Talking About *Chira*: Negotiating Shared Responsibility of Childcare Among Luo Mothers

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ABSTRACT

Chira is a local illness often described in the literature as a wasting illness. However, a sudden and acute illness with high fever, diarrhoea and vomiting could also be interpreted as *chira*. Its diagnosis is based on examination of social incidents such as adultery, people's neglect of rituals or improper mixing of incompatible categories. Qualitative data for this paper was collected over a five-month period in Bondo District. The study reveals that *chira* in children is perceived as the result of mother's violation of *kwer* which causes conditions of ritual impurity. The presence of *chira* in a child gives Luo mothers a chance to enrol kin members in the daily childcare.

INTRODUCTION

Chira is a local illness, which often has been described in the literature as a wasting illness. However, this study reveals that also a sudden and acute illnesses with high fever, diarrhoea and vomiting could be interpreted as *chira*. This fact is relevant for appreciating the complexity of local perceptions of malaria. Rather than moving from symptoms to diagnosis, mothers moved from the contexts of the specific situation to recognising the illness. The characteristics are that the diagnosis of *chira* is based on examination of social incidents such as adultery, people's neglect of rituals or improper mixing of incompatible categories. The moral ideas behind *chira* are that violations of *kwer* (ancestral rules/taboos) cause conditions of ritual impurity – *chira* (sinful consequences such as illness or other misfortunes). But *chira* is not only an illness, it is also a "mediating device" with which young mothers can manage the daily responsibilities[2] of children's health and survival. The following discussion shows how young Luo mothers through *chira* are enabled to talk within their homes about matters that normally are out of younger women's domain. *Chira* gives Luo mothers a chance to enrol kin members in the daily childcare. With *chira* they try actively to make an independent interpretation of illnesses and deaths in the home.

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[2] I have chosen to look at responsibility in two ways; firstly a responsibility which is about the practical activities regarding healthcare for children (visiting health clinics/healers, buying/preparing medicine, bathing, cooking etc.). Secondly a cause related responsibility (actions which violate ritual rules which lead to misfortunes e.g. illnesses).

AN ANTHROPOLOGICAL MALARIA STUDY IN A BROADER SOCIAL AND MORAL CONTEXT

I heard many stories about *chira*[3] during my fieldwork in Kenya in 1995. My intention is therefore to discuss the complexity in young Luo mothers' use of *chira*. In this article I wish to argue for the relevance of *chira* in a broader understanding of childcare[4] in a Luo village in western Kenya. The paper shows how *chira* is one of many elements involved in a mother's considerations when seeking treatment for her children - economic, practical as well as moral and social.

This discussion will contribute to a further understanding of children's health situation in the Siaya (now Bondo) District. Such understanding, which we often lose in the 'objective' quantitative measures of mortality and morbidity, is highly relevant for a further comprehension of the complex social situations in which childhood diseases such as malaria are interpreted. Inspired by Kleinman (1995), I became aware of the importance of looking at the local moral processes as they emerged in the specific local context. This focus I found could give insight into the complexity of mothers' treatment choices![5]. Linda[6] explained to me:

"Malaria like this, which is caused by chira, I treat with manyasi (local herbal medicine for chira), but it treats only the diarrhoea and the vomiting, the chloroquine (injections) will then treat the malaria and panadols will cool down the body" (Linda).

FIELDWORK

The present study is based on five months of fieldwork in the present Bondo District in western Kenya's Nyanza province, from March-August 1995. The research project was set within The Kenyan-Danish Health Research Project (KEDAHR). I was affiliated to the project involved with anthropological research on local practices of child health care, in particular what was done in the homes when children were having from a biomedical point of view, what might correspond to fevers/malaria.

The fieldwork period covered the peak season of malaria transmission. My part of the project was carried out in the small Luo-village "Lwak" near Lake Victoria. During fieldwork which was based mainly on the qualitative methods of participant observations and in-depth interviews, I carried out 90 planned visits, including those with my nine key informants and mothers with whom the number of visits varied from three to eight on average of half a day's duration. Some of my key informants were sisters-in-law and with them a lot of the interviews turned into group discussions. I worked with two local Luo field assistants (a young and a mid-aged woman) who acted as my interpreters. Interviews were tape-recorded. From each key informant I also

[3] All Luo-terms and informants' statements have been italicized.

