PUBLIC HEALTH AND VILLAGERS:

The Case of Masana Sub-location into the 21st Century

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Abstract

The founders of the colonial regime expressed horror at the situation they found among African peoples. Health standards and health delivery for example, were believed to be surrounded veiled superstition and an absolute absence of the basic principles of preventive health, like hygiene, sanitation and proper nutrition. They saw themselves as saviours, destined to change everything for the better and to raise general standards of living. The first independent government, in turn was appalled by what the colonial regime left behind. The problems in health delivery were identified as very poor and completely inadequate infrastructure in predominantly African gross inequity in distribution of services between European and African areas, even more inequity of distribution between various regions, a very inadequate trained staff, in terms of numbers and attainment, generally a very low standard of health among the Africans, especially in the rural areas, and a high degree of ignorance on preventive and promotive health. The officials of the Kenya government at themselves to attack these problems, with energy. However by the mid 1970s the same problems still sailed issues of health among Kenyans. A new problem identified was a much too rapid growth of population. By 1983, a series global economic crises as well as the pandemic of HIV/AIDS were playing a baleful part by rendering all efforts ineffectual.

Throughout the 20th and the 21st centuries, through colonialism and independence, Kenyans have responded to health challenges by retaining, their traditional health delivery systems and adapting new techniques where possible. The result has been a system of alternative medicine and health delivery, and health seeking behaviour.

1. Introduction

Public health has also been called population health, community health, environmental health, preventive and promotive health and many other names. In colonial Nairobi public health, defined and first legislated for under the Municipalities Ordinance of 1919 and then the Public Health Ordinance of 1929 tried to make a distinction between preventive and curative health delivery. For example, the Public Health Department of Nairobi Municipality created in 1929, became the preventive health arm of town health policy, charged with the responsibility of safeguarding the health of the public. Its sections included cleansing and removal of nuisances, mortuary services, control of infectious and communicable diseases, immunization, maternal and child welfare, a special treatment clinic targeting skin infections and venereal diseases (now known as sexually transmitted diseases or STDs), malaria control, rodent and vermin control and others. It was supposed to work in close liaison with the municipality's water and sewerage section. Generally speaking, curative health delivery was supposed to fall under the preview of central government.

In the rural areas this distinction was not so easy to maintain. Rural people tended to see all western medicine as delivered by *Wazungu* or their agencies. Furthermore, by the time it was taking over, the first independence government saw itself as the primary health delivery agency, albeit in partnership with others, such as the Christian missions, private practitioners and donor agencies. It can be convincingly argued that by 1963, especially with reference to rural areas the definition of public health could be seen as any health delivery systems and any efforts to safeguard the health of the people, undertaken by the government and its partners.

This paper aims at a survey and analysis of the Kenya government's policies on health and the responses of rural Kenyans with regard to their attitude to western medicine over the years and their own health seeking behaviour. In the collection of data for the paper extensive use was made of all the development plans since independence. Attention was paid to the Kenya government's detailing of what it was doing as well as its own

assessments of the successes and challenges of health policy implementation. Oral information was also collected from rural people.

Masana village was chosen as the central case study although comparative data was also collected from one other village in Kakamega and a third one in Siaya districts. The data collected were analysed in the context of a wide body of published literature and unpublished documents. The sampling of informants was first done through the purposive choice of two men and four women who grew up in Masana village in post independence years. One of the men is now a teacher at Chavakali Secondary School in Vihiga district with nearly two years left to retirement. The women were born in Masana but married in Siaya, Kendu and Bondo districts in Nyanza. In addition a focus group of six women, four of them in the child bearing age range and two beyond, all residents in Masana and married in the village was also interviewed. The oldest were a grandmother in her eighties and a second one in her sixties. The four youngest had children of ages varying from twenty to four. They were chosen on the advice of the teacher. Apart from four years at Mwihila Boarding Secondary school, a two year attempt at an accounting course at the Kenya Polytechnic College in Nairobi in the early 1980s and a two year diploma course at Kagumo Teachers Training College he has lived in Masana all his life. He has taught at Chavakali Secondary School, commuting from his home since 1985. The analysis and interpretation of the data was largely qualitative.

Masana village is a sub-location of Maragoli Location of Vihiga District in Western Province. On the east it borders Nyanza Province to the South and Rift Valley Province to the North. As a sub-location it is bordered on the west by Angoya River and on the east by a local river called Seke. These two rivers, have supplied, completely untreated, the requirements of a great majority of the population to the present. The wealthier families, about eight altogether, have brought portable tanks and use them to harvest rain water. This is sometimes with the aid of funds from the Constituency Development Fund (CDF). The same CDF has started a water project at Mang'ongo, in Angoya, which aims at piped water for all homes by 2010.[1] Rural electrification efforts have meant that all schools in the village have electrical power. This means that home electrification should

be within reach for all the villagers. So far, however, no home has been able to afford the funds to be connected.

The population of the village was estimated at 79,000 by the report of the 1999 census. The village lies within a zone with the highest population growth rate in the country.[2] It also lies within the belt identified by the 1999 National Poverty Eradication Plan (UNEP) as the most severely affected by poverty.[3] The village is inhabited by Maragoli and Luo ethnic communities with a road which runs from Tigoi to Angoya as the rough dividing line between the Luo to the East and the Maragoli to the West. In both cases the villagers within an ethnic group are organized in sub clans and lineages which consider themselves closely related, and whose members are therefore exogamous. Intermarriage is allowed across the ethnic line. It is a tendency in the village that the men do not marry women of educational levels high enough to enable them to engage in salaried or wage earning employment. The three most highly educated wives in the village attained Form IV and Form VI standards. Only two of them are in wage earning employment. One, a widow is a teacher in primary school. The second one, a secretary, has been separated from her husband since 1991. The third lives with her husband in Kisumu and is a small scale business woman.

Since the introduction of free primary education by the NARC government in 2002 primary school attendance is 100% for both boys and girls. Because of the introduction of reduced cost of secondary school education the secondary school enrolment rate for both girls and boys is practically 100%. However, the level of drop out of girls is estimated at 40% to 60%[4]. This is because of adolescent pregnancy. Grades achieved are usually low. Only one boy, raised and educated in Masana has gone through university. The only other graduates made up of two men and four girls are siblings who graduated in the seventies and eighties and have raised their children away from Masana. In turn they are the only ones who have produced graduates in the nineties and the first decade of the 21st century. They total eleven grandchildren of one man. Another four grand children, three males and one female are in the universities, and likely to graduate

in the next two years. One family has thus dominated higher educational achievement and the best paid professional employment as well as post retirement business.

Masana could be described as a small community where people know each other personally. Indeed, children grow up easily speaking both languages. They play together, meet at various points of the river to gossip or share news, bathe, wash clothes, and pots and pans, water animals or for the girls, fill up eathern or plastic containers with water to be taken home. However, the tribal feeling is deep, having started around independence over the provincial/constituencies demarcations debate. Before 1965 the provincial boundary between Nyanza and Western provinces was along the Tigoi-Angoya road. In 1965 it was moved to the River Seke, putting almost half of the Masana population, all Luo speaking into Western Province. Three generations later the Luo of Masana still register to vote in Kisumu Rural Constituency. The Masana Primary School of the early 1960s split up after the demarcation into two schools, within walking distance of each other, namely Masana Luo and Masana Mrere Primary schools. In the 1970s they also developed day secondary schools. Enrolment of students as well as the hiring of teachers is strictly on ethnic basis.

