

**A COLD WIND: LOCAL MAASAI PERCEPTIONS OF THE
COMMON HEALTH LANDSCAPE IN NAROK SOUTH**

by

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Maa (Maasai language) and Location Glossary

-The Maasai language is not standardized and there is no standard orthography used among researchers. As a result, there are various ways to represent terms in Maa. I have tried to phonetically represent the pronunciation that I heard, using the standardized Swahili orthography. Although Maa is a tonal Nilotic language, unlike the Bantu Swahili, and has features of pronunciation that are therefore not easily represented, it was beyond my ability to either represent, or in most cases even recognize subtle aspects of the language. Instead, I have used a simplified representation for the convenience of the reader. All definitions are from fieldwork experience and/or Frans Mol's Maasai Language and Culture Dictionary (Mol, 1996)-

Altamweya/enkarasoi: is the term for the loss of blood which leads to weakness

Enkai/Engai/Ngai/enKai/Nkai: the Maasai term for the creator god, as well as sky and rain.

Enkang: this term will be used for the circular multi-family homestead traditionally associated with the Maasai people. It is in singular form but for convenience sake will anglicized *enkangs* for the plural form.

Enkeya/enkea: direct acts of God that produce dramatic misfortunes that are not easy to explain by other means.

Enkijebe/enkijabe/enkijape: this term means cold wind, wind, cold, rain, cold rain, and is part of a phrase (the wind of God) described by Mol as an expression Maasai people use to attribute the cause of any unexplained illness: “Enkijape e Enkai’: the air of God, God’s air; diseases which the Maasai cannot find a cause for are attributed to God’s air” (Mol 1996).

Emoyano/emuiyan: common place illnesses affecting the community. Those that are considered most significant by this community are the focus of this dissertation.

Enkoye/enkoe: a locally identified illness entity ostensibly translated as ‘trachoma’.

Esakutoto: is the problem caused by curses that are typically mediated by laibon.

Laibon: this Anglicization will be used to represent both the singular and plural of the Maasai word *Oloiboni/iloibonok*- ritual expert, folk healer, prophet, diviner, female: *enkoiboni*.

Lemunya: a locally identified disease entity ostensibly translated as ‘pneumonia’.

Losho: this dissertation’s primary target community, of Purko Maasai pastoralists. It is located in Siana Valley.

Maa: the language of the Maasai people and several related groups throughout Kenya and Tanzania. It exists in various unstandardized dialects.

Mzungu: Swahili word for “Westerner”

Nang’ida: a locally identified disease entity ostensibly translated as ‘brucellosis’

Narok County: Southern county of Kenya’s Rift Valley Province, bordering Tanzania to the south and bordering the Masai Mara wildlife preserve to the south-west.

Narok South: Southern constituency of Narok County.

Olashambai: Maa term meaning ‘light-skinned’, usually used for referring to Westerners, but also to tease particularly dark-skinned Maasai.

Olkirobi: a locally identified disease entity ostensibly translated as ‘a cold’ or ‘the common cold’.

Olkurto: a locally identified disease entity ostensibly translated as ‘intestinal worms’

Oloodo: Maa word meaning ‘tall man’, one of my nicknames in the field

Oltikana: a locally identified disease entity ostensibly translated as ‘malaria’.

Oltung’ani: Maa word for ‘human being’.

Purko: Sub-division of Maasai people. This group is a culturally influential sub-group whose members regard themselves as quintessential Maasai people.

Shamba: Swahili word meaning ‘farm’ or ‘farming plot’.

Siana Valley: the community of Losho and the neighboring and closely related villages of ***Embiti, Olkiloriti, Megwara,*** and ***Ololaimutia***. It is located in an area known as Narok South.

Taifoid: a locally identified disease entity ostensibly translated as ‘typhoid’.

A Cold Wind: Local Maasai Perceptions
of the Common Health Landscape in Narok South

Abstract

By

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This dissertation examines and explores the popular health landscape, or lay health beliefs and models, held by Maasai people in the Siana Plains of Southern Narok. Specifically it is an investigation of the most common illnesses identified by community members and how these illnesses and the accompanying practices and beliefs reflect and illustrate the community's perspectives on hygiene, or the practice of being and staying healthy.

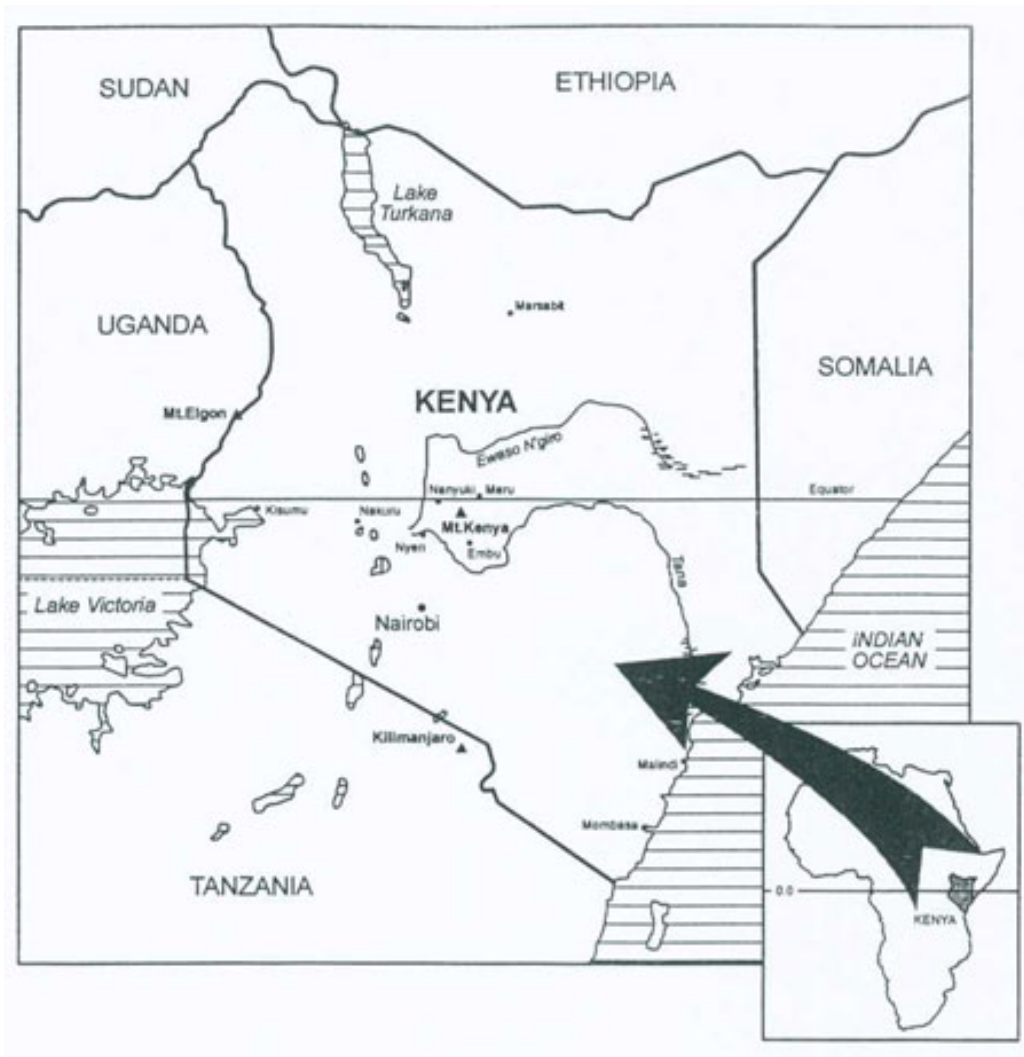
Local hygienic ideas of illness prevention and avoidance, represented in the way Maasai talk about common and significant health problems, are found to be shaped by the cosmological underpinnings of Maasai society through superficially inchoate "common sense" perspectives that embody the foundational premises shared across much of Maasai society.

This dissertation employs ethnographic methods of participant observation and semi-structured, open-ended questions, agreement surveys, and free listing in four series of interviews. These interviews were conducted with 107 people in 76 interviews. Response frequency tables were generated from the 27 interviews with Maasai in the series that employed free listing.

Findings demonstrate that the relationship the Maasai have with *Enkai*, the creator god, is both represented and reified in the language of the popular health sector through the metonymic symbols of *olari*, the rainy season, *enkijebe*, the cold wind, and with the specific disavowal of metaphysical presumption, which I refer to as “etiological agnosticism”. The explanatory model that emerges from this analysis is not merely descriptive, but represents a significant re-presentation of Maasai understandings of health and illness.

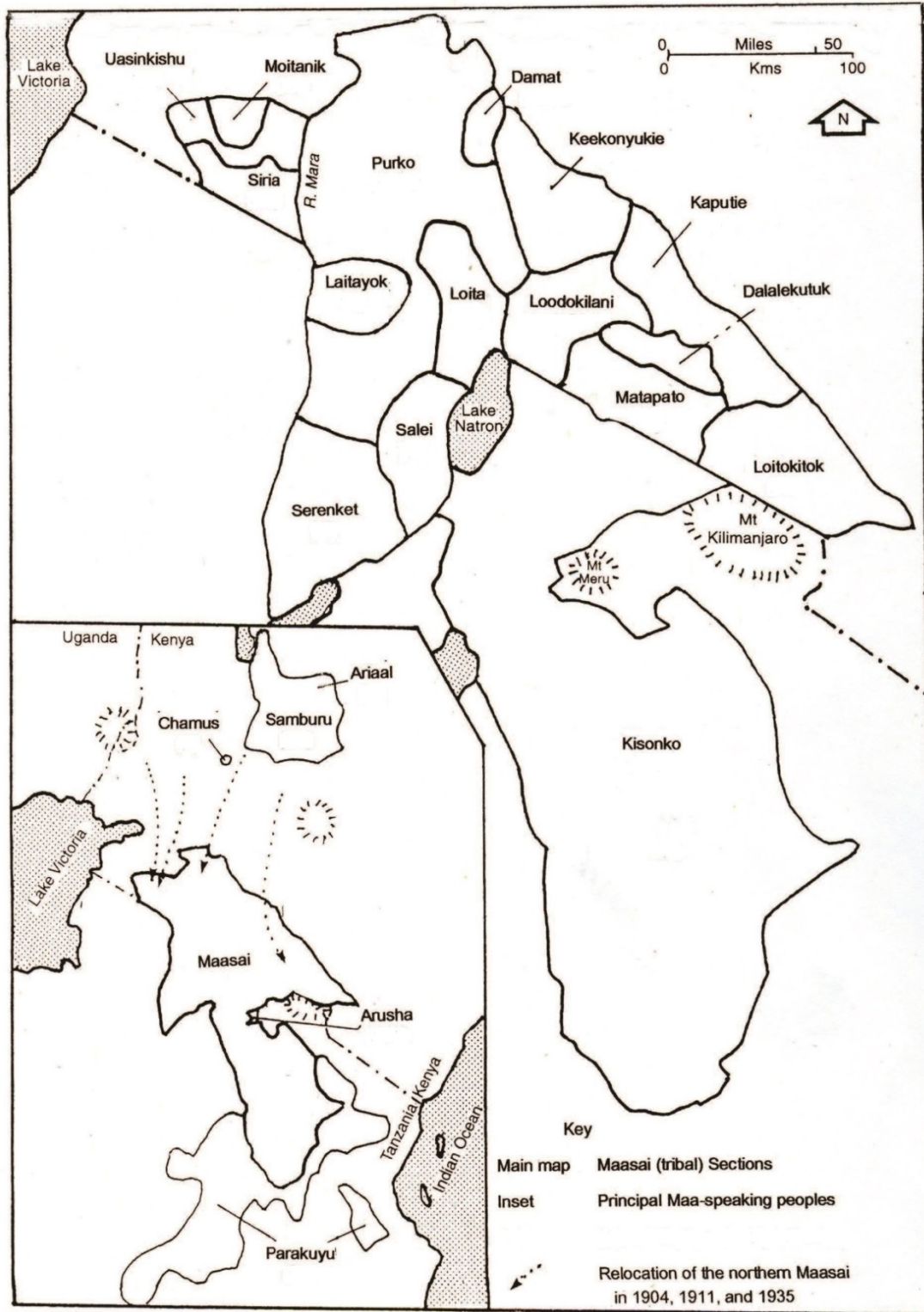
This dissertation contributes to our understanding of the influence cosmological premises have on everyday perspectives that form a community’s shared “common sense”, particularly in the sector of popular health. It contributes more broadly to development studies, African studies, and the ethnography of the Maasai.

Map 1 Kenya



(Gatebe, 2009)

Map 2 Maasailand



(Spencer, 2003b)

Chapter 1 “I have no idea!”: The Maasai and the Popular Health Landscape

Introduction

The horde of flies covered me and surrounded me in a cloud. I waved vainly at them but they were unrelenting. I was concerned their buzzing would make the audio hard to decipher later. Giving up the effort, I continued my questions through the translator. “So if you feel warm, you’re coughing and you feel warm, like for a fever? Those are the symptoms?”

I sat awkwardly on an overturned bucket in the low entranceway of the Maasai home. My hosts had given it to me over the piece of wood my translator was sitting on to better suit my greater height, but my knees were still approaching the level of my shoulders. Because of my need for the light I sat in this awkward place, peering into the dark of the house where the inhabitants were unmolested by insects. I sat with my back against the dried, brittle daub of clay and dung that plastered the walls, insulating the inhabitants from the equatorial sun and keeping in the warmth of the small central fire at night. Three small children stood outside a few feet away, staring at me and giggling nervously. Most likely they had never been this close to someone who looked like me. Each time I tried to pronounce a word in their language they shrieked happily with laughter.

“So if you feel warm, you’re coughing and you feel warm, like for a fever? Those are the symptoms?”

“Yes”.

“Where does *olkirobi* come from?”

“It is the air”. My translator ferried their comments to me.

“Any air, or special air?”

“*Enkijebe kirobi*” “The cold one”, my translator offers”

“So it is coldness in the air?”

“Yes”

“And how can you avoid *olkirobi*?”

“There is no way you can avoid *olkirobi*. The air is there all the days, normally it is there when you go out, the cold air -Flies buzzing into the recorder-”.

I tell them a story of how “at home” parents will tell their children they must wear warm clothes when it is cold to avoid getting something like *olkirobi*. I ask if it is true here. Can it keep a child safe here?

“Yes, it is true. How can you not say it to be true here?” The women laugh, and then add “but there is no guarantee”.

The above exchange was a typical one during my fieldwork, and for a time it was very frustrating. I felt as if my participants would contradict themselves often, first saying there is no way to avoid getting sick, but then adding spontaneously or in agreement with my suggestion, “It can help a little”. Other times, when I queried about avoidance or prevention I heard the phrase, *maiolo pi!* (I have no idea!). That phrase became such a regular chorus during interviews that I began to chime in with them, provoking laughter at my accent. The apparent contradictions and ambivalence regarding avoidance and prevention seemed at first to be reluctance to engage my questions, but a clear pattern eventually emerged. The responses came at a few predictable times, and never at others: everyone was happy to tell me of the illnesses that they perceived as common and significant, whether many or few. They were also happy to describe the characteristics of the problems and how they were treated (usually at a clinic). They became less enthusiastic when I asked about causation; often answering reluctantly when first asked about avoidance or prevention. At the same time, most suggestions that I offered as preventative measures were agreed to, often

with the air of it being painfully obvious. Thus, with regard to prevention and avoidance the responses seemed both practical as well as philosophical. Initially disavowing knowledge of prevention, and often causation, gradually emerged as a figurative convention rather than a literal expression. What emerged from those initially frustrating interviews was a cultural schema regarding illness, etiology, prevention and hygiene that is inextricably linked to the cosmological premises the Maasai people hold of their relationship with *Enkai*, God.

This dissertation examines and explores the popular health landscape, or lay health beliefs and models, held by Maasai people in the Siana Plains of Southern Narok. Specifically it is an investigation of the most common illnesses identified by community members and how these illnesses and the accompanying practices and beliefs reflect and illustrate the community's perspectives on hygiene, or the practice of being and staying healthy. The production and maintenance of health is a complex cultural process. In this dissertation, I will argue that it is a process which involves behaviors and values drawn from cosmological premises and world view. Local hygienic ideas of illness prevention and avoidance, represented in the way Maasai talk about common and significant health problems, are found to be shaped by the cosmological underpinnings of Maasai society through superficially inchoate "common sense" perspectives that embody the foundational premises shared across much of Maasai society. Furthermore, I will demonstrate that the relationship the Maasai have with *Enkai*, the creator god, is both represented and reified in the language of the popular health sector through the metonymic symbols of *olari*, the rainy season, *enkijebe*, the cold wind, and with the

specific disavowal of metaphysical presumption, which I refer to as “etiological agnosticism”.

The explanatory model that emerged from this analysis is not merely descriptive, but represents a significant re-presentation of Maasai understandings of health and illness. As will be discussed in the Literature Review and following chapters, ethnographic literature on the Maasai is scarce and competes with widely held popular misconceptions of the Maasai that obfuscate and misrepresent their world view, especially in regard to health and hygiene practices. Changing social, political, and environmental policies and practices in Kenya continue to make the Maasai vulnerable to intervention from outside their cultural community. An ethnographic lens that aims to understand their health concepts and practices as integral to, and inextricable from, their world view is urgently needed.

This dissertation is organized in the following way: The first chapter introduces the areas of focus: an explanation of the landscape metaphor that is central to connecting health concepts to world view, a discussion of the popular sector concept of health, and the evolution of this study from focusing on a national public health campaign aimed at solving the “trachoma problem” to a more broadly focused project on the cultural domains of etiology and hygiene and how they are situated in the Purko Maasai community of Siana Valley, Narok South. In the interest of reflexive awareness (Michrina & Richards, 1996), it presents the tensions and influencing logistical and

interpersonal factors of the immediate setting on my family and myself, and the effects this had on the direction of the research from its original articulation to its final form.

The second chapter reviews the relevant literature. This will begin with a review of representations of the Maasai in the Western and African gaze. It continues with a general introduction to Maasai history and then narrows the focus to the Purko subsection of the Maasai. At this point it will introduce key aspects of Maasai society: *enkanyit*, the age grade system, divine providence, and the unknown. It provides an overview of herbalism and divining. It will continue by reviewing the development of popular sector of health studies through the current state of the literature for studies of lay etiology and popular concepts of common illness. It will then review the anthropological study of rationality in Africa, starting with its colonial roots. Assumptions in the study of rationality, I argue, remain a central and problematic concern for studies of African cultures.

The third chapter presents the study methods and methodology, including the theoretical assumptions and how Cultural Consensus Theory contributed to its design. In an overview of the fieldwork process, this section reviews the development of research strategies and methods. It will give attention to the dynamics of conducting research with one's family. It will end with a description of the strategy behind the 4 stages of interviewing and the challenges for heuristic redesign that emerged during this process.

The fourth chapter is a presentation of the general findings as well as frequency tables. The tables present the constellations of causes, and prevention methods of the most common illnesses as determined by the community. The categorization and frequency of concepts in the responses presented here is key to my analysis and argument and will be presented in the following chapter.

The fifth chapter focuses on the analysis of the findings discussed in chapter three and illustrated in chapter four. It begins with a general introduction to the considerations and methods of analysis. The next part addresses the models nosology and etiology that can be constructed from findings, and their significance. The third part discusses the nature of the Maasai concepts of health prevention and illness avoidance, i.e. hygiene, and its relationship to Maasai ideals of respect, elderhood, parentage, and *Enkai*. In this chapter, I argue that Maasai health and hygienic concepts cannot be understood in isolation from their broader world view and discuss the various ways they are linked and mutually constituted.

The sixth and final chapter concludes the dissertation by summarizing the preceding chapters. It goes on to note the limits of this dissertation and the specific details of further research necessary to address these limitations. This concluding chapter discusses the significance of the outcome of the analysis chapter on the fields of anthropology, development, and the Maasai communities of East Africa. It ends with a call for further research and revisits the landscape metaphor as a fruitful avenue for continued research.

The Cultural Landscape of Health

The term health landscape is derived from “therapeutic landscape” used in cultural and medical geography (see Gesler 1992; Madge 1998; Leach et al. 2008). Leach et al. use the term “therapeutic landscape” to focus on available forms of therapy in a particular cultural and geographic locale (Leach et al., 2008). Gesler and Madge each step away from the focus on therapy, defining ‘therapeutic landscape’ as “a text to be read for what it says about human ideas and activities” and “the specific health care beliefs, practices and experiences of a particular group of people located in a specific place” with a focus on political-economic inequalities, respectively (Gesler, 1992; Madge, 1998). Gesler and Madge thus use “therapeutic landscape” as an emplaced version of “culture” as defined by interpretive anthropologists whereby culture is a “text” to be “read” (Clifford 1983; Geertz 1973). While this study is embedded in that interpretive tradition and thus could be regarded as simply about Maasai “culture,” I find the metaphor of landscape to be an analytically useful specifier¹.

“Landscape” originated as a Dutch term for paintings of nature scenes. It can mean both the distinguishing features of a geographic area and the genre of painting. The subjects of this genre were strongly influenced by Arcadian ideas of primitivism that have characterized early anthropology and psychiatry of Africans (Lucas & Barrett, 1995). Early subjects were pastoralist scenes depicting noble and innocent primitives, or occasionally ignorant and uncouth savages.

¹ See also Lyn Schumaker’s “Constructing Racial Landscapes” for an anthropological analysis in Africa using an extended metaphor of physical landscape to examine the historical relationship between anthropologists and their African assistants during colonialism (Schumaker, 1999).

Landscape painting is a useful reference domain for this analytical metaphor. This genre of art often focused on realistic depictions of nature and yet symbolized social values and is always subject to interpretation. The landscape scene is fundamentally perspectival. These are important characteristics in common with ethnographies and can serve to guide both their construction by the researcher and interpretation by readers.

The relevance of “landscapes” to this dissertation is drawn from the idea of a culturally constructed environment that hosts the community that has created it, rather than a physical environment. It is not a focus on an ‘objectively’ discerned ecological relationship, but a study of the cultural environment of health threats or aids, the nature of health problems perceived locally and how they are conceived and interpreted in the common space of the “popular health sector” rather than the professional sector populated by trained and regulated healers, or the folk sector populated by more idiosyncratic and localized healers (Kleinman, 1980). Additionally, the focus of this research is only indirectly on the therapeutic aspects of the landscape; as I will discuss in the 2nd chapter, Maasai therapies are disproportionately covered in the literature whereas health and illness concepts and their cultural schema are overlooked. Thus, this study focuses on the popular local perception of the health problems as they make up the broader landscape. I investigate how they are identified, caused, addressed and possibly avoided or prevented in this Maasai community of pastoralists. In my analysis I will argue these perspectives of the shared health landscape provide the context for

understanding how health concepts, experiences and practices are linked to the larger world view and cosmology of this community.

This metaphor of the sectors or perspectives as aspects of the health landscape in this community (and most likely in all communities to some extent) is productive in its imagery of folk and professional experts of all stripes being planted in, drawing life from, and anchored in the soil of the popular or common sense perspectives. Concepts planted in development campaigns that strongly clash with the local common sense environment will not take root but will wither. The landscape metaphor becomes even more pertinent and vivid when we consider that a word for “rain”, the life-sustaining event, is also the Maas word for God, *Enkai*, the cosmological source of all life (Mol, 1996). The coherence of articulated systems of health, which are able to thrive in the inchoate soil of common sense, leads to a thriving landscape that not only resists disintegration but thrives upon the rain/*Enkai*, the same agent of destruction as a source of life.

The Importance of Common Sense and the Popular Sector of Health

Lay beliefs of hygiene and common illnesses are important foundational principles that guide and influence the perspectives of everyone, expert, novice, or laymen in any society. The popular sector “...can be thought of as a matrix containing several levels: individual, family, social network, and community beliefs and activities. It is in the lay, non-professional, non-specialist, popular culture arena in which illness is

first defined and health care activities initiated” (Kleinman 1980:50). Thus lay beliefs or models of health and illness have an important influence on professional and folk sectors of health and healing in all societies, because the lay perspectives of one’s enculturation and socialization into one’s community is not set aside when specialized education and training occurs.

Lay perspectives on health and health maintenance are a challenge to study because they are by definition rarely explicitly articulated by members of a society. They tend to be givens, “common sense”, based on principles and ideals of a community that are expressly considered self-evident, and thus not in need of articulation. As Geertz stated in his proposal to address common sense as a cultural system, “As a frame of thought, and a species of it, common sense is as totalizing as any other: no religion is more dogmatic, no science more ambitious, no philosophy more general. Its tonalities are different, and so are the arguments to which it appeals, but like them –and like art and like ideology- it pretends to reach past illusion to truth, to, as we say, things as they are” (Geertz, 1975). Common sense notions appeal to a sense of reality despite their subjective and culturally contextual nature.

In addition to the difficulty in finding someone who is able to effectively express the unspoken but “obvious” common sense concepts, there is also a challenge in finding someone willing to do so. The combination of explaining something one has never had to precisely and directly contemplate, along with the fact that for members of the particular community, these concepts are by their nature the most banal, inane and

manifest, often makes willing indulgers of the investigator few and far between. An additional challenge is the seeming confusion of responses, contradictions between participants and even between the statements of one participant within the same conversation.

These types of difficulties inherent to fieldwork were notably recognized and described by Robert Pool (1994). He described ethnographic data collection as a performance, a co-production of meaning rather than a collection of information. The information is produced together with the informant and the translator, potentially changing with each discussion. According to Pool, as the beliefs and concepts discussed in fieldwork are unstandardized and unregulated, they are inherently unstable, indeterminate, and often contradictory: as an organic aspect of society, they are ever changing. Writing the ethnography is therefore an act of standardizing a dynamic process and therefore cannot present the situation perfectly. The inconsistency and contradiction are all parts of the lived reality of the community members (Pool, 2003).

A good deal of interpretive medical anthropology has focused on models of distress, such as Semantic Illness Networks (Good 1977); the disease/illness dichotomy, Semantic Sickness Network, Explanatory Models (Kleinman 1980; see also Young 1981); Sickness History and Ethnomedicine, Ethnopsychiatry (Gaines 1991; 1992); Illness Narratives (Kleinman 1988, Good 1994; Mattingly 1998). These models for understanding have, for the most part, focused on ill health, medicalized conditions (such as pregnancy), and healing rather than hygiene and health production or

maintenance. The expression of wellness, greater than simply the absence of disease, therefore draws on more than models of distress alone. Recognizing the premises of wellness maintenance/illness causality is also necessary. This research project requires a broader reference to the order of the world for the role of fortune or misfortune, tied into health in many societies, and therefore utilizes the metaphor of health landscape and its relation to the anthropological concept of cosmology.

From Trachoma to the Landscape of Popular Health Etiology

Researcher: What can you tell me about the trachoma health campaign the government has been conducting?

Nalamai: I don't know that one.

R: Have the community health workers come here to talk to you about trachoma?

N: Some of those learned people came. They gave us tablets.

R: Did they talk to you about trachoma or what the tablets were for?

N: They just give the tablets, tell us we must take them and then they go.

Through contacts between a founding member of non-governmental organization working to promote health in Kenya² and T.S. Harvey, a medical anthropologist and my mentor, I was invited to investigate the perceived reluctance of local people to take up the behavioral change components of the national trachoma

² Neither this individual nor the name of the non-governmental organization will be named in this dissertation. Their participation, as well as all the others, were elicited on the condition of confidentiality.

eradication campaign that was being initiated in the area of Narok South. The non-governmental organization leaders believed that Maasai community members had some sort of attachment to the hordes of flies that would plague their homes, particularly in the rainy seasons, as well as an unhealthy cultural aversion to bathing and cleanliness. This perspective was similar to the stereotypes of the Maasai people held by other Kenyans, as well as former colonial authorities (Knowles & Collett, 1989; Schneider, 2006).

In the resulting study, I found that every Maasai person I questioned about the flies hated them and would be happy if I found a way to reduce or eliminate their presence. There was a certain amount of positive symbolism represented by the flies, but it is limited to how their initial surge in population signals the imminent arrival of the life-giving rains. Additionally, nearly everyone I spoke to, old or young, male or female, suggested that regular bathing was in fact generally beneficial. When I asked about the stories of Maasai never bathing, I was often told that “that was then, things have changed and now bathing is a must”. I rarely encountered the sentiment that bathing itself was causing illness, and that the old Maasai people were “never sick” because they never bathed. But even these individuals, when asked if it would be best to return to the older practices would state that those times had passed, and now that people had begun bathing, it was necessary to continue. I was also told that cleanliness was in fact a Maasai traditional value and that it was taught by the elders and not something introduced by development agents such as the non-governmental organization that works to promote health in the area (see chapters 4 and 5).

In my original research proposal, I decided early that I was going to first establish the priority of trachoma eradication within the community before directly addressing people's view regarding the disease. My strategy was to start each interview with a verbal free listing of common or important illnesses in the community, in the opinion of the participants. Time after time, I was given a fairly consistent list of illnesses that did not include trachoma. In fact, the trachoma, or the Maasai word for it: *enkoye/enkoe*, were never mentioned at all unless the interviewee was prompted. Any eye problems were simply referred to generically by the Maasai term for "eye problems". When I inquired about the participants' views regarding the trachoma eradication campaign (which by this time had been ongoing for a couple of years), I was told that they had never heard of it. This was quite surprising, as the local NGO had been a supposedly vocal advocate of the campaign, particularly emphasizing the cleanliness behavior advocated by the SAFE (Surgery, Antibiotics, Facial cleanliness, Environmental cleanliness) strategy of the eradication campaign (Emerson, Cairncross, Bailey, & Mabey, 2000; H. Kuper et al., 2003; West, 2004).

These revelations early in my interviews made it clear to me that studying the perceptions of the eradication campaign would not be possible, because of the disconnect between the campaign and the members of the Maasai community (which is an interesting but distinct topic of its own). Instead, what emerged as a priority for the local Maasai people I interviewed was a relatively consistent and small group of common illnesses; namely they were concerned with what Westerners would consider

seasonal and recurring infectious illnesses. The exchange below is typical of the first round of interviews; see also table 5.

Researcher: What are the most common health problems in Losho?

Narikuu: At the time of rain, there is a lot of *oltikana*, because many houseflies will be present. And milk, and also cows producing a lot of milk.

R: Milk leads to *oltikana*?

N: Yes. Also there is *lemunya* and *nang'ida*. *Tibi* and coughing, *olkirobi*.

Translated into English, these are known Biomedically as malaria, pneumonia, brucellosis, diarrhea, and the common cold. Further questions and subsequent interviews gathered information toward identifying symptoms, etiologies, treatments and relationships between illnesses; from this data there emerged an illustration of a common sense, or popularly held, framework for concepts of hygiene.

Setting and Settling In

The previous section of this dissertation described the perspectives held by and of the Maasai. The following section presents a geographic and demographic description of the community.

The matatu (a Nissan van) had gone as far as it could go. It was in the center of a muddy plain that hid deep ravines. We had been driving for about 6 hours, from Nairobi. I was hitching a ride with the vehicle hired by the non-governmental organization that had been working in the area for about 7 years at that time. We had just been driving slowly through an acacia forest along the bumpy rutted path that led from the nearest

gate to the Masai Mara wildlife reserve. We had passed through the park because the more direct road had been rendered impassable by the recent rains. The NGO had a special pass that allowed them to cut through the park because the usual roads were reliably impassable each rainy season. The college undergrads who shared the seats in the back with me and the over-flowing luggage had been chatting happily about the animals we had seen on our way in. The pass was taken advantage of each time the NGO came to give the students a free safari before they returned home. They were here for what they called a service trip, what other people have called “volunteer tourism” (Zahra & McGehee, 2013). They became quiet as I clambered over the luggage to exit the vehicle. I pulled out a duffel bag and a backpack. The duffel bag was full of gifts and groceries for the family with whom I would be staying.

It was my 3rd time in Kenya, seven years since I had lived here while volunteering with the United States Peace Corps as a secondary school teacher and five years since I had done my fieldwork for my master’s thesis. A Maasai man in his early twenties stood near me, speaking excitedly on his cell phone. He was the only year round employee of the NGO and was the valley’s only university graduate. He was talking to his brother, asking him to come and lead me to their home *enkang*, which at that time was in the foothills on the other side of the plain. Before long we saw his brother quickly walking down from the hills, a small figure picking his way among the large stones while holding his hand to his ear. As he reached the muddy plain, the young man shouted into his phone, and the distant figure broke into a jog, only to quickly stop, turn and apparently urinate. We all laughed. As the figure finished, turned and began to awkwardly jog/walk toward us, the young man climbed back in the van. The older woman who had invited me to do this feasibility study stuck her head out the window, “Are you sure you’re going to be alright?” I assured her I would be, and the vehicle delicately picked its way back across the field to drier ground where it continued slowly, feeling its way carefully through the bush. Night was falling, and soon it was only visible by its lights.

Eventually I was joined by the panting Maasai man, dressed in the *orshiti*, or toga like cloths that had a red or blue cross hatched pattern that resembled an Italian restaurant tablecloth, over cargo shorts. They were brightly colored and polyester. He had put away his cell phone in its pouch on his belt, next to his sword, and stuck out his hand. After we greeted each other in Swahili, he grabbed one end of the duffel, I the other, and we set off slogging through the mud towards the enkangs on the hills, now lit up only by the moon and the firelight through their tiny windows.