[4] Women's contributions to the health-seeking activities are recognised all over the world. Recent studies show that the majority of health care takes place in the homes, and that women carry out up to 95% of that care (Amuyunzu 1998:491). A similar observation is made by Olenja (1991) in her study in Siaya District. This specific division in the burden of healthcare is particularly seen in polygamous households (Olenja 1991).

[5] Biomedicine is the name for the medical tradition that has its roots in western medicine. For further reference see Kleinman (1980) regarding the plural medical system.

[6] All names are pseudonyms. Persons quoted are all young mothers with more than four children.

collected narratives of recent illness episodes and of childhood deaths.

OBJECTIVES

My initial intention was to do an anthropological study of local perception and management of health and illness, mainly regarding malaria. But the study soon developed into a broader study of mothers' concrete experiences of and daily management of cases of illness and thereby into their specific experiences and concerns about childcare. The fieldwork showed me that we cannot stop at simply asking for different kinds of treatments - we have to ask why a mother has chosen as she has, in which context. Following Yoder (1997), this involves:

> describing the context in which individuals make decisions regarding their health and showing what elements enter into decisions, showing what elements they consider as relevant.... Before we ask why a mother gives oral rehydration to her child with diarrhoea, or gives a herbal bath to the child, or brings the child to a health centre, we must first understand how [and why] such events have been produced (Yoder 1997:141 [emphasis mine]).

Thus, my study soon focused on exploring how situations of illness interpretations, as experienced by my informants, had arisen and were produced within and in relation to specific moral ideas and norms. I wished to uncover the complexity of health-seeking behaviour and of the mother's choice of treatment and following Kleinman (1995), I wanted to identify what was 'at stake' for mothers when their children were sick.

THE RESEARCH SETTING

Ethnically the population in the research area is mainly Luo and the language is *Dholuo*. The Siaya and Bondo Districts are among the areas in Kenya where malaria is holoendemic and where malaria-related morbidity and mortality is highest. The under-five mortality rate in Siaya District in 1998 (at the time including also Bondo District) was 198.8/1000 and the infant mortality rate was 135/1000.

Lwak is special in the context of health initiatives, since it is a part of the pioneer work of the Saradidi Integrated Health Project. This project started nearly 20 years ago, mainly to reduce malaria problems in the area (Kaseje & Sempebwa 1989, Kaseje & Spencer 1987). Today Lwak also takes part in the 'Bamako Initiative' (B.I.). B.I. is a part of Kenya's decentralising of the health sector. Furthermore, Lwak has a mission hospital 'Saint Elizabeth', and a nutrition centre 'Family Life Training Centre', where mothers at the time (in 1995) could stay with their children (see Ringsted & Ringsted 1996, 1999 and Ringsted 2000).

FINDINGS

(a) *Chira*, young mothers and agency – towards an actor-oriented analysis

Chira is often perceived as the result of a mother's inattention. The moral ideas behind *chira* are, that violation of *kwer* (ancestral rules/taboos[7]) causes conditions

[7] *Chira*-rules: I was told a large number of rules, which were connected to family relations and actions/behaviours within the *dala*, such as sowing and harvesting, giving birth, death, parent-child relations (Ringsted 2000, see also Parkin 1978). These principles were clearly present in the daily life of young mothers in the *mier*. The three most common causes of *chira* young mothers referred to were breaking the genealogical order, improper mixing of categories and failing to ritually finish a

of ritual impurity – *chira* (sinful consequences such as illness or other misfortunes) (Whisson 1964). We see how "a number of monographs report beliefs in pollution forces which strike when rules are broken, when categories are mixed and when proper order is not maintained in human affairs. In contrast to anthropomorphic agents, these forces are impersonal and abstract" (Whyte & Whyte 1981). Still, human agents may manipulate such forces, as the following case study will show - people who wish to "harm" somebody can manipulate the causal relations of *chira* in a way that others unwittingly make transgressions of *kwer*. The offender and the victim of *chira* are not necessarily the same person. Especially children are vulnerable to adults' offences (Abe 1981:134, Mboya 1984). This Whyte (1997) explains by the fact that children can be perceived as extensions of their parents. If the mother (consciously or unconsciously) offends a rule (or doesn't take precautions to protect her child), she can be affected through her child's illnesses (Parkin 1978, Whyte 1997).