There was an early entry of missionary Christianity. The Friends African Mission (FAM) began at Kaimosi and radiated into Luyialand while the African Inland Mission (AIM) established itself at Nyahera (Nyanza) and took a hold in Luo Masana. This was around the end of the first decade and beginning of the second decade of the twentieth century[5]. African independent churches have also followed the ethnic alignment in establishing themselves with the African Israel Nineveh church gaining converts mostly among the Luyia while Hera was accepted among the Luo.

The first round of converts told storied of the strict puritanism of the mission churches and their uncompromising stance against African traditional rituals, beliefs and practices. The earliest converts were physically separated from their communities and made to live in new Christian communities around the churches[6]. Thus a concerted assault was made on African rituals in areas such as child naming, burial and mourning, treatment of

widows, modes of dress and above all, health seeking behaviour. A certain measure of success was achieved. While it is justified to be skeptical about the depth of the inculcation of western values it is fair to point out that many who still cling to traditional practices in the 21st century to do so in secrecy, ashamed to admit to the truth. Thus, without downplaying the importance of change over a period of time it can be surmised that Masana village is a very patriarchal society which is accepting change very slowly in spite of being close to such urban centres as Kisumu and Kakamega.

The main occupation of the great majority of the families is still agriculture, with the production of maize, some millet, sweet potatoes, cassava and beans in conjunction with some fruits and vegetables. There is some livestock keeping but this is being negatively affected by growing scarcity of land. Production is both for consumption and exchange. The members of the prominent family, except for one who is a secondary school teacher live for the most part, away from the village, barely visiting. Thus for those strongly domiciled in the village the elites in terms of income have over the years, been teachers as well as sub-ordinate employees of the Kenya Railways and the Posts, the various local dispensaries, health centres and the schools. The teachers and dispensary and health centre workers have normally lived at home and commuted to work, while those who worked with the Kenya Railways and the Kenya Posts lived as far away as Kericho, Nairobi and even Mombasa. These became the largely absentee heads of families who sent remittances home for school fees, agricultural work, fertilizers, clothes, household utilities and others.[7]

Though the women in general do not take employment in the formal sector, neither are they 'stay at home' mothers/housewives, apart from those lucky enough to receive remittances from working absent husbands and therefore only supervise agricultural work on their farms. The women who have no such support work on their own farms with the supposed help of children and husbands. Recent research has shown however that the children go to school while the young men are away looking for jobs or engaged in business or casual work *(kibarua).* Many of the wives end up also working on farms owned by wealthier persons for pay *(otong'o).* This would, of course, be in addition to

the normal gender based chores within and round the home like housework, cooking, fetching firewood and water and tending small livestock and chickens. Women also engage in trading, making trips to the various markets where they exchange surplus produce for money. Generally it is the mother who initiates a child's formal education by providing uniforms, exercise books, pencils and such like. Some of the women's earnings are also used to buy special food items like fish, meat, milk, sugar, tea and so on.

In Masana Village, the process of land adjudication, consolidation and registration was completed in the 1970s. Generally speaking this was a high agricultural potential zone, lying in the Western Highlands, receiving rainfall of over 1,500 mm p.a in two seasons. These enabled villagers to reap two harvests in December and August. Increasingly, over population, re-current droughts and costly agricultural inputs have meant growing marginarisation of agriculture.

2. Evil, Health and Health Seeking Behaviour before Modernisation

There is a wide available literature, published and unpublished, spanning many decades, which has described various researchers' and commentators' perceptions of African medicine and medical care and African health seeking behaviour. All agree that Africans lived in communities which emphasized people as members of a larger group - village, family, lineage, clan and so on, - rather than people as individuals. Sickness, suffering and death were not accepted as normal; they were believed to be caused by various agencies. J.S. Mbiti for example distinguishes between natural and moral evil. There are others who support this view.[8]

Moral evil was seen as resulting from the provocation of God, the ancestors and other supernatural agencies through the immoral behaviour of humans. Evil could also come about through the machinations of evil people because they had power to control spirits to the harm of others. Mbiti and others distinguish in this category witches, sorcerers and

others. Herbalists were specialists in communities, with a wide and profound knowledge of the medicinal value of roots, barks, leaves and seeds of special plants and who were able to concoct brews, powders and such like to treat a wide variety of illnesses and conditions. Mineral solutions could also be made from special soils and some kinds of soft stones were also chewed and swallowed for their special properties. Animal parts could also be used in the preparation of various potions for treatment.

In addition, researchers have emphasized the importance of the Africans' holistic approach to health. The well being of the individual and the community also depended on how each member related to and fulfilled obligations towards peers, juniors and elders of the opposite or the same sex. Relations also had to be good with the recently as well as the long departed. There were rules and taboos which established societal norms and breach of such rules was believed to result in a whole range of misfortunes including poor harvests, death, especially infant and child mortality infertility and various kinds of illness including psychological and psychiatric conditions.[9]

Under these circumstances, other specialists who could consult with supernatural powers were approached to provide solutions. These usually involved firstly efforts to re-establish harmony where it had been broken or violated but also some sacrifice or offering to mollify offended spirits. The so called diviners, have also been described as community sociologists and intellectuals, very well versed in the social and cultural nuances of relationships in a community, often spanning decades. They used their wide knowledge and experience to try and maintain harmony in a complicated network of positive and negative relationships.[10]

3. Christianity and Western Medicine

At their point of entry at the end of the 19th Centuary, Europeans prided themselves on their scientific knowledge and technological development. Carrothers argued in the

1950s that by the end of the 19th century Europeans had realized the connection between hygiene and sanitation with germs and diseases, between vectors like mosquitoes, tsetse flies and molluscs with human health, while Africans had not.[11] For their part, as Sindiga has argued with the low level of scientific knowledge among them put Africans in a place of high dependency on beliefs in the powers of the supernatural and the perceived need to negotiate a harmonious co existence between, as it has been so aptly put, the dead, the living and the yet to be born.[12]

Thus 'hygiene' in European health concepts involved clean water properly inspected foods and drinks, fresh air, ample accommodation, correct disposal of sewage and human waste and so on. For the Africans the safeguarding of public health meant cleansing the community of witches with evil eyes. It meant protecting the community from the 'filth' believed to attach to those who had been associated with the newly dead, such as widowers, widows, orphans, siblings and others. This would be through ritual processes like *ter* (widow remarriage), *tero-buru* (mock combating and overpowering of death after a burial). shaving off of hair for the bereaved, and other such. It meant identifying the persons, responsible for the death of children or the infertility of one's wives through whatever machinations they had undertaken. It meant periodic interventions in prayers, divinations, and sacrifices during the agricultural cycles for rain, good luck, healthy children and so on. It also meant that all rituals of naming, marriage, funerals and burials were carried out in the proper way to ensure that there were no angry spirits running loose, creating problems for the living. This was also ensured through the proper care of orphans, widows and other dependants left behind by the departed.[13]

