

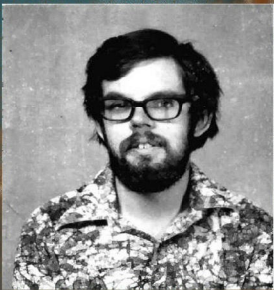
THE INFANCY OF EDWARD SHELONGA

An extended case highlighting the interplay of traditional and modern health care among the Nkoya people, Zambia, 1970s

From the introductory chapter 1:

'In this argument I shall present a case history based on the health experiences of a Nkoya boy in the early years of his life during the 1970s. This case sheds considerable light on one of the crucial medical problems of the Third World: *the interplay between cosmopolitan (i.e. Western, modern) medicine, and such other forms of medicine as exist locally*; the latter forms usually are part and parcel of the local religion. Use is made of the 'extended-case method' of the famous Manchester School, which sees in the relationships between people within one social field, and in the evolvement of these relationships over time, the major key to structural principles, *in casu* those governing the interplay between the various forms of medicine.'

WIM VAN BINSBERGEN (*1947) studied sociology, anthropology and general linguistics at Amsterdam University, prior to teaching theoretical sociology at the University of Zambia. That newly independent country was the empirical hub of some of the most significant developments in the social sciences after World War II. Using this unique opportunity to do extensive fieldwork within a greatly inspiring and politically motivated international network, and familiarising himself profoundly with the language and culture of the ethnic minority of the Nkoya people, Wim van Binsbergen addressed in great detail the interplay between traditional and modern medicine as one of the greatest challenges facing the Third World. In addition to his earlier work on popular Islam in North Africa, this laid the foundation for his distinguished international career as a social scientist, historian, comparative mythologist, and intercultural philosopher.



<< the author at the time (1972) when the events described in this book were about to come to an head

Wim van Binsbergen

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An extended case highlighting the interplay of traditional and modern health care among the Nkoya people, Zambia, 1970s

by Wim van Binsbergen

'A classic of medical anthropology'

Sjaak van der Geest, Chair of Medical Anthropology, Amsterdam University



The infancy of Edward Shelonga

BOOKS / INDEPENDENT PUBLICATIONS BY WIM VAN BINSBERGEN

literary work not included, see chapter 12 of this book;

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ABOUT THE AUTHOR

WIM VAN BINSBERGEN (*1947) was trained in sociology, anthropology, and general linguistics, at Amsterdam University (Municipal). He held professorships in the social sciences at Leiden, Manchester, Durban, Berlin, Yaounde, and Amsterdam (Free University). At the latter institution he took his *cum laude* doctorate (1979) and was the incumbent of the chair of ethnic studies (1990-1998), prior to acceding to the chair of Foundations of Intercultural Philosophy, Philosophical Faculty, Erasmus University Rotterdam. Simultaneously, he held senior appointments at the African Studies Centre, Leiden. Over the decades, he has established himself internationally as a specialist on African ethnicity, African religion, ethnohistory, globalisation, intercultural philosophy, divination, comparative mythology, the Mediterranean Bronze Age, and transcontinental continuities between Africa and Asia in pre- and proto-history. He was founding member, and president, of the Amsterdam Association of Anthropology Students (1965-1967), president of the Netherlands Association of Students Reading Anthropology (1966-1968), president of the Netherlands Association of African Studies, 1990-1993, president of the Netherlands / Flemish Association for Intercultural Philosophy (1998-2022), and one of the founding members / directors of the International Association for Comparative Mythology, 2006-2020. From 2002 he has been the Editor of *Quest: An African Journal of Philosophy / Revue Africaine de Philosophie*. His many books include *Religious Change in Zambia* (1981), *Tears of Rain* (1992), *Intercultural Encounters* (2003), *Ethnicity in Mediterranean Protohistory* (with Fred Woudhuizen, 2011); *Black Athena Comes of Age* (1997 / 2011); *Before the Presocratics* (2012); *Vicarious Reflections* (2015); *Religion as a Social Construct* (2017); *Researching Power and Identity in African State Formation* (with Martin Doornbos, 2017); *Confronting the Sacred: Durkheim Vindicated* (2018); *Rethinking Africa's Transcontinental Continuities in Pre- and Proto-history* (2019, ed.); *Sunda: Pre- and Proto-historical Continuities between Asia and Africa* (2020); *Sangoma Science: From ethnography to intercultural ontology: A poetics of African spiritualities* (2021); *Joseph Karst: As a pioneer of long-range approaches to Mediterranean Bronze-Age ethnicity: A study in the History of Ideas* (2021); *Van vorstenhof tot internet: Fragmenten van een culturele antropologie van Afrika* (2021; in Dutch); *Pandora's Box Prised Open: Studies in Comparative Mythology* (2022); *Religion and social organisation in north-western Tunisia, Volume I: Kinship, spatiality, and segmentation* (2022); *Africa Intercultural* (2022). His published work is also available from <http://www.quest-journal.net/shikanda>. Wim van Binsbergen is married with the classical (European and Indian) singer and breathing therapist Patricia Saegerman, and has five adult children. Besides his scholarly work, he is a published poet, the adopted son of a Zambian king, and a certified and practising diviner-healer in the Southern African *Sangoma* tradition.

THE INFANCY OF EDWARD SHELONGA




**An extended case highlighting the interplay
of traditional and modern health care
among the Nkoya people, Zambia, 1970s**

greatly augmented edition, 2023

by Wim M.J. van Binsbergen



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COVER ILLUSTRATIONS: *front and back*: the main cover photograph forms a sequel to the extended case that is central to the present book: nearly 40 years later, Rusha (our protagonist no. [15], and the author's adoptive sister's daughter; see Fig. 4.1, below) has become a healthy mature woman holding her latest baby while waiting in the porch of the Mema Rural Health Centre, Mema Valley, Kaoma District – whose construction was greatly inspired by the chain of events recounted in this book; for lay-out reasons the photograph has been mirrored. *Back cover*: the author as photographed in Lusaka, Zambia, 1972, when the events described here were about to come to a head (courtesy *Vehicle Licensing Office*, Lusaka)

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to the memory of the late lamented Henny E. van Rijn (1936-2019), Mandanésima, my first wife, the mother of Nezmja, and my loyal and inspiring companion during my first and main Nkoya fieldwork, 1972-1974; the 2023 edition is dedicated to the nursing staff, the medical staff and the house-keeping staf at the Intensive-Care ward of the Spaarne Gasthuis (location Haarlem-South, the Netherlands), who while this text is being reprinted, have successfully fought for months in order to preserve the life and restore the health of Patricia van Binsbergen-Saegerman, MmaSara / Mandáshikanda, my second wife, the mother of Vincent, Shikanda, Muchati and Hannah, and my loyal and inspiring companion during fieldwork in Africa and Asia from 1983 onwards

Ter herinnering aan de diep betreunde Henny E. van Rijn (1936-2019), Mandanésima, mijn eerste vrouw, de moeder van Nezmja, en mijn loyale en inspirerende deelgenoot tijdens het eerste en voornaamste Nkoya veldwerk 1972-1974. de 2023 editie is opgedragen aan de verpleegkundige, medische en huishoudelijke staf van de Intensive Care afdeling, Spaarne Ziekenhuis (locatie Haarlem-Zuid, Nederland), die terwijl deze herdruk ter perse is, al maanden vechten, en met succes, voor het lijfsbehoud en de gezondheid van Patricia van Binsbergen-Saegerman, MmaSara / Mandáshikanda, mijn tweede vrouw, de moeder van Vincent, Shikanda, Muchati en Hannah, en mijn loyale en inspirerende deelgenoot tijdens veldwerk in Afrika en Azië van 1983.

PRELIMINARIES

PREFACE AND ACKNOWLEDGMENTS

Elsewhere I have already told the rather embarrassing story¹ of how, when living in Lusaka and teaching at the University of Zambia (UNZA), in 1971, I got into contact with the Nkoya people. Only a few months earlier I had joined that institution's Department of Sociology and had cheerfully taken up my teaching obligations. Appointments at UNZA were typically for a few years only. One of my newly-won colleagues, the Indian medical sociologist Raja Jayaraman, had found a subsequent job in Australia, and would be leaving Zambia. He needed a good home for his fairly large watchdog, a Golden Retriever by the name of Lisa. Our small family, consisting of my first wife Henny, our infant daughter Nezmia, and myself, had occupied a little house in a spacious plot on the Great East Road near Munali, the neighbourhood was constantly being burgled, our darling little dog Jinn had been brought from the Netherlands but would not deter anyone, and a big watchdog seemed a good idea. Raja could be very convincing. Come to think of it, could we not also take over the Jayaraman's domestic help, Muchati, a pleasant and active young man from Western Province, who knew Lisa's ways and diet? And he was also very good with the children – of with the Jayaramans had plenty. We went over to the Jayaraman's house, saw the huge bedroom with the spacious bed in which the entire, large family spent every night in cosy togetherness, inspected the dog, met Muchati, and immediately realised that with him our house, daughter, and dog would be in the best possible hands.

I could not know then that the extent of Muchati's competence and responsi-

¹ There is poetic justice even in fieldwork, transcontinentally and interculturally, as we shall see in the course of this book – towards its end (p. 193) I return to the discussion of dogs, and there the apparent connotations of class and colonial subordination of the present passage will take on a rather opposite meaning.

bilities in our lives would soon be dramatically expanded – within a few months, his lively and passionate stories about his rural home and his handful of relatives in Lusaka, all going by the ethnic label of ‘Nkoya’ (a Lozi subgroup, for all we knew in those ignorant early years), would lead to a point where he would begin to share major aspects of Nkoya culture with us, initiate us into his language (and it was high time, too, if we wanted to understand our own daughter – for Nkoya was to be her first language since, at the back of our yard where the ‘servant quarters’ were situated, she spent her days playing with Muchati’s infant son and his mother), and prepare us for the glorious day when we would be visited by the royal chief of the Mashasha Nkoya, Mwene Kahare Kabambi (his membership of the select national House of Chiefs occasionally required his presence in the state capital), emerging from his white Volkswagen van where he had been seated on a simple throne surrounded by huge and priceless elephant tusks.