Through this paper I will show how such a specific event is produced and how this influences the mother's considerations in managing the specific illness episode. As *chira* is an illness that often directs blame at the mother, it has been dealt with in anthropological analysis of Third World women and mothers in a way that often only represents them as passive subordinated victims. However, during the following discussion I will show how mothers also are actively and creatively seeking to create a space for themselves to manoeuvre in every-day child care.

Olenja (1990) writes of *chira* "It is also important to note that the responsibility for ensuring "proper behaviour" seems to lie heavily on women, so that even in an adulterous situation where the husband is guilty, it is the wife who ensures that the child is protected through the application of relevant herbs" (Olenja 1991:56). Furthermore, *Chira* has been seen in earlier analyses as an illness diagnosis that covers a system of threats and sanctions. A system which the older generation, especially the older women in the home (*dala*) produce and preserve to limit young women's chances to act (Kryger 1992).

But young women also refer to *chira*. This happened when the *chira* was directly related to their own neglect of *kwer*, consciously or unconsciously, causing *chira* in their child. In some cases young women admitted the responsibility for *chira*, even when it had caused the death of a child. As a mother explained; *"...it was chira (which killed the child) because I had given my sister who hadn't finished her widowhood*[8],

liminal period. A break in the genealogical order could be neglect of the rule that senior women (couples) in the *dala* always are supposed to harvest as the first people in the dala. Improper mixing of categories was a common explanation among the mothers for illnesses and death. Thus *kwer* is related to incest taboos (Parkin 1978:145), but is not restricted to sexual relations, e.g. between father and daughter. It also extends more broadly to avoidance of certain other intimate relations, such as if a child is sitting on his still reproductive grandmother's lap (near the vagina) or if a mother breast-feeds her child after she has become pregnant again. The fundamental idea in the last example is that through the nursing, the two children's bloods become mixed, and they have in a figurative sense an incestuous relationship, which is improper.

[8] A widow must be "taken over" (*tero*) by a levir and go through ritual intercourse (*chodo kola*), which will clean her from the pollution she has got by being in touch with the death. Anne's sister had not

permission to sleep in my house" (Anne). Statements like this led my attention to the possibility that perhaps young mothers "could do something" - "get something done" within the homes, with a *chira*-diagnosis. For instance, call upon the sense of responsibility and compassion of her family members, in a way that she would not be left alone with the responsibility of taking care of her sick child.

Moreover, it showed that we couldn't just consider young Luo women as passive victims - oppressed by among other things patriarchy, religion, tradition and policies that don't favour them. Representations like these represent, of course, structures of the community, which cannot be left out in analysis of Luo women's life. But such an analysis completely misses the role women themselves play in the process of recreating the very same structures and ideologies that 'suppress' and 'control' them. These analyses also omit the processes where women have the possibility to manipulate social situations. My point is that although young women of a subordinated position in the patrilineal *Luo* community have limited personal agency, even they are co-actors in creating, maintaining and changing social relations and systems of responsibility (Ringsted 2000). Holland et al. put it this way: "Even within grossly asymmetrical power relations [as between young Luo mothers and the older generations (mothers-in-law)] the powerful participants rarely control the weaker so completely that the latter's ability to improvise resistance become irrelevant" (Holland et.al. 1998:227 [emphasis mine]).

