Title: “Kachinja are coming!” Encounters around medical research work in a Kenyan village.

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**Abstract:**

When conducting medical field research in a Luo village in western Kenya, my colleagues and I were occasionally suspected of being blood-thieves, locally called *kachinja*. The article contextualises these blood-stealing accusations within the practices of medical research that prompted them, and within the local historical experiences which they, I shall argue, refer to. Further, it examines two social situations, in which blood-stealing accusations were raised against me and people who were in contact with me, in order to show how the *kachinja* idiom is used in social practice, as part of long-term social processes as well as of momentary situations, within local patterns of relatedness. These observations show how global structures and processes are articulated and moulded in a particular locality through idioms that carry memories of individual as well as collective, historical experiences, and how they are enacted by people within webs of contemporary local social relations.

**Keywords:** Kenya, Luo, history, medicine, research, blood, knowledge, rumour, idiom
“Kachinja are coming!” Encounters around medical research work in a Kenyan village.

A medical field study in western Kenya

Early morning in a primary school in rural Luoland, western Kenya. The disciplined silence of the school is interrupted by the sound of a Land Rover. It stops in front of the headmaster’s office, the only room with windows and a door. The head of the research team greets the headmaster while the field staff, assisted by pupils, arrange some of the few available desks for the physical examination of the children and the collection of stool and blood specimens. The teachers and field staff speak Dholuo to the children and English, which few children understand well, with the non-Luo researchers. Accompanied by a field technician, the headmaster interrupts the lesson of the classes that will be examined. The names and numbers of the children enrolled in the study are read out from a list. The children stand up, respond “Present!” and leave the classroom. Outside, they are lined up in the order of their study numbers and wait to be individually measured, given stool containers, or bled. The team members note results and collect specimens, which are labelled, numbered and stored in cool-boxes. Although they are given a soft drink, most of the children fear giving venous blood, but none of them runs away, very few protest.

After the examinations, the children return to the classroom and the researchers leave with the specimens. In the afternoon they return to pick up a teacher or children to direct them to the homes of children who had been absent from school that day. The children enjoy the ride in the Land Rover and the teachers seem to appreciate the break in their routine. In the homesteads, the parents are greeted, the numbers of homestead and house (written on the doorframes) and of the child are confirmed, measurements are taken, the child is asked to produce a stool sample, and a blood specimen is taken. The containers are labelled and the researchers move on to another home or return to the laboratory in Kisumu town, about two hours drive away. Some time afterwards, they return to the school to treat children who were found to be infected with intestinal parasites. The names of the children are read out, they are lined up, weighed for correct dosage and given some bread before ingesting the tablets. To see whether they have swallowed their pills, the local nurse who administers the treatment, asks them to open their mouth and stretch out the tongue. Children absent from school are again visited in their homes and treated there to ensure complete coverage of the ‘study population’.

One morning the research team is met on the road to one of the schools by hostile parents, who, although they previously agreed to participate in the study, do not want blood samples to be taken and, after a heated debate, throw stones at the project car and force the team to drop the school from the study protocol. Their protest does not last, and some of the parents apologise during the following week and ask for their children to be included in the study. The project proceeds as planned, but the research work
continues to provoke occasional confrontations between researchers and researched, as well as within the community.

Introduction
In this paper, I will look at these moments of friction between medical researchers and researched – African and European cosmopolitan health experts and people in a Dholuo-speaking village on the shore of Lake Victoria. I shall focus on venous blood taking as the most salient aspect of medical field research, around which people’s concerns and critique take shape, and on a local idiom about blood-stealing strangers – kachinja (derived from Kiswahili ‘-chinja’, ‘to slaughter’) – which was evoked as part of these conflicts. The account is based on my own experiences as natural scientist involved in medical fieldwork in Siaya (now Bondo) District, western Kenya (1993-1997) that predate, and partly triggered, my training as social anthropologist (1999-2003). This had methodological implications: I participated in medical fieldwork with limited opportunities and skills to observe or engage in local social life; when I was confronted with the study populations concerns about our work, I talked with community members and colleagues, learning about the kachinja idiom and related rumours; subsequently I situated these within the historical and ethnographic literature; and only when I later returned to live in the village to conduct ethnographic fieldwork on unrelated matters, I understood some of the earlier conflicts, and realised people used kachinja in local social practice.

The structure of this paper reflects this movement from the reality of medical research to an anthropological understanding of social practice. In the first part, I describe my own medical field research and the responses and reflections of the children, parents, teachers and researchers involved in it that emerged from conversations during or immediately after this fieldwork. In the second part, I situate the idiom in the historical and ethnographic context, including the existing literature on African blood-stealing. In the third part, I present two events that occurred in the first weeks of the medical fieldwork, but which I only understood after I had lived for some time in the study village. The cases give evidence of the social use of kachinja. Kachinja and similar narratives provide a latent stock of idioms that feed on local historical experiences and can be adapted to new, challenging situations, in which they open up pathways of action. These idioms do not simply reflect specific experiences or confrontations, but draw, sometimes surprising, links between different histories and contexts, and serve as flexible hypotheses to explore and act upon new situations. Drawing on historical memories, and experiences and imaginations of their contemporary world, people intertwine local patterns of relatedness and wider global connections that are evoked by this research situation. Thereby, they make use of the latter’s powers within local social processes, and explain and respond to their experience of a wider world.
In order to describe how blood-stealing suspicions and accusations are used in social interaction, I prefer the term ‘idiom’ to ‘discourse’ with its deterministic (and implicitly textual) connotations, and to ‘model’, suggesting the representation or moulding of reality. I find it more suitable than the textual categories of ‘myth’ or ‘rumour’ to designate a cluster of speech and non-verbal practices as they are employed between people in specific situations and localities to engage with each other and to make sense of their relations. ‘Idiom’ is used here in order to emphasise the social relations in which narratives like the blood-stealing stories are told – the specific localised situations and processes it is made to work in. An idiom is a mode of creating and dealing with relations in practice. As these relations are entangled with contemporary, past and future ideas, actions and relations, the truth of an idiom unfolds in an open process. Who is implicated by the idiom and by whom it is employed, changes. It is a mode of acting towards present concerns with past and future in mind, a way of taking issue with the uncertainty of social life and the confrontation with adversity and evil that it entails. Through idioms like *kachinja* people evaluate unforeseen encounters and situations with reference to familiar relations and engage them in ongoing social processes.

**Researcher and researched**

*Biomedical research as experience: intrusion and hierarchy*

The above description of medical field research stems from my participation, as a PhD student, in a medical ‘intervention study’ around the village of Uhero in western Kenya (Geissler 1998; 2000). As part of the study, we gave schoolchildren worm-treatment and vitamin tablets for an ‘intervention period’ of one year, and collected repeated blood and stool specimens from them (Olsen *et al.* 2002). Our aim was to show that deworming and nutrition would improve the study children’s growth and cognitive development. At the time, the link between worms and child development was popular in international health research (Nokes 1996). Studies like this emerge from ongoing policy and academic discussions and their stated aim is to prove the effect of new health interventions in order to convince policy makers and aid donors to support these. The inconvenience caused for the study subjects is regarded as justified by a greater good. After some time, the priorities of the policy and research community change, and new waves of research projects replace older ones, due to new research findings or emerging problems, or because of the drive towards innovation inherent to academic and institutional competition. Research projects also provide opportunities for researchers to collect data for degrees and publications, which often translate into employment or promotion, and personal interests and attitudes influence aims and outcomes of research. Moreover, the participating institutions often depend financially upon project work, causing relations of dependency between researchers and funders. International health research is thus played out within a global hierarchy that brings together officers in aid agencies and political institutions, academics, field and laboratory staff, and rural parents and children. Here, I am concerned with the lowest
level of this hierarchy: fieldwork, the execution of the study protocol in a specific ‘study area’, and the scientists’ encounter with their ‘study subjects’.

