state of physical normalcy and the re-establishment of lost harmony. In either case, dis-ease brought to light, and clarified, a number of matters in cases whereby confessions were called for.

What was disturbing to the AbaNyole was the simultaneous introduction of the hospital and the insistence on the part of the government and the missionaries that ritual sacrifices be done away with because "they were the work of the devil." 27 While the ban on ritual sacrifices as healing processes threatened the very principles upon which Nyole harmony and equilibrium depended, the introduction of the hospital privatized dis-ease as it at the same time removed confession from center stage in the healing process. According to the AbaNyole, there was another, equally sinister, motive behind the establishment of hospitals. The individuals behind this project, especially doctors, insisted on patients "giving blood, excreta, and urine, saying that it was easy to find disease this way. They also asked many questions and wrote down all that was said, including names." 28 This worried many people because "they wondered: 'what is the white man going to do with my blood, excreta, or urine? These are strangers and aren't they going to ensorcell me?' " 29 These practices were sources of anxiety because the asking of questions and writing down
the answers was, for example, construed by many people to be a form of witchcraft whereby the doctor captured the patient's name and genealogy in symbols on a piece of paper. And the taking of specimens for culture was resisted on the grounds that effluvia like feces was thought to not only add to the well-being of the earth since through it potent men passed onto it the potency of the body, but also because such effluvia, being part of the person, had to be guarded against sorcery. This is why the getting of such specimens and enclosing them in a covered container led to panic: it was because of this that relatives insisted on being present whenever a doctor wanted such specimens. After his experiments he had to either safely dispose of the material, again in the presence of the patient's relatives, or gave it back to them. This attitude also informed the 1940s and 1950s when, during campaigns for Bora Afya (good health), the digging and use of pit latrines was resisted on the grounds that they were fixed and known and sorcerers could get to them whenever they wanted. When reminded that it was impossible for sorcerers to know which feces was whose, most informants pointed out that since feces was continuous with the individual, the use of pit latrines indiscriminately did not help, either. Furthermore, because of this same reason, the bringing into contact feces from different people more often than not led to contamination of individual sanctity. It was also taboo if not bad manners to defecate in the same hole your mother or mother-in-law had used. 30

The establishment of hospitals also led to anxieties over the fear that "most people who went there for treatment were brought back dead, or never seen again." 31 Like in the Belgian Congo where doctors were thought to be human leopards (Schweitzer, 1931:28), many AbaNyole saw doctors as amanani (man-eating monsters) who, because they were thirsting for human flesh, shape-shifted into human beings whenever a patient was brought before them. Anaesthetics were considered as death-dealing and whenever a patient came out of hospital alive, stories quickly spread that so-and-so had cheated Omboko (the white man) out of his share of human flesh. Thus, like in the cases Albert Schweitzer (1931:28,
38-39) relates in the Belgian Congo, most AbaNyole, at least in the plague years, distrusted doctors because, first, unlike them African healers recognized death when it was approaching: they thought that white doctors were only interested in inflicting lasting death.\textsuperscript{32} Rumor about cannibalism in hospitals only confirmed the people's belief that one went to this institution not to get well but to die.

This discourse on the relationship between hospitals, death, and the disruption of composition, continuity, and completion was elaborated on at other sites on the meaning of \textit{ebiata} (operation theaters), \textit{esindani} (injection), and the differences between \textit{obulwaye bwe sia'frika} (African diseases) and \textit{obulwaye buchenithuhia} (foreign or new diseases). Perhaps because inoculations, vaccinations, and later injections were not very different from 'Nyole time-honored methods of introducing potency and resistance to evil by introducing substances under the skin through \textit{tsisalache} (scarifications), these practices were not resisted the way \textit{ebiata} was.\textsuperscript{33} It can also be argued, as one informant put it, that the sensation, or pain, either inoculation, vaccination, or an injection caused on the body resonated well with the 'Nyole notion of \textit{okhwekhamisia} (the joyful pain one experiences when taking in medicine meant to heal).\textsuperscript{34} As Dr.Ouya put it,

\begin{quote}
    it might seem an exaggeration but AbaNyole have always insisted on being given an injection because they would feel its effects almost instantly. The patient would feel the pain, even smell it, feel it move in his or her bloodstream. In fact if an Omunyole is given an injection and there is no pain, he or she would feel cheated by the doctor or nurse. He would ask you why there was no pain. Pain was treatment. In fact, many Asian doctors running private clinics capitalized on this knowledge. Knowing that injections meant treatment, some of them gave less doses so that the patient would come back for more.\textsuperscript{35}
\end{quote}

Be that as it may, it seems that what made it even more urgent for people to accept these practices was simply the fear of going to hospital for treatment. As Marc Dawson (1983:92, fn.67) has pointed out, rumor about cannibalism in hospitals in Nyanza Province started to spread sometimes in 1908 when "a European Medical Officer was seen eating his
lunch in the autopsy room. The African assistants simply assumed a very different lunch menu." Whether this was an assumption or not was however not the issue; during the month of June, 1908, plague in the African locations of Kisumu town had claimed over fifty-nine lives, causing widespread panic among the residents. According to the P.M.O., during this outbreak Africans used all sorts of evasive tactics to keep their dead away from hospitals. Failure to report these deaths was not, according to the P.M.O., due to the burning of all infected villages, but rather because of a widespread belief that the corpses were used in hospitals as food and for making medicines. It was also believed that "if you were old, the doctors could intentionally kill you to get certain important parts of your body. Ebiata was performed on people without major health problems in the name of treatment. Otherwise why did the doctors bother operating on motor vehicle accident victims, or for that matter people who had been murdered or those who had committed suicide?"

According to Dr. Ouya, people like his paternal grandmother died without ever having seen the inside of a hospital because they strongly believed that the tablets dispensed there "were made from dead peoples' obwongo (brains) and indulwe (gall)." Furthermore, during the anti-plague campaigns, men were forced to hunt for rats' tails which they in turn took to the District Commissioner at Emuhaya. Since the District Commissioner never explained why silikali needed rats' tails, the AbaNyole thought that they were being collected so that they could later be used in the making of drugs. This, together with rumors that people were deliberately killed in hospitals so that their brains, spleens, and gall could be used in the making of tablets made many AbaNyole conclude that aheli esindani (rather an injection). They never took anything white because "it resembled brain. They had slaughtered chicken and other animals and knew that brain was white." To prove that doctors were amanani, or people were operated upon for purposes of getting certain body parts for making medicine, most informants wondered why people were not
allowed to bury their relatives who had died in hospital. According to Dr. Ouya, for a very long time "people were not allowed to transfer dead bodies from the hospital for burial. This was because there were no mortuaries to preserve the bodies for long. This, coupled with lack of transport which could bring relatives to collect corpses in time for burial, forced hospital authorities to dispose of the bodies before rotting." 39 Though discussion on this issue revolved around the discourse on cannibalism, behind 'Nyole anxieties was the fear that such burials went against notions of being and belonging since they were carried out outside Bunyore and without all the necessary burial rites and rituals.