Agency is seen here as an ability of people to act more or less goal-directedly and reflectively within a complex of social relations. People are able to repeat, recreate and change the world they live in (Inden 1990 in Holland et al. 1998:42). In a similar way, Villareal (1992) states that through acting, actors manipulate life restrictions. This they do not only to survive but also to change their situation (Villareal 1992:257, 262). Luo mothers did have a feeling that their agency had an influence on how specific situations developed and changed for the better or worse. But a Luo mother is not an individually isolated actor. Rather she is entangled in many different social relations (Whyte & Kariuki 1997, Katahoire 1998). Therefore, we have to see social agency as a process of social engagement (Mogensen 1998:3) - something that happens between people. This means that especially in an East African context social agency is constituted within social relations and can only be effective through them. Mattingly (1994) expresses it in this way: "... our actions are taken up, reworked and redirected by the responses of other actors, we still have some success some of the time in working toward endings we care about. And sometimes we are even able to negotiate with other actors so that we move in directions cooperatively, cumulatively" (Mattingly 1994:813). We see this, when a young mother only through negotiation with and enrolments of family members has the possibility to go to the hospital with a sick child. She must "find" money, find somebody in the home to take care of the other children, find transportation etc (Ringsted 2000). And as Mattingly writes, the mother's agency will be interrupted many times before she can be on her way.

been taken over, and still in the shadow of the death. Therefore Anne's child died, as a consequence of her being in improper contact with the death.

(b) *Chira* as a mediating device

To understand young mothers' use of *chira*, I have applied Vygotsky's (1978) concept of "mediating devices". It will take us a little bit further than noting that *chira* is about morality in terms of norms, by reminding us that morality is not just conforming, being socially controlled, but equally about controlling the social, making a moral community. People use mediating devices as a means of influencing their own or others' way of thinking, feeling or behaving and of creating shared attention. Mediating devices are socially and culturally constructed by ascribing meaning to an idea and/or an act. But the attribution of meanings and values on acts is not simply individual. Rather, a mediating device is a part of a collective process, often evoking a sharedness out of already existing values. Even though individuals constantly construct and reconstruct their mediating devices, these take form within social interaction and are rooted in specific social and moral contexts (Vygotsky 1978). As a mediating device, *chira* is rooted in the social and moral context of the Luo *dala*, and in the ideas about and expectations of childcare within the home. Within this context, the mediating device is evoked, collectively developed, individually learned and made socially and personally powerful.

(c) Social relations, *chira* and hierarchies of respect within the luo-*dala*

As *chira* was the main diagnosis mothers referred to when they were concerned about children's illnesses and death, I was inspired to look more closely at the social and moral universe connected to the ideas and norms surrounding *chira*. East African studies of women attach importance to how kinship and marriage structures have an influence on women's position and status in their families and communities (Evans-Pritchard 1950, Wilson 1968, Southhall 1966, Parkin 1980, Håkansson 1994, Francis 1995). The Luo practice exogamy, and a Luo woman will first through marriage get her legal, ritual and economic rights and obligations (Ocholla-Ayayo 1976, Parkin 1980).

Respect (*luor*) for rules and senior persons are the most fundamental values within the Luo-*dala*, and are practised to regulate social behaviour and interaction. *"It is the Old People who made the traditional rules* kwer, *in such a way that living Luo people also will show respect for the rules of right behaviour. If you pass or cross (break them), the Old People will become angry, and you will be hit* (kumo) *by a disaster,* chira" (Monica). Among the foundations of ancestral rules is a genealogical order, in which the axis of age is strongly emphasised. This idea is collectively created, recreated and is seemingly lived by in the contemporary Luo community. In practice it ranks from God (*Nyasaye*) to the youngest baby in the community (Ocholla-Ayayo 1976). Ndisi (1969) writes thus "when a child met an elderly person he was expected to greet him and then leave the path for him as a sign of respect" (Pp. 64). To go against ideas about respect sets the young woman in a very vulnerable situation, for she will immediately get the surroundings' disapproval and punishment. Furthermore, she will get into conflict with her self-understanding, learned in childhood, of being a good respectful wife and daughter-in-law (Ringsted 2000).Van der Geest (1997) shows how relations of respect reflect the social categories in a community, but stresses at the same time that any category change depends on the context (Van der

Geest 1997:535). Thus a woman has in one context to show respect to her mother-in-law, but in another context she can expect to receive respect from her younger co-wife. Young newly-married women are in that way placed just a small step above the children in the *dala*, and are in principle subordinated to all men, parents-in-law and other adults who rank higher than them. Her position as an "outsider" (due to exogamy) will always have an influence on her ability to manoeuvre and receive help within the *dala*. This problem is especially urgent if the "marriage" is not formalised (when the bride price is not or only partially paid). A situation like this is not uncommon; lots of younger couples live together without preceding marriage arrangements.