Medical fieldwork in rural Africa is marked by professional routines and group work (see Smith and Morrow 1993). Our fieldwork team consisted of a driver and several technicians from the project’s host, the Ministry of Health’s ‘Division of Vector Borne Diseases’ (DVBD). These were seasoned fieldworkers, some with over 30 years of medical research experience (a few had been in government service since colonial times), who knew the area well. I accompanied them on their daily drives to the study area, but as their work experience exceeded my age and they spoke Dholuo, I followed them and learned from them how to collect blood and other specimens, rather than leading the work. Nonetheless, our team was perceived in the village as headed by a European, who was seen as the representative of other Europeans and high-ranking Kenyans in distant places like Nairobi and Europe, and I was addressed as ‘daktari’ (Kis. ‘doctor’ or ‘PhD’). The villagers’ experience of our research were shaped by this imagination of an operational hierarchy, which consisted of globally connected people at its top, who came from the capital city and were hardly seen in the field, except for rare and brief public relation visits in comfortable project cars, and a group of local intermediaries, of which I was an odd member, who in their battered Land Rover came out to the village and did the work. We were a familiar feature in the local landscape, yet tainted by the fact that we served unknown outsiders. We acted as mediators between two distant separate social spaces that rarely interacted directly and that were conceptualised, by researchers and villagers alike, in dichotomous terms like: urban-rural, modern-traditional, international-local, educated-lay or government-people. In the study area, we collaborated with the local administration and the formally educated elite in order to gain permission and acceptance of our work. Local Chiefs and Elders, who shared our position in between local sociality and wider flows of power and knowledge, conveyed public meetings (baraza’s) where we presented our work to ‘the community’. In these meetings, I initially spoke English and the other researchers spoke English or Kiswahili, which many villagers had little command of, and field staff, teachers and local dignitaries translated our words into Dholuo. This language-use, and the use of titles, enforced the impression of a hierarchy with its apex outside the locality and with the villagers at its bottom.

Prominent features of the research practices were intrusion and control. We interrupted school activities, enlisted and numbered the children and turned them into ‘study subjects’. The research hierarchy expanded the close association between bodily discipline and knowledge, already present in the rural schools, beyond the limits of the locality: the emissaries of the government and the university in the capital city arrive in a government car and, rescinding the existing regime of bodily discipline and inducing even teachers to break their routines, access the children’s bodies, inflict pain and extract blood. When the collection of medical specimens was extended to the village, this hierarchical order of research expanded further, intruded into domestic life and incorporated the children’s families: From the distant
city and from overseas, researchers travel in big cars to the end of the tarmac road, follow dirt roads, branch into footpaths, and plough through the bush as far as they can drive; further on they move on foot, into a family’s homestead, where they enter hastily and noticeably without social purpose; they enter the house of a mother, examine her child and take some of its bodily fluid with them. Research confronts the people in the village with a hierarchy of power, wealth, education and mobility, which embraces global spaces spanning from Africa to Europe, village to capital city, wealthy to poor, powerful to marginalized, in which they themselves are at the periphery and at the bottom. They are expected to conform to a procedure defined by outsiders who do not engage in ordinary social relations. They see educated and well-off people employ time, money and physical effort to obtain blood and other bodily matter from strangers’ children. The intrusive character of these data-collection activities was noted by some of the field assistants, who felt uncomfortable with these ‘home-visits’, as these were no visits in an acknowledged social sense. Some of them tried to maintain, and to teach me, the slow step and extended greetings that Luo custom demands from a visitor, but this did not solve the problem. The main implication of a visit – a highly valued social practice in the village – is to share food, time and conversation, for which our work-schedule left little opportunity. As one of the fieldworkers said: "How can you come and visit, and then you ask for blood and faeces?".a

Venous blood-collection is in itself an intrusive practice which severs bodily boundaries. In the context of medical research this is but the pointed end of an intrusive movement, which from the community’s perspective originates in unknown places, sites of power and knowledge beyond the villagers’ control, and which aims at the community’s essence, children’s blood. During the examination in a distant laboratory, scientific knowledge is applied to the blood. Hereby, blood is re-contextualised, not as a source of life, but as evidence of disease. Further, the knowledge derived from blood is in an incomprehensible way of value to the researchers. All this raises concerns and questions.

Responses of children, parents and teachers: research evaluated and contested

The children’s responses to the research varied.b They were excited about the interruption of school routines and meeting a European but regarded the examinations with fear and did not like the sight of their own blood. Some children liked the well-organised procedures as an occasion to perform well and display self-control. They memorised their personal numbers, formed lines in numerical order, and corrected the team if mistakes occurred. Others took the data collection as an opportunity to challenge our authority and the school’s discipline. They obstructed the regularity of the procedures, exchanged stool samples, mixed up names or numbers, pretended to swallow tablets and spat them out. Whether these were specific reactions to our research or spontaneous responses to external control, I cannot tell, as the recalcitrant children did not offer explanations.

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a Interview with male field assistant around 40 years of age, Kisumu, October 1995.
b Group discussions with pupils during the research and compositions written in class, November 1995.
In compositions written about “Research”, the study children perceived us as coming from far away, a realm of knowledge beyond their reach and comprehension. All mentioned travel and the distant, ambiguous location of the “laboratory”, “white people” and “outsiders”. They identified “research” with medical research and referred to other studies they had seen or heard about, underlining the prominence of research in the medical landscape. Specific brands of big cars, associated with government (Land Rover) and development projects (Japanese brands) featured in many of the accounts as symbols of the power, wealth and mobility in medical research. Several children wondered how the researchers came to “know them” before they even had come to the school, and how their names and numbers had been printed in the enrolment records, pointing at the researchers’ privileged access to knowledge and power.

When they described research, the children emphasised three stages: firstly “blood is taken”; secondly “it is studied with the microscope”; finally “we are told who is ill and given medicine” (some well-informed children added a fourth one: “you get a PhD”). The children understood research as the application and expansion of knowledge with strange techniques that originate from a distant place, resulting in the transformation of their bodies into diseased bodies that in turn require intervention. When I asked a boy why he thought that we collected blood samples, he responded that the blood would reveal whether he had malaria. When I asked him whether he himself thought that he had malaria, he responded “I cannot know, but you should know”, since I had taken his blood. The notion that the research in some sense creates the diseased body was expressed by a girl who explained that “these days, we also have bilharzia”. When I asked, “since when?”, she responded, “since you came”. One boy suggested that research and blood collection serve to produce new medicines, but this did not necessarily refer to clinical trials, since one girl wrote: “Whites used to make medicines from blood and bodies”. Another boy put the link between research and value in straight words: “whites can make money from shit”.

Some parents voiced their suspicions openly, as in the hostilities described above. Others kept their children at home on the examination day or revoked their consent to blood sampling. The written consent form that the parents had signed seemed to contribute to their concerns as it was interpreted as a contract of sorts, signing away children’s vital fluid. In a society where rare birth and death certificates and land titles are the only signed documents, a written, quasi-legal document about the rights in one’s child’s blood provokes concerns, and several parents demanded the document back. In public discussions that were organised to improve our communication with the community and from conversations with participants during and after these meetings, I learned later that people’s worries involved blood-thieves (kachinja). Few people drew directly on the kachinja-idiom in these discussions and when an inebriated participant suggested that I was a blood-thieve the agitator was silenced by fellow villagers. Reference to kachinja was mainly made indirectly, referring to other people’s “traditional superstitions”, “stories of
“long ago” or “rumours” about our research, and in this displaced form, the idiom was present in all community meetings I attended.

