CONTINUITY AND CHANGE IN INDIGENOUS HEALTH CARE SYSTEMS AMONG THE MAASAI OF KAJIADO DISTRICT, KENYA, 1850-2002.

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DECLARATION AND RECOMENDATIONS

Declaration

This thesis is my original work and has not been presented for examination in any other University.

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Recommendation

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DEDICATION

To my family and friends for their continued support and encouragement. I offer my regards to all who supported me in any respect during the study and completion of my thesis.

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ABSTRACT

Indigenous health care includes diverse health practices, approaches, knowledge and beliefs, as well as procedures and rituals applied to treat, diagnose or prevent illness. Indigenous health care systems are important in many African communities. They have not only enabled people to maintain healthy lives but also to cope with emerging challenges. But indigenous health care systems, like any other social phenomenon, are affected by ecological as well as socio-cultural factors. Indeed indigenous health care has been affected by several factors. For instance, the colonial administration in Kenya introduced policies that undermined and redefined indigenous health care systems. The introductions of Christianity and Western medicine as well as the spread of new diseases are some of the factors that have influenced indigenous health care systems. Despite these challenges the Maasai indigenous health care system has been resurgent. Health care systems are embedded in the social system of meaning rules for behaviour. How people view health is indicative of their own cultural norms, values, practices, and beliefs, which are culturally constructed. Health is thus shaped by cultural and social factors governing perceptions, explanations and value of experience over time. Though the Maasai indigenous health care system is fairly old, it has been influenced by Western medicine as well as political and social changes. The interaction (articulation) of two different systems of health care coupled with social, economic and political changes have led to a redefinition of indigenous health care among the Maasai of Kajiado. Articulation of modes of production theory was used in analyzing the interaction between aspects of the Maasai indigenous health care system with those of modern medicine. The methodology of the study included collection of both primary and secondary data as well as archival reading and field work. Informants were selected through snowball and purposive sampling procedures. The study utilized internal and external criticism for data analysis. This entailed examination of sources and oral narratives collected through field interviews. The primary information was incorporated with information from books, journals, newspapers, magazines, and seminar papers. It is hoped that the information in this thesis will contribute to the debate on the place of indigenous health care systems in the contemporary world.

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GLOSSARY OF TERMS

Oloiboni (pl.*illoibonok*):	refers to a traditional healer among the Maasai. The word is often spelled as *Oloiboni*.
Orkuma:	A black magical stick which is believed to automatically pass on healing, divine, and prophetic power to a successor.

DEFINITION OF TERMS

Indigenous Health Care system: Includes diverse traditional health practices, beliefs and knowledge, as well as procedures and rituals used to treat, diagnose or prevent illness

Modern/Western Medicine: This is used to mean a health system that is based on modern science.

Traditional Medicine: The totality of all knowledge, used in indigenous health for diagnosis, prevention, of physical, mental or social imbalance and relying exclusively on practical experience and observation handed down from generation to generation whether verbally or in writing.

CHAPTER ONE

INTRODUCTION

Before the arrival of the Europeans, in a long sequence of movement and adaptation, the population of East Africa had begun to establish their present social and economic structures. The experience of colonial rule modified this to some extent but did not fundamentally alter the structures laid down by 1900. Though the political and economic structures introduced during the colonial and post- colonial period did not replace the existing ones, they played an important role in determining the process of health and healing in most African communities. Health is rooted in the cultural order of a society and any changes in political and economic organization affect health systems.

What is perhaps of interest is the articulation of the two different structures in the African experience in the face of colonial forces. How did they perceive and deal with the situation? How did colonial policies, biomedicine and Christianity influence indigenous structures? Were Africans passive recipients of colonial ideologies? Through the Maasai experience, the study examines change and continuity of indigenous health care system in the face of colonial factors. According to Janzen changes in health care cannot be understood apart from changes in control over political institution and economic organization. The changes in the political and economic organization are associated with changes in health and healing is forced to provide meaning to the changing reality.

Colonialism was concerned with construction of its own rule and legitimacy of its authority and control. This provided space within which its general structures and ideologies penetrated the African Society, as they were presented as superior. This ideology shaped the discourse of colonial medical science, of self-definition above indigenous medicine. Africans were seen as disease stricken and under threat of extinction (Maasai) and their health care backward/primitive. These perceptions and experiences shaped the way the Maasai engaged in the search for health and well-being in a variety of ways and at various times. Thesis argues that the establishment of colonialism as a cultural enterprise is inseparable from rise of biomedicine and spread Christianity. Biomedicine was both a cultural force as well as a tool of colonial control; Christianity was also a part and parcel of colonialism in trying to domesticate the realities of the ‘dark’ continent.

1.1 Background to the Study

Health and healing are an integral part of any society. Every community has developed ways of dealing with serious misfortunes, diseases and the threat of death. The historical analysis of conceptions of health and healing in many traditional African societies offers an interesting avenue for the study of the contradictions and ambivalences within definitions of medical knowledge and the concept of disease. Indigenous medicine and knowledge in African society brings to mind the challenges of writing and investigating the therapeutic knowledge of indigenous societies and provides important suggestions for the study of indigenous medicine and knowledge systems in Africa. Therapeutic knowledge is about culture, and adds to our understanding of the resilience of indigenous practices in contemporary Africa.

Indigenous health care includes diverse health practices, approaches, knowledge and beliefs, as well as procedures and rituals applied to treat, diagnose or prevent illness. Before the colonial period African societies have had systems of health care that took care of diseases, ailments and injuries of the people. In most societies, both general and specialized medical knowledge existed. Particular individuals or a select group practised specialized knowledge, while the whole community practiced the general health care like cold and headache treatments.

In the last decade, indigenous or traditional medicine has attracted a lot of interest among policy makers, researchers, and the pharmaceutical industry globally. This has been occasioned by the inadequacy of modern health services in many parts of the world, leading to a large proportion of the world population to depend on indigenous health care systems. According to the World Health Organization (WHO), 80 per cent of the world population depends on traditional medicine for health care provision.[1]In Kenya, approximately 70-80 per cent of the population depends on indigenous health care.[2]

Among the Maasai, indigenous health care is pervasive. A study done by Kiringe in Kuku Ranch in Kajiado District suggests that over 80 per cent of the population in the area

[1]WHO, *The Promotion and Development of Traditional Medicine*, (Geneva, World Health Organization, 1978).
[2] Correspondent, 'Clinics may give Herbal Drugs' *Daily Nation*, September 1, 2006.

relies on traditional medicine as their preferred type of treatment.[3] According to Maasai oral traditions, indigenous health care is an integral part of the Maasai culture and is learnt progressively throughout one's life. The knowledge is passed from generation to generation through apprenticeship. Like other communities, the Maasai have acquired indigenous knowledge over centuries through practical experimentation with results that are invaluable to the modern world. Unfortunately, this knowledge is disappearing owing to the pressures of westernization.

The Maasai of Kajiado District has been greatly influenced by immigration of other ethnic communities into the District. In the recent past, several areas in the District have been affected by socio-economic changes that have impacted on both the indigenous knowledge system and the natural environment. The community is shifting towards agriculture and other forms of income generating activities due to capitalism, urbanization and the influx of other ethnic groups into the District. These factors have greatly transformed the Maasai society. The current study focuses on changes in the indigenous health care system.

In addition to exploring indigenous health care among the Maasai, this study endeavours to define the Maasai's experience with health and healing in the colonial and post-colonial period. The study attempts to understand the indigenous health care system of the Maasai as well as examining change and continuity in the indigenous health care system of the Kajiado Maasai in the phase of colonial and post-colonial policies.

1.2 Statement of the Problem

During the colonial period, indigenous health systems were treated with suspicion. They were perceived as paganism, sorcery, superstitions, and irrelevant in the face of western medicine. Traditional health providers were harassed by missionaries, colonial administrators and later by African elites. Despite the onslaught, indigenous health systems have been resilient. This research examined the resilience of aspects of Maasai indigenous health care system in the face of western medicine, Christianity and new diseases. The study also assessed how these experiences transformed the Maasai meaning of diseases and healing.

[3] J. W. Kiringe, '*Ecological and Anthropological Threats to Ethno-medicinal Plants Resources and their utilization in Maasai Communal ranch in Amboseli Region of Kenya'*,Journal of Ethnobotany vol 13, 2005. pp.231-241.

1.3 Objectives of the Study

The main objective of this study was to examine continuity and change in the indigenous health system of the Maasai of Kajiado District from pre-colonial times to the present. The specific objectives were:

1. To explore the nature of Maasai indigenous medical knowledge during the pre-colonial period.
2. To investigate the place of indigenous medical knowledge during the colonial period.
3. To assess the impact of Christianity and other forces of westernization on the indigenous health systems of the Maasai of Kajiado.
4. To analyse the effect of new diseases on indigenous health systems of the Maasai of Kajiado District.
5. The study sought to explain resilience in Maasai indigenous medicine

1.4 Assumptions of the Study

The study proceeded with the assumptions that:

i. The Maasai had an elaborate knowledge of medicine during the pre-colonial period.
ii. Colonial and post-colonial policies redefined indigenous health systems among the Maasai of Kajiado District.
iii. The introduction of Christianity and other forces of westernization grossly undermined indigenous medicine among the Maasai of Kajiado District.
iv. The spread of new diseases posed a great challenge to indigenous medicine among the Maasai of Kajiado District.
v. Maasai indigenous health care system has continued despite the changes caused by different aspects

1.5 Justification of the Study

The study provides a historical analysis on a range of issues impinging on traditional medicine among Maasai of Kajiado District. Kajiado District was selected due to its proximity to the city of Nairobi with its urban influence, interaction among communities as well as various modes of Westernization. The study provides valuable information for schemes for promoting traditional medicine. The study also fills a gap in the historical study of Maasai indigenous medicine, as most of the information is anthropological and does not show changes in indigenous health care

practices. In addition, the study contributes to the debate on indigenous health care in the contemporary world.

1.6 The Scope and Limitations of the Study

The study covered the period from the late nineteenth century (1850) to 2002. This period is important for the purposes of tracing the changes that took place with the introduction of western medicine, Christianity and new diseases. In the late nineteenth century, the Maasai experienced great ecological crises that undermined their health care system. The year 2002 is significant because the government introduced a bill in parliament which was meant to integrate indigenous medicine and modern medicine. The study was mainly concerned with the analysis of change and continuity of indigenous health systems among the Maasai of Kajiado District, Kenya, because of their close proximity to Nairobi and other modernizing factors like major transport networks in the country.

1.7 Literature Review

Several studies have been done on indigenous health care. These studies mostly focused on different therapies available and the different kinds of healers present in communities. However, little has been done on the Maasai of Kenya in general and those of Kajiado District in particular. The works below were reviewed following a thematic approach to bring out issues relevant to this study.

Numerous scholarly works have been done on the Maasai. However, most of these studies have focused on the socio - political organization of the Maasai. Early accounts of the Maasai are from travellers and colonial administrators. Alan Jacobs, for example, divided the Maasai into two distinct groups, the *kwavi* and *iloikop.* According to Jacobs, only the *kwavi* are real Maasai: pure pastoralists who represented the ideal cultural practice of the Maasai.[4] Others were pretenders who sought to copy the Maasai, although the division does not exist among the Maasai as later discussed by Spencer. Later, the identity of the Maasai becomes a topic of interest as scholars sought to examine 'Maasainess'. Spear and Waller in *Being Maasai* edited several articles from different authors that address 'Maasainess'. The authors argued that individuals and groups can move into and out of 'Maasainess' over time and space.[5] The authors attached Maasai identity to pastoralism, which might not be an identity defining characteristic. A. C. Hollis states that Maasai are clearly distinguished from the Bantu races by their language, custom and appearance.[6] However, these issues are beyond the current study but provide crucial background information.

Sankan, writing in the seventies mentions Maasai indigenous health care in passing. He states that the Maasai used herbs, barks and roots for treatment.[7] They boiled some in soup that were taken for prevention of ailments. He also makes a distinction between practitioners and charlatans. He argues that charlatans played with people's psychology by performing tricks to amass wealth, while the healers had power to treat people not for personal gain. This work does not, however, address the process of change in indigenous health care among the Maasai. However, this work is significant for the study because it gives insights into the pre-colonial indigenous health care among the Maasai.

[4] A. Jacob, *The Political Organization of the Pastoral Maasai* (Oxford: Oxford University, 1965).
[5]T Spear and R Waller (eds), *Being Maasai: Ethnicity and Identity in East Africa* (London: James Currey, 1993).
[6] A. C. Hollis, *The Maasai and their Language and Folklore* (Oxford: Clarindon Press, 1905).
[7] S. S. Sankan, *The Maasai* (Nairobi: East Africa Literature Bureau, 1971) pp. 60-61.

Sindiga discusses the concept of disease among the Maasai and categories of traditional healers present in the community. The author also lists herbs used by the Maasai, the conditions they treat and mode of application.[8] In another study, Rivers argues that the Maasai do not attribute diseases to the actions of the spirits and rarely to human agents.[9] In other words these studies attribute disease to nature. However, Sharman states that the Maasai sometimes attribute the cause of diseases to God and thus offer prayers to him for healing.[10]The current study attempts to resolve this disjunction between natural and supernatural causes of diseases.

In another study, Sindiga analyses the ecological imbalance created by European invasion,[11] that the population movements caused by the 1904 and 1911 agreements between the British and the Maasai.[12] According to Sindiga, ecological destruction led to the spread of disease. For example, spread of sleeping sickness to the whole of Kajiado District which was coterminous with the Southern Game Reserve. He states that colonial policies on pastoralist were responsible for the ecological imbalance. In a study in Tanzania, Kjekshus claims that changes in the relationship between man, his domestic livestock and wild fauna created during the colonial period were responsible for the change in the disease patterns such as sleeping sickness.[13] Another study on disease has been done by Kihumbu, who explains how new diseases like gonorrhoea spread among the Maasai during the colonial period.[14] He further claims that the white men in Nairobi took Maasai girls as concubines. When they got tired of the girls, they sent them back to their parents. Kihumbu's study was useful to the current one as it provided insight into the spread of new diseases among the Maasai.

The issue of spiritualist (*illoibonok)* among the Maasai was first discussed by Jacob. He states that there are three different kinds of spiritualists differentiated by the role they play. The first category specialises in treating illness only; while the second kind treats

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[8]I Sindiga, 'Maasai Traditional Medicine' in *Traditional Medicine in Africa* edited by I Sindiga, C Nyaigotti-Chacha, and M P Kanunah, (Nairobi: East Africa Educational Publishers, 1995), pp. 94-106.

[9] W H Rivers, *Medicine, Magic and Religion* (New York: Kegan Paul, 1924,) p.72.

[10] M Shaman, *Kenya's People of the Plains*(London: Evans Brothers,1979), p.21.

[11]I Sindiga, 'European Expansion as a factor in Degrading Maasai Ecology', MA Thesis, Ohio University, 1981, p.158.

[12]See works that cover British - Maasai Agreements like Kituyi, '*Becoming Maasai'*(1990), Ley, '*Kenya*' 1925

[13]H Kjekshus, *Ecology, Control and Economic Development in East Africa; case of Tanganyika 1850-1950*, (London: Heinemann, 1977), p.166.

[14] K Thairu, *Africa and the AIDS Holocaust:A Historical and Medical Perspective,* 2nd edn, (Nairobi: Phoenix Publishers, 2003), p.11.

illness, provides protective medicine and also prophecy. The third kind is derived from the second category and deals with prophecy, protective medicine and presides over communal rituals. The categorisation depended on the popularity of individual practitioners. A practitioner could move from the first category to the third as his/her influence increased[15]. This work provided information on different categories of healers present among the Maasai.

Spencer also looks at the issue of diviners (*oloiboni*) among the Maasai. He states that the diviners are the descendants of *Kidongoe* (first *oloiboni*) who had divine powers. His descendants form the *enkidongi* clan which has magical powers for healing and preventing misfortunes. Spencer also mentions the rituals involved in treating infertility. He argues that this is the domain of men who wear traditional women shoulder aprons and spiral earrings, pray and bless the women in an organized ceremony[16]. However, the author does not examine the role of women healers in treating infertility. The current study will explore the role of women in health care provision.

Comoro discusses in passing the transfer of traditional medical knowledge of *Oloiboni* among the Maasai of Tanzania. He argues that, although the wives of the ailing medicine man are involved in the passage of *Orkurma* (a black magical stick that automatically passes on the healing, divine, and prophetic power to the successor) the choice depends on the medicine man he thought had learned the practice. The stick is usually given to the eldest son.[17] This is supported by Maundu *et.al*'s account of transfer of medical knowledge by *oloiboni* among the Loita Maasai.[18]The authors also observe that the powers of the *oloiboni* have waned due to the impact of Christianity and change in the political system. On the same note, Swantz argues that the role of the medicine man among the Zaramo of Tanzania has been changing. He states that the *mganga'*s role is not a static one, as it adapts to new social situations and the needs of his clientele.[19] These works give significant insights into the changing roles of the medicine man (*oloiboni*). The works are, however, limited in scope and do not discuss aspects of change in detail.

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[15]Jacobs, *Pastoral Maasai*, p.23.

[16] P. Spencer, *Time, Space and Unknown* (New York: Routledge), pp. 98,78.

[17] C J Comoro, 'Traditional Medical practice and Western allopathic medicine in Tanzania: A Look at Bottlenecks towards Universal Health Care by the year 2000 or beyond *Internationales Afrikaforum*, Jg. 29,Quart. 2, (1993), pp.159-175.

[18] P Maundu *et.al* , 'Ethnobotany of the Loita Maasai: towards a community management of forest of the lost child' *People and Plants Working Paper* (Paris: UNESCO, 2001).

[19]L Swantz, *The Medicine Man among the Zaramo of Dar es Salam* (Uddevalla: Scandinavian Institute of African Studies, 1990), p.135.

Kanyangezi regards medicine men as leaders among the Maasai society. He argues that the Maasai *oloiboni* had a political role. He promoted relations between age-sets. The *oloiboni* was also capable of controlling diseases, sterility, birth and death.[20] This particular study concentrated on the political role of the *oloiboni*. The current study however discusses in detail the role of the *oloiboni* as a medicine man.

Feierman points out that during the pre-colonial period healers played a role in organising production, which was linked to holders of political power, or held it themselves. He asserts that African healers lost some of their status in the society during the colonial period. However, colonial conquest deprived healers of this control over production and broke most links between healing and public authority.[21] This assumption will be examined in the case of the Maasai, whether the medicine men, especially the *illoibonok*, lost some of their roles in the society.

Kiringe examines gender roles in medical knowledge among the Maasai of Kuku Ranch in Kajiado District. In his study, Kiringe argues that men know more about herbal plants than women.[22] This assertion is supported by Bussman *et.al* and Sindiga. Although Bussman *et.al* refers to the Sekenani Valley in Narok District, the Maasai socialization process is similar throughout Maasai land.[23] Sindiga states that Maasai boys acquire knowledge in the forest while herding livestock, whereas girls learn from their mothers and grandmothers. He further claims that Maasai women use a lot of herbs in the twentieth week of pregnancy in order to control weight, aid digestion and facilitate easy delivery.[24]

Carman's work on the medical history of Kenya focuses on the development of modern medicine in the Kenya Colony and devotes one chapter to indigenous health care. The author describes his experience with indigenous health care and the position of indigenous healers before the colonial period. He asserts that the *mganga* was a legitimate

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[20]T A Kanyangezi 'The Medicine man as Leader in Traditional Africa-Mbatiany, 1824-1889', in *Politics and Leadership in Africa* edited by A Ojuka and W Ochieng (Nairobi: East Africa Literature Bureau, 1975), p.30.

[21] S Feierman, 'Struggles for Control: The Social Roots of Health and Healing in Modern Africa' *Africa Studies Review*, vol.28, No. 23, (19d85), p.73-147.

[22]J W Kiringe, 'Ecological and Anthropological Threats to Ethno-medicinal Plants Resources and their utilization in Maasai Communal ranch in Amboseli Region of Kenya', *Journal of Ethnobotany* vol 13, 2005. pp.231-241.

[23] R W Bussmann et al, 'Plant use of the Maasai of Sekenani Valley, Maasai Mara, Kenya' *Journal of Ethnobiology and Ethnomedicine* vol 2 2006.

[24]I. Sindiga, 'Indigenous (medical) knowledge of the Maasai.'*Indigenous Knowledge and Development Monito*r 2 No. 1 (1994), pp16-18.

practitioner, who had knowledge of remedies for each case.[25] This work will be important in providing background information for the present study which focuses on perceptions of traditional medicine during the colonial and post-colonial periods.