As places where death occurred, hospitals were dangerous in another way. These were polluted and polluting spaces especially for pregnant women who were never "to see a corpse or be near one in this condition." 40 Second, many informants pointed out that "if a pregnant woman died in hospital in the absence of relatives, there was always the danger of the hospital staff burying her with the foetus still in her." 41 Third, there was great concern over the "disposal of lochial blood, the placenta, and the navel cord." This not only touched 'Nyole conceptions of the body and its continuity with the social unit, but also because "lochial blood and the placenta were supposed to be buried in a place where they could be prevented from scorching the earth and bringing dis-ease to people, and no sorcerer could work charms over them to put an end to the mother's fertility. Also on the disposal of the navel cord often depended the future life of the new individual: how could one be assured that all this could be observed in a hospital?" 42

The idea that doctors were amanani found winding its way in the 1940s and 1950s in the discourse on matandalwa or masinzaji, and it captured the continuing tension between Western biomedicine and African ways of knowing, on the one hand, and anxieties and uncertainty over the recent experiences with plague. This was exacerbated by typhoid outbreaks in the late 1940s and early 1950s, increased incidents of sexually transmitted diseases after the Second World War, and the Mau Mau famine of 1953. For
the AbaNyole in this period, nothing was more symbolic than the image of *Matandalwa*, a white male who, in the 1950s, was said to patrol roads at night in "a vehicle without windows and drained peoples' blood." 43 Told in the same breathe as those stories that filtered into Bunyore on *masima moto* (fire fighters) and their "death looking and wailing vehicles,"44 the discourse on *Matandalwa* represented something of a mythical passage from stories on postmortems, the material from which *em'pi* (M&B) was made, and death-dealing white doctors, to white males nocturnally patrolling roads, looking for live bodies. Needless to say, all these stories about cannibalism in hospitals, the manufacture of medicines from human body parts, and white males drinking peoples' blood along roads at night were officially discounted as the work of ignorant people and disgruntled African witchdoctors. How can this be explained?

8.4 Rumor and 'Nyole Experiences with Western Biomedicine

As experiences of suffering, but also as expressions of solidarity and reassurance in the course of events unleashed by both new diseases and Western biomedical practices, these narratives were as political as they were sociological. In the absence of any concerted explanation from the state why certain medical practices were necessary, these narratives constituted, first, "an attempt to anticipate and explain what the government was up to" so that people could take appropriate action whether this was in form of flight, evasion, or resistance (Arnold, 1993: 223). Second and flowing from the first, the narratives constituted a subtle "relation to authority" (Kapferer, 1990:14). As Jean-Noel Kapferer (1990:14) has suggested, by "divulging secrets, suggesting hypotheses," the narratives as rumor not only constrained "authorities to talk while contesting their status as the sole source authorized to speak," but also, spontaneously, vied "for the right to speak, no previous invitation having been made." Thus, like any other rumor, stories about cannibalism simultaneously involved "oppositional speech" since they remained
"unconvinced by official disclaimers," and triggered off what Patricia A. Turner (1993:23) has called "subliminal associations" whose symbolic meaning lay in the combination of "fundamental elements involving human bodies, death, eating, and ritual behavior."

According to Turner, when "symbolic associations between the most basic activities of food consumption and procreation" coalesce into a single pattern, they offer "insights into a given person's or people's attempt to develop a cogent sense of social order."

From this perspective, it can be argued that as experiences of suffering these narratives were not necessarily a way of degrading Western biomedicine. As Jean Noel-Kapferer (1990:138-139) has convincingly argued, to see such narratives as degradation is to assume that the "content of a rumor results from the destruction of the original truth... .This amounts to forgetting that often, there is no original truth: rumors result from a constructive process. Faced with an ambiguous event, the members of a group put their intellectual resources together to arrive at a satisfying definition of reality." Second, though these rumors were "garbled accounts of an unfamiliar medical technology," it was not only the nature and novelty of Western biomedicine that set them flying (Arnold, 1993: 223-4). Epidemics like plague and still more the state measures deployed against them "were seen to have a deeper meaning and to reveal the underlying intentions of British rule. In this effort after meaning, rumor pasted together in a vivid collage aspects of the current crisis" -- the disease, the burning of houses, the hunting of rat tails, and hospitalization -- "along with other disturbing or exciting scraps of news and gossip" (Ibid.) on, for example, how government-appointed chiefs were running mad or dying. All this brought out the question of social death since almost all the rumors were embedded in the general feeling that *silikali*, through *ekilauni*, was out "to finish us." 45 Seen as polluted and polluting spaces, such institutions as hospitals and, by extension, colonialism itself, were thus confounding. Death from this perspective was not necessarily the product of epidemics. Social death as the result of the interpenetration of boundaries elevated colonialism to probably the greatest
olubi (misfortune) the AbaNyole had encountered in recent times. It was thus not death, as a phenomenon, but the social crisis brought about by new diseases and by Western biomedical practices, that led to the heightened moments of anxiety and uncertainty in the years before the Second World War.

But, if 'Nyole perceptions of social death heightened anxiety and uncertainty over the dangers posed by such new diseases like plague, these perceptions were not very different from those of either the colonial state or Western medicine. Both the 'Nyole world and that which had been brought about by colonialism were, in their own ways, concerned with the preservation of human life. However, since Western medicine perceived things from an individualistic understanding of the 'Nyole world, it never saw 'Nyole concerns as cosmological concerns. It can be argued that the exclusion of 'Nyole cosmology in comprehending the meaning of disease to the entire community reduced Western medicine's concern to an ideological position that was in one way or another bound to conflict with 'Nyole ways of knowing.

Finally, by either pointing at the conveyors of 'civilization' and calling them cannibals, or claiming as one informant did that the AbaNyole were more lucky than their neighbors during plague's ravages, these narratives 'temporarily relieved anxiety and frustration' since misery found company and thus decreased (Kapferer, 1990:135). Thus, as Tamotsu Shibutani (1966:175) has pointed out, as collective adjustments to crises brought about by wholly new diseases and new medical practices, these narratives were "not just responses to events; they [were] also shaped in the reactions of men to one another . . . . All those who [were] involved in the situation alter[ed] their perspectives in consultation with one another. It [was] through communication that new experiences and modes of action [became] shared."