Direct suspicions were expressed in a mundane idiom, questioning the inequality of power and exchanges of value. These worries were not dissipated by our explanations about the common benefit that the research eventually would achieve. Experiences with earlier (medical, agricultural and historical) researchers who had visited the area and “just took what they needed and never came back”, made people sceptical. They wondered why we came driving in a big car to examine poor children, who paid us and the fuel we used, and what we got for their efforts. They asked why we only treated school children and not everybody, and why we did not rather provide the community with water supply to improve the children’s health, as such a measure “would benefit everybody”. Even if our research was beneficial – why would strangers wish to come to a remote African village and do good? Some community members opposed blood-sampling, because they feared its HIV-status would be determined, others because they suspected that the blood would be sold. The small benefits, such as free treatment for simple ailments and soft drinks given after blood collection, were perceived as given in exchange for children’s blood, which raised ethical concerns about the exchange of blood – a principal medium of sharing that should not be alienated or exchanged – and economic concerns about the fairness of this exchange. These were expressed by mothers during a later study on pregnancy, when additional blood specimens were requested for a nutritional sub-study: “Do we still have to pay back” (for medical care received during pregnancy)?

The fact that our work was part of my, and other colleagues’ academic training exacerbated, contrary to my initial expectations, people’s suspicions. The monetary value of academic degrees, especially medical doctors, is well known throughout rural Africa for people to suspect personal interests, and community members liked to point out the economic benefits I would gain from my PhD, such as the prestigious Japanese 4x4 vehicles that then were popular among higher development officers. Since colonial times and until recently, education has been the most important route to social achievement for Luo people in Kenyan society, and accordingly diplomas or PhDs are readily converted into monetary value. The symbols of academic development are thus regarded as precious commodities as well as honorary titles, and markers of social differentiation.

Important contributions to these discussions were made by members of the study area’s formally educated elite. Most of them supported the research in their role as advocates of development and progress, but others voiced politically and ethnically charged concerns, suggesting that the research was part of the government’s work towards the “eradication of the Luo”. This proposition resembled rumours that were widespread at the time, which attributed AIDS to the government’s aim to “eradicate the Luo” or to “the Americans”’ attempts to “kill black people”. These rumours were tied into the complex political situation with a (then) USA backed government and an initially socialist, Luo-led opposition, and they reflected
people’s experience with a plethora of Euro-American NGO’s working on HIV/AIDS. Others thought, along similar lines, that crocodiles had been brought to Lake Victoria by the government to decimate the Luo and were protected by foreign game rangers and researchers. Others again interpreted the daily vitamin supplementation we provided as birth control, supporting their claims with newspaper reports about forced sterilisation and older rumours according to which school milk donated by foreign agencies had made children infertile, drawing on a common understanding of birth control as a means to depopulate Africa. These critics of the research focused their fears on children and the community, blood and reproduction, and tied them to common perceptions of oppression and exploitation, which on a national level are organised along a political-ethnic axis, and on a global scale along a political-economic axis mixed with notions of race. These political-economic arguments and the kachinja stories merged into one evaluative idiom which provided a way of giving meaning to research and blood-collection within the given social and political context and enabled some form of response. This idiom expressed fears about the extraction of value from bodies and about unequal exchange, being drained by an uncontrollable outside power possessing superior knowledge for antisocial purposes.

In the public discussions, mothers were very concerned with our research and some voiced strong objections to the taking of blood samples. While they also drew upon the arguments quoted above, they had often more immediate, experiential concerns about blood and bodily well-being. One mother argued that “blood is strong”, others complained that “our children have too little blood anyway”, or demanded: “give them food to give them more blood, but don’t take blood away”. Their arguments related to their own experience of anaemia and of their children’s precarious health in relation to blood and nutrition. An older man agreed: “women know about blood”. However, later in the research process, many women took a pragmatic stance and supported the study once they discovered that it had advantages for their children’s health.

The teachers in the studied schools were generally supportive of the research and open to discussions about kachinja with the researchers. According to a primary school teacher, kachinja are “people who drive along the tarmac road at night in big white Land Rovers, and if they meet you there, … they catch you and drain your blood and leave you in the bush. It’s been around for some time, but not in the old days. It started in our parents’ time”. Other teachers agreed and stressed that kachinja was not a pre-colonial “Luo tradition”, but a recent issue – according to some a “superstition” – associated with the historical, colonial and post-colonial experience. Some of them suggested that the original “headquarters” of the kachinja had been in the firebrigade building in the nearby town of Kisumu (built in the 1930s). Others proposed that blood-stealing had been organised in the Provincial Hospital (next door

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8 Interview with male Primary School teacher around 50 years of age, Yimbo, April 1996.
9 Group discussions with teachers in study schools, Yimbo, June 1996.
to the firebrigade) or the Division of Vector-Borne Diseases (DVBD) (situated between the two), which was our research group’s host.

The teachers offered different historical explanations for what they rendered as “villagers superstitions”, namely the colonial wars and gold mining, the post-colonial state, and relations between biomedicine and global capitalism. Many of the teachers traced kachinja back to the First World War during which many Luo men had been forcefully recruited. Some suggested that the British occupiers had by force extracted blood from Africans for their white soldiers or that seeing blood transfusions in the war had shocked the men. Another set of local histories focused on a certain white man who, during colonial times, had run a gold mine nearby and had been known to drain blood from his workers. Fears of working under dangerous conditions under ground and deadly accidents in these mines had merged here with speculations about the nature of relations between labour and value, bodies and money, which gold mining provoked. Although the man, the archetypal kachinja, had long since died and his mine been abandoned, the names of people who had died in the mine were cited as a proof that blood-stealing was a real danger in the area.

Others suggested a more recent origin of kachinja, referring to the stories about “devil worshipping” which were in the national press at the time, and which implicated politicians and businessmen in blood sacrifice to obtain power and wealth. They explained further that some politicians kept spirits (djinn) obtained from overseas or the Kenyan coast, which helped them to keep their power. According to rumour, these had to be fed with blood, which suggested a connection between the local activities of kachinja and the centres of power, and a link between the occult idioms of djinn and kachinja. Another provenance of kachinja that the teachers suggested were hospitals, which were said to extract blood for the “international market”, where blood was sold to cure the diseases of white people and wealthy African elites. These stories were supported with reference to newspaper reports on the international trade in blood and organs. A political connection was made between this heinous trade and efforts to privatise and restructure the Kenyan economy including the health care system during the era of ‘structural adjustment programmes’. Particularly the policy of ‘cost sharing’ or payment for medical service was seen as evidence for a new profit-orientation of the health system, of which blood-trade was another aspect. Exacerbated health care inequalities were thus linked to the material transfer of bodily substance from the weak, local people, to the powerful people outside. A story that circulated at roughly the same time and which I heard about much later, according to which blood donations collected in the local secondary school had been declared to be contaminated with HIV and thus worthless, and then secretly sold to a large private hospital, may have fed into these explanations. The teachers said they knew that the small amounts of blood gathered by us could not be sold, but the fundamental mistrust around blood-issues still formed the basis of their perceptions.
Many teachers thought that *kachinja* existed. Their views formed a continuum ranging from detached explanations of other people’s erroneous beliefs and a taken-for-granted knowledge that blood-stealing was a reality. This continuum was characteristic of the *kachinja* idiom: at times people dismissed the rumour or belittled those who believed in it (in a given situation), and at other times they embraced it and took action against the suspected *kachinja*. The teachers did not necessarily agree with the application of this idiom to our research, but they were not without ambivalence about it either. Underlying their interpretations of *kachinja* was a secular critique of research and its global economic and political context. Polite comments and kind jokes displayed a critical awareness of the economic world system, within which rural teachers and metropolitan scientists were attributed different (though not necessarily antagonistic) positions. The teacher’s critical thoughts rarely resulted in hostility, but fed into challenging discussions about the research and the construction of the world. When we for example discussed the concerns about the “eradication of the Luo people” by the USA or the government and I expressed doubts about the existence of such policies, a teacher reminded us of the European history of extermination that justified some degree of suspicion. He referred to the movie “Escape from Sobibor” about the resistance of Jewish prisoners in a German extermination camp, which was shown regularly in the local car-battery driven video-cinema. Comments like this showed both the profound sense of insecurity and threat, which is characteristic of contemporary Luo and reflects a general age of anxiety in Kenya, and the wide frames of imagination in which even rural Kenyans situate their confrontations with state power and Europeans.