The *dala's* physical organisation reflects the hierarchical order in which respect is socially sanctioned: between living and dead, between fathers and sons, between mothers-in-law and daughters-in-law, between first wives and second wives and between sons. This hierarchy sets the principles for the genealogical order, which ascribes status in relation to lineage seniority (Ocholla-Ayayo 1976). The *dala* (pl. *mier*) is the fundamental unit around the extended family. A founder of the home (*wuon dala*) lives in the *dala* together with his wives and sons, and their wives and children. Every married wife has her own house (*ot*). The houses in the *dala* are placed in a circle. The first wife's house (*od mikayi*) is placed opposite the gate, the second wife's house (*od nyachira*) to the left, and the third wife's house (*od reru*) to the right. By the gate the first son lives to the right and the second to the left[9] etc. (Ocholla-Ayayo 1976). Movements in the *dala*, such as entering the gate or bringing in the harvest, reflect a similar order:

Monica's statement *"I can't do anything before my mother-in-law" refers both to the fact that "as a young woman, you can't enter the compound before your mother-in-law, or take decisions about childcare before consulting your mother-in-law or harvest before her"*. The last example is more than an offence against ideals of social respect -it also causes *chira*. Monica continues her story; *"...I brought in the harvest without knowing it was wrong... The following day we did not wait and finished the rite (ritual intercourse) for the bean harvest. But my mother-in-law had not harvested her beans yet, and she said we should not have the intercourse* (gimoro), *but we had already had it. That's why we knew it was* chira *the child had..."* (Monica).

This idea about harvest and senior succession was so great a problem in the area, that the local leaders at the Chief's *Baraza* had to encourage the older generation of women to start the harvest and the connected rituals so the younger women could harvest, because the children were starving (Mother-in-charge, Lwak Family Life Training Centre 1995). Social relations of respect and ideas about *kwer* and *chira* are thereby closely connected.

In the next section, I will examine some of the same hierarchical tensions in a case from my research. This analysis will examine how an episode of diarrhoea and vomiting opens up for the possibility to express concern about social matters within the family. A *chira* diagnosis is a mediating device that can evoke ideas about responsibility and compassion in childcare.

CASE STUDY

During my fieldwork, I was in one specific *dala* more than 20 times. Here I visited four

[9] Today we see *mier* in many stages of development. In reality, many persons who are not covered in this ideal structure also live in the *dala*.

young mothers. They were sisters-in-law, married to the sons of the late first wife of *wuon dala*. Nowadays, they have a shared fear of their "new" mother-in-law's manipulation of the *chira*-rules. She has only given birth to a single son, and unfortunately he is about to pass away without leaving any descendants. That's why, they explain, she is evil and envious, and tries to kill all the descendants from her late co-wife's line in the *dala*. Furthermore, the sisters-in-law accuse the father-in-law of not finishing rituals after the death of his first wife. He should have slept in his first wife's house after her burial until she had come back to him in a dream, before he went and slept with his second wife (see also Whyte 1990). Now he is, according to the young women, "in the shadow of death", and will bring *chira* to the children in the home.