It can be argued that behind the mythical passage from dead to live bodies, the stories about cannibalism that re-emerged in the 1940s and 1950s in the discourse on
Matandalwa was a social discourse that exposed the relations between the AbaNyole and ekilauni during the colonial era. But this discourse, developed alongside a symbolic phrase, singa khasoto (like always), harked back to primordial symbols of disruption that call for the examination of, albeit briefly, the relationship between Mutoka's text in this chapter, and the story of Libokoyi and Olusaka in chapter three. Though Mutoka's text does not reproduce the tale in chapter three, the message in it, like the one in the tale, reproduces the same archetype, the same hidden, unconscious scenario. Even though it speaks about concrete facts, it largely draws on the imaginary in that it is very close to the popular tale in its approach. This observation is significant. Its significance lies in the fact that as narratives presented outside a written tradition, they allowed a remarkable degree of the condensation of past time through an appeal to the collectivity and an observation of substitutions. As Jean-Noel Kapferer (1990: 142) has argued, in rumors the "signified remains the same, while the signifiers change ... it reveals, behind the multiplicity of version, the permanent common ground, the message's thesis, i.e. the rumor's raison d'être." Thus, behind the apparent content of a rumor as people search for meaning is a second message. What was this message in the case of the AbaNyole?

The answer lies not in the content of the rumors but in, first, the place or culture in which these rumors circulated and, second, in the rumors' particular publics. If by condensing past time through the appeal to the collectivity and the observations of substitutes the AbaNyole were, consciously or unconsciously, falling back to what they knew best -- the use of symbols in conveying concepts that were beyond spoken words -- it was the oral part that carried the burden of narration, formulation, and conceptualization. At first sight, there in nothing mysterious about these narratives. But, looked at critically, the intense emotional satisfaction derived from them as they circulated had the effect of obscuring from the open cleavages and tensions colonialism had unleashed within the 'Nyole society itself. Most immediate to this study are, first, the position of African
therapeutic experts and what later became to be known variously as 'bush doctors', 'itinerary doctors', 'barefooted doctors', or simply medical quacks in the emergent medical social formation and, second, gender relations during such heightened moments of anxiety and uncertainty. Given that the AbaNyole conception of space was inseparable from ritual and gender ordering, it was inevitable that biomedical's social engineering was bound to produce tensions over these two aspects of 'Nyole life.

8.5 Beyond Rumor: The AbaNyole and Bora Afya

Though the establishment in Bunyore of such medical institutions as dispensaries was first mooted in the early 1930s, it was not until the 1950s that the government through the African District Council began to get fully involved, institutionally, in the area through the building of health and sub-health centers. A "fundamental principle of the health centre work", N.R.E.Fendall (1955:132) has written, was the provision of health education to the African rural people through, first, domiciliary visits by health workers, formal talks to village elders and headmen on matters pertaining to the prevention of the spread of epidemics, and the organization of special clinics for pulmonary tuberculosis, leprosy, and venereal diseases. Under the team leadership of a Hospital or Medical Assistant, this aspect of the new policy enlisted the services of other government departments like education, and coordinated activities at homecraft centers in matters that touched community development generally. Second, the health center oversaw, under the leadership of a midwife, the establishment of child welfare clinics both at the center and in selected villages. The midwife also coordinated visits which were either follow-ups of cases delivered at the health center, or as to many families as possible where the standard of health had been revealed by clinics, health education by the clinics to groups of mothers, or through previous direct visits to homes. Third, the health center oversaw the teaching of aetiology and the prevention of communicable diseases through the provision of pure water supplies.
This was done through the protection of water springs or the provision of shallow wells; the building of latrines, mostly pit, "and to see that they are used" (Fendall, 1955:152); improvement in housing and building generally; general sanitary measures; and the inspection of food premises like butcheries and eating houses. As Fendall (Ibid.) has pointed out, personal health service required "most supervision and it (was) this aspect that (was) regarded as the most important." Health Inspectors or Health Visitors were, by force if necessary, required to "get into the homes to prevent secondary cases of infectious diseases arising; experience (had) shown that it (was) at the time of sickness that the African (was) most likely to be receptive to advice on preventive measures." Lastly, the Health Center Concept emphasized team work through the holding of clinics in various villages throughout the district on a fortnightly basis.

Thus, based on the dictums get "into the homes of the people and teach them the right way to live," and "concentrate on health education all the time" (Fendall, 1955:154, emphasis mine), the health center concept was in Kenya revolutionary only in terms of both the time in which, and the gusto with which, it was applied in North (Kavirondo) Nyanza District. If the concept was borne out of the need to take "medical services to the people instead of the people having to come to the health centre", and it enabled "the centre to really attack disease and poverty with a view to their prevention and the promotion of a better standard of living" (Ibid. 153), it was, as an idea, certainly not new. This is the more so because, first, 'the health of the native' as an object of a specifically colonial medical science had throughout the interwar period occupied a central place in contestations over knowledge between, on the one hand, a British colonizing ethos and African ways of knowing, between 'science' and 'tradition' and, on the other, various shades of 'knowing' within this British colonizing ethos over what the colonial project was all about. Indeed, to get "into the homes of the people and teach them the right way to live" was, as a central tenet in the Health Center Concept, a fallback onto what A.R. Paterson (1931:310) had in
1931 diagnosed as the main psychological problem which faced the "hygienist and the statesman...in Africa...how to induce a will" in the colonized to "live better" since this was the motor force "without which improvements in agriculture and commerce will not give an adequate return." There was thus no fundamental difference between Paterson's observation in the early 1930s that the solution to rural health in Kenya lay in "instruction of the peasant in the techniques of living" (Ibid.) and what the advocates of the Health Center Concept stood for in the post-Second World War period.

Second, the principles upon which this concept was based were part of an early twentieth-century British discourse on the welfare of mothers and children. Organized around European middle class notions of motherhood, this discourse, along with the social, intellectual, and political baggage of British policies on maternal and child welfare, was carried by missionaries, teachers, and doctors, or what Barbara Ramusack (1992) has called "maternal imperialists", to the colonial world. According to Anna Davin (1978:12, 16-17, 52-54), these "policies were based on health officials' perceptions of infant mortality as a direct result of the 'failure of motherhood'." It was not by mere coincidence, therefore, that emphasis both in Britain and in the colonies came to be placed on hygiene and nutrition through education or the essentials of 'mothercraft' (Ibid.:39; fn.116).