As the above vignette illustrates, the fieldsite for my research was relatively remote, but at the same time was not out of contact with the outside world. People, who could afford them, had cell phones and there was fair network reception through one of the largest network providers. Despite this, this area was widely considered fairly traditional. This was mostly due to the distinctly Maasai clothing, the *orshiti*, worn by men and women, but in different patterns and colors. Women favored solid pastels of pink and blue, over plaid skirts. Their cell phones were housed in synthetic leather pouches carried on a cord around their necks.

The people in this area were also considered traditional because of their pastoralist lifestyle, generally disdaining agriculture. They were only semi-nomadic, grazing their livestock in a transhumant pattern depending on whether it was rainy season or drought. Their wattle and daub houses were also a visible reminder of their choice to eschew the shanty style homes of many poor rural Kenyans. The above story describes my first visit to Losho, which is introduced further below.

Research Site

Losho is a small town in the Siana Valley area of Mara Division, Narok District, of the Rift Valley Province. In the town and surrounding area there is a population of 1200 to 1600 semi-nomadic people. This is an ethnically Maasai area that lies adjacent to the Masai Mara, a famous wildlife preserve that straddles the border of southern Kenya and

northern Tanzania. The area abuts the *Oloolaimutia* Gate, the southernmost Kenyan entrance to the park.

Tourism is a major source of income for Kenya, and Maasai people in the area see, on a nearly daily basis, various types of tourist vehicles pass by, foreign faces inside (Akama, 1999; Bruner, 2001; Manyara & Jones, 2007; Ondicho, 2010). Some vehicles are full, often of students. Some vehicles are empty but for a Kenyan driver and a single foreigner, often holding an enormous camera, projecting an aura of self-regarded seriousness. Herd boys far from home and children on their way to or from school in their school uniforms, or chasing each other around homes close to the road, have learned to gesture to the vehicles, hoping for money or candy thrown by the tourists. It is a common belief throughout Kenya that these tourists literally have bags or boxes full of cash. Because the tourists often do not bargain over prices, they give the appearance that they have an endless supply of money. Although most of the money passes into the national park system or into safari lodges owned by non-Maasai, serious local entrepreneurs have organized with their community to try to develop tourist attractions based on the flashier aspects of Maasai culture with dances and songs by men dressed as warriors, or model villages where women live in shifts, to give an interpretation of an idealized, traditional lifestyle. In Losho they have one of these tourist attractions, known as the cultural manyatta, or *maendeleo* (see map 4 in appendix).

Losho is a fairly remote area that, in comparison to some other parts of Kenya, has only recently had large-scale uptake of Western style education, in the form of

primary schools. There are not yet any secondary schools. Illiteracy is commonplace and is nearly universal among women. Community members speak Maa, and most men also speak Swahili (which is the official and national language along with English) to some degree. Knowledge of English is uncommon. Running water and electricity are not available at the farm and ranch compounds, called *enkang*. These compounds hold multiple households of extended relatives. They do not have latrines.

The Maasai of this area are pastoralists and live in close proximity with their livestock in a circle of small houses, with the walls and roofs usually made from wattle and daub, with the holding pen for the cattle in the center and another for the sheep and goats off center. There may also be a small hut to house breeding rams. Within the homes there is usually one main room and one small closed off area near the entrance where lambs and kids are kept at night. Many of these aspects of Maasai life are criticized by both government and non-governmental organizations' health campaigns. One volunteer of the NGO told me he felt that their living conditions were "not compatible with human life" (Pat, undergraduate male). These foreign criticisms of central aspects of Maasai life contribute to a situation in which many of the recommendations of national health campaigns in the area are often not deemed viable or even valuable by the Maasai community.

If the *enkang* is near a forested area there may be an additional wall of thorn bushes surrounding the entire housing area. These are multi-family compounds, generally made up of relatives with the occasional un-related nuclear families of close

friends. They are temporary establishments, although they may exist for many years. As houses decay, they may reach the point where they are not worth repairing and a new house may be built alongside the older one. The age of the *enkang* may be estimated by observing the level of the floors in the animal pens since they rise with the addition of the manure generated by the animals over the years. This can reach the point of being a small hill in the center of the compound, producing streams of animal urine and feces running out and around the houses when it rains. The thresholds of the houses are often raised to prevent the entry of these streams of effluent, sometimes detected, like roof leaks, in the midst of a rainstorm. Periodically women will move manure from the pens to growing hills of dung outside the *enkang*.

Challenges and Community

I shifted the gunny sack on my shoulder as I struggled to walk in the soft sand after crossing the muddy field. I was back on the broad dirt path that served as a road once a week. It was market day and I was just entering the forest after crossing the plain on which sat the *enkangs* of Erkedisho Laibori (Lower Climber, see map 4). Near these *enkangs* was the house that I rented for my family. When I looked back, I could see it at the foot of the Siana Hills, but it soon disappeared as I entered the forest. I had to quickly scramble off the road as a decrepit and reeling lorry on bad suspension blew past in a cloud of dust and shouting. Despite its rickety and battered appearance, it was filled with local folks heading to the market in the town of Oloolaimutia, about ten miles further down the road. Most of the people were in the load area in the back, with some men perched on the high walls that surrounded the truck bed, standing on the rear bumper and gripping the welded metal bars easily, or sitting on the top of the cab itself. The load area was mostly filled with women, dressed in bright clothes for this social event, carrying their goods for their stands. In the bushes beside the road I was engulfed in the red dust of the road and greetings, both friendly and teasing, from the passengers. I saw my translator, riding standing in the

back, waving and shaking his head at my strange desire to walk when I could afford transportation. I waved and grinned. Everyone was excited to see the sights of the markets and socialize.

As the truck passed out of sight, I stepped back into the dusty path and kept walking. I could feel the blisters already starting to rise on my feet and the sun was unrelenting. I may have made a mistake choosing to travel in sandals. However, this was my first time walking to market and I was too happy to care too much. I was unable to persuade any one to come with me by foot, and so I was alone, but not for long. As I walked, half uneasy by the idea of passing through this forest by myself, and tensing at every snapped twig and rustle in the bushes, I spotted sheep and goats grazing up ahead. As I came closer I saw there was a young man, leaning on a cane, watching me approach. When I reached the point of the road that was closest to him, he met me, greeting me in Maa as “*Olashambai*”. I explained to him that my name was Ole Kasuti³ and proceeded to use the phrases I had memorized in Maa, asking about his health and the health of his livestock. He laughed in happy surprise at my ability to communicate and we began to chat. After he introduced himself and I had explained that I was going to the market to pick up supplies, he nervously lowered his voice to a whisper. He asked where “my friend”, the landlord, was. When I shrugged disinterestedly, he appeared relieved but continued with his voice lowered so that I had to concentrate to hear him. He began to complain about the landlord, speaking quickly and just as quickly going beyond the abilities of my limited Maa.

Although I had to struggle to understand him at this point, the significance of this conversation was immediately apparent. Until this point I had heard only praise for my landlord, from the NGO organizers, to every person I had met when walking from *enkang* to *enkang* with my translator, throughout Losho. I now realized that there were people bitterly opposed to him, and suddenly memories of interactions in the preceding weeks, of sidelong glances and a few strident conversations my translator had (but did

³ A Maa-ized version of my name, Casucci, which also humorously sounded like the Swahili word for “little suit”.

not translate) seemed to gain some context. In the presence of my translator, a colleague of my landlord, people were often noticeably restrained in their discussion of the NGO, and certainly of the landlord himself.

As described in the vignette above, there were competing interest groups in this community and loyalty to one or the other could be demonstrated even unintentionally by the company one did or did not keep. Peter Metcalf describes his experience in Borneo in *They Lie, We Lie: Getting on with Anthropology* where he finds out after experiencing exasperating obstacles created by an influential old woman, that he had unwittingly associated himself with an opposing interest group in the small community (Metcalf, 2003). His association with that group drew the attention of their competitor, this woman, who made it her mission to direct his research into areas that she preferred. In my experience with my landlord the pressures were fortunately limited to hiring the individuals he selected among his constituency that he wished to reward with my employment. However, it served a purpose in reminding me that translators do not play a neutral role in data collection and their influence must be assessed and adjusted for during the interviewing process and considered during analysis. The presence and dynamic interplay of interest groups was an ever-present characteristic of our new home.

Our family settled into a plank shack on a plain in the valley of Losho, at the foot of the Siana Hills and down a gradual slope from Losho Primary school where the NGO was headquartered. We stayed in the only house of its type in the area, constructed a

few months before our arrival, of cedar planks that were carried down from where they were cut in the hills (poached from an adjacent protected area). They were carried down piece by piece by women hired from the area. It had a corrugated metal roof and cement floors, a status symbol for our landlord, an aspiring politician. In fact, he was meant to move out and leave it to us, as we were paying a substantial rent, but he did not seem to be in any hurry. It was furnished with his wife's furniture dowry, two stuffed chairs, a sofa, and a very large china cabinet. It consisted of three rooms, with one external door to the center room.

The particular challenges I experienced during data collection and generally throughout fieldwork were quite difficult in many ways. Corruption, in its many forms, was the most significant obstacle, as it is for much ethnographic fieldwork (Metcalf, 2003). It interfered with communication and therefore access to information. For me, this meant my options were presented to me by a restricted set of interested parties, oriented for their own benefit rather than for the success of my data collection (until I became aware and adjusted my research design to take this into consideration). For the community, this restriction on communication had its effect by eliminating any democratic decision-making regarding support, opposition, pursuit or rejection of development goals and methods, whether by foreign or local organizations or individuals. This is a complex situation for many reasons.

The first reason is the proximity of the field site location to a tourist mecca of Kenya. The tourists come from all over the world and have one thing in common, they had money to spend. In a cash poor region like Losho, even coins were not easy to

come by and the drivers would sometimes encourage the van loads of tourists to toss them to the children they passed. The foreign tourists, accustomed to the much higher costs of living in their home areas, were rarely hesitant about paying extravagant sums for mundane items or even giving cash away as gifts. Just as in other areas of Kenya that held tourist attractions, there were exchanged stories of the local who became rich just because he asked for money from a tourist. People who have little contact with the foreigners felt cheated of the opportunity to become rich. When they did come across Westerners, like the researcher, they often felt their turn had come. When I had to inform them that I was not giving compensation for participation, it was not uncommon for them to immediately cease the conversation and to bitterly go back to their chores. As I explained to my translator and assistant, the reason I did not offer compensation was because it would compel participation in this cash-strapped area and these daily refusals were demonstrations of their agency, despite its effects on our morale and research progress.

A second reason for the problem of corruption is the specific concept of “development” brought by foreigners. Generally, the model for this development draws from a source domain metaphor of “progress”, or change towards increasing technological, economic, social and political complexity and “superiority”, i.e. high modernity, reflecting the continued influence of traditional European-derived Western concepts of primitivism, and social evolution (Chakrabarty, 2000). Primitivism, of course, is made up of two views of the Other against which the West defines itself: Arcadian primitivism and barbaric primitivism (Lucas & Barrett, 1995). These reflect,

respectively, the Abrahamic fall from grace of humankind versus the rise from savagery. The more invested in local perspectives and less burdened with these Western philosophical traditions, the more likely a perspective of “development” will resonate with the members of a community such as the Maasai of the greater Losho area.

This active local non-governmental organization has also affected the relationship expectations of foreigners held by community members in a more direct fashion. The NGO’s missteps with the community, in addition to the tourism financial dynamics, have created a demand among the local community members for financial compensation for almost any interaction with outsiders, in a way comparable to the tourist industry. These demands influence the nature of relationships as well and prompt constant negotiations and defensiveness regarding exploitation, as well as a certain rapaciousness in interactions with foreigners (de Sardan, 1999; Haugerud, 1997; Smith, 2010).

The third reason is the bottleneck created by a local individual hired by the development organization as their project manager. Although this is a single case in this community, I believe it is not an unusual fieldwork experience. (see Metcalf 2003 for a similar scenario).

The individual in my case is an aspiring politician, quite fluent in English and Swahili, as well as his mother tongue of Maa. He had worked for a foreign veterinarian in the area as a boy and had become adept in “development speak”. His awareness and ability to manipulate the values held by the Western development organizations allowed him to uniquely position himself between the community and the

aforementioned development organization. This position had made him wealthy, and able to build the house that I would subsequently rent from him.

The NGO members, despite the fact that they had spent more than a decade coming to this area annually and spending months at a time in the community, had never acquired any language skills that would allow them to communicate with the community members without complete dependence on this individual or the people he personally hired. The community is constituted of fluid interest groups that constantly contested control and authority in the area (also see Spencer 1988 for Maasai historical interest groups competing for independence and influence over Maasai society in Matapato, and Metcalf 2003 for the role an individual concerned with local micro-politics can play in challenging fieldwork objectives) (Metcalf, 2003; Spencer, 1988).

The project manager and his translators were all young men known locally as “learned”. This label indicates that they finished secondary school, but they were also members of the small local Protestant church. They represented a relatively new interest group, which competed with the elders as a voice of the authority in the community. Their ability to communicate with foreigners gave them an advantage in interactions with tourists or development organizations, especially those who wished to promote education. In total there were about 20, and each were easily identified by their habit of wearing trousers, shoes and shirts instead of the more traditional toga like sheets over shorts that were the common dress of men their age who had not spent as much time in school. Additionally, they rarely carried more than a walking stick outside of their homes. The “Western” clothes were both a conscious identifying marker of

their education, membership in the church, and a habit acquired from their many years of wearing school uniforms. Furthermore, the non-school going young men uniformly carried a club and/or sword in addition to a walking stick and often a switch for driving animals. The club and sword are signs of masculinity that they would have begun carrying as they entered the warrior age grade as newly circumcised entrants to manhood.

Though traditionally ten to twenty years in duration, this stage of life was often limited to a week or less for the newly circumcised who were continuing with schooling. They would be ceremonially ushered into early “young elderhood” in order to permit them to pass around the strict and demanding food and drink taboos that characterize the warrior age grade (Spencer, 1988). As a result of living apart from their warrior counterparts, there has come to be a fairly distinct interest group of “learned” young men who are invested in a more ‘Westernized’ lifestyle. These young men have access to salaried work as a result of their language skills and education, but a limited understanding of skills of herbalism, bushcraft and animal husbandry that are extensively developed as warriors, and are traditionally emblematic of manhood (Spencer, 1988). This may extend to even ‘deep’ understanding of the Maasai language. Women and men who have not gone to school typically are able to speak extensively without using coopted Swahili or English terms that appear in the speech of the “learned” ones. This can result in a certain amount of tension about the authenticity of the educated young men’s Maasai identity, and can contribute to the sense of competing interests groups (Hodgson, 2001b; Spencer, 1988).

The fourth source of fieldwork challenges was the language hurdle. Despite my enthusiastic and relentless efforts to learn Maa, the dearth of instructional materials, the tonal aspects, the unstandardized language made up of many dialects, my complete beginner status in this Nilotic language (previous experience in the field took place in Swahili-speaker areas outside of Maasailand), and the limited English language fluency of most of the available translators/tutors were significant barriers. Despite having finished secondary school, and their best efforts, most of them spoke limited English and were therefore hard-pressed to teach me their language. This was a particularly limiting factor when trying to explain complex aspects of Maa, a tonal language that has a grammar quite distinct from Swahili. This made understanding subtleties of participant comments during interviews and casual interaction much more difficult. As untrained but fluent English speakers who have attempted to teach English know, it is very difficult to teach a language without formal understanding of its grammar⁴. Although I speak Swahili at an advanced level⁵, I also struggled to explain to them what I was trying to learn.

All of these challenges contribute to logistical difficulties in constructing a representative shared common health landscape for community members of the region. In addition to interpreting the responses from the participants, it was necessary to carefully monitor the translating to avoid influence by ulterior motives. For this reason, I was highly motivated to learn Maa on my own and communicate directly with more

⁴ I learned this myself as I was trained to receive my Teaching English to Speakers of Other Languages (TESOL) certificate from the University of California, Riverside.

⁵ As evaluated by the U.S. Peace Corps Swahili fluency exam

typical community members as much as possible. I also addressed this challenge by hiring an woman who was fluent in both Maa and English to review the audio recordings. It was also important that I established myself as independent from the interest group of 'learned' young men so that people could speak freely with me. In a village, gossip is rampant and it became a useful strategy to spend time passing through the forest in remote areas alone so that I could be seen and approached as an individual, unaffiliated with any political faction.

Conclusion

All of these challenges served to underscore for me the need to be constantly aware of the perspectives I was representing or assuming in my portrayal of this health landscape. The popular health sector has a potential to be fluid and dynamic by virtue of its generally unregulated and un-reflexive perspective. It may involve various frameworks of reasoning, whether based on an introduced system received through national schooling, or the empirical schooling of the herdsman or mother, steeped in traditional knowledge, experience and advice from elders, or through interaction at government clinics and instruction from chemists. A realistic landscape must somehow encompass all of this. An essential consideration for comprehensive research is the consideration of perspective and earlier representations of the subject matter; this is the topic of the next chapter.

Chapter 2 The Maasai and Health Research in Africa

Introduction

This chapter will introduce the Maasai people and the particular significance of the Purko subsection that makes up the community in Losho. It will begin by reviewing the primitivist ways the Maasai have been represented historically and up to the present in order to give context for understanding the implicit assumptions influencing the perception of the Maasai. It will then present the relationship between Maasai and non-Maasai in national and international health-related development efforts and academic research.

The third section will present the Purko Maasai. It will review key aspects of their society: *enkanyit* and the age grade system as well as divine providence and the unknown. It will then review disease and illness concepts among the Maasai and give an overview to therapy systems with a description of the Maasai diviners and the practice of Maasai herbalism.

The next section will summarize the history of anthropological study of health and illness literature of the Maasai, so that we may understand how this study fits into and contributes to the existing body of literature. The fifth and final section will review the history and current state of research on the popular health sector, particularly in

Africa, with a focus on studies of rationality in Africa, and the importance of studying hygiene.

Maasai in the Western and African Gaze from the Colonial Period

The Maasai have long held particular fascination to Westerners, particularly as iconic representations of Africans (Bruner & Kirshenblatt-Gimblett, 1994; Bruner, 2001; Knowles & Collett, 1989; May & Ole Ikayo, 2007; Pálsson, 1990; Schneider, 2006; Spear & Waller, 1993; Spencer, 2003b). However, their reputation has been manipulated, arguably from before the colonial period, by traders who wanted to keep their exclusive access through territories controlled by the Maasai. These traders would portray the Maasai as blood-thirsty war-mongering warriors in order to discourage their competitors from seeking passage from the Swahili coast into the interior. This reputation was probably to the advantage of the Maasai people as well in discouraging their enemies as they sought to expand their sphere of control and gain range and livestock. This was the situation that met the earliest European explorers and missionaries who wrote about the Maasai (Akama, 1999; Hodgson, 2001b; Hollis, 1905; Knowles & Collett, 1989; Tignor, 1972).

The treatment of the Maasai as one sort of primitive or another has continued after Kenya's 1963 independence, where they have been stereotypically regarded as 'stinking' 'uncouth' 'bumpkins' or akin to 'animals in the forest' by other Kenyans. Even today, the 'Maasai as bumpkin' is a popular comedic stereotype on Kenyan television

shows, e.g., the character of Olexanda on *Vioja Mahakamani*, or *Daktari*. The specific historical situation of reluctance to permit their children to be taken away to boarding schools (as done with the mainstream of Kenyan students) has left them in a situation in many communities where many Maasai, especially women, do not speak any language other than their mother tongue (Hodgson, 2005; Knowles & Collett, 1989). This is unlike the average Kenyan who has had some schooling (nominally free) who often speaks at least three languages to some extent: English, Swahili and mother tongue. This has, in some cases, separated some communities from mainstream Kenyan culture where fluency would have allowed them to counter some stereotypes more adroitly. This situation has spawned social science literature that has addressed the image of the Maasai in Kenya, to the West, and to themselves (Akama, 1999; Bruner, 2001; Hodgson, 2005; May & Ole Ikayo, 2007; Nakamura, 2011; Schneider, 2006; Spear & Waller, 1993; Youngs, 1999).

The Maasai people currently inhabit a stretch of territory from the Rift Valley Province of Kenya to the south into Tanzania. Throughout their territory they vary in modes of economic production (classically pastoralists but spanning a continuum into complete agriculturalists) and acceptance of Western associated culture, from language to apparel, to housing style and language (Schneider, 2006; Spear & Waller, 1993). In literature about the Maasai, considerable space is given to questions of identity (Berntsen, 1980; Cronk, 2002; Homewood, Kristjanson, & Trench, 2009; Jennings, 2005; Little, 1998; Switzer, 2010; K. D. Thompson, 2010; Wangui, 2008). This has been a topic of interest to Westerners as long ago as the reports of the early European explorers and

missionaries (e.g., Krapf 1854, Merker 1904, cited in Spencer 2003). Under both the colonial and independent governments they were often regarded as threats or embarrassments (Schneider 2006, Spencer 1988; Hodgson 2001). The colonial administrators often regarded them as both incarnations of the primitive, both Arcadian and savage, sometimes romanticizing them as warriors, and other times scapegoating them as arrogant and ignorant over-extendors of grazing land (K King, 1972; Knowles & Collett, 1989; Tignor, 1972). This was reflected in the colonial reports (Hodgson, 1999c, 2001b; Knowles & Collett, 1989).

Unlike most Kenyan ethnic groups, during the colonial period they were put into bounded homelands. Like the Native Americans, the boundaries of these territories were manipulated, shrunk and eliminated until they were left in areas undesirable to the British agriculturalists (J. Galaty & Salzman, 1980; Knowles & Collett, 1989). Eventually settled into communally owned 'ranches,' many Maasai areas in Kenya have since been divided into private lots and distributed to the inhabitants in a continued effort by the government of Kenya to encourage agriculture and sedentarization.

Beginning in the colonial era, there have been periodic efforts to both "pacify" and westernize the Maasai communities through the restricting or banning of the warrior age-grade and the requiring of families to send a quota of children to state or missionary schools for forced classroom education (Kenneth King, 1971; Knowles & Collett, 1989; Tignor, 1972). The Purko Maasai, among other groups, were known for their resistance to these policies (Hodgson, 2001b; Knowles & Collett, 1989; Spear &

Waller, 1993; Spencer, 1988). As traditional pastoralists, the Maasai relied upon their warrior age grade to protect them from livestock thieves of outside communities, as well as other subsets of Maasai (Spencer, 2003b). They also enriched the herds by practicing livestock theft of their own (Spencer 1988; Galaty 1982; Berntsen 1976). The study of the “cattle complex” and the associated warrior and other age grades of male pastoralists were a common topic of scholarly study in pre-modern and early modern anthropology (Evans-Pritchard, 1940; J. G. Galaty, 1982; Herskovits, 1926; Hodgson, 1999c; Spencer, 1988).

As pastoralists in marginal lands, uninterested in Western style education and culture, the Maasai were often able to outwardly maintain symbolic displays of cultural identity (despite aggressive government policies of repression), such as wearing ochre, dressing in hides and later red tunics, as well as continuing to mark their ethnic identities on their bodies through cutting and stretching holes in their ears and removing the center teeth from their lower jaw (Schneider, 2006). They were also relatively slow to allow headway by missionary organizations (Hodgson 2005, etc). As residents of communally owned lands known as ranches, they have come to assert an indigenous status. Many activists have used this status in efforts to gain recognition and assistance from the international development community (Hodgson 2011; Galaty 1994 etc.).

As primarily pastoralists they have historically lived in close proximity with their livestock. In many communities they continue to do so, maintaining older African

traditions once commonplace throughout Kenya, e.g., living with young sheep, goats and cattle inside their wattle and daub homes (Spencer, 1988). Continuing these older traditions and only slowly adopting changing housing styles associated with colonially defined “civilization”, such as square houses made of permanent materials, has contributed to their depiction as cultural conservatives. The living conditions, with animals, central fires and limited ventilation, and homes made of clay and dung have also contributed to their depiction as dirty and unhygienic in the Western gaze (Knowles & Collett, 1989). Interviews and casual discussions with members of the Narok South Maasai community revealed that many Maasai agree with the view that in “the old days” bathing either never occurred or was a rare event. Many now semi-sedentary communities continue the practice common among nomadic pastoralists of not using latrines, preferring the anonymity and relative cleanliness of the bush. This practice is labelled ignorant and unsanitary by outside communities, including Western development organizations (Jackson, 2004).

Public health and international development literature has focused on sanitation education and clean water access, especially in regard to infectious disease, e.g., trachoma (Birks et al., 2011; Chan, 2008; Curtis, 2001; Dugger, 2006; Haasnoot, Boeting, Kuney, & van Roosmalen, 2010; Newswire & Eyesight, 2007; Patel, Eisemon, & Arocha, 1988; Pinfeld, 1999; Schémann et al., 2010). The practical limitation of access to water makes many of these development projects futile efforts during the dry seasons.

Introducing the Purko Maasai of the Siana Valley

This section introduces the Purko Maasai of the Siana Valley. It will describe the community and why they are appropriate for the study of health landscapes related to the popular health sector, as well as how they may be considered fairly representative, or at least influential, in relation to the rest of the Maasai community in both Kenya and Tanzania. The Maasai community exists within a broader social context, both locally and globally, rather than in a completely independent and distinctly bounded group; thus I will attend to how they represent themselves, as well as how they are represented by non-Maasai, African and non-African.

The Purko Maasai of the Siana valley are an important community with whom to conduct ethnography because they regard themselves as representative of the Maasai community, and are respected as such by many other sub-divisions of the Maasai (Spencer, 2003b). As Spencer notes, “In Kenya, the Purko see themselves as the true representatives of Maasai society: ‘Purko’ is synonymous with ‘Maasai’, and they regard what they do as the only valid version of true Maasai practice” (Spencer 2003a). They have a special role as the initiators of the “opening” of the period of initiation for the Maasai *morán*, or warrior, age grade for all the subsections of Maasailand. This initiation is achieved through the circumcision, and thus the transformation of boys into men. They are also known and respected for their historical role in resisting colonial authority and post-colonial authority (Knowles & Collett, 1989; Spencer, 2003b).

In order to study any community it is essential to understand the assumptions that already exist in popular perspectives, namely the perspectives held by non-Africans,

non-Maasai Africans, and the Maasai themselves. The following is a description of these perspectives and their assumptions.

Maasai people are icons to the world of Africans, most often in the form of tall, slim, male warriors holding spears, smeared with red ochre and clad in red tunics (Bruner, 2001). They also have a reputation with other African Kenyans. They have been represented in popular Kenyan television shows or described to me by non-Maasai Kenyans variously: just like animals living in the forest, appearing poor but having a great deal of wealth invested in their livestock but regard their sale or slaughter as an extreme step to avoided at all cost (e.g., shoes for their children, school fees), eating meat every day (a sign of wealth), being 'dangerous', 'filthy', 'stinking', 'savage', and willfully 'ignorant'. Their representations seem ubiquitous in tourism, from "traditionally" dressed security guards, to song and dance entertainment, to tour guides with a "natural" affinity to animals and the environment, to male sex workers employed by middle-aged European women (Akama, 1999; Bruner & Kirshenblatt-Gimblett, 1994; Bruner, 2001; Knowles & Collett, 1989; May & Ole Ikayo, 2007; Schippa, 1999).

The Purko are an influential sub-division of the Maasai. Their territory begins in Narok County, Kenya, and extends across the border into Tanzania. As indicated by the quote by Spencer above, they regard themselves as quintessential Maasai and they are respected widely in Maasai for their historical resistance to colonial and independent government domination. They have been the seat of resistance to compulsory Western education and bans on *moran*-hood. Their refusal to accede to the government's programs to eliminate the *moran*, or warrior, age grade, and disregard of the national

education participation requirements have forced policy concessions in these areas (Holland, 1996; Spencer, 2003b).

*Olashambai/mzungu*⁶ stereotypes among the Maasai are similar to those held by other Kenyans: Westerners are fragile, fussy, oblivious, rude, self-absorbed, unimaginably wealthy, socially-connected people who understand high technology while being unable to handle the most basic of daily tasks. The Maasai view (held in the area of my field site), is that these foreigners also admire and envy Maasai. I was approached by Maasai who saw the blanket or club I carried and, in the course of conversation, would give me some knowing look and ask me “you want to be Maasai?” It is understandable when one considers the trade in Maasai jewelry and blankets to the foreign tourists, that local people might assume that the buyers are planning to use them in the way these objects are used by a Maasai person.

Furthermore, in other parts of Kenya, the souvenir sellers are often professional merchants who may have little connections to the cultures that produced their goods, or the goods themselves may be expressly made for the tourist trade and no longer indigenously, or perhaps were never used in any sense outside the tourist industry. Perhaps because the majority of the local Maasai community rejects Western-style clothing, housing, and other ethnic markers that were not strongly associated with Maasai ethnic identity, they saw the purchase of the clothing, jewelry and tools by foreigners as a desire on their part to abandon Western ethnic markers and replace them with Maasai ones—in a sense, in a desire “to become Maasai”. This may

⁶ *Olashambai* is the Maa term for a Westerner, literally meaning “light-skinned”. *Mzungu* is the Swahili term.

contribute to a diminishment of respect for *Olashambai/mzungu*, similar to their appraisal of Maasai or non-Maasai Kenyans who have adopted Western ethnic markers, seemingly at the expense of their own ethnic identity.

This was illustrated to me by an experience I had outside of my house one day, early in my fieldwork.

On a blindingly bright, hot day, there was a group of young and middle-aged men sitting and standing about the masonry stones that littered the grassy expanse around where my family and I stayed. We were in the middle of the Siana plains. An area like a great lawn, between the forest on the hills and the brushy areas around the seasonal streams, runs the length of the valley. The grass was very neatly kept, cropped short by the teeth of many hundreds of goats, sheep and cattle (and a score of donkeys) during the day, and gazelle, zebra, dik-dik and sometimes even buffalo at night. It was broken up in some areas with great wounds of erosion, running down from *boma* (settlements) on the hills, trampled flat and lifeless by the hooves of the livestock in their daily passage to distant grazing areas in some places, and deep enough to hide a tall man in others. When it rained, the hard-beaten black and sandy soil, jagged with hoof prints, would turn into cloying clay that would build on the soles of your shoes, weighing them down like divers' boots and increasing your height like mushy platform shoes. The ravines would run with very fast, churning brown waters, sometimes impassable.

The men in the group were dressed in the red or checkered sheets they wore tied together over each shoulder, usually with shorts underneath, except for one man. This man was a Tanzanian who went by *Oltung'ani*, which means 'human being' in Maasai. He was dressed like most Kenyans (and I have to assume like most Tanzanians) in well worn "Western" clothes: a button down shirt with trousers and trainers. One of the group, an older man of my age grade, was teasing the Tanzanian about how he looked. The Maasai man, who I will call Thomas, was telling Yusuf⁷ how ugly he was. "See your clothes! You dress like a white man. Look at me, I'm a Maasai and I dress pure Maasai. Look at Tall Man (*Oloodo*: one of my names) he is a *mzungu* and he dresses pure *mzungu*. Ha ha! Look at your face! Look what the sun has done to you while you work in the fields!" The younger Maasai men laughed and Yusuf just muttered feebly to me "I do God's work in the *shambas*. I'm not ashamed".

⁷ Also not his real name. In order to maintain confidentiality, all names have been changed.

When introduced to me as Human Being, Yusuf insisted that his name was Yusuf and that is how he should be addressed, speaking directly to me. I replied agreeably, but I was intrigued. Later, I asked my translator about his Maasai name, Human Being. My translator said that when this man appeared in their valley (which is about 20 miles from the national border that many Tanzanians crossed to find farm work with wealthy Maasai), he insisted that they call him “human being”. Ben, my first translator and a high school “leaver” from the local community, did not know why he wanted to be called that then, or why he insisted on Yusuf now, but seemed to enjoy the man’s temper and continued to intentionally call him Human Being. I never found out from Yusuf either, but it is very common in many communities, and it was true for this Maasai community, to call people by their ethnic marker instead of their names. Ben insisted that there was no negative dimension, but the simple reduction of a “human being” to the name of their ethnic community was most often used by the relatively powerful on the weak, and never the reverse, in my experience.

Of course, the names in many languages for people outside of that language group are often derogatory as well, and farmers in general were often looked down upon by this community of proudly pastoralist Maasai (although more maize fields were emerging every year). It seems likely, in both of Yusuf’s modes of address that he was fighting to be recognized as an individual person in different contexts. As an extreme minority in a relatively homogenous community, he was mocked.

Thomas, when I saw him again months later, was dressed in a suit. I never saw him again dressed as a “pure Maasai” that year or the following year. I do not know

whether he has abandoned the clothing he used to wear. I do know that on one occasion, before his dress change, I saw him being teased by other Maasai men. It was revealed that he had sold to tourists his *olalem*, his short, double-edged sword, that strong symbol of Maasai identity, of masculinity, and of a disregard for authority outside of his community (carrying personal weapons, although historically common across Kenya, was illegal and could lead to police harassment). When asked, he told me in a defiant, but frustrated tone: “With the money they gave me for it I can buy four more!” That was one of the last times I saw him in his blanket and tunic. I never saw him with another sword.

The financial and social aspects of the tourist industry had strongly influenced this community, as this example with Thomas demonstrates. In many other communities in Maasai land, under different pressures from the colonial or later, independent governments, subject to more or less successful missionizing attempts or Westernizing/“civilizing” attempts by the governmental school system, communities had transformed to varying degrees. The ones that outside cultures had made inroads upon had adopted farming and Western clothes and religion to a greater extent. In the community of my field work, they had resisted these pressures for a long time, although of course, change is relentless. For example, in the literature there are photographs of Maasai from the past—some more than a century ago—, wearing red ochre and hides and hide sandals, heavy metal jewelry and leather capes (Hollis, 1905). Today, at my field site and all other places I had seen, there were the seemingly “traditional” red tunics made of cloth, ochre only worn by the few warriors (apparently fresh from

Tanzanian Maasai land), tire or cheap plastic sandals, and plaid blankets (and the odd pink or rose decorated bed sheet) worn as those earlier capes. Additionally, there were ever present cell phones in the belts of even illiterate herdsmen, who could not enter names in their address books but recognized the numbers of friends and relatives. Swords were also different, now created by grinding down Chinese-made machetes.