June 1995. Everything is quiet this morning in Onyango's *dala*. The sisters-in-law are together in Linda's small house. She is particularly concerned about the threat of *chira* today, because her new-born baby in her arms has got high fever. Linda says, "*To take care of children, especially baby boys, is extremely hard. You know, the child here was healthy and laughed a lot yesterday, but suddenly he became very weak, and then I started thinking about chira, and tried to find out what's going on in the home*" (Linda). Suddenly their mother-in-law is standing in the doorway. She doesn't enter, she only sends her greetings into the darkness. We greet her with the degree of respect a woman of her age and status has to be met with. Nobody goes out to her. After she leaves, anger and anxiety is in the air. Linda continues in a low voice; "*These days I am very concerned, because I have been placed in a very bad situation. My new mother-in-law had, without saying anything to us young people, harvested corn from her* puodho *(garden), and my husband and I hadn't ended the* tieko (a ritual intercourse after birth) *for our new-born son. Now he is very sick with* chira, *and I don't know whether he will survive... We should have ended the* tieko *before my mother- in-law brought in the corn, but she never informed us. To bring in the harvest is quite all right, as long as one shows respect for the traditional rules of* chira. *When she brought in the harvest in secrecy, I knew she didn't mind if my son dies. It was she who was responsible for the* chira *coming into the home, but it was I who should have been watchful and thereby prevented it*" (Linda).

The sisters-in-law show their compassion for their young co-sister and agree that their mother-in-law on purpose manipulated the traditional rules/taboos. One of them says, "*Yes, she just wants to eliminate us young people, because her line is finished*[10]". Another takes over, "Yes even our father-in-law causes *chira* in the home, by neglecting the traditional rules of widowhood...he doesn't care, and just continues to sleep in that lady's home (his second wife's)." After this the sisters-in-law start a shared criticism of their parents-in-law for neglecting the expected parents-in-law obligations. Achieng explains: "*You know, they have this hotel along the road, but they don't help us with some money or other necessities, not even when our children become ill and we really need it*". (Achieng')

The case here raises several questions, and in the following analysis I will try to answer at least some of them. For example, how can young women express their concern and indignation with what they feel is neglect from their parents-in-law, without going against the fundamental moral ideas about respecting hierarchies

[10] "Line is finished" refers to the fact that she has no male descendants.

without going against the fundamental moral ideas about respecting hierarchies within the community? How can Linda get people's help without at the same time drawing their attention to the fact that her child possibly is ill because of her own neglect?

The above event was socially produced within the specific moral context of a Luo *dala*, as a consequence of the young women's concern about the increasing illness and death among their children. Two small children had passed away within the last year, and others were sick at the moment.

Linda tried to find explanations outside the usual "hospital explanations". She had been to hospital for repeated chloroquine injections, but nevertheless the fever seemingly kept recurring. Furthermore, a "hospital diagnosis" often contains associations of blame, of being personally accused for being neglectful, being lazy and not cleaning and draining the compound, or not coming soon enough for hospital treatment, or not giving the prescribed medicine etc. Linda says, *"and then they (hospital staff) accuse me of coming too late... and said it was the reason that my child died."* By searching for illness interpretations which are socially and family related, she instead seeks to redefine her childcare from individual responsibility (the mother's alone) to collective responsibility (a family matter).

In that way I experienced how young women acted particularly goal-oriented. I found they were co-actors in manipulating and changing difficult life situations. To attain this, I saw how *chira* became their means of "getting things through" in the family, in spite of their subordinated position. This is not to say that a *chira* diagnosis doesn't also contain ideas about blame; the mother didn't take care, she didn't follow the rules or did not prevent a *chira* threat by using herbs. But a *chira* diagnosis is also open for negotiation of the responsibility in a way that hospital diagnoses aren't. Linda used *chira* to influence others, especially her sister-in-law's understanding of the specific situation with a sick child and her father-in-law's acknowledgement of the problem. She tried through *chira* to create shared attention to her problem and thereby change her surrounding's attitudes and behaviours.

Furthermore, use of *chira* in that way made their expressions and explanations possible in public, which normally is out of younger subordinated women's domain. To come up with a suggestion about a *chira* threat in the home, which evidently is acceptable, is not the same thing as would be a young woman criticising her mother-in-law being mean and unhelpful, which is totally unacceptable. It was obvious to me that although these young women felt indignation of what they perceived as their mother-in-law's manipulation and father-in-law's neglect, they also did agree with the socially and morally constructed ideas about respecting hierarchies. Calling attention to *chira* in the home in this specific manner was a culturally acceptable way to express among themselves, their insecurity and anger against senior people - their parents-in-law.