Arriving in Kenya in the interwar period but reconstituted into the Health Center Concept after the Second World War, this discourse emphasized several objectives. First, emphasis was put on the building of ante-natal and child welfare clinics and on the teaching of the people that 'prevention was better than cure'. Second, domiciliary services for expectant mothers and for other illnesses generally were put on the top of the agenda for purposes of providing direct entry into peoples' homes. As a policy, direct intervention in the private domain of an African household was considered to be extremely important because, according to N.R.E.Fendall (1955:154), "health education begins in the home with the children and their parents, particularly the mother." Third, sanitary matters were
tied to therapeutic matters, the argument being that the coordination of the two spheres of health depended on the prevalence of communicable diseases like typhoid fever, meningitis, and tuberculosis as means of explaining the need for pure water supplies and pit latrines, proper ventilation in houses, and the dangers of overcrowding, respectively. Fourth, through the health center, health was propagated not only through education on all possible occasions, but also by example, because 'an ounce of example was worth a ton of advice'. Central to these objectives was therefore the notion that health education was 'the fundamental aim of the health center: trouble and time (had) to be taken to coach staff in the ways and means of putting this across'" (Ibid.:154).

Known in Bunyore as Bora Afya (good health), the implementation of this program took place against a backdrop of the incidence of serious diseases like the typhoid and ikhol'lo ya sipakali (whooping cough) epidemics of the late 1940s and early 1950s, and mounting incidents of what oral narratives call obulwaye bwe'siafrika (African diseases) or obulwaye bwo'khulokwa (diseases caused by witchcraft or sorcery). Thus, while most efforts were directed towards the protection of water springs and the drainage of swamps, the planting of eucalyptus trees to reduce water in such swampy areas, and the teaching of people that diseases were caused by ebichemusi (germs)47, there were raging debates among many AbaNyole over, first, the question whether these new activities were different from those which the government initiated and fully took part in during the plague epidemics. Second, questions were asked as to whether these new developments were fully equipped to deal with African diseases.

There was a consensus, for example, that though biomedicine had played an important role in fighting diseases like gonorrhea, typhoid, and whooping cough, African diseases were not amenable to such medicine. Thus, though Chiefs' barazas (palavers) had by the late 1940s and early 1950s become important fora for the dissemination of ideas about Bora Afya (good health), and inoculations, vaccinations, the protection of water
springs, and the drainage of swamps were the order of the day, ensorceration remained perhaps one of the most intractable health problems in Bunyore in these years. As one informant put it,

I go to Church because I believe in God. I consult a herbalist because our traditional medicine cures some diseases which when taken to hospital only speeds up your death. But I go to a hospital or clinic because I know their medicine works to treat certain diseases. So the three -- Christian faith, herbal medicine, and European medicine -- cure diseases whose causes can be understood by these three individually and differently. Not all diseases can be cured in hospitals and also not all diseases can be treated through prayers or by herbal medicine. For example obulwayne bwo'khulokwa is best treated by a herbalist or through omusango (ritual sacrifice). Obusula or ebikhokho can only be treated by an African specialist because in this type of disease white medicine can only make it worse.

Felesta Hoka Chapia, a retired nurse who operates a private clinic at Ebuyangu in West Bunyore, and Rael Nyangweso, an 'itinerary doctor', agree. Trained in Western medicine as nurses, both Hoka and Nyangweso argued that though this therapeutic tradition is the best thing that ever happened to the ABA Nyole, there are certain diseases that can only be diagnosed by an omufumu (diviner) and treated either through an omusango (cleansing ritual), or by a herbal expert. Most of those interviewed and who claimed to be God-fearing Christians did not however agree with this position, their argument being, as one of them put it, that "the so-called traditional healers are liars who feed on their clients' misfortunes." According to this informant who is a former employee of the East African Community, retired primary school teacher, and presently a lay preacher with the Church of God Mission, he lost his "confidence in traditional healers because of the experience we had with them. Our first born died in their hands. Every healer claimed to know the cure to her illness and all the cures they claimed to know never worked."
Speaking from personal experience, Archbishop Festus Olang' (retired) of the Church Province of Kenya (Anglican) was of the opinion that the reasons given by those who discredited traditional medicine were not a true reflection of the work done by traditional medical experts. According to Olang', these are the same reasons given by missionaries who "heavily punished those who sought treatment from traditional healers. Missionaries were hard pressed in understanding that herbal medicine did work." For example,

my office clerk had an accident in which he broke his hand. He was taken to hospital where the hand was put in plaster. But when the plaster was removed, serious defects were discovered. His parents literally invaded the hospital and threatened to beat me up. I was so scared I had to invite elders to tell them what had happened. After the meeting we decided to try an African bone-setter from Ebusakami. This expert used some herbs mixed with ghee to rub and massage around the affected area after which he tied sticks all around the hand. After some days he removed the sticks and to the amazement of all the abasomi (Christians), the hand had straightened and healed! When I told Dr. Leech about this he decided to invite the bone-setter to the hospital but Leech was disappointed because the man refused to answer any questions relating to his knowledge. This was because, he later said, he did not want the white man to steal his knowledge. He further said that this kind of knowledge cannot be productive if one was profit-minded; he could only transfer it to a trustworthy member of his family.... He gave it to a woman relative before he died.52

Asked in 1991 by Mary Nyangweso (1992:105-106) what he thought about the relationship between the teachings of the Church and 'Nyole beliefs in ancestral spirits, Archbishop Olang' was unequivocal in his answer. According to the Archbishop as quoted by Mary Nyangweso, it required "strong faith in God and great courage to be able to counter the power of spirits of the dead." To prove this, Olang' in his formative years as a Christian challenged his 'parents' traditional belief in ancestral spirits by going to the shrine and touching the shrine rod. According to the Abanyole, it is a taboo for anybody to go to the shrine and touch the shrine rod. Only the traditional priests are allowed to go to the shrine when making sacrifices . . . . There was no effect on him as Abanyole traditionalist (sic) would have expected."
To Olang', therefore, there was a big difference between the belief in ancestral spirits and the efficacy of traditional therapeutic practices. But belief in ancestral spirits, like in witchcraft, has persisted among some Christians. As Mary Nyangweso (1992:86-87) found out in 1992, many Christians still visited "witchdoctors to treat illnesses believed to have been caused by witchcraft." She recorded the following from JohnCanon Ogendo, one of her informants:

As a Padre who has been in office for twenty eight years, I know what I am talking about. Let me tell you one incident. One day we had a Padre's convention. I will not tell you where it took place but I want you to get the message. In this convention, both Anglican and Church of God Padres met to discuss some issues affecting the Church .... After the agenda, we had what we call the A.O.B. At this time one Padre belonging to the Church of God ... stood up. He said he had a personal problem which he wanted to share with the rest of us. We were ready to listen to him. So this Padre told us how sinful he was because he practiced witchcraft. He explained that he had been a witch and continued to be even after converting to Christianity. This shocked many of us. I laughed and asked him, 'Do you still believe in witchcraft?' He answered that it was the devil's work.