Okoth Owino and Calestous Juma discuss the legal position of the practice of indigenous health care system in Kenya. They argue that since the colonial period, the health policy and the laws of Kenya have been rather hostile to traditional healers. Subsequently, indigenous health care was marginalised and ignored. They also point out the challenges of protecting intellectual property rights of indigenous healers.[26] This issue is further discussed by Njau who states that indigenous health care is regulated by the Ministry of Culture and Social Services and not the Ministry of Health.[27] These works were relevant to the study in examining the impact of health policies to indigenous health care in Kenya.

Beck traces the development of western medicine in Kenya. She argues that the development of medicine was affected by prevailing trends in the political interpretation of the duties of the colonial state. For instance, most progress in health care systems was a response to threatening epidemics. She also highlights the position of indigenous healers during the colonial period. She claims that the Witchcraft Ordinance of 1927, which prohibited the practice of indigenous healing, greatly undermined traditional healers.[28]Although the work does not touch on Maasai indigenous health care it was important in analysing the impact of western medicine and colonial policies on Maasai indigenous health care systems.

Mburu examines the provision of health care services to Africans during the colonial period. The study reveals that the medical services introduced were meant to effectively exploit African labour since the health of the labourers would affect that of the European settlers.[29] This is evident in the small budget allocated for the provision of medical services

[25] J Carman, *A Medical History of the Colony and Protectorate of Kenya: A Personal memoir* (London: Rex Collings, 1976), p. 43-57.

[26] A Okoth-Owino with C Juma, 'Property Rights, Medicinal Plants and Indigenous Knowledge', in, *In Land We Trust: Environment, Private Property and Constitution Change* by C Juma and J B Ojwang (ed), (Nairobi: Initiative Publisher, 1996), pp. 297 & 300.

[27] E Njau, *Pharmaceuticals and Therapeutics: A Manual for Health Personnel in Rural Africa* (Nairobi: AMREF, 2002).

[28]A Beck, 'History of Medicine and Health Services in Kenya 1900-1950', in *Health and Disease in Kenya* edited by L C Vogel, (Nairobi: Kenya Literature Bureau, 1974), p. 64.

[29] F. M. Mburu, 'The Social Production of Health in Kenya', in *The Social Basis of Health and Healing in Africa*, edited by J. Janzen and S Feierman (California: University of California Press, 1992), pp. 410-422.

to Africans and the fact that most of these services were concentrated in the urban centres. This phenomenon will be examined among the Maasai of Kajiado District.

Kanogo analyses the issue of women and health in Africa. She argues that there were African midwives who dealt with issues that concerned women, such as childbirth and pregnancy. She points out that during the colonial period; Christian dogma was used to discredit local constructions of pregnancy, giving birth, still births and infant mortality. Traditional midwifery was perceived as unhygienic and superstitious by the missionaries. On the other hand, western medicine and maternity were applauded.[30] Although traditional midwifery was not criminalized, other forms of traditional health delivery were driven underground. Kanogo's work offers useful information on traditional women health care specialist and the current study will examine changes that have affected such specialist in Maasai land Kajiado District.

On the introduction of new diseases, Zeleza argues that African health standards declined sharply during the late nineteenth century and early twentieth century as a result of the introduction of new diseases like gonorrhoea and cholera to Africa.[31] Dawson argues that change in patterns of population concentration (caused by movement during famine and colonialism) aided the spread of diseases.[32] Similarly, Ogot writing in the late seventies, states that culture is evolving and this has also altered the pattern of disease in both man and animals. For instance, tuberculosis and syphilis are major diseases today while yaws and leprosy have disappeared.[33] These works give important insights to the factors that affect the spread of diseases.

On the political economy of health in Tanzania, Ferguson argues that the socio-economic system under which people live determines their health. He states that the health problems that confronted Tanzania after independence were products of the demands and

[30] T. Kanogo, *African Womanhood in Colonial Kenya 1900 – 2005* (Nairobi: East African Educational Publishers, 2005).

[31] T. Zeleza, *A Modern Economic History of Africa*, volume 1*: The Nineteenth Century* (Nairobi: East Africa Educational Publishers, 1990), p.41.

[32]Dawson, 'Smallpox' in *Health and Disease in Kenya*, edited by L C Vogel (Nairobi: Kenya Literature Bureau, 1974), p.90.

[33]B A Ogot (ed.), Hadithi 7: *Ecology and History in East Africa* (Nairobi: East Africa Literature Bureau, 1979) p.3.

priorities of the colonial system under which people lived. Colonial health services were provided along racial and capitalist lines.[34]

Doyle points out how colonialism affected indigenous health systems in Bunyoro. The author claims that colonial rule weakened traditional medicine through rigorous repressive policies that drove all Banyoro traditional ritual practices underground.[35]

Waite attempts to address changes in traditional healing during the colonial period. She argues that changing social conditions in East Africa during the colonial period gave rise to flourishing of spirit possession. This change was probably caused by diminishing powers of the mediums and rainmaking shrine. Waite also observes that indigenous healers adopted products of industrialization like face bowls and mirrors using them in divination. The author mentions that traditional healers responded to new diseases like syphilis and gonorrhoea by trying herbal medicine on people affected by the diseases. She gives an example of Ngoni healers.[36] The work provides insights on analysing the transformation of indigenous health care. The current study examines the response of healers to the emergence of new diseases among the Maasai of Kajiado.

Feierman and Janzen argue that healing in Africa is rooted in society. Therefore as society changes, so does healing. They assert that healing traditions have been forced to provide new interpretations of rapidly changing reality. In most parts of Africa, conditions of health and disease have changed. Healing traditions therefore had to find answers to the changes.[37]The above observation will be examined in the light of the Maasai of Kajiado healers' experiences.

Mbiti's book gives a general overview of medicine men in African societies. He describes the medicine men as a specialist group and how their knowledge was transmitted in the communities. He draws examples from the Azande and Ndebele. The author highlights the duties of medicine men among the Ndebele,[38] which include healing, rain making and

[34] D E Ferguson, 'The Political Economy of Health and Medicine in Colonial' in *Tanzania Under Colonial Rule,*edited by M H V Kaniki (London: Longman Group, 1978), pp. 307,313.

[35]S Doyle, *Crisis and Decline in Bunyoro; Population and Environment in West Uganda 1860-1955* (London: James Currey, 2006), pp. 157-162.

[36]G Waite, *A History of Traditional Medicine and Health Care in Pre-colonial East Africa*,(New York: The Edwin Mellen Press, 1992), p. 109.

[37]S. Feierman and J Janzen, *The social Basis of Health and Healing in Africa*, (Los Angels: University of California Press, 1992), p. 5.

[38]J. Mbiti,*African Religions and Philosophy*,(Nairobi: Heinemann, 1969), pp. 166-172.

giving protective medicine (charms). These ideas are general and offer insight to this study. However, there is need to assess whether medicine men continue to play similar roles in the contemporary society.

Nangoli takes a general approach in discussing traditional medicine in Africa. He argues that African societies have different forms of medicine which are used to heal both physical and spiritual illnesses. The application of this medicine depends on the form of illness; for example, mental illness is healed using mystic power (psychological treatment).[39]The charges also depend on the nature of illness, cows, sheep, and goats are used as a form of payment.

Outside Africa, Craigs points out that Tibetan traditional medicine was transformed by the state. The author argues that Tibetan medicine was changed in theory, practice, and methods of training physicians.[40] On Iran, Hormoz argues that the introduction of western medicine led to alteration of institutions of traditional medicine. There was internal change that led to integration of western medicine within Iranian medicine. The author claims that the integration was made possible by Iranians' attitude towards western medicine.[41] These works assisted in understanding the process towards integration of traditional and modern medical systems.

The above works provided useful insights to this study. For instance, some authors have mentioned that the role of the diviner (*oloiboni*) has changed. Others have looked at the effect of western medicine on indigenous medicine. However, change has been discussed in passing. This study fills the gaps outlined in the literature review by exploring continuity and change in indigenous health care systems among the Maasai of Kajiado District.

1.8 Theoretical Framework

The articulation of modes of production theory was used to analyze changes in indigenous health care systems among the Maasai of Kajiado District. Articulation of modes of production emphasizes the momentous consequences of linking two radically different societies. It involves the confrontation of different societies propelled by different tendencies of development or "law of motion". Consequently new structures are formed and others

[39] M Nangoli, *No More Lies About Africa,* (USA: A.H. Publishers, 2002), p.108.
[40]J. Craig, 'Transformation of Tibetan Medicine', *Medical Anthropology Quarterly,* vol 9, No 1. pp.6-39.
[41]E. Hormoz, *Modernization, Medicine and Power in Iran,* (Iran: Chamber Society,2001).

destroyed as societies interact with each other.[42]Articulation of modes of production theory has roots in the works of Karl Marx. It was initially developed from the structuralism concept of 'social formation' consisting of a hierarchical linkage of several modes of production under the dominance of the capitalist mode of production. It was used to explain underdevelopment and the apparent persistence of the pre-capitalist forms of production at the periphery of the global system.[43] The focus was the continuity of peasantry in most population segment in Africa. Thus, articulation was developed to correct the criticism of underdevelopment theory. It tries to examine how specific Third World pre-capitalist modes of production articulated with the dominant capitalist modes of production.[44] During the colonial period, African societies were subjected to contradictory patterns of transformation, destruction and preservation of their internal structures, resulting in a wide variety of intermediate and hybrid social forms.

According to Berman, indigenous societies were not just passive receivers or resisters of European capital/control but often contained reactions to it that led to the emergence of a distinct and contradictory internal transition[45]. Although this concept has been used to explain the interaction between the capitalist mode of production and non-capitalist modes of production, it helps in analysing the historical specificity of different social formations during the penetration of colonialism. The essence of this analysis is that historical actors can be analysed within the context of their relationship, which moulded their world and defined their position within a given social and political formation.[46]In the current study, this theory will be used to analyse the interaction of westernization factors with indigenous health care systems of the Maasai of Kajiado District. For instance, the interaction between western medical systems with indigenous health care system which were viewed as opposites as indigenous medicine is associated with spiritualism and magical practices whereas western medicine is associated with materialism, experimentation and verifiable theories.

Structural-functionalism is used to analyse the relation between different social systems in the Maasai community. According to the structural-functionalism, society is built upon order, interrelation, and balance among parts as a means of maintaining the smooth

[42]B Berman, *Control and Crisis i40n Colonial Kenya, The Dialect of Domination* (Nairobi: Heinemann, 1990), p.*37*.
[43]Ibid,p.35.
[44]D Harrison, *The Sociology of Modernization and Development*, (London: Routledge, 1988), p.151.
[45]Ibid p.39.
[46]D Newbury, 'Modes of Production analysis and Historical Production', *Canadian Journal of African Studies*, vol. 9, no. 1(1985) pp.35-45.

functioning of the whole. Structural-Functionalism views shared norms and values as the basis of society; focus on social order based on tacit agreements between groups and organizations, and views social change as occurring in a slow and orderly fashion.

In Functionalist models of society such as those outlined by Talcott Parsons, all social structures are interconnected and depend on each other. Hence change is evolutionary- which means change in one part of the society will eventually occur in another part. Parsons believes that change trickles through-out society. Functionalists acknowledge the fact that change is sometimes necessary to correct social dysfunctions (the opposite of functions), but that it must occur slowly so that people and institutions can adapt without rapid disorder.[47]

1.9 Research Methodology

1.9.1 Study Area

Kajiado District, which is the focus of this study, comprises six administrative divisions, namely: Namanga, Mashuru, Loitoktok, Ngong, Magadi and Central. The District covers a total area of 21,105 km^2 and borders Tanzania to the south-west, Taita-Taveta to the south-east, Kiambu District to the north, Machakos and Makueni Districts to the east, Nairobi city to the north-east and Narok District to the west (see map overleaf). Plains and occasional volcanic hills and valleys constitute the general topography of the District.[48] A large part of the District is semi-arid and pastoralism is the main economic activity. The inhabitants of Kajiado District are mainly the Maasai, who are classified as Nilotic-speakers of the eastern branch[49].However, since the colonial period communities like the Kikuyu have migrated into the District and settled in such areas as Ngong Division. In 1989 the District had a population of 258 659, which was projected to grow at the rate of 4.5 per cent to 402 907 by 2001.

1.9.2 Data Collection

The study was based on both primary and secondary data. Primary data was obtained from the Kenya National Archives (KNA), the archives of organizations such as Africa Medical Research Foundation (AMREF) and oral interviews. The archival records include District and provincial annual reports as well as District Council reports. Data from the archives was corroborated with data from oral interviews. Oral data was collected through in-depth interviews using an interview schedule. By use of sample questions guideline the

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[48]Kajiado District, *Development Plan 1997-2001*, 1997.

[49]G. Sommer and R.Vossens, 'Dialects, Section-Lects, or simply lects?' in *Being Maasai* by T. Spear & R. Waller, p. 25.

informants were allowed to talk freely after the introduction of the topic. The oral information was tape-recorded for accurate retrieval. However, some informants refused to be tape-recorded and notes were taken, which was challenging as recording all information provided was not possible. Primary data was corroborated with relevant data from secondary sources. Secondary sources included books, journal articles, magazines, theses/dissertations, and seminar papers.

1.9.3 Sample Population

The population sample comprised of men and women, mainly, practitioners and consumers of indigenous medicine. Due to the nature of the study, informants were selected from three divisions of Kajiado District occupied by the Maasai in Kenya: Ngong Division due to its proximity to Nairobi and its occupation by non-Maasai communities; Central Division owing to the insignificant influx of other communities, and Mashuru Division which is dominated by the Maasai and is also less modern. The informants were chosen through purposive sampling technique, where informants help the researcher identify other potential informants. The criteria for selection were age, gender and knowledge or experience with indigenous health care. Thirty seven informants were interviewed.

1.9.4 Data Analysis

Three analytical frames were used to analyse data. These include; theoretical reflections, documentary review, and content analysis. Theoretical analysis involves using the selected theoretical framework to analyse the data. Documentary review involved identification of relevant documents then extracting the relevant information. Direct quotations are also used in document review analysis to reinforce an argument, while in content analysis involve itemizing collected data against objectives set and the chapters of the work. Corroborating documentary data with oral data as a way of internal criticism were also used. Tape recorded data was transcribed then analysed. The data collected was used to test the research assumptions in the light of the theory used to form the basis of analysis and interpretation.

CHAPTER TWO

2.0 MAASAI INDIGENOUS HEALTH CARE SYSTEMS BY THE EVE OF THE PRE-COLONIAL PERIOD

2.1 Overview

Generally, this chapter discusses the general aspects of Maasai indigenous health care in the pre-colonial period, the concepts of disease, diagnosis and the specialists present in the pre-colonial Maasai community. The first section of this chapter focuses on the different perceptions of indigenous medicine, the relation of indigenous health care system and religion in general and among the Maasai in particular. The chapter also discusses the different kinds of specialists among the Maasai and their role in the pre-colonial period. Lastly, it examines the ecological crises of the nineteenth century and their impact on the Maasai indigenous health care system.

The discussion in this section provides an overview of the Maasai cosmological system with the argument that the Maasai cosmology is a 'living' entity arising from the process of culture development- which may be impeded but is continuous as long as culture exists and from an experiential reference for Maasai existence. Thus, specialists of Maasai therapeutic system situate their curative ideas and conceptions directly to the Enkai cosmology. Such a design, indigenous healers serve as experts of the complex cultural system and its spiritual conventions.

2.2 Indigenous Knowledge

The term indigenous is increasingly becoming popular but also highly contentious due to various definitions. At times the term is used to refer to knowledge of and uses of specific plants and animals for medical purposes, often referred to as indigenous or "traditional medicine'', which is an important aspect of life in most African communities.[1] Indigenous knowledge is identified as the knowledge held by "indigenous peoples," as defined in Article 1 of the International Labour Organization (ILO) Convention 169. Although indigenous knowledge is generally considered traditional, not all traditional knowledge is indigenous. Indigenous knowledge is similar to traditional knowledge in its transmission, scope, and diversity. It is appropriate to consider indigenous knowledge as overlapping with, rather than being a subset of traditional knowledge.

[1] Badri, B. (1994) "Women and biodiversity", *Development, Journal of SID* 1:67-71; Bell, M. "The exploitation of indigenous knowledge or the indigenous exploitation of knowledge, Whose use of what for what?" *Institute of Development Studies*, 10 (2) (1979): 44-50.

For the purpose of this study, indigenous knowledge implies the body of knowledge that evolves within a community over time and is orally communicated from one generation to the next with the aim of moulding it for the sole purpose of ensuring survival and progress. Scholars have explained African indigenous health care by using different theories based on its features. First are its social characteristics: the description, explanations, causes, treatment and prevention of illnesses are linked to the quality of human interactions. For example, some illnesses are linked to curses, ancestor's displeasure, hatred and jealousy while others are linked to witches[2] as observed by Feierman and Janzen. Indigenous healers live among health consumers, bringing a social context to the healing system.

Health problems are also interpreted in religious terms and treated through rituals linked to the maintenance or restoration of well-being in the community. It is also thought as irrational to basic well-being solely on supernatural causation and ignore natural cause and effect. Religion is seen as having a social and historical existence. That is to say a source of action and systematic ideas. Third is prevention: that indigenous medicine focusses only on curative measure. Contrary to this misconception, prevention is central to Africans everyday life and follows logically from their preoccupation with religious and social values. Van der Geest notes that African indigenous healers concentrate on the deeper origins of illness and insist that something should be done about them to avoid repetition of a misfortune. They also provide their patients with moral and social guidelines to prevent them from catching the same illness again. Geest observed that this is hardly noticed by an outsider who does not believe in the social and religious roots of illness. [3]

The fourth characteristic is that African indigenous health care is more comprehensive than western medicine. Health in Africa cannot be adequately translated in specific medical statements as it affects and includes all aspects of life. Another characteristic used to explain indigenous health care is the cost of treatment. Contrary to popular beliefs, indigenous healers are paid for their services. Paying for received services/treatment is a sign of respect and appreciation. If payment is not given in some instances the patient runs the risk of falling ill again. Indigenous medicine is also viewed as a secret. Thus, indigenous medical practitioners consider the knowledge personal and keep it secret.

[2] Fierman and Janzen, 'The Social Basis of Health and Healing', p.111

[3] S Van der Geest, 'is there a role for Traditional Medicine in Basic Health Services in Africa? A plea for a community perspective' in *Tropical medicine and International Health vol 2 No 9pp 903-911,* (Blackwell Science Ltd, September 1997), P 905

2.3 The Setting: Indigenous Medical Systems

There are many similarities in different indigenous medical system among African communities. Some of the general features of indigenous medical systems were summarized in the previous section. This section will mainly focus on the Maasai indigenous health care system. Nevertheless, there are several cultural strands within this system that are the result of different historical experiences. In common with medical systems worldwide, the indigenous medical system in Kenya comprises several basic and interrelated components; medical specialists, techniques for diagnosis and treatment, types of illness, and a belief system that makes these components intelligible and welds them together. Unlike modern medicine, the indigenous medical system is based upon what modern scientists call "biosocial resonation,"[4] meaning the unity of social and biological forces. It is a holistic approach to health where the past is equally important as the present.

According to traditional beliefs, anything that makes a person or community dysfunctional or weak places that individual or society in a state of danger. For example, puberty is like physical illness in that uncircumcised youth represent a weakness or dangerous state in the community. The community is strengthened when the youths are admitted to adulthood. A state of danger for a family is also associated with the death of a relative, which is also viewed as illness.[5] For example, among the Maasai language a family that is mourning is referred to as sick. Menstruation can also be likened to illness because during that time a woman is not supposed to perform some of her normal activities such as salting the soup. Her normal routine is disrupted, placing her in a socially dysfunctional state, because her condition is believed to make other people susceptible to illness. New-born babies are also in a state of danger, only it is not they who cause illness. Rather, they are vulnerable to developing illness as a result of their parents' negligence. In these dangerous states, people are often protected by taboos.[6] Among the Maasai a lot of actions are governed by taboos. For example, it is a taboo to eat meat and drink milk at the same time as it is thought to cause stomach upsets.[7]

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[4] G. W. Moss, *Illness, Immunity and Social Interaction,* (New York: John Wiley & Sons, 1973).
[5] Victor Turner, *The Forest of Symbols: Aspects of Ndembu Ritual,* (Ithaca and London: Cornell University Press, 1967), pp. 19-92.
[6] Anita M. Drake, "Illness, Ritual, and Social Relations among the Chewa of Central Africa" (Ph.D. dissertation, Duke University, 1976)
[7] Ole Ngiroyia, Oltepesi Village, 25.6.2011.