For Europeans, missionaries, administrators and anthropologists alike this was all superstition, ignorance and filth.[14] For Africans in Central Kenya, it was necessary to 'cleanse' a young girl in preparation for pregnancy and motherhood through circumcision (now known as Female Genital Mutilation (FGM). For missionaries this practice was not only cruel and inhuman it led to complications for pregnant women during child birth. For British colonial administrators among the Kikuyu Embu and Meru in the 1920s – 1950s, the practice of throwing away the dead and terminally ill into the bush to be eaten

by wild animals was a serious public health hazard. To those African groups it was the only way of protecting a community from the smear of death and disesase.[15]

According to Sindiga, Kenya's communities had developed, by the beginning of the 19th century, medical and health care systems that were reasonably sufficient for the complex of local diseases. It was accompanied by fair food production systems, given population density.[16]. The 19th century, however,as it progressed changed this delicate balance completely, first with a series of agricultural catastrophers like droughts and locust invasions. Secondly, there was the increased frequency and ever deepening extent of long distance travel brought about by the rapid expansion of caravan trade. Areas and peoples that had been isolated for centuries came suddenly into close contact with one another. The increased scale of contacts, not only brought new items of diet and new techniques of production to enhance the well being of peoples. Endemic diseases were also taken from their traditional locales to zones hitherto unaffected and therefore very vulnerable. Other diseases, like Tuberclosis (TB), venereal syphilis, a more virulent form of small pox and others, unknown before, were introduced. The droughts and the resultant famines intensified the levels of population movements while the deepening crisis of the slave trade was rendered even worse by civil wars in particular arrears. Quoting Kuckzenski, Sindiga argues that population levels must have declined catastrophically from the end of the 19th century.[17]

British administrators, of the early 20th century, like Charles Eliot, John Ainsworth, Charles Hobley and the missionaries who tried to establish palliative medical services expressed horror at the state of near chaos that they were presented with.[18] Some scholars have pointed out that the scenes of desperation painted were exaggerations meant to provide an apology for colonial occupation. But it has been generally accepted that mortality rates were high, especially, among children below the age of five and that population growth rates, though based entirely on guestimates, were very low. In fact the vicissitudes of the establishment of the colonial regime rather exacerbated the situation.[19] The wars of pacification, colonial burning of barns and fields and the looting of livestock as punishment for those who fought back, exacting labour and tax

demands especially during the world wars, enforcement of new diets, the faster travel brought about by improved transportation and the resulting introduction and dissemination of even more new diseases rather created a situation of near chaos almost to match the late 19th century.[19] Negative population growth is recorded up to the 1950s in despite of the colonial propaganda that linked colonialism with planned improved health and well being for Africans.

Health care and new medicines did come from the west but initially and for a long time in qualities and quantities barely to have an impact. Government services in the countryside mostly targeted their own European staff, and hardly adequately. Africans in the rural areas were left largely to the efforts of the various mission stations, which were even more limited in terms of resources targeting health. Their central concern was evangelization, with other social projects like education and health being seen as auxiliary activities for the more complete capture of souls.[20]

The very inadequate spread of colonial health and other social services was made even more ineffectual by the fact that Africans were generally very slow in a accepting them. Health officials in Nairobi for example complained that in spite of high levels of morbidity and mortality Africans showed very little interest in medical services offered. Maternal and child welfare clinics for instance were notoriously disregarded. Furthermore, apparently no amount of public education and public campaigns seemed to persuade patients, for example, to keep to regimes of treatment for the required period for such conditions as TB and STDs. As late as the 1960s medical officials in Nairobi complained that their campaign against poliomyelitis (polio) was rendered ineffectual by Africans' tendency to interrupt treatment before the three doses were complete, any time that the agricultural cycle demanded that they ago back to the rural areas.[21]

Declining population rates, were a matter of grave concern to the colonial regime. Firstly they were bad publicity for a self declared modernizing regime whose sole objective was supposedly to raise standards of living through the eradication of rampant ignorance, hunger, illness, violence and other such problems. Secondly, negative population growth

affected African labour supplies upon which the colonial settler agricultural economy was based. In the urban areas for instance, concern was expressed about the prevalence of infectious diseases like TB, syphilis, and gonorrhea. The persistence of African labourers' migrancy between the urban areas and villages, and the perceived widespread refusal of Africans to stay for treatment long enough for full recovery raised concerns. Firstly the diseases were going to spread to the rural areas - regarded as the crucial base of labour production. Secondly drug resistant strains were going to be the ones transferred to the villages where health delivery was openly admitted to be pathetic.[22] Kanogo and White have argued that the dominant patriarchal ideology of colonialism blamed this pending catastrophy at least where STDs were concerned on African prostitutes in urban Kenya. With the help of equally patriarchal African local administrative systems and African urban 'tribal' welfare societies tried rather ineffectively to drive away or bar the entry of African prostitutes in urban areas. Kanogo also identifies the young women who ultimately ended up as urban prostitutes as young pre-circumcised girls who got pregnant in the rural areas, becoming unacceptable in the rural social order. In retirement from urban prostitution they returned home armed with money and sexually transmitted diseases, to spread among the villagers.[23].

In Vihiga District where Masana sub-location lies, the situation was and still is different. Girls who got into pre-marital pregnancy, if they were not so 'lucky' as to get some kind of husband immediately, did ultimately leave the village but the culture did not accept them back. They remained in town from whence rumours of their 'outrageous' conduct wafted back and were used by mothers and grandmothers to counsel young girls against sexual misconduct. Information available indicates that syphilis and gonorrhea was brought back by husbands who lived and worked in town and came back periodically to visit wives and children.[24] Statistically, at least, where such men were financially responsible, these families, were the most well off comparatively in terms of standard of living. At the same time these wives were surrounded by rumours about their diseases and their secret visits to 'bush' doctors.[25] They were therefore used as subject matter for counseling of young girls by older women *(pim)* against rushing into early marriages and the likely mis-treatment of wives by husbands. Men who went to town made no secret of

entering into temporary informal relationships with urban women. Largely, the women in these relationships were not acceptable as wives by older male relatives at home. However, the ideology of village life throughout the 20th century and into the 21st century has maintained that a man could maintain a pleasure *(raha)* woman in town and the 'real' wife at home. The said wife had no say in the arrangement being heavily dependent on the remittances of the husband for needs such as education for her children and medical care for the family. Colonial officials noted with concern that husbands often treated themselves for various diseases and reneged on responsibility for the treatment of the wives actually multiplying the challenges of western medicine for Africans. The Kilbrides and others, have pointed out
that 20th and 21st centuries, with their establishment and growth of various degrees of capitalism, and their tendency to entrench control of cash incomes in the hands of men have increased the vulnerability of children and women in such vital areas as health and nutrition[26].