Prior to accepting my first ever appointment at UNZA, while completing my training in anthropology, development sociology, and general linguistics at Amsterdam University, the Netherlands, I had worked for three years on the analysis and writing-up of my first anthropological fieldwork, on popular Islam in the highlands of Northwestern Tunisia. While teaching at UNZA I was not particularly looking for a new fieldwork topic and site. When I had left for Zambia one of my principal professors, the Europeanist / Mediterraneanist Jeremy Boissevain, had assured me out of his own initiative that he would accept my comprehensive Tunisian research as more than sufficient for a PhD under his supervision. So I could sit back and watch – already assured of the PhD degree indispensable for my further career in the social sciences.

However, sitting back idly was far from obvious. At the time Zambia was a Walhalla for state-of-the-art anthropological research; in the preceding three decades it had received the most excellent coverage by high-ranking researchers; and it was the empirical hub of Great Britain’s Manchester School which, under the guidance of South-African born Max Gluckman, represented an innovative, agency-centred, politically committed, vocally anti-racist form of social science, as a healthy alternative for the conservative structural-functionalism² that was still the social

² Despite the similarity in designation, the huge difference must be appreciated between structural-functionalism and structuralism as leading paradigms in anthropology in the 1950s to 1980s CE. Both are in a way descendants from the early sociology of Emile Durkheim (1858-1917) in France, the author of such leading texts as *De la Division du Travail Social* (1893), *Les Règles de la Méthode Sociologique* (1895), *Le Suicide* (1895), and *Les Formes Élémentaires de la Vie Religieuse* (1912); the international specialised literature on Durkheim is enormous, an illuminating, authoritative, and extensive early guide is Parsons 1949 / 1937,

sciences's dominant paradigm. Jaap van Velsen, one of the most original, brilliant, radical, and socially impossible, exponents of the Manchester School,³ had become

also *cf.* Hsu 1973, Pope 1973, van Binsbergen 2018, 2021 for a selective introduction and bibliography. Structural-functionalism – never a monolith – by and large developed out of Durkheim's notion of *the social*. It came up in the United Kingdom and the United States of America, with such initiating authors as Radcliffe-Brown, Malinowski (also *cf.* Barnes 1963), Parsons, Merton, Warner, Fortes, Evans-Pritchard; these references are only peripheral to the present argument and without further discussion I must refer the reader to the bibliography at the end of this book. Structural-functionalism offered a coherent perspective on society conceived to consist of integrated patterns of social relationships, organisational forms, norms and values; its societal image was usually artificially formalised, unified, undynamic in its insistence on integration and its abhorrence of conflict and change. By contrast, structuralism rather developed out of Durkheim's approach to the symbol as an essential but arbitrary aspect of the sacred (an approach mediated via Durkheim's prominent student Marcel Mauss to the latter's student Claude Lévi-Strauss, also *cf.* de Josselin de Jong 1952; Shapiro 1991), but took in much wider contemporary developments in the world of linguistics (de Saussure) and psychology / psychiatry (Piaget, Lacan); again, these references are only peripheral to the present argument and without further discussion I must refer the reader to the bibliography at the end of this book. The central concept of structuralism is the notion of *structure*, which in principle is an abstract, contentless and meaningless web of logically describable relations, but it is the concatenation, contradiction, and evolution of structures and their constituent elements which are supposed to constitute the backbone of culture, a worldview, a language etc. – even if partly unconscious. In French academic thought, structuralism became the dominant paradigm after World War II, only to be temporarily challenged by neo-Marxism (*e.g.* Althusser 1965; Godelier 1973; Terray 1969; Meillassoux 1975; Rey 1971; *cf.* van Binsbergen & Geschiere 1985; Gerold-Scheepers & van Binsbergen 1978, 1984c).

³ In the 1960s, when I read anthropology at Amsterdam University, this was still largely in the classic structural-functionalist vein, although the main stock-in-trade of Jeremy Boissevain (who took up his Amsterdam chair in 1966) was to challenge that paradigm, as one of 'the three B's' (Barth, Boissevain, and Bailey; not to be confused with 'the three K's' of the Ancient Central Mediterranean, the ethnic groups of the Cretans, Cappadocians, and Carians (the original Greek has a κ, *kappa*, for the initial consonants here), feared for their piracy; van Binsbergen & Woudhuizen 2011; van Binsbergen 2021g). (The point is not in the least to accuse the three B's of piracy in the sense of illicit appropriation, in other words plagiarism, but to convey the unsettling sense of threat they inspired in some of their more conservative and less innovative colleagues within the 20th-c. CE social sciences.) At the time, Amsterdam anthropology was preoccupied, not only with cross-cultural comparison as Köbben's (1961 / 1952, 1967, 1970) main claim to international recognition, but also with the battle against Lévi-Straussian structuralism; the latter was met with the irrational hatred of ignorance, perhaps partially brought about by my Amsterdam colleagues's relative ignorance of the French language as compared to English. At the time, English texts, and classic British anthropology in the vein of Fortes and Evans-Pritchard, was the Amsterdam standard. If I had at all heard of the Manchester School (another challenge of the established classic anthropological paradigm, and one that had in fact produced Bailey) in the 3.5 years of my

the director of UNZA's Institute of African Studies (proud continuation of the colonial Rhodes-Livingstone Institute – situated in its own premises close to Munali (Zambia's most prestigious secondary school), Lusaka. At UNZA's main site along the Great East Road, the Department of Sociology was headed by the radical jurist Jack Simons, who likewise entertained close ties with Manchester, and even more importantly, who with his wife Ray Alexander was the principal representative of the South African liberation movement African National Congress (ANC) – their splendid house in Roma, a Lusaka upper-class suburb north of the Great East Road was the ANC's main strong house outside South Africa, and here my wife and I were privileged to occasionally meet the principal future leaders of the new South Africa. Moreover, personal curiosity and love of the anthropological profession combined with my awareness that, if I was to seriously teach my Zambian students about their own society (many UNZA students were the blinkered products of Christian boarding schools, largely ignorant of the details of Zambian village life), I could not just rely on the existing scientific literature (extensive though it was – and I was well-read in it) but needed the authority of first-hand experience through extensive local fieldwork. UNZA obliged by welcoming, and funding, my proposal for a survey of Lusaka religious organisations – for I had specialised in religious anthropology. Soon however the closely-knit network of Nkoya migrants in town, with their peculiar brand of great practical psychology, rural directness and familiarity (after all, we were a young family of uprooted expatriates, deprived of any kin support), and with their near-weekly weekend ceremonial gatherings around healing cults, female puberty rites, and funerals, gave me a sense of relevance, human encounter, and belonging that the largely Christian

undergraduate studies at Amsterdam (1964-1968), it was through a short, popular piece which the Amsterdam lecturer and at the time PhD candidate Bonno Thoden van Velzen (no relation) had contributed (1966) to *KULA*, the periodical of the Netherlands association of students reading anthropology, whose President I had been for a few years (1965-1967). Bonno happened to be one of my first teachers of anthropology, and his seminars on race relations in the Caribbean (especially the incredible atrocities attending slavery in Surinam, the last Dutch colony, nearly half of whose inhabitants yet flocked to the Netherlands at the attainment of Independence in 1975) made a deep impression on me; later Bonno became a trusted and generous patron of my career (securing my access to the Leiden African Studies Centre, 1976, and to the Netherlands Institute for Advanced Study, 1994), only to end up as my fellow-administrator of the national research programme on Globalisation and the Construction of Communal Identities, which Peter Geschiere and I had initiated in the early 1990s. My years in Zambia proved a ticket to Manchester, which I frequented in the 1970s-1980s, even to the point of occupying the Simon Chair there, like the famous anthropologist of religion Victor Turner before me. Later I attempted, in the footsteps of several others (Werbner 1984, van Teefelen 1978), to synthesise the Manchester approach in an ambitious article (van Binsbergen 2003 / 2007, 2006); but when it appeared in print Gluckman had been dead for three decades, and the Manchester School largely with him.

formal organisations in the religious domain could only sporadically accord – much as I enjoyed the church scene in the mushrooming new suburb of Mutendere, or preaching at popular request in the African Independent churches I frequented (after all, in the African urban perception I was White, hence a Christian, hence versed in Biblical scripture – never mind that apostate Dutch Roman Catholics, like myself, were by and large not any of the last two things).

Among these research opportunities tempting me as an ambitious and committed young anthropologist, not Manchester,⁴ but UCLA (the University of

⁴ Although I was immediately very close with the former-Dutchman of part-Indonesian background Jaap van Velsen, who in ways I could fully appreciate (I had been a student of the Marxist Indonesianist Wim Wertheim, a vocal anti-colonial critic of the Dutch government's excessively violent response to Indonesian Independence) had relinquished his Dutch nationality in protest, and for that reason adamantly refused to speak our native Dutch with me – even though his English, like mine, had always retained a touch of foreign accent. I can still see him before my eyes, fanatically speeding along the Great East Road from his office to his home and back on his little motorbike, – his imposing tall frame in short trousers, a motor helmet on his bald head, and protruding from under the helmet a few stray locks of hair like a lion's manes tossing in the wind – the proverbial pioneering anthropologists whose only home is the field. I cannot conjure up this image without realising that Jaap's principal disqualification of other people and their work was in terms of them being 'pedestrian' – well, he avoided that despised form of locomotion at all costs! His game as Director of the Institute of African Studies, north of the Great East Road and Munali, was to treat newly-arrived foreign researchers (and the old Rhodes-Livingstone reputation still attracted quite a few of them) to a devastating verbal ordeal – many left his office in tears – meant to demonstrate their ignorance by confronting them with a litany of the most recent regional scientific literature – Jaap was painfully conscious of working at an intellectual backwater and, while publishing preciously little himself, made every effort to keep up-to-date in his reading. (This was decades before the digitalisation of academic libraries made intellectuals in Africa merely dependent on reliable and fast Internet.) Jaap did not give me his full vicious treatment, partly because my UNZA appointment had been the fruit of his personal friendship with my principal professor, André Köbben; partly because, as soon as I had figured out his game, I repeatedly kept him at bay by randomly citing non-existing recent publications of my own invention, ignorance of which he had no choice but to admit. (It was a game I had played before, in the final years of secondary school, at evening sessions of our school's debating club, when my best friend the precocious poet and later President of the Netherlands Writers Union Hugo Verdaasdonk (cf. my autobiographical text 2015b) and I, even without prior consultation with one another, would pull our audience's leg by engaging in a long quasi-literary discussion on the merits of the non-existent brilliant novel *Uitgekauwde Kauwgom / Chewed-down Chewing-Gum*, and its Angry Young author.) But once this ground had been cleared, my regular consultations with Jaap at the Institute for African Studies proved immensely stimulating – they brought me to produce my first, tentative synthetic accounts of my Lusaka fieldwork (e.g. van Binsbergen 1972a, 1972b, 1987e, 1987f; cf. 2000) while Jaap's insistence on extended cases and on the painstaking unraveling (as in his own, brilliant book *The Politics of Kinship*, 1964) of all the strands and implications of the local social process, greatly helped me to further improve the fieldwork methods which I had learned at Amsterdam University under the supervision of the late lamented Douwe Jongmans and Klaas van der Veen. Jongmans, incidentally, with his work on fertility behav-