Moreover, when a child becomes ill, it also draws social others' attention to a mother's ability as a caretaker. This process she has to have an influence on, by taking an active role in defining the cause of the illness. If she manages to do so, it puts her in a more powerful position in the home. This position allows her, at least partially, to set the framework for how her childcare is further evaluated, which again has a

positive influence on her social reputation in the family as well as in the community, thereby giving her support. Participation like this was closely connected to a person's personality and positive self-understanding, and could have motivating strength in doing something, which felt right and necessary (Quinn 1992).

In our case Linda used *chira* actively to create an independent interpretation of her son's illness, because she felt it was right. She tried to manipulate the ideas about *chira* (mothers are the only ones responsible), in such a way that she would not be left alone with neither the cause nor the practical related responsibilities. She based her appeal for help on the accepted ideas about compassion, which are connected to the idea of respect in family social relations. Mogensen (1998) demonstrates too, based on her research in Uganda, how social relations of respect also are very powerful systems of reciprocity. I observed that young women did expect that senior persons should show compassion and responsibility downwards in the age hierarchy. Mathilda from Onyango's *dala* said: "A good mother-in-law should look after your children in a good way, and if I do not have any food, she has to give me something" (Mathilda). In this way, *chira* as a mediating device is socially constructed. Mothers participate in this by attempting to evoke meanings of reciprocity in the idea of respect hierarchies and in the act of showing respect and compassion. Thus it is expected within the Luo *dala* that a person should receive support from the persons she shows respect - they will subsequently receive further respect. In this way, a mother's ability to call upon family members' compassion has a crucial influence on how she and her children prosper. Linda tells me; "*If only they had come with the* manyasi *for my child, it wouldn't be dying now; this child just waited for his people (family) to come*".

Through her talking about *chira*, Linda could open a debate of social relations of respect and compassion, and through that diagnosis, if she could manage to persuade them of its justification, remind her parents-in-law of their responsibility to help their younger generation. She could attempt so by enrolment of her parents-in-law through involving them in a cause-related responsibility of an illness, which many would agree always needs to be countered by rituals. In this way, an unwelcome allegation of at least shared responsibility would be out-balanced by the shared need for action, the ritual being non-escapable and *chira* being a thing that must be said. Not all allegations of *chira* go all the way to direct confrontation of the wrongdoer with the diagnosis. I was unable to follow the case throughout to such an eventual stage, due to the limited timeframe of my fieldwork. Evidently, their shared diagnosis of *chira* shaped the mothers' perceptions, attitudes and practices towards childhood illness. My main argument has been that this springs not from the diagnose itself, but from the social circumstances, that mothers are able to do something with a *chira* diagnosis - make things happen such as appeal to the support of others. But in the end, we need to ask in what way the young mothers succeeded in their attempt to use talking about *chira* to influence others' thinking and behaviour? They did, at least partially, because people around them (neighbours, friends, trading women in the neighbourhood) agreed that the young mothers' mother-in-law was manipulating them and that their father-in-law had neglected important rules. In that way they

saved their reputation as good responsible mothers. Unfortunately, I am not aware of whether they had success in getting their parents-in-law to feel a shared responsibility for their children's health. Linda sought out a variety of treatment sources and forms of treatment and utilised a number of different ways of manoeuvring in order to initiate specific treatment. And her baby survived.

CONCLUSION

I have now described a particular social, cultural and moral context in which these Luo mothers consider and decide what actions to take regarding their children's health. I have shown how the situation was socially constructed and connected to specific social and moral ideas of respect and compassion. I have demonstrated how responsibility for children's health is not solely connected to the mother-child relationship, but depends on relationships between adults in the *dala*. It is this specific context on which we must base our understanding of health and childcare in Bondo District. Specifically, we must understand how "simple" episodes of fever, diarrhoea and vomiting can be rationalized by using explanations such as those outlined above. Processes like this are normally not a result of Luo women's lack of knowledge about e.g. malaria symptoms or its treatment. This they have. Rather, as we have seen, situations may develop during young mothers' urgent need to transform the agency surrounding children's health care from an individual responsibility to a family responsibility, in hope of getting help to initiate treatment – chloroquine as well as *manyasi*.

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