Other diseases commented upon in the 20th and 21st centuries have been malaria, bilharzias, and various forms of helminthic diseases, especially hook worm which combined with malnutrition to ravage the health especially of vulnerable children and pregnant women. Diarrhea diseases have always been also high on the list. In the 1950s colonial medical officials in Nairobi exclaimed at the pathetic conditions of children brought into dispensaries and post natal clinics after a visit with their mothers in Western and Nyanza Provinces. They were reported to be plagued with dermatitis, malaria parasites, protein deficiency, hook, round and tape worms, and others, with "their mothers scarcely in better conditions"[27]

It is interesting therefore to note at the same time that throughout the 20th and into the first decade of 21st centuries, colonial and independent governments lamented the strong resistance that confronted western medicine among African people. This can partly be explained by the radically different conceptualizations of public health and hygiene already alluded to between the two forms of medicine. The belief that there are problems which cannot be treated in hospitals is practically universal, in rural villages in Nyanza

and Western Provinces. For example a woman's husband or child might waste and if no action is taken - even die because she engaged in adultery. A widowed man or woman might sicken and die because they participated in sex before they ritually cleansed. More importantly, other people's children might be struck with dangerous illness because a recently made widow amongst them refused to engaged in the rituals necessary for her cleansing. A child might have convulsions *(sikhokho)* because a person with the evil eyes, cast a spell over it willingly or unwillingly. A woman might be struck with secondary infertility because she or her teenage children broke the code of sexual distance supposed to be observed between parents and their children. There are many other such. The belief is that practitioners of western medicine are well aware of all this and are just unwilling to admit it publicly.[28]

Luise White's study on rumour in colonial history is partially an attempt to explain the confrontation between western and traditional world views. She argues that medicine and health delivery constituted one of the crucial areas in which Africans tried to understand, explain and deal with what was culturally alien. White is supported by a great deal for oral information on fears, anxieties and rumours connected with western medicine and its association with *wazungu*, their African agents and various other symbols of colonial domination.[29]

Missionary medical personnel and their treatment paraphernalia - drugs, bottles, equipment like stethoscopes and blood pressure monitors, needles, syringes and others were treated with awe or suspicion. After all, in traditional treatment a diviner's or herbalists equipment and paraphenelia - costumes, containers, agents of administration and so on and even the location were important in the whole set up of treatment and the healing process. An evil minded person might use them to harm the patient. When the two systems found numerous details and areas in which compromise could not be struck rumours mushroomed about what happened in hospitals, on examination tables, mortuaries and others. Was blood being sucked out of unsuspecting victims? Were body parts being stolen? Were drugs being manufactured from human blood, brains or other body parts. Indeed, many African breakaway church members in those churches which

discourage western medical treatment firmly believe that western medicines are made out of human blood and body parts.

Tabitha Kanogo, argues that colonial policies on maternal and child health and colonial efforts to establish such facilities and deliver the services to Africans were also regarded with ambivalence by the target population.[30] First and foremost, pregnancy and childbirth were and are still regarded not as a health problem but normal and natural phenomena. The Kilbrides correctly point out that pregnant women carry on their normal tasks up to the onset of labour.[31] In Masana village such occurrences as a difficult labour, obstructed delivery or anything to harm a woman's safe delivery of a live child is more likely to be seen as resulting from the machinations of another person, usually a jealous co-wife or childless woman. Elderly women who had buried their spouses, children and close relatives were also suspect.[32]

Secondly, colonial maternal and child health delivery, on principle, not only deprived African women of an area in the social systems where they traditionally wielded much valued power. They also lodged that power in younger women and sometimes even men who were culturally barred from such functions.[33] Thirdly the medicines, equipment and procedures employed were suspect or unacceptable. For women they were associated with unnecessary caesarean or vacuum extraction delivery, unnecessary episiotomies and even maternal and child mortality.[34] From the late 1950s after the introduction of family planning, and particularly in the seventies and eighties when official family planning in a culture which prized fecundity, seemed to be reaching a point of hysteria many women associated hospital births with non-consentual sterilization. This is to say nothing of interminable lectures delivered by hospital personnel on women perceived to be giving birth too often. Rumours flourished claiming that contraceptives did not prevent pregnancy. They merely postponed them, incubating babies in some mysterious corner. Women who used contraceptives were believed to eventually give multiple births of as many as five infants.[35]

Colonial medical reports contained many complaints that despite the strenuous efforts at health education made, medicinal services were used as a very last resort when the situation was already beyond remedy.[36] There was also the issue of payment. In almost all cases the numbers of those who sought medical attention plummeted, when the system tried to make health delivery anything other than a welfare service. When for example the Nairobi Municipal council tried to introduce a charge for treatment of venereal diseases the numbers of those seeking treatment fell to a level where the World Health Organization (WHO) had to remonstrate. This was especially a problem because men and women who presented with symptoms were refused treatment without, not only their regular partners but any others that they had sexual contact with men were usually expected to pay.[37] Colonial authorities could not adequately emphasise the importance of education to enlighten African minds about the right health seeking behaviour.

7. Independent Kenya Governments and Health Services

The end of the colonial period ushered in an enthusiastic independent government that took the challenge of social welfare for after *wananchi* very seriously. After all, it did declare for "African Socialism". Sessional Paper No. 10 of 1965 lamented among other things the extreme scarcity, non existence or backwardness of health facilities, particularly in the rural areas. It was probably fair at this point to blame the colonial regime for the lopsided economy and welfare delivery services which had favoured white people and their areas of interest to the detriment of the African areas in towns or rural areas The arid and semi arid lands (ASAL) had suffered gross neglect. But the majority of Africans elsewhere lived in extreme poverty and to make matters worse the country had experienced a crisis of investment confidence leading to capital flight. In the management and delivery of health as in all areas of the public sector, previous education and employment policies had resulted in the domination of all senior and middle level position by non Africans. Many of them left in the panic of the immediate post colonial period. Many more continued to leave as it became clear to them that the former racial ranking of personnel would not hold after independence.[38]

In vihiga district the African Inland Church (AIC) and the Friends Church had been running hospitals and health centres at Nyahera and Kaimosi. But the missionary organizations were also suffering from a massive flight of non-African personnel. In addition, they were experiencing drastic reductions in funding which had traditionally come from abroad.

Thus the picture on the ground, presented in Sessional Paper No 10 of 1965 was of a health services and delivery system which was extremely thin on the ground, where buildings, where they existed were inadequate, dilapidated, unsightly and even a health hazard and where trained staff, such as existed were grossly inadequate in qualifications and numbers. The sessional paper made its central slogan "the eradication of poverty, ignorance and disease," rightly recognizing the close association of the three.

The Kenya government obviously expected to succeed where its predecessor had failed in educating the public at large about preventive health and the promotion of good health and well being for example in proper nourishment of the human body. After all, they were ushered in by massive good will as opposed to the direct sabotage that had often been the lot of the colonial regime. The sessional paper announced the first Kenya Government Development Plan which envisioned among other things a massive development of the rural infrastructure, for health delivery, in the erection of health centres, dispensaries and maternal and child welfare clinics and an injection of new funds in the collapsing missionary health delivery system. There was to be a programme of training of medical personnel of all levels to improve the ratio between this personnel and the people at large. In preventive health there was to be a great campaign of education as well as an attack on vectors of diseases such as mosquitoes, mollusks, tsetse flies and others. Research would be encouraged in co-operation with the East African Common Services Organization (EACSO) to provide the knowledge base necessary in the combat against diseases. The provision of clean water as a measure of control against diarrhea diseases was also a challenge set for the newly independent government.