California at Los Angeles) was to force my hand in writing a first research paper on Zambia for an international audience, when that USA institution organised the Conference on the History of Central African Religious Systems in Lusaka in mid-1972 (main organiser: the PhD candidate and soon close friend Robert Papstein, preparing for historico-linguistic fieldwork among the Luvale of Northwestern Zambia – historically and linguistically closely related to the Nkoya).⁵ This event drew an inspiring set of prominent researchers to Lusaka around the then leading historian of African religion, Terry Ranger. In addition to a theoretical paper on possession and mediumship (mainly inspired still by my Tunisian work, in which the trance dance of the Qadiriyya Islamic brotherhood had been prominent), I insisted on presenting an empirical paper on a healing movement among the Nkoya – based on only a few weeks of interviewing, in Lusaka, immediately before the conference. Even though I was still in the initial state of learning the Nkoya language, Muchati's network of Nkoya

ior in North Africa, had had a considerable affinity with medical anthropology, and it was at a scientific meeting convened by him that I first tried my hand at an account of the data around which the present argument is built. Later, Klaas van der Veen developed into a prominent medical anthropologist, in mid-career greatly expanded his scope by becoming an MD himself, and worked as a barefoot doctor in Asia (but without the ideological Maoist Chinese connotations of that term). However, after my Tunisia fieldwork Klaas and I had too little personal contact for these laudable achievements to have an impact on my own work, except in this respect that he, with Sjaak van der Geest, was to be the co-editor of the 1979 collection of essays *In Search of Health* where the present argument was to be published for the first time.

⁵ Such closeness was brought home to me on several occasions, in addition to my scholarly exchanges with the late lamented Robert Papstein. Luvale urban migrants were slightly more numerous in Lusaka than Nkoya ones (with their fellow-circumcising groups from Northwestern Zambia, the Chokwe and Luchazi, they had secured their own ethnic niche in the urban job market in the form of the Lusaka Sanitation Department – which more or less stigmatised them as the 'Untouchables' of the country); and occasionally they organised their own boys puberty rites in Lusaka, erecting a special circumcision / training lodge. Apart from special exceptions notably in royal circles, the Nkoya ceased circumcising their boys around 1900 CE, and meanwhile circumcision has grown into a conscious urban ethnic boundary marker between Nkoya and Luvale (van Binsbergen 1992a, 1993c). When I was allowed to visit a Luvale circumcision lodge in Lusaka in the 1970s, I was struck by the general closeness *vis-à-vis* Nkoya culture, apart from circumcision. At the Kazanga Cultural Festival, which prominent urban Nkoya have organised in Kaoma District ever since the 1980s, selected Luvale expressive cultural manifestations have appeared sporadically, but so far (in my limited experience) not the famous and spectacular *makishi* masks (*cf.* Ellert n.d.; Jordán 2006; Mwondela 1972; Phiri 2012) that are the Luvale's most conspicuous ceremonial expressions – and that used to be known among the Nkoya, too, up to the middle of the 20th c. CE. Around 1990, I studied to be a *Sangoma* diviner-healer at a lodge in Francistown, Botswana; one of my fellow lodge members was a Luvale lady from Zambia, and we found that we could easily converse, she using Luvale, I Nkoya.

migrants in Lusaka proved eminently accessible, co-operative, and knowledgeable, and that first paper on the *Bituma* cult ultimately led, nine years later, to my first major scholarly book, *Religious Change in Zambia* (1981), where also a final version of the possession paper was to be accommodated. Effectively, Muchati's role of domestic servant was already fading into the background, as he became my language teacher and research assistant, to end up as the close relative, to be precise the elder brother, which he has remained ever since.

The overlap between Raja Jayaraman's, and my own, appointment at UNZA had been too short for him, as an accomplished medical sociologist, to have any great impact on my research, but in the months before his departure he would occasionally, and inspiringly, describe his fascinating (sometimes embarrassing) experiences in Lusaka hospital wards, and the special problems of communication and hierarchy he was encountering there as a non-medical non-White. I never realised that my indebtedness to him would even reach beyond the dog Lisa, beyond even Muchati, whatever the latter's decisive impact on my life and career. Echoes of my communications with Raja can still be heard in the present book.

In his *Essai sur le Don*, the great French early sociologist Marcel Mauss (1923 / 1966) launches the notion of the '*fait social total*' / 'the overwhelming social given' – a social phenomenon of such all-encompassing significance in the society at hand, that as a magnifying glass or an X-ray it brings out that society's crucial relationships in their most relevant shapes and interconnections. In the lives of the Nkoya migrants in Lusaka in the early 1970s, such a central theme was not (like for Mauss) 'the gift' and the relationships, expectations, and hierarchies it engenders, but 'the quest for health'.

Initially my focus on the Nkoya people would be strictly local and be limited to the relatively small community of Lusaka migrants, many of whom I got to know personally in the course of a few years. But already in the autumn of 1972 – still on a learner's driving license, which gave me an opportunity to experience the leniency of the Kaoma police – I drove with Muchati to Nkoyaland, to visit his rural home, meet all the people who are to play parts in the case history around which the present book revolves, and to pay a courtesy return visit to what was then officially becoming 'my friend' Mwene Kahare Kabambi,⁶

⁶ Zambian royalty have found, in the expression of *friendship*, a compromise so as to negotiate the otherwise irresolvable status contradictions between Black royal superiority and White racialist arrogance; cf. Clay 1968.

former Northern-Rhodesian Army sergeant⁷ and (like me) map maker, and (very much unlike me) accomplished hunter – but who was ultimately to become my adoptive father, publicly announcing this state of affairs on numerous occasions, and – in recognition of what he chose to consider my achievements in the scholarly, medical, and political field, for the sake of the Nkoya people – formally bequeathing to me upon his death in 1993 both his Royal Bow (*cf.* van Binsbergen 2020b) and (with my middle daughter Shikanda) a huge piece of land (25 km² in the Mushindi Valley which however, being permanently inhabited and cultivated by the local villagers, we have never bothered to effectively take possession of).

Also in rural Nkoyaland, the quest for health would prove paramount, and soon all but completely eclipsed all other themes and topics I had had in mind when deciding to conduct a substantial spell of fieldwork in Nkoyaland – Boissevain had let me down, my expectations of a Tunisian PhD had been thwarted, and I had no choice but to mobilise my unique Zambian resources in order to create an alternative empirical basis for a doctorate. Already in the first weeks after settling in Nkoyaland with my small family and Muchati's (and after our dear cat brought from Holland had been shockingly immolated as a stray wild animal by the village children), the villagers would knowingly intimate:

'Now we understand why you have come to live here. You have come in order to understand why our children are dying all the time.'

Although Henny, my first wife, had worked for five years in the Medical Faculty of Amsterdam University prior to our departure for Zambia, she did so as a biophysicist, lacking all clinical expertise and experience just like I did. My own training as an anthropologist had, beyond numerous prophylactic injections, barely included advice as to how to stay alive and fit in a challenging tropical environment. After two years in Lusaka our physical reserves were already depleted, and while our subsequent fieldwork effectively culminated in the tragic death, in my arms, of Edward Shelonga's little cousin Patrick – that fieldwork was at the same time practically terminated because my wife had to be hospitalised in distant Lusaka, blinded for two weeks by *bacterial conjunctivitis*, totally weakened by *mononucleosis*, and, when in the Lusaka University Teaching Hospital, contracting *typhoid fever* to boot. The '*fait social total*' had overtaken us, and almost destroyed us. I had contracted *hepatitis-A* mid-December 1973 (two weeks

⁷ Like, during World War II, my mother's first husband in whose name I was registered at birth, because her legal divorce had only been too recent; my actual father's father died of the Spanish Influenza a few years after having been mobilised into the (internationally neutral) Netherlands Army as a private soldier in World War I.

later moribund Patrick turned out to suffer from the same condition, and so did soon the Mangango doctor's entire family who had charitably insisted that Henny, with our daughter and me, should stay with them in their house rather than in the hospital ward which they considered to offer slim chances of survival). The only one who survived our fieldwork ordeal unscathed (apart from a mild and ephemeral jaundice) was three-year old Nezmja, who ever since her baby days had partly been roughing it in fairly authentic Nkoya environments. While our little family fled the Mema Valley for Lusaka, Muchati stayed behind in the village, took full control of the questionnaire survey I had launched, and proudly brought home to Lusaka 200 exhaustively and reliably completed case forms of 16 pages each.⁸

But before we had come to that stage, the villagers at the Mema Valley (simply assuming – correctly – that we were in possession of patent medicines, and perceiving our excellent contacts with most of the fewer than handful of cosmopolitan medical doctors that Kaoma District possessed)⁹ had more or less forced us to

⁸ The irony of this inconceivable intercultural triumph (let us not forget that Muchati never had more than six years of primary education) – an irony still aggravated by the fact that my mother in the last, breathless years of her life spent several months coding these questionnaires and making them amenable to statistical analysis by computer – has been that my administrative duties at the African Studies Centre Leiden as from 1980, in combination with an insatiable curiosity bringing me to precipitate into ever new and apparently more exciting new research and writing projects, and my discharge of a series of part-time professorships outside the African Studies Centre Leiden, meant that all this unique, splendid material on rural life in Nkoyaland was never adequately analysed, let alone published, to the full extent statistically possible. Today, at age 75, dozens of book projects later, I am not sure if here lies a meaningful imminent task for a pensioner. I am still producing several books a year, that is not the point. And at least statistical facilities on personal computers have dramatically improved since the 1970s, when personal computers were only beginning to be available. And while I am at it, I might have a second look at my 1988-1989 Francistown quantitative material, which likewise scarcely survived beyond the coding phase of computerisation. But given a choice (and my enormous book output of the last ten years does give me that choice), I would rather concentrate on my poetry.