*Researchers’ views*

As I did not speak *Dholuo* when I began my research, and since my colleagues initially were embarrassed about what they regarded as ‘superstition’ and ‘ignorance’ and wished to protect me, their visitor, I remained at first blissfully unaware of the serious accusations raised against me. I sensed some hostility at public meetings, but it took time to place the fragments in which the *kachinja*-idiom emerged in different encounters with people in the village into a broader frame. Apart from the practical problems that the *kachinja* rumours posed to our fieldwork, which DVBD’s experienced field-workers mostly overcame, I was first offended and then intrigued by the radical contrast between my naïve self-imagination as a development-worker of sorts, contributing to the solution of a health problem in rural communities, and the idea that we were engaged in an exploitative business. Specifically, the connotations of a ‘PhD’ were revealingly different: for me it was a pleasant way of extending my studies, but certainly not a route to wealth – rather the contrary - but when, in the public debates, I argued that I was ‘only’ a PhD student, this increased the suspicions as it drew attention to issues of individual achievement, power and privilege.

Through conversations with my friend and colleague Mr Ilondanga wa Lwoba, a disease control expert who had worked with DVBD since the 1970s and was in charge of the Kisumu branch of DVBD since
1987, I learned more about *kachinja* and research. He recalled that as a child he had been told not to walk around at night because of *kachinja*, who in his Luhya-speaking area were also called ‘machinaji’ or ‘wazimamoto’ (‘firemen’). According to his grandmother, these blood-thieves wore “the helmets and dark goggles of firemen”. They “parked their ambulance cars at night along the road”, waited for “young men as they knew that they have most blood, … tied them and took blood, stored it in cool boxes and left”. Mr Lwoba thought that *kachinja* could have originated in a misrepresentation of blood-donation during the war periods, but that “people wrongly believed that they took *all* the blood, but they only took a litre. They (the British) needed the blood for their soldiers in the war”. I could not verify from archive sources whether or not forced blood donations ever took place, but what matters here is that they are part of collective memory. Rumours about *kachinja* in western Kenya often referred to the Division of Vector Borne Diseases (DVBD) in Kisumu. This pioneer research institution was founded in the 1930s as a yellow fever control centre and subsequently expanded under the Division of Insect Borne Diseases (DIBD), later renamed DVBD, which had spearheaded medical research in Kenya before regular health services had reached areas like Uhero. Remaining ambiguous about whether DVBD had actually conducted blood collections or whether he regarded this as a comprehensible misunderstanding, Mr Lwoba explained: “DVBD was the first (medical institution) here. They started with yellow fever, sleeping sickness and malaria control and research. They had vehicles, know how and laboratory facilities …, this (blood-taking) was like research, they went after the people and persuaded them”. Mr Lwoba’s own father had worked for DVBD, too, and his khaki uniform with its red cross on chest and cap had been a source of pride as well as fear, since “people knew he was involved with blood and research and they became scared”. Mr Lwoba also remembered that during his training as a field researcher in the early 1970s, people refused to come near to their tented camp for fear of blood stealing. He recalled more recent incidents with *kachinja* scares in western Kenya, implicating international research teams that he had worked with. In his description he stressed repeatedly that the presumed blood-thieves were unrecognisable outsiders, without identity or relation to the victims, and that they followed the victims, and that they indeed resembled researchers in this: “they were the first medical people out here in the rural areas and they went after people, they did not wait for them to come”. This combination of distance and tightness applies to various forms of contact with the state, medicine and research, be it colonial or post-colonial. Significantly, our conversation moved spontaneously from the technologies of the supposed *kachinja* to imaginations of the intricate machinery of the gallows in Nairobi’s colonial high security prison, where, Mr Lwoba was told, the freedom fighters of the 1950s: “walked down an empty alley, alone, blindfolded, until they fell into a hole in which the machine broke their necks”.

What struck me in Mr Lwoba’s recollections was how much *kachinja* rumours simply were part of the medical research work that his father and now he and myself engaged in. The way in which he

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* a Conversations with Mr Alfred Ilondanga wa Lwoba, Kisumu, May 2000.
spontaneously embedded these stories about research within other narratives of colonial and postcolonial violence made me aware of the naivety of my own initial conception of value-free research. Although he of course dismissed the stories about our work as untrue and pointed out misunderstandings in other kachinja rumours, he accepted the possibility of blood-stealing in this world like anybody else I talked to in the field. Characteristic for the kachinja-idiom, the boundary of real and unreal was blurred: technical details of research supported blood-stealing stories, and vice versa, Mr Lwoba did not rule out the possibility that researchers had participated in forced blood collection. Whether he attributed the kachinja-idiom the status of truth or erroneous belief depended upon the context of the situation. In this ambivalence, I would argue, lies the potential of idioms like kachinja to be applied to varying social situations and to transform them.

Local contexts of kachinja

Blood-stealing in colonial and post-colonial Africa

Mr Lwoba’s familiarity with kachinja – both as a real threat and as a rumour about his own work – underlines the historical continuity between the idiom we encountered in 1994 and earlier responses to medical research in western Kenya. Similar rumours have been reported in Eastern Africa since the times of colonial occupation and are known in large parts of Africa (e.g. Ceyssens 1975; White 1990; Fabian/Tshibumba 1996; Pels 1999). At different times and places, blood-thieves were given different names, but they were always white people or their black collaborators, who operated at night and employed European technology – cars, medicines, electricity, syringes – to get blood from local people. Often, medical doctors or researchers were implicated by the rumours, but elsewhere other people and institutions such as firemen, game rangers, gold prospectors or missionaries were suspected of blood-stealing (White 2000). Blood-thieves were believed to sell the blood or to transform it into other commodities, such as medicines. In these rumours blood figures as the essence of life, vitality, fertility and strength. Being fluid, it can be more easily be appropriated, transacted and used than other parts of the body. Blood-thieves use bodies to generate value, either directly, using the power of the blood, or indirectly, by entering into exchanges with external (supernatural or overseas) agencies. Their power relies upon these links beyond the every-day world of local people that connect them to global flows of power, knowledge and value.

These stories provoked the interest of colonial social scientists. They lent an intriguing twist to European perceptions of ‘native superstition’, reflected European imaginations of African cannibalism back to their origin, and gave a magical touch to European superiority. Evans-Pritchard thus found “some humour … in the fact that many Azande were convinced that the British doctors were cannibals” (Evans-Pritchard 1960:257). Others represented blood-stealing rumours as African misunderstandings of autopsies (Baker 1946:109), red wine (Trant 1970:127-143) or blood donations (Odhiambo 1974:172). Some post-colonial
authors interpreted them as “myth of the oppressed” (e.g. Ceyssens 1975), i.e. as pre-rational African response to the experience of “oppressive acculturation” (Ibid.:550) which later was replaced by rational “political consciousness” (Musambachime 1987:213). These interpretations rightly identified a resistant potential in the rumours, but oversimplified the nature of the colonial situation and the workings of the rumour, and they ignored the persistence of blood-stealing idioms long after independence. Despite their anti-colonial orientation, the distinction they made between real conditions and irrational beliefs followed colonial categorisations of knowledge and failed to appreciate how blood-stealing idioms served people to know and act upon the colonial and post-colonial situation.

Contemporary research on African blood-stealing rumours owes much to White, who, based upon historical documentation from the 1920s onwards, interpreted them as adaptable articulations of varying colonial experiences in different places and situations, such as gender relations and urban life (1990), capitalist labour and production (1993a), mission and labour (1993b) and medical research (1995a). White moved beyond generalising readings of blood-stealing as representation of colonial oppression, looking at the particular social and cultural changes that were elaborated and constructed through blood-stealing rumours, which she showed to be texts that ultimately “debated the merits of modernity” (1993b:772). White turned archival evidence supported by interview materials into a rich source of social history, underscoring the social role of rumours and revealing variations in colonial experiences and discussions (2000).