The government recognized its own weakness from limited resources and planned to seek and obtain the partnership of the United Nations and its agencies, like WHO the United Nations' International Children's Educational Fund (UNICEF) and the United Nations' Educational, Scientific and Cultural Organization (UNESCO). Sessional Paper No. 10 of 1965 thus set the tone and spelt out the ambitious plans of the Kenya government in the rural areas *vis a vis* a determined attempt to bring health services increasingly within reach of all people and to reduce the disparity in standards of health services provided in various districts.

For example in a mid term revision of the plan in 1966 the government declared:

> Existing hospitals will be expanded and improved and new ones built. Health centres will be increased from 160 to 270 …. strenuous efforts will be made to train more medical stage at all levels … Training of nurses will be expanded so that by 1970, 350 community nurses will produced p.a (there were none in 1965) … The number of health inspectors in the field will be raised from 117 to 350.

This coincided with the launching of the 1967 Africanisation policy, to replace non African personnel with trained Kenyans, gradually.The 1965 Sessional Paper proposed to establish a Faculty of Medicine at the then Nairobi University College which was part of the three college University of East Africa. The objective was to train full doctors. The doctor/patient rate in 1965 was calculated at one doctor per 60,000 of the population. The ultimate aim was to improve this ratio and by 1970 to establish a post graduate medical school. An enlarged Kenyatta National Hospital (KNH) was made an associated teaching hospital. The new medical school opened its doors to the first 30 students in July 1967.

The plan also raised concerns about the uneven distribution of private and government hospitals, Nairobi town was the best served with an exceptionally high ratio of hospital beds to the population. The government proposed to narrow this gap, by establishing several district hospital to house over one thousand beds. Homa Bay and Kisumu district hospitals in Nyanza province were among the first. Kisumu also benefited by the building of an additional 500 bed hospital with the help of USSR Government.

The Kenya Government advocated the participation of the people through "the spirit of Harambee" in education and health. Preventive measures were recommended for harambee through the improvement of environmental health by the protection of water supplies, bush clearing for the eradication of malaria and sleeping sickness, development of access roads and improved housing in the rural areas. For the control of more serious problems like TB and leprosy the government hoped to partner with international agencies like WHO, UNICEF, Nuffield, Rockefeller Foundation and others. The first independent government took up the regimes refrain on the ignorance of Africans and the needs to educate them in preventive and preventive and promotive health. Thus in the rural areas a network of health centres were to be used. Health centre were defined as small facilities which laid emphasis on education on preventive and primitive health, better eating habits, better hygiene and child care rather than on curative drugs. But health centres were unpopular because women especially felt they had no time to go for a lecture. They spared time to go to a centre when they needed drugs. There was, grave concern over the much too rapid population growth rate estimated at 3% p.a in the mid 1960s and expected to reach 4% p.a in the 1880s if the infant survival rate and overall mortality were to respond to the concerted efforts at health improvement.

An official policy, launched in 1967 charged the Ministry of Health with supervision and co-ordination of the efforts of the Government and such partners as the Family Planning Association of Kenya (FPAK) the International Planned Parenthood Federation (IPPF), church organizations and the (KNH). The policy objective was to educate people to adopt various child spacing techniques voluntarily. By 1969 there were 160 locations in total, mostly funded by external grants and donations. The KNH offered short courses in motivations and techniques to clinical and medical assistants, enrolled nurses and midwives from all over East Africa.

Through the next three development plans which covered the period up to 1983 this continued to the basic tone of the Government of Kenya as it continued to project itself as deeply involved in the expansion of health facilities, provision of equipment and trained

personnel and promoter of good health and well being through the education of the public. It expanded its responsibilities greatly; for example in 1970, county councils were relieved of any responsibilities for health centres and hospitals – though central Government also appropriated for itself the proceeds of the Graduated Personal Tax hitherto meant for local authorities.

However, there was a growing disillusionment and discontent expressed by the government itself, because the rate of expansion of facilities, personnel, equipment and drugs always fell short of what was planned and also behind the growth of the population meant to be covered. The 1970-74 Development Plan graded hospitals into three main categories. Hospitals in Grade 1 category made up of only 15 hospitals in the country, and including KNH and most provincial hospitals were the only ones which could be said to be reasonably equipped and staffed. On the down side they were under heavy pressure. They could not avoid admitting numerous ordinary patients even though in theory they were supposed to be referral hospitals. Grade II was made up of the majority of district hospitals and a few run by church organizations. They numbered 75 countrywide and boasted one residential doctor. Grade III included some 85 small hospitals, some government run and the others private. They were without a resident doctor and were served by medical assistants, clinical officers, registered and enrolled nurses and such like. Of the total hospital bed space given as roughly 9,325, excluding Mombasa and Nairobi 63% were general, 19% maternity and 18% mental or infectious. This was for a population of 9,235,000, making a countrywide ratio of 0.99 beds per 1000 of the population. The heaviest concentrations continued to be in the large towns, especially Nairobi and Mombasa. Nyanza province registered the lowest ratio of 0.79 beds per 1000 of the population, with Western and North Eastern Provinces very close behind.

The search therefore continued for a ‘cost effective rural health service’. The result was a ‘new concept’ based on the idea of health units, health teams and family health’. Rural health units were meant to target areas of 50,000 people. Maternal and child care and family planning services were to be attached, as well as mobile units to visit all schools

and daycare centres in the unit area, on a fortnightly basis. In terms of phsycial facilities and personnel each health unit was to have three points of contact with the population. Firstly there was to be a health centre made up of one preventive and one curative clinic blocks, with one in patitent block of twelve beds. It was to be staffed by one medical assistant, four community nurses, one health assistant, two family planning field workers, one statistical clerk and an attendant staff. Secondly there was to be a health sub-centre with a similar outfit but without an in patient block, and staffed by one medical assistant, two community nurses, one health assistant, one or two family planning assistants and the attendant staff. The third proposed point of contact in the health unit area was described as a dispensary equipped with one clinic, one community nurse, one health assistant and the attendant staff. In special cases, not defined, one upgraded nurse and one or two field workers were to be added.

Formal medical training was to be reinforced with the focus shifting to nurses and medical assistant because they reached more people than the doctors, who were moreover, so much more costly to produce. In addition the government still hoped to reach a large number of the population through a health education programme "to assist the population to learn, accept and put in practice measures to prevent ill health and promote healthy living". The target for the Plan period was set at 95% of the population. This was hardly achieved. A pregnant complaint in the colonial period and often repeated afterwards was that it was cynical to advise people to eat eggs, fruits, meat, pulses and drink milk when they did not have the means to obtain such foods.