⁹ Kaoma District (population 162,568 according to the 2000 CE census) has an area of nearly 9,000 km², *i.e.* just over one quarter of the (continental part of the) Netherlands. At the time, Kaoma District boasted three hospitals: the state hospital at the district capital likewise called Kaoma, and mission hospitals at Mangango (Roman Catholic) and Luampa (South Africa General Mission, an Evangelical Protestant mission body). Most of the time, each hospital had only one fully qualified physician as its Medical Officer in Charge. The population of adjacent Lukulu District also in part identifies as Nkoya; that district boasts a hospital of its own. This is not the place to discuss the historical vicissitudes of district boundaries and district names, within Western Province (former Barotseland Protectorate) and adjacent areas such as Zambezi District / Balovale, and Mumbwa and Namwala

start, and operate on a twice-daily basis, an informal rural clinic where we were seeing – with a reluctance bordering on despair – up to forty patients a day, keeping succinct records of every patient and every consultation, and making a weekly run to the distant hospital of Mangango whose medical officer in charge, a fellow-countryman of ours, kept us supplied with simple medicine and good advice for the ten most frequently encountered rural complaints. (We had no electricity and no refrigerator, and cooled our medicines in a hole in the ground, fringed with charcoal over which we regularly poured water – the evaporation had a distinct cooling effect.) It was a foolish, psychologically almost unbearable, and medically dangerous undertaking, which might have ended even much worse than it did. However, we simply felt that we had no choice, crushed as we were under justified popular demand, shattered by the sheer medical misery which surrounded us, and which worsened by the day when our closest rural network was affected by practically one fatal case a week, and the community never stopped mourning any more. I was trained as an anthropologist of religion, and it was only in the field in Zambia, that I realised the great extent to which in Africa the two spheres of religion and healing are inseparably intertwined.¹⁰ This en-

Districts.

¹⁰ The realisation came preciously late, in line with the fact that medical anthropology, like divination, had *de facto* been a no-go area in anthropological education at Amsterdam University during the 1960s. This explains the rapid success, at Amsterdam University, of an initial outsider like Sjaak van der Geest.

Divination and healing were certainly major aspects of the territorial and ecstatic cults I had studied in Tunisia and on which I had worked practically full-time 1967-1971. In major songs of the *fuqra* (local adepts of the ecstatic cult) the *faqīr* is presented as crying out 'I am wounded' (*thamūni*) and as looking for a doctor (*tobīb*), notably the invisible saint in whose honour the ecstatic dance is performed. There are (like in the South Central African cults of affliction) many different tunes for the ecstatic dance, and the specific tune to which the prospective *faqīr* is to selectively respond by dancing functions as a divinatory device. Local healers (*māddab*) and Qur'ān teachers are in possession of one or a few magical books that – although locally surrounded with an aura of being extremely rare and expensive, are in fact in wide circulation in North Africa, available at virtually every bookshop; they show the self-styled specialist, often through simply diagrams, how to write amulets and how to interpret dreams. At the regional market, itinerant diviners-healers (who may constitute a distinct endogamous clan of their own) offer their own forms of divination (*tekēza*). I was unable to get particulars on the latter divination method, and the root *t-k-z* does not seem to belong to Arabic; and none of the Zulu semantics to be listed shortly, readily translate into an Arabic word remotely similar to *tekeza* (Doniach 1983; Al-Faraīd, 1967). Admitting the non-Arabic nature of the word, one obscure website suggests that it means 'mutual lying' (Anonymous, n.d., 'takazu') – not totally inappropriate (at least, for the sceptics) in a divinatory context. I only managed to find the term *tekeza* back, at the other end of Africa across 5,000 kms, as a term for 'vernacular, non-royal, peasant-like' in Zulu, a Southern African Nguni language

abled me to produce the present argument, which has gone down in the annals of science as ‘something of a classic of medical anthropology’ (the piece’s assessment by Sjaak van der Geest (1996), for decades the incumbent of the chair of medical anthropology at Amsterdam University).

Perhaps it was not just the pressure from the Nkoya villagers which drove me to the anthropology of health and healing. I have recently (in my book *Africa Intercultural*, 2022) maintained that anthropological fieldwork, as a humble sharing of initially strangers’s lives in a bid to get to know and understand them on their own terms, for me has been one of the most obvious and rewarding forms of being human (besides conjugal love, parenthood, teaching, and writing poetry), and of giving expression to

(Harries 1993: 107; the closely related Ndebele language was one of the *linguae francae* at the Francistown lodge, Botswana, where I trained as a *Sangoma* 1990-1991, so I am on somewhat familiar ground here). The standard Zulu dictionaries may help us refine these semantics. Bryant 1905 and Colenso 1905 give a meaning ‘to visit’ (also: *tekela*). Doke-Vilakazi 1990 give ‘totter, speak in a quavering voice’, which is exactly how in the Nguni tradition (which is also that of the *Sangoma* cult) spirit mediums in trance impersonate (to take the objectifying, etic perspective; for the local participants, the medium does not impersonate but is, emically, only a conveyer belt, and the voice we hear is actually that of the dead ancestor) the voice of the *visiting* (!) ancestor who manifests himself or herself during a seance; Roberts 1900 concurs, and also Colenso gives this meaning as a second choice. I take it, therefore, that *tekeza*, in the Southern African context, refers (*inter alia*) to an ancestral oracle; and in general to sub-standard, non-native-speaker speech. The remaining puzzle is how this word with this semantics could have landed up in North Africa – but it is of the same order as the question as to how Chinese medicine (van Binsbergen, in press (c)) or Hindu gods (Wuaku 2013) could end up on the West African coast; or what adequately interpreted Taoist symbols are doing in the hands of an illiterate diviner in South Africa (Hook ffarington 1975: 22 f.); or why the first attestations of Proto-Bantu should occur not in sub-Saharan Africa but in Syro-Palestine, with such names as Jabbok, Canaan, Lot (van Binsbergen & Woudhuizen 2011: see Index; van Binsbergen 2021g); or how Venda divination vessels (Southern Africa) could be virtually identical to Yoruba ones in Benin and Nigeria and very similar to antiquated Chinese astrological divining bowls with their rims depicting as many as 36 zodiacal animals – and the Sunda Hypothesis offers a very convincing answer (van Binsbergen 2012e, 2017, 2019, 2020c). Considering the ubiquity of geomantic divination in the Islamic world and, on the wings of Islam, its wide though sporadic distribution throughout sub-Saharan Africa, I surmise that also in the Tunisian context (like in the Southern African one, for that matter; van Binsbergen 1995c, 1996a) *tekeza* is a form of geomantic divination, in other words, of ‘*ilm al-raml*’, ‘Sand Science’; cf. Fahd 1966; van Binsbergen 2005b, and 1993e, with extensive references.

In retrospect, then, a research perspective more centrally informed by medical anthropology, and focussed on healing, rather than on Durkheim and social organisation, and fertilised by a keen awareness of transcontinental continuities, might have given a rather different slant to my first fieldwork, my first ethnography, and my first original theoretical work. But this is how one learns.

the fundamental unity of humankind which as a principle has increasingly informed my intercultural philosophy. But was this in the first place a *cognitive* curiosity? A service which I rendered to the sake of science? For many years I regularly gave seminars, besides serving as an external board member) at Louvain University, Belgium, where my close friend and colleague René Devisch had created one of the most inspiring and profound present-day institutional contexts for the study of Africa, delivering an unending stream of brilliant doctorates. After addressing these attentive, critical, and highly competent audiences a number of times about my research into ethnopsychiatry among the Manjacos of Guinea Bissau, West Africa (early 1980s), it was time for me to share with them my experience in the domain of the Southern African *Sangoma* divinatory and healing complex. As an experienced scientist and research manager, I had no difficulty presenting my experiences as a recognisable quest for knowledge, the response to a cognitive challenge that has been a major characteristic of North Atlantic culture. I joined the *Sangoma* cult (something that emically, *i.e.* in the local actors conscious views, can never be a personal act of will, but only an ancestral election) and became a certified diviner / healer in my own right. I did dwell on the knowledge-political implications of my demarche against the background of a Southern Africa that was at long last, and painfully, shedding racist oppression and exploitation (whilst largely retaining, unfortunately, the capitalist and imperialist infrastructure that had called forth such unfortunate structures in the first place; van Binsbergen 2001b). However, I was genuinely surprised, puzzled, when in his first comment, with which he was accustomed to give direction to the entire discussion that was to follow, René dwelled on what he claimed was the unmistakable motivation of charity, of compassion, of intercultural love, that he detected under all my pretence of sound scientific procedure and strategy. Our bush clinic, he implied, had been not just an instrumental strategy of public relations deliberately meant to placate our potential interlocutors among the Nkoya villagers. And when, a few years later (with the help of Princess and District Councillor Mary Nalishuwa, and working from the palace of Mwene Kahare, sleeping in his bed even, as if I were indeed his son) I launched the Mema Rural Health Centre project, in order to furnish (with Dutch aid money, and with the collaboration of the Zambian Ministry of Health) Mema Valley (and, at a mere 5 kms distance, Mushindi Valley) with adequate cosmopolitan medicine, even if it took more than a decade to complete the project in selfhelp and even if the twice-daily musical performance of Mwene Kahare's orchestra had to be abandoned in the process (otherwise the Seventh Day Adventist church (considering the royal orchestra a form of ancestor worship or idolatry) could not give its decisive assistance towards completion of the project), – this was again far beyond the instrumentality of a research strategy, and simply reminiscent of the common pattern of the son of the village mobilising his outside resources for the benefit of his home community after returning from a successful long stay abroad. Fieldwork is ultimately about human fellowship, and I have always realised that nowhere is that fellowship – the recognition of the other as simply one's own – more

manifest, and more indispensable, than in the sphere of health and healing, of illness and death. It is among the Nkoya that I learned that every adult has a tacit obligation towards all children of the world, and an inalienable right to fulfil that obligation. Nkoya neighbours, when they see that a child is neglected, exploited or otherwise burdened beyond its strength, do not look the other way – they publicly challenge the offender¹¹ and give him or her the opportunity to make amends.