At the same time, social anthropologists in Eastern Africa realised that their informants suspected them to be blood-thieves (Pels 1992; Jarosz 1994; Weiss 1998). This experience provoked self-critical reflections and ethnographic studies of the social processes within which accusations of blood-stealing occur, adding observations of concrete social practice to White’s historical analyses. Pels examined blood-stealing in relation to mission practices (1999); Jarosz followed their use in the struggles between political factions (1994), moving the focus from the colonial antagonism to tensions within a post-colonial state; Weiss used them to study the relation between embodiment, economy and sociality in the constitution of a post-colonial society (1998). These studies revealed the potential of blood-stealing as an element of social processes and showed how social relations criss-cross the major lines drawn by colonial and post-colonial antagonisms, how the narrative of oppression and resistance is retold and varied in transient local stories, and how global tensions are realised in different localised situations.

The Comaroffs’ recent commentary on similar phenomena attempts a broader explanation, suggesting a recent “dramatic rise” in blood-stealing and other “occult economies” in South Africa (1999:279) and attributing this to post-1989 global “millennial capitalism” (281). In her critique of this “imaginative interpretation”, Moore warns us not to “turn contemporaneity into causality”, “general context into particular explanation” (1999:306) and asks for “local variation and variation in time” (Ibid.:306).
Although idioms like *kachinja* obviously are related to people’s economic experiences, imaginations and practices, and to historical transformations, Moore’s methodological caveat not to reduce particular social creations to causal effects of global processes is a valid one, as well as her call for ethnographic observations of the localised and historical processes, in which global and local are interlaced through specific social relations.\textsuperscript{12}

**Local histories of kachinja**

The people quoted above all saw *kachinja* as a new phenomenon, associated with the advent of Europeans, and did not relate it to ‘traditional’ Luo evil figures, such as sorcerers, whose practices are of a different nature: sorcerers or their employers are part of sociality, whereas *kachinja* explicitly are not; sorcerers assault others within social relations of hatred or envy, while *kachinja* use their bodily fluid but remain morally detached from the victims (for Luo concepts of evil see e.g. Hauge 1974; Ocholla-Ayayo 1976; Mboya 1983 (1938)). The term *kachinja* is not originally *Dholuo* but derived from the Kiswahili root ‘chinja’ (to slaughter). Its use during the 1950s is documented for the area (Odhiambo 1974), the neighbouring Luhya use ‘machinjaji’, and similar terms are also documented for eastern Zaire and Burundi (Ceyssens 1975; see White 2000:10-12). The shared Bantu root suggests links to rumours elsewhere in Africa and probably a recent origin, and White’s suggestion that blood-stealing narratives in the form described here took shape in this part of Africa after the First World War (*Ibid.*) is supported by the fact that I did not find reference to blood-stealing in a medical context (by *kachinja* or other agents) in published material, East African newspapers, the Annual Medical Reports of the colonial administration or in diaries of Kenyan medical practitioners before the 1920s, whereas they do occur afterwards.\textsuperscript{13} The emergence of *kachinja* in relation to our medical research should thus be linked to the villagers’ historical experience, particularly of medicine and medical research, which were crucial elements in the colonial and post-colonial construction of subjectivity and power relations (see e.g. Comaroff 1991; Vaughan 1991).

The area of present-day Bondo District belonged first to the Ugandan Protectorate and became in 1902 part of the East African Protectorate. Contact between the residents of the remote lakeshore and the European occupiers remained scarce until the second decade of the century. Subsequently, contact intensified gradually: administrative structures were created, chiefs appointed, taxation and legislation introduced and workers for railways and farms recruited (Cohen and Odhiambo 1989). In the second decade of the century, mass recruitment for the First World War (and high death tolls) initiated the people of this area into the nature of colonial occupation (Hodges 1986), and after the war the expansion of ‘white’ farming and the subsequent designation by the government of Luoland as a ‘labour reserve’ sealed their integration into colonial society and economy (Hodges 1972; Stichter 1982).
Since the onset of colonial occupation, medical officers were among the few representatives of the Empire around Lake Victoria (Beck 1970), but it was only in the late 1930s that a small dispensary, staffed by a ‘native dresser’ was built near Uhero village. Before that, people’s experience with western medicine was limited to the war and farms and cities, which few of them went to, and to medical research, which was for many the first and most intensive biomedical experience. While research in western society seems a small part of medical practice, in places like Uhero it was (and is in some ways until today) the most prominent aspect of the medical endeavour, which continues to influence perceptions and responses to medicine. The modesty of the first research efforts seems not to have made them a source of major tensions between colonial occupants and local people. Resistance to medical research seems to have developed from the 1920s onward, possibly due to the shift of the colonial situation that occurred concurrently with, and partly because of, the First World War (Ogot 1968; Hodges 1986; White 2000).

Due to the high prevalence of infectious diseases, the northern shore of the Winam Gulf, where Uhero village lies, has been a preferred field site for medical research since colonial times. Sleeping sickness research and control during and immediately after the end of colonial occupation had a particular impact upon people’s lives in Uhero (Wellde et al. 1989). The administration conducted mass examinations for sleeping sickness (including blood sampling and confinement of infected individuals). Vegetation was cleared, and cattle and people removed from their ancestral land in the areas that were declared tsetse infested (Wijers 1969; see Hoppe 1997). The sleeping sickness ‘campaigns’ of the post-war era were organised in military style and sometimes supported by the police; with few exceptions they were headed by European researchers, formerly ‘officers’ later ‘experts’, who led the field activities but stayed socially apart from the research team, eating by themselves and sleeping in the town rather than out in the field. These campaigns gave concrete evidence of government power: In Uhero, the entire population had to leave the area during the initial epidemic of sleeping sickness, and the resettlement continues to be a source of conflicts between village families and clans. According to a retired DVBD researcher, it was during the contested sleeping sickness control campaigns of the 1970s – during which infected persons were taken for month-long treatment, bush was cleared and the lakeshore sprayed with DDT, killing cows and Hippopotami – that kachinja accusations had for the last time run high in Uhero. Moreover, these campaigns had used the dominant local families of the (colonial) chiefly clan as an operational base and to recruit fieldworkers. Thereby, the concerns raised by medical research were tied into older tensions about leadership and evolving social differentiation (see Ochieng 1975, and below).

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a Conversations with the late Rev.Dr. Paul Wasonga, Yimbo, April 1997.
b Interviews with Mr Otiende, retired Head of DVBD Kisumu, March 2001.
c Interview with the late Ex-Chief Mr Magoye, Yimbo, January 2002.
d Interviews with Mr Otiende, retired Head of DVBD Kisumu, March 2001.
Blood and knowledge

When the kachinja-idiom is engaged with medical research, widely shared concerns with blood and knowledge are brought to work on an unusual situation. Blood is a principal substance of relatedness, including kinship, and of life, growth and continuity. Among people in Uhero blood – of humans and of cattle – is identified with people’s relations and the ties between the living and the dead, and (since the land is the abode of the dead) between people and land. As food is thought of as being converted into blood, and food-sharing is the fundamental social practice of relatedness in Uhero, ties of blood and commensal ties of food are conflated into webs of relatedness and belonging. The spirits of dead ancestors (juogi) are understood to feed on the blood shed on the earth when cattle are slaughtered. This happens at ceremonial occasions, particularly funerals, which underscore the bonds of belonging between living and dead people and their place, and the shared consumption of the animal’s meat confirms and creates bonds of commensality and relatedness among the living (Evans-Pritchard 1950). Blood represents and sustains relations with the past and in the present, and it is from blood that future life is made: the foetus is understood as consisting of maternal blood and is referred to as ‘blood’ (remo). Kinship relations are central to Luo social organisation, land ownership and agriculture and blood is therefore linked to economic life and subsistence. But blood is not only a metaphor of relations and the lineage, land and production. It is also a concrete bodily experience among people in Uhero, many of whom have experienced periods of anaemia, locally described as ‘lack of blood’. Blood is here not merely a metaphor, but also a measure of strength and vitality and of the effect of historical changes on food production and social relations, individual health and communal well-being.