For the first time the 1978 – 83 Development Plan mentioned traditional medical and health care. There was concern about the constant blurring of the line between modern and traditional medicine as traditional practitioners began to incorporate (legitimately or illegitimately) aspects of modern medicine. On the one hand the government seemed to appreciate their impact in the reduced queues at government hospitals. The traditional practitioners seemed to charge "popular" prices. On the other hand there was concern about drug quality and the security of Government Medical Stores, which were psuspected of being looted. Even worse was the issue of correct dosage, as "the modern

sector is presented increasingly with resistant forms of diseases or aggravated physical conditions". But it had to be accepted that these systems of alternative medical treatment were perversive, especially in the rural areas and that many of them were effective. The Ministry of Health therefore established a Traditional Medicines Unit and the Medical School of the University of Nairobi was brought into association with it "to evaluate the functions and role of traditional medicine and determine the extent of the need for such a service".

The Fifth Development Plan seemed to be largely an apology and a flood of explanations for the apparent failure to achieve the objectives of public health policies, still described as "increased coverage and accessibility." The unequal distribution of services, personnel and infrastructure between the urban and rural areas seemed, rather, to have grown the development of health infrastructure in the rural areas still lagged far behind that of the urban areas. A long list of problems was blamed beginning, naturally with the erstwhile colonial regime which had created the spatial and racial imbalances in health delivery. One of the most important corrective measures, namely free medical services for all who needed them, especially in the rural areas" was hit by numerous crises.****

This led to a steep increase in the price of crude oil and of all imported goods. The result was a substantial and progressive drop in Gross Domestic Product (GDP) growth from 6.7% in 1964-72 to 3.1% in 1975. In 1974 there was a prolonged drought which reduced the agricultural GDP by 0.2%. Every effort was made to prevent or curb inflation through new import tax measures. They failed in their objective and there was a steady rise in inflation. A coffee boom (1976 – 78), though initially beneficial ultimately led to increased consumption and therefore further inflation. The collapse of the East African Community which severely reduced the market for Kenya's goods was followed by a second oil crisis and a world recession. This in turn was followed by the political disturbances of August 1982. By 1987 there was an open admission that provision of health services was still inadequate, with inequitable spatial distribution, shortage of manpower, and lack of proper public information still featuring as the main challenges. An additional challenge identified was the low level of hospital operational efficiency,

with KNH and provincial hospitals experiencing a 100% bed occupancy though they were meant to be referral hospitals. This was because of the apparently incurable concentration of drugs, equipment and high level personnel in those hospitals.

Furthermore, as a result of international pressure through structural adjustment programmes (SAPs) imposed by lending institutions the government was forced to cut down on welfare services. The public health sector had to adopt cost sharing as a policy to help free health. The Government declared that the poor and disabled and vulnerable would be safeguarded from desperation and exploitation and proceeded to introduce amenity wards in all district and provincial hospitals as well as the KNH. The aim was to ensure that fees was charged at graduated levels so that those who could afford to pay more did so. Cost sharing was officially introduced in 1989 though the Government tried to soften its impact by excluding all children under 15 years of age, and the treatment of TB, and STDs.

In 1983, the year of the launching of the 5th Development Plan, was also the one in which the Kenya Government ceased to deny the impact of the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) pandemic as having a castrphic impact on the national health improvement plans. Data available from a 1987 study also revealed a high incidence of sexually transmitted diseases (STDs). The most common were syphilis and gonorrhea, but chlamydia, herpes and chancroid were also important. The association of the conditions with vulnerability to HIV infection was emphasized, but their importance was particularly underlined in complicating in maternal and child health challenges, quite apart from their impact on morbidity and mortality generally.

More and more people were being driven to traditional medicine because of rising costs of living and increasing poverty. The government decided during the 6th Development Plan period not only to investigate its power of attraction but also to try and alleviate some of the problems associated with traditional health care for example, drug quality and safety as well as its vulnerability to quackery. Associations of professional

traditional medicine practitioners were to be encouraged with a view to gathering information which would facilitate use, development and appropriate adaptation of traditional diagnostic, therapeutic and rehabilitative control technologies so that traditional medicine could become part of formal medical care.

The 6th Plan also announced the government's formal acceptance of the 'Alma Ata Declaration of (1978). Basically this was the introduction of the primary health care principle through which public health policy would shift from concentration on government provided hospitals, personnel, equipment and drugs to the encouragement of 'full participation of the communities themselves'. With cost sharing, primary health care was seen in the realms of public debate as the final abdication by the government of its commitment to the provision of health to the public. The ideal suggested a system with eight components. These were basic sanitary facilities, including the supply of clean water and proper waste disposal, appropriate health education, provision of proper nutrition, maternal and child care including family planning services, immunization against major infant diseases, control of local endemic diseases, appropriate treatment of injuries and the provision of essential drugs.

From the late 1980s, though the Kenya government continued to state that it was fighting to reduce poverty, create employment and raise standards of living, the only 'positive' outcome was a sharp drop in fertility rates. Otherwise, a long catalogue of ills - poor weather conditions, declining prices for coffee on the international market, increasing input prices for agricultural production, reduced manufacturing output resulting from power rationing created by drought, large inflows of refugee population – was blamed for the fact that 'real growth slowed progressively since 1990" Even the reinstatement of multiparty politics was accused of contributing to difficult conditions by creating an atmosphere of uncertainty which had a negative impact on investment, tourism and manufacturing.

Furthermore the government had to admit that its heavy recurrent expenditure on health was largely on personnel (70%) with only 30% targeting operations and maintenance.

The result was a steady decline in the quality of care. Dissatisfaction continued to be expressed, on the large percentage of resources used on curative medicine and the comparative neglect of the comparatively less costly but in the long term more effective preventive and promotive health activities.

By the rolling out of the 1997 – 2001 Development Plan no major improvement had occurred to alleviate the now common trends of the concentration of facilities and personnel in urban areas, the very thin spread of services and delivery in the rural areas and the dilapidated nature and/or dearth of medical supplies in the increasingly impoverished rural areas. The government was moved to announce the National Poverty Eradication Plan (NPEP) of 1999 - 2015. It was posited that previous, national development plans and national policy frameworks "have been too costly and macro in their focuss" and that there was need to "set operational policies on the poor". Yet the strategy announced was a mere echo of previous policies. With regard to health, the same expansion of facilities, re-deployment of personnel, to rural areas, maternal and child welfare with family planning, immunization against childhood diseases, incorporation of traditional medicines and traditional practices were stressed. The same emphasis on health education to encourage communities to adopt better nutritional practices, observe hygiene, prevent diarrheal diseases through proper disposal of waste, boil drinking water to make it safe, seek immediate and sustain treatment (with partners) for signs of STDs, participate in malaria control by trimming bush and hedges, and discard traditional practices that encouraged the spread of communicable diseases, was to be adopted . The HIV/AIDS pandemic naturally came in for blame for negating gains in child, maternal and general morbidity and mortality and in life expectancy. The NPEP, however, was posited on the basis that there must be at least a 6% p.a economic growth rate for the full realization these objectives of the plan.