Throughout humanity, it is the same body that gives us pleasure and pain, and that reminds us of the fundamental unity of all humankind – and of the universal care, the charity, which we are born to show to each other as fellow human beings.

Often do I return in my mind to a few highlights of my short career as a reluctant uncertified practitioner of cosmopolitan medicine. Little Patrick was beyond my help, much as I tried. Little Edward survived and – with a little help from Henny and me – grew into a son to be proud of (cf. Fig. 9.10, below) – and of course, in the Nkoya language he is simply my son, just as my children are counted as children of Edward's father. On festive occasions (such as the Kazanga Annual Festival has offered since the 1980s), one chances into people one may not have seen for decades. Thus I ran into the father who, as a Watchtower¹² adept in the Mema Valley in 1973, had rather risked his young daughter's blindness than take her to a state hospital – so my wife and I abducted the child and rushed her in our car across the district to the distant hospital where her eyesight was saved; we feared

¹¹ Adult Nkoya villagers may impose, even out of court, a fine in the form of a small amount of money to be paid by the offender. In blatant cases (presumably also including sexual child abuse, cf. Chileshe *et al.* 2005, although – if we set the limit of childhood at age 12 – I have never in fifty years seen any evidence of that among the Nkoya) the neighbouring women may take off all their clothes in public and threateningly dance around the offender, shouting:

'So, you make us work? Well, try this one. We'll make you work.'

Ridicule especially by impromptu mocking songs has been a major instrument of informal social control among the Nkoya, and has been very effective. Against the background of my own, and my Netherlands siblings's, wasted and unprotected childhood, dangerously secluded from the outside world (even though in a popular urban neighbourhood) through boundaries of misplaced petty-bourgeois privacy, such institutionalised solidarity with children on the part of bystanders has greatly moved me, and persuaded me to bring elements of Nkoya family life into my own family. Which I did.

¹² Rejection of all state intervention in private life is one of the tenets of the Watchtower Bible and Tract Society of Pennsylvania, United States of America, founded by Charles Taze Russell in the 1880s, and spreading to Central, South Central, and Southern Africa in the early 20th c. CE. From the 1930s it has been a major spiritual option in these parts of Africa, even if often only a phase in people's spiritual career (Fields 1985; Greschat 1967; Cross 1973, 1978; van Binsbergen 1981; Hooker 1965). Watchtower also often provided the Christian idiom with which self-styled witchfinders / returning labour migrants addressed local communities in this part of Africa after World War I.

that this highhanded act would mean the end of our fieldwork, but we merely won general esteem from the community at large, and at long last the father, and the daughter, thanked me profusely, thirty years after the event. Another such case was the young unmarried mother (not a big deal in Nkoyaland at the time), who because of a mammal ulcer could not breast-feed her baby; for a few days, I serenely milked her monstrously swollen breasts by hand, several times a day, until my wife and I commandeered – by sheer intimidation, I admit – the only breast pump in the possession of the Kaoma state hospital, across a distance of 85 kms; the baby survived, grew into a beautiful young woman, and her aging mother thankfully reminded me of the event when I saw the two of them at Kazanga, decades later. With a strange mixture of horror and pride I recall the grandmother from the one Kaonde blacksmith village north of the royal capital; the advanced and incurable, oozing cancer wound in her back was seen by the Mangango doctor during his only visit to us at Mema Valley, and for a month I would (as the doctor had stipulated) daily wash and dress that wound and thus restore the lady's dignity, until she died and one of the area's rare chickens was to be my tangible reward. Moreover, at my request, her grandson translated into English and for a mere token sum, one of the very few Nkoya texts circulating;¹³ I could not yet read Nkoya without great difficulty. Such cavalier acts during our fieldwork endeared us with most of the villagers around us (although there were rumours that the local diviner-healers resented our disturbance of their lucrative market, and were about to hit back at us; perhaps they did), but it did not consciously register with us that altruistic though reluctant healing satisfied a great personal urge inside ourselves.

In 1988 I shifted my main fieldwork site from Zambia to Francistown, Botswana, and after three quarters of a year of beating about the bush, almost unable to make genuine contact with anything but the performative façade of African urban life such as it was engendered by decades of *apartheid* experience of Batswana as labour migrants in nearby South Africa, the *Sangoma's* dazzling promise of divinatory and healing knowledge and powers made both my second wife Patricia, and myself, break through the oppressive veil of otherness and exclusion, and join the *Sangoma* cult which was actively recruiting us. This step was undoubtedly prepared for by the Zambian experiences shared in the present book. It opened up decisive new vistas in my thinking, research and writing, and added divination and healing, intercultural philoso-

¹³ Anonymous [J.M. Shimunika], n.d., 'Muhumpu wa byambo bya mwaka – Nkoya', s.l. [Luampa, Mankoya]: s.n. [South Africa General Mission], typescript in the author's possession. I have not yet come around to making this text, and its translation, available of the Internet but have been intending to do so for years.

phy, transcontinental continuities, astrology,¹⁴ comparative mythology, and cosmology (basically, almost everything I have worked on during the past three decades) to my range of interests, activities and skills.

What particularly strikes me, overlooking my trajectory of the past 40 years, is the unexpected great role played repeatedly by *Sjaak van der Geest*. Sjaak's early career ran parallel to that of two others among my most important academic and personal contacts, Matthew Schoffeleers and René Devisch; it also reminds one of that of my brilliant PhD student, commentator, and adoptive son Pius Mosima; and echoes the career of another close friend and intellectual sparring partner of mine, Valentin Mudimbe. All these were born in a Roman Catholic family, initially studied for the priesthood; became captivated by the spiritual alternatives available outside the church, e.g. in time-honoured African cults, or in transcontinental academia; and all finally made the grade as internationally recognised academic writers and teachers. Still before his ordination into the Roman Catholic priesthood, Sjaak went to Ghana as an apprentice missionary, studied anthropology at the University of Ghana at Legon,¹⁵ and spent a considerable formative

¹⁴ The divination system prevailing in Francistown, and which I learned as a trainee *Sangoma*, turned out to belong to the globally distributed *geomantic* family of divination systems, which was mediated to sub-Saharan Africa as a derivative for the Islamic divination system of *'ilm al-raml*, علم الرمل, 'Sand Science'; the latter's astrological background has been argued widely in the literature, already by the Tunisian historian Ibn Ḥaldun (1980) in the 14th c. CE (cf. van Binsbergen 1996a; Ibn Ḥaldun 1980). For most of my numerous publications on this form of divination, see the specific Bibliography of my work relevant for medical anthropology, at the end of this book.

¹⁵ A Eurocentric bias has prevailed in the History of Ideas for centuries (Afrocentrism, and the *Black-Athena* debate, have recently somewhat corrected this tendency), and the reader may be pleasantly surprised that the North Atlantic career of a distinguished anthropologist like van der Geest began at an African university. Nor is his the only case in point. Also René Devisch first studied anthropology at the Lovanium, a Jesuit university in Leopoldville (the colonial name of Kinshasa, capital of the Democratic Republic of Congo). Also the great African philosopher and historian of ideas, my dear friend Valentin Mudimbe, studied at the latter institution, though not necessarily anthropology, and for some time Matthew Schoffeleers was his class mate; and just before Matthew's death (cf. van Binsbergen 2010d, 2011e), Mudimbe, on a visit to the Netherlands, requested that I take him to see his old class mate in a convent in the southern province of Limburg. (The trip was an embarrassment: Matthew proved so much under the spell of Alzheimer's disease that he failed to recognise Valentin, and condescendingly and unctiously, in the manner well-known of Roman Catholic clergymen of his generation, treated the greatest African intellectual alive as a little boy at the mission school). Anthropology and African Studies, as well as African philosophy (cf. van Binsbergen 2005) have an inveterate substrate of Roman Catholic studies for the priesthood, to which also e.g. the pioneering African philosopher Placide Tempels, and the prominent German / American / Dutch anthropologist Johannes Fabian have been indebted. And whereas many of these institutions (offered as what custo-

period in a Ghanaian village. His autobiographical account (*cf.* Bleek 1978) of his Ghanaian fieldwork brings out that there he did not only learn the Twi language and the basics of Akan local-level social organisation, but also had decisive (that is, for an aspiring celibate missionary and priest)¹⁶ sexual experiences which he describes with endearing sympathy and (for an anthropologist) exceptional candour. Sjaak wrote an excellent M.A. thesis for Legon (van der Geest n.d.), which made him eligible to pursue a PhD at Amsterdam University, under supervision of the West-Africa specialist André Köbben, and on the strength of the original Akan fieldwork, apparently without a substantial new spell of fieldwork being required.

Throughout the mandatory seven years full-time during which I read anthropology at Amsterdam University, André Köbben, as head of anthropology, and as lecturer of significant courses and seminars mandatory in every specific year, had dominated the scene as, effectively, my principal teacher of anthropology. It was Köbben who in 1971 – in collusion with Jaap van Velsen – had persuaded me choose the job at UNZA from among six jobs he could offer me (an incredible luxury by today's standards!), and in that same connection subsequently arranged my final examinations to entirely concentrate on Zambian anthropology. After the shipwreck of my Boissevain PhD adventure, Köbben immediately obliged by finding me, within two weeks (he was on the foundation's board), a writing-up scholarship with the Netherlands Foundation of Tropical Research (WOTRO), in preparation for a PhD under his supervision.

So this is how, from late 1974, Sjaak and I found ourselves as members of Köbben's select PhD class – to which also Simon Simonse temporarily belonged (the basis for our close friendship ever since), and of which Niels Mulder was to be the first in line to defend his PhD thesis. Among the peculiarities of Netherlands academic culture we find the institution of the two *paranymphs*, the PhD candidate's seconds who stand next to her as she is being publicly examined by the committee, and whose other minute tasks include distribution of individual copies of the printed thesis to the committee members when seated in the examination chamber, and attending to the details of the post-examination celebrations; in principle the paranymphs also have the right to assist, even prompt, the candidate on the spot during the oral examination, but this is rarely seen. Sjaak was a

marily were called *seminaries*) were situated in the North Atlantic region especially Rome, others could be found in Africa, usually largely with expatriate staff, often producing excellent results. In van der Geest's case, however, the principal establishment of the University of Ghana at Legon, was an institution of higher learning overseen not by the Roman Catholic church, but by the famous University College, London, UK.