At my field site, the strongest influence was not Christianity, which had made few inroads. The Catholic missionaries had tried many years ago, but had given up, claiming, as told to me second hand by one of the founders of the local NGO, "These people don't pray". Now, there was a small Protestant church (with a very large sound system), sponsored by U.S. church organizations, that attracted few local people. There was a primary school, which most children still did not consistently attend despite periodic roundups by local low-level government authority figures. There was also that development NGO that had such trouble enacting their desired changes.

The strongest influence of change on this community was related to the gate, ten or twelve miles from where we lived, which was the southernmost entrance to one of the most famous wild animal parks in the world, the Masai Mara National Reserve. There was also the road: a brown ribbon we could see in the distance, followed on a nearly daily basis (depending on the season) by white Nissan vans and large sport utility vehicles, racing by, with no intention of stopping before reaching the lodges just outside the gate or inside the park. These vehicles mostly came all the way from Nairobi that morning, a four hour trip. Some would have come from the two large hotels in Narok, the Maasai town half-way down that journey from the country's capital city. The

Nissans and SUVs were not the public transportation called *matatu*, these were carrying tourists with revenue for the tourist industry. This opportunity for wealth is obvious. Those with access to the tourist industry became wealthy, while the rest waited for the payoff from their shares in their own community's tourist attractions, unfortunately located further from the gate, or by Maasai politicians' yet-to-be-fulfilled promises of enrichment. Few made distinctions between types of outsiders. It was difficult to see me, this "Tall Man," as being outside of this money mill and not as an opportunity for entry into the good life. Even the NGO had been shown time and time again to be a source of wealth for those who had access.

The Cosmology of the Maasai

The medical anthropology of Maasai has its foundation in studies of religion, herbalism, and pollution (J. G. Galaty, 1979; Hollis, 1905; Spencer, 1959). The Maasai have been described as having religious beliefs and practices characterized by individuality, flexibility and incoherence, and a cosmology that allows for no other supernatural beings than the Creator God, *Enkai* (Hurskainen, 1989; Westerlund, 1989) and sometimes not even that much (Westerlund 1989; although see Hodgson 2005). The Maasai do not fill in the gaps of explanation for health or illness with Biomedicine - although, as in most places in Africa, there is medical pluralism- (Westerlund, 1989). There is folk medicine, with a populist tradition of amateur or lay practitioners who appear to become experts through trial and error of caring for their own families. However, as in perhaps all societies, most of the practice of maintaining or regaining

health is understood and practiced on a popular, common sense level of understanding how the world around one works, and how one interacts with it to various outcomes of fortune. In other words, the popular sector, or “nexus of the boundaries of the different sectors” as well as the other sectors themselves (for the professional sector of Biomedicine, see Hahn and Gaines 1985) all lie within and draw on the shared notions of intersubjective reality that are drawn from a culture’s cosmology (see figure 1 below).

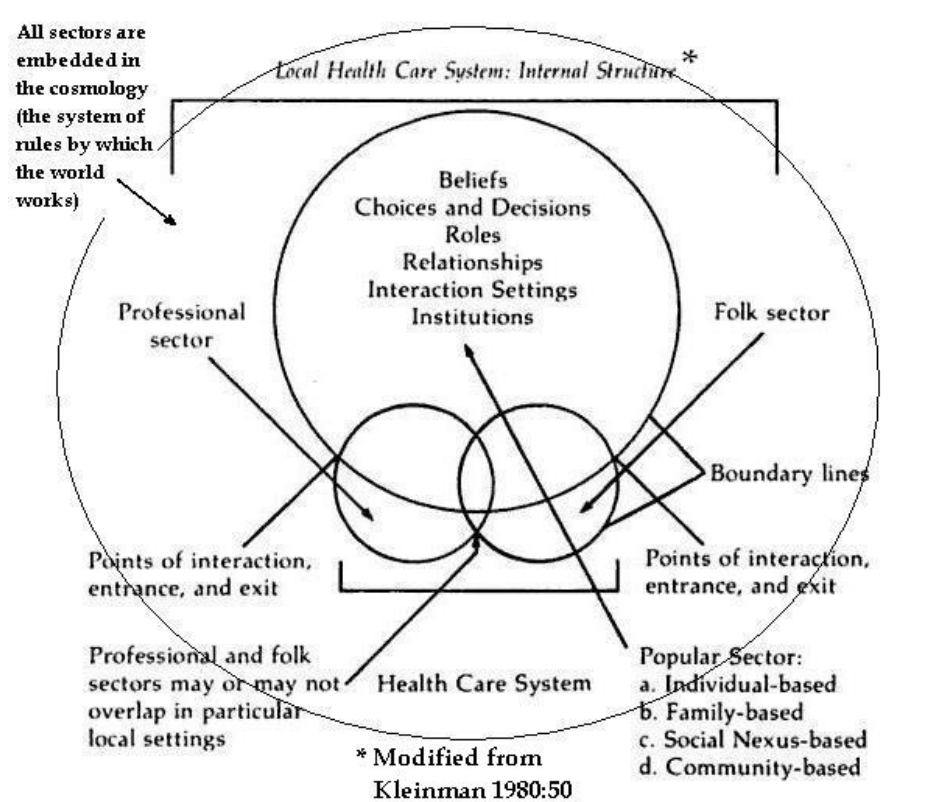


Figure 1 Popular Sector and Cosmology

In anthropological literature, Maasai society has been characterized by strong delineations of age and gender categories. These categories are maintained and reproduced through rules of food and association and also by relationships with

livestock and the natural environment to prevent pollution/contamination and taboo violation (J. G. Galaty, 1979; Hodgson, 2001b; Pálsson, 1990; Spencer, 1988; A Talle & Pálsson, 1990). In order to understand and analyze these categories -especially to understand how they structure the relationship between health and illness- they must be analyzed in reference to the “total structure of thought” (Douglas, 1966), i.e., cosmology. The discourse of these concepts and practices by the Maasai are “...in part, a metaphorical language for talking about human relations and social identity” (Pálsson 1990:14). These social systems are subsumed in Maasai cosmology as an underlying symbolic system that shapes practice, structures identity, and makes up the world (Talle 1995; Pálsson 1990; Spencer 1993; Talle and Pálsson 1990).

I am using the definition of cosmology given by the Encyclopedia of Social and Cultural Anthropology- as a “...theory of the universe as an ordered whole, and of the general laws which govern it... Cosmology in anthropological usage is both more and less than religion. In some way or another, the study of cosmology means taking account of the relationship between the whole and the parts: the macrocosm and the microcosm. Because the word *kosmos* can mean ‘order’ as well as ‘world of order’, in Greek thought microcosm can signify not only humans in relation to the universe, but also any part of a thing, especially a living thing that reflects or represents the whole it belongs to” (Barnard & Spencer, 1996), as well as A Dictionary of the Social Sciences- “Cosmology is that aspect of religious or philosophical belief which concerns the fundamental character of the universe... While the cosmology and cosmogony of a society may find expression in the science of that society and may in part be shaped by that science,

fundamentally they are parts of the religious and philosophical belief system and tend to be embedded, even in civilized societies, in myth (q.v.) and ritual (q.v.)” (Titiev, 1964). Consider also: “Ideas concerning the place of man in the world, his destiny, his main values, his attitudes in relation to his fellow men, the rules of his behaviour, and the meaning of the invisible world...” (Maquet, 1954).

***Enkanyit* and the Age Grade System**

Frans Mol defines *enkanyit* as “decency, honor, respect, obedience, awe, and good manners” (Mol, 1996). It is a central tenet of Maasai society and is linked closely to the age-grade system, most elaborately with men, but affecting and presenting in both male and female roles to some extent. The age-grade system is the visible representation of the classic African pastoralist social structure of the segmentary lineage (Evans-Pritchard, 1940; Spencer, 2003b). Spencer describes it as an all-encompassing system that disciplines the Maasai perception of time and life course experience

First described by E.E. Evans-Pritchard, the segmentary lineage/age grade system is an integral part of a non-centralized society, horizontally structured upon age grades that chronologically advance upwards through age-based ranks. There are two main parts: age grades and age sets. Age grades are like grades in an elementary school that all eventually pass through. The age set is like the cohort of a particular class that travels temporally through these grades together. Boyhood is considered to precede

the age system, which begins with circumcision into manhood as moran, or warriors. Again like a grade school, all age sets move upward into the next grade. The amount of time an age set stays in each grade is about 15 years. There are festivals that are conducted at the beginning and end of each term, 'opening' or 'closing' the period in which the participants can be initiated into the next stage. This is considered an androcentric and patriarchal system, in which boys graduate to warriors, and then move into elderhood, levels of senior elderhood, and then retired elderhood. Women and girls, however, provide essential roles at each stage as lovers or mothers, and the androcentric portrayal of the events may be a result of the patriarchal assumptions in the Western gaze, as argued by Hodgson. She has found evidence that the British colonial insistence on recognizing property and leadership rights of men over women were seized by Maasai men and naturalized through retrospective rationalization (Hodgson, 2001b).

Women are initiated from girlhood to womanhood through circumcision. In contrast to the warrior grade, where young men are restricted from marriage until the term has ended and they have been initiated as junior elders, women are typically married quickly in arranged unions. At this point they are in a third stage of pre- or early motherhood. The mature motherhood stage, paralleling the junior elder grade among the men, is recognized with a new title when several children have been born. Eventually grandmother status gives senior elder status. The biggest difference between the male and female systems of aging is the lineal unity of the male age grades. This is also a distinct characteristic that distinguishes 'Maasai proper' from the

family of 'Maa speakers', and is demonstrated by participation in Maasailand wide initiation periods. All 'proper' Maasai subsections recognize the 'opening' and 'closing' of the initiation periods and act accordingly. As a result, an ideal is promoted of Maasai unity among men of a particular age set.

Vertical integrity of the society is maintained through *enkanyit*, which includes a reverence for gerontocracy. Older age grades are strongly associated with maturity and wisdom, and even charisma in very senior elders. They are viewed as closer to God, and possessing the ability to direct awesome power through blessings and curses. The older set's blessings and participation are essential for the proper conducting of important life stage rituals.

This power of elderhood is, in turn, based on the basic relationship between parents and children and the fundamental ability for a parent to curse their offspring (Evans-Pritchard, 1940; Hodgson, 2005; Spencer, 2003b). The older the age grade in relation to oneself, the greater the respect that must be shown, the greater the esoteric knowledge possessed by the elder, and the greater the curse that can be incurred if one gives offense. Spencer speculates that *Enkai* is a Freudian representation of the ideal of elderhood (Spencer 2003).

When considering the Maasai understanding of *Enkai* as God, it seems reasonable that the hierarchy of Maasai society could extend to *Enkai* as the infinitely eldest being, most steeped in Maasai esoterica, and the ultimate in authority. As such, the intentions of *Enkai* are not questioned and are deemed unknowable. When

interacting with someone much senior to oneself in Maasai society, you wait to be spoken to. This silence is analogous to the *maiyo*, or “I don’t know” response, given in many interviews in response to the question of how a person may avoid or prevent an illness. “It is God’s will”, “Only God knows”, “There is no cause” (as in ‘it just happens’), and “You can’t know!” also fit this category. It is a refusal to be presumptive and an act of humility as demonstration of respect for the mysteries known only to *Enkai*.

***Enkai*, Divine Providence and the Unknown**

Pastoralists are often characterized by a concept of a lone and distant creator god and the Maasai are often considered to follow this characterization although not without some dispute (Hodgson, 2005; Spencer, 2003b). Using George Foster’s dichotomy of naturalized and personalized systems of effect, they are often considered classic naturalists, meaning that they often do not attribute the causes of various fortunes or illnesses to people, living or dead, or supernatural beings (Foster, 1976). In the literature of Maasai cosmology, misfortune and fortune both are regarded as ultimately according to the will of God/*Enkai*, whose actions are inherently inexplicable. There is a general faith in orthopraxis, i.e., correct behavior as defined by Maasai culture, will lead to blessings from God, such as many children, fertile livestock, and long life, (but this is not regarded as quid pro quo, as discussed in chapter 5).

Spencer has written extensively on Maasai reticence to discuss cosmological details, or even to express curiosity regarding metaphysical knowledge beyond

orthopraxis and its basic premise that correct behavior as Maasai is propitious and brings the Maasai closer to Enkai. He states that “no one can seriously claim an esoteric knowledge of the unknowable, they insist: ‘Only God knows’. Maasai are confident that their tradition has served them well, but this is in the context of an enigmatic order of things that can be only dimly perceived. Even myths of origin can be dismissed as just myths. God is the hidden figure of Providence, the guiding hand behind the unfolding of events, and the supreme agent in the operation of mystical forces” (Spencer, 2003b).

The authority and power of elders derive from their perceived closeness to God, but this changes with death. As opposed to child birth, where the presence of Enkai is very near, in death Enkai is virtually absent, and there is fearful avoidance of even discussion on the topic. The names of the dead are not spoken. When a death occurs, and after the initial wailing, there is mourning in the avoidance of personal decoration, the extent of which corresponds with the prestige of the deceased. An entire *enkang* may remove their decorations when an elder dies, but an infant may only be mourned by its mother. Traditionally the bodies are disposed of by leaving them in the forest to be eaten by wild animals, in a process Spencer refers to as annihilation. Among non-Christian Maasai, there is no concept of afterlife. Death is a reduction to nothing and is to be avoided. If a person has been injured, or is sick and on the verge of dying, they will be moved to a hastily built hut outside of the *enkang*, to avoid the unpropitious occurrence of death within its confines (Spencer, 2003b).

The leaders of the NGO in Losho told me, with an exasperated air, of their gift to the local Maasai Christian minister. They had carefully prepared a photograph of his recently deceased daughter and put it into an attractive frame. They presented it to Kotikesh with a few words of condolence. His reaction was to swiftly place the image face down on the table and to ignore the topic. As Kotikesh was a born again minister in the local church, this suggests that the Maasai value of silence in the face of death and the unknown is a fundamental aspect of their society and identity.

Health and Illness among the Maasai

“Even if you are clever, God does not give you everything at the same time”.

Aud Talle uses this Maasai proverb to illustrate his argument that a premise of Maasai health cosmology is that the future is unpredictable. Good and bad fortune are generally experienced at random and cannot be controlled (Aud Talle, 1995). There are certainly proverbs that would support this argument: “The nose does not precede the rest of the body”, “You are informed about where you are coming from, but not where you are going”, but “The hyena said, ‘It is not only that I have luck, but my leg is strong’” (Hollis, 1905; Ole Sankan, 1986). The first of these three proverbs means that you are not able to sense danger before you are involved with it. The second proverb is fairly self-evident, you know your past but you do not know your future. The last proverb adds to the unpredictable nature of the world, to show the importance of effort and ability. In other words, though we cannot know the future, we are not without agency,

and like the hyena we can make a certain amount of luck for ourselves. There is a difference between an unpredictable future and an inevitable fate. Maasai also say that “persevering and being able are not the same thing”. Hollis recorded this proverb in 1905 and argued that it was a double entendre that meant both that persevering is more commendable than simply being able, as well as ‘though you persevere, it is not inevitable that you will succeed’ (Hollis, 1905). In regard to the future, fortune or misfortune, health or illness cannot be predicted. This is clearly not fatalism. We must endeavor to have the strong leg of the hyena take advantage of luck when it comes. Living properly according to Maasai tradition is propitious as well.

In addition to the unpredictable nature of future fortune or misfortune, Talle describes the Maasai concept of illness as a projection of cosmic disorder upon the body (Aud Talle, 1995). He argues that transgressions in social and divine relationships are therefore regarded by Maasai as the causes of disease. This should be clarified to specifically address dramatic and strange illness, or illness as a result of cursing. Curses are ideally used by parents and elders to control the immoral behavior of the young. Cursing, in fact, is so strongly associated with the moral order that they are often considered useless against young children and foreigners, who cannot know the moral significance of their behavior (Spencer, 2003b). Another type of illness is *emoyano*, the common and everyday illness that will be discussed further below. They are the epitome of the Maasai ‘naturalist’ view of illness. *Emoyano* simply occur, and by default are a part of nature, i.e., unknowable Providence. Nature symbolizes and represents the cosmological order of *Enkai*. Therefore, it is more accurate to say that illness is a

projection of either disorder or order, upon the body, depending upon the illness category.

There are three other types of health problems, and corresponding causes of ill health (including death), that are recognized by the Maasai (Århem, 1986; Spencer, 2003b; Aud Talle, 1995). Two of them are discussed in detail by Arhem 1989. The first is *enkea*. This is directly affected by *Enkai*, in a dramatic way: a sudden, unexpected and fatal illness, accident, or animal attack. Spencer gives the example of a rhinoceros that unexpectedly plunged through the thick thorn fence surrounding the *enkang*, or multi-family compound, in the middle of the night, in the process killing a warrior. This shocked the community and it led to a lot of reflection as to how something like this could occur. Then it was remembered that the young man had openly disrespected a senior elder at a recent important ceremony (Spencer, 2003b). Thus, this otherwise inexplicable occurrence was attributed to the will of *Enkai*, who enforced the Maasai belief that orthopraxis, or right living, in ritual and daily life will ultimately lead to fortune, and that disregarding it would lead eventually to misfortune (Århem, 1986; Spencer, 1993). It is particularly rich in this example, as the important ceremony likely represented one of the many ritual transitions between life stages for the Maasai life, which is a foundational aspect of Maasai culture (shared transitioning life stages) and the show of respect between age grades (Spencer, 1993). As the ultimate embodiment of elderhood, *Enkai* is inexplicable, distant, and respected in the most extreme form, demonstrated through avoidance (Spencer, 2003b).

The second time of illness/misfortune is represented by *esakuto*. In English this may be considered witchcraft and includes curses and charms. It is caused and defended against by *laibons* (which is a central reason for the ambivalence of many Maasai towards them as a group) (Spencer, 1991, 2003b). This is the manipulation of magical and natural material to cause ill health, misfortune, and death. It is the cause of misfortune that is referred to in the anthropological literature as “of man” (Foster, 1976), and fits Talle’s concept of illness caused through social transgression. Within Maasai society this is considered a fairly rare occurrence, and there are some in my experience and the literature who doubt the powers of the *laibons* completely and regard them as conmen (Spencer, 1991).

In one interview with a grandmother and her junior elder son I had my most dramatic example of this skepticism of *laibons*. We were just an hour’s walk from the home of a well-known *laibon*, as well as in the part of Purkoland that borders the area typically controlled by the Loonkidongi, the subsection of the Maasai known for the most powerful *laibon*. I was asking the mother if she thought there were health problems that only a *laibon* could treat. “No, we do not go to them. They are useless. The old man has forbidden it”. She was referring to her deceased husband, the former patriarch. Although the Maasai of this area do not believe in the curses from ancestors that are a serious concern of other African communities, they are firm believers in the curse of an elder, particularly a father or patriarch. This was a special, conditional curse that was still potentially in effect despite the patriarch’s passing. If it was violated, even now, it would afflict the transgressor. She explained, “The old man saw these *laibons*

turning men against each other, making them fight, to get money. He saw that they are conmen and has forbidden everyone in this *enkang* from going to them”.

The third illness situation is considered a type of blood loss, or low levels of blood content in the body. This is typically a result of circumcision or child-birth. In Maa it is referred to as *altamweya*. It is treated with the consumption of blood drawn from animals and mixed with milk.

The fourth cause is the aforementioned, and forms the basis of this dissertation. It is called *emoyano/emuiyen*, and it is often translated as “problem” though it is only touched on lightly by Århem (Århem, 1986), as in “health problem”, “stomach problem”, “eye problem”, especially when the specific name for an illness has not been identified. From my fieldwork I have determined that these are the vast majority of health problems of the Maasai. They are regarded as not caused by man, or by a dramatic corrective act by *Enkai* or one’s parents. Like all good and bad things, it is ultimately from *Enkai* (this perspective is represented amply in my interviews, see causal response tables in appendix), but it is not associated with correct or incorrect behavior or moral issues. *Emoyano* illnesses “just come”, and as one cannot see them coming and they are delivered ultimately through the inexplicable will of *Enkai*, the idea of avoidance or prevention is problematic. Henceforth, references to illness will be limited to *emoyano*. The next two sections will describe further the Maasai diviner, or laibon, and then the Maasai practice of herbalism.

***Laibon*: Divination and Curse**

The exceptions to the 'naturalist' rational are curses, which can be given by parents or grandparents, and *laibon*, or traditional healers, diviners and historically prophets, misunderstood by the British colonialists to be political leaders (Århem, 1986; Hodgson, 2005; Spencer, 1991). The phenomenon of the Maasai *laibon* is regarded as essentially a closed circuit. The curses that the *laibon* can protect you from are the curses that can only come from another *laibon* (Spencer, 1991). Curses are exceptional and are suspected generally in times of social conflict or when dramatic and mysterious misfortune occurs. As a focus of this study of etiological concepts related to the common health landscape, this keeps the common illnesses restricted for the most part to a 'naturalist' playing field. Although there is a class of expert healers and diviners called *laibon*, traditionally men of the Loonkidongi clan, there are also rarely female diviners and lay people who have become known as experts in treating specific conditions, whether worms, or bone-setting (Århem, 1986; Fratkin, 2004; Olsson, 1989; Spencer, 1991). The medicine they provide for their clients is specially processed material used in charms, called *entasim* (Århem, 1986; Olsson, 1989). It stands in contrast to the widely known herbal treatments made from local plants.

***Olchaani*: Maasai Herbalism**

Although this dissertation is not focused on treatment and therefore not on herbalism, but prevention and concepts of etiology, herbalism is a significant aspect of

popular health knowledge and will therefore be described in overview. In most health care cases, scholarship has suggested that Maasai communities have extensive knowledge of herbalism for primary care. In the communities in which this herb lore persists, it is widely shared knowledge (Århem, 1986; Burford, Rafiki, & Ngila, 2001; Bussmann et al., 2006). There have been many studies of the herbs used by the Maasai, and their identification by Latin names as well as speculation or experimentation regarding their “active properties” and their role in Maasai health and healing. Indeed, there have also been studies of the symbolic value of Maasai herbalism (Bignante & Tecco, 2013; Burford et al., 2001; Bussmann et al., 2006; Ibrahim & Ibrahim, 1998; Kiringe & Okello, 2005; Kiringe, 2006; A. C. Koch, 2005; A. Koch, Tamez, Pezzuto, & Soejarto, 2005; Maundu, Berger, & Saitabau, 2001; Ongugo, Osumba, & Tuzo, 2011; Parker, Chabot, Ward, & Johns, 2007; Sindiga, 1987; Spencer, 2003a). Maasai people often refer to the use of medicinal plants as *olchaani*⁸, which means tree. In fact, herbalism in general does not refer to the strict of herbs but any plant material for medicinal purposes and the Maasai have demonstrated a very encompassing knowledge of the plant materials available for human and veterinary use (Olsson, 1989).

In common Maasai parlance there is a telling phrase, “trees are medicine”, and in fact there is a medicinal alcoholic drink referred to by this phrase in Swahili, “*Miti ni dawa*”. Plants are widely used and respected by Maasai people and they often represent both uniquely Maasai wisdom and experience versus the medicine of the

⁸ This word, *olchaani* is written how it is pronounced in this region (according to the standardized and widely known Swahili orthography).

sipitali, but also the blessings of God, from whom all of the blessings of nature, as well as of the *enkang*, come. They are recognized as inexplicably linked. The rain, (also another word for God), brings life to the environment, which in turn feeds the livestock, which is another gift from God, whose purpose is creating sustenance for the Maasai people. The bounty of nature as well as the bounty of animal husbandry are both recognized as active signs of the blessings of God (Århem, 1986; Hodgson, 2005; Mol, 1996). The significance between this representation in both nature, which provides *olchaani*, and livestock, particularly cattle, which provides life through the essential parts of the Maasai diet, will be discussed in relation to the findings of this research in the analysis chapter.

In the Maasai landscape, the sphere of nature demonstrates *Enkai's* blessings to the Maasai, which are represented by the forest and grasslands. The domestic sphere also represents the beneficial relationship the Maasai have with *Enkai*, which is represented by livestock, particularly cattle, and children to look after them. These fundamental cosmological premises are the bedrock that forms the basis of the local health landscape perspective and experience (Hodgson, 1999b, 2005; Spencer, 2003b).

Social Science Studies of the Popular Health Sector

In order to contextualize this study of the perspectives on health and healing held by the Purko Maasai of Narok South, this section consists of two parts. First, it will review the evolution of literature on the study of lay perspectives on the etiology of

health and illness in order to illustrate the importance of examining the popular health sector of a society. The second section will review the particular state of the study of popular sector perspectives on etiology, rationality, and hygiene in Africa to demonstrate the role of Western subjective perspectives in the treatment of African societies as objects of study.

The Evolving Study of Popular Etiology

The study of etiology has been a focus of medical anthropology and related fields, such as medical sociology, since the early 20th century (see Clements 1932; Foster 1976). Social science has historically focused on professional and folk perspectives of etiology of health, or on specific diseases in regard to the lay sector (Hughner & Kleine, 2004; Kleinman, 1978a). Early anthropologists in Africa were often missionaries, and studied the rituals and religion of the communities with whom they interacted. Later anthropology was often conducted by colonial authorities, or those who sought funding from them, which led research on local political structures, often involving religious leaders (A. Kuper, 2001). Still later anthropologists, like Victor Turner, were interested in symbolism and looked for it in healing rituals (V. Turner, 1967). The study of health in Africa derived from these academic traditions.

With more recent observations that the popular sector underlies and precedes all other sectors of health care systems the study of etiology has expanded into an examination of the factors that influence care-seeking and treatment decisions (e.g.,

Kleinman 1980; also see figure 1). Thus, the popular sector has been examined in relation to its influence on the utilization of professional and folk sectors of various health systems (Bedelian, Nkedianye, & Herrero, 2007; Shaw Hughner & Schultz Kleine, 2008; Wanzala, Hassanali, Kibet, & Dossajee, 2005). When studied by Biomedicine and aligned fields, such as public health, the popular sector perspective has been typically evaluated as an irrational or pre-rational contrast with Biomedicine⁹ (Ackerknecht, 1971; A. Kuper, 2001). Popular, or lay, perspectives regarding the cause of illness and the nature of healthful practices have often been examined in relation to adherence to the prescriptions of Biomedical care, with applied research oriented towards gaining compliance to Biomedical standards. In addition to studying lay perspectives of health and illness in relation to biomedicines, lay perspectives have also been examined in regard to blame and responsibility for illness causation (e.g., Patel, Eisemon, and Arocha 1988; Birks et al. 2011; Coast 2007; Haasnoot et al. 2010). This section of the literature review will discuss the history of social science and Biomedically related study of popular sector perspectives on the etiology of health and illness.

Lay perspectives of health in the literature have been historically regarded as reflections or consequences of expert perspectives of the society in which they exist. As a result, the study of lay perspectives in the West has often been oriented toward an evaluation of the distance between them and the particular biomedicine of the researcher's society. It has also allowed for a primitivist dichotomy which enables dominant sectors to position the contrast as one between 'rational and irrational',

⁹ Although for an early examination of Biomedical culturally based variability see Hahn and Gaines 1985

'civilized and savage', and 'evolved and primitive' (Knowles & Collett, 1989; Lucas & Barrett, 1995).

This has been dramatically represented in cross-cultural studies of mental health, or conditions which have been attributed to a Western concept of mental illness. An example of this would be the gender-bound "hysteria" that women regarded as troublesome could be diagnosed with until the early 20th century (Showalter, 1987), the "drapetomania" of runaway slaves (Szasz, 1962), or the "psychological evaluation" of the desire for independence of the colonized in European colonies around the world (McCulloch 1995; Vaughan 1983; e.g., Carothers 1953). The women, the slaves, and the colonized could be expected to disagree with this interpretation of their behavior and beliefs. Their perspectives, in conflict with the biomedicine of their time, was regarded as mental illness (see also Devereux 1980 for the relationship between culture and mental illness perception).

The study of mass "hysteria", often in the form of "culture-bound" syndromes can also be regarded as an examination of lay perspectives that were ultimately determined by the Biomedical viewpoint to be either delusional folk beliefs or mental illness. These studies were typically of foreign communities whose perspectives were particularly regarded as exotic by the researcher. Interestingly this has not be limited to Western views of non-Western perspectives, as the original coiner of the term "culture-

bound” syndrome was a Chinese psychiatrist named Pow Meng Yap who remarked on the culture-bound reaction of young American girls to pop stars (Yap 1951; Yap 1962)¹⁰.

Additionally, there are seminal works of sociology, psychiatry, and anthropology that have looked at the role of social causes of illness (also with a focus on mental illness) in which the culturally constructed perspectives of the people of a society were held to be responsible for their conditions (e.g., Durkheim 1966). This, of course, is a foundational premise of Freudian psychoanalysis and the Culture and Personality movement in anthropology (e.g., see the works of George Devereux; Piker 1994). Perspectives held by the sufferers and their families are often contrasted to normalized Biomedical perspectives. The goal is often to identify the cultural factors that influence the popular expressions of these shared experiences, rather than to do the same within the Biomedical perspective (for an exception see Hahn and Gaines 1985).

Contemporary Studies of Popular Etiology

Medical anthropologists have employed varying methods to get at the lay perspectives of patients, including by eliciting narratives and explanatory models. Typically this has been to examine the agency of the patient and the patient’s family in co-creating meaning with the medical professionals for an illness experience (Elstein &

¹⁰ Originally Yap proposed “atypical culture-bound psychogenic psychosis” in order to replace the misleading term “exotic psychosis” (Yap 1962). This was to illustrate his observance that the Western world was not immune to “culture-bound” illness, e.g., “possession” states and “the unnamed condition referred to by Linton (Linton 1956 cited in Yap 1962) in which adolescent American girls swoon at the voice of a crooner” (Yap 1962).

Holmes, 1981; L C Garro, 1998a, 1998b; Hunt & Mattingly, 1998; Kleinman, 1978b, 1980, 1981; Mattingly, 1998; A Young, 1982; Allan Young, 1981). Anthropologists, philosophers of science and other feminist scholars have also addressed the popular sector influences on the professional sector of Biomedicine, especially concerning the role of metaphor (Eisenberg, 1977; Markel & Stern, 2002; Mühlhäusler, 1995; Scheper-Hughes & Lock, 1986; Skelton, Kai, & Loudon, 2001; Van Der Geest & Whyte, 1989). Emily Martin has studied the value laden metaphors used in biological text-books to demonstrate the persistence of popular sector values in ostensibly “objective” texts (E Martin, 1988). Susan Sontag has examined the expression of victim blaming in psychoanalytic therapy for cancer victims (Sontag, 2001). These researchers have demonstrated the rich field of meaning in the metaphor and overlooked significance of popular culture concepts in professional language. Thus, eliciting narrative from the popular sector provides data in the everyday language that can be analyzed for its relationship to cultural values and social relationships, which can, in turn, influence professional and folk sectors.

The Importance of Etiology, Rationality, and Hygiene in Africa

The Western literature on health in Africa spans a broad spectrum. It runs from accounts from colonial administrators and missionaries, to early anthropologists, to Biomedical and public health experts, to African Biomedical physicians, public health experts and later anthropologists. For the most part it has focused on either the

application of Biomedicine in Africa, communal health rituals, or the local expertise of folk healers. In the field of Biomedicine, the local beliefs, whether expert or lay, have historically been conceived of as obstacles to (Biomedical) healing (Schneider 2006; Manderson 1998; e.g., Launiala and Kulmala 2006; Pulerwitz 2006; Carothers 1953; Edgerton 1971). In public health this has also been the case. Local beliefs have been posited as obstacles to the dissemination of Western style hygienic practices that have come to be associated with Biomedicine, but actually stem from a period preceding germ theory (Burke, 1996; Hansen, 1999; McClintock, 1995). This is particularly been true in the colonial period.

Histories of anthropology in Africa vary greatly in describing the relationship of anthropology to colonialism (e.g., Kuper 1996; Moore 1994; Bohannon 1964). They range from the critically reflexive theoretical schools of social science that have contested the viability of grand social theory in the understanding human behavior, to the apologists who insist that, either anthropology is not accountable for the horrors of colonialism and criticism in any case is self-serving political correctness (see Moore 1994), or defend colonialism, itself, as a simple “misunderstanding” for which “no one is to blame” (see Bohannon 1964).

Anthropology was often valued for the colonial enterprise, but anthropologists often were not. Anthropologists frequently, in orthodox Malinowskian tradition, did not address social change, ignored the presence of colonialism and urbanization, and homogenized and reified the people they interacted with into bounded “tribal” units (A.

Kuper, 1996). There were exceptions that noted social change (although typically did not focus on it), attempted to address specifically the interaction of Africans with colonists and in urban situations, and identified exceptions to their generalizations (e.g., the Manchester School). Anthropologists, until acquiring regular academic sources of aid after WWII, were dependent upon colonial institutions and their imperial governments for most of their funding (Kuper, 1996). Thus, they spent a lot of their time arguing for the relevance of anthropology in solving the problems of managing colonies in Africa. As a result, early applied anthropology was a colonial enterprise (Pels & Salemink, 1999). However, anthropologists were not often utilized, and when they were, their efforts were often ignored (Kuper 1996).