The beginning of the 21st century ushered in a generally pessimistic picture of the economy's performance. Blame was once more attributed to drought, the attendant power rationing, and a slowdown of 'external resource flows'. Agriculture, still considered the most important basis of the economy was the worst affected. Industry had

also suffered badly leading to market losses, declining foreign exchange earnings and unemployment. Though the population growth rate had experienced a marked decline anxiety was expressed over keeping the rate stable. The high level of HIV/AIDS prevalence (though reference was continually made that this was in keeping with levels in the rest of sub-saharan Africa) came into high blame for reversing gains aims achieved in life expectancy and general health standards.

The Development Plan of 2000 – 2008 divided the history of the nation's health into two phases. The first was 1063 to 1990 and the second from 1990. For example, life expectancy at birth had grown from 44 years in 1963 to 60 in 1993 while infant mortality fell from 120/1000 in 1963 to 64/1000 in the same period. Between 1993 and 2000 this trend was reversed with life expectancy at birth dropping from 60 to 47. Infant mortality rose from 64/1000 to 72/1000 in 1998 with 36% of children dying before attainment of their 5^{th} year. Maternal mortality remained high at 590/100,000 in 1998, higher than the world figure of 500/000,000, accounting for 27% of all death of women in the child bearing age bracket.

Moreover the inequitable distribution of health services continued in terms of access and affordability, with only 42% of the population having access to a health facility within 4 kilometers (km) of their residence. The urban areas enjoyed a doctor/patient ration of 1,700 while the rural areas, on average had one doctor per 30,000 of the population. The government's response to all these problems was to launch the Kenya Health Policy Framework in 1994, and in 1999 the National Health Strategic Plan (1999-2004) to map out the strategy for achieving the objectives of the policy. Once again the government declared the same objectives that had been repeated with each national development plan since 1965, namely streamlining the provision of health services, redistribution of services to rural areas, a greater emphasis on preventive and promotive health and collaboration with partners on nutrition, efficiency in health delivery, financing, training and research.

8. Masana Village: Health Services and Delivery

The central concern of this paper was to assess the extent to which the policies and efforts of the government have had an impact on the rural populations of Masana sub-location in particular, and to a lesser degree on populations in Kendu, Siaya and the rest of Vihiga which were used for comparison. As pointed out Masana sub-location lies squarely within the area identified by the Kenya Government in its 1999 NPEP, as the poverty belt in which a total of 12.6 million Kenyans were estimated to be living in absolute poverty.

As indicated formal employment is largely in teaching in the local primary and secondary schools, as well as in working in dispensaries and health centres as sub-ordinate staff. For educated but unemployed men there is access to finance through borrowing from the Youth Development Fund. Young men form into groups of ten to twenty, register and obtain loans of KShs. 50,000/- KShs. 100,000/- payable within three years. The loans are popular and the rate of default is low partly because requirements for referencing are exacting. The loans are used to finance fish farming, poultry keeping, horticulture in French beans, peas and others, zero grazing for the production of milk for sale and such like. Women do not participate.. Men plough their profits back into their businesses. They also use profits in the education of their children and generally in taking care of their families in the education of their children. Some of them have attempted, to diversity by buying bicycles and motor bikes for short distance transportation (*boda boda*). There are about twenty of these vehicles.

There are two village polytechnics nearby at Boyanyi in Maragoli Division and at Dago in Nyanza. Both are within walking distance of the primary schools. They train school leavers in tailoring, welding, mechanics, masonry and others. The locals however, consider them too expensive though enrolment is generally to capacity from areas outside Masana.

Health delivery available is at Nyahera, a district hospital in Nyanza, about three kilometers away from the primary schools. There is in addition a sub-district hospital in Tigoi in Rift Valley Province, also about three kilometers away. Both have in-patient facilities and are headed by clinical officers, graduates of the Medical training Centre, (MTC) in Nairobi. Within the sub location there are sub clinics at Angoya and Inzaro both within a radius of one to two kilometers, from the two primary schools. They are without in patient provisions, and are headed by nursing officers.

Informants argued that because of the fairly strong presence of Christianity and the fair levels of education there is no strong feeling against western medicine. It is just considered cumbersome and unreliable except for the very sick. There is no regular *matatu* service. The two villagers who own cars live in Nairobi. Wheel barrows, bicycles and motor cycles are known to have been used in night time emergencies but are generally considered not very practical for rushing sick people to hospital. Moreover there is a registration fee of KShs. 20/- for all adults presenting themselves for treatment and this is considered unaffordable for many. Only four men in permanent residence have regularly taken their wives for delivery in maternity institutions. As a rule, all the other women have their confinements at home under the care of traditional birth attendants otherwise known as *wamurewa.* This is partly because of cost. The District Hospital at Nyahera, for example, charges KShs.500/- for maternity services.

Most families believe that it is unnecessary and even dangerous to give birth in hospital. They are believed to h*ave* a tendency to adopt emergency measures too quickly. There is a strong confidence in *wamurewa*. They are normally older women with records of safe deliveries, literally running into hundreds and spanning over decades *Wamurewa* are believed o treat primary and secondary infertility. Most pregnant women do not attend prenatal or post natal clinic where it is offered. They object to the lack of respect and sympathy exhibited by young nurses. They also object to attention by male personnel which sometimes occurs.[40] Moreover, the practice is for *wamurewa* to attend to pregnant women throughout, massaging the belly periodically with herbs. They successfully treat threatened abortion with boiled herbs. They can detect malpresentation

very early and they treat it with regular gentle massages to achieve re-positioning of the foetus. They can also treat malpresentation at birth as well as retained placenta by manipulation of the uterus and cervix. They detect possible future obstructed labour, particularly when the passage is likely to be too small for a baby. In such cases they advise hospital delivery. Caesarian section deliveries are however, highly unpopular because they are still considered a life threat for mother and child and are associated with secondary infertility. There is one case of a traditional birth attendant with a wide clientale, who specializes in safe, normal deliveries of women who have had caesarean operations before.[41] Infant immunization is practically universal. It is, after all, offered free of charge.

General illness is handled by two categories of health providers – herbalists and bush doctors. Knowledge of herbal medicines and their potency is generally passed down to children especially daughters, by parents, and tends to be common. Medicines may be in the form of roots, bark, leaves or solutions of various soils. Some are chewed, some others are boiled and the resulting tisana drank, while others may be applied to a wound or massaged onto a swelling on the skin. Some herbs are ground into powder and taken as snuff. Some are mixed with warm bathing water to treat various skin conditions while others, soaked in hot water can be inhaled by a patient seated on a stool and covered up, together with the medicine, in blankets. Belief in their potency for all kinds of conditions is very strong. Girls as future mothers learn to detect and use herbs in the treatment, for example of illnesses of infancy and childhood. The following by no means exhaustive list was collected from Masana.