Blood is the essence of the body, as a social symbol and as a physical experience. Moreover, blood embodies the principle of equality of human needs and of the emphasis on sharing that underlies village social life. Losing blood endangers one’s life and the alienation or accumulation of blood is an abomination (similar to but worse than the alienation of food, land or labour). The notorious difficulty of finding blood-donors in western Kenya (regularly referred to in the Kenyan Annual Medical Reports) stems from this concern with the equal and shared nature of blood. Even in 1965, after Kenyan independence, when growing numbers of donors were recorded, the report notes: “the emphasis still had to be on the donation of blood by the patient’s relatives and friends”, i.e. blood could not be used outside existing bonds. Up to today, blood donations can only be obtained either from institutions like boarding schools, or by tying blood transfusions to a ‘refund’ of the blood used for them by the patient’s relatives. The latter practice has evolved into a banking system of sorts, in which donors retain rights to certain quantities of blood, if they donated too much. This ‘rational’ system of exchange, however, raises, rather

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than dissipates people’s worries, because it implies analogies with monetary and other profit orientated exchanges, which people find inappropriate in relation to blood.

Just as blood is a matter of sharing and relatedness, which is, in local views, contradicted by exchanging it, so knowledge is in many contexts in Uhero village constructed as a social, shared resource, which exists in relations and creates them (Prince and Geissler 2001), and the accumulation and exclusive use of knowledge is regarded as dangerous (Grigorenko et al. 2001). For example, herbal medicines are known and used by most women, and very few remedies are exclusively known to ‘healers’ (Johns et al. 1990; Prince et al. 2001; Geissler et al. 2002). Medicinal knowledge is shared and tied into relations of kinship, domestic life and commensality, and like these, it creates lasting bonds between those who shared particular knowledge. Secret knowledge or knowledge that exceeds what most people share is ambiguous, to the extent that very few people acknowledge such knowledge or claim for themselves the title ‘healer’ (jathieth), which immediately raises suspicions about the dangerous side of knowing: sorcery. The exclusive expertise of (bio)medical doctors contrasts starkly with this concept of knowledge as shared matter, intertwined with other forms of shared substance. Some people in Uhero told us they feared medical doctors, because of their secretive knowledge and their link to the government as source of power and knowledge. They mistrusted them because of their separation from village social life and their relative wealth. These traits – exclusive expertise, power, social distinction and unequal wealth – appear in even sharper relief in medical research. Researchers’ knowledge is specialised, their social position high, and they are connected to overseas sources of power and material wealth. Their practices are more complex and unfamiliar than hospital routines. The resources employed in data collection are conspicuous and provoke questions about the value research generates. Moreover, research is more threatening than other medical practices as it is proactive – following the subjects – and it extracts and alienates parts of their bodies. It denies (or is unable to engage in) sharing of knowledge and sociality. These traits are clearly perceived by communities exposed to research, which is therefore feared and contested.18

Both blood and knowledge are thus, among people in Uhero, ambiguous and contested matters, and it is the broad social tensions that both contain: between sharing and exchange, between communal resources and continuous relations and individual accumulation and advancement, that in the kachinja-idiom are tied in with the historical experiences of colonial and post-colonial deprivation and with contemporary ideas about local-global, people-state, South-North connections. It is from this multiple frame of reference that kachinja gains its power to negotiate changes and mobilise resistance and its usefulness in the social life of the village.

The idiom in practice

The uses of kachinja
The following narratives of two encounters with people in Uhero will show how the kachinja idiom is engaged in social relations and situations. The first case concerns a primary school teacher with whom I got acquainted during the first days of the research, and where an initial impression of mutual understanding gave way to a realisation of distance; the other one is about a larger family homestead, in which initial miscomprehensions and suspicions turned into a lasting engagement with each other.

Mr Osunga’s dilemma

A dynamic, young headmaster at one of the study schools befriended us during the early stages of the study and invited us repeatedly to lunch in his home, a well-kept compound of concrete houses with high trees, characteristic for the mission-educated old local elites. The path from the main road to the home was indicated with enamel signboards carrying the name of his late father. After few days, he suggested that we should stay with him and his family and build our house in his compound. He belonged to a dominant clan of the area, and his father had been a colonial chief. He found it appropriate to welcome the overseas visitors, both out of friendliness, to provide his children an educational experience and to confirm his family’s status in the area. During the conflicts described above, he attended community meetings and tried to convince people of our good intentions and of the ‘development’ that our project would bring to the community.

At some point, he told me about a boy who suffered from chronic illness and introduced me to the child’s father, the owner of the local store, a successful, but somewhat secretive and little liked man. The child had a severely swollen liver and I offered to take a blood slide to our laboratory. A week later, I returned with the (negative) results of the examinations and was met with unusual hostility by the boy’s father, who refused the offer to take the boy to the district hospital. Startled, I looked for my acquaintance in the school, hoping to get an explanation. The headmaster met me politely but was less welcoming that he had been and declined knowledge of the boy’s case. Our relationship subsequently declined and reached rock-bottom when he at a parent-teachers’ meeting agitated against our team, putting particular emphasis on the collection of blood-specimens.

During the following year, I gathered some elements of an explanation: my relationship with Mr Osunga, the son of the late colonial chief, who had hosted the sleeping-sickness research teams operating in the area in the 1970s, had revived the idiom of kachinja. The shopkeeper, whose child’s blood specimen I had taken, was widely believed to entertain spirits, which he had brought with him from the coast, to support his business. Rumour had it that these had to be fed on human blood, which he procured from people he killed. His son’s illness was attributed to his victim’s revenge. When the headmaster brought his white visitor one evening to backroom of the little shop in order to take a blood specimen from the very sick child, observers combined memories of colonial times with present social tensions and suspicions and since all three protagonists were concerned with blood, this served as the red thread in the
(not completely coherent) narrative that connected them with each other, with the past, and with the wider world. The headmaster was suspected of collaborating with the white intruders in their ominous tasks (following family tradition), and the shopkeeper, whose business already relied on dealings with blood was an obvious local partner. As a result, Mr Osunga had to publicly dissociate himself from the presumed masters or kachinja. Hence his open rudeness, very uncommon in Uhero, towards me and our group. At the time, Mr Osunga’s volte-face terminated our social contact, but when I met him a year later at a community meeting, the conflict and the accusations were forgotten, and he asked me for medical advice. For a moment we both had got entangled in the kachinja idiom, but as our work raised less and less anxieties in the village, kachinja had become useless for both Mr Osunga’s critiques (who did not, because of that, like him better) and for his public defence.

This encounter between two educated, economically entrepreneurial men of the locality and a travelling researcher shows the variability of the kachinja-idiom, its multivalence, and its changing impact on social relations. It can designate people from different geographical origins, educated, political figures and wealthy people. It plays on associations of knowledge and money, colonial history and local politics; and it can change function in the social process in which it is evoked. While this case confirms familiar patterns of modern occult accusations, pitching elite men against peasants, the second case is more complex, and I think more characteristic for the uses of kachinja.