In the traditional belief system, chronic illness, sudden malaise, and misfortune are often attributed to malevolent activities like witchcraft or sorcery. The activities of sorcerers are of medical concern because they threaten an individual's health and ultimately the health of an entire community. Moreover, sorcery is detected and eliminated through medical techniques. Diseases of metaphysical or social origin are not the only ones known in the indigenous African medical system. However, since modern medicine recognizes only biological causation, Westerners tend to exaggerate the metaphysical aspects of African medicine. The African medical system links numerous diseases to biological processes, and since pre-colonial times biological bases have been known for sleeping sickness, smallpox, leprosy and other diseases.

Transmitting agents can be identified for most illnesses, although what ultimately counted were personal forces. Transmitting agents for sorcery included medicines and other material objects. People are the agents of transmission for certain diseases when they violate taboos and other codes of behaviour that are used to contain pollution or prevent those diseases. Diseases brought by God can also have vectors. Leprosy is known to occur because of "worm-like" substances in the body[8] and the Maasai know that trypanomiasis is caused by the tsetse fly.[9] Spirits are the agents in spirit possession illness, calamities, and some infancy diseases. Four principal categories of causality can be discerned in the pre-colonial Maasai community. These are a High God, ancestral spirits (connected to taboos and curses), sorcery, and biological causes. Each cause has under it a number of diseases that have similar symptoms and prognoses. These aetiologies, or causes, represent human neglect (illness requiring propitiation), human hatred (illness caused by sorcery), and human misconduct (illness caused by taboo violation). Humans, therefore, are important in health maintenance, disruption, and repair while mortality and morbidity are inseparable from morality.

The belief that personal forces are basic to disease causality is an important difference between indigenous medicine and western medicine. Western medicine focuses primarily on microbes to explain illness, giving little or no attention to the social milieu. Yet, like their counterparts in modern medicine, indigenous doctors are not at the mercy of personal forces any more than modern doctors are at the mercy of impersonal forces.[10] Both groups of

[8] Interviews with *healers in Kajiado, Olemurkat village.*
[9] Frank Lambrecht, "Aspects of the Evolution and Ecology of Tsetse Flies and Trypanosomiasis in Prehistoric African Environment," *Journal of African History 5*, (1964), pp.1-24.
[10] Robin Hoi-ton, "African Conversion," *Africa* 41, (1971), pp.101-107.

doctors try to control, or at least try to influence, the course of disease and illness. Treatments are provided by either specialists or laypersons and, unlike in the West, under the Maasai indigenous system, health care is not monopolised by a professional class. A limited number of specialists are present, but they supplement rather than provide all of the health care. Choices of laypersons over practitioners depend upon the malaise and its degree of seriousness. Most adult villagers know a good deal about their environment and what plants to use for common ailments and conditions. The family and the individual have some responsibility for personal health, and so they acquire some medicines on their own. They may also seek medicine from specialists and non-specialists who are more knowledgeable than themselves. Medicines have a prominent role in indigenous health care. They are used to restore and disrupt health, to protect households from sorcerers and livestock from thieves, and to protect people in their enterprises and help them succeed. They are generally made from all parts of plants and are processed through fire or solar heat. Medicines may be taken internally, rubbed into specially made cuts at specific places on the body, rubbed onto the body, inhaled through steam, planted in the garden, or worn around the body. The action required by the medicine determines the method of application. Substances of animal or mineral origin are often added to activate medicines. These substances are not considered medicines themselves but are said to become a part of medicine when they are added as they make the medicine become more powerful or prevent harm on humans.[11]

Other activities are also important to the healing process. Some of these activities are for appeasing the spirits, while others serve to bind the community together, or the community to the afflicted person. Still other activities, such as limiting sexual contact between parents of infants and isolating (quarantining) infected persons, are used to prevent the spread of illness. Two groups of people, namely medical practitioners and elders, hold the most important roles in health care among the Maasai. Elders and age set leaders are also responsible for controlling the spread of epidemic diseases, which they do by proclaiming quarantines. Elders also tend to monitor the health of the villagers on a daily basis, including inquiring about the health of the people each morning. If there is illness, it is the duty of the family to share about it with neighbours, otherwise its members might be held responsible if death occurs. Upon receiving reports of illness, other villagers and family heads provide advice or, if the cause or treatment of the illness is unknown to the village or the family, the patient is referred to a specialist.

[11] Ole Mututua, Imanyatt Village, 4.7.2010

Healing skills are generally acquired through apprenticeship to a practicing family member or to an outsider. Sometimes illness precedes the acquisition of healing powers in the sense that some healers learn through their own treatment. Often, knowledge of treatment is thought to come through dreams and it is believed that Enkai reveals the medicine to his people to save them from diseases. Among the diviners and *Iloibonok* the healing power is thought to be inborn as they belong to the *Ikindongi* clan, though diviners like *Ilaenak* belong to the *Ilkerin Inkishu* clan.

Generally, there are two main divisions of healing among the Maasai: those that use herbs and skills to treat diseases mostly of natural cause, and those who treat disease caused by spirits, sorcery or curses. The division of healing corresponds to belief in different disease causality. Disease aetiology influences therapy seeking behaviour. The therapy and aetiology are not always systematic as one illness may be thought naturalistic and later treated as from divine causes. Thus therapy seeking behaviour moves from herbs to spiritual treatment.

Rainmaking was an activity that is controlled by diviners and mediums in other communities in Kenya. However, among the Maasai, rainmaking is a community affair although the *Iloibonok* play a role and is of medical interest because inadequate rainfall can lead to hunger and disease. According to Hinde, during drought the whole community (men, women and children) participate in invoking Enkai for rain. The *Oloiboni* and elders sent a proclamation to the villages that on a given day children must assemble and sing and perform other activities. Men and women participate in offering prayers and sacrifices to Enkai for rain.[12] Historically, African societies have depended on rain-fed subsistence production. Because rain is so vital, therefore, the cycle of production revolves around it. High God or aggrieved spirits of the village, chiefdom, or kingdom are believed to be responsible when rainfall is inadequate or untimely, or when some other natural disaster occurs that leads to hunger and disease. Rainmaking is thus an important part of the indigenous health care system and is a major illness prevention activity in which the entire community participates.

It is believed that spirits respond to people's complaints and prayers through dreams that are experienced by only a select few. Among the Maasai, as among other societies in East and Central Africa, traditionally the people so inspired wielded great influence, though their presence and level of influence varied over time and place. Another important health

[12] S Hinde & H Hinde, *The Last of the Maasai*, (London: Heinman), p.102

care activity is the control of sorcery.[13] It is believed that sorcerers obtain power by manipulating medicines. These medicines are called "bad medicines" (*isentani*) to distinguish them from the "good" medicines that are used to heal and protect. Sorcerers carry out their work in various ways, visiting people's homes at night disguised in the form of material objects or animals. They leave medicines directly or through medicated objects in people's food in the daytime, place medicines on the road, and obtain people's wastes or body parts like nails and hair for the purpose of mixing them with medicines. Sorcerers are never seen doing these things. Although the aim of the sorcerer is to cause death or some other calamity, indigenous healers can sometimes intervene and prevent death or end the misfortune. When a person becomes progressively sick very quickly, or when a number of people die without any known cause, sorcery is suspected. Sorcerers wilfully employ medicines to cause the ruin or end of other people's lives, and this is probably why sorcery is considered a criminal offense.[14]

In some pre-colonial societies, spirit mediums identified sorcerers through inspiration from spirits. In other societies, poison ordeals were used to make suspected sorcerers (and also sometimes their accomplices) to identify themselves and confess. Chiefly authorities controlled poison ordeals, which was a balance to the monopoly of sorcery control enjoyed by mediums. Whatever method was used to reveal sorcerers, the heads of the accused might be shaven as a warning after the first offence or for repeated offenses. In some societies, after identification sorcerers were killed for the first offense either through burning or with a lethal dose of the poison that simultaneously established their guilt.

Although this brief overview does not do justice to the complexity of the indigenous medical system, it nevertheless points out several characteristics of the system that make it distinct from modern medicine. It was not a static system, however, and it is possible to identify several developments that have occurred in it over time. The remainder of this study will be an exploration of these developments from the pre-colonial period to the contemporary post-colonial period.

[13] A distinction must be made between sorcery and sorcery control, since knowledge of, including experience with, sorcery does not mean that one is able to take steps against sorcery or heal its physical manifestations.

[14] Ole Nasioki, Oltinga Village, 23.6.2010

2.4 Maasai Indigenous Medical Knowledge

Since time immemorial human beings have tried to meet the challenges confronting their own health and well-being, including the health of their livestock. The Maasai indigenous health care system defined disease and illness within its social context. Thus illness and disease are interwoven. To understand the indigenous medical system one has to understand the social significance of disease and illness, the political and economic systems, as well as the religious practices. Indigenous health care is affected by the community world view, values and institutions which have developed overtime and is no different among the Maasai. The Maasai had a wide range of methods of healing that were embedded in religious, customs and subsistence activities and that served to integrate the community and provide individuals with systems of meaning to make sense of illness and diseases.

Health and healing are closely influenced by a community's religious beliefs and practices. The Maasai believe in one God (*Enkai*) and do not have a name for their religion. However, it is monotheistic and personal. Individual and group prayers are the means of contacting, supplicating and honouring God, though there were no patterns of regular community congregation for such purpose. However, in time of adversity such as drought or epidemic, personal or family crisis, animal sacrifices were offered to God

In Maasai cosmology, there were no divinities or spirits below *Enkai*, no belief in afterlife or any realm of ancestral spirits. Maasai cosmology is in sharp contrast with those of the majority of people in East Africa, where spirits play a major role in cosmology. However, according to their mythology, *Enkai* has two main aspects; the good (*Enkai Narok*) that provides and protects, and the bad (*Enkai Nado*) which punishes and brings misfortune when angered, especially when he is dissatisfied with the behaviour of people. In his anger *Enkai* may cause disaster and even famine when necessary.[15] With the belief that there is a hidden danger that will bring misfortune to anyone who behaves without care, the Maasai have taboos, values and ritual that should be observed correctly to avert misfortune. The Maasai believe that *Enkai* is the source of welfare and misfortune, and that he is active in their daily life. They display their behaviour and attitude toward God both orally and ritually. They pray as a community during major ceremonies and individually in daily life.

[15] Arvi Hurskainen, Invasion of Spirits; Epidemiological Spirit Possession among the Maasai of Tanzania, *Nordic Journal of African Studies* 14, Special Issue (2004), pp. 6,7

According to Spencer, ritual correctness among the Maasai is a reverse of sorcery; it is the performance of timely acts that are thought to avert misfortune according to context. These rituals range from handling a corpse during death, identification of which ox to be sacrificed during ceremonies, nomination of the ceremonies, age-set formation and childbirth to daily relations between women, men and children.[16] For example, certain men are chosen to lead ceremonies because of lack of moral and physical blemish and coming from a good family. Failure to follow leads to misfortune to the family or the people involved, consequently to the whole community. The ceremonies are viewed as important practices to avert misfortune in the community, leading to a healthy community. In case of a misfortune (drought, famine, epidemic), the prophets (*Iloibonok*) give advice on special ceremonies and sacrifice with a view to reversing the misfortune. In their prayers, elders and women may also invoke God 'in the sky and below' to bless their land. From the above discussion, health among the Maasai is linked to beliefs (religion) that controls daily behaviours and the mystical punishment for misdeeds.

Among the pre-colonial Maasai, there were interrelations between the social and political systems, though each was autonomous from the others. Maasai political organization was based on age set, with the senior elders age set carrying the major responsibilities of administration. These leaders were mainly appointed during the age set formation. The Oloiboni, who was a prophet and healer, was consulted during the selection of leaders and was also involved in the rituals and ceremonies for blessing them.[17]

The clans played a role in the selection of leaders, for example the *Ikidongi* would not be selected to other leadership positions since they were prophets. Health care was dominated by prophets (*ilobonok*) from the *inkidongi* clan. One of the informants from *Oloirien* shared that some preventive measures of Maasai indigenous health care like family planning, protection against an epidemic (which was done in form of rituals) were carried out by people from a particular clan called *ilkerin-inkishu*. Leaders were selected from the main clans and most clans would be represented in the leadership.

[16] Spencer, '*Time, Space and the Unknown*', p.

[17] Elders from Oloirien Village, in group discussion, 24.6.2010.

2.5 Concepts of Health and Illness

Maasai indigenous health care is closely linked with their cosmological beliefs and they appear to have clear ideas to what causes disease and misfortune. The categorization represents the cause of the disease rather than the nature of the disease or illness

According to Frankit, the Maasai distinguishes health problems by causality, they distinguish those illnesses caused by 'natural' or expected events from those unusual occurrences believed to result from 'mystical' causes such as the curse of one's kinsmen or the immoral attack of sorcery directed by known or unknown enemies.[18] Rivers argues that the Maasai do not attribute diseases to the actions of the spirits and rarely to human agents. In other words they attribute disease to nature.[19] On the other hand, Sharman states that the Maasai sometimes attribute the cause of diseases to God and thus offer prayers to him for healing.[20] According to informants, the Maasai attribute diseases to both natural (physical) and spiritual/mystical causes. The Maasai believe that disease and illness may occur in several ways: naturally through air, food or water through humans, sorcerers or from breaching of taboos.

According to the informants, infectious diseases, wounds, fractures and burns are accepted as natural illnesses. The Maasai believe that some health problems are caused by the presence of 'unclean' substances (worldview based on clean and unclean) in the body. This belief is found in other African communities. According to Sindiga, the Maasai believe, just like the Luo, that disease emanates from the environment via food, water, hygiene, sex and changes in weather. Eating contaminated food is thought to cause abdominal pains and diarrhoea. Change in weather is thought to cause health problems like colds and coughs. The Maasai also recognize diseases spread by wildlife. For example, they believe that the wildebeest foetal membrane carries a virus that affects humans as well as cattle (*enkeeya oinkati)*.[21]

Diseases may also be caused by mystical factors. For example, through witchcraft (from an enemy or competitor), evil spirits, and curses from elders. Belief in the power of curse is associated with legitimate authority, underpinning social order. A curse is compared

[18] E Frankit, 'Traditional Medicine and the Concept of Healing' in *Journal of Ethnobiology,* Vol.16.No.1, pp. 63-97.
[19] W H Rivers, *Medicine, Magic and Religion,* (New York: Kegan Paul, 1924), p.72
[20] M Shaman, *Kenya's People of the Plains*, (London: Evans Brothers, 1979). p.21.
[21] Sindiga. P.101

with arrow poison placed on skin which has no effect unless there is a cut. In other words, unless a wrong has been done there is no harm. A curse is mainly used by elders to instil fear and good behaviour among the young. It is believed to bring illness and even death when a wrong has been done.

Sorcery/witchcraft on the other hand expresses forces of chaos and evil that undermine social order; it is like poison in the hands of a malicious person that requires only technique and no moral justification to be effective. Elders disclaim knowledge of sorcery; everyone is expected to adopt a lifestyle that would neither attract the jealousies of sorcerers nor the suspicion of others that he might himself be a sorcerer. Among the Maasai during age group formation, sorcery is a threat to any festival/ceremony. The sorcerer may creep and contaminate the ceremony with evil charm (*isetani*). Prophets play an important role in this as they all descent from the *inkidongi* dynasty from which sorcery is assumed to ultimately emanate. The power of the prophet is based on the belief that they have ability to 'see' from a distance the traps that sorcerers are laying. He cannot help identify them but provides effective counter-sorcery and advice that give people an edge over sorcerers. This creates a dependence on prophets in ceremonies and sacrifices.[22]

The Maasai also believe that illness, diseases and misfortune can result from a person, family or community breaching taboos or the accepted behaviour. For instance, the Maasai observe a number of eating taboos such as prohibition against drinking milk and eating meat at the same time. This was thought to cause stomach upsets and misfortune. Marriage was also not allowed within one's clan or with close relatives of one's mother. Maasai believed that this would cause mental illness or disability when the taboos were broken. During pregnancy and immediately after delivery, women must observe certain taboos and regulations related to sexual relations and are forbidden from eating some foods. For example, women are forbidden from any sexual intercourse during pregnancy as it is thought to cause miscarriage and infections on the baby at birth and diarrhoea during breastfeeding. Taboos transgression causes illness and sometimes instant death.

2. 6 Therapeutic Behaviour

The above discussion reveals that the pre-colonial Maasai believed that disease and illness were brought about by several factors. The different explanation for diseases and illness meant that therapy was sought in multiple ways. Therefore, disease etiology

[22] Spencer, *Time, Space and Unknown,* pp. 219-221

influenced prevention, treatment and management of diseases. The Maasai used different measures to prevent and treat illness and misfortune that were both physical and spiritual. For example, people would use charms and medicine, especially on children, to prevent illness and misfortune ascribed to spiritual causes. This was mainly to prevent diseases caused by human agents through jealousy or 'the evil eye'. One of the most common in this category is the 'evil eye' (e*mbusurek*). Young children wore a protective emulate (*ebisili*) on their necks to prevent sickness or harm from people with 'evil eye'.[23] Protective magic was also used by people to prevent illness during epidemics. This was mainly done by people who were thought to have a gift in protection (*ilayenak*).

Another measure used to avert misfortune or illness was isolation. For example, when someone was thought to be cursed because of murder or other misbehaviour, he/she was isolated from family members until a cleansing ceremony was performed and the penalty for murder paid or the curse was reversed through blessing. Taboos and culturally acceptable behaviour were also put in place to prevent disease, illness and misfortune. In case where an illness or misfortune had already occurred, several measures were taken to restore health and stability in the community. The action taken depended mainly on what diagnosis revealed as the cause of the illness.

Diagnosis is both an art and a method of seeking to discover the origins of the disease and determining what it is.[24] The diagnostic process not only seeks answers to the question of how the disease originated (immediate causes), but who or what caused the disease (efficient cause), and why it has affected this particular person at this point in time. The Maasai have several methods of diagnosis which varied depending on specialist. Diagnosis system places the individual concern in the context of normative social lifestyle, which falls within the framework and interpretation provided by cultural systems. Among the Maasai, there were different specialist who dealt with different problems in the society. The specialists included herbalist, bone setters, midwives, masseurs and diviners. One of the diagnosis systems is divination. Divination is an inquiry into the meaning and immediate cause of the illness. It mainly leans on the divine/spiritual realm where the unseen is revealed and the unheard articulated. A previously unknown condition is given a cause and treatment starts.

[23] Rose Tonkei, Samuli Village, 17.07.2010
[24] K Ngetich, 'Indigenous Knowledge, Alternative Medicine and Intellectual Property Rights Concerns in Kenya' 11th General Assembly, Maputo, Mozambique, 6-10 December 2005, p.4.

Cultural wisdom requires men and women of all ages to possess basic skills in case of unforeseen emergencies. It is the duty of every Maasai child to learn about the medical value of herbs as he or she grows up. Traditionally, boys are assigned the task of looking after small stock (goats and sheep) around the homesteads. In the process, they also pick up the knowledge of herbal medicine used in the home. Girls receive their knowledge of herbal medicines from their mothers and grandmothers with whom they spend a lot of time. This reveals how division of labour among the Maasai affects the health care system. According to oral data, most herbal medicine are collected by men in the forest as they herd cattle, women although they can use the herbs and know their healing qualities they rarely go to harvest the medicine as their work is centred in the home expected for medicine used for women illness.

Maasai health specialists are mainly set apart along kinship lines, distinctions that are signified by their respective unique functions. Their functions are conceptualized not only as concrete activities for many in the kinship lines, but most specialist do practice in terms of knowledge and power transmitted through inheritance. Majority of the healers have learnt the art through their relatives such as a father or uncle, or a mother or aunt in the case of a female healer. Among the Maasai, there were different specialists who dealt with different problems in the society. These included: herbalists, bone setters, midwives, masseurs, and diviners.

The following table as compiled by Sindiga gives a summary of healers and their roles present among the Maasai.

***Table 1**: Maasai Traditional Medical Specialists*

Category	**Maasai name**	**Role**
Diviners, spiritualists, fortune tellers	*Oloiboni*	Divination, foretelling, ritual expert, medicineman
Herbalist	*Enkaria*	Treat various conditions
Traditional birth attendant (TBA)	*Enkaitoyioni*(*pl.inkatoyiok*)	Antenatal, prenatal and postnatal care
Surgeons (male and female)	*Olamuratani, enkamuratani, oltorobani*	Circumcision, clitoridectomy
Bone settler	*Olaenani looloik*	Fractures and wounds
Dentist		Remove bad teeth from infants and children, however this role can be performed by other healers

Source: Sindiga

The healers specialise in particular areas. However, there was cooperation among healers and some healers performed more than one role. The *Oloibonok* dispensed both herbal remedies to treat physical ailments, and also conducted rituals to absolve social and moral transgressions. The *Ilobonok* were highly regarded spiritual leaders in charge of Maasai religious, customary and traditional affairs.