Some anthropologists did describe the detrimental effects of colonialism and the changes wrought by European imperialism in Africa. On the other hand, no one fundamentally challenged the right of European nations to practice colonialism as a whole. For these reasons, anthropology was not quite a handmaiden of colonialism, although it wanted to be, and was not quite a champion of the African, although some wanted to do more than they, in the end, were able to do (A. Kuper, 1996). Although anthropologists have at times been accused of being “handmaidens” to colonial, Biomedical, or public health endeavors in this regard, much of early Africanist anthropology examined healing ritual as part of the anthropology of religion or magic (e.g., Evans-Pritchard 1940; Evans-Pritchard 1937). Healing ritual and expert perspectives were also examined as symbolic representations of local cosmology (e.g., Turner 1967).

The Study of Rationality in Africa

Byron Good has established the contrast between “belief” and “knowledge” in the social sciences and how their juxtaposition has enabled the examination of non-dominant perspectives to be contrasted with an un-reflexively examined scientific or Biomedical perspective positioned as reality (Good, 1994). This has historically been particularly true in Africa. Anthropologists examined healing practices, also as a part of religious perspectives, as a way of examining what they saw as alternative rationalities held by non-Western mind that did not have the cultural benefit of scientific philosophy (Edgerton 1966; Wilson 1970; Horton 1967; Horton 1993; Fortes and Dieterlen 1965; MacGaffey 1981; but see also Young 1982; Owusu 1978). The pre-modern anthropologists argued over the mental abilities, or rationality, of the “other”. This topic became further legitimized by being the inspiration for studies of magic, religion, ancestors, and witchcraft that continue today (Fortes & Dieterlen, 1965; R Horton, 1993; Robin Horton, 1967; Karp & Bird, 1980; Nemeroff & Rozin, 1994; Rosengren & French, 2013; Ruel, 1997; Wilson, 1970). The pre-moderns argued the extent that these “exotic” behaviors demonstrated “childlike”, irrational, “prelogical”, etc. The shift from uniform consideration of the African as mentally deficient came in two ways. One came when anthropologists like Evans-Pritchard argued that Africans had logical behavior when one took into consideration their cultural context (Evans-Pritchard, 1937). That is to say, ‘Africans are logical in the way Westerners understand logic, if their social environment is sufficiently understood’.

The other take on the question of rationality, made most extremely by cultural materialists, argued that African behavior is rational according to functionally materialist arguments (see Harris 2001). That is to say 'Africans are logical in their behavior when their physical environment is sufficiently understood, (however, their own explanations are often illogical)'. The first path, as might be expected, advocated seeking out emic explanation and experience, while the second path either effectively decried local views as ignorant, tolerated in the name of limited relativism, or 'translated' into a language the researcher could agree with, e.g., often as a 'poor cousin' of Western science (see Horton 1993).

A third way has also emerged, that is probably more closely related to the second. In order to avoid the exoticization of cultural landscapes, and how they affect the thoughts and behavior of their inhabitants, cosmological differences are simply ignored. This is often the case in public and international health anthropology, inspired by the Biomedicine-centric foreign aid organizations. A fourth way would be to not assume that African peoples' logics must be like Western logics to be rational. Instead, disbelief and "scientific" evaluation is suspended in order to simply understand the subject perspective on its own merit, not as "really" meaning anything that the anthropologist has the exclusive ability to perceive (e.g., Turner 1987).

With the shift in some sectors of anthropology away from the assumption of local perspectives as obstacles to improved health standards, or toward a sense of responsibility to the communities subjected to our attention, the focus on rationality

and cosmology shifted to a focus on understanding local health practices as functionally Biomedically effective practices indigenously conceived (e.g., Turner 1967; Janzen 1978) or as effectively ensconced local outreach that could be incorporated in development practices with Biomedical goals or joining with Biomedical practice (e.g., Vontress 1999; Asuni, Schöenberg, and Swift 1994). Lay practice, although famously explained by Arthur Kleinman as popular sector practices that overlap and inform all members of a community, (whether professional, folk or lay), has been under-examined for its role in influencing health practice, particularly hygiene, i.e., healthy living practices (Kleinman, 1980) (for an exception see Lau and Hartman 1983).

There may be several reasons for the under-examination of the health related popular sector. First, the study of health and healing practices by Westerners or Western style scholars proceeds from a focus on health rituals, usually performed by experts. Experts, whether professional (such as in Biomedicine) or folk (such as in many, though not all, African healing traditions), can often articulate their perspectives, their rituals and their guidelines. This is not always the case (see Pool 2003), particularly in the more idiosyncratic traditions where practitioners are selected through powers greater than themselves, rather than through apprenticeship or when lay practices have been largely taught from early childhood and learned through imitation, e.g., shamanic tradition.

The “common sense” practices, when actually common in a community, are often so common that no one has ever asked why or needed to be told. Therefore,

although everyone “knows”, they have a difficult time articulating it to strangers foreign enough to not have anything similar in their own culture that would allow them to simply “know” it. Finally, in the dominant cultures of the West, Biomedicine has a prestigious position. It is often regarded as determining what is “actually” wrong. As an example, what is required in our society in most cases for an excusal from work or school? The word of the sufferer? Or the note of a Biomedical expert? One may feel physically sick, but if the physician determines that one is not, than one may be regarded as shirking, or mentally ill. Likewise, the situations in which mentally ill people deny their illness but are treated on the word of the physician are almost cliché.

The Study of Hygiene in Africa

With this focus on the expert perspective, perhaps it is no wonder that studies of health in Africa, as well as everywhere else, have largely been focused on the perceptions of the folk and professional sectors. However, all illness begins at the popular sector (Kleinman, 1980) and the point at which one fades from healthy to ill is held at bay by the illness preventing tactics of hygiene. The word “hygiene” is strongly associated with cleanliness and sanitation. It stems from a minor Greek and Roman goddess of illness prevention (Hygieia: the daughter of Asclepius the god of medicine and Epione the goddess of the soothing of pain) and from at least the Victorian period of miasma theory, hygiene has been associated with the “civilizing” mission of Western colonialism, saving the primitives from their dirty cultures and morals (Burke, 1996;

Halliday, 2001; Hansen, 1999; McClintock, 1995). The name of the goddess derives from the Greek *hygies* meaning “living well”. In some societies, the hygienic practices may be largely dictated by its healing experts, but in daily practice, it is arguably more strongly influenced by the popular sector (Pinfold, 1999; B. Scott, Curtis, Rabie, & Garbrah-Aidoo, 2007). Hand-washing, for an example, is a practice aggressively promoted by Biomedicine and yet there is need for the extensive literature on the failure of even health professionals in health institutions such as hospitals to adequately do something as simple as washing their hands (Bloomfield, Aiello, Cookson, O’Boyle, & Larson, 2007; Curtis et al., 2003; Erasmus et al., 2010; Sladek, Bond, & Phillips, 2008).

Soap and washing have a particular significance in post-colonial Africa, providing another source domain to conceptualizing modernity. Anne McClintock describes soap as a fetish of the Victorian British Empire as an “icon of non-fetishistic rationality” from times preceding the advent of germ theory in biomedicine (McClintock, 1995). The ‘filthiness’ of the African, and his/her ‘need’ for the knowledge of hygiene and the technology for soap was seen as directly analogous to the ‘need’ of these ‘primitive’ people for the guidance of colonialism. Soap was one of the first commodities to exist as a British imperial monopoly and emerged alongside the mass-marketing forms of advertising that created the first consumer culture ideologies. It was also strongly associated with morality in colonial ideology (Burke, 1996). Timothy Burke states that “Soap had by that time been heavily promoted by colonial institutions connected with domesticity and hygiene as the material embodiment of their campaigns to produce ‘modern’ bodies and manners” (Burke, 1996).

The popular, or lay sector, beliefs and practices regarding health and healthy practices are an important and arguably underrepresented area of study in medical anthropology (Kleinman, 1980). Though often not articulated, the popular sector lays at the foundation of a society's cosmology, sense of fortune and misfortune, and may display the influence of trends and outside influence (Clouser & Houfford, 1993; Hughner & Kleine, 2004; Kleinman, 1980; Stainton Rogers, 1991). Experts of ritual and belief seek to exert influence over popular beliefs and practices, but may represent popular sector beliefs of an older period through habitus or episteme (Bourdieu, 1977; Foucault, 2002).

Conclusion

Study of the Maasai requires a reflexive awareness of presumptions in historical representations as they have often been portrayed as reactionary primitives. This continues today in the historicist narrative used by national development efforts as well as the local NGO of Losho. One of the founders remarked to me, as we were discussing my interest in studying the health issues of the community, "We need to bring them into the 21st century!" As illustrated by this quote, the metaphor reviewed above of development as movement through time, and the portrayal of Maasai as somehow incarnations of primitive predecessors of the West's modernity, still remain dominant paradigms in the language of development. This is particularly true in regard to behavior change campaigns that make assumptions regarding rationality, and a loaded

topic like hygiene that can be considered a Western fetish of modernity. That Western gaze, coupled with the Maasai cultural etiquette requiring a disclaiming of metaphysical knowledge or certainty had to be recognized and anticipated in the research design presented in the third chapter, as well as taken into consideration for the findings that will be presented in the fourth chapter.

Chapter 3 Designing and Applying Research in Maasailand

Introduction

This chapter presents the methods used for information gathering in this study, as well as their rationale. It begins with an overview of the goals of the research: identifying the popular health landscape of the Maasai in Losho. It goes on to explain the theory behind the primary data gathering technique of free listing. This section is followed by an overview of the fieldwork. In the next two sections, the dynamics of living in the field with a family as well as the role of translators in the collection of data is described. The iterative research design process that took place in the field is then presented. The chapter finishes with an assessment of methodological challenges met in the field and a conclusion summarizing the chapter.

Theoretical Assumptions

The design of the research for this dissertation was dependent on a set of specific assumptions. The first is that every day language used by community members can reveal deeper meaning about the community than what appears on the surface. Cognitive linguist George Lakoff (Lakoff, 1987) and feminist anthropologist of science, Emily Martin (E Martin, 1988; Emily Martin, 1994), have demonstrated through their analysis of everyday and scientific and professional language that metaphorical

understanding of physical and biological processes are both revealing and reproducing of ideological perspectives, often in extremely subtle ways. Every day discourse on the topics of hygiene will be influenced by these metaphors and thus can be examined in order to determine the health cosmologies of the members of the Maasai community. Further assumptions are outlined in the following discussion of Cultural Consensus theory.

Cultural Consensus Theory and Free Listing

In order to examine the popular health landscape of the Maasai in Losho, I spoke to people at every *enkang* about the most common and significant illnesses experienced in the community, their symptoms, causes, and potential for prevention. These interviews provided a significant amount of information about the worldview, or cosmology of the community. The questions used in the various interviews (see the discussion guides in the appendix) were designed in accordance to the assumptions in Cultural Consensus Theory. The responses were elicited primarily through a technique strongly associated with Cultural Consensus Theory, called free listing (Weller & Romney, 1988; Weller, 1984a).

Cultural Consensus Theory assumes that each member of a community knows something about each topic raised in the structured interview. In this case, the most common and significant illnesses of a community can be safely assumed to be a domain that each member of the community should have some knowledge. Weller and Romney

define a cultural or semantic domain as “an organized set of words, concepts, or sentences, all on the same level of contrast, that jointly refer to a single conceptual sphere. The items in the a domain derive their meanings, in part, from their position in a mutually interdependent system reflecting the way in which a given language or culture classifies the relevant conceptual sphere” (Weller and Romney 1988: 9).

The second assumption of the theory of Cultural Consensus is that the amount of correlation between members in their responses to questions regarding this shared domain indicates the “truth” of the perspective among the members. Another way to say this is that if most members agree that chameleons are dangerous, then the concept of chameleons being dangerous is “correct” for that community (Weller & Romney, 1988).

The technique of free listing is particularly ideal for establishing the parameters of a cultural reference domain. In this case, the reference domain elicited is of common and significant illnesses of the community. Unfortunately, Cultural Consensus Analysis was not possible in this data gathering. Cultural Consensus Analysis is a statistical analysis that creates a graphic representation of responses to illustrate the homogeneity or disparity of the concept within the community. This statistical analysis requires elicitation of responses from individuals for this type of analysis to take place (Weller & Romney, 1988; Weller, 1984a, 1984b, 2007). In my experience in the field, about half of the participants preferred to be interviewed in groups. In free listing, additional significance can be ascertained from the order in which the items are listed, not only

from the content of the list (Weller, 1984a). When there are multiple participants, this discernment is not possible to make. However, the technique of free listing is still a useful one for establishing the boundaries of a particular cultural domain. In addition to the types of illnesses, participants were asked to list symptoms used to identify the illnesses, typical causation of each illness, treatments for each illness, and finally methods of avoidance.

Fieldwork Overview

After my initial 6 week feasibility study, I entered the field with a multi-stage plan. There were 3 stages in total, the last one corresponding with 4 series of interviews (see table A below). The first stage was immersion into the language and daily living situation of the Purko Maasai of Losho. The second stage was walking throughout the village of Losho, visiting each far flung *enkang* to introduce myself and my project, as well as try to build up the rapport begun in my feasibility study visit. The third field work stage was the beginning of the 4 part series of interviews.

The first part of the interview series consisted was conducted with local Maasai adults to discuss their views of local health issues and the efforts made to combat them. The 2nd series of interviews was to interview the volunteers and employees of the non-governmental organization that worked at health promotion in the community. The 3rd series of interviews was to extend the interviews into the four surrounding villages, which had less contact with the main non-governmental organization centered in Losho

Primary School. The 4th series of interviews was to interview the biomedical health experts of Losho and the surrounding areas.

For inclusion in this study, participants were required to be adult in the view of the community (married with children). There was also an emphasis on recruiting female participants as primary care-givers to the immediate family, while men were represented as convenient. There was also a recruiting emphasis on senior elders (*iltasati*) as authorities on tradition in a patriarchal society. Again, the recruitment emphasized the inclusion of female elders as highly experienced authorities in home-based health care.

I spent most of my time extensively interviewing at every family and multi-family compound in the valley. I sampled randomly selected compounds from surrounding communities, as well as in a bordering location. The participants were all Maasai of the Purko sub-section, of several clans in that section. They were all locally recognized as adults, from *siengiki*: circumcised girls recently married and having few or no children yet, to *iltisati*: senior elders who were most likely great grandparents.

Fieldwork with Family

I found suitable housing for my family and myself near a centrally located *enkang* and the only latrine in the village outside of the primary school compound. It was down the hill from a potable water supply (a capped spring next to the primary school) and yet

separated from the non-governmental organization by enough distance to help my effort to be perceived as separate from that organization (see illustration A).

My wife and two children provided a usefully contrasting perspective to my own. As non-anthropologists, they did not have the professional obligation of constantly struggling to maintain objectivity and would speak frankly about how they were experiencing life in the field. My 8 year old son was an enthusiastic participant in the life of a Maasai boy. He regarded his work as a herd boy quite seriously and was unflagging in his efforts to assist the men (he did not have this enthusiasm about being home-schooled). Although he did not speak any Maa or Swahili, he communicated well enough with the other boys that he would come home each day eager to tell us about the games they had invented and spent the day playing. His take on the perspectives and experiences of the other small boys was an insightful addition to my own observations and participation. My wife was able to interact with the local women and children in ways that were not as easily accessible to me. Though burdened with an isolating level of housework and childcare while I wandered about with the translator, she also provided me with insight as to how the neighboring women perceived us as a family. My daughter, at 4 years old, was kept close to home but also was a constant assistance with her relentless joy of life.

Translating Research

When I had collected interviews from every *enkang* in Losho proper (total of 19), I conducted interviews in English with the NGO workers. Then I trained a new translator who was a respected member of the surrounding villages. There were four major villages in the surrounding area and I conducted five interviews in each collection of *enkang*. At this point, I redesigned my interviews and began approaching the health professionals in the nearby small towns, *Megwara* and *Oloolaimutia*, as well as the nurse at the Losho clinic, all of whom I was able to interview in English and Swahili and therefore did not require a translator.

After the interviews with local Maasai community members, which required the use of the two translators, I hired and trained a young woman who had been working as a translator and preschool teacher for the NGO to transcribe and translate verbatim a randomly selected set of interviews done in Maa. This was to ensure the validity and reliability of my previous translators in their work interpreting for the interviews. Her work demonstrated that the first two translators had been effectively translating my questions to the Maa speaking participants, as well as effectively translating their responses back into English. The young woman who performed this work was not from the Siana Valley, but from a different Maasai community. Her work with the NGO had given her a fluency in the local dialect.

Developing Strategy in Losho– In Consideration of Initial Findings

Once in the field, I commenced my research with participant observation as well as systematic data gathering associated with cultural consensus modeling (Michrina & Richards, 1996; Trotter et al., 1999; Weller, 1984a, 1984b, 2007). Cultural consensus modeling requires interviews with individual participants. This made true consensus modeling impossible, as most participants were not comfortable being interviewed by themselves. However, the interview method of free listing, was an important and useful in eliciting a discussion of the local health landscape. Although the results could not be subjected to statistical analysis, the results were represented well in the subsequent frequency tables.

The first step of the field work strategy used in the field (and one to be continued throughout my fieldwork) was to develop and encourage rapport. This was done by visiting various homes throughout the area in order to introduce myself and my family, and my purpose for being in the area. This necessitated the hiring and training of interpreters. The second step was to map the Losho community to understand how the population was laid out, and therefore develop a geographically based sampling system (see map A). The third step was the development of a set of open ended questions for a semi-structured interview or focus group session. The fourth step was data collection through the implementation of the interviews, with staged redesigns to triangulate responses as sampling areas increased. This was simultaneous to detailed note-taking and journal keeping for data gathered through participant observation. The

fifth step was the cleaning and coding of the data in the form of transcribed interviews, journal entries and written up field notes. The final step was the interpretation of the gathered and processed data.

Designing Interviews: Questions and Strategy

As an iterative data-gathering process, the interview questions were redesigned over several stages, focusing on arising topics and triangulating on information provided in early interviews. The 4 interview series were: the 30 interviews in Losho proper, the 16 interviews with the volunteers and employees of the main non-governmental organization of the area, the 20 interviews in the four nearest neighboring communities in Siana Valley, and finally the interviews with the health professionals of Losho and the surrounding areas.

Near the end of the data-gathering portion of the Siana Valley field work period with Maasai lay people (the 3rd interview series), a summary of the themes emerging from the 1st series of interviews was used to supplement the interview question set as it evolved into a focus on the understood vectors and causality of common illness. The summary utilized the results of the systematic collection focus of the early series of interviews and allowed the conclusions to be verified in the 2nd series of interviews in a format that remained open ended for further explanation by participants. If responses were given that were unexpected in relation to earlier interviews, they were followed by probes for further information. This was also the case in situations in which the

participants laughed, demonstrated incredulity or any other forms of emphatic response. Generally this elicited further discussion of what could or could not cause illness, which at times became quite lengthy and taxing to the interviewee.

Defining the Health Domain: Interviewing the Community

The initial set of interviews were designed to allow the participants to establish what they saw as the most common and significant illnesses affecting their community. In other words it was an elicitation of a profile of the health and illness landscape as perceived by the average adult of the local community. The interview began with a free list of health problems. After this list was made, noting the order in which the illnesses were mentioned, the participants were asked to describe the symptoms of each illness. Subsequently they were asked to describe the causes and treatments. At first I also asked them what were general methods to stay healthy and avoid disease, but there seemed to be difficulty in the participants understanding the question. I changed the format to asking for specific prevention techniques for each listed illness in turn. This did not yield up much of an advantage.

The initial set of 27 interviews also included questions about folk-tales, songs, and proverbs. These, along with poetry, are known in Kenya as oral literature (Akivaga & Odaga, 1982). Oral literature has been considered a common form of instruction for cultural norms and values in many societies especially when there is a high level of pre-literacy. However, the participants had difficulty understanding the nature of my

inquiries and although the people in this area were in the majority illiterate and few have finished the available national schooling, they generally denied the use of folk tales, whether for teaching or not. Because the goal of the question was to determine methods of teaching appropriate behavior, specifically related to health, the question was changed to asking directly how these types of lesson were taught in the community.

Losho Community Sampling

Sampling, like all other aspects of data-collection, was carefully considered for multiple dimensions. In addition to seeking data unbiased by the method of collection, I was also concerned with protecting the privacy of the local people and the confidentiality of their choice to participate or not to participate, as well as not contributing to any local micro-politics by seeming to favor certain families over others. I wished to select participants as randomly as possible, but was limited by specific constraints. One constraint was access. Men often travel with the livestock as they go out to remote areas to graze and were widely dispersed. Women generally work in and around the *enkang* and therefore were easier to locate. Besides this issue of access, the women are generally considered primarily responsible for the health of their immediate family, particularly their children. As such, I sought to represent them more completely in my sample. I also represented fathers as much as possible, although their participation was much more opportunistically recruited. Elderly men and women were also found in small groups around the *enkang*, often napping in the shade or basking in the sun. Occasionally middle-aged men, wrapped head to foot in their *orblanketi*

(blanket) would also be in groups, at some distance from the noise and bustle of the *enkang*, sleeping off hangovers from the local home brew. I attempted to engage each group as often as I could.

Because there were only 19 *enkangs* in my initial data collection population (the Siana valley), I decided to visit them all, in random order (generated by drawing pre-assigned numbers from a hat). I would approach the adult members of the *enkang* who met my criteria and would explain to them, through my interpreter, the nature of my research. I continued by explaining the nature of their potential participation. If they were interested in participating, we would either join them where they were already seated or move to a nearby location that was considered comfortable by the participant or participants. Often they were at work, minding children, doing beadwork, repairing their homes or engaged in domestic tasks within their homes. Additional participants might step in or out of the interview, participating or observing as they liked. There was no particular concern for privacy, both because of the nature of my described research, i.e. their opinion of health issues in the community, and the nature of the family compound and village life as a place where privacy was very difficult to maintain and privacy seeking behavior was likely to attract more attention than otherwise.

Contrasting the Maasai Health Domain with the Western Development Perspective: Non-Governmental Workers

The second set of interviews was with the workers of the non-governmental organization that has been a presence in the Siana Valley for more than a decade. The workers were predominantly undergraduate college students who were volunteering their time in a form of development tourism. The purpose of this series of interviews was to underline through contrast the unique perspectives of the local community in regard to their health landscape as well as to evaluate the influence of the long term presence of this Biomedically and public health oriented organization on the locally held perspectives. Finally, it helped reinforce awareness of my own perspectives and assumptions as a fellow Westerner by generally presenting an exaggerated view as a result of their short term exposure to the local community.

NGO Workers Sampling

Because this series was focused on a small community of influential foreign nationals, the goal was saturation, which I believe I achieved with the 17 interviews and participant observation.

Re-Defining the Health Domain: Revisiting the Community

This 3rd series of interviews was designed to explore the themes that were emerging through the health and illness landscape profiled in the first series of

interviews. Like the first series of interviews, also conducted in Maa through a translator with local Maasai community members, this series approached community members at their home *enkangs*. The *enkangs* selected were from the villages surrounding the original set of *enkangs*. They were essential an extension of the original target community, by sanguinal and affinal kinship.

Surrounding Communities Sampling

This interview series, a revisiting of the greater local Maasai community, utilized a sampling strategy identical to what is described above in the first series of interviews. The *enkangs* of the 4 communities surrounding the original location were mapped out by my translator (see maps B, C, D and E). They were then enumerated so that they could be selected at random. We then proceeded to approach 5 randomly selected *enkangs* within each community and conduct 1 interview at each location with the first individual or group of persons who met the participation criteria and were willing to participate after having the research explained to them.

Contrasting the Local Health Domain with Kenyan Biomedicine: Siana Valley Health Professionals

The 4th series of interviews had two goals. The first was to evaluate the relationship between biomedical professionals on the popular perspectives of members of the local Maasai community, and vice versa. The second was to evaluate the

similarities and differences between the health perspectives between these Kenyan professionals, the foreign NGO workers interviewed in the 2nd interview series, and my own potential assumptions about what constitutes “biomedical perspectives” in case I was presuming a correspondence that did not really exist between the biomedicines.

The health professionals approached for participation in this series of interviews were Ministry of Health employed nurses at government dispensaries, chemists in local shops, and private clinicians. The nurse stationed at the new dispensary in Losho, was the only Maasai professional in Siana Valley, although he was from another Maasai area he spoke a similar dialect and was able to converse easily with the Losho locals. The three other nurses employed by the Ministry of Health in the area were located in the slightly larger neighboring towns.

Biomedical Health Professionals Sampling

The final interview series was conducted with the biomedical and public health professionals of the Siana Valley. This population can be divided into trained employees of the Kenyan Ministry of Health and private clinicians and chemists/ chemist shop employees. These two groups are widely considered influential representatives of biomedicine in the local community. All Ministry of Health employees in the area were interviewed (three nurses, a pharmacy technician, and a US Peace Corp Public Health Extension volunteer working with the Ministry of Health), as well as a private clinician from a large clinic (who was also an employee of the Ministry of Health at a hospital in a nearby city) and two chemist employees.

The purpose of interviewing these participants was to evaluate the influence of biomedicine conducted by or closely with Kenyan nationals, as well as the Kenyan government. Utilization of these biomedical resources was very highly reported among Maasai community members and therefore had the potential to be very influential in their perception of the make-up of the local health and illness landscape.

Methodological Challenges

Changing methods and adapting strategy while in the field are, of course, important steps to take in any field work when faced with changing or unexpected conditions. There are always un-anticipated extenuating factors that must be dealt with and adapted to as they arise. In this case there were both methodological issues and local micro-political issues that caused me reassess and redesign my data collection as well as to successively hire and train a total of four different translators. Additionally, because of my limited *Maa* language skills, I was hampered in my ability to monitor how my translators may have affected the reception of inquiries and presented to me the participants responses. In order to verify that the questions were being worded appropriately and that responses were being relayed to me reliably, I hired a formally educated Maasai woman who, although from a different community, had experience with the greater Losho region dialect, to review a representative cross-section of interviews on these points. Additionally, I conducted interviews with Westerners and Kenyan medical professionals directly in English or a mixture of Swahili and English.

The first research design also was made up of three parts. The first would be direct interviewing and participant observation. The second part would be learning Maasai and examining everyday language for idioms expressing common reference domains for understanding health and illness. The third part was to be the collection of “oral literature”, which is the Kenyan term for oral traditions and practices, including poetry, songs, folktales, jokes, riddles, etc.

This quickly proved to be overly ambitious. *Maa*, the language of the Maasai, is an unstandardized language. It has very little grammar books, dictionaries or other educational texts published on it, most of those which do exist are quite old, and each having their own idiosyncratic orthographies. It is also a tonal language belonging to the Nilotic family, a very far cry from the Swahili that I have learned over the years. In addition to this, there were very few people in the valley who were capable of understanding, much less explaining, the nuances of grammar that contrasted in the languages of English, Swahili, and Maa. Despite intensive efforts during the year of my first stay in Maasai land, my abilities to converse did not extend beyond a rudimentary level. This, obviously, helped me with rapport immensely but not with language analysis. Additionally, there was a seemingly inexplicable reluctance to relate oral literature. I was told variously that it was no longer used or was never used (to their knowledge) to teach lessons of behavior, especially not regarding hygiene. When there was someone who claimed to be aware and able to relate tales of folklore, they would be later reluctant to meet me regarding providing examples of it. There were complex

local politics at work, with my landlord in the thick of it, which effectively shut down this potential line of data gathering.

After completing the 6 stages of fieldwork research, I returned to the United States. At this point I reviewed all notes and transferred them onto computer files. I reviewed all of audio files of the interviews and transcribed relevant portions. The interviews were coded with a priori and open ended coding based on emerging themes. The responses to the survey style questions of the first 27 interviews were assembled into frequency tables. At this stage the findings were ready for further analysis and assessment in relation to the literature reviewed in chapter 2 in order to understand and present the essential components of the common health landscape shared by the members of the Purko Maasai community in the Siana Valley.

Conclusion: From Collecting and Cleaning to Identifying Results

This chapter has presented the methods used to define the popular sector health domain in Losho. It has described the various stages of research and how they were iteratively redesigned in the field to ascertain the dimensions and content of this reference domain in the form of illnesses and the associated identification, causal attribution, treatment, and avoidance behaviors, or hygiene.

There is a certain paradox in asking questions in interviews about behavior, particularly about behavior like hygiene, which is often given a moral value. Direct

observation is more informative in providing details of lived behavior. In responding to a question about behavior, it is to be expected that an informant may wish to represent themselves well and avoid embarrassment. In cases where the researcher has prestige or influence, the participant may wish to please the researcher with his or her response. Finally, there is a limit to memory that is also affected by ideal conceptualizations, and what one recalls as one's "typical" behavior, may in fact be more of an ideal. However, idealized behavior can be valuable as well in revealing concepts of behavior related reasoning.

This research, in the format of what is done typically, or hypothetically, in the circumstances of common and significant illnesses is well-served by both typical and ideal responses that describe behavior. In the next chapter it will be shown that the most common responses received in these interviews fell clearly into categories that symbolically represented the relationship of the Maasai with the creator god, *Enkai*. The type of response itself is significant and revealing behavior, as we shall see in the 5th chapter when the "I don't know" or 'non-response' response is demonstrated to represent the cosmological premise of etiological agnosticism in regard to the plans or designs of *Enkai*.

Chapter 4: *Emoyano*: Common and Significant Illnesses among the Maasai in Losh

Introduction to General Results

The local shared health landscape of the Maasai community is perceived to be dominated by 5 illnesses: *oltikana*, *olkirobi*, *nang'ida*, *lemunya*, and *taifoid*. Although 24 illnesses were listed in the free listing exercises of the first 27 interviews, the aforementioned five illnesses are the only ones which were listed in over nine percent of the interviews. The discussions of causation and prevention in these interviews, though initially frustrating, were consistent in their representation of dynamics involving the mystery of divine providence, aspects of the rainy season, and aspects of the cold air, or wind.

This chapter will present the responses to the interviews conducted in Losh and analyzed with the benefit of insights derived from participant observation and 3 other series of interviews undertaken in surrounding villages, with Westerner development organization employees and volunteers, and nearby Biomedical health professionals. The information collected throughout this fieldwork was reviewed and coded. Audio recordings were reviewed and relevant portions transcribed. The responses to the 27 health landscape interviews were arranged into tables below and then discussed.

Tables and Their Significance

The following tables, and others in the appendix, were constructed from 27 of the 30 interviews that took place in the original location of Losho. The three unused interviews were disregarded for the tables because they were explorations of a different format of interview.

The 27 interviews used for the tables were focused on eliciting the common or significant health problems affecting the community, as perceived by the participants (see the first interview series research guide in the appendix). The local community members were asked to list the common or significant illnesses of the area and then to describe the symptoms or signs used to identify the health problems. Subsequently, they were asked to describe all known causes of the health problems, as well as their treatment and methods of prevention, if any.

Additionally, the participants were asked to discuss any efforts that were being made in the community to address health issues, whether driven locally, nationally, or internationally. There was also an effort to determine how the socialization of health behavior values in children, but this proved to be an unfruitful line of inquiry. Most respondents replied that children were taught only by using a switch and that folk tales were not used anymore. When asked whether “old times” were different in terms of the illness burden, most stated that it was worse now. They explained that there were now many diseases that did not exist in the past, and that the new illnesses required new behavior, e.g., herbs did not work as they once did. At the same time there were

those said that it was better now, and in the past Maasai “just died” without knowing why, and that herbs were not available in those days.

Common or Significant Health Problem Listing

Table 1 Percentage of Interviews Listing Each Illness

Percentage of Interviews (n=27) Listing Each Illness	
Illness Name/ ostensible English translation (24 in total)	N=27 (%)
<i>Oltikana</i> / ‘malaria’	25 (92.6)
<i>Olkirobi</i> / ‘a cold’	24 (88.9)
<i>Nang’ida</i> / ‘brucellosis’	12 (44.4)
Lemunya/ ‘pneumonia’	10 (37.0)
<i>Taifoid/Emoyano engoishuwak</i> / ‘typhoid’	10 (37.0)
<i>Kuendesha ortumbo, olodoto engoshoke</i> / ‘diarrhea’	9
‘Eye problems’ *	9
<i>Tibi</i> / ‘tuberculosis’	6
<i>Orbaie</i> / ‘gonorrhoea’	5
<i>Tetamaji / musanduku</i> / ‘chicken pox’ (the italicized are Swahili terms)	4
<i>Norubat</i> / ‘joints’	4
Respiratory system problems (including <i>aasima</i> ’asthma’)	3
‘Mouth problems’ *	3
‘Ear problems’ *	2
<i>Olkurto</i> / ‘worms’	2
HIV	1
Allergy	1
<i>Emporoto</i>	1
‘Teeth problems’*	1
<i>Normawei</i>	1
Measles	1
<i>Nalopone</i>	1
<i>Enkeeya ekoriang</i> / back problems*	1
“Maasai illness” flies in chest	1

When asked to list the health problems that they saw as common or significant, the participants responses were written verbatim, that is to say, if they mentioned a Maasai name there was no assumption that this was the equivalent of what the translator considered the English translation unless indicated by the participant (see above table 1). This was to avoid etic assumptions of Biomedical meaning associated with the health problems listed. In one circumstance, a middle-aged woman did indeed make a distinction between *oltikana* and 'malaria', the ostensible English translation. However, this was the exception. In other cases, the English term was more prevalent, e.g., typhoid and pneumonia. However, as the participants understanding of these illnesses were different than the Biomedically defined entities, I have represented them phonetically, to represent their similarity while allowing for emic meaning, e.g., "*taifoid*" for typhoid, "*tibi*" for t.b./tuberculosis, and "*lemunya*" (the common, but not exclusive, pronunciation) for pneumonia. Other health problems were represented with a general expression, such as "eye problems". These vague terms are commonly used euphemisms for more serious illnesses as well as health problems that did not have specific names. If the participant was able to provide a more specific term, it was listed as such.