Well, since he was repentant, we prayed for him and asked God to forgive him. Later we proceeded to his home to burn his witchcraft items. I do not fear witchcraft so I volunteered to burn these items. We all gathered around these items then I lit fire which burnt them. You know what! As the smoke blew up towards the people they continued to sing the tukutendereza song which we were singing in praise of God while most of them dispersed unnoticed to their homes. They feared that such a smoke could affect them .... What am I saying? I am telling you that even among the Church leaders, there are those Christians who believe in witchcraft.

What can we make of these examples? What do they say about Western biomedicine, as a discourse-in-the-making, and its relationship to African therapeutics?

It seems that the recently converted AbaNyole were, in public, agreed on the fact that the basis of 'Nyole backwardness lay in the peoples' fatalistic belief in ancestral spirits. In this case certain 'Nyole perceptions of disease causation were discursive metaphors for this backwardness. But these perceptions were not a given since they were, in private, extremely important in the definition of the boundaries between life and death, between Christianity and 'Nyole cosmology, between science and tradition. Thus if, in public,
preachers sought to win followers through the denigration of popular beliefs on disease causation, this was effectively done through the appropriation of the language of biomedicine that saw belief in witchcraft as a basically psychological problem. Informants like Dr. Ouya, Archbishop Olang', and lay preacher Litaba Imbaya were quite unequivocal about this. However, there were also moments of articulation and condensation which, by appreciating the importance of both African and Western therapeutic traditions, brought out instances which showed how meanings about the two traditions were liberally appropriated to explain why this or that tradition was better than the other. There were cases in such instances whereby people turned to herbalists and made no secret about it so much so that the much the Church could do was to "turn the other way and pretend that nothing was happening." 53

It can be argued that what has in anthropological and historical scholarship been described as medical pluralism in Africa is not just a definition of the relationship between two therapeutic traditions. According to the evidence we have adduced in the case of Bunyore, medical pluralism also occurred at sites between and within the same therapeutic system. There were, and still are, stories about certain biomedical doctors capitalizing on the 'Nyole strong belief in injections to the extent that they gave 'water' instead of 'real medicine' to their patients. This, together with the examples we have given above, raise a crucial question about the position of African therapeutic experts, as well as that of those people variously described as 'barefooted doctors', 'itinerary doctors', 'bush doctors', quacks, or simply daktari (doctor) in the emergent medical social formation. It can be argued that once banished to the periphery or underground, African therapeutic experts, like sacrificial rites and practices, ceased in the colonial period to be regular community activities. If this was the case, they also, in the process, ceased to be mere continuations of pre-European practices.
The examples we have given above, together with the moments they capture and portray, are indicative of the fact that the career of biomedicine in Bunyore was not a monolinear enterprise: it was at once complicated and transitory. Furthermore, these examples shed a good deal of light upon the more confusing and haphazard processes at work. Illustrative of this is the way in which 'itinerary doctors' or daktaris accepted everything about biomedicine, including this therapeutic system's rituals, yet, quite ironically, applied and used them in ways that had more in common with African clandestine practices than with what they had learned in nursing schools. Apart from being far removed from the learnt theorizing of their urban colleagues, most of these individuals were empirical in orientation; did not keep account books or records of their patients' illnesses; had cultural similarities with their patients who paid them (the daktaris) in kind; and tended to rely on familiar 'Nyole diagnoses of disease. Symptoms were described to them by their patients and, more often than not, they were translated into modern medical terms and consequently treated thus. However, some relied on plant-based remedies as most of them knew, and insisted, that there was a difference between African diseases and those diseases that could be effectively treated by Western medicine. Thus, they were sensitive to what the AbaNyole thought to be unpopular medical technologies like family planning.54 But, most crucially, a consideration of the daily activities of these individuals shows that apart from working and living among peasants, they also operated in that space that was, and still could, accommodate the traditional healer. What does this tell us? Before answering this question, a few case histories will be in order.

Nelson Nanga Esikuri was born in 1922 at Eb'bayi Esirabe village, Eb'bayi Sub-Location, North Bunyore. After his primary education at the local school, he joined Maseno Junior School in 1940 and, in 1941, was admitted at Maseno School. In 1943 he quit Maseno School "because of lack of school fees" and joined the East Africa Army Medical Corps where he trained as a nurse. When he was discharged from the army in
1946 he got a job as a nurse at Kisumu District Hospital. He resigned from this job in 1958 to go home "and help my wife run the home and see my children grow." Though he never set up a formal clinic where he could put his nursing knowledge to work, he has since his resignation been involved in "the health of the people in my village." Operating from his house in the village, Nelson's clients have always been teachers, farmers, local administrators, and urban dwellers who pay occasional visits to the village during holidays. Since 1958 his popularity has "spread far and wide in the village because of my proximity, accessibility, and knowledge of the village and the health needs of the people. My patients come to me or I go to them when asked to." Though he uses all sorts of medication, he is careful to point out that there are certain drugs like M&B which he doesn't use because they have "been declared not safe because they lead to heart problems among patients." He however has in his pharmaceutical arsenal anti-biotic capsules and all types of popular remedies which, alongside injections, have endeared him to his clients. Though he approves of the efficacy of herbal medicine, he rarely refers his patients to herbal experts. Nelson's activities as a daktuari are not treated as a profession since he is also a farmer and village elder who is consulted on all sorts of issues that range from the settling of disputes in the village and dowry negotiations in a villager's daughter's or son's marriage.55

Julius Tianyi Eupilia, like Nelson Nanga Esikuri, was a nurse in the East Africa Army Medical Corps between 1941 and 1946. He trained as a nurse orderly at the then General Hospital, Kabete (now Orthopaedic Center, Nairobi) between 1941 and 1942. After seeing action as a nurse with the 40th Uganda Battalion in Sir Lanka and India (West Bengal) between 1942 and 1944, he was discharged after which, in 1948, he joined Medical Training School in Nairobi as Hospital Assistant. In this same year he was transferred to King George (now Kenyatta) Hospital. Between 1949 and 1978 he worked in several hospitals in the country, including Nakuru Provincial General Hospital (1949-1955), Eldoret District Hospital (1955-1960), Nyanza Provincial General Hospital in

Also a farmer, church elder, and chairman of the Board of Governors of Ebusiratsi Secondary School, Julius, unlike Nelson, is an avid reader of medical literature and attends seminars on all sorts of medical issues. His patients come from as far as Kisa, Maragoli, and Idakho and he attributes this to the fact that unlike medical quacks "who know nothing about modern medicine because they learned about what they are doing by heart," he is a good doctor and "everybody knows about this." To Julius, all or most of the so-called itinerary doctors "had no proper training. They could have been working as grounds men or as cooks and sweepers in hospitals, and through seeing what doctors did they thought they could do the same. These are practitioners that can easily infect one with AIDS through unsterilized syringes." Julius has no room in his world for herbalists, either, because "they mishandle their patients, have no knowledge about dosages, and they always claim they can treat diseases they know are beyond them. This has always led to people's suffering, or even death. According to Julius, he uses Western medicine not only because he believes in it, but also because he can only use herbal medicine "if the Kenya Medical Research Institute (KEMRI) says such medicine is efficacious." According to Julius, there are no such diseases called African; this belief is mostly "propagated by women the reason being that they are women who want to think that they can bewitch anybody including their husbands." How is he paid by his clients? Because money is not easy to come by in his part of the world, "I occasionally accept a bunch of bananas, maize, beans, or anything the patient can use to clear his or her debt." 56