¹⁶ I observed (201f; 2020a) a similar breaking point in the abortive missionary career of René Devisch, initiating his life-long conjugal relationship with the physics teacher Maria Devisch.

total newcomer to Amsterdam University, and had no support network there. In age, Roman Catholic upbringing, professional ambition, perhaps even personality, he and I had much in common, we soon became good friends, and I was invited to serve as one of his paranymphs for the examination of his PhD thesis (Wolf Bleek – his pseudonym – 1976); I had been Niels Mulder's, too.¹⁷

¹⁷ Cf. Mulder 1976 / 2005. This was the time, at least in the Netherlands, of the Sexual Revolution (prompted, among other factors, by World War II and the invention of oral contraception), and the attending sexual candour not to say ostentation. At long last shaking off the yoke of imposed decency and good taste, this was also the time of pubescent *oh-la-la* car-bumper stickers, and a particularly cherished one read (much to the vocal indignation of the Leiden professor of development sociology Hans Speckmann) *ANTHROPOLOGISTS DO IT IN THE FIELD*. Mulder published (2004) a counterpart of van der Geest / Bleek's personal fieldwork account, in which Mulder (2004: 7) deprived my beloved teacher of fieldwork the late lamented Douwe Jongmans of his co-editorship (with the Buganda specialist P.C.W. Gutkind) of the seminal collection *Anthropologists in the Field* (1967) and replaced Jongmans by André Köbben (Mulder's 1976 supervisor) – a significant and painful mistake, for in the mid-1950s Köbben and Jongmans had been competing for the chair of their teacher the armchair ethnologist Fahrenfort (cf. 1927, 1933), and Köbben had been successful (fortunately for the future students and staff of Amsterdam anthropology, for Köbben was to turn out the better administrator, and to realise an incomparably better publication record and international presence), but Jongmans's rejection has been justified by the ridiculous sophism that Jongmans's PhD had not been on fieldwork but has been a mere 'armchair' library study; the ironic truth is that Köbben's (1955) fieldwork, among the Agni of Ivory Coast, had been fairly *pedestrian*, whereas Jongmans on the strength of his very extensive North African researches soon established himself as Amsterdam University's main teacher of fieldwork (van Binsbergen 2010). Köbben, with all his politically motivated ostentatious respect, as a modern social-democrat, for his fieldwork 'informants' (whose language he did not speak) had little of the proverbial anthropologist's pioneering charm – although I remember that during our first encounter, in his office prior to my starting out as an anthropology freshman, I was charmed by the fact that he wore his cuff links wrongly, upside down.

However, this bibliographic blunder on Mulder's part is more than compensated by the fact that Niels reveals his own favourite, and eminently effective, fieldwork method: *to engage in amorous relationships with Bangkok Thai prostitutes*.

In addition to a number of poems, I have produced extensive texts on my own fieldwork experiences in Tunisia (van Binsbergen 1987a, 1987c / 2003, 1988b, 2022h) and Botswana (van Binsbergen 1991a, 2021a), which took place round about the same time as Mulder's and van der Geest's. However, my literary and epistemological concerns in these accounts, as a well as respect for my two successive wedded wives and their children, precluded any personal reflections, on my part, on the truism (as firmly established by such uncontested authorities as Trubetzkoy, Chomsky, Malinowski, Sapir, Boas, and Evans-Pritchard) that *the fundamentals of a language, and of a culture, are best learned in bed*. Anyway, the Tunisian rural situation, my tender age (21), my fidelity *vis-à-vis* my fiancée Henny, and my research topic (popular Islam), imposed absolute restrictions on anything sufficiently transgressive to keep with the times in terms of sexual confessions. My infatuated description (in my novel *Een Buik Openen / Opening up a Belly*, 1988) of village neighbour Najma bint Hassuna, my age mate but already married and mother of three boys) in all its truthfulness was sufficiently serene to allow my wife Henny to make her acquaintance and to accept her wholeheartedly as Islamic godmother of our daughter. Not for the last time in my life as a field-

Our initial bond through Professor Köbben would only occasionally lead to close scientific collaboration between Sjaak and me, although throughout our career we

worker was I to be unconsciously captured (in a form of projection perhaps typical of fieldworkers and discussed in my book *Intercultural Encounters*, 2003 (see that book's *Index* s.v. 'transference') by the image of my own young mother, who in her early twenties had to see her three infant children (not yet me) through World War II single-handedly, at great personal including moral costs.

Significantly, Sjaak (who in the course of his long and productive career has also published several collections on the interface between anthropology and *belles lettres*) has repeatedly (e.g. van der Geest 2018) expressed a considerable liking for my literary work as inspired by fieldwork. Very recently he surprised me by quoting from memory several lines from a duly anthologised poem of mine, on FRIESLAND (FRISIA; from the collection *Vrijgeleide*, van Binsbergen 1984), a region where Sjaak and I, with our families, had spent a splendid short holiday in the 1970s. And as was to be expected against the background of the above, he was particularly impressed with my short story 'GOD PRUTST MAAR WAT, BIJ HET SCHEPPEN ('GOD MAKES A MESS OF CREATING', in my first book of short stories *Zusters Dochters* (*Sisters, Daughters*), 1984:

'Het verhaal was uit. Ik rolde terug op mijn rug, en Pauline vouwde haar armen weer onder haar hoofd. In het licht van de bijna opgebrande kaars glommen haar ogen van de tranen, maar toch straalde ze. Ze neuriede een paar maten van het lied van Shongo, en zuchtte weer, met een bijna bittere glimlach. Ik schaamde me over de opwinding waarin het verhaal me gebracht had en probeerde dat te zeggen. Maar ze leidde mijn hand terug naar haar onderlichaam en drukte hem tegen zich aan waar ze zacht en vochtig was van ons eerdere vrijen die avond, van haar beelden van Patrick, van mij nu stil tegen haar aan, en van een verlangen waarvan we allemaal maar willoze instrumenten zijn, ongeacht de jaren van ons leven, de zorgen, het verdriet, de heldhaftigheid, die wij investeren in de strijd daartegen.

"*Mukondo wámi owē*," fluisterde Pauline. "*Mukondo wami, nikushinga kushingura nako nowe. Shingurungáko!*" - Hé, mijn jongere broer. Mijn jongere broer, ik wil met je vrijen. Kom dan toch."

Ze blies de kaars uit, maar de hoofddoek bleef op zijn plaats.'

"The story had come to an end. I rolled back onto my back, and Pauline once more folded her arms under the head. In the light of the nearly spent candle her eyes were gleaming with tears, but none the less she was beaming. She hummed a few bars of Shongo's song, and sighed again, with a smile that was almost bitter. I was embarrassed by the excitement which the story had brought over me, and tried to say so. But she guided my hand back to her abdomen, pressing it against her where she was soft and still moist from our love making earlier that evening, from her images of Patrick, from me lying quietly against her, and from a longing of which we are all the helpless instruments, never mind the years of our lives, the worries, the sorrow, the heroism, we may invest in our struggle against it.

"*Mukondo wámi owē*," Pauline whispered. "*Mukondo wami, nikushinga kushingura nako nowe. Shingurungáko!*" - Hey you, my younger brother. My younger brother, I want to make love with you. What are you waiting for!"

She blew out the candle, but her headscarf remained in place.'

would consider ourselves very good friends.¹⁸ I think Sjaak was soon hand in glove with Köbben because their social and political views were largely in agreement: implicitly social democratic, convinced of the makeability of humans and society (Köbben's brother-in-law was Joop den Uyl, sometime Labour prime minister of the Netherlands; the latter would co-opt Köbben as – inexperienced and in fact barely-qualified! hence ineffective – advisor on ethnic conflicts around the tragic but violent post-Independence Indonesian minority of the Moluccans in the Netherlands), taking for granted (*pace* Quine 1970) the self-evident full translatability of cultural orientations worldwide, and implicitly rejecting such subtle emphasis on symbols, on culturally informed perception, on cultural structures, and on cultural specificity as was the point of departure for Lévi-Straussian structuralism, and as had become, by and large, the hallmark of Leiden anthropology – and of its French and Belgian counterparts, for that matter. In other words, as anthropologists we have followed very different roads.

Despite his initial loyalty in applying for my writing-up scholarship, Köbben soon began to qualify his initial wholehearted support of my work and person. When an American fellow-researcher of Zambian judicial processes, in his typical cocky and belligerent national academic fashion, pulled a fast one on me at a Leiden international conference on African law opened by Köbben,¹⁹ and I visibly took offence, Köbben (an Americanophilic snob if ever there was; and this was at the height of the

¹⁸ Below I shall set out the two principal moments of such collaboration: Sjaak's work as an editor (with my old teacher of fieldwork Klaas van der Veen) of *In Search of Health: Six Essays on Medical Anthropology* (1979), in which context the present book was drafted and found its first edition; and his initiative as convener of the '9e Marktdag Medische Antropologie', Amsterdam, the Netherlands, 1990, when he prompted me to write my first piece on four-tablet divination in Southern Africa. In the 1970s we would frequent each other's homes and holiday haunts. On one of these occasions I remember Sjaak having an inquisitive medical-anthropological conversation with my mother, a short, slender, outspoken woman nearly 30 years older than him or me. When she boasted to have personally breast-fed her four children (including me), she noticed his assessing, quasi-expert, critical look at her modest bosom (after all, he was not only a medical anthropologist hence half a doctor, but also a former Roman Catholic missionary, and she still resented the arrogant conversations of parish priests during pastoral home visits, inquiring if it was not time for the next Roman Catholic baby), and she could not help calling Sjaak to task with the kind of snappy, belligerent remark that has been typical of Amsterdam popular culture, and of our family. As late as 1986, Sjaak contributed a chapter to an edited volume on the African state and local communities edited by van Binsbergen, Reijntjens, and Hesselting (van der Geest 1986). As a self-styled chronicler (1996) of the rise of medical anthropology in the Netherlands he would highlight my contribution in that connection. Later he would sit in on the Cameroonian philosopher Godfrey Tangwa's seminar on African views of the unborn child, and then off-handly, and rather typical for his methodology, dismiss my discussant's account of birth control through induced abortion among the Manjacos of Guinea Bissau – his PhD had admittedly been on Ghanaian young people's desperate need of access to reliable birth control, but local cultural practices do not usually follow scholarly accounts of related practices 2,000 kms away. I was immensely gratified by Sjaak's very personal and admiring contribution (van der Geest 2018) to my 2018 *Festschrift* – a fragrant discussion of my treatment of human defecation in the opening pages of my fieldwork novel *Een Buik Openen* (1988).