There were also terms for which I was unable to find translations or more descriptive information, from my translator, other participants, or the little literature available on the Maa language of the Maasai. This may have been a result of an error in initial transcription, an obscure problem, or most likely, the participant "enjoying" the researcher. Fortunately, this teasing did not occur too often, as represented on the

table. Usually I would not become aware of the ruse until later. For example, at one point I was trying to compile the herbal treatment responses I received during the domain establishing interviews. I had then an opportunity to interview a friendly old man, who was not only interested in documenting his knowledge of traditional treatments, but was also a practicing *laibon* and therefore had knowledge of that sphere of remedies. During an interview, I recited to him the list I had made, asking him the most common purposes to which they were used. At one point he became concerned and told me that the word that one respondent given me as a typical herb, actually meant only “stones”. I am sure that was the source of unexplained laughter in previous interview encounter, but as any experienced fieldworker can tell you, being laughed at is part of the job, and it did not set off alarms for me. This experience, combined with potential influence of my landlord (discussed above in relation to corruption) was the catalyst to have the interviews reviewed by a third party fluent in Maa, for integrity in translation.

Some terms used locally, such as HIV, have Maasai translations but they were not used during my fieldwork. In the case of HIV, this is most likely a result of the term being raised by only one participant, as the Maa translation is a fairly well-known term, *bitia*. The listing of *tetamaji/msanduku*/chicken pox was an unusual situation as the first terms are actually Swahili, rather than Maa, and *msanduku* translates from Swahili as “box” (this is possibly a misheard translation from the English “pox”). I was unable to find a specific term in Maa for chicken pox, despite being told by the NGO workers that there was a large break out at the Losho primary school.

Symptoms

The symptoms listed in the descriptions of *oltikana*, *olkirobi*, *nang'ida*, *lemunya*, and taifoid were varied, but the most commonly listed symptoms of each illness strongly corresponded with many of the characteristic physical symptoms used to diagnose their ostensible Biomedical counterparts (see tables 17-22).

Oltikana is commonly translated as malaria. The Maasai participants had a high rate of agreement for the symptoms of fever and headache, which are two symptoms also commonly used to diagnose malaria in the rural Biomedical clinics referred to as "sipitali" by the Maasai.

Olkirobi is commonly translated as the common cold. Like the symptoms associated with "a cold" in the West, the symptoms most commonly listed by the Maasai participants were sniffing or runny nose ("hissing"), and coughing.

Brucellosis is the common translation of the Maasai term *nang'ida*. The Biomedical entity of brucellosis is characterized by back pain and painful and swollen joints in chronic cases. Likewise, the Maasai participants mentioned these symptoms most frequently. However, the Maasai participants did not make a distinction between initial and chronic symptoms. If, indeed, the illnesses are the same, this would make sense, as the Biomedical description of the initial symptoms to be similar to a flu or malaria, and thus may be diagnosed differently at that stage by the Maasai.

Lemunya, the Maasai illness entity commonly considered by English speakers to be translated as pneumonia, is characterized by the Maasai with general symptoms of coughing, difficulty breathing and pain in the ribs. This would potentially correspond with a Biomedical diagnosis of respiratory infection.

Finally, taifoid, the illness entity that is translated ostensibly as typhoid, is described as being typically recognized with the symptoms of noisy intestines, no appetite, diarrhea, and vomiting. The local Biomedical authorities also used severe diarrhea and vomiting and dramatic stomach turbulence to diagnose typhoid, but it was also difficult to distinguish from cholera. Although giardia shares similar symptoms when person is initially infected, as the local population is continually exposed to it through the local water sources, a higher tolerance is widespread.

Causes

Local etiology is an area that often varied from Biomedical reasoning in interesting ways. There seems to be a bit of uncertainty, or at least overlap, between the various types of causes given for the five illnesses by Biomedicine. Dirtiness of various types, contact with certain types of insects, either directly or through food, and the consumption or contact with water or milk without boiling, or when they had become contaminated in some way were commonly given across the board. Another consistent set of responses, although not quite as frequent, were references to Enkai, the will of Enkai or that only Enkai could know the answer. This includes basic

disavowals of knowledge in regard to a cause. In addition to these responses were causes that made reference to coldness, particularly associated with wind and rain. These responses were grouped around concepts of the rainy season and of a specific term for cold wind/air, *enkijebe*. These patterns of causes listed for these most common and significant illnesses are associated with symbols representing central premises of Maasai cosmology, as will be discussed in the fifth chapter.

Table 2 *Oltikana* Cause Listing Frequency

<i>Oltikana</i> Cause Frequency (12 causes listed in 25 interviews)	
Causes	N=25 (%)
Unboiled milk	16 (64.0)
Mosquitos	13 (52.0)
Houseflies	8 (32.0)
Stagnant water	6 (24.0)
<i>Maiyolo</i> ("I don't know")	3 (12.0)
From <i>olkirobi</i>	3 (12.0)
Dirty plates	2
<i>Olari</i> ("time of rain")	2
Cow dung	1
Unswept house (brings flies)	1
Contact with mucous	1
<i>Enkijebe da Enkai</i> ("Wind/will of God")	1

The causation of *oltikana* was most frequently associated with consuming unboiled milk or water, or some sort of contact with flies or mosquitos, or a combination involving insect contact with milk or water. In addition, there were also disavowals of knowledge, references to dirtiness, and aspects of the rainy season and *enkijebe*.

Table 3*Olkirobi* Cause Listing Frequency

<i>Olkirobi</i> Cause Frequency (16 causes listed in 24 interviews)	
Causes	N=24 (%)
<i>Enkijebe</i> (cold wind/ air)	17 (70.8)
Contact with flies and/or animals	5 (20.8)
Dust	4 (16.6)
Coldness	3 (12.5)
Cold rain	2
Sharing cups with someone affected	2
Being near someone coughing	2
Just <i>Enkai</i> ("God")	2
House flies coming from feces	1
Cold bath or drinking cold water	1
Smell of flowering trees	1
Smell of rotting animal carcasses	1
Drinking stagnant water	1

The causes listed for *olkirobi* were strongly associated with cold wind/air, specifically stated as "*enkijebe*". It is important to note that "*enkijebe*" is not the only way to say cold wind/air in Maa, but the alternative, "*osiwo kirobi*" was not used, as far as I was able to discern, even in reviewing the audio recordings.

Table 4*Nang'ida* Cause Listing Frequency

<i>Nang'ida</i> Cause Frequency (8 causes listed in 11 interviews)	
Causes	N=11 (%)
<i>Maiyolo pi</i> (" I have no idea")	6 (54.5)
Unboiled milk	3 (27.2)
<i>Enkijebe</i>	2
<i>Olari</i> ("time of rain")	2
Only God knows	2
Walking in wet places	1
Poorly roasted meat	1
Smokey meat	1

The causes listed by the participants regarding *nang'ida* were the most highly associated with a disavowal of knowledge. Second to this came the Biomedical explanation of consuming unboiled milk. It was not uncommon for the milk response to be given as an explanation told to the participant (s), and then followed by the disavowal. It seems to indicate the influence of Biomedical teaching, but not necessarily local uptake. The sentiment was explained to be that Maasai have consumed unboiled milk for a long time and this *nang'ida* is a new thing. If it was really the cause, would they not have always had it? And why is it that many people who do drink unboiled milk do not fall ill?

Table 5 *Lemunya/ Pneumonia Cause Listing Frequency*

<i>Lemunya/ Pneumonia Cause Frequency</i> (4 causes listed in 11 interviews)	
Causes	N=11 (%)
<i>Enkijebe/ cold wind</i>	10 (90.9)
Bathing in cold water	2
Cold rain	1
Germs in air/ from wind	1

Lemunya, was described as being caused by cold and/or wind/air. There was mention that this perspective was shared by the local Biomedical authorities. This may indicate the extent of Biomedical teaching and influence on the community, but it is important to note that uptake is much higher than the cause of unboiled milk for *nang'ida* taught by the Biomedical experts. This may suggest that the local agreement

with cold wind, in addition to its specific interpretation as *enkijebe*, is a result of its resonance with local perspectives.

Table 6 *Taifoid/ Typhoid Cause Listing Frequency*

Taifoid/ Typhoid Cause Frequency (9 causes listed in 10 interviews)	
Causes	N=10 (%)
Dirty, untreated water	5 (50)
Maiyolo (“I don’t know”)	3 (30)
Dirty food	2
Dirty things (e.g., utensils, water)	1
Dirty hands	1
Bad/ old food	1
Advanced <i>oltikana</i> entering intestines	1
<i>Enkijebe</i>	1
There is no cause	1

Taifoid is described most commonly in a way that corresponds with the Biomedical perspective. It is an illness that is Biomedically associated with water contaminated by infected feces. As a result it is considered to be caused by the lack of latrines in the area. Another factor would be the increased population density and sedentism that has occurred in the local community. Thus, this reasoning would support the Maasai perspective that it is a new illness in their population.

The other listed causes, dirtiness of various types and bad food, can also be attributed to Biomedical perspective. The disavowal of knowledge comes second to dirty water, and can be associated with *enkijebe* and “there is no cause” (in the sense, ‘it just happens’). *Enkijebe* is part of an expression, “*enkijebe e Enkai*”, meaning “God’s

air". It is an expression that means "random", because of the mystery and unpredictable nature of divine providence.

Treatments

As stated in the second chapter, the therapy practices among the Maasai have been extensively studied and as a result are not the direct focus of this study. Virtually all participants mentioned that they would go to the *sipitali* or local health clinic if any illness seemed serious or had not responded to readily available herbs. While at the beginning of my fieldwork, the nearest full-time clinic was a walk of about 2 to 3 hours away, while I was there the local NGO was able to get a building that they had built staffed by a government nurse and so biomedical treatments for most issues were readily available. Two health problems *olkurto*, or worms, and a unique illness referred to as "flies in the chest" were referred by 2 participants respectively as "Maasai illnesses". *Olkurto* was listed by two participants, one who described herself as a specialist in treating the illness and another who said that it was easily treated by readily available and well-known herbs. "Flies in the chest" was listed by only one Maasai participant, although I had heard of it before in a casual conversation with an NGO volunteer. The Maasai participant, a grandfather who was incidentally also a bonesetter and sprain specialist for the community, did not claim expertise in treating it, but explicitly stated that it was "not understood at the *sipitali*" (Ole Mbatieny, male senior elder).

When asked treatment options for the health issues listed by the participants, most responses were “*sipitali*”, i.e. ‘hospital’. By this, the participants were referring to Biomedical services provided by the government nurses at newly established Losho health clinic and the long established clinic located within the primary school campus in Megwara. The participants also included workers in the private clinics located in Megwara and Oololaimutia town, who provided Biomedical medications and treatment, often by moonlighting government health workers. These clinics were commonly referred to as “*sipitali*” and the workers there as “*daktari*”. When I pressed them for all options, they would include Maasai treatments. Occasionally, when initially asked for treatment options for a particular health problem, they would ask “*sipitali*” or “*olchaani?*”, meaning in this context ‘Biomedical treatment’ or ‘Maasai treatment’. *Olchaani* literally means ‘tree’ or ‘wood’ in Maa and is also used to refer to the use of plant material for healing.

When discussing treatment of the most common illnesses, except going to the “*sipitali*” if all else fails, there is also a variety of *olchaani* treatments. As herbalism is the most common first step in popular sector health care, and knowledge of herbalism is quite widespread among members of this community of the Maasai, it is curious that the responses, even in terms of herbal treatment, are not more consistent. This issue of intracultural variation in lay and folk medical knowledge has been noted in the literature (Linda C. Garro, 2012). The variation of herbal treatments for particular illnesses in this community may suggest that the types of treatments listed may in fact match the variety of symptoms that may be regarded as characteristic of these illnesses. In other

words, the treatment may be addressed more in response to the symptom, rather than to the illness as a distinct entity. In this possible situation, the taxonomy of illnesses could be less important than symptom clusters. It may be that instead of healing being a practice instrumented by a healer or a medication, it is the management of symptoms that would allow a body to heal itself, or even to allow a person to more comfortably endure while one's fate comes to pass, as decided by Enkai. Foley describes "waiting for God" in Cameroon where sick people who have run out of options simply wait to see if they get better or die (Foley 2009). Two participants informed me, "If you tried to avoid that, it is only for Enkai to bring another way" (Olonana and Senteu, 2 elder men). This sentiment will be addressed instead in an examination of etiology in the Analysis chapter. As mentioned above and in the Literature Review chapter, Maasai herbalism has been addressed extensively in the literature and lies outside of the scope of this current work.

General Hygiene: Health Maintenance or Illness Prevention

Table 7 General Maintenance/ Prevention Listing Frequency

General Maintenance/ Prevention Frequency (27 methods/responses listed in 23 interviews)	
General Hygiene Methods	N=23 (%)
Balanced diet	7(30.4)
Clean body (2 of whom noted it “helps little”)	7(30.4)
Herbs for strength	6(26.0)
Stay warm/ Avoid <i>enkijebe</i>	5(21.7)
<i>Maiyolo</i> (“I don’t know”)	4
Keep compound and house clean to avoid flies/insects (1 noted “flies come anyway”)	4
Regularly drink clean/treated/boiled water	3
Wash hands	3
Bug spray for flies/ mosquitos	2
Clean utensils properly/things of kitchen	2
Distance from animals	1
Cutting grass	1
Herb <i>iseketek</i>	1
Avoid drugs (bad, old, <i>banghi</i> /marijuana)	1
Herb <i>olorien</i>	1
Breast feed	1
Not possible (specifically for children because of contact with sick children)	1
General cleanliness (“maybe”)	1
Avoid dirty clothes	1
Advise your neighbor to be clean (maintain clean environment)	1
Stay alone, avoid people	1
Special sheep and herbs meal	1
Clean food	1
Special goat soup with herbs	1
Boil milk	1
Brush teeth	1

Most participants simply scoffed at the notion, or struggled to think of behavior that a person could engage in to maintain health or prevent illness, sometimes seeming to try to recall the behavioral prescriptions of Biomedical authorities, school or NGO projects. It was at this point in the conversation where people would be most likely to

tell me that health problems “just come”, that they are not like vehicles coming down the road, where you could see them coming and get out of the way. Illnesses cannot be predicted. I would try to probe for reasoning by asking them whether avoiding the specified behaviors that they had previously listed as causing specific illnesses. The response to these probes was usually agreement that it “could help” but with a qualifier to remind me that nothing was certain. I was told several times, “Yes, washing your hands can help. But help little. There are those who never wash their hands, and they do not get sick. There are also those who always wash and they do get sick” (Nashipae, junior elder woman). When I asked why the ones that did not wash remained healthy, I was given the same explanation, “They are just used (to it), if you are not used you will become sick. If you are now washing, it is a must to continue” (Nashipae, junior elder woman).

Illness Specific Prevention

Unlike illness listing, and the listing of symptoms of those illnesses, or even the listing of possible treatments of each of those illnesses, the responses to the request for participants to list prevention behavior for the illnesses that they considered most common and significant in the community were very often met with disavowals of knowledge.

Table 8

Oltikana Prevention Listing Frequency

<i>Oltikana</i> Prevention Frequency (12 methods/responses listed in 19 interviews)	
Methods of Prevention	N=19 (%)
Boil milk	12 (63.1)
Can't avoid	4 (18.1)
Maiyolo ("I don't know")	4 (18.1)
Boil water (1 of whom volunteered that "It helps little")	4 (18.1)
Only God decides	3 (15.7)
Use a bed net	3 (15.7)
Bathe to avoid flies	1
Avoid sharing utensils with infected people	1
Strain milk for mosquitos	1
Slash compound grass to control mosquitos	1
Go to hospital	1
Treat <i>olkirobi</i> early	1

Oltikana seemed to have some overlap with the Biomedical concept of brucellosis in regard to prevention, despite its translation as malaria. In this area there were very rarely mosquitos. Most of the time it was quite dry, with no standing water. This may be why it was not associated with malaria, yet the diagnosis of malaria by Kenyan Biomedical experts was not unusual. This was most likely the result of a strong national campaign being waged by the government of Kenya, and the fact that in most cases it was diagnosed through symptoms rather than a blood sample. The fevers and joint ache are relatively indistinguishable to Biomedical diagnosis and both react noticeably to the antipyretics that make up the medication available for malaria.

As indicated above, the next set of responses are a denial of the possibility of avoidance, a disavowal of knowledge, and a relinquishing of ability to *Enkai*. In the midst (frequency wise) of these responses, a few mentioned the public health standby

of boiling water. The rest of the options listed were also apparently gleaned from public health messages; of these, only mosquito control measures are associated by local Biomedical experts with malaria.

Table 9 *Olkirobi* Prevention Listing Frequency

<i>Olkirobi</i> Prevention Frequency (12 methods/responses listed in 22 interviews)	
Methods of Prevention	N=22 (%)
Not possible to prevent/ from God	11 (50.0)
Keep warm (3 of whom noted “it would not help much”)	8 (36.3)
Don’t share cup/utensils with sick person	4 (18.1)
Avoid sharing bed (with sick person)	3 (13.6)
<i>Maiyolo</i> (“I don’t know”)	2
Avoid bathing when it was cold	2
Avoid stagnant water (1 of whom noted “it would help little”)	2
Special medicine	1
Keeping flies away from food by sweeping house	1
Avoid coughing people	1
Avoid strong wind (but also noted that “it was not effective”)	1
Herbs for prevention (“maybe”)	1

Olkirobi is an interesting consideration regarding cause. Its cause is most commonly given as “not possible to prevent” or “from *Enkai*”. When we consider how “the common cold” is regarded in the West, upon reflection I believe, many Americans would acknowledge that there really is not any way to be sure of avoiding get this illness. On the other hand, our public health efforts are such that a grade schooler can easily list behaviors that are taught to “prevent” colds and flus, from sneezing or coughing a prescribed way, to washing ones hands often. The methods of prevention listed by the Maasai participants were generally acknowledge to not be practical. Again,

there was an agreement with suggestions that I drew from listed causes, from the same interview or previous interviews, but often with a qualification, “it helps little”. Some people volunteered their opinions that these things were impossible, more stated that it was not possible when I explicitly asked them if it was.

Table 10 *Nang’ida* Prevention Listing Frequency

<i>Nang’ida</i> Prevention Frequency (6 methods/responses listed in 10 interviews)	
Methods of Prevention	N=10
Unavoidable	8
<i>Maiyolo</i> (“I don’t know”)	2
Boil milk	2
Herbs for strength and prevention	1
Cook meat properly	1
Stop drinking alcohol	1

Most Maasai participants regarded *nang’ida* as unavoidable. Again, there were also disavowals of knowledge. As in regard to causation, most participants were ambivalent about whether milk had any role. They were being strongly encouraged by the Biomedical experts that they utilized, as well as by the development education projects of the NGO, to boil their milk, and water, but their uptake was equivocal. This may have been a result of the absolutist nature of the public health message, “unboiled milk causes brucellosis/ *nang’ida*”, and its conflict with the experiences of their grandparents, friends and perhaps in their own experience of drinking unboiled milk. When milk is plentiful, it is a more extensive effort to boil it before consuming. If

drinking it once without apparent ill effect falsifies the absolute claim of Biomedicine, why should it be believed, especially when inconvenient?

Table 11 *Lemunya/ Pneumonia Prevention Listing Frequency*

Lemunya/ Pneumonia Prevention Frequency (4 methods/responses listed in 8 interviews)	
Methods of Prevention	N=8
Dress warmly (5 of whom noted “it helped little”, only children, or when very cold)	8
No way	3
Avoid cold water	2
<i>Maiyolo</i> (“I don’t know”)	1

In Biomedicine, pneumonia is a general condition that can be caused by many situations, but most likely an impaired immune system. The “dress warmly” response listed above was a response to my probing with listed causes, most still insisting that it does not do much to help. If not for my prompting, those responses would have remained, “I don’t know”. Unfortunately, at the time I viewed that response as a “non-response”, and thus the suggestions.

Table 12 *Taifoid/ Typhoid Prevention Listing Frequency*

Taifoid/ Typhoid Prevention Frequency (6 methods/responses listed in 9 interviews)	
Methods of Prevention	N=6
Boil/ treat water	3
Not possible	3
<i>Maiyolo pi</i> (“I have no idea”)	3
Only God knows	1
Avoid dirty food	1
Wash hands	1

Taifoid's prevention responses did not have heavy agreement. There were three responses that were each only mentioned in half of the interviews in which *taifoid* was considered a common and significant health problem. As shown above, those are drinking only clean water, a denial of the possibility, and a disavowal of knowledge. If the last two are combined with "only *Enkai* knows" it becomes the strong majority of the responses.

Participation and Cooperation

As one might expect, not everyone approached was willing to participate in these interviews. Because I did not offer compensation for participation (out of concern for undue influence in this cash poor community) many people refused to indulge the foreign researcher. There were often occasions in which, once learning that there was no compensation, an eager group of potential participants would become quiet and simply get up and walk away. It was outlined in the beginning of each potential interview that there would be no compensation, and the participant could refuse to participate at any time. It was not uncommon to have participants call an end to an interview when they were bored or tired. At this point I would ask if an opportunity to continue at a later date were possible. If so, it would be scheduled. If not, the individual or group would be thanked and my translator and I would move on.

The ability to refuse participation was emphasized before and during interviews and as a result was occasionally used. For this reason, I am confident that the patterns of responses were not influenced by a desire to placate, or discourage, the researcher.

In particular, the disavowal responses of “I don’t know” and variations on “God only knows” as noted above, are consistently patterned. If they were a result of a passive resistance, in the fashion described by James C. Scott in Weapons of the Weak (J. C. Scott, 1985), they would most likely occur more at the end of an interview (or from the beginning), when the participant grew tired, bored, or changed their mind about participating. This pattern was not observed. Instead, the disavowals were consistently associated with either questions of causation, or questions of prevention.

Interview Series 2-4

NGO volunteers and employees 18 interviews (18 participants)

All of these participants were working as primary school teachers, focusing on English language and hygiene/sanitation. Two participants in this sample were Maasai women who held high school diplomas and had community health worker training. The rest of the participants were Americans, 14 female and 2 male. Of the 16 Americans, 3 were currently completing their MPH degrees and one was a first year medical school student. There was also one trained teacher who held a child development and psychology degree. The rest were undergraduates working on education, biology, psychology or social science degrees.

The shared perception of the health landscape of the Maasai community was primarily based on their interaction with the primary school students. As a result, they

were concerned with injuries, e.g., thorn punctures on feet, or insect stings. The American workers were also struck by the amount of ringworm experienced by the students. One participant described the dilemma of trying to greet the students respectfully. In Maasai society, children greet adults by leaning forward and presenting their heads. This is a passive greeting that awaits acknowledgement from the adult. Adults then lay a hand on the head of the child and greet them verbally. The problem for the American volunteer was that the closely shorn heads of the younger students, were often covered with the distinctive rings created by ringworm, a highly contagious fungal infection. This created a significant reaction in the American volunteers and was subsequently considered a significant issue of the community.

Surrounding Maasai Communities 20 interviews (28 participants)

There are 4 communities that surround the initially sampled community of Losho. They are Olkiloriti, Embiti, Megwara, and Oololaimutia. The majority of the residents have relatives and friends within Losho. There is a lot of travel back and forth, particularly among children attending primary school at Losho primary, and virtually everyone attending the market on market day in Oololaimutia. Megwara and Oololaimutia are larger villages and lie along the road from Narok town (the largest town in the region). Most of the traffic on that road are tourists in tour buses heading non-stop to the Maasai Mara. The *enkangs* sampled from the Oololaimutia region surround the Oololaimutia town center, which is primarily occupied by non-Maasai who

provide services, such as barber shops, carpentry, mechanics, and general stores, to the tourist industry as well as the local Maasai community.

Like Losho, the enkangs are populated by local Purko Maasai who dress almost exclusively in the 'traditional' Maasai attire of tunics, the men bearing weapons, and the livelihoods predominantly pastoralist. Although there are two primary schools, in Megwara and Oololaimutia, Megwara Primary is an elite boarding school and Oololaimuti Primary appears to be made up mostly of children of the non-Maasai inhabitants of Oololaimutia town center.

Biomedical Health Professionals

8 interviews (8 participants)

The health professionals in this series of interviews were located primarily in Megwara and Oololaimutia, with only one residing at the clinic in Losho. The clinics in these three locations were commonly referred to as hospitals or "*sipitali*" in Maa. Likewise the nurses or technicians at these locations were generally referred to as "*daktari*", meaning doctor in Swahili. The other health professionals interviewed were employees of chemists, i.e. pharmacies.

The nurse at the Losho clinic was a young Maasai man who worked for the Ministry of Health. He was from a Maasai community that had long shifted their main mode of production to agriculture with the division and privatization of their lands. The people in his community wore Western clothes and enforced attendance in the national

schools. He had attended nursing school in Nairobi and was regarded as extremely urbane by the local “learned” young men¹¹.

There were three health professionals working for the Ministry of Health in Megwara and they were located inside the compound of the boarding primary school. They were Kalenjin nurses and, like the young Maasai nurse in Losho, were serving their terms of service with the Ministry in what they regarded as remote bush locations, with the hope of eventually transferring closer to their home regions. The Kalenjin people have a Nilotic language that shares some similarities to Maasai and so the Megwara nurses had easily learned basic fluency in Maa. The Kalenjin are a group of smaller ethnic groups that were closely related. (The former president, Daniel Arap Moi, is a member of this community and over the 24 years of his presidency he promoted economic and infrastructure development in the lands associated with his communities. The Kalenjin homeland had historically accepted agriculture and Western education without the apparent reluctance of the Maasai.)

The Megwara nurses, like the Losho nurse, felt that the local Maasai of this area were foolishly clinging to an outmoded way of life. Unlike the Losho nurse, the Kalenjin men described being regularly insulted by the locals who came to them for care, perhaps unaware of the extent of their fluency. The local Maasai would call them “snakes” and converse with each other about “chasing them out”. (This is extremely dangerous talk considering the violent ethnic and politically based strife that had

¹¹ The people (at this point, only men) who finished secondary school (with a passing or failing grade) refer to themselves as “learned”.

recently swept the country). Like the Maasai nurse in Losho, they had been posted to this location by the Ministry of Health and were waiting for the opportunity to someday transfer out to a location closer to their home areas.

In Oloolaimutia town there is a government health clinic staffed by a nurse from the Kamba community and an American Peace Corps volunteer for public health extension. The Kamba nurse, although a non-Maasai, was married to a Maasai man and lived with him in the town center. This afforded her a certain amount of acceptance into the community, as demonstrated by her ability to remain in town when the other Kamba were banished¹². Unlike the other health professionals interviewed, she did not blame “Maasai culture” for the health problems of the area. Instead, she considered most of the problems to be a result of corrupt politicians withholding funding for community development and the “learned” Maasai not helping to educate their fellows in the community.

The U.S. Peace Corps volunteer interviewed for this dissertation lived at the “*sipitali*” where the Kamba nurse works, to assist the nurse. His views regarding the health problems of the area were similar to those described by the American NGO volunteers, injuries, sanitation-related, and additionally he described upper respiratory infections. The volunteer associated each of these major areas of health problems with

¹² A young Kamba man from the town center had been caught stealing a motor bike. He was brought to the police in Narok town. Upon his release after being fined, he tried to retaliate against the people who reported the bike theft by burning down their shop at the Oloolaimutia town center. He was caught before he was able to complete his attempt. On the way back to the police station in Narok, he was killed by the young Maasai men who held him captive. Because he was Kamba, the local Maasai elders banished all Kamba people from the area.

aspects of Maasai lifestyle and culture. The injuries were primarily burns, which are a result of the ever-burning open fire in the center of the traditional houses. Sanitation related illnesses were said to be related to flies landing on the faces of children, which he associated with living in the traditional houses made with cow dung. Finally, he saw the upper respiratory infections as most likely related to the smoke filled interiors of the local houses, which normally only have a small window the diameter of a softball for the purpose of allowing smoke to escape, which is often plugged with a rag at night to keep out the cold. At the same time, he believed that it was not ignorance that led to this situation, but a combination of the logistical difficulties of accessing clean water for washing and a simple preference for that lifestyle.

The private clinicians and chemists of the area were all located in Megwara or Oololaimutia, with the majority living and working in the Oololaimutia town center. They were all non-Maasai Kenyans who generally regarded the area as a remote and “backward” outpost. The ones that participated in this study were all from ethnic communities in Kenya who had historically embraced Western style education and valued the national education system highly. They regarded the local Maasai people as ignorant and demanding. In their view, the main health problems of the area were a result of the ‘conservative’ or ‘arrogant’ nature of the Maasai culture in its perceived rejection of non-Maasai culture, the laziness of Maasai people in their perceived lack of ambition to acquire prestigious commodities, such as ‘permanent’ houses and Western clothing, and the ‘refusal’ of the Maasai people to part with any of their livestock in order to get the cash necessary to pay for education for their children. Their view of the

Maasai in this area was congruent with the most popular stereotypes of the Maasai held by other Kenyans.

Conclusion

In summary, I have discovered that the local shared health landscape of the Maasai community is perceived to be dominated by 5 illnesses: *oltikana*, *olkirobi*, *nang'ida*, *lemunya*, and *taifoid*. Although 24 illnesses were listed in total, these five were the most agreed upon in the free listing conducted in Losho during the first 27 interviews. Free listing is a useful method in outlining a cultural, or semantic, domain. Cultural Consensus Theory argues that the more agreement across community members in the free listing exercise, the more the listed terms or concepts can be considered true from the perspective of the community (Romney, Brewer, & Batchelder, 1993; Weller, 1984a, 2007). A clear difference has been demonstrated between the perspectives of the Biomedical experts and the local Maasai lay people as to the most significant health threats. This contrast can be useful in its underscoring of local versus introduced concepts and where they overlap. The difference between these perspectives appears to extend to where lies the responsibility or ability to prevent these problems. On the contrary, it will be argued that this difference is a contrast in emphases between ultimate and proximal, or direct, causes. This will be explored in the following chapter.

Chapter 5 “Only God Can Know”: Mystery, Ambivalence, and Orthopraxis

Analysis

This analysis of the findings will be presented in four sections. The first section will discuss the questions emerging from the research process and the resulting relationship with analysis methods. The second section will discuss the methods used this analysis of the findings. The third section will present the lay, or “common sense” nosography and etiology of illnesses by the Purko Maasai in Narok South as represented by the interviews and participant observation.

The fourth section will analyze the concepts of hygiene, i.e. the prevention of illness and maintenance of health held by the community in relation to basic cosmological premises. In particular, it will present the significance and complex meaning represented by a disavowal, or “no answer” response, in this context. What appears on the surface as a refusal, or inability to describe or recognize the steps taken by members of this community to prevent or avoid illness, may indicate information much more significant than popular sector prevention measures, but rather the cosmological framework in which concepts of all types of fortune and misfortune are couched.

Emerging Issues and Questions

Interviewing local Maasai people in southern Narok has raised many questions. There have not been easy or expected clarifications of my original basic inquiry. First, I discarded the pursuit of direct opinions regarding the trachoma campaign as most people were not aware of it and no one prioritized the illness. In fact, when asked “the most common or important illnesses for the region”, most participants responded with a list of common minor ailments as well as recurring chronic ailments that occasionally result in death for previously weakened, elderly or very young victims. Most of the ailments did not seem to be very distinctly defined, either by symptoms, treatment options, causes or prevention. Despite a broad sense of overlapping definitions, the illnesses did fall into rough constellations of characteristics. Although often referred to by ostensibly English or Swahili terms, the meanings of the terms were often apparently colloquially or locally defined. Table 1 lists the generally given English translations for the Maasai illness entities.

Similarities to Western Biomedical and folk beliefs included a concept of contagion, of insect vectors and the relationship between some sort of material pollution and ill health. Some illnesses, like *olkirobi* (often translated as “a cold,” which is itself often considered an equivalent of the Swahili *homa*, or “flu”) have been described as being caused by the wind carrying germs or some unidentified contagion or pollutant. Importantly, the Maa language has a word that is also sometimes used instead of “wind” which is *enkijape* (Mol, 1996), pronounced in this community as

enkijebe. This is generally used as a synonym of 'cold wind', although an older meaning, as described in Fr.Mol's Maa/English dictionary, is of a cold wind of God¹³. This may be to express a fateful aspect of misfortune. Spencer reports the usage of the phrase as an idiom of unpredictability, as capricious as wind in the sky (Spencer, 2003b).

This seemingly fatalistic aspect of Maasai belief regarding illness is expressed in the common response to my question regarding prevention. "You are not seeing when it is coming so that you get a way to avoid" (Naramat, elder mother). "You can't see a disease coming and then prevent" (Oldipesh, senior elder man). Prevention is not regarded as possible in many, if not most, circumstances, even ones in which a concrete cause was given, e.g., contact with the ill, exposure to cold or wet conditions, etc. When asked directly in a follow-up question, about avoiding those conditions described as causing the illness, the participant would generally agree that could be considered a prevention option. So why did they not reply that way to begin with? The response that "there is no way to prevent" was often given with a laugh or a scoff. Did it represent Western ideals regarding hygiene that were regarded as foolish in the perspective of the Maasai in this area?