Iloibonok used different kinds of medicine. Galaty notes that they offered two different kinds of ritual medicine. One is *Entasim*; medicine which is either directly consumed or applied to an individual or object of ownership. The efficacy depends on the proper use of substance and apparent favourable divine interventions.[25] The second kind of medicine is referred to as *intalengo* (charm), which is mainly an object that has received a special blessing by *Oloiboni* with the application of various drugs or ritual medicine considered to bear powers appropriate to the need. The *Oloiboni* also treats people with herbal medicine as well as psychologically (*aitobir*) as in cases of mental illnesses.

Inkatayiok also acted as a children's dentist as well as women's advisor on the kind of herbs to use during pregnancy and after delivery. The surgeons as well as bone setters also

[25] J Galaty, *The Pastoral Image: the Dialectic of Maasai Identity*, (Chicago, University of Chicago,1977). P. 306

used different herbs during treatments. There is also other specialist among the Maasai like masseurs/kneaders, seers, as well as those who deals with preventive medicine.

2.7 The Maasai Prophets- Iloibonok

The *Ilobonok* are the ritual and spiritual leaders of the Maasai society, whose authority was based on their mystical as well as medical/healing powers. The term *ilobonok* identifies the office or institution of ritual specialization. The name originates from the term *aibon* which means prophecy.[26] There are different accounts of the origin and geology of medicinemen. Some scholars start with *Kedongoe* as the first *Oloiboni* and others argue that Olomweya was the first *oloiboni*. The others claim *Olomweya* to be of the third generation of *Kedongoe*. Spencer states that all diviners are the descendants of *Kedongoe* who had divine powers. His descendants form the *enkidongi* clan which has magical powers for healing and preventing misfortunes.[27]

The position of *Oloiboni* is confined to only one family in the *Nkidong'i* clan and is inherited. The origin of the family is unknown. Some claim that he dropped from heaven, while others that he was found by moran's from the *Ilmokesen* and *Ilaiser* clan, and the *Ilaiser* moran took him home. Hollis argues that *oloiboni* was found as a boy by the morans of *Laiser (Ilaiser)* clan on Ngong hills. Other scholars who support Hollis argue that the boy was found around Mt Kenya (*oldonyio keri*).

Most of the families of prophets claim that they were the first prophetic family among their respective tribes. The legends of the arrival of the first prophet and his acceptance by the people differ to some extent from one sub-tribe to the other sub-tribe, but there is a common theme which runs through them. Reduced to a basic framework, the legends state that the first prophet came as a boy or young man (the implication being that he was not circumcised) from some higher place, either from a nearby mountain or from the sky. The young boy showed his miraculous powers by performing deeds associated with water: lighting a fire in the midst of a rainstorm, drawing water in a waterless area, or providing his patron's cattle with abundant pasture and water in the midst of a drought. In each case, the legends imply that except for the prophets, the society and social structure existed in much the same forms as they do today, and in some cases the tribe was occupying its present area. Jacobs and Fosbrooke suggested that the prophets had not been part of the original Maasai

[26] Ibid
[27] P Spencer, *Time, Space and Unknown* (New York: Routledge), pp. 98&78.

society but an adaptation imposed on self-sufficient organization of Maasai government through age-grades. Many elders claim that before the prophets arose among the Maasai, the age-sets the elders and warriors had ruled the Maasai. However, if one considers these traditions alongside the general position of the prophets in Maasai society, they are one more element emphasizing the uniqueness of the prophets in the society. The prophets and the prophetic institution are outside the mundane, repetitive world of the age–sets. The age-sets provide social stability and a framework for the basic relationships between individuals and between generations. The prophets enabled the people to adapt more rapidly to changing situations and to some extent control their fate.

The Maasai word for prophet, *Oloiboni* (p. *il oibonok),* is a derivation from the word *aibon*, which means to prophesy or foretell. Prophets foretold the future, and if there was possibility the of misfortune provided the charms and advice which would enable his followers to overcome or avert the misfortune. Some of the techniques of prophecy used by Maasai *Ilobonok* were not unique to them, but were utilized by the prophets of various peoples of the Rift Valley and its environs. Prophetic dreams and the prophetic interpretation of natural phenomena were two of the most widely-used means of prophecy, especially among Kalenjin prophets, Kikuyu prophets, and Maasai prophets. A few families, especially the chief prophetic family of the *Purko-Kisongo* and a few others used the *enkidong*, either a large ox horn or an ordinary gourd similar in all respects to the calabashes used for storing milk. The gourd or horn held a large number of black and white stones, or the white and black seeds of the wild banana. The smooth black and white stones were obtained from river beds or from the drops of ostriches. Some prophets, but not those of the *Purko-Kisongo*, employed a few stones of special colour or shape as markers, stones whose presence was significant in them or in association with a configuration of other stones.

Evidence of Kalenjin influence upon the prophetic institution can be found in the Maasai reference to some prophets as *ol kuyantiki* (p1 *il kuyantik*) rather than *ol oiboni* in certain situations. Dr. Christopher Ehret stated that a very similar word, ol goiatiki, collected among the Southern Cushitic Aramanik, was derived from the Kalejin word *Orkoiyo* (pl. o*rkoiyot*). *Orkoiyo* was the Kalenjin word for prophet and its use and the presence of prophets among the Kalenjin certainly pre-dated the changes in Nandi prophetic institutions attributed to Maasai refugees in the middle of the nineteenth century. However, among the Maasai the term*il kuyantik* referred to witchdoctors/sorcerers rather than healers or prophets. Among the Maasai, the use of *ol oiboni* indicates the importance and the degree of influence of the

prophet and in many cases indicates the attitude of an individual toward certain prophets. The Maasai always addressed and referred to the chief prophet of their tribe or section as *ol oiboni*, never as *ol kuyantiki*. His brothers and sons, who did not share his ritual authority in public affairs, were addressed as *Iloibonok*. The word *ilkuyantik* carried nuances of "false prophet" in the sense that individuals referred to prophets who their family at least considered charlatans, men without real prophetic or medical ability.

Genealogy of the prophets extends far back beyond the earliest remembered age-sets. The first prophet according to most traditions was *Kidongoi*, or as he was often referred to by informants, *Saei Kidongoi*. *Saei Kidongoi* was succeeded by *Lesigereshi*, *Mweiya*, *Parinyombe*, *Kipepeto*, *Sitonik, Supeet, Mbatian* and his brothers, and their descendent. The names from *Sitonik* to the present are always given in the same order, and thus we can assume that they are more relevant to the history of the Maasai Prophets. The earlier names can be found in most recorded lists though not always in the same order. The name of the "first prophet", *Kidongoi,* is of special interest. Prefixed by *ol* which means 'the tail" and is thus the source for traditions which claim that the first prophet had a tail. Although one could dismiss this as simply a pun, references to the word "tail" drawn from neighbouring peoples are perhaps indications of the composite nature of the Maasai prophetic institution. Some Meru traditions state that their first ritual leader, the *mugwe* (pl*agwe*) was called *Gicuthi*, the man with the tail. Ehret noted that a Sonjo word, *esai*, meant "tail" and perhaps was derived from se:i-, a word of pre-Nilotic or Kalenjin origin.

A few of the other names are possibly references to past neighbours of the Maasai or to certain areas. The name *Lesigereshi* seems to refer to the Somali-Galla people. The name seems to have fallen from general use today, to be replaced by the names in Maasai, *IlShumari* and *IlGaflagalla*. Contacts between the Maasai and both these peoples have been minimal since the beginning of the twentieth century. *Mweiya*, the third name, or as it is sometimes written *Ole Mweiya*, is perhaps related to the Ngong hills south of modern Nairobi. The hills were also known as Lamwea and Lemunyo and part of the general highland mass, *Ndoinyo Narok* (the black hills). According to other scholars, Lemwea was the name of a Kwavi chief, who gathered his followers about him and determined not to leave the above region but to live and die there. His followers, since the death of their chief, have long since migrated."[28] The names Parinyombe and Kipe-peto have no other associations and no other

[28] Ehret *The Civilizations of Africa: A History to 1800*

referents. Sitonik also belongs to a "pre-historic" period in the sense that elders do not associate any events with him, nor today do they associate him with any specific age-set. However, the chief prophetic family of the Maasai is occasionally referred to as the *Enkang e Soitonk*, but more often as the *Enkang e Supeet*.

Another area of contention is the transfer of powers by the OLoiboni to his successor. Comoro observed that the transfer of traditional medical knowledge by Oloiboni among the Maasai of Tanzania, that the wives of the ailing medicine man are involved in the passage. The Orkurma, a black magical stick which automatically passes on the healing, divine and prophetic power is handed over to the successor.29The stick is usually given to the eldest son. This is also supported by Maundu et.al's account of transfer of medical knowledge by oloiboni among the Loita Maasai.30

There is also a difference in the recount of whom and how Mbatian gave his powers to his sons. Hinde argues that Mbatian placed his medicine into a living tree and proclaimed that whoever of his two sons Senteu and Olonana would find the medicine would be the appropriate successor.31 According to Hinde, Olonana found the medicine and this proved his fitness to succeed his father as chief. Accordingly, power was transferred to Olanana when Mbatian took off his right leg sandal and put it on Olonana's right foot to show that he would follow his footsteps. Then he unbuckled his sword and placed it in Olonana right hand, indicating that his battles would be Lenana's. He then took a piece of the skin garment he was wearing and fastened it around Olonana's neck as a symbol that his possession was made over to Olonana. Finally, the royal medicine was handed over thus completing the ceremony.

Hollis argues that Mbatian called the elder son Senteu and gave him instructions on what to do in order to get the medicine. 32 However, all along Olonana was listening and he informed his mother who directed him on what to do to get the medicine instead of his brother. Olonana followed his mother instructions and succeeded his father. Mbatian blessed Olanana and gave him the iron club, medicine horn, guard, stones and the bag. Despite the above accounts of the transfer of medical power, the descendants of Oloiboni had to learn the

[29] C J Comoro, 'Traditional Medical Practice and Western Allopathic medicine in Tanzania: A Look at Bottlenecks towards Universal Health Care by the year 2000 or beyond,'' *Internationales Afrikaforum*, Jg. 29,Quart. 2 (1993) pp.159-175.

[30] P Maundu et.al , 'Ethnobotany of the Loita Maasai: towards a community management of forest of the lost child' *People and Plants Working Paper* (Paris: UNESCO, 2001).

[31]Hinde,Last of the Masai, p.10

[32] Hollis *The Maasai and their Language and Folklore* P.329

art/trade though it is hereditary. The successor was not necessarily the first son as the Oloiboni selects one of his sons according to the successor's suitability for the post. In this regard Mbatian preferred Senteu and had prepared him to succeed him; he could allow him to deal with some of his clients to gain practical knowledge and influence In this respect Olanana was relatively disadvantaged, though he might have learned the art from his uncles and cousins more than by occasionally observing from what his father did to his client33.

The Oloiboni's roles among the Maasai were multiple. These included officiating and directing ceremonies and sacrifices, healing people of physical, mental or spiritual ailments, and providing advice to elders on the spiritual aspects of community. They also acted as prophets, shamans and seers, and are the ones (with help from the elders) who name the successive age-sets. They also open and close the various ceremonies of age-set transitions.

The main function of the Oloiboni, was essentially to bridge the gap between man and God (or "the other world"), Oloiboni's influence was generally limited to 'reading' the mind or the intentions of God. In this capacity the Oloiboni are especially consulted whenever misfortune arises, like the failure of rains, disease epidemics or military losses. Harlow divided the Maasai Oloiboni into three categories according to practices; diviners, rainmakers and senior Ilobonok. 34 Jacobs also divided them into three groups but according to the population they served. These include private practitioners who treated illness by divination and ritual prescription but are not consulted to make prophecies or to make protective charm. 35 It is felt that they were not skilled enough or divinely inspired. The second group is Oloiboni consulted by a group (e.g kraals, groups of age-mates or kinsmen). They treat illness affecting the entire group and give advice for future courses of action. This group, also prophecy and make protective medicine for the groups in respect for future events. The third group is the 'tribal' ritual experts who are, according to Jacobs, chosen from the second group. They mainly participate in warriors' graduation ceremonies (the group generally known as the Oloiboni among the Maasai). The informants divided Iloibonok into different categories according to the methods they used in diagnosis and treatment of the population. But all are referred as ilobonok.

The Oloiboni also commanded a lot of power depending on his personality and efficacy. This was the case with Mbatiany (Batian, whom Mount Kenya's highest peak is

[33] P Ndege, *Olanana Ole Mbatian,* P.14
[34]W Harlow, *History of East Africa,* (Oxford: Oxford University Press, 1982), p.603
[35] Jacobs p.323-324

named after), who managed to command many Maasai sections at the time of the British colonization. Kanyangezi argues that the Maasai Oloiboni had a political role in promoted relations between age-sets. 36 The Oloiboni was also capable of controlling diseases, sterility, birth and death in the community. Feierman also mentioned that during the pre-colonial period, healers played a role in organizing production, which was linked to holders of political power, or held it themselves.37 However, among the Maasai, the Oloiboni had no political power but had great influence in officiating age-set ceremonies and influenced choosing of leaders by the age set leaders.

Olonana was neither a Maasai king nor chief, he was simply an Oloiboni. Plainly put, he was a medicine man and his duty was to divine future events, with the administration of drugs and the practice of witchcraft. The British colonialist were fully aware of this; Sandford states that "It does not appear, however, that the Ilobonok (iloibonok) have ever attempted to assume a position resembling that of kings of native tribes, and the appointment by the government of Lenana (Olonana), and, at his death, of his son Seggei (Seki), to the office of paramount chief of the Maasai was, in fact, as a result of misunderstanding of the normal state of affairs which steps have now been taken to rectify."[38]

Even today, the role of the Oloiboni is still very important, being so deeply entrenched in the social life of the people to the extent that physical ailments that cannot be treated by a traditional physician are taken to the diviner. Dispensing herbal remedies to treat physical ailments, and ritual treatments to absolve social and moral transgressions.

2.7 Herbalist

A herbalist, as described by Mburu, is a person who deals with herbs and herbal medicine of whatever brand concocted from selected leaves, roots or any other properties of plants. The medication is explicit for specific diseases39. For one to be an herbalist, one is expected to have empirical knowledge of herbs. The herbalist is expected to tell between the poisonous and non-poisonous plants. He is expected to know the herbs fit for external or

[36]T A Kanyangezi 'The Medicine man as Leader in Traditional Africa-Mbatiany, 1824-1889', in *Politics and Leadership in Africa* editedby A Ojuka and W Ochieng, (Nairobi: East Africa Literature Bureau, 1975), p.30.

[37] S Feierman, 'Struggles for Control: The Social Roots of Health and Healing in Modern Africa' in *Africa Studies Review*, vol.28, No 23(1985) p.73-147.

[38] Sandford, *The Administrative and Political History of the Maasai Reserve*

[39] F. M Mburu, "The Social Production of Health in Kenya," *The Social Basis of Health and Healing in Africa*, By Steven Feierman and John M. Janzen (Berkeley: University of California, 1992 p.168

internal use. Among the Maasai, herbal knowledge is generally open to all. Traditionally, boys learned through their fathers, uncles, grandfathers, and neighbours. This knowledge was mainly passed on during the day when herding livestock. The girls learned from their mothers and mostly got limited knowledge because of less exposure to plants in the forest as the girls spend most of their time doing domestic work. The herbalist should also know the effect that the plants have on the human body.

Herbal medical knowledge is almost communal among the Maasai, in the sense that nearly everybody in the community can make use of traditionally available medication for common colds. Researcher note that the majority of elders, especially men can identify large numbers of species and freely communicate the specific parts of the plant that are used, the process of preparation and, in some cases, explanatory models for how the medicines work. It is evident – as has been noted in previous studies of Maasai culture, that this extensive knowledge of medical plants is communal. However, not everyone is equally knowledgeable in the preparations and dispensation of the medicine.

Wilson Sakuda is a 65 year young man and a practising herbalist. He learned the practice from his grandfather. Who took him in the forest and showed him which plants have medical properties and what they treat. At the age of ten, he was introduced to general plants morphology and how that related to their healing properties. He was invited to seat through diagnosis which was mainly through listening (client explaining the problem) and observation.

The herbalist uses many plants in their environment for illnesses common in daily life. One of the major uses of plants is for medical purposes for both human and animal. The herbs are used to solve problems like wounds, parasites, body aches, burns and also herbal purgatives to cleanse patients. The spiritual significance is also very important in herbal medicine, when a patient is taking an herbal infusion, he/she expects to benefit from the life force of its ingredients and from the power of God (Enkai).

2.8 Surgeon and Bone Specialist

The Maasai also had specialists who specialized in bones and surgery. They had vast knowledge on bones structures and systems in the body. In cases of deep cuts, they would stitch up the wounds with sinew from the back of an ox and bind the wound. If the bones were affected, they would cut through the flesh, take out the splitters and bring the edges of the bones together, after which they stitched up. When a rib was broken, flesh was skinned from

the wound and rib of the sheep was inserted in the place of the broken one. Sheep fat was then poured to the areas before it was sewed up. A dietary restricted to meat and herbs was followed during the period of healing. However, the rib case seems exaggerated. For a fractured or broken limb they fastened a ligature around the limb, to support it and if it was totally broken they at times had to amputate. In case of intestines protruding, the wound was washed and the intestines returned to their place. Hot sheep fat was mainly used as a disinfectant to wash the intestines and wounds.

2.9 Women as Healers

Indigenous health care system, like any other cultural practice was shaped by the social ideals governing the society like gender norms. Gender creates information on indigenous medicine. Men and women not only had different knowledge of medical plants but also their knowledge is structured in different ways, reflecting the division of labour and inequality of social power.

The difference in gender participation in Maasai indigenous health care is evident. Several scholars (Bussman et.al40, Kiringe41 and Sindiga42) note that men had greater knowledge of medical plants than women; though women as mothers, wives and daughters play greater role in health delivery, especially at the family level. Women also had different health problems from men and responded to diseases differently due to social expectations. Nelms and Gorski argue that women in Africa utilize, indigenous healer timeless and ancient care giving when faced with health symptoms, probably because of their status in the community43. Most women healers dealt with women illnesses and issues. These included, traditional birth attendants (TBAs) or midwives, circumcisers and others involved in general health.

The women healers (TBAs) generally have specialized knowledge of medicine used during prenatal and post-natal delivery for the care of women and children. Most TBA around 70% have been influenced by relatives like grandmothers, mothers, aunts who were TBAs.

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[40] R W Bussmann et al, 'Plant use of the Maasai of Sekenani Valley, Maasai Mara, Kenya' *Journal of Ethnobiology and Ethnomedicine* vol 2 2006.

[41] J W Kiringe, 'Ecological and Anthropological Threats to Ethno-medicinal Plants Resources and their utilization in Maasai Communal ranch in Amboseli Region of Kenya', *Journal of Ethnobotany* vol 13, 2005. pp.231-241.

[42] I Sindiga, 'Indigenous (medical) knowledge of the Maasai.'In *Indigenous Knowledge and Development Monito*r 2 No 1 (1994), pp16-18.

[43] Nelms L & Gorski J., 'The Role of Traditional Healers in Women Health', in *Journal of Transcultural Nursing*, Vol 17 No 2, 2006.

The transfer of knowledge is informal, received through accompanying and assisting during deliveries. Learning usually took many years and most started practicing after giving birth. TBAs are indigenous midwives. The TBAs are mainly women who are recognized in the communities for their skills in child bearing. They are skilled and assist in antenatal, prenatal and postnatal care. TBAs get involved from when the woman gets pregnant, to childbirth, and postpartum care.

During pregnancy, the TBA gave advice on diet and medication (herbs and roots of trees) in case of illness. But some herbs are given to women to clean the stomach and blood system. These are mostly mixed in soup. The diet of a pregnant woman was highly controlled. Food was progressively reduced while water quantity was increased. The Maasai believed that much food (milk and meat) causes the foetus to fatten consequently making the process of giving birth difficult.

In childbearing, the TBA examines the labouring woman's belly to assess the baby position if the baby was correctly positioned, that its not inverted or obstructed and to ascertain that it is still moving to the right direction. In some cases, she tries to fasten the process by use of certain traditional remedies; herbs (like orkinyie) are given to cause vomiting which was believed to hasten the process.

Labour is monitored by involving the woman in labour and massaging the belly. When it is ready (way is open), the woman is made to sit in a semi-upright position with a woman supporting her shoulders. The TBA squats behind her to receive the baby; the umbilical cord is cut and the following words pronounced, 'bunga otau lino maibunga olalai' (hold your heart as I hold mine). Meaning the child is a different entity. The mother is then given hot drinks, tea or animal fat or fresh blood taken for a bull if the baby is a boy and from a heifer if it is a girl.