¹⁹ My conference contribution was soon published as van Binsbergen 1977b.

Cold War) subsequently took me to task for what he considered a lack of proper scientific attitude and of humility unbecoming a mere doctoral candidate of his. Obviously I was under the spell of a status incongruence which was partly Köbben's own doing. Soon (1975) I would be drawn – partly on Köbben's recommendation – to Leiden, the enemy camp, being invited to act in the chair of African Sociology and Culture, which John Beattie had vacated.²⁰ When end of 1976 that temporary appointment ended, and I was invited to join the African Studies Centre in Leiden, the (attractive) details of my contract were favourably arranged by both André Köbben and Bonno Thoden van Velzen as members of the board – although my contract was actually signed by Rudi van Lier, minor poet, specialist on Surinam social and ethnic structure, and the ASC's chairperson at the time.²¹ Meanwhile I was invited to participate in one of the most prestigious anthropological gatherings worldwide at the time, the ASA (Association of Social Anthropologists) annual meeting (this time convened by Richard Werbner, around the topic of *regional cults*),²² while I was being groomed

²⁰ At the time I had so long imbibed the Amsterdam aversion of structuralism that I initially resisted exposure to the frequent expressions of structuralism in the Leiden context. My acquired anti-structuralism never led to painful confrontations in Leiden, not only because soon I left the Department of Anthropology there to join the (inter-university) African Studies Centre, where by that time mono-disciplinary issues, and theoretical debates, used to be shunned anyway; but also because I gradually began to appreciate that as a religious anthropologist, notably in the analysis of myth, I could not do without the structuralist perspective (van Binsbergen 1980 / 1985). Gradually, also because of my exposure to Belgian anthropology especially through the persons of René Devisch and Patricia van Binsbergen-Saegerman, and also through my explorations of the mythical dimensions of Nkoya oral traditions (especially van Binsbergen 1992, 2010c), I began to realise the shallowness of the Amsterdam social-relationship-obsessed, sociological perspective, and I began to use more and more structuralist, Lévi-Straussian elements in my own work.

²¹ In my critical essay on Otterspeer's biography of the leading Dutch literary author Willem Frederik Hermans (van Binsbergen 2014a; Otterspeer 2013). Hermans's brother-in-law Rudi van Lier makes a short but painful appearance, but the episode recounted there occurred a year later, in 1975, when I assumed my temporary duties in the Leiden chair of African Sociology and Anthropology.

This marked the beginning of my work at Leiden, where I would continue to hold appointments ever until my retirement in 2012. Already in 1974 however I had a brief encounter with my long-standing friend and colleague the Leiden structuralist anthropologist Hans van den Breemer, which led, on my part, to an impetuous and partly unjustified text attacking Leiden structuralism for what I wrongly took to be their lack of transcultural empathy – but which also contained the seeds, I can see now, of most of my later anthropological, historical and intercultural-philosophical work; so much so, that in 2022 I went through that 1974 text thoroughly, adding many (largely self-critical) footnotes and a bibliography, and at long last made it see the light of day (van Binsbergen 2022e).

²² My contribution would soon be published in an ASA volume as van Binsbergen 1977a.

for the Simon Chair of Anthropology at the Victoria University, Manchester – the epicentre of the famous Manchester School; meanwhile, also in the United Kingdom, the leading historian of Africa Terry Ranger (e.g. 1972, 1978) would go out of his way to advertise and praise my historical and theoretical work on the long-range history of religion in South Central Africa (work partly in collaboration of Matthew Schoffeleers, who from a Roman Catholic missionary in Malawi, via an Oxford PhD, had made Reader, soon Professor, of religious anthropology at the Free University Amsterdam).²³

With his large number of standard, docile PhD candidates, and his tacit ambition of relinquishing his Amsterdam chair (which he had occupied from age 30, since 1955) in order to establish, in Leiden of all places, a Centre for the Study of Social Contradictions (focussing on the Netherlands, primarily), Köbben was not keen to thresh out the contradictions surrounding the interaction between him and me (even the reader has already noticed some of the less attractive sides of my character, including vanity to the point of narcissism, proness to boasting, hypercritical sarcasm, an iron memory, and a freakish fixation on bibliography), and my professor of over a decade's standing transferred me to Jaap van Velsen – which effectively meant that I was banned into exile. When Jaap's UNZA contract had ended he had attempted to secure a prestigious anthropology chair in the UK or the Netherlands, but (given the shocking paucity of his – yet eminently seminal – publications, and his notorious personality, he had had to make shift with the chair at Aberystwyth, Wales, UK – a heaven for Welsh studies and (for the British crown prince, at least) the stepping-stone to the British crown, but a backwater as far as anthropology was concerned. Here he was preoccupied with feminism, macro-economics, and his enviably large library, never to reach again the level of the publications that had made him deservedly famous. Although he knew my Zambian research well and was impressed with it, our collaboration for my PhD never came off the ground – his scribbled impromptu remarks in the margins of my drafts were as passionate as they were unhelpful. Within a few years Matthew Schoffeleers and I would be organising an international conference on *Theoretical Explorations in African Religion* (which was to yield our 1985 book), and Matthew agreed that in that connection it would be better if I had a proper PhD – which as Reader in Religious Anthropology he had the right to confer, with a minimum of supervision or interference, simply on the strength of my articles already published (van Binsbergen 1979 / 1981). Thus the credit for this doctorate (and the substantial premium from the Association of Netherlands Universities, perhaps to the tune of about EUR100,000 by today's currency) all went to Matthew, with a minimum of

²³ Cf. Schoffeleers 1979, an edited collection which contains a major paper from my hand (van Binsbergen 1979, reprinted in my 1981 book); van Binsbergen & Schoffeleers 1985; van Binsbergen, 2010, 2011e, and 1991b.

effort on his part. At the time I never realised²⁴ that Köbben, having successfully applied for the one-year writing up subsidy, might have resented that outcome in which he was not given a formal role to play; anyway, the real costs of my first and decisive Nkoya fieldwork had been paid by Henny and me from my UNZA end-of-contract allowance. Working from Leiden, later the Free University Amsterdam (when Köbben had already left for Leiden), and Rotterdam (where I was scarcely rubbing shoulders with anthropologists any more), for decades I had no contact with Köbben, although I have always continued to consider him as my principal teacher of anthropological theory. In 2017 I compiled a collection of my work on religious anthropology, and since Köbben had been the first to introduce me to that field (with his studies and lectures on the 20th-c. CE Dutch prophet Lou de Palingboer / the Eel Monger, and of prophetic movements worldwide; Köbben 1964) I decided to dedicate the book to him. This I did – but when I contacted him by e-mail in order to ceremoniously hand him the book, he claimed that he no longer knew who I was; he died a few months later, aged 92.

It was not the first time that (incomprehensible to me with my exceptionally good memory) someone who had played a central role in my life as a researcher, failed to remember me decades later; the same had happened in 2002, when with my eldest son, Vincent, I made a return visit to highlands of northwestern Tunisia, and my ancient field assistant Hesnawi ben Ṭahar (by then nearly an octogenarian) confessed to have no conscious memory of me, although in 1968 we had for months worked painfully closely together for 20 hours a day on fieldwork, sleeping in a small house of 2x2 meters internal floor area, although he had visited me in my Amsterdam home a few years later, and although he had been all but the protagonist of my fieldwork novel *Een Buik Openen / Opening Up a Belly* (1988).²⁵ The pangs of that moment of Köbben's denial made me realise that I had occasionally resented²⁶ the ease with

²⁴ This realisation only came to me decades later, when a previous PhD student of mine, the musicologist Jan IJzermans, for whom I had successfully applied for a WOTRO subsidy concerning musicological research in Zambia, after several decades of delay due to the candidate's pressing other commitments, finally took his PhD elsewhere without involving nor informing me any further, despite our loyal and friendly co-operation until the moment of the lapse in his preparation of the thesis.

²⁵ – Where he comes out much more sympathetic than the field-working main character himself; the main challenge of portraying Hesnawi and his conversations in literary prose turned out to be: rendering his admirably dextrous and inventive manoeuvring with his curtailed French vocabulary of only about 500 words.

²⁶ Given the most traumatic relations I have entertained with my own father, and the fact that apparently for much of my life I have been more or less neurotically in search of father figures – in my teachers Köbben, Boissevain, and Jongmans, but also in Teilhard de Chardin,

which Sjaak van der Geest had won Köbben's heart, and an Amsterdam professorship to boot, whereas *vis-à-vis* my *alma mater* I had always felt like a prodigal son (*Luke* 15:11–32) never allowed back home, or an elder son who has squandered his right of primogeniture (*Genesis* 25:33). In the mid-1970s I was invited to contribute to Köbben's *Festschrift* (van der Veen & Kloos 1975), but failed to make the deadline. By the same time Köbben, pressed for time when preparing his own contribution for the *Festschrift* for the nestor of Netherlands religious anthropology Jan van Baal, sought my advice on conditional contracts between humans and spirits, of which my fieldwork in North Africa had offered numerous examples; I was rewarded with a generous acknowledgement (Köbben 1975).²⁷ Yet, given my deception with Boissevain, I scarcely frequented the Amsterdam department of anthropology in later decades, although I did maintain good relationships with Johannes Fabian, Klaas van der Veen, Sjaak van der Geest, and Wim Wertheim. And Sjaak was still to play a surprisingly (given the geographic, institutional, and personal distance that had grown between us) crucial role in my research career, on two separate occasions, eleven years apart.

Sjaak's 1976 Amsterdam PhD had concentrated at sexual relations and birth control – topics with substantial implications for the field of medical anthropology. Around 1978 he was teaming up with my former fieldwork assistant-teacher Klaas van der Veen for the production of a collective volume in the same field. Given its closeness to religious anthropology, especially in the African context, I was invited to contribute a piece on Zambia. Spasmodically, my submission grew from ordinary article length to near-booksize, but with amazing patience and generosity the editors continued to accommodate ever new text again, and ever more delays. When their book finally came out, (van der Geest & van der Veen 1979) my account of the 'Infancy of Edward Shelonga' filled half of it, and they were still not disgusted.