Robert Pool describes an incident in which he expresses frustration to his translator regarding his participants' unwillingness to attribute an explanatory model to their health issues. When the translator inquires about the practices in Pool's own community, Pool describes an explanatory model volunteered to him by a friend who

¹³ "Enkijape- wind, cold wind, cold air, breeze, coldness... enkijape e Nkai: the air of God, God's air; diseases which the Maasai cannot find a cause for are attributed to God's air" (Mol, 1996)

had been having back pain, in which the pain was attributed to cold entering the friend's back through a window left open in the night. This explanation was regarded as so ridiculous by Pool's Cameroonian assistant that he broke down hysterically laughing and crying out that "He lies!" Pool muses that Westerners may have their own 'culture bound' idiosyncrasy in the need to find explanation for the most minor of situations, while Africans have been characterized (stereotypically) as unable to accept drastic events, like the collapse of a granary on a particular person, as simply unfortunate coincidence. This raises a series of important questions: Are these two perspectives then just arbitrary cultural predilections? What does it tell us about our society in contrast to the "big explanation" societies? Is the conceit of power and control over the common ailments in our societies a peculiarity that offers insight into the societies that hold these views? What can we learn from societies that seek to explain what is regarded in the West as an irrational question (e.g., why did the granary fall on me and not you?), but by many Maasai as unknowable, particularly because it reflects the will of God?

Methods of Analysis

Andrea Caprara has identified three significant problem areas in the analysis by western anthropologists of non-Biomedical health systems in regard to contagion (and therefore hygiene) (Caprara, 1998). These areas are semantic discrepancy, nosography and taxonomy, and finally concepts of transmissibility. The potential

incommensurability of these areas, particularly in regard to the prevention of illness, are a significant challenge in research of this kind (Baer et al., 1999; Caprara, 1998; Pool, 2003).

Semantic discrepancy refers to the labelling of illness in one language or dialect versus another. They may use the same term, but the meaning may be significantly different. An example of this is the Swahili term, “homa”. Ostensibly, it means “fever”, but in some parts of Kenya it is used colloquially as “the common cold”. Trained medical personnel at government clinics with whom I spoke were certain that it meant simply “a cold” and attributed the listed meaning in my Swahili/English dictionary as being a result of the author being a Westerner and therefore less competent in the language. If a term this fundamental in health parlance of a country like Kenya, where Swahili is the national language (together with English), then it gives some indication to the challenges when studying the concepts of health in a completely unstandardized language like Maa, where there can be great dialectical differences within a small geographical region.

An entire dissertation could be written on the significance of a small range of terms that were uncovered by the common illnesses described by the participants of this research, but that is outside the scope of this study. Instead, the variation with these terms, even within the same small community can be considered to illustrate the general, amorphous or ambiguous meaning attributed to these commonly used terms. Although in the general descriptions they tended towards symptoms in common, when described there were also many descriptive outliers that were mentioned by only one or

two participants (see tables 18-22). Additionally, etiology that might be considered defining characteristics in Biomedicine are sometimes mentioned across multiple illness entities, e.g., unboiled milk as a cause of both 'malaria' and 'brucellosis' or exposure to houseflies causing both 'the common cold' and 'malaria'. What can be drawn from these observations? Caprara suggests that the systems, taxonomic, nosographic, and otherwise, used to understand illness contagion in a particular community may be based on a very different foundation (what I am calling the world view or cosmology) than what is found in, for example, the germ theory of Biomedicines (Caprara, 1998).

In addition to semantic characteristics that may indicate a referential domain through idiomatic usage to the specific terms used, and the simple challenges and confusions involved in translation, there is also the selection of characteristics used to classify and describe illnesses. An example of this can be considered when comparing the dominant germ theory to the previously dominant miasma theory of Western medicine. Germ theory relies on a definition of illness as something that inhabits an individual body. Miasma theory relies on the idea that general social conditions of cleanliness and the factors influencing the production of fresh or foul air influence the health of the community as a whole (Halliday, 2001). Another example would be to compare it to the central concept described in [Your Pocket is What Cures You](#) by Ellen Foley (Foley, 2009; Halliday, 2001). Foley describes the relationship perceived by some Senegalese between social and economic inequality and the preponderance of health problems among the poor: without money, there is no treatment (Foley, 2009). This relationship between poverty and illness is one illustrated by one elder Maasai man who

told me of an illness that he considered caused by lack of food: the treatment is to eat enough food that you feel better. If this were as easy as it sounds, it would not be considered an illness.

In other words, how we define illness is fundamental to how we view the dynamics of health, and it is naïve to suppose that even a concept like “illness” is simply translated between cultures. Is illness a necessarily individual experience? Is it primarily bodily? Does the body include the mind? Can what the West considers supernatural influence health? Is it “really” psychological? If one can be run tautologically ragged by these questions, perhaps we can agree that the most important definition of reality in any circumstance is one which is effective, that is to say that it accomplishes goals desired by the inhabitants of the health landscape under consideration. According to this perspective, our reality is fundamentally based on metaphorical interpretations of experience and, as philosopher of science Paul Feyerabend has stated, is simply “the most plausible explanation of experience at any given time” (Feyerabend, 1993). Plausibility then becomes the question, and in the popular health sector, acceptance depends on the resonance of proposed meaning with common sense, itself rooted in world view or cosmology (Geertz, 1975; Koltko-Rivera, 2004).

In the cultural constructivist perspective, the meaning of terms and concepts are determined by those that use them and their value can only be assessed when the context in which they exist has been understood (Gaines, 1991, 1992; Hahn & Gaines,

1985). In this case, the meaning, description, and organization of illness and hygiene as established locally among the Maasai of Losho, is one that is variable; in other words, by articulating terms and practices that may not have ever been articulated before by that individual, the concepts are, in a sense, being standardized through the narrative. This is a fundamental aspect of the creation of ethnographies by anthropologists, as explored by Robert Pool, Peter Metcalf, James Clifford, and others. Ethnography itself is a process of interpretation and decision making. Thus, there are the vagaries of circumstance in one's social and physical environment that may not be realized until years or decades later (Clifford, 1983; Dumont, 1978; Metcalf, 2003; Pool, 2003).

What we can best hope for in this process of ethnographic fieldwork, is an accurate snapshot of a moment in time. However, like a snapshot, or a video, there can be much concealed or generated by subtle variables of lighting, timing, equipment, and serendipity, which can all combine to give a specific, accurate, representation that is nonetheless misleading if taken as portraying more than it possibly could. 'Accuracy' is problematic as well. The researcher is limited to co-creating (with participants and translators) a representation that is 'accurate' to one moment in time, to one perspective that immediately becomes historical and may never be completely undisputed within the community in question.

With all of that in mind, this analysis focuses on the depictions of significant and common illnesses of Losho, as perceived by the Maasai residents, in terms of diagnosis, etiology, treatment, and prevention/avoidance, and seeks to explain the system or

systems that are employed by the members of the community in order to derive understanding of it.

Nosography and Etiology of Common Illnesses

The local Maasai community also has a broadly varying set of concepts regarding the pathogenic landscape in which they live, but this is commensurate with the nature of the public/informal sector: constantly varying, guided by shared premises, but widely interpreted. There is no question that this can lead to inconsistency and contradiction, even within one participant's worldview, or within one interview (Geertz, 1975; Pool, 2003). In a general sense, the premises upon which the interpretations of the pathogenic landscape are expressed are broadly adhered to in order for these expressions to be supported by the concept of "common sense". It is the nature of these premises that I am seeking to discover and illustrate in this work.

In this study of the lay perspectives of the Purko Maasai in Losho and the surrounding villages, there is evidence of Biomedical influences to a greater or lesser degree, overlaying the community's cultural foundation of health concepts. This seems to be related to how much formal education or other exposure to official health expertise, national education, or the public health focus of the influential local non-governmental organization. For the most part, the Biomedical or western public health influence does not amount to the acceptance of a coherent set of health concepts. Instead, certain premises have been accepted, at least nominally, to affect multiple

illnesses. This seems to be the result of messages being mixed between the above sources. As a result, for example, unboiled water or milk is often given as a cause of various problems. The cause of the tainted aspect of unboiled milk or water is often associated with contact with certain insects marked by those non-Maasai health perspectives, specifically flies and mosquitoes.

“You know, in the time of rain, there is actually some germs which are within a stagnant water. Maybe the rain rains and it comes to stop once more, and then in a certain dam, it starts to leave stagnant water around, then some insects started to just go loiter around with a cream, so if the water becomes dirty so much, that cream, which has been laid in the dam, that is why the... If you go to take a shower in a certain dam, when the cream gets your body, you get to sick together with disease” (Leonard, ‘learned’ young man).

In this example, the insect is not specified and the young man struggles to relate the concept of contagion he remembers from school in English. The water is contaminated by contact with insects, but in a vague way that does not quite represent Biomedical perspectives or ‘traditional’ Maasai perspectives. It represents an overlap.

Nosography: Description or Classification of Illnesses

The lay people of Greater Losho organize the common and significant diseases that are seen to affect their community in ways that are probably similar to the illness taxonomies used by most lay people. They tend to define illnesses by characteristic symptoms. For example, coughing, fever, aches. The majority of respondents have listed 5 specific illnesses as the first 3 illnesses when asked to name the most significant

or common illnesses in their area. These are *oltikana*, *olkirobi*, *nang'ida*, *lemunya*/pneumonia, and *taifoid*/typhoid. Typhoid and tibi/TB are more readily evident, but the others are commonly translated as: *oltikana*=malaria, *olkirobi*= a cold, *nang'ida*= brucellosis and *lemunya*=pneumonia (see table 1).

This suggests that these 5 illnesses can be agreed upon by the populations of greater Losho as the consensus of the most significant or common illnesses in these areas. They may be categorized by the most commonly reported symptoms as characteristic of the illness. These five illness entities/emoyano are the most commonly listed in the 27 interviews in Losho that qualified for inclusion in the frequency tables. Each of them was mentioned first in at least one interview. They all also refer to discrete illnesses, as opposed to a collection of possible problems, e.g., 'eye problems', or a characteristic symptom that may also have various causes, e.g., diarrhea. For these reasons they best represent the common health landscape shared by this community.

Oltikana is ostensibly translated as malaria. It was listed in 25 out of the 27 interviews. It's perceived prevalence may be related to the emphasis that malaria has been given in the Kenyan Ministry of Public Health and Sanitation and by international health organizations (Statistics, 2011; USAID, 2013). Nationwide, it remains a devastating illness (Statistics 2011). In most clinics malaria is diagnosed symptomatically, rather than by blood sample analysis. Colloquially, malaria is often a synonym for almost any possible acute illness across Kenya. For example, while in the Coast province I stayed at a Kenya Medical Research Institute building where the

askari/guard was an old friend. When I greeted him, I asked about his son and he replied “He has had malaria. I think he ate too many unripe mangoes”. The child’s primary symptom was diarrhea, but the illness was glossed as malaria.

The medical doctor who was a co-founder of the local non-governmental organization focused on health in Losho also suggested that the illness was over-diagnosed in this area, where she had been coming for 12 years. She saw the local clinicians diagnosing malaria by the presence of intense high fever. When they prescribed the recommended anti-malarial medications, the patient would respond well. She argued that this would be the case with any fever causing illness since the government provided medications were anti-pyretics. At the same time, there was a complete absence of mosquitos to vector the malaria virus, except during the rainy season. At the time of rains, their presence was still limited in Siana Valley. As a result, most Biomedically recognized cases of malaria would have to be seasonal or brought by people who had been infected in other areas.

This is not to suggest that my participants were ‘wrong’ in their perception of *oltikana* as a significant and common illness in this area. Instead, it is a reminder that *oltikana* is a Maasai illness entity and not necessarily translatable into Biomedicine. The community members identified *oltikana* primarily by fever and headache (see table 5). As explained by my participants (see table 2), *oltikana* is caused by both unboiled milk and mosquitos, and most descriptions of the role of mosquitos was not as a vector through biting people, but by contamination of milk through direct contact. This

suggests an overlap with the Biomedical concept of brucellosis, which is caused by contact with contaminated unboiled milk.

The second most commonly identified illness entity is *olkirobi*, at 24 out of 27 interviews. This is ostensibly translated as “the common cold” and, like the English word, shares its root with the Maa word for the temperature: ‘cold’, *kirobi*. It is most commonly identified by rhinorrhea (runny nose) and coughing, which make it seem very compatible with the Biomedical construction (see table 19). The cause accorded to *olkirobi* is predominantly *enkijebe*. This seems to correlate with both Western folk causes of the common cold, and may be encouraged by a cosmologically resonant interpretation of Biomedical germ transmission as it was sometimes further articulated as caused by dust (or rarely ‘germs’) in the wind (see table 3).

The third most commonly listed illness entity described in these interviews was *nang’ida*, generally translated as ‘brucellosis’, at 11 out of 27 interviews. It was identified by the symptoms: leg swelling, joint pain, swollen joints, and back pain (see table 20). The Biomedical entities of malaria and brucellosis are easily confused with each other by lay people as they are both characterized by fevers and joint pain. Participants who identified *nang’ida* primarily claimed to have no idea what caused it. This was followed by the Biomedically recognized cause of drinking unboiled milk (see table 4). However, several participants explicitly said that they did not believe that milk caused *nang’ida*. “The learned people say that milk brings *nang’ida*. Us, we don’t have any idea. Wouldn’t we [women] be sick? How can you be sick and you are the one to

milk?” (Naramat and Narikuu, senior elder 2 women). Another point that was made was that their ancestors had always drunk unboiled milk, and yet *nang’ida* was not considered an old disease. I was also told that *nang’ida* came sometimes to people who drank only boiled milk, and not always to those who drank it unboiled.

Nang’ida, ‘brucellosis’, may serve as an example of over-reach by public health efforts. According to Biomedicine, brucellosis is not ‘caused by unboiled milk’, but by ‘unboiled milk from animals contaminated with brucellosis’. This is a technicality, but an important one that represents a common issue in public health efforts, particularly in Africa, where the judgement of the target populations are often not adequately respected. Public health efforts at behavior change can be constructed in absolutes, which will swiftly be recognized as inadequate by critical audiences. Abandoning the practice of drinking unboiled milk may also be viewed as abandoning a critical aspect of Maasai identity, as will be discussed below.

The fourth most commonly identified illness entities were *lemunya* and *taifoid*, both at 10 out of 27 interviews. *Lemunya* / ‘pneumonia’ is characterized by coughing, difficulty breathing, pain in the ribs, and sensitivity to cold. There was not a majority consensus, however and even the most commonly listed symptoms were not mentioned by more than 50% of respondents each (see table 21). *Lemunya* is considered to be caused by *enkijebe* by a large majority of participants (see table 5). *Taifoid*/typhoid was identified by participants by noise in the intestines, often described as “krr, krr”. “Your intestines are just crying” (Naimodo, senior elder woman). The next

most commonly listed symptoms were lack of appetite, diarrhea, and vomiting (see table 22). Dirty, untreated/unboiled water is considered the cause in half of the interviews that mentioned *taifoid*. The next most common response was “I don’t know” (see table 6).

Despite the English origins of the terms *lemunya* and *taifoid*, they cannot be simply dismissed as introduced illness concepts. It is unlikely that the Biomedically conceived pneumonia was ever unknown to the Maasai, and Frans Mol lists a term for typhoid, *olmuriang*, of apparent Maa origin in his dictionary (Mol 1996). The terms of English origin may have become more popular than the Maasai originals, possibly because of their use in the schools and clinics.

There is a broad spectrum of identifying symptoms associated with these five illnesses. This might suggest that these categories are not so distinctly categorized. In addition, they are also a variety of treatments suggested, that might also suggest that there are various conceptualizations of the illnesses, more varied, in fact, than the 4 names would indicate. Lastly, causation is, among all the illnesses listed, the most varying category for responses. This set of responses suggests influence from the formal Westernized education of the national schooling system, as well as the edifying public health projects of the dominant local non-governmental organization, which are made up primarily of Westerners.

The findings and previous ethnographies suggest that causation is not the initial concern of this population, or is not something that the lay Maasai person might feel

comfortable speculating about. The cosmology of the Maasai has been described as having certain tenets of mystery regarding the supernatural. Demonstrating too much knowledge of the supernatural is to invite suspicion of witchcraft practice (Spencer, 2003b). Among the Maasai for the most part, it is simply regarded as an area that ‘no one knows’, and to claim knowledge is to speak foolishly (Hodgson, 2005; Spencer, 2003b). “God only knows” was not an uncommon response in my interviews and in the field.

Enkai, the Maasai name for the monotheistic creator god, is given multiple and intriguing aspects in Maasai speech and oral literature. Sometimes symbolically described as multiple, black and red, or even white to represent aspects of personality: unforgiving or merciful, or neglectful (Hodgson, 2005; Spencer, 2003b). *Enkai* is also arguably male at times and arguably female at other times, perhaps also associated in this way with gendered concepts of authority, creativity, fertility, etc. (Hodgson, 2005; Spencer, 2003b). Dorothy Hodgson has argued that an older understanding of *Enkai* is as a female god, in contrast to the perspectives of several, but not all, male missionaries and anthropologist (Hodgson, 2005). Paul Spencer has posited *Enkai* as the embodiment of the ideal of elderhood, representing the ultimately ancient and all-knowing elder, who cannot be questioned, and holding unquestionable power over all others (Spencer, 2003b).

In Maasai appeal to *Enkai* for favor or fortune, it is suggested in the literature and my field experience that orthopraxy is the ideal, while orthodoxy is restricted to

asserting ignorance in terms of *Enkai* and the supernatural (Hodgson, 2005; Spencer, 1959, 2003b). In terms of practice of daily and ritual life, the oldest elders are recognized as having access to the most ancient, and therefore correct ways of acting. Correct behavior, in terms of ritual or in terms of daily life for a proper Maasai, is seen as a way of acting to at least deserve the blessings of *Enkai*, although notably nothing can guarantee it.

Thus, I argue that in asserting that “we have no idea” or “Only *Enkai* can know”, the participants were not claiming ignorance. Instead, they are asserting a kind of etiological agnosticism. The ultimate cause of everything is known: *Enkai's* Providence. Claiming to have “no idea” when asked the proximate cause of illness is an assertion that etiology, other than the will of God, cannot be known. It suggests that to assert otherwise is both foolish and a conceit, disrespectful to *Enkai*. Likewise, an ambivalence regarding potential causal behaviors might also be supported by this premise of Maasai causality.

Siana Valley Health Landscape

The two major constellations of the etiology of the shared health landscape in Siana Valley are Maasai health cosmology and Biomedically related ideas. The components of Maasai health cosmology can be broken down further into *Enkai*, *olari*, and *enkijebe*. That is to say: ‘God’, the ‘time of rain’, and the ‘cold wind’. ‘Biomedical’ influence originates from outside the community, from national education, government

and private health clinics and chemists, and health campaigns by Kenyan Ministry of Health and non-governmental organizations. The first three are integrally interrelated. Both *olari*, or 'the time of rain' and *enkijebe*, 'the cold wind' have important links to the expression of *Enkai's* will in Maasai reasoning.

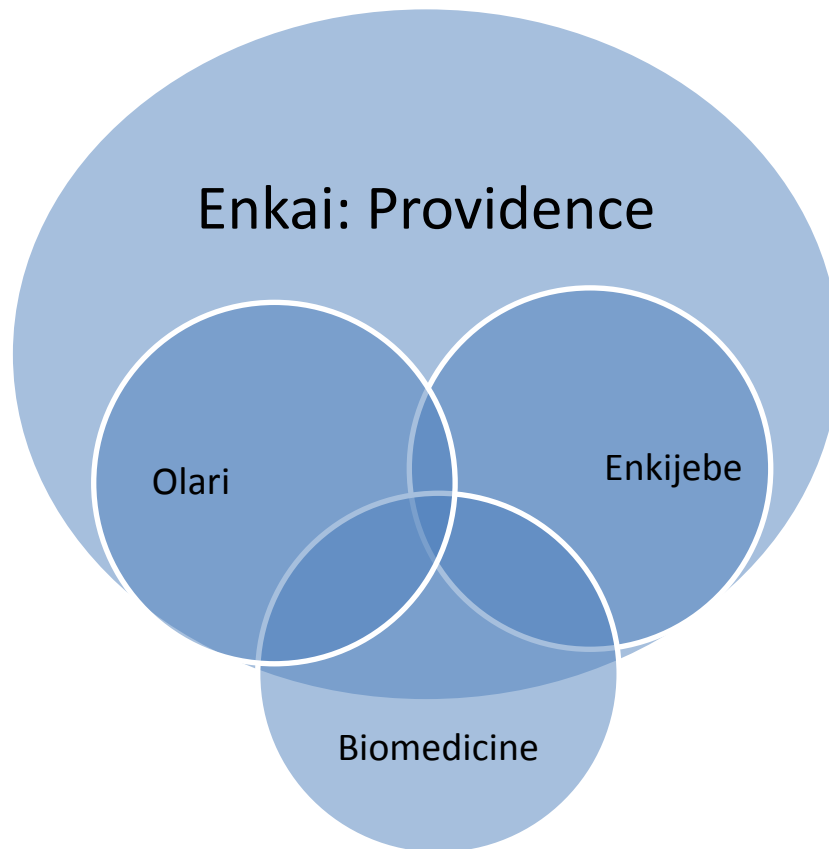


Figure 2 Maasai Etiology

These are the categories, or constellations of characteristics, into which all of the causes of illness can be classified. *Enkai*, as a representation of authority and mystery, represents the exclusive knowledge and authority of the elders, a key component of the segmentary lineage system that has traditionally made up many pastoralist societies like the Maasai.

Enkai is also an evaluator of orthopraxis (Hodgson, 2001b; Spencer, 2003b). It was explained to me that when people are living as ‘proper Maasai’ it is believed that they will in general have good fortune as they will be living as *Enkai* intended. This seems to be distantly related to the concept among Bantu speaking communities in which living in a way that the ancestors approve of will encourage their protection, but much less directly (Mbiti, 1975). When the corruption of a local politician was complained about in my presence, a companion reminded the speaker that he would eventually receive the misfortune he deserved as a person who varied so much from the community-minded Maasai ideal.

Likewise, references to *enkijebe* may also be references to the will of God. There is another word for ‘wind’ in Maasai: *osiwuo*. *Osiwuo kirobi* means ‘cold wind’, and yet this phrase is absent in my interviews (Mol 1996). It may be that the association demonstrated through the phrase ‘*enkijebe e Enkai*’ has a survival in this distinction and gives additional levels of meaning to the term. Arguably, it can include the causes listed as coldness, cold rain, cold baths (augmented by the cold wind blowing), and perhaps even dust (described as carried by wind) and ‘germs’ in the wind. When reminded of the causes that they listed for a particular illness, e.g., *olkirobi*, such as exposure to cold, cold rain or cold wind, and asked if it could be prevented by ‘dressing warmly’, there would often be immediate agreement, with no sense of contradiction. Sometimes the agreement would be qualified by the statement that it “would help little”, or “there is no guarantee”. The participants agreed that these behaviors may help a little, but nothing would have an absolute effect, which is possible only for *Enkai*.

Olari is another category made up of causes with metonymic associations.

Although some participants specifically listed ‘the time of rain’ as a cause of illness (see tables 2 and 4), many participants would mention *olari*, and then specify aspects of this season that they saw specifically causing illness. These aspects include walking in cold places, drinking cold water, walking in wet places, and bathing in cold water. As etiological constellation, it includes causes that may also be associated with *enkijebe*, such as rain, and cold rain. There are three other significant types of causes that are represented by the ‘time of rain’. These are house fly related causes, mosquitos and unboiled/untreated water and milk related causes. Flies are a traditional Maasai symbol of the rainy season, and it is believed that their appearance in a dry period is a signal that the rains will come soon. They are not valued for themselves. In my interviews I often asked if there were a way to get rid of all flies, would the participants be willing to do so? They would enthusiastically say yes. One participant joked that I was already taking them since I was covered and surrounded by a horde of flies during the course of the interview. “You have come to take our houseflies!” (Naramat, junior elder women) Everyone present thought that was hilarious.

As stated above, this region had no mosquitos outside of the rainy season, and only populated in a few areas during it. They were associated with rain and the lush grasses that were a result of the rains. In comparison to the numbers of flies, they were insignificant and not regarded as symbolic. Despite their limited presence, the Government of Kenya has an ongoing campaign of providing treated bed nets and encouraging their use (Statistics, 2011). The local nurses in charge of handing them out

often complained of the local Maasai tendency to use them as bed mats instead.

Apparently the anti-mosquito treatment was also effective for bedbugs, endemic in the area.

Plentiful milk is a specific symbol of the blessing of *Enkai*, as well as a marker of *olari*. As the product of a central symbol of Maasai society, the cow/*enkiteng*, it is a particularly potent symbol. The Maasai origin story tells of how all the cattle in the world (as well as sheep and goats) were specifically given to the Maasai from *Enkai* as gift (Hodgson, 2001b). Water, of course, is also associated with the 'time of rain', and large standing pools near the homesteads give a break to the women and the girls who normally may have to travel far to carry heavy containers of water every day. That standing water, washed down from the hills, is usually rich in the bacteria and parasites from human feces.

Rain itself is symbol of the blessing of *Enkai*. One of the words for rain is actually also '*Enkai*' (Mol, 1996). The timely appearance or prolonged absence of rain is often associated with the general approval or disapproval of *Enkai* for the community. Orthopraxis, proper Maasai behavior, however it is constituted, is also believed to be conducive to the approval of *Enkai* as evidenced by the previously mentioned blessings of rain, milk, and the resulting grasslands to feed the livestock, as well healthy children. As a result, observing traditions considered to be Maasai is orthopraxis and thus is related to the providence of *Enkai*. Likewise, grievous failure to live a properly Maasai life will end in eventual misfortune of some kind. Århem describes *enkea* as disruptions

of Maasai moral order that are typically diagnosed retrospectively after a dramatic death has occurred, indicating the action of *Enkai* (Århem, 1986). In my experience in Losho, the balancing providence of *Enkai* is a gradual and eventual thing, expected within the lifetime of the wrong-doer. Orthopraxis may be a daily way to demonstrate respect to *Enkai*.

Table 13 Listed Causes and Category

Listed Causes	<i>Enkai</i>	<i>Enkijebe</i>	<i>Olari</i>	'Biomedical'
God's will	X	X		
Only God knows	X			
There is no cause	X			
You can't know	X			
I don't know	X			
Cold wind		X		X
Cold rain		X	X	
Cold baths		X		X
Dust		X		X
Germs in wind		X		X
Coldness		X		X
'Time of rain'			X	
Rain			X	
Walking cold places		X	X	X
Drinking cold water			X	
Housefly related			X	X
Walking in wet places			X	
Unboiled milk			X	X
Unboiled/stagnant water			X	X
Unswep house	X			X
Dirty plates/utensils	X			X
Dirty/bad/old/badly cooked food	X			X
Sharing with the sick	X			X
Contact with mucous				X
Mosquitos			X	X

Ambivalence in Maasai Notions of Illness Prevention

In my interaction with Maasai people of Siana Valley, it was made evident that my participants often held broadly ambivalent ideas about ill health causality and prevention. In addition to various illnesses being presented with multiples forms of causation, the derived forms of prevention given within one interview may be

disavowed or down-played in the next sentence. The emphasis was always on uncertainty: “There is no guarantee”.

This was not simply a refusal of Biomedical explanatory models. Some participants stated that they did not know if a technique could work in preventing illness only because they had not tried it, but that they were willing to try new methods. They refused to accept a change in health behavior without evidence that it worked. When asked about a method to avoid olkirobi, a grandmother replied, “I don’t know. We have never tested to find out” (Nolepeta, senior elder woman). A grizzled grandfather in another interview stated, “If there was a way to prevent the disease, we would have take. If we had a guarantee that it would prevent the disease if we don’t bathe, we would have done so. So we are just, we are just... we don’t have a straight road to follow. We just try” (Ole Saingeu, senior elder man). These statements counter the traditional international public health perspective suggesting that Africans suffer out of cultural conservatism or ignorance.

Senior elders demanded proof that a method would work before changing their lifestyle in any direction. I had asked the elder above if the Maasai would be better off if they turned back to the ‘old way’ of not bathing. Not only was he willing to bathe or not bathe if it could be demonstrated to be beneficial, he was nonplussed that I would ask a question that seemed to suggest that Maasai people did not necessarily act practically when it came to their health. Practical application of health behavior was often commented on, “because say when you have gone to look after [the cattle] and you

have become very dusty, and you come to the stagnant [water]. You will take, because there is no otherwise” (Ole Mpatieny, senior elder man) and “As Maasai, we don’t have very warm clothes. Because maybe it rain when you are looking cows, and you don’t have a way to avoid it; maybe when you are milking and it start raining, you must be there. If you go to bring the cow inside the house when it is raining, so you can’t avoid it” (Normasegela, senior elder woman). Women milk the livestock morning and evening, every day without exception. This grandmother was pointing out that they do not have the luxury of “avoiding” rain.

Another area of ambivalence regarding danger or benefit was in regard to bathing. Expense or effort was not raised as a factor. Instead, benefits and risks were mentioned when I asked if it could prevent illness. Bathing is universally considered beneficial, at least aesthetically: “It brings a lot of disease but it makes your body to, makes light and smoothly, and makes your clothing look nicely” (Naisena, senior elder woman). When asked why she bathed, “We have been informed there are germs” (Naisena, senior elder woman). At the same time, bathing is recognized as dangerous for the exposure to coldness that it represents. Bathing typically took place in streams or ponds and not with heated water in basins as in some parts of Kenya. At best, it may be of neutral effect. “We assume bathing is meaningless” (Naramat and Narikuu, senior elder 2 women). “We bathe as we can able. If you feel like bathing, you go bathe” (Nalamai, senior elder woman). When asked if people who feel like bathing get sick less often, she replied “It will be opposite, because maybe somebody bathing will be attacked by most diseases than somebody who is not bathing”, suggesting that there

may be danger in contagion from sharing soap (Nalamai, senior elder woman). For most, the concern was with coldness, “Bathing regularly can prevent disease, but bathing with cold water, you will become sick” (Naimodo, elder 2 women).

Despite the correlation between coldness and *enkijebe* and *olari*, the two symbolic representations of Enkai’s will, there were several participant who explained that they had been told about the dangers of coldness by the Biomedical health experts in the clinics, “You feel very sick when it rains, because of the coldness. Those are the ways of the doctor” (Naramat and Narikuu, senior elder 2 women), “Hospital said cold air attacks” (Naimodo, elder woman). This was supported in my own experience. I was speaking with one of the government nurses, Moses, about how he might be issued a motorcycle for transportation. I suggested he get a helmet and a durable jacket (for crashes), he agreed enthusiastically, but because of the danger he felt was posed by the cold air he would be feeling while riding the vehicle.

Biomedically associated causes and methods of prevention do not appear to be based on a consistent model. Instead, they suggest bits and pieces or ‘shreds and patches’ picked up from clinic visits, intermittent or incomplete schooling, interaction with school goers, and health education campaigns from the NGO and local health workers. One young woman, Nalamai, reported that she learned most of what she knew regarding health from government sponsored radio programs. Because biomedical causes blame some central symbols of Maasai identity for ill health, e.g., milk, they remain suspect by many. Unwittingly, they may be presented as oppositional

to Maasai orthopraxis, and thus contrary to important parts of maintaining the support of providence.

Enkijebe/Enkijape is a word that encompasses many things, as supported in the literature and my observances in the field (Mol, 1996; Spencer, 2003b). Cold, coldness, cold air, breeze wind, cold wind, and is the core of the phrase “*Enkijape e Enkai*”, “the wind of God”, an expression used by the Maasai people to denote the cause of otherwise unexplainable illness.¹⁴ *Enkai* is often attributed as the cause of illnesses, even to those to which there are otherwise attributable causes. This is due to the understanding of Providence as an underlying cause of all fortune or misfortune. This seems to be true in the sense that all that occurs is permitted by *Enkai*, if not caused by *Enkai*. In the end there is a belief in the orderly unknowable plan of *Enkai*, Providence. The one who acts badly, or improperly, will one day get their just desserts. This is a matter of faith and it is expected to occur during life, as in the “traditional” view there is no proof of life after death. There is nothing, and nothing is expected. Death is thus a fearsome mystery to be avoided. That is what is known: it is a mystery and it is fearsome. Bodies of the deceased are taken to the forest for wild animals to dispose of. Even the names of the dead are not to be mentioned. Similarly, what is known of God is not dogmatic beyond the mystery, and that *Enkai* is to be respected but cannot be known. Skepticism may be considered a defining characteristic of Maasai philosophy, and mystery is the most defining characteristic to be recognized (Spencer, 2003b).

¹⁴ “Diseases which the Maasai cannot find a cause for are attributed to God’s air” (Mol 1996: 181)

In the cause of any illness, it is generally recognized that it is permitted by *Enkai*, either by indifference or intent. Likewise, it is generally recognized that the cause of any illness is tied to what Westerners would call the natural world. However, in Maasai philosophy, the natural world is the world of *Enkai*. They are one and the same. There can be manmade causes of illness, but these are rare, and are ultimately not inherent to the Maasai, but almost entirely introduced from foreign sources. Even the curses and other powers of the laibons are generally believed to have their origin outside of the Maasai proper, and are also the ultimate source of the unrelenting suspicion under which the members of the *Loonkidongi* clan still remain (Fratkin, 2004; Hodgson, 2005; Spencer, 1991). The chief exception to the laibon source of curses is the parental curse. In effect this is the curse of the father, as many regard mothers as unwilling, at the end of the day, to employ this drastic and final discipline against their children (Spencer, 2003b). This is not believed to be the case with fathers. It is held among the Maasai, and may be a pan-African belief that parents have the ability to curse their children fatally. It is the final compulsion to honor one's father and mother. The parental curse is understood to cause misfortune unto madness and death. These curses are seen as very real, and yet they are not the cause of much misfortune or most illnesses.