After delivery, TBA would support women through advice on herbs to use for cleaning the uterus especially if the mother was a young woman (giving birth for the first time). Some of the herbs used after birth includes: Oseki, Ormirongiro, Oleturot and Oremit. Most of them were boiled and taken orally or sometimes mixed with tea. The TBA also gets paid after the work, mostly in kind. The payment was in form of animal fat from the animal slaughtered for the mother usually a lamb. However, this changed to money after the money economy was introduced to the Maasai. TBAs are mainly used in rural populations, probably because of poor access to health centres. The midwives acquire their knowledge from a

relative or apprentice. TBAs among the Maasai play a very important role in reproduction health care because hospital or dispensaries are unavailable, as western medical centres are very far. As noted earlier, women healers mainly deal with women illnesses, like pregnancy complications, fertility and at times advised on health. An example is a woman spiritualist healer (enkoiboni) in Ngatataek village in Kajiado central, known as Nakutuk. She treated all women illness and advices at times on what women should do in the face of community misfortune.

Men also get involved in women health at the community level. Rituals for treating infertility are the domain of men as observed by Spencer. During these rituals, men wear traditional women shoulder aprons and spiral earrings, and they pray and bless the women in an organized community ceremony. Some women healers treat the whole community (men, women and children), mainly in removal of foreign substances in the body (ang'ob). The Maasai believe that foreign substances can get into the body mainly through sorcery and cause illness.

2.11 Payments

Reciprocity and payment in indigenous health care among most African communities is believed to contribute to the effectiveness of the treatment. A small number of Maasai healers received payment for their services. Most of them received the fees after the clients had been cured and others just when they commenced treatment. The fees charged mainly depended on an individual client's ability to pay for the medicine. In some instances, it also depended on the complexity of the illness. Over the years, the types and methods of payment for traditional healing have changed, especially in urban settings, where practitioners are increasingly demanding monetary payment

2.12 Summary

Indigenous health care among the Maasai in the pre-colonial period was linked to political, economic and religious practices. Consequently, we have seen the dynamics of the Maasai pre-colonial nature of health and we have seen the interconnectivity between various specialists among the Maasai who collaborated in the health process. For example, the Ilobonok are both prophets and healer as well as participate in rituals that are connected to leadership in the community. The main function of the Oloibonii, was essentially to bridge the gap between man and God (or "the other world").A Oloiboni's influence was generally limited to 'reading' the mind or the intentions of God. We have also seen that indigenous health care system, like any other cultural product, is shaped by social ideals governing the

society like gender norms. Gender creates information on indigenous medicine, as men and women not only have different knowledge of medical plants but also their knowledge is structured in different ways reflecting the division of labour and inequality of social power. Women healers generally had specialized knowledge of medicine used during prenatal and post-natal delivery for the care of women and children.

CHAPTER THREE

3.0 COLONIAL AND MAASAI MEDICAL PRACTICES, 1895-1963

3.1 Overview

During the colonial period, the Maasai were conspicuous for their unwillingness to become involved in, or to co-operate with, colonial rule in Kenya. Between 1895 and 1904, however, the Maasai and the British had entered an informal alliance to further their mutual interests. The Maasai, badly hit by the human and animal plagues of the 1880s and early 1890s, needed time to recover their stock and to reorganize their society. The British, hampered by lack of money and troops and a weak position, could not afford to antagonize the Maasai who controlled their lines of communication. Co-operation proved fruitful for both sides. The Maasai were able to get stock by joining punitive expeditions, while the British relied on them to supply irregular troops. Olonana, the Maasai Oloiboni, was able to enlist British influence in support of his claims to paramountcy against his brother, Senteu, who lived in German territory. The contrast between German and British policy towards the Maasai illustrates some of the advantages which the British and the Maasai gained from their alliance. After 1904, this alliance began to break down as their interests diverged. Olonana was left isolated as both sides began to work out a new understanding. Therefore, colonial period is critical in a study on the transformation of indigenous Maasai healing practices. The colonial administration, in the late nineteenth and early twentieth centuries, suppressed indigenous medicine specialists with laws (that controlled/forbade the use of some aspects), introduction of biomedicine and Christianity into the country. The colonial administration viewed medicine as an important tool to assert colonial control over the African population, which led to overemphasis on western medicine and suppression of indigenous medicine. In this chapter, we argue that during the colonial period western medicine and Christianity were used to enforce the idea that the African way of healing was primitive and perverse and in need of reformation. Science, education and religion were used to harness the effect of this transformation.

3.2 The Establishment of the colonial rule in Maasai land, 1895-1913

Colonial rule was established in Africa in general and in Kenya in particular against a backdrop of changes and development in Europe. In nineteenth century, Europe experienced a lot of changes in thought, education, and values, which influenced European perceptions of Africa and its people. It was during this period that the discourse on black female sexuality emerged in the figure of the ‘’Hottentot Venus’’ and the idea of social Darwinism. While the

former was used to constitute Africa as a sick continent with sickness tied to blackness, sexual anatomy and pathology, the later was used to develop a scheme of biological classification with Africans at the bottom of the schema.[44]

During this period, there was also an expansion in scientific knowledge in biology, metals, and chemicals- all of which were of great value to medicine. There emerged out of these advancements new therapeutics, including synthetic drugs, vaccinations, blood transfusions, and antibiotics. The development led to scientific medicine based on the germ theory of disease. Doctors no longer received their training through apprenticeship or learned of remedies through dreams. Instead, they were trained in formal schools and, upon entering practice, were regulated through licensing and to a lesser extent through their membership in medical associations. Consequently, western medicine had no place in it for priests, except at the deathbed; nor did churches have any room in them for healers. Micro-organic disease theory represented the new systems of thought in Europe. This discourse and development shaped the general European, African relations at the onset of colonial rule. It was under the above discourses that exploitation was born and the invention of Africa as a ‘‘Dark Continent’’ that needed civilization formulated. Africa was constituted as a disease plagued continent, Africans as primitive, and practices as barbaric/pagan. Colonialism was more than a creation of political authority and exploitation of the non-European world; it was an ideology concerned with the creation of its own authority and legitimacy. As argued by Ferguson, there is no evidence that diseases were more widespread in Africa than other continents at the onset of colonialism.

Christian missionaries shared the same cultural strand with the colonial administrators and consequently shared negative perceptions about Africans. The missionaries saw Africans as ‘fallen man’ Rebmann referring to the coastal people stated that ‘the deep fall of man from his creator shows itself in these countries especially in circumstances that nature exercises its fill over him.[45] The missionaries also saw Africans as a suffering people (fallen men). Olumwullah observed that the missionaries perceived Africans as an excessively superstitious being with customs and excessive fear of witchcraft which formed a pathological continuum and Christianity was the solution.[46]

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[44] Olumwullah, Disease in Bunyore, P.3

[45] Quoted by Kasiera, ‘Patterns of Mission Penetration in Kenya’ in *Christian Missions and Social Transformation; a Kenyan Perspective*, J.N.K Mugambi, (Nairobi: NCCK, 1989), P.34

[46] Olumwallah, Disease in Bunyore, P.137

Krap, while urging the churches to send missionaries to the Maasai land, stated,

> May it soon be granted to our Protestant Churches, to send missionaries to the millions of Wakuafi and Masai, to proclaim to them the word which preaches reconciliation, so that these worst of heathen, a nation scattered and peeled, a people terrible from their beginning hitherto, may be brought as an acceptable offering in the sight of the lord God of Sabaoth to Mount Zion, and taught to know, to love and to honour the true Naiterkob.

Krapf believed that the Maasai, like other Africans, were 'fallen men' who had to be converted as well as civilized. To Krapf, the Maasai were the worst of heathens that needed salvation and 'civilization'. According to Krapf, Christianity and civilization went hand in hand. Hence he also became an advocate for European political intervention in the area. He believed that colonial control was a necessary condition for successful evangelization.

Krapf and Rebman members of the Church Missionary Society, is believed to be the first Europeans to contact the Maasai in the late 1840s, though they did don't venture to the interior to evangelise. This was probably because of stories of terror and danger circulated to the Europeans, which kept the missionaries away from the interior believing that the Maasai were too dangerous to work with. The situation changed with the ecological crises. This situation seemed to offer an opening that the crisis would make the Maasai more open to 'civilization'. The missionaries hoped that once the big cattle herd of the Maasai were no more and raiding forbidden (by colonial laws), then the Maasai would turn their spears to spades and their swords into reaping hooks and under such circumstances the missions would reach them.[47]

The ecological crisis of the late nineteenth century in East Africa caused a lot of disruptions and instability in many communities. The decade 1884—94 is simply referred to in the Maasai traditions as 'The Disaster' or 'When the Cattle Died'. The Maasai and the herds on which they depended were ravaged by the outbreaks of epidemic disease. The outbreak of rinderpest, bovine pleura-pneumonia, smallpox and famine, seriously affected the Maasai and their cattle. About 1883, bovine Pleuro-Pneumonia spread from the north and lingered for several years. The cattle were seriously affected but the Maasai were able to concentrate their remaining stock, seeking support from kin and clan, and then set out to augment the herds by raiding their neighbours.[48]

[47]R.Waller, 'They Do the Dictating & We Must Follow: The African Inland Mission in Maasailand' in *East African expressions of Christianity*, by Thomas T. Spear, Isaria N. Kimambo, (Oxford, James Currey, 1999).
[48] J. Thomson, *Through Masailand* (London; Searle& Rivington, 1887), PP. 206, 333, 337.

A second and far more serious blow fell early in 1891. Rinderpest appeared for the first time among the herds at Loitokitok. It had been brought in by raided cattle. The disease spread rapidly throughout Maasai land in the same manner. By March, it had reached the Kinangop, although there was still 'a vast quantity of cattle' in the Kedong valley.[49] The weight of the disease thus seems to have fallen unevenly and it is difficult to estimate the damage done to the Maasai herds as a whole. Clearly, it was considerable. Ford has estimated a mortality of perhaps 90 per cent. Tradition suggests that the herds were all but wiped out, and that people were reduced to eating donkeys and, even hides. According to Dawson, the outbreaks like that of smallpox caused the Maasai to move to high population density areas which had more favourable conditions for disease spread, because Maasai population densities did not normally support endemic smallpox. The Maasai had little immunity to the disease when they were eventually exposed to it, hence a high death rate.[50] Travellers recorded harrowing descriptions of starvation and death.

At the same time, the Maasai were also gradually losing the initiative in the vitally important struggle to control their resources of stock and grazing lands. Kamba, Kikuyu and Kalenjin raiders were already making inroads into Maasailand and Maasai raids in retaliation were becoming less successful. Further to the North West, the Suk and Turkana were pressing inwards.[51] Even without the depredations of disease, the Maasai were being forced onto the defensive in the period immediately before contact with the British. This was partly the result of a disparity in manpower between the pastoralists and the settled peoples, and of long-term population movements. The above situation helped to set the grounds for European and Maasai relations. The decimation of Maasai population as well as death of their cattle and the pressure put by the settled communities influenced colonial opinions about the Maasai, specifically their ability to survive as an ethnic group. Following the events, the general observation was that many Maasai lost their lives and their population declined a lot during this period. Jacob estimated that over half of the human population died.[52]

The colonial administrators' perceptions were developed against the backdrop that the Maasai were on the brink of extinction. The perceptions are well stated by Tignor, who

[49]A. B. Percival, 'Game and Disease', *journal of the EastAfrica and Uganda Natural History Society*, VI (1918), 310-11.
[50]Dawson, 'Smallpox', in *Health and Disease in Kenya*, edited by L C Vogel, Nairobi, Kenya Literature Bureau, 1974, P.90.
[51]Thomson, *Through Masailand*, PP.168, 334.
[52]A Jacob, 1979, P.47.

argues that "there were certainly many British officials who felt that the Maasai reluctance to embrace change was the result of a declining civilization, one that had lost its vitality at the end of the nineteenth century".[53] The British believed that without their intervention the Maasai would have been extinct as a tribe. The nineteenth century saw the emergence of a new image of the Maasai of a once-strong ethnic group, now reduced in numbers and strength by successive famines and disease outbreaks. As early as 1902, the British believed that the Maasai would decline in numbers due to high sterility among Maasai women. Johnston reported that, "...the Maasai females are becoming increasingly sterile". He attributed this to the increased use of prostitutes by Maasai men, associated with the arrival of the Mombasa-Uganda railway through Maasailand.

The preoccupation with extinction perhaps formed the basis with which the 1904 British-Maasai agreement, which created the Southern and Northern Reserves, was drawn up. These areas were to ''be enduring as long as the Maasai as a race shall exist''. The British were expecting the Maasai to decline in numbers and after sometime be extinct and the British could occupy the highly potential agricultural land. The British opinion was also grounded in Maasai cultural practice and their environment. The British believed that the Maasai tradition of relations between Morans and pre-pubescent girls and the sexual access of a husband's age-mates to his wife or wives was responsible for reduced female fertility and hence the population decrease in the tribe.

Eliot in 1905 stated that, 'it is extraordinary that a custom which must be disastrous for the physical wellbeing of the race, and is doubtless responsible for its decrease in numbers, should be tolerated'.[54] Hollis referred to the practise as "sexual communism or something very like it" resulting in "a state of group marriage". [55] These led to the view that sexually transmitted diseases were common among the Maasai and were the main cause of sterility and consequently population decline.

The description of the Maasai as suffering from venereal disease formed the theme of western biomedicine among the Maasai. Western medicine was established in the Maasai reserve with an objective of controlling venereal diseases. These are observable in a series of scientific enquiries undertaken among the Maasai. Most of the surveys and medical safaris

[53]Tignor, *The Colonial Transformation of Kenya*, 1976, p.16
[54] Ibid.
[55] Hollis, *The Maasai and their Language and Folklore*. P.480

done in the Maasai reserve were on venereal diseases. Despite these perceptions of the biomedicine during this period was only focused on the European population.

The colonial perception of the imminent extinction of the Maasai and diseased Africa shaped political relations as well as the establishment of western medicine in Maasai land. The Anglo-Maasai treaties to a large extend influenced the perception of the Maasai by Europeans. That 'agreement' was signed between the British colonial Government and the Maasai, the Governor, Sir Donald Stewart, represented the British while Olonana ole Mbatiany 'represented' the Maasai. The Maasai on their part did not abide to the agreement. To the Maasai, land was not a commodity to be exchanged but to be utilised. The lease concept was a foreign practice to them, thus they did not keep it. Another possibility as argued by the informants is that the Maasai were not privy to the content of the agreement. The British colonialists came up with yet another 'Agreement' signed in 1911, which created the southern and northern reserves. The Maasai reaction was the immediate filling of a suit to nullify the agreement. But the case and a subsequent appeal were dismissed as the court ruled the agreement was actually a 'treaty' between two 'states' and that the court had no jurisdiction to handle such cases. The Maasai did not give up. They planned to lodge a final appeal in London. This was nipped in the bud when the protectorate quarantined Maasai cattle when it learned of efforts to sell cattle and raise money to file the case.[56] The 1911/12 move marked the beginning of a long retreat by the Maasai from involvement with the colonial power and the replacement of a highly flexible and innovative response to the advent of colonial rule by a determination to preserve their society, which was both rigid and deeply suspicious of further colonial development. The Anglo-Maasai relation had led to change of the position of Oloiboni from a medicineman to a political leader. The change of Olonana from ritual expert to Government chief affected his flexibility, which was an essential ingredient of the Oloiboni's success. Moreover, the demands which the British made upon Olonana in return for their support began to erode the basis of his own support among the Maasai. As he drew closer to the British, he became more dependent upon them. The British were aware that their demands were eroding Olonana's authority and that 'he might be "left" by his people', as Ainsworth puts it. This would leave the British without any obvious ways of influencing the Maasai. Moreover, Olonana himself might conceivably turn against his backers since 'with the Maasai; he is chief, while under the protection of the Government,

[56]The *EastAfrican* August 16, 2004.

without his Maasai, he 'would be absolutely nobody'.[57] To avoid this, more Government influence should be brought to bear on Olonana. It might then be possible to avoid an open clash with the Maasai by getting Olonana to side with the British and to ask for assistance in dealing with 'trouble makers'. Despite British support, Olonana's loss of influence continued, as Maasai interest in British rule continued to wade. The role of the *Oloiboni* as a healer; capable of controlling diseases, sterility and death was greatly reduced. The *Oloiboni* acquired a new political role and his relations with the morans, ilmurran as well as elders diminished. The confidence on his prophesies which earlier were thought to be for the general interest of the Maasai society waned. Ole Konka[58] and other interviewees for example blamed the *ilobonok* for hostilities between the Maasai sub-sections which mainly emerged on the onset of colonial rule and the loss of land. The colonial period led to loss of status and power for the Maasai spiritual healers, has pointed out by Feierman, colonial conquest deprived healers of their control over production and broke most links between healing and public authority[59]

The Protestant missions fully supported the concentration of the Maasai into one reserve, thus giving a blessing to the demands of the settlers and the pro-settler administration. Missionaries supported the policy from what they argued was a moral point of view. Bishop Peel [of the CMS] put this moral Christian point of view even more sharply, that is putting the Maasai into one reserve was, according to the bishop, "sound administration and a wise step in the moulding of these remarkable people afresh in civilization, but admitting of conservation of anything good in the end of keeping them from all the peculiar evils of their present system and customs."[60] The Vicar Apostolic of Zanzibar and British East Africa seized the opportunity to warn the Governor that if the Maasai were not confined to one reserve they would be a major source of trouble for the administration in the future. Echoing the Protestant missions' view, he wrote, "You are only aware of the moral condition of a people if they are brought together and firmly controlled by government."[61] That far, it had been difficult to evangelize to the pastoral tribe, so the missions believed that work among them would be easier if they were restricted to one area.

[57] Gilkison to Ainsworth, 1 July 1896, Coast Province: Ukamba in 1896, KNA

[58] Ole Konka, Oral Interview 21/6/2010, Kimuka Village.

[59] S Feierman, 'Struggles for Control: The Social Roots of Health and Healing in Modern Africa' *Africa Studies Review*, vol.28, No 2/3(1985) pp.73-147.

[60] Temu (1972), quoted in P Rigby, Pastors and Pastoralist: The Differential penetration of Christianity among East African Cattle herders, *Comparative Studies in Society and History* Vol,23, No.1 (Jan, 1981) pp.96-129

[61] Ibid

The Maasai interaction with the missionaries was characterised with suspicion and distrust. Missionaries viewed the Maasai as uncivilized fallen men whose culture and lifestyle need to be destroyed. Their strategy for evangelization was based on settling the Maasai and making them abandon their customs and culture; their traditional rites and rituals were regarded as against the Christian faith and morals. Some Maasai customs turned out to be hard for the missionaries to accept like pastoralism and polygamy. Missionaries were also uncomfortable with Maasai rituals during ceremonies. The missionaries also, had reservations about the dancing, customary Maasai dress, religion, body painting and ornaments as well as the arrangements surrounding many local events. The cultural contradictions between the Maasai and missionaries led to difficulty in converting the Maasai to accept the missionaries' way of life.

Missionaries believed that the Maasai were doomed and the only hope for the tribe was if they would settle and practice cultivation. This implied that the Maasai had to lose their wealth, identity and lifestyle to gain salvation. This perception created a link between Christianity, sedentarization and impoverishment that characterised missions in Maasai land. The missionaries expected their converts to live simple and self-sufficient life and not to concern themselves with material things which the missions could not provide. This led to abject poverty among Maasai converts. In Maasai words, the converts were referred to as *Isinkan,* meaning servants. Thus Christianity was identified with poverty.[62] This created isolation and disrespect of the convert and the mission station. The general perception that the Maasai were not fit for Christianity because of their traditional lifestyle helped to reinforce the isolation as missionaries insisted on complete separation of the convert from his/her past. This led to a clash between missionaries and the Maasai. The connection between the missionaries and European control, become clear to the Maasai. African Inland Mission (AIM) activities were viewed with distrust brought about by the relocation, leading to loss of Maasailand to settlers and creation of the Maasai reserve. The missionaries, like the colonialists, believed that the concentration of Maasai in the reserve would enable them to reach the Maasai and convert them. Another factor that worked against missionaries' activity was that Maasai Reserve was a closed District; access to outsiders was at the discretion of the colonial administration which was acting as trustee for the Maasai. Hence, the government controlled the activities of the missionaries. In other parts of the colony where missionaries

[62]R.Waller, 'They Do the Dictating & We Must Follow: The African Inland Mission in Maasailand' *East African expressions of Christianity*, by Thomas T. Spear, Isaria N. Kimambo, (Oxford: James Currey, 1999). p.8.

were more numerous and well connected, their opinion could be brought to bear on government. But in Maasai land, the mission had no supporters, and missionaries viewed as outsiders who could be commanded to leave[63]. In 1913, the Maasai refused to allow missionaries to open stations in the southern reserve, this remained in effect for a long period.