**Mr Okoth’s family**

I was introduced to the extended family of Mr Okoth by the household head’s 10 year old daughter, who had, when we collected stool specimens in her school, showed me some herbal medicines for worms and, noticing my interest, invited us home to visit her grandmother (see Geissler and Prince in prep.). Our first visits to the home of Mr Okoth, his four wives, two mothers, 16 children and 7 grandchildren, were friendly but distant. Mr Okoth was a proud host but his wives were aware of the kachinja rumours and suspicious about the research. They fulfilled the duties of hospitality but asked my research assistant hostile questions. Repeated visits to the second of Mr Okoth’s wives established a closer relationship. She voiced her concerns but was satisfied by our explanations. However, this emerging friendship provoked the animosity of her younger co-wives, who now raised kachinja accusations against both the second wife and us. These accusations also reflected long-standing tensions between the different women in the household. The second wife had lost most of her children and had to take care of those who survived on her own, while her youngest co-wife had many children and was better supported by the husband. These long-term tensions had at other occasions been articulated in terms of ‘evil eye’ (sihoho) and accusations of sorcery. Under the impact of our sudden appearance, they temporarily took the shape of the kachinja idiom.
Eventually, we succeeded in restoring our relationships with all the wives, and all four women welcomed us to their houses and supported our work. These friendly interactions with the women, though, provoked the hostility of Mr Okoth. Rumours reached us that he now publicly accused us of stealing blood or in any case of being self-interested and untrustworthy. When we first had come to his home, we had been his prestigious visitors, not least because he himself had been a public health technician until his retirement and had, as we learned later, worked in the 1970s as a field assistant for the sleeping sickness campaign. Based on this experience, he practised as an ‘injectionist’ treating other villagers against common illnesses. Our visits to his ‘office’ at the centre of the homestead confirmed his reputation. But when we had established friendly relations with his wives (which in itself might have disturbed him, as it reduced the time we spent with him) his association with the outside visitors turned other villagers against him and revived memories of the days when the sleeping sickness researchers had had their camp in his home. Led by a neighbour, some older men accused Mr Okoth of being a *kachinja*, collaborating with us to steal the village children’s blood.

The neighbour in question, Mr Odhiambo, had an outspoken suspicion regarding white people. He was an orthodox member of Legio Maria, a syncretistic Catholic church, and the only person I met in Uhero who occasionally wore a loincloth or a hide (see Prince 1999). As an immediate neighbour, he disagreed with Mr Okoth, who then was Anglican, about religion, and he had old land conflicts with Mr Okoth’s family, and his (indigenous and dominant) clan, which partly stemmed from the resettlement of the area after sleeping sickness. The thrust of Mr Odhiambo’s accusations concerned Mr Okoth’s former state employment and his work with research and blood-collection, which made him a likely *kachinja* working on behalf of remote power-holders. Issues of wealth, status and education, state and religion, and antagonistic knowledges about the body merged here in the *kachinja*-idiom. It was activated by our appearance in the village, but it was used in a long-standing quarrel between two neighbours about land, ideology, and lifestyle. Mr Okoth was thus caught between his wives and the other men, and in response he turned temporarily against his wives and us, but at the same time defended his family against his neighbours’ claims that his homestead was involved in blood-stealing.

In shifting constellations – researchers versus homestead, second wife and researcher versus younger wives, wives and researcher versus husband, homestead and researcher versus village – *kachinja* was used in different ongoing conflicts involving various overlapping fields of interest. Gradually, our position shifted from being outside the family and a threat to it, to being in some situations a part of it vis-à-vis the rest of the village. At no point had the suspicions lead to a breakdown of contact or violence. The difference established by the idiom was perceived as situational, momentary, tied to changing social relations. After some time, the *kachinja* idiom disappeared from use around us. Blood collection was no longer disputed and people even voluntarily brought children for examinations. Messrs. Okoth and Odhiambo made peace with us (though not with each other). Rather than evoking *kachinja*, Mr Odhiambo
would now discuss with us about religion and the colour of Christ, and Mr Okoth would try to obtain syringes and needles for his own practices from our research team. The conflicts remained, but if I now mentioned *kachinja*, the topic was no longer met with suspicious silence, but with laughter or accounts of events “long ago”, “far away”. The idiom had lost its use-value in the situations at hand and had given way for everyday interactions. It will re-appear, however, once a change in the local situation renders it useful for social practice again.  

**Conclusion**

As its emergence and disappearance in Uhero village shows, *kachinja* is one of several latent idioms, a “quiescent belief” (Douglas 1970:xxiv), a narrative that is generally available, but only voiced or realised in practice in a situation of strained relations. It is not a straightforward reflection of specific events, such as research, but it belongs to a store of hypotheses that can be applied to unclear or threatening social situations. Its use depends on whether details of the idiom fit the particular social situation and if significant other persons agree with it, and upon the social or material benefit that its use brings. As White showed, rumours do not seek out a truth, but rather question and evaluate experience (2000). Neither the conditions nor the social tensions, which render an idiom useful in a given moment, are stable. They are moments, situations in social process. This is clear in the case of the women in Mr Okoth’s home, where the ascription of *kachinja* and the positions of accuser and accused repeatedly changed.

This case shows how the idiom is created, changed and disposed of in social practice. People make pragmatic use of it when appropriate. This does not imply that their misgivings are less real – the women do know about the importance of blood – but that *kachinja* is speculative, evaluating, trying out possible understandings and actions, a “subjunctive” mode of action (Whyte 1997) and not an established truth. The discourses and actions it gives rise to are among many attempts to protect children’s health and well-being. It evokes a possible danger, it does not state facts. It proposes a hypothesis to link empirical facts, memories, and experiences at a specific junction in the social process, and to direct action. *Kachinja* is not a permanent social category identifying a person or group as evil blood-thieves, nor is it a defined and bounded political analysis of the capitalist, post-colonial world system. It expresses a temporary relation within it, which changes as part of ongoing social processes. As with all good hypotheses, it is contested and gives way to others, as social life and its evaluation progress, and as people continue their pragmatic search for a way through the uncertainties and concerns of life.

The material presented here shows how colonial and post-colonial tensions are refracted, reflected and transformed on the micro-level of social interaction. It shows that a too clear-cut antagonistic representation risks missing the concrete complexity of post-colonial situations, which are always
articulated in localised and often interdependent social fields. Global antagonisms are realised within these fields, in local practices that are shaped by conflicts, for example about gender, generations, land ownership, religion and lifestyle, that are partially independent from the post-colonial condition. Sources of power that partly inhere to these fields (as for example domestic relations) and partly originate outside it (as the state) work on people and influence their social praxis. Tensions within a community are temporarily charged and polarised by wider structural tensions, when encounters like those described here change the existing web of relations. Individual positions, and relations between them, are enforced by powers beyond the confines of the village, when, due to an event like the research-intervention, the kachinja-idiom is used in social action. Through kachinja, global structures of inequality are enacted by local agents, and at the same time global agents (such as the researchers) get entangled into local structures and histories. In their mutual interaction, practices and epistemology of biomedical research are evaluated and criticised in their wider political and economic context. But kachinja is more than an “occult” reflection of the global political economy. Rather, the idiom makes use of historical traditions and lived experiences in order to create a space within which the encounter can be evaluated, and in which global connections are tied into local patterns of relatedness, and both are made to work upon one another.21
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Notes

1 Dholuo words, except names, are italicised. Non-English words from neighbouring African languages are put in single quotation marks, as well as characteristic medical research terminology.

2 Teachers, parents and children had been informed about the study’s aims and parents had signed a consent form agreeing with specimen collection, in accordance with ethical guidelines and the approved study protocol.

3 The term ‘idiom’ can designate a “system of belief”, which creates experience and guides actions (e.g. Evans-Pritchard 1937). More specifically, it can describe cultural representations, discourses that render complex experiences intelligible. White reads vampire rumours for example as “idiom with which labour was debated” (1993a:767). Often, the idiom seems to exists as a cultural structure, independent of social practice, either producing experience, or expressing it, or both (see Kapferer 1983:9, 87-8). I find it useful to distinguish between ‘idiom’ and ‘narrative’. In all societies exist narratives, within which experience is congealed, and which can in turn shape meaning and direct social practice. Ardener suggested the term “templates” for these “themes in belief, from which replication occurs if other elements in the physical and social environment combine to allow this” (1970:156). Despite the mechanical metaphor, Ardener’s emphasis on the conditions of replication underscores that the narrative as such is just a material that is put to work in particular situations.

4 The people of Uhero speak Dholuo, a Nilotic language. Most of them settle in scattered patrilineal, virilocal family-homesteads and live from subsistence agriculture, fishing and migrant labour (Cohen and Odhiambo 1989). The area is relatively poor, and malnutrition and ill-health are widespread (Friis et al. 1998). Geographically, economically and politically the area is at the Kenyan periphery (Cohen and Odhiambo 1992).