Sogu - Stomach ache, diarrhea
Owayo - pounded and pasted on a wound
Ombasa - powder inhaled or congestion of chest and nose
Pumpkin and Melon leaves - pounded and mixed with bathing water to clear body rash
Ogaka (Aloe Vera) – juice is rubbed on cuts /rashes and small wounds. It can also be boiled in water and the resulting drink used for headaches, stomach aches
Nya-lwet kwach - boiled in water and the drink used for a variety of conditions

including diarrhea, poor appetite, nausea,

Akech – akech - stomach ache

Oluo – chiel - stomach ache

Onyiego - tooth ache

Buoboe - flu symptoms

Angue - measles

Osiro - paralysis in children

Some treatment may be regarded as superstitious and is done tongue in cheek. For example, it is believed that going round a certain tree three times is a very potent treatment for mumps.

Much of this information and more is now available in various publications. Apart from this general knowledge there were also people who became renounced herbalists visited by clients from as far away as Uganda and Tanzania.[42] They handled malaria, diarrhea diseases, children's illnesses, diabetes, STDs, various forms of cancer, TB, mental illness and many others. Recently they have ventured into the treatment of HIV/AIDS infection symptoms.

Bone setting is a highly regarded skill. Patients are regularly withdrawn from hospitals on the point when they are about to lose a limb. The patient is held by several men, or tied down with ropes against the excruciating pain. The bones are then set, the wounds cleaned and treated with herbal poultices,[43] over a period of time. Mostly they are ultimately able to walk again.[44]

The second category of health care givers are the bush doctors. Sometimes they combine both types of health care. Bush doctors are usually men who worked or still work in hospitals and dispensaries at any level, beginning from cleaners and messengers, to dressers and other sub-ordinate staff. They buy, help themselves to or otherwise procure medicines which they use to treat various illnesses like headaches, malaria, diarrhea, skin rashes infections of all sorts, intestinal worms, and others. They give injections of

various forms of drugs for malaria and STDs. A drug by the name of 'procaine' is widely given to those presenting with symptoms of STDs and with long term coughs. Their popularity is based on the fact that they charge what is affordable and they give the treatment on demand There is for example, a general high regard for treatment by injection parents taking children to hospitals get very disappointed when trained medical personnel refuse to administer injections. There is also a high level of self treatment for various ailments from over the counter medicines and others sold by hawkers. Government concerns and the various media campaigns about the harmful effects of such treatments seem to have had no effect. There is for example a widespread habit whereby people who procure prescription drugs legally from trained personnel share those drugs with siblings, friends and relatives with similar symptoms. It is still very hard to persuade patients to continue with treatment after pain or symptoms disappear. Drugs that cause drowsiness are especially unpopular because they interfere with work schedules.

Lastly there is also treatment by traditional psychologists and diviners Much of this tends to be done in secret because it is frowned on by the church. Widows are still allowed to have relationships *(ter)* with in laws partly because it is also accepted that if they are abandoned by in-laws they will leave with the children, or abandon the children and go to town . Many bereaved will still confront neighbours with a 'bad reputation' and accuse them of bewitching their young children or killing their loved ones. Where members of the same family have died in too quick succession it is still common for a specialist *(jayath*) to be brought in, sometimes at great cost to perform protection rituals and to administer potions *(manyasi*) to the bereaved close relations of the departed. Rituals of mourning and burial which are overly dramatic like *tero buru,* hair shaving, mourning with livestock, or conveying a dead body into the home through a specifically made gap in the hedge rather than through the gate are no longer important. However, the traditionally sanctioned days of mourning (three for a woman and four for a man), sexual abstinence of close relatives before burial of the dead, feasting and slaughter of bulls are still held. Occasionally, when there is a cholera outbreak *askaris* have invaded funerals and scattered the mourners to prevent public feasting in unquestionable sanitary conditions. It is still believed that the dead value the attention, grief and cost bestowed at

their death, that they are keen on the handling of the people and property they left behind, the exact spot of their burial in the compound and so on and they show evidence of anger in a manner that may affect the living.

9. Conclusion

It can be argued that thought the government, on taking over a situation with numerous challenges from the colonial regime, declared and actually attempted many policies for betterment of health considered one of the most important inputs to economic growth, the effect has been well below the expected target of health for all especially among the rural poor as declared in Sessional Paper No 10 of 1965 and in subsequent development plans.

In the rural areas health services and personnel continue to be very thinly spread, and therefore ineffective. Moreover, continuing and deepening poverty ensures that increasingly, for a great majority of the population of rural communities such as Masana, alternative health care often but not always of questionable or even harmful potential is the preferred mode of health seeking.

End notes

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3: National Poverty Eradication Plan (NPRP) 199-2015, by Kenya Govt. Printer, 1999.

4: Oral Information : Wilson Tolo *op cit.* Also Stella Mukhovi, 18.09.09.

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6: Ibid. Also oral information from the late Johanna Tolo & Thomes Ondu of Masana Village.

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8: J.S. Mbiti. *African Religions and Philosophy 1969*, Heinemann Educational Books Ltd London. *Passim* Also Ayot, H.O. *A History of the Luo Abasuba from AD 1760-1940.* Kenya Literature Bureau, 1979, Nairobi pp 162-191. Also Paul Mboya's Luo Kitgi Gi Timbegi, A translation into English by Jane Achieng, Published by Atai, Joint Ltd, Nairobi, 2001. Passim. Compare with "Public Health in Precolonial Equatorial African Therapeutics" in *The Social Bsis of Health and Healing in Africa* Fierman, S. & Janzen, T. (eds) University of California Press, Berkley, 1995, pp 208-211.

9: *Ibid*

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14: Carothers, *op cit*.

15: See for example Jomo Kenyatta, *Facing Mount Kenya*, Heinemann Educational Books, First published in 1938. See 1971 Edition *passim*.

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17: *Ibid.*

18. Carothers, *op cit.*

19: Sindiga, *op cit*.

20: Amatsimbi-Misigo *op cit*. Also Sessional Paper No. 10 of 1965, Kenya Government Printer, 1965.

21: Report of the Medical Officer of Health (MOH) Nairobi City Council, 1959.

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28: *Ibid.* Also oral interview, John Odhiambo Obombo, (15.09.09).

29: White, L. *Speaking with Vampires: Rumour and History in Colonial Africa,* University of California Press, Berkely, 2000, Capt. 2.

30: Kanogo *op cit.*

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32: Kanogo, *op cit*. Also oral informants: Agneta Okun (20.9.09), Rhoda Tolo (20.09.09), Pauline Midamba (17.09.09).

33: See J.S. Mbiti *op cit*.

34.Oral Information, Rhoda Tolo

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36: Loise White, Speaking with Vampires. Also oral information, Agneta Okan, Pauline Midamba, Rhoda Tolo.

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39. Sessional Paper No. 10 of 1965 *op cit.*

40: Compare with Thomas, Kanago op cit.

41: Esther Wambedha, born in Nyahera Village, married in Oboch Village, Nyakach.

42: See for example the late Pius Achola, generally addressed as *daktari* (doctor), of Uloma Village, Asengo East Sub-location, Asengo Location Siaya District.

43: See for example Owili K'Ombogo who was involved in a motor vehicle accident and suffered multiple fractures on one of his lower leg bones. After several weeks at New Nyanza General Hospital Annexe (popularly known as Russia Hospital) he was told to expect amputation. His family withdrew him. He was treated as described above and walks today.