3.3 The Colonial State, Epidemics and the establishment of Biomedicine in Kenya, 1914-1963

The development of Western medicine in Kenya can be understood in terms of the health priorities, perceptions and initiatives of the British colonial government. This is primarily because the British focused their health initiatives on the European population, providing medical attention only when epidemics broke out amongst the Africans. When epidemics like 'olkipei' and jiggers arose in Maasai land, the British resorted to their customary epidemiological measures of isolation of those infected[64]. The local population was resistant to the colonizer's foreign and unexplained ideas of health and healing especially isolation. The sole concern regarding the health of the native population was keeping them barely healthy enough to work[65]. The medical practices were to a large extent clinical (curative). However, between 1913 and 1914, other aspects of medicine were introduced, which were preventive and mainly focused on sanitation. A Sanitation Division was established which focused on town planning and prevention of epidemics through urban planning and sanitation. In urban planning, the colonial government used a policy of segregation for residential areas as well as hospitals, requiring separate medical facilities for the European community, given first priority, then for the Indian community, next, and finally for the African community. However, it is important to note that in relation to the rest of Kenya, Maasai reserve was granted minimal medical resources. Medical services in the African reserves were to a large extended provided by the missionaries. The missionaries demanded the indigenous health practitioners to discontinue their work[66]. Missionaries played a role in health provision in many parts of the country like western Kenya, according to Olumwullah, missionaries played a major role in health care among the Abanyole of

[63] P Rigby, Pastors and Pastoralists: The Differential Penetration of Christianity among East African Cattle Herders, *Comparative Studies in Society and History,* Vol. 23, No. 1, (Cambridge University Press, Jan., 1981), pp. 96-129.
[64] Ole Kaaka, Olemurkat Village,
[65]F. M. Mburu, "The Social Production of Health in Kenya," *The Social Basis of Health and Healing in Africa*, By Steven Feierman and John M. Janzen (Berkeley: University of California, 1992), p.410.
[66]Charles M. Good, *Ethnomedical Systems in Africa: Patterns of Traditional Medicine in Rural and Urban Kenya* (New York: Guildford Press, 1987) 37-39.

Western Kenya during the colonial period[67]. However, among the Maasai missionary contribution in the medical services was insignificant. The only visible missionary activity was education. The missionaries as well as colonial administrators believed that the Maasai could change through education, which would enlighten them to abandon their customs, especially pastoralism[68].

According to Donovan, the missionaries' strategy was to lure Maasai children to schools where they were indoctrinated with Christianity in the hope that they would go back to their parents and tell them about Christ. The schools were a place where children were taught to reject native culture and replace it with western ideas and practices[69]. Saitoti in his autobiography stated that there were religion sessions in the school. The teachers denigrated Maasai ways and customs were regarded as out-of-date, unclean and ignorant. Western ideas were presented as a high culture and its acquisition a blessing. However, according to Saitoti no child continued to practice Christianity after leaving school[70]. Masharen states, that the missionaries failed to make a major impact as it attempted to implant the elements of a quilt culture which was doomed as it clashed with the definition of values the Maasai were committed to defend.

In 1918, after the First World War, policies and perceptions started to shift due to the rise in epidemics that threatened European population and African workers away from the urban-focused medical system. The shift led to focus on preventive measures and provision of heath advice and leadership to the local authorities. This can be observed in Gilks statement in the report where he argues that in the early colonial days 'The energies of Medical Officers attached to the administration were chiefly directed towards the maintenance in health of the Europeans and native employees of government''. Policy also changed to focus on both preventive and curative medicine, this formed the parameters within which for several years colonial biomedicine redefined itself and push aside indigenous health care. It can be argued that the realization of the need to provide both preventive and curative services to the native population formed the basis under which the 1921 Health Ordinance was passed. The Ordinance provided details on prevention and suppression of infectious diseases, communicable or preventable diseases and the provision of medical advice and leadership to

[67] O Olumwullah, (1995), p.
[68] Annual Medical Report
[69] Vincent Donovan, *Christianity Rediscovered*, (London: SCM, 1978)
[70] Tepilit Ole Saitoti, Maasai

the local authorities in the colony and protectorate. The Ordinance also called for the promotion of research and investigation in connection with the prevention or treatment of human diseases as well as preparing and publishing reports and statistics or other information relative to the public health[71]. Though, the emphasis in the Ordinance remained on preventive medicine, it become apparent to the colonial government and general European section that the establishment of facilities for medical treatment and control of epidemic diseases among the African population was a matter to be undertaken at the earliest opportunity[72].

The rise of epidemics was mainly due to the breakdown of natural quarantines which were brought about by the opening of the Uganda Railway line. Troop movements also during the war spread contagious diseases. Main changes towards provision of health services in the rural areas were also started provision was made in the estimates for the appointment of 10 more Sanitary Inspectors with the intention that the officers should work in the Native Reserves and accompanied by travelling dispensaries to undertake treatments and control epidemics. In 1922, the colonial government started to include Africans in their provision of medical care. The National Laboratory in Nairobi began to train Africans in basic laboratory and clinical technician procedures, including preparing blood samples. At the same time, health administration for the population was moved to the District and it was the duty of the Local Authority to take all lawfully necessary and under special circumstances reasonably practical measures for preventing the occurrence or dealing with any outbreak or prevalence of any infectious, communicable or preventable disease, to safeguard and promote the public health.[73] Thus, responsibility for safeguarding health in the Native reserves lied with the District Commissioner and Medical Officer acting together as one authority.

After the First World War, the medical department was no longer considered merely as an organization maintained by the government to facilitate administration by maintaining personnel health, but as a government department 'responsible for carrying out one of the most important function of government; maintenance of good health of the general population of the country and the improvement of conditions under which the population lives'74. This was believed to be one of the functions to which the government was established.

[71] Annual Medical Report 1921.p.19
[72] Ibid.
[73]Ibid.p.20.
[74] Kajiado District Annual Report 1921.p.18

Some scholars have argued that, the realization of the medical need in the Native reserves and African population by the colonial government after the First World War was mainly due to the fact that the epidemics that had been laying waste the countryside began to threaten first, the European population and, second African labour. It was feared that the depletion of African population by the epidemics would pose serious problems to the labour required for plantations and/or mines75. The attitude of the colonialist was basically one of indifference to the health of the work-force. This was in accordance with the capitalist idea of working with unlimited supply of labour.

Another possible reason for this development is that, the colonial government was concerned with the activities of Missionaries operating in the various part of the country. Gilks, the presiding officer of medical reforms during the interwar period, argued that the missionaries were doing a good job in alleviating the poor health conditions in the reserve and are reaping the benefits and proposed that the government should take over the control of medical services. In 1921 medical report, he stated that,

The desirability of the government itself undertaking the medical work in the reserves rather than subsiding missions to do it for them. The work in government units can be standardized and kept to high levels, 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 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 the 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.76

The text above illustrates the struggles between the church and the state over the colonization of the African mind and the centrality of biomedicine as an ideological apparatus used in the struggle for conquest and control. Biomedicine was seen as a tool to conquer and influence Africans to accept the colonial government as working for their ‘best interest’. This

[75]Olumullah.Disease.Medicine and Social Change among the Abanyole in Western Kenya, 1995.p.157.
[76]Annual Medical Report 1921.p.23.

powerful tool, according to Gilks, should not be left under the hands of the missionaries but government should use it to advertise its activities and to achieve its purpose like labour recruitment. Western medicine was also used as a justification for colonialism, resonating with the idea of the 'white-man's burden' in Africa that white Imperialists had a moral duty to educate people in nations they considered less developed. This was the idea upon which colonialism was built on.

The British also used Native leaders especially among the Maasai to carry out colonial medical policies at the local level which made medicine an important aspect of colonial imperialism. Comaroff argued that western medicine was both informed and funded by imperialism in Africa and elsewhere. It gave validity of science to the humanitarian claims of colonialism, while finding confirmation for its own authority in the living laboratories enclosed by expanding imperial frontiers77. Kenya, like the rest of Africa, was viewed as a disease infested area and the population was under threat of extinction, thus the need for protection. The Kenyan rural society was seen as a patient suffering from diseases causes by poor sanitation and the need to use western medicine and knowledge to mitigate the suffering, hence the betterment of African health. These perceptions are well illustrated in the 1926 and 1928 Annual medical report as below:

The sanitary problems of Africa is how to improve the standards of living among a population; 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.78

The African body from this text was objectified and his environment seen as a vehicle for the transmission and spreads of diseases. The above text mentions the 'stage' of civilization as well as the poor health conditions. The report also noted that western education to the people would bring the desired effect on consumption of western medicine, it was thought that, in education lies the possibility of sanitary progress, that education would secure

[77]Comaroff, 1993.p.324.

[78]KNA; Colony and Protectorate of Kenya, Annual Medical Report for the year ending 31st December 1926.

the desired progress in biomedicine79. According to the British colonialist, medicine and civilization are interconnected. In addition the 1928 Annual Report stated that:

Almost every African native is infested with some type of intestinal worm. A large proportion suffers 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 toll of life. The circumstances of the people are such that they live under such conditions, which are admirably suitable for the existence and spread of the causal agents of diseases or of their animal hosts. Even where huts and villages are not overcrowded with humans, they are always overcrowded with the causative organism of diseases or the carriers of these organisms, so that escape from infection is for the great majority of people impossible.[80]

The above text reveals that Kenya was viewed as a patient that needs the use of western knowledge and medicine to mitigate the suffering. The native population is thought to be generally infected with diseases that are related to their culture, environment and economic practices. The interpretation revolves around western medicine interpretation of what constitutes cleanness and how this was a root of the health problems in Kenya. Thus, poor health condition was perceived as caused by unhygienic conditions, and the cultural practices. According to the above text, Africans are presented as a repository of diseases, death and degeneration, this perception lay in the myth of race, science and religion that represented European penetration of Africa. These claims were used to marginalise African system of health and healing. The African body was constituted as a social space and as a cultural boundary a unique site for contestation between African and western healing traditions. Western biomedicine defined itself within and above African healing system, defining itself as superior offering the solution to conquer diseases through science.

The 1931 report stated that 'the root of all sickness and in sanitation in Africa, lies ignorance with regard to crops and animal husbandry, and system of land tenure.....this can change through education for the benefit of the world and African himself[81]'. These perceptions formed the basis of the establishment of western medicine and marginalisation of indigenous medicine.

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[79] *Ibid*.p.6

[80] KNA:Colony and Protectorate of Kenya, Annual Medical Report for the year ending 31st December 1928

[81] Annual Medical Report 1931.p.22.

3.4 The Maasai Experience with Western Medicine in the Colonial Period

An account of western medicine among the Maasai must be situated within the context of the perception of the colonial administrators about the Maasai as well as Maasai perception of the colonialist. There was a strong view held by the early travellers that the Maasai were on the threat of extinction. The Kenya Land Commission observed that 'but for the British protection the Maasai would have become a factor of comparatively minor importance and their country might gradually have been occupied by other tribes'.82 In a Medical Report, the Maasai were referred to as,

> ...a decadent race that have survived through being brought under the protection of the British rule. But one that could certainly have been exterminated by the more virile and numerous African tribes'.[83]

The description of the Maasai as suffering from venereal disease formed the theme of western biomedicine among the Maasai. The western medicine was established in the Maasai reserve with an objective of controlling venereal diseases. These are observable in a series of scientific enquiries undertaken among the Maasai. Most of the surveys and medical *safaris*done in Maasai reserve were on venereal diseases. The Orr and Gilks[84] comparative study of venereal disease among Maasai and Kikuyu carried out a field survey of 12,000 Maasai "random healthy individuals". It was estimated that gonorrhoea accounted for approximately 8% of "diseases encountered most frequently" among Maasai compared with 1% among the neighbouring Kikuyu. While the presence of venereal disease among the Maasai during the colonial period is acknowledged by many informants, it was considered "insufficient" to account for the observed sterility and low population and was instead attributed to the restricted pregnancy diet of Maasai women and the nomadic lifestyle.[85]

Though the colonial administrators viewed the Maasai as suffering and at the rim of extinction little was done to develop health system in Maasai reserve. There was only one medical centre in Narok, which was to serve the whole of Maasai Reserve. This was not easily accessible for the Maasai in Kajiado. A dispensary was later opened in Kajiado, this was under the supervision of the medical officer based in Narok. Medical officers made occasional journeys through the reserve treating minor ailments and carrying or persuading serious cases to hospital, as western medicine was not easily accepted by the Maasai. The

[82]Report of the Kenya Land Commission, KNA/CP/333/2/KEN.

[83]Maasai Reserve Annual Report. 1921

[84] KNA: Colony and Protectorate of Kenya, Annual Medical Report for the year ending 31st December, 1931.

[85] Ngoto Ngeleo, Ole Kaaka, Ole Mututua

cultural lifestyle of the Maasai was blamed as a challenge to the setup and establishment of western medicine, 1926 medical report noted that, 'it's a problem meeting medical needs of the Maasai…40,000 nomads wondering over 18,000 square miles of road-less country, cannot be served by one medical officer nor one hospital'. However, despite the observation little was done to increase the health centres or the mobile visits in the reserve.

A medical survey of Maasai Province in 1930-1 concluded that, 'Gonorrhoea and all its sequel and complications is practically universal…it is the most common sterilising diseases of women and the Masai themselves know that large numbers of their womenfolk were sterile but did not know the cause'. It also states that the population is not increasing and if conditions are not altered they must slowly disappear.[86] A subsequent Medical Report in 1935 concluded; "as a result of a high incidence of this disease [gonorrhoea]…the tribe perhaps in danger of ultimate extinction"[87]. Ndilai agrees that venereal diseases, like gonorrhoea were common during the colonial period, but disagree that this was responsible for infertility among Maasai women, and not as common as purported by colonialist. According to Ndilai and Ngoto Ngeleo, the Maasai had herbal treatment for sexually transmitted diseases like gonorrhoea thus the diseases did not cause much harm to the general population.[88]

Disease among the Maasai, just like in other communities during the colonial period, was viewed as causes by unhygienic conditions and poor diet. The 1931 Maasai Medical survey argued that, the Maasai are still a primitive people living under conditions and have not change much, their huts are a refuge for flies, which breed in the dug in the cattle sheds. Consequently, 1933 Annual medical report stated that,

> 'Maasai just like other African people live in insanitary conditions…filth & filth is not compatible with health' and that 'ill health is clearly a poor dietary, another lack of culture with regard to the case of the fields, and …it emerges clearly in the case of Maasai-lack of knowledge on how to adapt old customs to the changing times.'[89]

The association of Maasai and venereal diseases, hence sterility and low fertility is not difficult to trace. Henfrey went on a "Venereal Safari ", and treated 1,908 cases of gonorrhoea and 435 cases of syphilis in Narok District, but did not provide any data on the

[86] *Ibid*. p.26.
[87] Annual Medical Report, 1935.
[88] Joseph Ndilai, Olepolos Village,
[89] Annual Medical Report 1933

incidence of venereal diseases at the population level.[90] In 1944, new adult admissions (n=647) to the Native Hospital in Narok, were tested, and the conclusion was that approximately 20 per cent of all Maasai in Narok District were suffering from syphilis. However, the way in which the data were collected, including the self-selection of infected individuals into the "sample" does not permit any population-level infection rates to be calculated. The fertility "data" collected during these surveys were taken as a priori evidence that venereal diseases-induced sterility that was causing low fertility among the Maasai.

Treating venereal disease was accorded relatively high importance under colonial rule, and there can be no doubt that venereal diseases were present in the colony. This was not only observable in Maasai province, but throughout the colony, especially during the interwar years. This was mainly due to increase of venereal diseases during war due to conditions cause by war. A medical report in 1944 indicated that there was high incidence of venereal diseases reported among the African soldiers and incidence of civilians presenting themselves for treatment. Legislation under the Defence Regulation was introduced to permit compulsory examination and if necessary, treatment of persons suspected of being prostitutes or reported to suffer Venereal disease. Treatment was intensified in a number of stations and special clinics were opened in cooperation with the military[91]. Among the Maasai, this was more observable due to the perception that, Maasai women participated in prostitution.

In 1950, a further medical survey was carried out in Maasai Province. McKay, who begins his report by stating, "For many years it has been common talk that the Maasai are in danger of dying out owing to the sterility and miscarriage induced by venereal diseases. He wrote that

> the Maasai continue to cling to their old customs involving sexual promiscuity……heroic measures are required to achieve success in even partial eradication'[92].

The purpose of McKay's study was to provide treatment, rather than an epidemiological survey, and "sufferers naturally did their best to be included in the sample when they knew that treatment was available after examination"[93]. Therefore, his results cannot be taken to be representative of the Maasai population as a whole. He concluded, however, that "there has been little change in the high incidence of similar associations'.

[90]W J Henfrey, 1937, 'Maasai Reserve Veneral Safari', Medical Department Report, KNA.
[91]KNA: Colony and Protectorate of Kenya, Annual Medical Report for the year ending 31st December,1944,

[92]D H McKay, 1950, 'Veneral Diseases in Masai, a field Survey-June & July 1950 ' in*The East African Medical Journal*, pp.451-457, KNA.
[93] Ibid. p.455

Venereal diseases and the Maasai during colonial rule can be summarised by White argument; she argues that the venereal diseases experience among the Maasai was about power and control, she states that the colonial administration controlled access to new treatment for gonorrhoea, which dependent upon ethnicity. She suggests that the colonial authorities "sought to construct a demand for paid venereal disease treatment"[94] among the Maasai by deliberately limiting its distribution and also probably by creating the perception that Maasai were at risk of extinction caused by venereal disease. The colonial government was trying in vain to persuade Maasai to sell their cattle in order to meet the growing urban demand for beef. The Chief Medical Officer at the time decided to supply the drug, for the treatment of venereal disease, to the Maasai in return for cattle. In Paterson's words, "the discovery of the drug has provided an unrivalled opportunity for encouraging the Maasai not only to sell large numbers of cattle for the provision of Medical Services, but to get into the habit of selling cattle" As White concluded, "Beef was the main issue here, not babies. Areas with birth-rates low as or lower than the Maasai were neither given nor sold until the end of the war". Colonial authorities spent a lot of effort on investigating and treating the levels of venereal diseases among the Maasai, and manipulated this to meet their interest. The emphasis given to acquiring beef cattle from the Maasai probably overshadowed the real extent of the level of STDs in Maasai land. Early data combined with the notion of population decline was to provide evidence for policy of land acquisition for settlers, illustrating a manipulation of demographic reality.

The data reveals three main assumptions of the colonial authorities about the Maasai: high levels of secondary sterility leading to low levels of fertility (in combination with high mortality) resulting in a low rate of natural increase and high incidences of venereal diseases. This is in contrast to views from the informants who argued death and diseases were not that common among the Maasai until recently[95]. They agree that during the colonial period, there was an increase in incidences of gonorrhoea, but did not cause high death rates or infertility as presented in the colonial records. The argument of high incidence of venereal diseases was a political ideology used to control beef market and Maasai community. The exchange of drugs with cattle according to informants also created a perception that western medicine is more superior and therefore expensive.

[94]White, 1990, p.117.
[95]Ngoto Nkeleo, Olemurtkat Village.

It is difficult to separate Maasai culture with their religious practices, as argued by Rigby who observes that the reproduction of the pastoral social formation give rise to religious practices and beliefs which involve the whole community and in which, in a sense, are perceived as being one with pastoralist economic, political structures as well as health care. The denigration of Maasai culture which is part and parcel with the healing systems affected the perception of educated Maasai (most were Christians) on indigenous healing which was viewed as out dated and evil (Satanism).

While the Maasai cannot be termed as superstitious, the description of diseases from a Christian perspective has led to believe in spirit possession. Isichei noted that there was spread of spirit possession among the Maasai from the 1960s termed as *Orpeko* of interest is that in Maasai traditions divinity was Enkai and they lacked potentially possessing divinities or ancestors cults.[96] Maasai conceptual system did not include any categories of extra-human spirit, possession then was seen as an anomaly. Spirit possession was very difficult to understand and locate on the social map of the Maasai society, not to talk about handling it in some intelligent way. It seemed to violate the Maasai social system, and the prophets, *iloibonok* were totally unprepared to cope with this phenomenon[97]. This led to the rise in faith (Christian) healers who prayed and laid hands on the sick to get healed by expelling the demons.

The missionaries provided education during the colonial period. The education was not looked upon for education sake, but merely as a means of giving the native enough education to be able to read the scriptures and away of indoctrinating them on Christian world concept. Given the religious bases of indigenous medicine and culture, most missionaries in colonial Africa adopted a hostile attitude toward them. The missionaries' denounced indigenous medicine as barbarism while modern medicine was associated with civilization.