Leah Otieno, a herbalist of great repute in Vihiga, Kisumu, Siaya, and Kakamega Districts, was forced to quit school after two years of education because of "a medical problem in my right leg. When I was pulled out of school I was taken to all types of
hospitals in this region. When my parents realized that no hospital could handle the problem they decided to take me to Tanzania where I was finally treated by a herbalist. I was fourteen years. By this time the disease had eaten me so much that I have since remained a cripple." According to Leah, three things contributed to her decision to become a herbalist. The first and obvious reason was that it was herbal and not Western medicine that saved her life. Second, she got a lot of encouragement from her grandmother who was a well known medicinewoman in her area. As a child Leah used to assist in collecting herbs in the nearby hilly places in her home area in present-day south Bunyore. Through this she was exposed to "various medicinal plants that have served me well in my career." Third, after her treatment in Tanzania she decided to further her knowledge through apprenticeship in places like Ugenya in Luoland, Nakuru, and Ukambani. Because of the experience she has amassed through the years, she gets patients from "all over Western Kenya. Most of these people come to me after hospital medicine has failed to cure them. I am their last hope." Like the itinerary 'doctors', she accepts payment in any form though she has never had problems with this since all her clients know that "once they disappear with my fee the medicine won't work."

Though practitioners of biomedicine have dismissed her as a liar and "a person who capitalizes on my condition as a cripple," Leah says that she has absolutely no problem with Western medicine. This is the more so because there are "all types of diseases in this world and if one or the other type of medicine works then we shall have all contributed to the health of our people." According to Leah, "it is common knowledge that diseases like obusula or ebikhoko (the bad eye) don't agree with injections. If you inject a person suffering from these types of disease that person will sure die. Are we wrong to step in and treat such a person?" 57

Mzee Gabriel Okunda, like Leah, is a licensed traditional doctor. He acquired his knowledge from his grandfather "who was a famous medicineman before Omboko (white
man) arrived in this part of the world." Gabriel has no formal education though he "studied briefly with Roman Catholics at Juja in Central Province when I was pursuing a religious course." He started practicing his trade in 1922 when his grandfather, the man he always accompanied on various healing missions, died. According to Mzee Okunda, he was "born with a stone in his hand," a sign that he was not only the chosen one to take over from his grandfather but also because God was "behind all these arrangements that I should be a healer." When his grandfather died he was taken in by the latter's friends "who wanted me to add onto what the old man had taught me." However, since his healing powers "are God-given, I must always pray first before administering any treatment. That is why, as a devout catholic, I must always have my crucifix on before embarking on the treatment of a patient." His work, but also the need to increase his knowledge in both medicinal plants and "other healing technics" have taken him to Mbale and Gulu in Uganda, Arusha in Tanzania, and Kinshasa in Zaire. He has also kept abreast with changing disease profiles, as well as with people's changing medical needs. The medicineman also uses modern methods of storing his pharmaceutical arsenal like the "use of clean bottles because we must change with the times." He does not venture into treating diseases he does not know, like AIDS "which started at the coast when some Mswahili decided to rape a fish called papa (mermaid)." His patients include "barren women, those who have been bewitched, and impotent men. I also treat snakebites using the Malindi stone that sucks poison from the bloodstream." Though Mzee Okunda was vague in his answer to the question of who Zainabu and Musa, the 'people' he kept consulting before answering any question during the interview, were, it was clear that these were what his neighbors called amajini (genes) which he acquired on his many trips to Malindi at the Kenya coast.58

From the foregoing it seems that, first, despite the emphasis put on biomedicine by both the colonial state and Christian missionaries, there were doubts about its efficacy, doubts which were instantaneously turned by many AbaNyole into situations of the
triumph of African 'ways of knowing and doing' over those brought by *omboko* (the white man). Second, the above case studies demonstrate how itinerary 'doctors', Western biomedical experts, and African healers negotiated the twentieth-century therapeutic terrain in an economy of make-shifts. Third, we are introduced to the problem of the conflation of economic and social issues, as well as moral thinking in the fast-changing 'Nyole society. This issue becomes even more pertinently so over what constituted medical quackery as emphasized by people like Dr. Ouya, a biomedical expert, and Litaba Imbaya, a former school teacher-turned-preacher. Where does one draw a line between genuine concerns on the part of itinerary 'doctors' and their clients, on the one hand, and Christian and biomedical attempts to denigrate the competition of these healers, on the other? To preachers like Imbaya, but also to biomedical practitioners like Ouya and Espilal, quackery constituted a threat to peoples' health and its practitioners were not different from herbalists and/or what they described as witchdoctors. 59 But most AbaNyole's position was that the services provided by these 'doctors' were cheap, accessible, and the practitioners were "of their own." 60 Furthermore, it was argued, apart from accepting to be paid in kind, these individuals could tell whether a patient was suffering from a disease that could be treated in hospital or from *obulwaye bwesia frika* (African diseases) and could advice the patient accordingly. From this perspective, what was in the eyes of people like Ouya and Espilal a question of malpractice that threatened the health of the AbaNyole was to these same AbaNyole a foreign concept. But itinerary 'doctors' had their own discourses against not the herbalists but their counterparts in the biomedical mainstream, especially Indians. As one of them put it, most of these doctors were "crooks since more often than not they gave half doses or diluted medicine to their clients so that they could keep going back." 61 To these 'doctors', in such cases the interest was not the health of the people as they wanted everybody to believe but economic.
Last but not least, these examples draw our attention to the relationship between biomedical practitioners like Ouya and the state, on the one hand, and the place of what scholars like John Janzen (1978) have come to call therapy management groups in the emergent medical social formation, on the other. One thing that was disturbingly clear during fieldwork was how biomedical practitioners always appealed to the State to either check on the activities of itinerary 'doctors' because they were both a danger to the health of the people and that they looted government pharmacies, or drive them from the market the way traditional healers had been. This appeal tells us at least two things. First, these individuals were either downplaying the importance of these 'bush doctors' in maintaining the health of the people, thus missing the whole point about the intricacies of health, or failed to understand 'Nyole experiences with Western biomedical therapies and new illness, as well as 'Nyole ideas about disease and its eradication. Second, it tells us a lot about biomedicine, in general, and biomedical thought and practice in particular. It can be argued that the appeal by biomedical practitioners to the State to check on the activities of the so-called 'bush doctors' was both about the protection of a profession, and about the propagation of the idea that in the final analysis it was the government that was responsible for the health of those it saw necessary to govern. Here the issues involved draw our attention to what biomedicine, as a profession, thought about the State and its role in maintaining an interventionist stance in health affairs among the peasants, but also to the webs of signification and meaning about health, illness, and healing in Bunyore. The issues thus reveal not only the processes involved in the construction and maintenance of social and political relationships, but also many of the non-medical factors people took into account when choosing a healer: friendships, patriarchal relations, and economic or social status. Patients went to either 'bush doctors' or herbalists as much for their qualities as mentioned above, as for their knowledge in mediating them. From this perspective, medical care or services as provided by these individuals was apparently not predicated on
notions of exchange of goods and services. Thus the itinerary 'doctor' or the herbalist, whether under or above ground, increasingly came to occupy a circulating center of power that looked back to the 'Nyole idea of community as opposed to the emergent notion of individualism that was propagated both in biomedicine and in the commodification of the 'Nyole peasant society.