In my experience, the Maasai people of Losho are reluctant to state any etymology baldly, other than the fact of all illness (as well as all fortune and misfortune) to be allowed by *Enkai* for some reason or no reason. What is not known is not known. To claim what cannot be known, is to speak foolishly. The lack of elaborate doctrine

appears to be the result of the skepticism bred from the premise of mystery being inherent in the world.

Prevention and Avoidance: Hygiene Where Illness ‘Just Comes’

In this study of common sense notions of health, illness, and hygiene among the Losho Maasai and surrounding Maasai communities, I have been presented with a distinct conundrum. As a study of hygiene, I have been particularly interested in how the members of these communities conceive of the nature of these common illnesses and how that nature relates to reasonable methods of preventing or avoiding these illnesses. However, as revealed previously in Chapter 4, this was an area where there was seemingly little cooperation or coherent agreement, except to relegate the potential for sickness or health, to the realm of *Enkai*. For a significant amount of time this appeared to be a stone wall, a sterile area of information gathering. This was both irritating and confusing. Even when the participants provided specific conditions that were understood to cause a particular illness, there would not be a seemingly obvious correlation with prescribed avoidance behaviors. Instead, there was the most consistent explanation that there is “no way to avoid” that illness, that it is “God’s will”. In the field, and for some time after, this seemed like a failure of fieldwork. I was reluctant to blame obstructionism or obtuseness in my participants over my own ham-fisted interviewing methods. I questioned my translators. I constantly reframed my questions and redesigned my interviews. Although, as in all fieldwork, I received varying

levels of cooperation and helpfulness, this seemed a consistent feature. What it took me some time to realize, was that in this case, what seemed to be no answer or a knee-jerk or flippant refusal to respond, was that the attribution of “no way to avoid or prevent” was a response that consistently illustrated a guiding and fundamental aspect of Maasai cosmology. This cosmology, in turn, has been argued by Spencer and Hodgson separately to reflect as well as inspire some of the most significant and persistent social structures of the Maasai culture.

One of the differences apparent between Maasai society in Southern Narok and my own experience of Western society in the US is that Americans tend to believe (or act as though they believe) that there are instrumental and effective ways of avoiding illness. This can be a result of different things: 1. Simply, we have these beliefs and some others (such as the Maasai) believe differently. 2. We have been socialized to express these perspectives in a particular way that lends itself to articulating a response to questions such as “How can you avoid becoming sick?”, while others express themselves according to other beliefs or reference domains. 3. We idealize the relationship between ourselves and our environment as one in which we are capable and worthy of taking control (or expressing our ability to take control), and others do not. In my interviews with Maasai locals I found a consistent response to the question, “How can you avoid becoming sick?” (even in the context of specified illnesses). It was “You can’t. It is the will of God”. It must be remembered that the Maasai do not believe in a “micromanaging” conceptualization of God. Individual illnesses are not necessarily a specific decision that was made to punish or humble a person, as what might occur in

a personalistic perspective. The “will of God” seems to be more of an expression denoting the acceptance of fate determined by an aloof and unknowable controller (Spencer, 2003b).

What can be said about a society that sees illness as something that just happens? Robert Pool seems to shrug his shoulders at the problem. He has studied an illness that can lead to death in children, and that places it in the extreme category, which can be sometimes explained in the Cameroonian society he studied as a (ultimately) supernaturally caused illness (Pool 1996). This seems to be the safe rule of thumb for many societies: if it is an extreme illness, sudden, unexplained, unexpected, unresponsive to treatment, it will be considered personalistic because there seems to be something more than nature at work (Foster, 1976). That “something more” may be a moral component of justice. For example, when a healthy person falls ill and in such a way that does not respond to typical treatment, a person who would be expected to be least likely to be effected in such a way, it seems to suggest intentionality. Thus, in cases of unjust illness, misfortune or death, there is suspicion of supernatural tampering. What registers as “unjust” seems to vary between societies. Many Maasai, described in the literature as highly “naturalistic”, still seek recourse with *laibon* when felt to be in unjustly dire straits and therefore suspecting sorcery. However, in both Spencer and Hodgson’s writings, their Maasai participants gave them examples of dramatic deaths of relatively important individuals that were retrospectively explained as being a result of the violation of some norm of relations (and thus of Providence), regarding ceremonial performance or a disruption of the respect relationships that

categorize Maasai society and therefore had been punished directly by *Enkai* (Hodgson, 2001b; Spencer, 2003b).

There is also something seemingly paradoxical in the fact that, when presented with their own descriptions of disease causes, my subjects would inevitably agree that there is in fact something that can be done to prevent disease. Pool points out that his subjects contradict themselves, that they are inconsistent in explaining the course of illnesses, their nature, their etiology (Pool, 2003). I am not convinced that he asked all of the right questions (and who does?), but I do agree that ethnographies are not simply a description of societies and their models of health and illness, but creations. But this creation, co-created by the ethnographer, is not in error when it expresses contradictions and inconsistencies when this is representative of the way they exist in the community (Geertz, 1975).

Minor ailments, which are the most common of illnesses, or more dangerous illnesses that follow an expected progression may also fit into the category of “illness that just happens”. But what is the shared logic in the community for the nature of these “natural” illnesses? It may be inarticulately and inconsistently explained by laymen and experts alike, but there must be some boundaries in which the explanations fall, or there would be no explanations regarded as ridiculous or wrong. There would be no explanations more plausible than others, and this is not the case. Pool illustrates that in common sense explanations of common illnesses there is often much that is not

held in common. There is multiplicity in explanation, by the same person and sometimes even in the same conversation (Pool, 2003).

The Maasai have been described in some of the earliest accounts by Westerners, and subsequent anthropologists, as being characterized by their reluctance to speculate about supernatural characteristics and dynamics (Spencer, 1988). What I had been confused by was an evaluation of African rationality that has traditionally informed the anthropology of health behavior, particularly in Africa. Because I did not understand the basis of their 'non-responses' I was unable to immediately realize that they were meaningful. At the same time, there may be importance in ambiguity for popular models. Popular perspective is "regulated" only by popular opinion, which may never exist in much detail, so small continuing variation must be expected to occur to adjust to changing situations (Lau & Hartman, 1983; Zou et al., 2009).

The evaluation of rational behavior cross-culturally is an enduring problem that has been the basis of debate in anthropological theory since its beginning (Evans-Pritchard, 1965; Ray, 1976; Tambiah, 1990). In order to be able to understand rationality of behavior cross-culturally, the subjects would not only have to be presented with similar, if not identical, physical environments, but would also have to have the same goals in their interaction with this same environment (Shweder, 1979). The subjects would also be required to have the same interest level in the activity, and the same desire and ability to interact honestly in regard to the activity. In addition, the subjects must share the same notions as to what constitutes proper avenues and

strategies towards accomplishing their shared goals. In other words they would need to share norms and conventions to the degree that only exists between members of the same culture (Shweder 1979:282-287).

Another postulate used in the evaluation of rationality is the explanation by reference to consequences (Shweder, 1979). That is to say, it is the development of personality from constraints of the social and physical environment (Shweder, 1979). There are three theories most commonly used for this postulate. They are the theory of “rational choice”, Darwinian “natural selection”, and the “law of effect”. The first theory, “rational choice” is really more accurately described as a criterion or presupposition than a hypothesis. It is the idea that the option that is most likely to succeed will be the option taken by the rational actor. Rationality is in fact much more difficult to analyze, as suggested by the above postulate. In order for assessments of rationality to be valid they must be assessed by a member of the same culture who can be reasonably thought of understanding the test situation as perceived by the actor, in other cases they can only be performed retrospectively and thus losing predictive value. “Natural selection” is a functionalist theory that is also used for retrospective evaluation in reference to consequences. It is limited to evaluating behavior in terms of the goal of survival for reproduction. It is thus subject to what Marshal Sahlins has called the “fallacy of an a priori fitness course” (cited in Shweder 1979). The last theory, the “law of effect”, is a definition of what should be considered a reinforcement or consequence of an action, rather than a “law”. It states that behaviors are guided by what effect results from the actions taken. Shweder suggests that this is simply the “rational

choice” theory in a different medium. Like the “rational choice” theory it requires the recognition of specific goals and specific contextualization held and experienced by the subjects, and thus is not generalizable while parsimonious (Shweder, 1979).

In the Maasai popular sector, people are not overly concerned “why” they are sick. There may or may not be an articulated mechanism for illness, according to one system or another, but in the end it is not a critical issue, or even a particularly interesting one. People are not actively concerned about avoiding future sickness for the type fitting the category of “most common” illness, because of its intrinsic or defining nature: commonality and unpredictability. What everyone gets, perhaps, one cannot expect to avoid. This is the category of “affliction affecting everyone”. There does not seem to be any behavioral prescription that can insure health, so it is respected for being an unknowable aspect of Providence.

An example is getting the common cold. People follow basic protocol of healthy behavior, of whatever time and fashion, e.g., washing hands, but some kinds of sickness occurs for which there is no point in tracing the origin. In Biomedicine, there is arguably a protocol for avoiding common illnesses, if followed correctly and diligently. However, even within Biomedicine there is great difficulty getting the most schooled in the etiology and preventability of illness to follow the easiest and most basic prevention measure, hand-washing, in a constant fashion (Erasmus et al., 2010; Sladek et al., 2008). That is a bigger issue, as the potential iatrogenic/nosocomial disasters are extreme in the hospital environment, but it may also speak to the reason and degree in which the

relationship between hygiene common illnesses are disregarded popularly (Cave & Curtis, 1999; Curtis et al., 2003; Schnall, Benton, & Harvey, 2008; Schneider, 2006).

If the role of the healer in the diagnostic system is therapeutic (Foster 1976), because there is no mystery to the cause of the naturalistic affliction, then how do we explain naturalism in the Maasai system? In the literature of laibons, there is a quest for answers and/or services to some unusual situation (Fratkin, 1996, 2004; Spencer, 1991). Why is the commonplace illness regarded as natural/of God, if none of my participants seems to be able to easily tell me what it is? The unarticulated is not necessarily mysterious. What you “just know”, but struggle to express, or struggle to be motivated to express in terms of causality, is not the same as what you are confused, concerned, or perplexed by. There is a very wide-spread knowledge of herbalism, but when one is confronted by something for which one doesn't know the treatment, or fails in the initial superficial attempt and the affliction remains, one can ask an acquaintance, or perhaps skip the initial step and go directly to the old lady or man who has a reputation for being able to effectively treat that particular ailment. *Laibon*, male or female, are primarily diviners, secondarily witches. Supernatural power is distrusted in general. Divining is needed for upsetting inappropriate mysteries. Maasai cosmology has mystery, but not that can be accessed by humanity. In Maasai cosmology, without a rigid doctrine, with a faith in the unknowable-ness of certain things: death/afterlife, God, some things cannot be known (Fratkin, 2004; Spencer, 1991, 2003b).

Where does the utilization of Biomedicine come in? It is the specialized knowledge of certain people, outsiders and often non-Maasai, but it does not seem to be held in particular respect. According to participants, It often works when herbs do not, and herbs do not work “like they used to”. In general, the elders concede, “things are not the way things used to be”. The average person cannot go without baths and live on meat and blood alone. That made the ancestors strong, but things change. Bathing has been introduced, during a general period that coincides with the perceived introduction of many new illnesses. This is entirely possible from a Biomedical perspective, considering it also coincided with more sedentary and densely populated habitations, and the increased interaction with foreign communities. This confluence of factors may have contributed to the association of potential danger with bathing. When the easiest step of treatment with Maasai medicine has not satisfied, then there is the walk to the clinic. The clinics are free or require minimal co-pay. The private clinics in Oloolaimutia and Megwara charge their patients, but may have preferred medicines and be better stocked, previously run by moonlighting biomedical workers, sometimes with stolen supplies.

Yet, there is little respect for the Biomedical experts, despite their widespread use, as they are often viewed as exploitative interlopers. There also seems to be little interest in causality in their interactions as well. As stated above, some causes for illnesses given in interviews were learned from Biomedical health experts. This does not seem to be elite or exclusive knowledge, persuasive or memorable. There is merely the practical focus, what Foster calls the focus on the “efficient cause” in how it relates to

cure. This may reflect the type of cynicism felt towards the laibons. Unlike the Biomedical experts, laibons are too dangerous to disrespect openly, but they were considered responsible for causing all of the types of problems that they were subsequently employed to address. As one informant told Spencer “If there were no laibons, we would not need laibons” (Spencer, 2003b).

Locus of Responsibility

The theoretical foundation of research into “health behavior” revolves around a sense of responsibility and agency (Barnes, 2007; Guttman & Salmon, 2004). Is this responsibility and ability to act located in the individual? In the community? In greater human society as a whole, or the wealthy communities of the West? Or is it outside of human hands and can be considered an inevitable aspect of fate, nature, God, or biology? There is no question that in any perspective it will be more than one of these “loci”, but what matters in the consideration of health development efforts is the principal locus, the location idealized by the community, whether the Maasai or development community, into influencing the principles upon which we make our decisions for individual, community, or national behavior or policy (Amuyunzu, 1998; Barnes, 2007). My participants repeatedly stated that only God could prevent illness. When I would mention the behaviors that they had listed as causes for a particular illness and asked them if avoiding that behavior or circumstance could prevent the

illness, they would agree. Despite superficial appearances, this does not suggest an internal contradiction.

The statement of God having the responsibility and ability of preventing (and therefore also of allowing illness to happen) is a statement of a shared basic premise of Maasai cosmology. There is only so much one can do, so in the end it is out of one's hands. Conceding this point to a higher, inscrutable and distant power, may be a way of dealing with questions of fate. E.E. Evans-Pritchard described the infamous granary falling on the Azande (Evans-Pritchard, 1937). An unexpected event occurred and the community asks, "why?" The Azande answer their own question in the same way that many Bantu language communities do, it is the negative supernatural effects by persons living or dead, known or unknown, intentional or unintentional (Evans-Pritchard, 1937; Parkin, 2006). Western communities often respond to this question with a denial of its legitimacy, that this question cannot be asked because there is no intentionality involved. It is a random sequence, having no pattern, or colloquially "bad luck". The Maasai I spoke to also indicated that it was unexplainable and unknowable, but not because it is random, but unknowable just as the providence of *Enkai* is unknowable: "You don't see that *oltikana* coming that you could have prevent or run away. Maybe you slept, the whole night, and then tomorrow you wake up and you, unfortunately, became sick" (Kokoo, senior elder woman). "Because you are not seeing when it is coming so that you get a way to avoid" (Naramat and Naseina, elder 2 women). Of course there are varied perspectives in the West that have lost or gained authority over time. The perspective of a higher power as dispensing misfortune as a judgment of

moral virtue is one shared with many Christian and Muslim Kenyans, Maasai or non-Maasai alike. The monotheism of the Maasai that is regarded as traditional holds as a basic principle that Enkai is so distant from our understanding that the theological perspectives of the Abrahamic religions would be presumptuous, even to the idea of any sort of afterlife. For the Maasai, the denial of supernatural causes of illness or misfortune are not so much a secular perspective as one in which all power, understanding, and intentionality is conceded to God (Hodgson, 2005; Spencer, 2003b).

Like many African societies, the Maasai have very strong notions of filial piety, especially in patriarchy. Respect is often shown through avoidance and passivity in greeting. Women greet their husbands and older men in the same fashion as children, silently and with bowed head. In effect, they do not greet, but wait to be greeted. I was informed in my interviews, that properly behaving children will get up and leave when their father enters the house of their mother¹⁵. Adult masculinity, an important cohesive institution for Maasai society today and military society historically, is somewhat egalitarian in the pride expected to be demonstrated by any circumcised (and therefore properly adult) male. Men do not bow. The system of filial piety is also one that is paramount to Maasai society. Spencer discusses Maasai relationships with God as being, as in many religions, like that of the father of a family to the children (Spencer, 2003b).

¹⁵ Women build and are considered the owners of their houses. Married men divide their time between the houses of their wives (Hodgson, 2001a; Hollis, 1905; Spencer, 2003b).

One of the broadly acknowledged supernatural powers in Kenya, and one could venture to say Sub-Saharan Africa (if not through much of the world), is the curse of the parent. The father's curse in particular is recognized. It is regarded as fatal if not lifted by the father himself. There is no other remedy, (this may be contested on principle by some Christian Kenyans but with no haste to test it) and it is regarded as inevitably resulting in death and ruin for the individual cursed. Maasai society has been noted as also possessing other curses that can be given by older male age groups to younger.

When one considers that age-grade organized African societies, even ones considered less strict than the Maasai, it is considered appropriate that age-mates of one's parent are to be respected as one's one parent, this presents a problem for men greeting men of older age grades. This is typically solved by the younger man simply approaching and then standing near the elder, waiting almost as if indifferent, to be acknowledged with a greeting initiated by the elder. I learned this the hard way. When collecting age and gender appropriate greetings, I was told by my translator that the greetings for men the age of a grandfather is "*kakuiya*". This is indeed the greeting, but only for age-mates. For a relatively younger man like myself, it was ridiculously presumptive. Fortunately, the elders I initially approached thought my boorishness was hilarious, and to my chagrin, insisted on shouting "*Kakuiya!*" to me across whatever distance existed when they first spotted me. This was also considered a hilarious reference to my early faux pas of greeting various people from a distance, many of whom ignored me, to my initial confusion.

Greeting one's father is even more problematic than greeting any other elder. The relationship of the child to the father does not really change over time. There is a proverb used by the Maasai, recorded by Ole Sankan, that translates to "A man is only really circumcised when his father dies" (Ole Sankan, 1986). Circumcision, the major rite of passage into adulthood for both men and women, changes a submissive and often distrusted mischievous boy into a universally respected and responsible man, except in his relationship with his father (Spencer, 2003b). Respect shown to one person reflects the respect one is viewed as showing to all of that person's age-mates. Respect shown to one man, as a man, may even be seen as respect shown to the patriarchal aspect of a society (Spencer, 1988). However, one's father is never, even symbolically, one's equal. The greeting of a son to a father is to silently approach, without a bow. But the hand of blessing is still extended from the father, not upon the head, as it would be to a woman or a child, but on the shoulder. I have not seen or heard of this type of greeting in any other circumstance. Thus the significance of the father to child relationship in Maasai society, and if this is also accepted as a metaphor for the relationship between the Maasai and *Enkai*, it can be viewed as the model for the way misfortune and illness can be attributed to God, inscrutable and unknowable.

The significance of this relationship of extreme respect between a child and a parent, and in particular between a child and a father is suggested to be analogous to the relationship between the Maasai people and *Enkai* (Spencer, 2003b). Signs of presumption by the junior person would be a sign of disrespect and is avoided. Claiming knowledge of the ways in which Providence is enacted through the experience of

everyday illness or the dynamics of its causation may be considered to be presuming to know the unknowable. Attribution to the iconic representations of Enkai, or simply a disavowal of knowledge is a nod to the basic premises of Maasai cosmology, as well as orthopraxis for a respectful Maasai. The disclaimer is a demonstration of respect for *Enkai*, the epitome of elderhood, and conventional recognition of the inherent uncertainty of the future due to the mystery of divine providence.

Chapter 6 Cosmology and Causal Attribution, Respect and Reality

Conclusion

The production and maintenance of health in a community is a complicated process involving behaviors and values that draw from cosmological premises and world view. In drawing from these premises, these processes form the nature of health and illness as understood by its members. Without the reference to these domains of common sense, the nature of simply how the world works, there would be no resonance with the community and as a result, the behaviors and the immediate logic in which they are based would be regarded as senseless.

I have argued that the Maasai of Losho and its surrounds, consider both a proximal and ultimate cause when asked to consider the etiology or hygiene of illness. The ultimate cause of anything in the Maasai world, is the providence of *Enkai*. The Maasai have faith in this precept. That the world is driven by divine providence is known. What is not known, at least what cannot be presumed, is how this occurs. Not in a practical, immediate sense, but in a philosophical sense. If you claim to know these things, you are a fool at best and a sorcerer at worst. Combined with the fact that in the face of a superior, silence or avoidance is the most polite behavior, disclaiming or disavowing ultimate knowledge is polite and respectful, and in the sense of ultimate cause, at least as legitimate as any other perspective.

Evans-Pritchard presented to anthropology the concerns of the Azande: why did the granary fall then, and on those people? What intentionality directed it, with all other factors being equal? In the West, some might argue that those people were bad and being punished by God, but this perspective is generally regarded as archaic. A more popular contemporary view is that it is not a legitimate question to ask. A lack of intentionality is a basic premise of our world view in these cases. In the primitivist tradition of the West, we have historically assumed that the non-Western perspective is driven by either innocent or barbaric ignorance of termites, and wooden support poles, and how these things work together to cause granaries to fall. But this dynamic is known to the Azande, just as practical and proximal dynamics are known, and accepted otherwise when presented reasonably, by the Maasai people (Knowles & Collett, 1989). The primitivist perspective takes the opportunity to try to secure the West in the position of the intellectual, and the Other as the brute, while missing the point entirely. The ideal Maasai says the ultimate cause is known only to *Enkai*, but not that the proximal cause is unknowable.

Despite the continued representations of the Maasai people as conservative and reactionary, they have historically shown themselves practical and open to innovation¹⁶. However, they are unwilling to accept Western values and behavior without demonstration that they make more sense than Maasai tradition (Knowles & Collett, 1989). It is an article of faith that Maasai tradition has served them well (Spencer,

¹⁶ I do not mean to reify “the Maasai” in an abstract bounded sense. See Hodgson for the seizing of specific British patriarchal traditions by Maasai men to disempower Maasai women (Hodgson, 1999a, 2001a, 2001b, 2011)

2003b). They continue to exist and prosper in the sight of *Enkai* because of it. The blessings of Enkai: children, cattle, milk, grass, rain, the many uses of the plants of the forest, continue to come.

The conceit of Biomedicine and public health, as in every ethnocentric perspective, is that they represent objective reality, or “the way things are”. Presenting an authoritarian message, in absolute terms based on the premises of a foreign cosmology, they are often not successful in persuading communities, even within Western sub-cultures, much less among a community as distinct from the West as the Maasai (Banerji, 2004; Barnes, 2007; Cave & Curtis, 1999; Crawford, 1977; Justice, 1986; Loevinsohn, 1990; Mckinlay & Marceau, 2000).

This dissertation has been the study of the common health landscape shared by a Maasai community in Narok South, Kenya. This community is located in Siana Valley and includes Losho and its surrounding villages. The people of the targeted population in this community are primarily pastoralists living in ‘traditional’ housing and wearing non-western dress. Siana Valley is located in the southern portion of Narok South, a constituency in Narok County of the Rift Valley Province, of Kenya. In order to identify, describe, and analyze the shared health landscape, it has focused on the locally determined most common and significant illnesses. These illnesses have been presented and analyzed in relation to foundational cosmological premises of the Maasai community. They have been demonstrated to be meaningfully rooted in these premises.

The data for this dissertation was gathered from over 15 months in Kenya and supported by nearly 4 non-consecutive years of living in Kenya. This dissertation's findings have been systematically gathered through participant observation and open-ended interviews. The interviews featured open-ended questions and free listing in an effort to establish the domains of illness, diagnosis, etiology, healing and hygiene that make up the most prominent landmarks of the local health landscape. Unlike previous literature, this dissertation has focused on the lay, 'common sense', or popular health sector and has cultivated the local perspective on the local health experience.

The fieldwork consisted of 6 stages of research over 15 months. The first 2 stages involved immersion, language study and participant observation. Participant observation continued throughout the fieldwork period. The next 4 stages involved 4 series of interviews for a total of 76 interviews, involving 107 participants. The findings of the first series of interviews have been collected into frequency tables of responses. These frequency tables, along with the coded transcripts of the other interviews, were analyzed in light of the relevant literature. Based on this original research, it was demonstrated that the concepts that make up the major landmarks of the common health landscape are informed directly from the core cosmological premises of elderhood, respect, the relationship of Maasai with the providence of *Enkai*, and the nature of *Enkai* as mysterious and fundamentally unknowable.

The primary foundations of health landscape of the Siana Valley Purko Maasai community are these Maasai cosmological premises, influenced by a largely incoherent

and disjointed bits and pieces of Biomedical concepts that tend to be accepted or rejected according to the degree of their correlation with Maasai concepts of orthopraxis. Concepts central to Maasai society, elderhood, respect, and the relationship between the Maasai people and *Enkai*, give a framework to illness entities that make up the common health landscape. Respect for elders is demonstrated by silence and symbolically passive greeting. *Enkai*, the ultimate progenitor, represents the epitome of wisdom, knowledge, and power that are embodied by Maasai elders. Like silence in the face of greatly senior elders, the questions of etiology and hygiene are often initially answered with “non-answers” that in fact signify a refusal to address the realm of providence, or the divine order of the world, which can be known only to God.

Further Research

This research was inevitably finite in its scope and nature. It was an examination of an entire popular health sector of a particular community, in a particular place, generally with a particular culture, narrowed only to the self-identified most common and significant illnesses. Identifying cultural domains such as this is essentially a semantic exercise. With the language dynamics as they are in this region, much of the analysis had to pass through up to 3 languages. Further research should focus on direct interviewing by a researcher fluent in the local dialect. This would require a significant commitment of time and effort. Another limitation, directly involved with developing language fluency was the skill levels of the translators involved. Most of them were

secondary school leavers, though among the educated elite for the area, were not necessarily effectively educated in grammar concepts in English or Swahili and so were limited in their ability to both translate easily and tutor in language learning effectively. The cultural anthropologist has an obligation to learn the language of the studied community (Owusu, 1978). True fluency takes years of intensive effort and this process cannot be rushed or taken lightly. Maa, in its many dialects, is a language yet to be standardized, in grammar, vocabulary, or orthography. Like every spoken language it is fluid and dynamic. It is also in the Nilotic language family with tonal aspects, vastly different from Swahili. Research by anthropologist fluent in Maa is essential for further exploration and confirmation of the findings in this dissertation.

In terms of subject matter, the popular sector has inherent difficulties, especially in a society which may be influenced by folk medical concepts that are also not codified or standardized. With the health landscape, and its domain of local health priorities established by this study, the individually listed illnesses are now appropriate for more focused study of an individual health problem, supported by the collection of individual illness narratives and explanatory models.

Likewise, a similar study should be pursued extensively with international health development workers in order to understand their reference domains, priorities, and cosmological premises. Unless in the situation of an indigenous anthropologist, with an indigenously derived anthropology, this research is ever an interaction of world views and it the presumption of objectivity that should always be called into question.

Significance of research

NGOs have had limited success in behavior change campaigns, evidence of which has been noted and critiqued upon for decades (see Barnes 2007; Banerji 2004; McKinlay and Marceau 2000; Cave and Curtis 1999; Loevinsohn 1990; Rodmell and Watt 1986; Justice 1986; Crawford 1977). A key problem, as perceived by international health campaigns that target behavior change, is “gaining the compliance” or “adherence” of their target population. There are many reasons given for this and they typically involve the metaphor of “barriers” of the local community: cultural, environmental, and economic (Manderson 1998; e.g., Launiala and Kulmala 2006; Population Council/Horizons Communications Unit 2006).

This “compliance” or “adherence”, which requires agreement of the target population with the Western treatment and prevention model with its implications regarding civilization, modernity and morality, is believed to hinge on the successful communication between NGO workers and members of the target community and can be hindered by misunderstanding on either side (Horton and Barker 2009; Tapias 2006; e.g., Krumeich et al. 2001; Scott et al. 2007; Sladek et al. 2008; Curtis et al. 1995; Bloomfield et al. 2007).

International health campaigns have a great deal of difficulty in achieving success in behavior change attempts (Barnes 2007; McMillan and Meltzer 1996; Campbell 2003; Cave and Curtis 1999; Loevinsohn 1990). Behavior change models of healthcare frequently provide formulas that cast the belief systems or cultures of the

targeted communities as the primary barriers (Barnes 2007; Fassin 2001). The beliefs are presumed to do this in their hindering of the practitioners in the “realization” of the problem as understood by foreigners (Westerners or other outsiders who are invested in a form of biomedicine), and/or the foreign method deemed necessary for its eradication. This health belief model has been recognized as insufficient but the paradigm of ignorance or false belief as a barrier is still a driving paradigm of public health (Barnes 2007; Tapias 2006; Horton and Baker 2009). Anthropologists have historically been used to broker the interaction of these vertical projects, translating local perspectives and identifying methods to overcome them (Manderson 1998). More recently anthropologists have examined macro-social perspectives, such as political economic factors, and less ethnocentric analyses of local perspectives on health and illness in order to find priorities for health efforts that could be more equally balanced between foreign workers and target populations (Merton and Haller 2007).

Social sciences research has shown that health campaign messages, particularly when regarding behavior change, are not morally neutral (see Sachs 1996; Barnes 2007; Cho and Salmon 2007; Tapias 2006; Horton and Barker 2009; see also Harris 1989). Psychiatric anthropologists Nemeroff and Rozin (1994) have demonstrated that Western concepts of contagion and pollution are related to moral evaluations and have a broader basis than germ theory. There is blurring of lines between physical/moral boundaries in popular sector contagion concepts (see also Douglas 1966). These Western “common sense” notions in turn saturate the framing and practice of health aid efforts as shown in bioethics literature (Guttman and Salmon 2004). International

health campaigns propose “cultural barriers” and “environmental barriers” that both involve behavior change as an element of the solution, thus attributing moral status to pre-existing behavior patterns of Africans, and the Maasai in particular (Schneider 2006). This blame falls along lines of historical and neo-colonial Western views of Africans in relation to modernity/civilization, cleanliness/soap, and barbarity (Burke 1996; McClintock 1995; Hansen 1999; Fredriksen 2000; Schneider 2006; see also Chakrabarty 2000). This is particularly true among disempowered communities that live far from “civilized” environments, such as pastoralists like the Maasai (Sheik-Mohamed and Velema 1999).

Maasai, who are iconic for African rejection of “the West”/ modernity to both Westerners and other Africans, are especially subject to this blame (Schneider 2006; Barnes 2007; Hodgson 2001; Swantz 1995). The Maasai, due to the complex way British colonial administrators saw them as both a representation of their own militant masculinity and as one of the most primitive of communities, have been subjected to paternalistic protection or neglect by both colonial and independent governments (Hodgson 2001). They fall into both aspects of the “primitive” described by Lucas and Barrett (1995): Arcadian and barbaric. Maasai provide the image, to the West as well as to other Africans, of the archetype of the Romantic noble savage of Rousseau, and the bestial, filthy antithesis of civilization and development (Hodgson 2001; Schneider 2006).

The popular sector of health remains an understudied area. This research addresses it directly in its description of the local health landscape from the perspective of Maasai lay people. Arthur Kleinman's three sector conceptualization of the realms of health and healing in every society is a useful frame to remind us that these three general perspectives exist, as well as overlap in important ways. In particular, it is the overlap that is the focus in this study of the shared health landscape of the Maasai people in Losho and its surrounding areas (the Siana Valley). All three sectors have influence on the perspective of the local lay people of the area, but what is most important, and I believe this is true in every case, is that the popular sector, the common sense perspective, has influence on all others through its direct foundation in the cosmology of the community. In this respect, the health landscape can be said to have a popular sector bedrock and soil foundation, occupied in parts by the *enkangs* of folk expertise set on the savannahs and beside the forest/ the trees/*olchaani* of shared popular sector herbalist competence, and lastly the urbanized sectors inhabited by professional traditions of biomedicine, public health, and international development.

This research is also significant in terms of ethnographic methodology. It serves to underline that all responses, even 'non-responses' are important data and tell the researcher something about the participants in question. What seemed like an initial refusal to engage the researcher in an explanation of the etiology of common illness entities in the community, was itself demonstrative of one of the most central aspects of the Maasai relationship with *Enkai*: the mystery of Providence.

Speaking for Themselves: Priorities and Relevance

Dorothy Hodgson demonstrated with the example of indigenous rights movement in Tanzania, that development organizations that impose their own priorities, or their own interpretation of local priorities, can be as effective as colonial and post-colonial government in re-creating their own sexist systems of oppression and disempowerment. Maasai women were pressured to adopt the priorities of foreign organizers by both the economic leverage they could exert, as well as the male dominated Maasai organizations that stood to benefit from the Western-style patriarchy that these ostensibly aid and development organizations would unwittingly institutionalize (Hodgson, 2011). Likewise, health improvement efforts around world feature the same dynamic, particularly when addressing rationality, decision-making, and behavior change (Bibeau, 1997; Coreil, 1997; Yoder, 1997). Through an inability to engage the target populations as mature, thinking communities, national governments as well as international organizations cement into place structural violence that often does the most harm to the populations they most want to help: the least empowered.

This research opens a pathway in which the most influential sector health can be understood on its own terms. Determining the health landscape of the Maasai people of Narok South does more than illuminate the playing field for health development efforts my national and international organizations. It demonstrates that the perspective used by the local community is fused both to a cosmological perspective central to the community, while at the same time practically oriented towards goals that

reflect the concerns of the community. If health development organizations can find agreement with the local priorities regarding health, and are able to propose efforts that do not promote illogical shreds and patches of a foreign etiological world view whose acceptance seems contingent on rejecting central premises of a community's identity, it is much more likely to obtain support and acceptance.