3.5 Summary

The colonisation of Kenya began soon after a series of natural disasters, rightly referred to as ecological catastrophies of the 1880s, during which the Maasai experienced high mortality combined with immigration of other ethnic groups. These major ecological upsets were instrumental in forming opinions about the Maasai, specifically their ability to

[96] Elizabeth Isichie, *Voices of the Poor in Africa.*
[97] Ibid.

survive as an ethnic group. An outbreak of bovine pleuro-pneumonia in 1883 was followed by devastating rinderpest in 1891, both of which had the effect of decimating Maasai livestock. The effect on the Maasai population was to force widespread migration in search of agricultural produce from other ethnic groups, such as the Kikuyu in Kenya and formed a basis for the Anglo-Maasai agreements. The agreements led to loss of power and influence of the Maasai spiritual healers, *Oloiboni*. As pointed out by Feierman, colonial conquest deprived healers of their control over production and broke most links between healing and public authority. The colonial administration viewed the Maasai as a disease stricken community with high infant mortality and infertility among their women. The diseases were seen as directly related to the Maasai way of life, housing condition, 'inadequate' clothing and lack of water. African culture and environment were viewed as a source of diseases and the role of education and economic development in the improvement of the African health status. Though the Maasai were suffering, the situation was exaggerated to portray the need to control the Maasai to move them off their land. In the colonial period, Medicine came to be viewed as an important tool for asserting colonial control. As stated by a Medical Officer, one Gilks, medicine was 'the best form of advertisement 'form which the government will achieve great influence'.[98] The colonial governments promoted western based health care and undermined indigenous health care system. The colonial government focused on establishing western medicine and suppressing indigenous health care. The policies established during this period criminalized the practice and use of indigenous health care. However, colonial control among the Maasai, made little impact upon the Maasai social structure. The Maasai like their fellow pastoralists in north and north east Kenya were excluded from the main centre of power and influence and were administered in isolation from the rest of the colony. This isolation was partly self-imposed and partly Government enforced. The Maasai was largely indifferent to Government-inspired schemes for development and hostile to attempts to penetrate their society from without or to change it from within. This helped in continuity of the indigenous health care despite the challenges faced in this period

[98] Annual Medical Department Report for the year ending 31 December, 1921 p.23

CHAPTER FOUR

4.0 POST-COLONIAL HEALTH POLICIES AND INDIGENOUS MEDICINE, 1963 TO 2002

4.1 Overview

At independence, health care was conceived as one of the main agendas that would drive development in the new state. The independence government inherited the colonial government health structures and health care policies from the colonial government. Political and economic factors that influenced the development of health care systems in the colonial period continued to shape health care in the independent state. International conditions and policies affected the development of western medicine during this period. Policies and plans were developed in relation to economic conditions and international agreements. These changes consequently influenced the interaction of indigenous healing with western medicine and redefining ways in which individuals' access and participate in health care. This chapter examines the case of the independent government efforts to provide accessible health services to all people and its effect on indigenous health care system by examining the development of Kenyan's health care policy and system after independence. We argue that during the post-colonial time, the ideology and health policies of the government and that of the educated elite had been concerned with the promotion of Western knowledge and technology at the expense of local culture and society. Western medicine was viewed as the only means through which full health care would be achieved. This perception led to the implementation of policies that aimed at a total replacement of indigenous health systems. However, the product of this articulation is not total replacement of indigenous health care but a transformation of the system. Central to the transformation of the Maasai indigenous health care system is the spread of Christianity in Kajiado. As Maasai practiced Christianity at a greater frequency and fervour, their attitude towards their cultural lifestyle as well as indigenous health care changed.

4.2 Early Independence Period, 1963-1990s

When Kenya gained independence in 1963, western medical facilities were unevenly distributed. They were concentrated in urban areas and little attention was given to rural healthcare. Determined to make a change, the new government created a welfare state with the idea of providing free healthcare to all citizens. The government created, *1966-1970 Development Plans*, which focused on promoting the western system of healthcare in rural areas and increased the number of dispensaries and trained health workers across the country.

As the first step was undertaken under the Development Plan, a free access policy abolished the Ksh. 5 payment operative in the colonial healthcare system until 1965. The policy proposed expanding coverage through centralizing the delivery responsibilities from the District councils and municipalities to the Ministry of Health. Although centralization achieved harmonization of the system, it neither eliminated regional disparities nor reached everyone.

The national plan was implemented based on *Harambee*, a Swahili term meaning "Let us all pull together." Communities, particularly rural communities, were encouraged to initiate "self-help" development efforts such as building health clinics, schools, dams, and other projects. Typically, local leaders mobilized their communities to donate part of the total resources required (including labour) to construct health clinics. Once the clinics were built, the state took them over and equipped, stocked, and managed them to benefit local communities. By 1970, there was massive construction of health centres. Many, however, suffered from lack of equipment, staff shortages and inability to meet recurrent expenditure, thus quantitative increase did not ensure that majority of the rural population had access to western health services.

The policies and plans initiated by the government continued to expand the western system of health care at the expense of the indigenous system. In late 1970s there was some change and acceptance of the indigenous medicine due to the Alma Ata declaration. The Alma-Ata Declaration of 1978 on Primary Health Care (PHC) recognized the role of indigenous medicine and its practitioners in achieving health for all. A research unit was an establishment for indigenous medicine at the Ministry of Health in 1980. At the same time, licenses were issued to indigenous health practitioners to operate outside the public system while many traditional midwives were recruited to work in government facilities especially in the rural areas where there was more need. In spite of recognition indigenous medicine continued to be treated with distrust and suspicions by supporters of western medicine.

During much of the 1980s, the health sector was negatively affected by drastic reduction in government expenditure resulting from the Structural Adjustment Programme. This adversely affected the strategy of utilising mobile health units to remote areas like Kajiado District with large geographical areas which were sparsely populated. In terms of health facility/population ratio, the District was worse off in 1980 than it was in 1979. This was also compounded by the high rate of population movement into the District. Although

the target for mobile clinics was achieved (36 units), their utilisation was seriously handicapped by inadequacy funds[99.]

In 1989 Kenyan government, under heavy pressure from the IMF and World Bank, reintroduced user fees in health facilities. The measures required citizens to pay for part of their health care and medications. These led to several detrimental consequences in Kenyan health sector. For example, most health clinics had no drugs even basic antibiotics. The main issue was that the government simply could not supply free drugs and relatively few Kenyans could not afford to buy expensive drugs on their own[100]. Combined with other factors like poor governance, widespread corruption, and a declining economy, the western health-care system in Kenya declined. The imposition of user fees and other unpopular measure required citizens to make new choices about where they could seek medical attention. In 1993, the *Daily Nation* newspaper declared, "Thousands of Kenyans are suffering because our hospitals and dispensaries lack essential drugs and equipment''.[101]

In late 1990's the Kenya Health policy framework focused on promoting the health status of all Kenyans through deliberate restructuring of the health sector to make it more accessible and affordable. This was mainly influenced by the World Health Assembly Declaration in 1997 of 'Health for All by 2000', which focused on accessibility of health services[102]. In Kajiado emphasis was on better record keeping, on child health, and future planning. Socio-cultural barriers were considered major constraints on nutrition and the general health status of children. Other issues included lack of community participation, due to nomadic life, lack of transport and lack of funds. The strategy adopted sought to strengthen health education facilities in the district and increase mobile units. Primary health care was to be supported with increased manpower in all rural health facilities. The policy also proposed an 80% increase in immunization cover, 80% increase in immunisation against tetanus, increase in the number of trained traditional birth attendants, in the use of contraceptives, reduction of malaria cases by 10% and increased construction of double latrines[103].

[99] Republic of Kenya, Kajiado District Development Plan, (1984-1988).
[100] P Kimalu e.t.al, A Review of the Health in Kenya, Kippra Working Paper .No.11
[101] Daily Nation, June 16, 1993
[102] Ministry of Health, National health sector Plan 1999-2004,(April 1999)p.13
[103] Republic of Kenya, Kajiado District Development Plan (1989-1993).

A development plan in the mid 1990 observed that health facilities were under-utilised in Kajiado due to the migratory lifestyle of pastoralists, low population densities in some areas, lack of water and inaccessibility due to lack of transport and poor communication network. Attendance to antenatal and postnatal clinics was as low as most deliveries took place at home with the aid of TBAs.[104] Although the nomadic lifestyle might have contributed to underutilizations of the health services, other factors also played a big role. Some of the informants interviewed, especially women, stated that they do not visit the hospital because of the mistreatment from the care givers. Many reported disrespectful treatment by nursing staff and the rushed nature of consultations with doctors. The biomedical practitioners are considered as cold, rude and unconcerned.

The biomedicine practitioners are viewed as arrogant and careless about the general wellbeing of the patients. One particular woman said 'I can't go to hospital to give birth and get slapped by a woman (nurse)'.[105] In addition, a 28 year old man who was involved in a road accident speaks of his experience in hospital. He was taken to Kajiado District hospital with multiple fractures in his hip. After two days in the hospital there was no observable treatment done as the hospital was preparing for his transfer to Kikuyu hospital. But this preparations was not communicated to the family, hence the feeling of abandonment and mistreatment. The failure to communicate led to opposition and indifference to Western health care. The family and relatives decided to take the patient home to an indigenous bone-settler, citing previous cases that were not treated in the hospital.[106] This reveals that patient expectations and experiences influence their choice of health care. The hospital bureaucratic systems and the long waiting times for public health services also impede the quality of care received by many patients, and the picture is clear of why the biomedical health care may not be so appealing for most rural Maasai population. A systematic inattention to patients and family dissatisfaction with western health care is also partly responsible for underutilization of the services.

In the above discussion, it also emerged that, central to Maasai therapeutic process is the network of kin, neighbours and friends who get drawn into the handling of an individual's illness. What Janzen termed 'therapy management group", influences the choice of health care for the patient, they collectively discus and make decisions on behalf of the

[104]Republic of Kenya. Kajiado District Development Plan (1994-1996)
[105] Ngoto Naserian, Olemurkat village.
[106] Katoria Laila, Olemurkat village.

patient (like in the above case of the 28year old man). The role of the network ranges from social support to social control of the patient and ideological control of the values implicit in therapy.

Like most areas in the country there is biased distribution of health facilities in favour of urban centres such as Ngong, Kiserian, Kajiado town and Loitokitok in the District. In remote rural areas, there were only a few health facilities which were widely scattered and patients had to cover long distances to access medical attention. As a result, most people in the rural areas in the District depend on indigenous health care. Though the development plan for the period 1997-2001 sought to make the distribution of health facilities more equitable with special preference to the rural areas[107], this is yet to be achieved.

Health services in Kajiado District to a large extent were provided by AMREF. AMREF complemented the government's health services in the rural areas. AMREF's work with nomadic people goes back to the early 1960's when mobile clinics were intermittently conducted to provide treatment and immunisation for the Maasai in Kenya and Tanzania; these mobile clinics became more regular after 1966. The focus was mainly on immunization but sick patients were also treated and health education and a mobile laboratory were later added. Thus the approach to nomadic peoples has had over 25 years to evolve. This generally had effects in remote rural areas in Kajiado District where health institution like dispensaries are not available.

AMREF involvement in health interventions in Kajiado District has had the longest exposure. This involvement has changed markedly over time and can be divided into four phases. Between 1957 and 1969, the nomadic health unit provided intermittent curative and preventive services in Maasailand. Following a review of the health situation and needs in Kajiado and Narok Districts in 1963 and 1964, the Mobile service delivery system was considered appropriate because of the geographical mobility of the Maasai.[108] The period 1970-1985 saw the introduction of mobile clinics with emphasis on teaching, training and prevention. The main geographical areas of focus were Isinya, Kajiado and Bissil.[109] During the period 1986 to 1999, emphasis shifted to community-based health care which included adult literacy classes, workshops/field visits, and establishment of health committees, safe

[107]Republic of Kenya, Kajiado District Development Plan (1997-2001)
[108]AMREF Annual Field Reports
[109] AMREF Annual Field Reports 1970, 1971, 1972, 1973, 1975, and 1976, Nairobi: AMREF

motherhood and trachoma control. Finally, during the 2000 to 2002, AMREF's focus shifted to water and sanitation interventions with the aim of improving the health status of communities. Specific interventions by AMREF can be grouped into six broad categories, namely: mobile clinics and health centres, community based health care, school health education, trachoma control, water and sanitation, and safe motherhood and reproductive health.

The post-colonial period also witnessed a rise of new diseases in Kajiado that were previously unknown. These included HIV&AIDS, diabetics, high blood pressure and asthma. Informants believe that the diseases were mainly caused by change in diet and use of western medicine. Ole Kusero argued that 'the hospital medicine are a form of disease that is introduced to the body and this fight with one disease and cause another'.[110] These diseases have caused a lot of challenge to the community since there is no known treatment for them, though some healers like Ole Mututua claim to treat cancer, there is neither known cure nor herbal treatment for such kind of illnesses.

The role of indigenous healers in the treatment of HIV&AIDS has been very controversial. Some indigenous medicines have proved to be of benefit in the treatment of some symptoms related to HIV&AIDS, such as fever, skin rash and diarrhoea. Some healers, however, have claimed to have found the cure for HIV&AIDS. These claims were not substantiated and have undermined the credibility of the indigenous healthcare systems in the community. Despite these set-backs, the value of the use of indigenous medicine in the fight against HIV&AIDS has been demonstrated. The HIV&AIDS epidemic also has imbued the dialogue between competing health sectors with gravity and renewed urgency. HIV&AIDS has made it imperative that public health policy finds new and imaginative ways to enable different health sectors to really engage with one another[111]. One of the most sustained efforts to achieve this sort of interaction has taken the form of HIV&AIDS training programmes for indigenous healers, and research done on herbal medicine especially some thought to boost immunity. There are also many limitations to the training programmes. And it might be problematic in the long run that the prospect of a two-way process of learning. In addition integration of indigenous healers into the western medical mainstream will introduce

[110] Ole Kusero, Mbirika Village.

[111]Chabu Kangale,'Engaging Community Leadership in Health and HIV/AIDS Programming: The Divide between Capacity Building and Capacity Utilisation', in *ARHAP International Colloquium 2007 Cape Town*, South Africa, March 13-16, 2007, pp134-139

changes to the field of indigenous medicine itself and has implications for its efforts at professionalization, especially where legislation has not been enacted to regulate this.

A survey of post-Independence research reveals strikingly similar themes with the colonial perceptions about the Maasai: low fertility, high sterility, and a low rate of natural increase as well as high incidences of venereal diseases. The perceptions about Maasai health from colonial period still exist in the post-colonial period as well as the marginalization of Kajiado District. Little development of health facilities is present and the few available in the rural area are understaffed and ill-equipped. Despite the development of health centres and health education carried out in Kajiado District, a big population still depend on indigenous health care. Western medicine is treated with a lot of distrust and suspicions.

4.3 Christianity and the Transformation of Indigenous Health in the Post-colonial Period 1990s to 2002

In the late 1980s and 1990s, there was a massive evangelization in Maasailand in general and in Kajiado in particular. This was spearheaded by ministries that did a lot of mission work in Kajiado District. The ministries were founded by Maasai converts from Ngong Division and Loitoktok. These areas had mission stations in the colonial period which led to a number of Maasai being converted. In the 1990s there was spread of Evangelical churches in Kajiado as the ministries planted churches. The Evangelical churches accepted some aspects of Maasai culture in the church like dressing, which led to large population accepting Christianity. The churches also provided spiritual and emotional needs to the members, covering every area of human life including healing. According to one informant, healing was an integral part of evangelism among the Maasai of Olobelibel location. The church would organize meetings which people would come for healing and some would carry cloths of their sick relatives who could not make to the meetings[112]. The church offered people hope for healing and protection against evil powers. Ole Molil observes that in their village many people become Christians after healing prayers.[113] Nataana narrated her story of how she become a Christian,

> I was sick for a very long time, my knee paining and I could not walk properly. I was taken to many and different kinds of indigenous healers (Ilobonok of all kinds, herbalist, bone-settlers). I was even taken up to Arusha but the pain continued. I was then taken to hospitals but nothing seems to bear fruit. Then preachers visited our home and shared the gospel then later they prayed for me and I was totally healed up to today. I believed in Jesus for He is the

[112] Daniel Ole Maison, Olobelibel location
[113] Ole Molil,Olobelibel location

> healer who is always near. That sickness was brought by the devil, but God has conquered through His servants.[114]

This informant believed that sickness is demonic, labelling it from a Christian perspective. The Christian gospel at this period focused on healing and diseases were viewed as demonic. The gospel of evangelical churches that emerged during this period, focused on healing, deliverance, health and wealth, combining North American teachings of prosperity and indigenous approaches to health and prosperity. In the meetings and advertisements, the preachers promised healing from all afflictions. This led to re-emergence of colonial perception that Christianity had come to save Africans from darkness, ignorance and superstition. These greatly undermined indigenous healing in Maasai land. Ole Kuraru[115] argued that, Christianity has made the *Oloiboni* office to disappear as their system of healing is thought as a way of darkness and the *Oloiboni* works for the 'devil'. People went to church and found the 'light' and are left their practices. When asked about indigenous health and Christianity, a female elder explained:

> Yes, only a few elderly people use that [indigenous healing]. The young people are in church now. The church tells you not to use indigenous medicine again, not to go to the Oloiboni, because he serves the devil.[116]

Informants believe that the criminalization of the Oloiboni practice by the church has led to abandonment of indigenous health practises by many people. One of the informants Ole Rukunyi, who belonged to *Ilkerin Inkishui* (who also practised some form of spiritual healing), confessed that he no longer practise *enaibon* because he is Christian now and has left the 'dark' practice. However, some like *Olentokot*i who was *Oloiboni* and now Christian practises a form of healing and divination that combine both Christian and indigenous knowledge. Maundu also observed that the powers of the *Oloiboni* have waned due to the impact of Christianity and change in the political system.

The knowledge of medical plants is also decreasing. The younger generation have joined schools and there is no enough time to train them on medical plants. On the other hand, most educated youths view indigenous healing as backward and primitive, thus they are not receptive to its knowledge and learning. In this respect, there is an increase in other forms of healing especially spiritual healing, combining indigenous and Christian ideologies. One informant shared that there is a faith healer in *Enkorika* location who uses the bible to

[114]Nataana Koyo, Olobelibel Location.
[115] Steve Ole Kuraru, Olotepes Village
[116] Nasha Ene Karino, Naibala Village

pray for the sick. He explained that the only form of payment is a new bible in Maa language. The healer is said to open any page in the bible and use it to pray for the sick.[117] Schoffeleers also suggests that Christian churches, among other things, hastened the demise of "territorial cults" that provided rainmaking rituals.

The development of Christianity went hand in hand with the medical field. During this period the evangelical churches build medical centres in Maasai land. For example, Christian Missionary Fellowship (CMF), which was established in the late 1970s, with the purpose of reaching inaccessible groups of people for Christ and established stations in Maasai land in partnership with the Kenya Church of Christ missionaries. The health needs of the local people demanded the missionaries' time and in 1980 CMF started mobile clinics at the evangelical sites. Over time, a system of rural clinics evolved to meet the health needs of the people. The medical work was an outreach of the local church and a means of demonstrating the love of Christ in a tangible way.

The CMF medical work among the Maasai of Kajiado is intimately integrated into the identity and function of the local church, thus serving as a main outreach and evangelistic tool of the local churches. Other missionaries also established medical work, for instance, *Orinie* clinic which is the only health facility serving *Olobelibel* location was established by Korean missionaries in the late 1980s. Kajiado childcare centre was also established by African Inland Church in the early 1990s as the missionaries realised that medical work could be used to evangelise the Maasai like education.[118]

While there was wide spread of Christianity in the post-colonial period, medical facilities initiated by missionaries were still limited. In a parliamentary discussion a member of parliament argued that unlike other areas like Central Province where missionaries provide 50 per cent of medical services, in Maasai land there were no missions hence missing the 50 per cent of the medical services.[119]

Though the missionaries did not build medical stations in Maasai land like other parts of the country, Christianity has helped shape conception of health and healing among the Maasai. Among the Maasai, good health is believed to be the result of appropriate behaviour that is, living in accordance to the values and norms of the society. One of the primary causes

[117] Nataana Koyo, Olemurkat village.
[118] Dalmas Tiampati, Olobelibel Village.
[119] Parliamentary Debate, July 5, 1994

of illness, then, comes from inappropriate behaviour. In addition, illness can also be the result of the work of bad people (sorcerers). In either case, illnesses have a spiritual basis, which in turn, requires a spiritual remedy. Hence Africans, including the Maasai, rely on social laws as well as spiritual forces to explain and control events and relationships. Healing is therefore intertwined with cultural and religious beliefs. It does not focus only on the physical condition, but also on the psychological, spiritual and social aspects of individuals, families and communities. Change in religious beliefs that control Maasai values, behaviour and health led to redefined explanation for diseases.