If these issues tell us something about the social constructs the AbaNyole confronted in their everyday experiences with Western biomedicine, they also, by the same token, show how meaningless either State legislation or Christian preaching against herbal medicine and 'itinerary doctoring' was to the people. This was the more so because what was in these circles seen as the medical dangers emanating from either herbal medicine or 'medical quackery' had completely different meanings to the majority of the AbaNyole. The mere fact that biomedicine as a discourse-in-the-making developed a language to denigrate other ways of knowing did not erase these ways by merely naming them. As Mary Lindemann (1992:163) has pointed out in another context, a biomedical quack was "an interloper, but not necessarily or even usually an incompetent. It was his very proficiency that was to be feared."

But if there were debates and controversies over the meaning and place of both African therapeutics and medical quackery in the emergent medical social formation, these were not as intense as those that came to surround the concept of Bora Afya in the post-Second World War period and beyond. This was so because while the issues involved in the debates on African therapeutics and medical quackery more often than not centered on the essence of biomedicine for the entire 'Nyole community, those that revolved around Bora Afya brought to the fore questions about gender relations both within the community as a whole and within 'Nyole household complexes.

There was, at the end of the Second World War, an alarming increase in obulwaye bwa'bahkasi (women's diseases like gonorrhea) which the AbaNyole attributed to the
breakdown of morals and the rise of prostitution; the development of new transportation networks and amatulela (trailers) plying these networks; and the growth of towns like Kisumu, Kakamega, Busia, and Luanda. These diseases were also said to have been brought about by returnee AbaNyole soldiers who had participated in the second World War. Why was this category of diseases called obulwayne bwa'bakhasi? In bars and tea rooms, at funeral wakes, and at formal church gatherings before and after service, answers to arguments touching sexually transmitted diseases after the Second World War always ended up with the question: who was responsible for the spread of these diseases, in the first place, in Bunyore? Were both men and women to blame? If men and women were equally responsible, then why didn't people also talk about obulwayne bwa'basatsa (men's diseases)? The answer to these questions, especially in places where only men were involved in discussions, was once powerfully captured in a Kiswahili symbolic phrase in a bar at Luanda: ugonjwa ni maumbile (disease is the way a body is made). This bar patron went on to argue that the constitution of the female body is not the same as in men that is why they were good at spreading these diseases. This rendering of female sexuality almost immediately brought to mind Shem Tube, a musician from North Bunyore, who had once sang that abakhana 'halahi hasila 'mang'ana (behind every beautiful woman lurks danger). Why is it that, in this period and beyond, so much attention came to be focused on women?

Part of the answer to this question lies in how Bora Afya, but also rumors on the nature of biomedicine during the plague years, had, consciously or unconsciously, brought into the open long simmering anxieties over gender roles in Nyole society. By targeting the domestic sphere as the best place of entry into this society, Bora Afya put women into the spotlight not only as the object of the recently reconstituted colonial medical gaze, but also as the source, at least in the eyes of Nyole men, of misfortune in society. Colonial medical authorities could, in the name of good health, teach Nyole women kitchen gardening, knitting, house-keeping, how to nutritionally and hygienically bring up
children, and, increasingly, how to be good mothers and housewives. They could also, through the use of terms like *abakhaye*, meaning women of substance, extol 'Nyole women to accept this program. Indeed, phrases like *abakhaye murake tsimboka* (ladies, you should plant vegetables) became magical catch phrases not because they conveyed new ideas: after all kitchen gardening had always been the work of women. The magic lay in the term *omukhaye* which in pre-European days had been used to specifically endow respect to the first wife or any woman beyond childbearing in the homestead. The term, in the late 1940s and early 1950s, came to bestow status on all women and hence became a major conduit for domiciliary medicine. Built on more or less similar schemes the Church Missionary Society at Maseno and the Church of God Mission at Kima had started in the 1920s, *Bora Afya* encouraged mothercraft as it spoke against the culture of promiscuity among African women. There definitely were differences between the missionary schemes of the 1920s, and what the colonial government was trying to implement in the 1950s. For example, while in the 1920s missionaries addressed questions that dealt mostly with ante-natal care and how a good Christian also made a good mother like Mary the mother of Jesus Christ, 76 colonial attempts in the late 1940s and the 1950s to see maternal and infant welfare in terms of public health not only brought the Church and the State together, but also tied questions about health to specifically social and environmental problems. This alliance not only shelved interwar differences between the two institutions, but also led to joint efforts in working out new educational schemes geared towards the making of good mothers out of the 'African native woman'. This was a development that saw education on health and hygiene as the harbinger of change, but also as a point of departure in addressing long neglected questions on the dislocating effects of migrant labor on the African family.