The Treachery of Text

As a post script, and to complete the extended metaphor of a landscape, let us remember that the landscape is a realistic painting of a natural scene. It has been used to romanticize the pastoralist community of Arcadia as noble primitives, the conceptual root of primitivism that has done so much harm to those who have been subject to the gaze of the West. However, to paraphrase Rene Magritte: this is not the Maasai people of Narok South. It is a constructed representation that must be interpreted for what is represented, with a critical eye toward symbolism and accountability. As much as possible, it has been co-created with input of all the participants, but there is only one who decides what gets painted over and what gets foregrounded.

Appendix

Research Guides

First Interview Series: Maasai people of Losho

1. (Demographic information was gathered from the translator who was acquainted with all the participants, in order to avoid embarrassment)
2. What are the common and significant health problems of this area?
 - a. What are the signs of this health problem? (repeat these questions for each problem)
 - b. What are the causes of this health problem?
 - c. What are the ways people treat this health problem?
 - d. How can this health problem be prevented or avoided?
3. What has been done to control or reduce health problems in this area?
4. What should be done to control or reduce health problems in this area?
5. Why do some people become sick and others do not?
6. What can be done to avoid being sick, or to stay healthy if you are healthy now?
7. How are children taught to be healthy?
8. Can you tell me a story, song, or proverb/poem that is used to teach people to behave in a health way?
9. Did people in the old days have more or less health problems than today?

Second Interview Series: Employees and Volunteers of the NGO in Losho

1. What is your age/school/major/year?
2. Is this your first time here? (what is your experience in Kenya?)
3. How did you come to be an employee/volunteer of this NGO?
4. What preparation did you have for this work?
5. Can you describe the work you do here?
6. Have you been outside of the school compound? If so, where have you been?
7. In your experience this far in Losho, what have you seen to be the most common and significant health problems? Can you describe them?
8. What are the causes of these problems?
9. What do you think should be done about them?
10. What would you think this community needs the most to improve health conditions?

Third Interview Series

- A. First Interview Guide for the 3rd series was essentially the same as the 1st, but with the addition of an agreement survey and the removal of unproductive questions
 1. (Demographic information was gathered from the translator who was acquainted with all the participants, in order to avoid embarrassment)
 2. What are the common and significant health problems of this area?
 - a. What are the signs of this health problem? (repeat these questions for each problem)

- b. What are the causes of this health problem?
 - c. What are the ways people treat this health problem?
 - d. How can this health problem be prevented or avoided?
3. What has been done to control or reduce health problems in this area?
 - a. What should be done to control or reduce health problems in this area?
4. (see Agreement Survey)
5. Can you tell me about the trachoma/enkoye campaign?

Fourth Interview Series

1. What are the main health problems of this area? What are the obstacles to dealing with these problems
 - i. How serious is trachoma/*enkoye*
2. How is this area unique in Maasailand, in Kenya?
3. What development efforts have been made by Maasai, non-Maasai?
4. What health campaigns or other efforts have been done in Maasai land?
 - i. How successful have they been? What should be done?
5. How has the perspectives of local people affected health campaign efforts?
6. Does Biomedicine/Western medicine cause any problems/obstacles?
7. (for Laibon) Does mzungu culture create obstacles for development and health problems?
8. (ask same for Maasai culture)

9. What role does selfish leaders or corruption play in development and health problems?
10. What are the existing projects for hygiene/sanitation here/in Kenya? What should be here?
11. What is your opinion of Maasai herbs?

Agreement/Disagreement Survey

(This survey was presented to stimulate conversation about etiology and hygiene, in addition to simple agreement or disagreement. It was compiled from causes given in previous local interviews. Causes that would be recognized on the coast of Kenya or in the United States were also added to provoke responses and explanations. Lastly, causes that were expected to be disagreed with were intentionally added to prevent participants from predicting agreement with causes before considering them carefully. Participants were asked to explain their responses.)

<ol style="list-style-type: none">1. Not bathing enough2. Bathing too much3. Dirty hair/Long hair4. Not washing hands5. Washing hands too much6. Dirty dishes and cups7. Unswept house8. Dirty clothes9. Eyes of jealous people10. Angry ancestors11. Curses from other people12. Contact with a sick person13. Contact w/ mucous of a sick person14. w/ saliva of a sick person15. w/ breastmilk of a sick person16. w/smell of a sick person17. w/soap of a sick person18. w/razor of a sick person19. w/blood of a sick person20. Sharing food with a sick person21. Talking about a sick person or a disease22. Contact with human feces23. Making mistakes in a ceremony24. Neglecting a ceremony25. Doing the wrong ceremony26. Making parents angry27. <i>Laibon</i>28. Bad luck29. Rudeness to elders30. Failing to greet people31. Having a fat body32. Eating sweets	<ol style="list-style-type: none">33. Drinking unboiled milk/water34. Drinking dirty water35. Drinking too much milk36. Eating wrong foods, e.g., birds, fish37. Eating smokey meat, raw meat38. Drinking cold water39. Drinking alcohol40. Putting shoes on a table41. Contact with sick livestock42. Contact with animal dung43. Contact with pests, their contact with milk/water/food44. Smell of dead animals45. Eating animals found dead46. <i>Enkijebe</i>47. <i>Osiwo Kirobi</i>48. Bathing in cold water49. Cold rain50. Dust in the wind51. Eating only one type of food52. Mixing different foods53. Children eating soil54. Walking on a grave55. Chameleons56. Failing to pray to <i>Enkai</i>57. Not sleeping under a mosquito net
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Demographic breakdown of interviews informing the frequency tables

Table 14 Total Interviews and Participants

Interview Series	Interview #	Participant #
1 st -Losho Maasai community	30	53
2 nd -NGO	18	18
3 rd -Surrounding Maasai Communities	20	28
4 th -Biomedical professionals	8	8
<i>Total Interviews/Participants</i>	76	107

Table 15 Age Range/Gender (not counting the 6 disqualified participants)

Age range	Female	Male
A- Teens to mid-20s	11	3
B- Late 20s to early 40s	12	11
C- Mid-40s and older	4	6
<i>Total</i>	27	20

Table 16**Participants per initial 27 Interviews**

Health Challenge Interviews	Age grade	Participants in interview	Male/ Female	# Illnesses listed
1 Losho	B	1	m	8
2 Losho	A	1	m	6
3 Losho	A	1	f	3
4 Losho	A	1	f	3
5 Losho	A	3	f	7
6 Losho	B	4	f	8
7 Losho	B	2	f	8
8 Losho	B, C	3	f	6
9 Losho	A	2	f	4
10 Losho	A	1	f	4
11 Losho	B	2	f	10
12 Losho	B	1	f	7
13 Losho	C	1	m	6
14 Losho	A	1	f	3
15 Losho	A	2	f	5
16 Losho	B	1	m	3
17 Losho	C	1	m	6
18 Losho	B	2	m	3
19 Losho	C	2	f	4
20 Losho	C	2	m	6
21 Losho	B, C	7	m	3
22 Losho	B	1	f	8
23 Losho	C	1	f	5
24 Losho	B	1	m	2
25 Losho	A	1	m	4
26 Losho	A	1	m	2
27 Losho	C	1	m	3

Table 17

Surrounding Maasai Communities Age Range/Gender

Age range	Female	Male
Teens to mid-20s	4	0
Late 20s to early 40s	11	8
Mid-40s and older	3	2
<i>Total</i>	18	10

Table 18

Oltikana Symptom Listing Frequency

Oltikana Symptom Frequency (25 symptoms listed in 25 interviews)	
Symptoms	N=25 (%)
Fever/ "feel hot"	12 (48.0)
Headache	11 (44.0)
Mouth bitter	8 (32.0)
Weakness	7 (28.0)
Vomiting	6 (24.0)
No appetite	6 (24.0)
Coughing	5 (20.0)
Sleep	5 (20.0)
Pains all over body	4 (16.0)
Bile in stomach	4 (16.0)
Fear cold/ enkijebe	3 (12.0)
Feel cold	2
Unable to breathe	2
Fear heat of sun	2
Rashes/ skin is not normal	2
Red eyes	2
Joint pain	1
Sweating	1
Yellow bile	1
Pain from bile/ pain in stomach	1
<i>Maiyolo</i> ("I don't know")	1
Dry mouth	1
Pain in the neck	1
Unable to walk	1
Preceded by <i>olkirobi</i>	1

Table 19

Olkirobi Symptom Listing Frequency

<i>Olkirobi</i> Symptom Frequency (19 symptoms listed in 24 interviews)	
Symptoms	N=24 (%)
Sniffling/ running nose	17 (70.8)
Coughing	16 (66.6)
Headache	9 (37.5)
Lots of mucous in nose	8 (33.3)
Fever	6 (25.0)
Tired	2
Tears	2
Feeling hot	2
Vomiting	2
Unable to breathe	2
Pain in chest	2
Sore throat	1
Feel heavy	1
Very weak	1
Fear cold	1
Not like sun	1
Nose pain	1
Does not want to breast feed	1
Face is unhappy	1

Table 20

Nang'ida Symptom Listing Frequency

<i>Nang'ida</i> Symptom Frequency (11 symptoms listed in 11 interviews)	
Symptoms	N=11 (%)
Leg swelling	7 (63.6)
Pain in the joints	6 (54.5)
Swollen joints	5 (45.4)
Pain on <i>mgongo</i> / back/ backbone	5 (45.4)
Unable to walk	4 (36.3)
Pain in legs	2
Feeling cold	1
Veins appear	1
Become weak	1
Fatigue	1
Pain in the bone	1

Table 21*Lemunya/ Pneumonia Symptom Listing Frequency*

Lemunya/ Pneumonia Symptom Frequency (10 symptoms listed in 10 interviews)	
Symptoms	N=10 (%)
Coughing	5 (50)
Difficulty breathing	5 (50)
Pain in ribs	4 (40)
Fear the cold air/ <i>enkijebe</i>	4 (40)
“Chest is closed”	2
Pain or “tackle the lungs”	2
Vomit blood	1
Unable to walk	1
High temperature at night	1

Table 22

Taifoid/ Typhoid Symptom Listing Frequency

<i>Taifoid/ Typhoid Symptom Frequency</i> (11 symptoms listed in 10 interviews)	
Symptoms	N=10 (%)
Intestines make noise	7 (63.6)
No appetite	5 (45.4)
Diarrhea	3 (27.2)
Vomiting	3 (27.2)
Doctor has to tell you	2
<i>Maiyolo</i> ("I don't know")	1
Pain in ribs	1
Headache	1
Feel pain in joints	1
Coughing	1
Fever	1

Table 23 Fieldwork Research Stages Timeline

Fieldwork Research Stages (6 stages over 15 months)		Months
1 st	Immersion in daily life of community (ongoing throughout fieldwork)	1-15
2 nd	Introducing myself and the research project at all the multi-family compounds/ Rapport development and Language learning	1-3
Begin 4 Series of Interviews		
3 rd	Interviews with Losho adults- 1st Interview Series	4-6
4 th	Interviews with NGO workers- 2nd Interview Series	7-9
5 th	Interviews with local people in surrounding villages- 3rd Interview Series	10-13
6 th	Interviews with local biomedical professionals- 4th Interview Series	14-15

Outline of Fieldwork and Fieldwork Design Process

First 2 Stages of Fieldwork: An Iterative Process of Developing Research Methodology

- Hiring a language instructor cum translator
 - Engaging language lessons
 - Training translator in research level translation
- Participant observation
 - Tasks of daily life, e.g.,
 - Collecting water
 - Inspecting livestock
 - Maintaining compound environment
 - Visiting neighbors
 - Weekly
 - Walking to the ten mile distant market to carry home a gunny sack of groceries
 - Because of the gossip obsessed nature of village life, many people felt more comfortable approaching me when I was alone in the forest
 - Many people made this same trek each week to shop and socialize
 - Irregularly
 - Visiting neighbors further afield

- Attending social events such as fund raisers and celebrations

Stage 3 - 1st Interview Series Losho Maasai Community

- Mapping all of the *enkangs* of Losho. There were 19 in total.
 - *See map A Losho*
- Employing stratified convenience sampling.
 - I approached every *enkang* in the area to recruit participants (stratification of single or multi-family compounds) in randomized order to avoid the appearance of favoritism.
 - I recruited only married adults, who were either newly married or parents. For men and women, adulthood commenced with circumcision. For women this generally immediately preceded marriage. For men, this traditionally preceded warrior status, followed by junior elder status, and then senior elder. I interviewed only men who had entered junior elder status, as warriors are not permitted to marry and typically do not have caretaker responsibilities for sick people.
 - I recruited a convenience sample from each *enkang* (the first that agreed upon approach). After finding that this led to a preponderance of mothers as participants, I made an effort to find male participants. This was challenging as most young fathers were out herding animals in distant grazing areas all day and to visit them at other times generally would inconvenience their families. Grandfathers and older fathers who

had sons old enough to take out their cattle, (or who could afford herdsman) were easier to find.

- Interview initially designed according to a model expecting language analysis and oral literature data, as well as accounts of trachoma. Because of initial findings, the interview was modified to specifically interrogate local priorities of health and illness, as well as popular etiology and taxonomy

Stage 4 - 2nd Interview Series NGO Workers

- Interview redesigned for eliciting the foreign perspectives of outsiders regarding priorities of health care and local hygienic practices
- At this point I approached the local non-governmental organization and attempted a consensus sample of the American volunteers and a convenience sample of the Maasai employees. (The Maasai employees were interviewed with the same goals as in the initial set of interviews).
- Volunteers were mostly undergraduate students. There was also a registered nurse and a medical school student. The Maasai employees were either high school leavers working as translators or herdsmen with little formal education working as a camp guard and a cook.

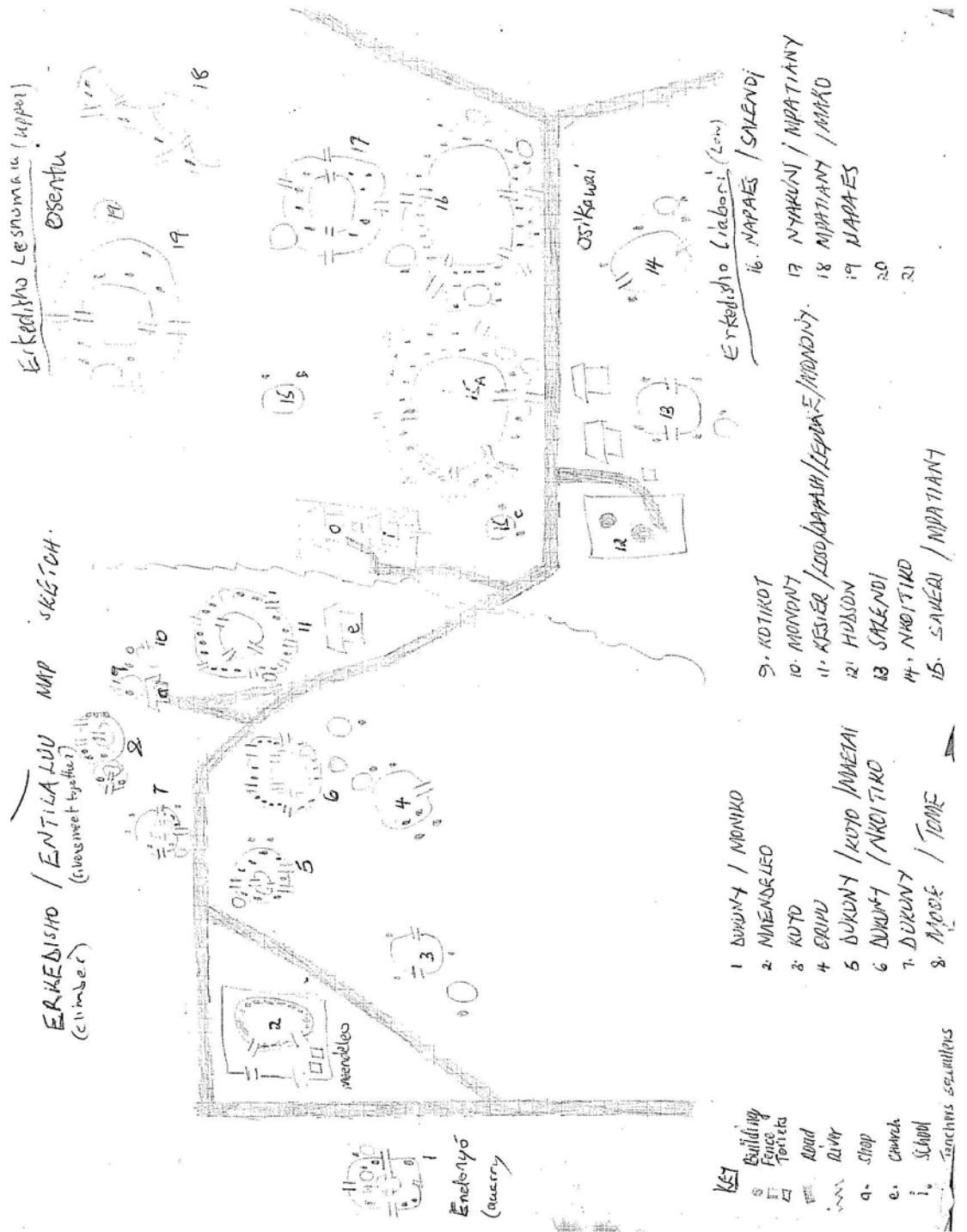
Stage 5 - 3rd Interview Series Surrounding Maasai Communities

- Formally redesign questionnaire after analyzing the results of the first 30 interviews to explore emerging themes from previous interview stages
- Training local translator

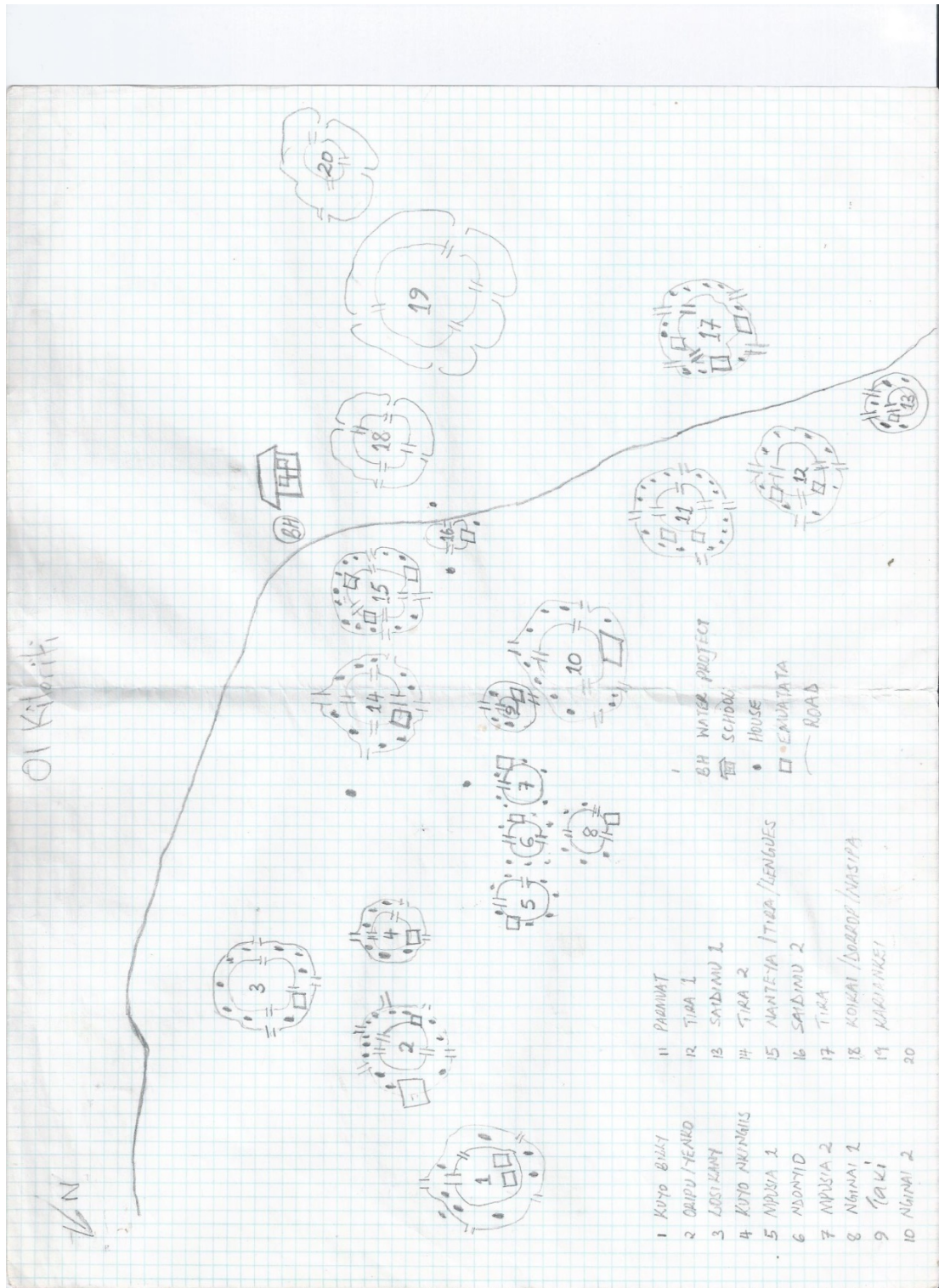
- Mapping *enkangs* of surrounding communities:
 - see map B (*Olkiloriti*), map C (*Embiti*), map D (*Megwara*, and map E (*Oololaimutia*))
- Recruiting a convenience sample from five randomly selected *enkangs* from each of the four surrounding communities

Stage 6 - 4th Interview Series Biomedical Health Professionals

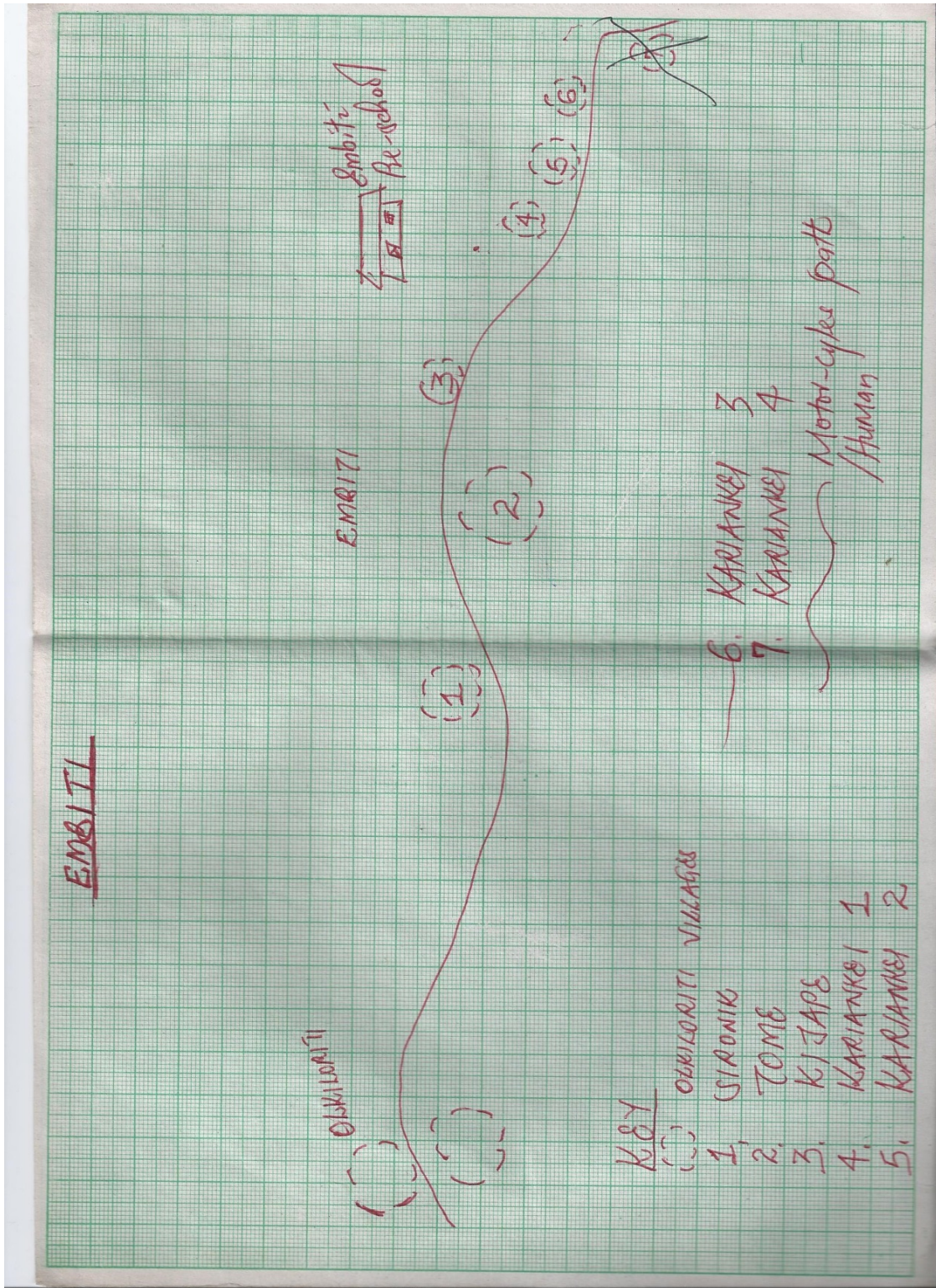
- Interview redesigned for Biomedical health professionals
- Health professionals identified in Losho, Megwara, and Oololaimutia. The first 8 to agree to recruitment were identified. Sampling was purposeful. 4 Ministry of Health employees: 3 nurses, 1 pharmacy technician; 3 Private sector: 1 Private clinician, 2 chemist shop assistants (employees of chemists are commonly consulted for medical advice throughout Kenya); finally, there was also an Peace Corps Volunteer working as a Public Health extensionist assisting the nurse at the government clinic in Oololaimutia.



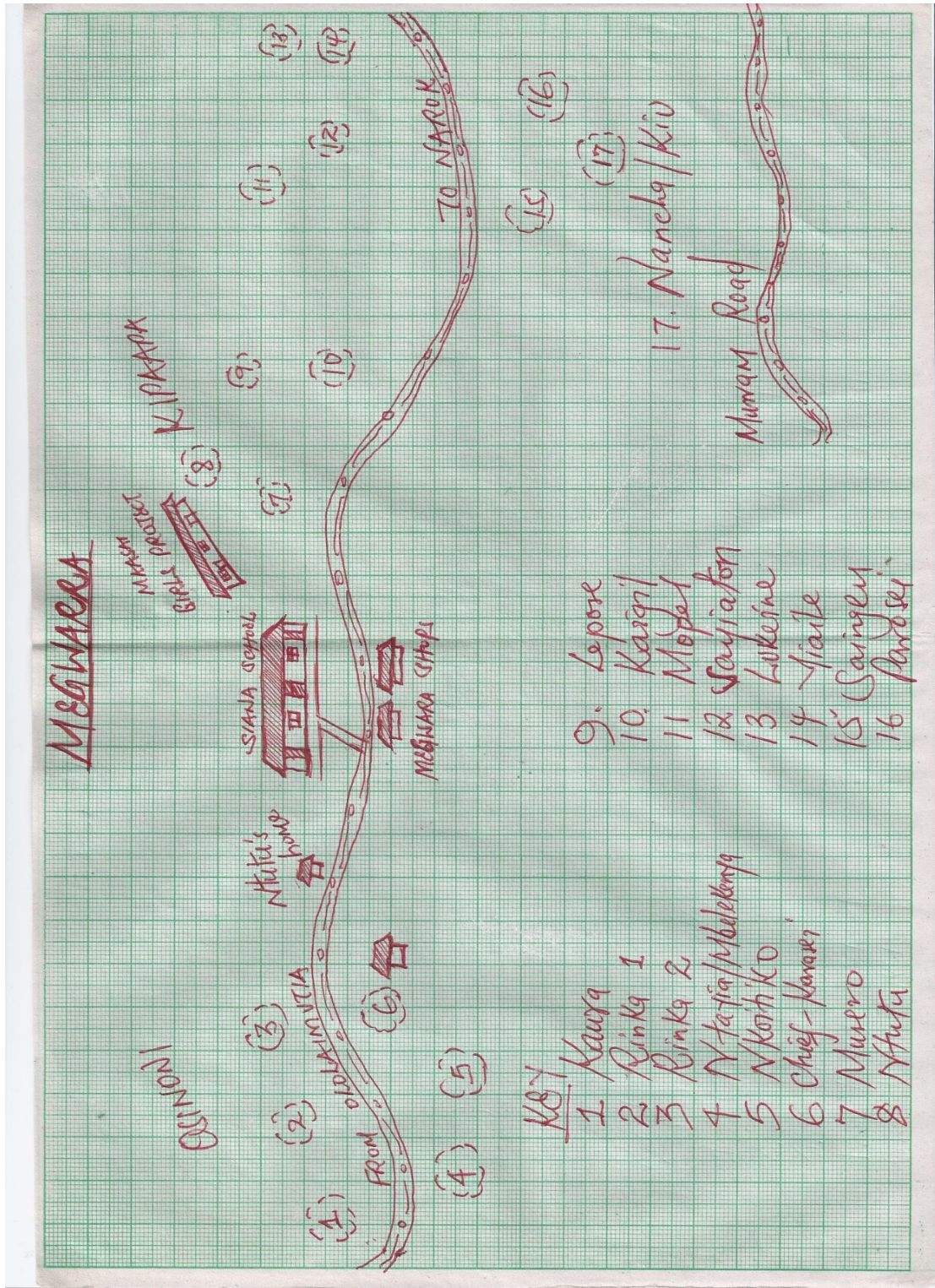
Map 5 Olkiloriti



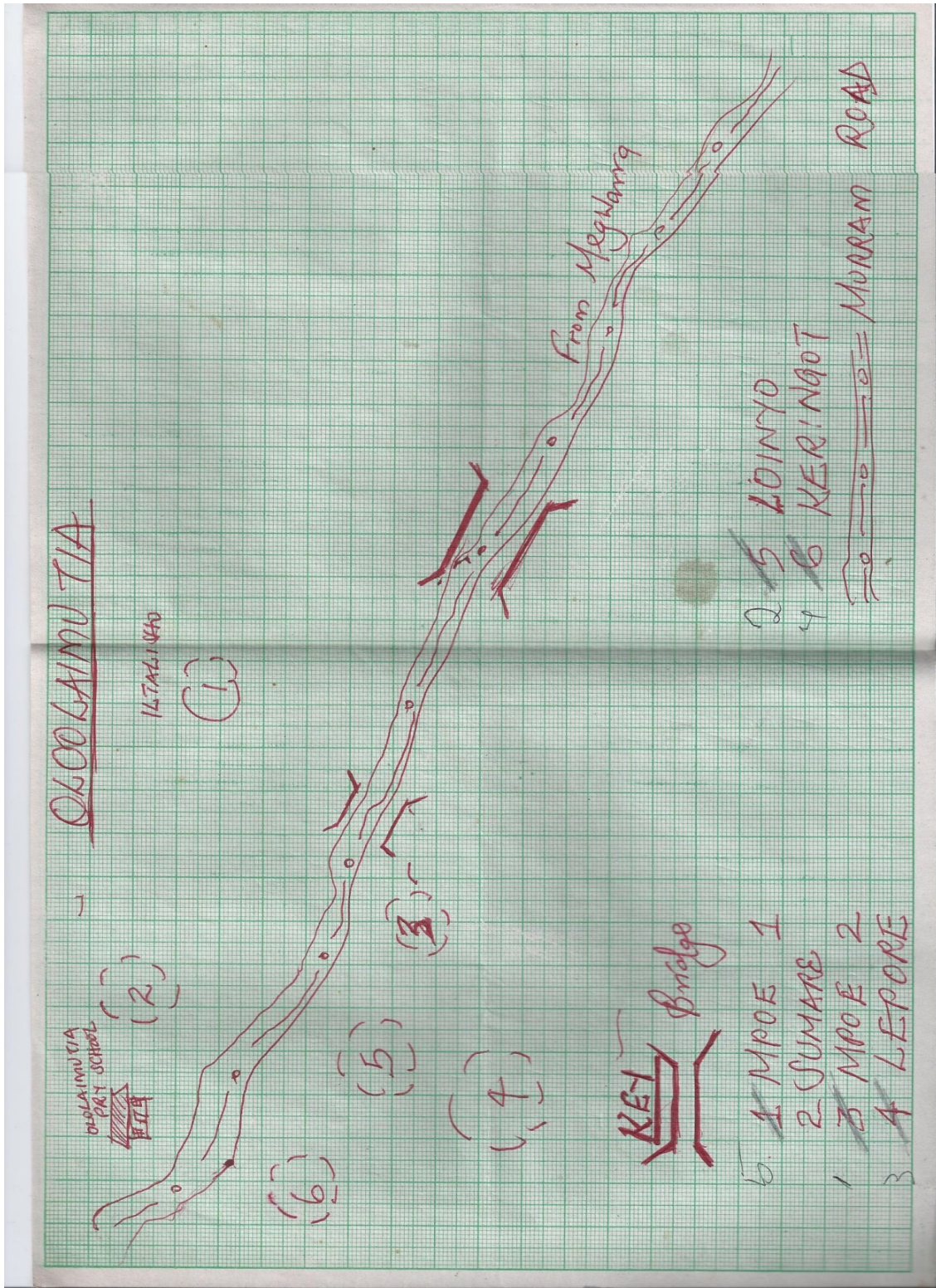
Map 6 Embiti



Map 7 Megwara



Map 8 Oololaimutia



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