5 The study was funded by the Danish International Development Agency (Danida) and carried out as a collaboration between different Kenyan and Danish research institutions (KEDAHR 1994). The research referred to in this article had been approved by medical ethical committees in Kenya and Denmark and was conducted according to ethical standards in medical research including informed, written consent and freedom of withdrawal for all study participants.

6 This idea is widespread in the study area (Prince et al. 2001) and is documented all over Eastern Africa (e.g. White 2000:11).

7 Biomedical training was the first formal career that colonial society offered to Africans, and biomedicine became also in this way synonymous with education, ‘modernity’ and social achievement; doctors remained after independence “the core of Africa’s modern educated elite” (Iliffe 1998:1).

8 The association between local power holders and their implication with the state, and blood stealing seems to originate in the colonial period when, according to Odhiambo “certain prominent persons were in local rumour named as kachinja” (1974:172).

9 Firemen were associated with blood-stealing in Nairobi and Kampala (White 1990). The Congolese equivalent of kachinja, the ‘white lions’ are depicted in a popular painting as fire-fighters (Fabian/Tshibumba 1996:49,298).
I focus here on Eastern and Central Africa, because of the differences between Western and Eastern African societies and between their historical experiences with colonial occupation, which have shaped blood-stealing and cannibalism rumours. Similar ideas have been found in other regions (e.g. Taussig 1980; Tsing 1993; Wachtel 1994).

The evidence of blood-stealing rumours all over Eastern Africa and throughout the later colonial period provoked questions about their origin and movement. Ceyssens proposed that traditional Congolese myths had moved eastward with colonisation (1976:549). Pels (1992), in contrast, follows Baker (1946) tracing the origin in Indian rumours that entered East Africa with Indian railway labourers and moved westward with the First World War (1992). White argues convincingly that rather than originating in one place and moving to the other, blood-stealing rumours were “part of a transcolonial movement of vampire accusations” (1993b:771), which produced “independent, though parallel local idioms that express local issues and concerns” (1995b:220).

Moore’s remarks bring to mind Meyer Fortes’ reflections about the global-local interface, which then was called “cultural contact” (1936). He proposes to study the interaction between colonial agents (e.g. administrator, missionary or dispenser) and local agents in specific localities and situations as a “dynamic process” to see how "individuals and communities react under contact" (Ibid.:26), where "the contact agents can be treated as integrally part of the community, and the mechanisms by and through which they react upon the community can be observed" (Ibid.:26-27). Fortes uses in this context the image of a “magnet”, which, as it enters into new ties and relations, re-orientates and re-charges existing social polarities and tensions in a given locality (Ibid.:28). Rather than simply assuming a confrontation of different agents in “cultural contact”, which would have been within the colonial frame of thought, this metaphor allows Fortes to imagine a “dynamic process”: the workings of relations upon relations, the transformations of power in social processes.

Rumours about sleeping sickness research appeared relatively late in Kenya, compared to the Belgian Congo, where already before the First World War rumours circulated that medical autopsies were a form of cannibalism and that white doctors killed Africans for the colonial state (Lyons 1992:188). This can probably be explained by the earlier confrontation of the Congolese peoples with colonial violence, which most East Africans only experienced since the time of the First World War.

Some archival notes relating to our study area illustrate the variation and, possibly, the changes in medical practices and local experiences of medical research. The Ugandan Medical Officer (MO) Hodges (1898-1918) dedicated much of his time to research (Dr. A.D.P. Hodges; Rhodes House Library, Oxford; MSS.Afr.s.1782). In 1902, he collected blood specimens in lakeshore villages around our study area during a sleeping sickness survey (pp.260-75). Hodges seemingly did not meet any resistance to blood sampling, although he could not rely on the threat of force; people even sent him presents inviting him to extend his research to their villages (p.265). He suspected that: “the poor souls look upon (blood-taking) as a cure… akin to vaccine.” (p.263). (This early local interpretation of blood-sampling might be rooted in the fact that rubbing medicine into incisions are common local medical practices (Ocholla-Ayayo 1976).) People’s positive attitude to his research could also have some explanation in Hodges’ open personal approach: he invited a local healer to practice with him in his hospital, in order to learn local treatments for sleeping
sickness from him, and his comments expressed interest and respect (pp.274-5). But Hodges’ experience was no exception: other sources from the century’s first decade indicate that blood collection received an overall positive response and do not contain reports of protest or resistance against medical research (e.g. Dr. Matson; Rhodes House Library, Oxford; MSS.AFR.s.1792, 3/98, box 20).

15 The Kisumu PMO recalls violent resistance to plague control immediately after the end of the First World War (Clearkin, P.A.: *Ramblings and Recollections of a Colonial Doctor 1913-1958*, pp.119-140; Rhodes House Library, Oxford; MSS.Brit.Emp.r.4/1). The Jinja MO, whose territory bordered our study area, reports violent resistance to smallpox vaccinations in 1927-29 in the course of which he ordered villages to be burned down and in turn was seriously injured (Dr. Kendall, pp.5-7; Rhodes House Library, Oxford; MSS.Afr.s.2032). Another western Kenyan MO recalls difficulties in collecting blood samples in the area in 1929, caused by the “belief that the government, through the Medical Department, employed vans like mine which cruised around at night and seized unfortunate Africans, shut them up inside, took them to the nearest hospital, cut their throats and did a post-mortem for some unspecified but nefarious purpose.” (pp.28-9) (Anderson, T.F.: *Reminiscences*, pp.28-9; Rhodes House Library, Oxford, MSS.Afr.s.1653 (thanks to Dr. Ombongi for sharing this reference with me). See Ombongi 2000, chapter 3). Similar problems were encountered by medical researchers operating in western Kenya in the 1940s and continued to occur after independence (Medical Department Annual Report 1948, Subsection: Division of Insect Borne Diseases, p.69; quoted in Ombongi 2000, chapter 5; see also Trant 1970:127-143).

16 For example, in 1932, all 11,345 inhabitants of then Kadimo Division were examined, and “special measures” recommended, which continued throughout the 1930s. Only after the 2nd World War, when sleeping sickness was declared absent from Kadimo Division (1948), were the cleared areas successively resettled. See Kenya Annual Medical Report 1931,32,33,37,38; Kenya Medical Research Laboratories Annual Report 1934, Rhodes House Library, Oxford, MSS.Afr.753.12.s.8.

17 Blood (*remo*) is considered a powerful substance among the Luo. Sorcerers are said to use hair, faeces, or blood to produce evil medicine. This potential of body products to be misused is of obvious relevance to the collection of stool and blood specimen in biomedical research. Resistance to stool and blood collections in South Africa, Namibia and Melanesia was reported to be due to fear of wizardry performed in this way (Duthie-Nurse and Nurse 1992; Elmar Saathoff, 1997, personal communication). It seems to me, though, as if the *kachinja*-idiom in Uhero had another, economical rather than magical, thrust: people were not concerned that the blood could be used by sorcerers, but that their children would be drained of their blood for somebody else’s benefit.

18 In public discussions about blood sampling in south-western Uganda, close to our own study area, three interrelated questions appeared in response to blood sampling (Lewis 1993:120). One is concerned with power and knowledge: Who defines the aims of research? One is interested in exchange: Who benefits from the research? The third relates them to the body: What do you use our blood for? (“Is (our blood) being stolen? Used to strengthen the whites? To spread AIDS?”). These questions link power, knowledge and exchange to the body of the subjects and the practices of research, integrating structural evaluation with bodily experience and practice.
All personal and place names have been changed, except for persons who explicitly requested to be called by their name.

Indeed, it reappeared whenever the characteristics of a particular researcher (irrespective of geographical origin) and her or his practices or characteristics fitted the profile of a kachinja.

Medical research ought to consider the specificity of local research settings, in particular the historical moment at which a study takes place, and the social relations and differentiations within any study population. To this end, research ought to be preceded and accompanied by ethnographic research on itself and its involvement in a study area and population.