In the 1930s and 1940s migrant labor as a dislocating force on African women had been talked about in terms of *abakhana bakatula* (girls who had severed their social stations
in life) or *abakhala* (traders). As a metaphor for prostitutes, *abakhala* stood for what was
outside society and, hence, as a signifier of both moral degeneration and uncontrollability,
it represented what Megan Vaughan (1991:144) has called "shorthand for a number of
related problems" that included "changes in property rights, in rights in labor and relations
between generations." But "the real issue ... was that with far-reaching changes taking
place in economic relations, so enormous strains were placed on both gender and
generational relations....[T]hese complex changes were described in terms of degeneration,
of uncontrolled sexuality and disease." It is, therefore, not surprising that when
missionaries and colonial authorities teamed up in the late 1940s and early 1950s to address
the health problem in the African countryside, the program of how change should be
brought about revolved around social diseases, poverty, ignorance, economic
backwardness, the unhygienic practices of native midwives, mothers' careless and
irrational feeding of infants, and superstition. It can be argued that by linking these issues
to the problem of public health in the countryside, colonial medical authorities and
missionaries, especially the former, were trying to find new ground for a new moral order
that would go well beyond the early colonial state's conquest stance. The conquest state
had, in its search for order before the 1920s, relied upon institutions like chieftainships
(recently invented or otherwise) to mediate gender conflict, "shaping gendered boundaries
and reformulating gender subordination" (Allman, 1994:28). Thus, though indirect rule in
this period used chiefs to provide administration "on the cheap" and to legitimate the
colonial enterprise, it also "facilitated colonization of the domestic realm -- the world of
marriage, divorce, adultery, childbirth and death...."

In this period the institution of chieftaincy "provided the political framework" in
which gender crises were addressed. In the period of the second colonial assault, that is
during the interwar period and beyond, "women's education, mothercraft and maternal and
child welfare efforts provided a social framework" which, after the state and the church
merged their efforts, authorized in the name of civilization the direct entry of medical personnel into the African private world. This was ekwandiangu (the backyard) which, as a liminal space lying between the oluhia (nation) and the esitsimi (the wild), was "the world where children were born, the sick were healed, meals were cooked, babies were bathed, marriages were negotiated, and deaths were mourned" (Ibid.). The capture of this sphere was therefore essential to the social transformation which the colonial project envisioned in its second assault stage. As several scholars (Ramusack, 1992; Comaroff and Comaroff, 1992; and Hunt, 1988, 1990) have been arguing, and Jean Allman (1994:25) has recently reiterated, as part of the larger discourse on hygiene and nutrition, the discourse on motherhood, maternal, and child welfare did not "require any critique of the economic or environmental effects of colonialism on maternal and infant welfare, but could be marshaled against a host of social problems, from population decline and infant mortality, to sexually transmitted diseases, prostitution and adultery."

But if this discourse initiated a shift in the way education was perceived in colonial and missionary circles, its centerpiece that sexually transmitted diseases were the result of the failure of African women to recognize their role as good mothers and good wives dovetailed with anxieties among 'Nyole men over their women who had become abakasi bachendani, meaning women with no fixed abode. This was a direct reference to notions of patriarchy, and how the slipping away of women from the jurisdiction of their fathers and husbands was the result of colonialism. Thus, like the missionaries and the colonial administration, 'Nyole men came to intimately link the incidence of venereal diseases with these 'women with no fixed abode', thus bringing out, as it were, the hidden script in the rumors that did the rounds in the colonial period. It did not matter whether such women were staying with friends, or having gainful employment in such towns. This feminization of pestilential tragedy was something of a re-invented notion of indwasi (diseases caused by female reptiles), and it spoke to, on the one hand, the 'Nyole man's search for his
quickly receding patriarchal past and, on the other, a moment of truth *confirming* that what was new was always dangerous.
Endnotes

1 This phrase translates as "development is death" and is an inversion of the tenets upon which Westernization in Bunyore were based.

2 This translates as "the clever ones these days bathe with their clothes on," and is a rendering of the pretensions of Westernization in Bunyore.

3 Oral Interview, Eliakimu Mutoka, Em'mang'ali Ebusamilia, North Bunyore Location, 27th September, 1992. The phrase translates as "those who have gone in the ground have refused," meaning the departed or the dead don't approve of the way the living are carrying on with their everyday activities.

4 The famine of omukolokolo, so-named after the one kilogram tin which was used as a measurement devise during the 1983-1984 famine.


9 Oral Interview, Eliakimu Mutoka, loc. cit. In the course of this interview in was learned that Mutoka, about 80 years old, had two sons and one daughter. The first son died in the 1970s from what the old man thought was powerful obutwaye buloke (witchcraft) while the second son died in 1989 from what he variously called eiti, obukhonyi, obwamunane, or musaada. The wife had died the previous year from some unknown disease.


14 Ibid.

15 Attraction here does not necessarily mean acceptance.


17 Oral Interview, Taisi Mukabi, ibid.; Mang'ong'o Mahanga Odalo, loc. cit.; Esialimba Amakoye, Em'mang'ali Ebusamia, North Bunyore Location, 29th. December, 1992; Elkana Atila Amuyunzu, loc. cit.

18 Oral Interview, Omukambi Glaid Nyamweya, loc. cit.

19 Oral Interview, Mang'ong'o Mahanga Odalo, loc. cit.
20 Oral Interview, Mang'ong'o Mahanga Odalo, *ibid*.


22 The Foundation of the Mission Station at Kima Bunyore - 1905, n.d. In the possession of Ex-Assistant Chief James Nasiali Om'muli, Ebunangwe Sub-Location, North Bunyore.

23 *Ibid*.

24 *Ibid*.

25 Minutes of the Education Committee of the Church of God Mission meeting, May 12th., 1951. In the possession of Ex-Assistant Chief James Nasiali Om'muli, Ebunangwe Sub-Location, North Bunyore.

26 Oral Interview, Eliakimu Mutuka, *loc. cit*.

27 Oral Interview, Mang'ong'o Mahanga Odalo, *loc. cit*.

28 Oral Interview, Dishon Aywa, *loc. cit*.

29 Oral Interview, Dr. Gabriel Okunda, Ebuyangu Sub-Location, Ekhakamba Village, West Bunyore Location, 14th. November, 1992.

30 Oral Interview, Dishon Aywa, *loc. cit*.


33 *Ibid*.

34 Oral Interview, Henry Akhwaba Otima, Em'mukunzi Sub-Location, North Bunyore, 8th. November, 1992.

35 Oral Interview, Dr. John A. Ouya, *loc. cit*.

37 Oral Interview, Justus Mukabane, loc. cit.

38 Oral Interview, Dr. John A. Ouya, loc. cit.

39 Ibid.


41 Oral Interview, Phoeb Musumba, Em'mukunzi Emakunda Village, Em'mukunzi Sub-Location, North Bunyore Location, 21st. November, 1992.


44 Ibid.

45 Oral Interview, Mang'ong'o Mahanga Odalo, loc. cit.

46 Oral Interview, Rufus Teka, loc. cit.

47 Oral Interview, George Malema, Emakunda Sub-Location, Em'mukunzi Village, North Bunyore Location, 10th, November, 1992.


49 Oral Interview, Konzolo Lutenyo, ibid.


53 Ibid.

54 Oral Interview, Felesta Hoka Chapia, _loc. cit._


58 Oral Interview, Dr. Gabriel Okunda, Ebuyangu Ekhakamba, West Bunyore Location, 14th. November, 1992.


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