The penetration of Christianity among the Maasai as argued by Rigby, was confronted by a socio-economic formation of relatively unique kind, with its own system of religious, ideological, economic, and political practices, with their associated forms of discourse and the constitution of subjects. The confrontation resulted in the marked failure of evangelization, despite strenuous efforts on the part of the missionaries. However, there is an increase in the number of Christian converts among the Maasai who confess Christ and still accept the Maasai way of life.

This view permeated most European discussions of the subject and was absorbed by the new elites who were trained in the mission stations. Though Christianity was not that well spread and established in Maasai land in the colonial period, the post-colonial period saw a rise in Christianity in Maasai land in the 1990s.

4.4 Contemporary Status of Maasai Indigenous Medicine and Health Care

The policies established in the colonial period focused health initiatives on the European population, providing medical attention only when epidemics arose amongst the Africans. The sole concern regarding the health of the native population was keeping them healthy enough to work. Health of the African population remained a low priority, important only when work for European farms became endangered; though there was change in the interwar period with introduction of curative medicine in the Native reserves and inclusion of Africans in the provision of medical care.

The British colonial government recognized the indigenous medicine was widespread in Kenya and decided to leave it alone “as long as it did not disturb the peace. For the most part, though, the Europeans had a policy of "benevolent neglect" toward African medicine

and practitioners.[120] Except for the occasional prosecution of people accused of ritual murder,[121]colonial officials did not interfere directly with indigenous medicine. For one, they did not fully comprehend the system, although they were aware that there were both "good" and "bad" medicines; that is, medicines used to heal and to harm, a distinction that the African people themselves made. However, the colonial government passed *The Witchcraft Act, Cap 67, 1925*, thereby outlawing witchcraft and causing indigenous medicine to become a hot-button issue. But the Europeans could not reconcile the mixture of supernatural explanations with the rational outcomes from the medicines the Maasai applied. They were, however, often impressed by the herbal knowledge of the Maasai and a few studies on herbal applications began to appear a few decades after the beginning of colonial rule.[122]

Colonial rule led to changes in social and cultural structures in the Maasai community. Consequently, systems of health care were redefined. Due to the enormously eroded economic base resulting from colonialism and industrial capitalism, ancestor veneration, which was carried out by mediums and chiefs, no longer had the value it formerly had. Among the Maasai, the appointment of the *Oloiboni* to a political office led to decline in his influence of healing and the general well-being of the community.

Changing social conditions gave rise to a flourishing of spirit possession. It is believed that spirit possession is more prevalent today than in the past.[123] It is even maintained by some that far from being an ancient disease, for many of these societies spirit possession is a relatively recent introduction.[124] Today, the incidence of possession illness is thought to be more widespread than it was in both the colonial and post-colonial periods.[125] Social changes brought by the Europeans also find reflection in spirit possession illness.

With the end of colonial rule in the mid-1960s, the new elites succeeded to the leadership of the independent African states. They continued to follow the policies established by the Europeans, including reliance on colonial institutions and laws. Indeed, in substantive terms, the medical, like the socio-economic system generally, changed very little

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[120] Ann Beck, *Medicine, Tradition and Development in Kenya and Tanzania, 1920-1970* (Waltham, Mass.: Crossroads Press, 1981), p. 73.
[121] Schoffeleers, "Introduction," p. 39.
[122]Beck, *Medicine, Tradition and Development,* pp. 68-70.
[123]Interviews with *Ole Taruru*.
[124] T.O Ranger and I. N. Kimambo, "Introduction," in *The Historical Study of African Religion,* eds. Ranger and Kimambo, pp. 12-13.
[125] Vim M. J. van Binsbergen, *Religious Change in Zambia: Exploratory Studies* (London: Kegan Paul, 1981), p. 237.

in the early post-colonial societies. State-run or supported clinics and hospitals remain, as do private clinics for modern medicine. Anti-witchcraft movements, too, continue to be illegal[126]. However, the new elites showed some interest than the European colonialists in providing modem health care for the people. Thus, large numbers of clinics were built and many medical training centres were opened.

Some of the new rulers were interested in using indigenous medicine in National Health Service. In the beginning in the late 1970s, the government instituted a policy of sponsoring research on medical plants[127]. The government recognized that indigenous medicine particularly herbs are effective with regard to some ailment. Hence Kenya Medical Research Institute (KEMRI) carries out research together with the University of Nairobi in order to establish the scientific basis of herbal medicine. However, the research findings so far have not helped to develop indigenous medicine.

With the signing of the Alma Ata Declaration in 1978, the period saw acceptance of indigenous medicine. The approach discouraged overreliance on doctors and led to incorporation of trained traditional birth attendance (TBAs) in the hospitals. The government trains Indigenous Birth Attendants (TBAs), who are modelled on indigenous midwives. As indigenous medicines and personnel are incorporated into modern health services, modem medicine will be affected. Rather than indigenous medicine taking from modern medicine, it is the other way around. It remains to be seen, however, how successful this transformation will be. Indigenous medicine has certainly been affected by the existence of a parallel and competing system of medicine. Although in Maasai land, it is the service readily available to large numbers of people; it receives little official support compared to that given to modern medicine. Only a few studies are being conducted on it, and these are generally carried out with little collaboration between the modern scientists and the healers.

Despite the realization of the importance of indigenous medicine in the provision of health care for all, the negative perception that emanated from the colonialist still exist, including the view that indigenous healers are witches practicing black magic. The Witchcraft Ordinance of 1925 is still operational and used by some law agencies to claim that indigenous medicine is illegal and practitioners as well as users are harassed and arrested. In 1992, during the multiparty elections, Webuye Member of Parliament was reprimanded by

[126]Larson, "Problems in the Study of Witchcraft Eradication," p. 97.
[127] Beck, *Medicine, Tradition, and Development,* p. 75.

the High Court for having taken an oath administered by an indigenous medicine man,[128] this led to a by election and the accused barred from either voting or being voted for in an elective office for the period of five years.

The legal position of indigenous medicine in Kenya is not clear. On one hand, there are some policy statements and on the other, there is lack of empowering statutory provisions. There is no legislation governing the production and registration of traditional medicine, though it is acknowledged as an important part of life for people in the rural areas. In 1991, WHO recommended that in order to ensure an appropriate use of medical herbs by patients as well as physicians, scientifically proven, innocuous, efficient traditional remedies be included in the drug policies of member states[129]. According to the WHO, traditional medicine offers the surest prospect of achieving total health care coverage of the world's population. In spite of this, concrete laws have not been passed and indigenous healers and herbal medicine remain the only indigenous care system recognized, like Ole Sakuda are regulated and given a licence by the Ministry of Culture and Heritage instead of the Ministry of Health.

The Kenyan government's relationship with indigenous medicine is vague. Though in 2002, the government passed the Traditional Medicine Act, which regulated herbal medicine, it has not been implemented due to western medical practitioner outrage. One physician at the time of the law's passing publicly asked, "Are we moving forward or backwards?" The law allows herbalists to practice and distribute medicine in standard medical facilities. The law provides a basic process of registration for indigenous healers through the Ministry of Culture, rather than the Ministry of Medical Services or the Ministry of Public Health and Sanitation. The government's Pharmacy and Poisons Board need not analyse any medical plants. To be registered with the Ministry of Culture, one must fill some forms, receive approval from the local authority and provide five herbal remedies to the Kenyan Medical Research Institute (KEMRI) for verification of non-toxicity. This certification applies only to herbalists excluding those who are primarily spiritualist (*Ilobonok*). This separation between herbalist and spiritualist suggests a greater validity granted to some indigenous healers and exclusion of other forms of healing. One of the herbalist interviewed shared that he is registered and has a certificate for practice; this appears to be a way of gaining recognition

[128] Daily Nation
[129] WHO, 2002

and credibility, especially for clients from other communities and the government (to avoid harassment).

Modern elites have shown great ambivalence toward indigenous medicine, although they have not failed to attempt to regulate it[130]. They clearly prefer modem medicine. Indigenous medicine has thus been left to function much as the subsistence agricultural sector does today, that is, as a provider of health care to many people whom both the governments and private employers are either unwilling or unable to care for.

Maasai indigenous knowledge especially herbal medicine derives from floral biodiversity, whose survival depends on the preservation of a wide variety of the plant species that are presently being threatened by changing land-use systems and inappropriate development interventions. The land is been cleared for farms, urbanization and medical and sacred trees are being destroyed. As the people become influenced by the market economy, they have involved themselves in the business of selling medical plants. The booming herbal industry has led to large scale harvest of the medical plants; unfortunately harvesters often do not obey the traditional laws of sustainable harvesting leading to depletion and loss of some medical plants. Though the industry is affected by great unease about the quality, safety and efficacy as well as the dosage of herbal products, there are often uncorroborated claims that seek to persuade the public that various herbal formulas are panaceas for all human ailments. Unfortunately, Kenya does not have regulatory policies that can effectively address these problems.

Indigenous medicine was the primary health care system for the Maasai community even though a good number of the respondents mentioned that they frequently sought western medical care provided by local dispensaries and clinics. A large part of the Maasai population use indigenous healers, as health facilities are often far away and public transport non-existent. The use of indigenous medicine is influenced by the symptoms of illnesses and beliefs about indigenous practice and medicine. Today a wide variety of illnesses and body conditions are treated and managed using locally available medical plants. The community had an elaborate and complex pharmacopoeia, supported by a wide range of plant species majority of which were readily harvested within Maasai land (some outside the District). Knowledge about the use of ethno-medical resources and the resources themselves are

[130] Murray Last and G. L. Chavunduka, eds. *The Professionalization of African Medicine* (Manchester: Manchester University Press, 1986).

threatened by rapid changes in lifestyles and cultural practices particularly the spread of Christianity, formal education and emphasis on reliance of western medicine from the government. Consequently, knowledge on indigenous plant health remedies was immense among the elderly compared to the youth.

4.5 Summary

While the Kenyan government has promoted extensive western healthcare initiatives, many are ineffective due to issues of access in rural areas of Kajiado District. Hence, the people have continued to use the indigenous health care system. Most of the informants interviewed use indigenous medicine as their first choice and later visit hospitals when the condition does not improve. The complexity of interaction that exists between western and indigenous health care caused contradictory health-related impacts among the Maasai population. While the government heavily emphasized on western medicine, as the form of health and healing accepted to be scientific and thus true, did little to change the Maasai belief on indigenous healing.

Indigenous health care has been re-named as 'herbal remedies', offering what is perceived as a more 'civilized' version of these remedies for mass consumption. Herbal part of indigenous health are only granted credibility when they are evaluated using scientific measures and perceived as having some commonality with western medicine, thereby maintaining the dominance and status of scientific medical discourse. Consequently, a segregated health system is reinforced and the indigenous health care remains quasi-legal or illegal, unregulated, and unlicensed.

On the other hand, the spread of Christianity among the Maasai redefined indigenous health care system. It has shaped the way the Maasai engage in the search for health and wellbeing in a variety of ways and at various times. The connections made in relation to health and religion is important to consider when evaluating which course of action to take and which type of healer to seek.

There is change in perceptions of health seeking behaviour influenced by 'civilization' in the sense that, for individual to be admitted into 'civilized' or 'modern' society, they have to abandon practising 'traditions' which include using indigenous health care. Hence Indigenous medicine was, illegitimated, illegalized, suppressed and abandoned by some people in the community, and the people practicing it were condemned and associated with out-datedness, a characteristic most people find demeaning. This led to a

generation that for the most of their health needs, do not understand, recognize, appreciate, value or use indigenous medicine.

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

Prior to European invasion and colonization, the Maasai had an elaborated indigenous health care system that had developed over time corresponding to their culture, economic production and health needs. When British rule was established several aspects were introduced. These were western and included; the western medical system, Christianity and education. These had a fundamental impact on Maasai Indigenous health care. The ecological crisis of the late 19th century also weakened the Maasai social structures. Christianity and western education were used as tools to 'civilize' the Maasai. Education was used to degrade/condemn Maasai cultural practices as primitive. Consequently the Maasai indigenous health care as well as other structures underwent changes.

In the colonial period changes in political and social structures led to loss of power and influence of the Maasai spiritual healers (Oloiboni). Colonial conquest deprived healers of their control over production and broke most links between healing and public authority. The colonial administration viewed medicine as an important tool to assert control which led to overemphasis on western medicine and repression of indigenous medicine. After independence the post-independence government established western medical centres in Kajiado District. The Maasai therefore had an alternative health care system. The elites (educated) of the Maasai community sought treatment in these facilities in a manner of showing the others that western medicine is superior and more efficient than indigenous medicine. However the general population treated western medicine with suspicion/distrust. Western medicine detachment with the social/community life of the patient during diagnosis and treatment made it more unpopular among the Maasai.

The way the Maasai of Kajiado interpreted and responded to illness is a product of the past and present, of continuity and change. The changes can be understood in the context of change in epidemiology pattern of diseases, western medicine, government policies, schools and missionary activities. While the colonial and post-colonial government heavily emphasized western medicine, they did little to convince the Maasai people of this belief. They provided limited medical infrastructure for the Maasai. Even where such facilities exist, they are understaffed, poorly equipped, lack essential drugs and are inaccessible to a most of the community due to poor infrastructure.

Concept on disease causation has been redefined, though the cultural perception is still resurgent even among Christian converts who still believe that it is possible for a person to get ill and even die due to harm caused by another through spoken curse. There is rise in new explanation of diseases especially among Christians who attribute some illnesses to supernatural powers (demons). While the Maasai attributed illness to sorcery and curses, supernatural causation is a recent concept in Maasai perception of illness.

The concept of illness is an important determinant in treatment decision. Change in perception of disease causation affects the choice of health care. While the conceptual distinctions of different kind of illness can be clearly stated, the application to specific illness is less clear. Hence, multiple explanations of an illness are entertained. This leads to use of both indigenous health care and western health care systems. Although herbal remedies are often used as the first resort among most informants, western medicine among the educated and Christians is the first resort and indigenous medicine is used as an alternative. Further, most informants believe that plant based health remedies are superior and more reliable than Western medicine. High levels of illiteracy, inadequate modern health facilities and inaccessibility to these facilities all contribute to Maasai dependence on their indigenous practices and cultural beliefs on indigenous health care.

The Indigenous health care among the Maasai has been resurgent despite attempts by Christian missionaries, colonial and post-colonial governments to suppress it; and it has continued to grow because indigenous healers are seen as offering a higher likelihood for cure of illness, it is easily accessible, affordable and forms part of the cultural system of the community. Health and illness are governed by cultural rules, which influence how people present their illness, when and where they go for care as well as how the care is evaluated (affected by cultural beliefs). While the understanding of health and illness has changed among the Maasai of Kajiado, indigenous health care continues to provide meaning and rationality for health care in response to disease. Although modern medicine is being widely sought by a large proportion of the community, indigenous perceptions of health issues and diseases, and their management using herbal medicine remain popular even among those who periodically seek Western-based medication. Indigenous plant based medicines, which are used to treat and manage various health related problems still remain their primary health care system amidst the influence of modern medicine.

RECOMMENDATIONS

This study has shown continuity and change of indigenous health care among the Maasai community. However, the knowledge base of variety of plant resources recognized to be of medicinal value for diverse health problems and their availability is threatened by changing lifestyles. This would be a tremendous loss to the community considering the poor availability and access to modern medical care and health facilities. Since the community is heavily dependent on medicinal plants. There is need to document, protect and measures taken to promote their sustainable utilization.

Likewise, integrating indigenous health care system into the national health plan as recently envisaged by the government in 2002 bill would have several benefits to the Maasai and other pastoral communities. In particular it would improve access to and easily affordable health care as well as promote conservation of important indigenous health care system that are locally available on their land. The Maasai indigenous ethics and practices that govern use of communal resources like medicinal plants have been instrumental in helping conserve important biodiversity types for generations. The findings of this research opened avenues for prospects in policy evaluation in integration of biomedicine and indigenous health care systems. There is need to seek further data from different communities, debate on the possible integration and develop effective policies that ensure health for all.

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The testimonies were recorded during a field study in Kajiado District. The interviews were done mostly in Maa language (local language) and Kiswahili, the Kenya national language and subsequently translated into English. Information has been provided on the informants including names, place where the interview took place and the dates.

List of informants

Name of informant	Sex	Age	Place of interview	Date of interview
1. Joseph Ndilai	Male	28	Olepolos Village,	10/7/2010
2. Kaaka Koin	Female	70	Olemurkat village	8//7/2010
3. Kaaka Meikan	Male	50	Olemurkat village	8//7/2010
4. Kakoye Richard	Male	60	Samuli Village	17/7/2010
5. Karino Nasha	Female	40	Naibala Village	7/7/2010
6. Katamboi Ezekiel	Male	55	Oloirien Village	24/6/2010
7. Kerea John	Male	65	Oloirien Village	24/6/2010
8. Kilelu Mututua,	Male	45	Imanyatt Village	4/7/2010
9. Kinga Meteur	Male	30	Olotulugum Village	13/7/2010
10. Kisemei Ole	Male	50	Isara Village	15//7/2010
11. Kisentu John	Male	30	Isara Village	15//7/2010
12. Konka Ole	Male	75	Kimuka Village	21/6/2010
13. Koyo Nataana	Female	50	Olobelibel village	5/7/2010
14. Kuraru Steve	Male	45	Oltepesi Village	25/6/2010
15. Kusero- Chief	Male	52	Oloirien Village	24/6/2010
16. Kusero Joshua	Male	30	Oloirien Village	24/6/2010
17. Laila Katoria	Male	25	Olemurkat village.	8//7/2010

18. Maakoi Semeloi	Female	70	Olotulugum Village	13/7/2010
19. Mailoji Kaaka	Male	80	Olemurkat village.	9/7/2010
20. Maison Daniel	Male	40	Olobelibel location	5/7/2010
21. Makooi Osiasai	Male	75	Olotulugum Village	12/7/2010
22. Molil Ole	Male	50	Olobelibel	5/7/2010
23. Mononi Nashipae	Female	32	Oltepesi Village	25/6/2010
24. Mpote Ngoto	Female	50	Olemurkat village.	9/7/2010
25. Nairowua Timothy	Male	35	Orinie health Clinic	5/7/2010
26. Nasioki Ole	Male	50	Oltinga Village	23/6/2010
27. Natu Jeremiah	Male	60	Oloirien Village	24/6/2010
28. Neliang Ole	Male	40	Oltinga Village	23/6/2010
29. Ngiroyia Ole	Male	55	Oltepesi Village	25/6/2010
30. Nkaroya Tiapapusha	Male	50	Kimuka Village	22/6/2010
31. Rukunyi John	Male	70	Oloirien Village	24/6/2010
32. Sakuda Wilson,	Male	38	Kimuka Village	22/6/2010
33. Shonko Easter	Female	48	Oloirien Village	24/6/2010
34. Terta Joseph	Male	40	Olotulugum Village	12/7/2010
35. Tiampati Dalmas	Male	32	Imanyatt Village	4/7/2010
36. Tonke Rose	Female	55	Samuli Village	17/7/2010
37. Toome Nchikina	Female	60	Isara Village	15//7/2010

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APPENDIX 1
Interview Schedule

Name……Place of Interview…….

Age……sex…… Date of Interview……

Section……Ethnicity……..

1. Indigenous Healers

Type of healer (herbalist, ritualist) ……Clan…….

When and how did you learn the art of healing?

Are you training anyone?

What kind of illnesses do you treat most frequently?

What do you think are the causes and symptoms of illnesses (those mentioned above)?

What methods do you use in diagnosing illnesses?

What kind of materials do you use for treatment?

Can you give some estimate of the fee (which form) charged for each treatment? Example of illness and usual fee. What determines fee payment (amount)?

What is your religion? Does it affect how you treat the sick? If yes, how?

Do you have any permit to practice healing? If yes, how did you obtain it?

Have you had any trouble with the law? If yes, how?

How much schooling have you received?

What other kind of work do you do (source of income)?

Which diseases were common among the Maasai before the coming of the Europeans?

Which diseases emerged after the coming of the Europeans?

What do you think were the causes?

How did healers react to these new diseases?

2. Other informants

Do you have complaints (sickness)?

Have you been sick recently (last 2-5 years)?

If yes what kind of illness?

What do you think caused illness?

What did you do about it (treatment)?

When you are seriously sick, where do you go for treatment? What do you try first?

Do you prepare (herbal) or prescribe (drug stores) medicine (for yourself)?

Have you ever gone to the hospital for treatment?

Do you go to indigenous healers for treatment? What is you perception of indigenous healing?

What is your religion?

Are there new diseases that were not there before the coming of the Europeans?

If yes, what do you think were the causes and how are they treated?

What kind of health services are available in your area?

Are there any new forms of health care in the area?

APPENDIX II

Map of Study Area