Vladimir Nabokov, Jack Simons, Chief / King Mwene Kabambi Kahare, Muchati's father Shelonga, and Martin Gardiner Bernal.

²⁷ If the same request had been made to me a decade later, I would have added the insight that contracts with land spirits (of which the Tunisian saints which I had studied in my first fieldwork – 1968, 1970 – were bowdlerised, superficially Islamised versions), formed part of a culture province characterised by land spirits and shrines, extending from the Northern shore of the Mediterranean (cf. van Binsbergen 1971a, 2021h, with extensive references) to Southern Africa (Schoffeleers 1979; Spierenburg n.d.; van Binsbergen 1981: index s.v. land spirits, and 2021a: ch. 2; Bernard 2009). I had studied manifestations of the same complex among the Manjacos of Guinea Bissau (van Binsbergen 1984b, 1985d, 1988a; cf. Crowley 1990; Werbner 1989 for West Africa). After 2000 it became clear to me that this land shrine complex is part of the Pelasgian cultural package, which arose in West Asia in the Neolithic and Bronze Ages, subsequently spread to the Mediterranean, and from there spread to all four directions, including sub-Saharan Africa, but also East and South Asia (and ultimately South East Asia and Oceania; cf. van Binsbergen & Woudhuizen 2011; van Binsbergen 2011b, 2021g, and in press (a).

My 1979 contribution did not mark, on my part, the beginning of a sustained identification with medical anthropology, although I continued to occasionally pursue this line, in my work on healing churches, healing cults,²⁸ an occasional contribution to Sjaak van der Geest's journal *Medische Anthropologie* (van Binsbergen 1992b, on the work of Devisch's student Filip de Boeck) and collaborations with Ronald Frankenburg (van Binsbergen 1988), Jean and John Comaroff²⁹ and René Devisch (Devisch 2004; van Binsbergen 1985b) – I frequently appeared in Devisch's Louvain seminars of the Unit on Symbol and Symptom – another pursuit of medical anthropology.³⁰ In the context of my research and writing over the decades, the real significance of my 1979 medical anthropological contribution as reprinted in the present book, was that it brought me to arrange and analyse my rich, and continuing growing, Nkoya material, in terms of the Manchester (par-

²⁸ van Binsbergen 1981, 1982, 1990, 1993, 2003f: chs 5-8, 2021a, 1991a; even outside Southern Africa, among the West African Manjacos: 1984b, 1985b; and even in Sri Lanka where I studied the syncretistic Hinduist-Buddhist trance healer Kirti (van Binsbergen 2011). In fact, my output in this field has been even much more voluminous, see ch. 11, below.

²⁹ We did not publish as co-authors, but John Comaroff and I spend a splendid and intellectually highly rewarding week in Belfast, 1978, on the invitation of Terry Ranger and with all costs covered by Jameson Whiskey (this is not a metaphor; that firm was actually, and with a drunk's lack of restraint, sponsoring the Wiles Lectures, which it was Terry's turn to deliver in 1978) and then again with John and Jean Comaroff (she was the medical anthropologist of the couple) in Paris when they together invited me to lend colour to their joint guest professorship at the Ecole des Hautes Etudes en Sciences Sociales, Boulevard Raspail, Paris, France, in 1995; in the same year I did a seminar with Jean Comaroff at Leiden, where together we explored the post-colonial African subject (cf. van Binsbergen 1995d). I had been instrumental in securing Jean's tenured position at Chicago, then one of the world centres of anthropology, and they obliged by making my book *Religious Change in Zambia* (1981 – a major influence on Jean Comaroff 1985) mandatory reading in their classes. However, as so often happens with anthropological friendships, the warmth of our friendship suddenly chilled when I publicly showed myself fundamentally critical their major book *Modernity and its Malcontents: Ritual and Power in Postcolonial Africa* (1993) – for which, as they boasted in private, their lavish Chicago funding had enabled them to enlist the services of an entire army of library research assistants whose summaries had made it to their book's final text...

³⁰ But it was a medical anthropology of a fundamentally different nature than van der Geest's, and although initially the Louvain anthropologists did contribute to the journal *Medische Anthropologie*, Devisch himself – perhaps with the time-honoured Flemish chip on his shoulder *vis-à-vis* the rash, manipulative, word-mongering, implicitly Protestant Dutchmen, who only apparently and in name spoke the same language – would soon take offence at that journal's, and its editor, empiricist (and in Devisch's eyes, simplistic and superficial) approach.

ticular Jaap van Velsen's, Bill Epstein's, and Vic Turner's) *extended case method*.³¹ Thus it gave a decisive boost to my understanding not only of Nkoya society and culture, but also of modern Zambia in general, and of the incomparable merits of the Manchester approach, including growing awareness of my own personal role in the extended cases I witnessed, and lived through, in fieldwork. But even without ever explicitly identifying primarily as a medical anthropologist, the specific bibliography of my writings in this field, incorporated in this book as Chapter 11, rather to my surprise takes up an amazing number of pages.

While all this is no mean harvest from one contribution to an edited collection, a decade later Sjaak was going to have an even greater impact upon my research and thought, with his instigation that I should contribute a paper on divination in Francistown, Botswana, to the 9th Market Day on Medical Anthropology, Amsterdam 1990. He had meanwhile established himself as the leading medical anthropologist in the Netherlands, had created the journal *Medische Antropologie* whose principal contributor he was, and was the convenor of this annual assembly of medical anthropologists. My paper would soon also be presented at an African Studies Centre seminar, 1993, and (as van Binsbergen 1993e) at the Conference on, 'Symbols of change: Trans-regional culture and local practice in Southern Africa', Berlin, Freie Universität, 7-10 January, 1993; a Dutch version (van Binsbergen 1994a) became a long contribution in a collection on medical technology edited by Sjaak van der Geest in conjunction with Paul ten Have, Gerhard Nijhoff and Piet Verbeek-Heida, whereas an expanded English version was published in two parts in *The Journal of Religion in Africa*, 1995-1996 (van Binsbergen 1995c, 1996a). So far I had given the topic of divination a wide berth, like I had (before 1979) medical anthropology in general, it had surprisingly not been touched upon during my seven years full-time of pre-doctorate anthropological studies at

³¹ van Velsen 1967; Epstein 1969, 1981, 1992; Turner 1957, 1968. For my research into Lusaka religious organisations I mainly relied on deep interviews with religious office-bearers and adherents, on textual documentation including archival one, and on personal participation in the religious organisations in question – as noted above, my interlocutors automatically surmised that, being visibly of European descent, I was a Christian and well-versed in Biblical scripture; so I happily obliged when repeatedly invited to deliver a sermon during especially Independent African Church services. My favourite theme (celebrating the intercultural brotherhood of which my participation of such services was beginning to remind me) was the descent of the Holy Spirit at Pentecost (*Acts* 2), finally overcoming the confusion of languages which in the beginning of civilisation (*Genesis* 11:7) had been imposed as a ruse to thwart the completion of the Tower of Babel. I was already trying my hand at the extended-case method, e.g. in my explorations of kinship, marriage and family law (van Binsbergen 1974 / 1977), and a detailed portrait of a Lusaka Christian woman church leader (van Binsbergen 2000; cf. 1972a, 1973b, 1987e, 1987f).

Amsterdam University; I had remained an embarrassed stranger to the topic, even though (or perhaps, precisely because) René Devisch (1985) had contributed a splendid synthesis on African divination to Matthew Schoffeleers's and my own edited collection *Theoretical Explorations in African Religion* (1985); and even though my close friend and principal Manchester contact, Richard Werbner, had developed into an expert on Botswana divination (Werbner 1973, 1989 – I had been deeply impressed by a preliminary version of the latter paper, as presented at one of the Annual Satterthwaite Colloquiums of African Religion and Ritual which had been established and convened by Richard). As related above, I had encountered divination as an aspect of popular Islam in North Africa, and it also plays a limited role (in the form of the axe-handle oracle) in my present account of a boy's early life among the Zambian Nkoya. But regardless even of the question as to the veridical nature of African divination,³² what the sustained close examination – in response to Sjaak's 1990 invitation – of my extensive data on Francistown divination (against the background of an international literature that proved unexpectedly rich), showed me for the first time, were the regional, continental African, and even transcontinental continuities attending the Francistown divination system. Later, in the context of my very different work, with Fred Woudhuizen, on *Ethnicity in Mediterranean Protohistory* (2011), I would begin to explore the very wide extent of applicability of Oppenheimer's / Dick-Read's / Tauchmann's Sunda Hypothesis (claiming extensive South East Asian prehistoric influence upon the Western Old World), and had I formulated my own Pelasgian Hypothesis, stressing transcontinental continuities emanating from the Ancient Near East and reaching out into every direction, including sub-Saharan Africa. However, by 1990 I began to see these (completely counter-paradigmatic!) transcontinental continuities in action in the context of African divination -- and they have constituted a major aspect of my research and writing ever since, throughout the next three decades.

The 1979 argument appears here in a considerably edited form, with a Preface written especially for this occasion. Since this is unmistakably a reprint of a text from the early stages of my career, I have not attempted to bring the argument, nor the attending bibliography, up to date in the light of the immense medical anthropological literature which has appeared ever since – I have limited myself to indicating where my own subsequent research has mean-

³² A moot point which I was to address explicitly in Chapter 15 of my 2015a book *Vicarious Reflections*: 'Does African divination "work", and if so, how it is this possible? Divination as a puzzle in intercultural epistemology'.

while suggested the possibility or need of amplification. The many long new footnotes bring this book selectively up to the current standards of my theoretical thinking and empirical research, in which comparative and long-range, deep-historical themes have come to take a dominant part, and where intercultural-philosophical issues have attached themselves to the more properly anthropological issues of more than four decades ago, when my text was first written. Thus it has become (somewhat in a nutshell, as compared to the very fat tomes I have published in recent years) a showpiece, not so much of medical anthropology, but at least of my personal sustained research efforts over half a century. In the process, it has benefitted from a great deal of later research I have conducted in the Nkoya context since 1979.

Having thus indicated (in great self-indulgent detail, I am afraid), and with a background in the History of Ideas, what the significance of the present argument, and of its instigator Sjaak van der Geest, has been in my academic career, it is high time that we turn to that argument proper. But not before examining some of my greatest indebtednesses for the present book.

Acknowledgments

By inviting me to present the first draft of this argument at the *10th International Course in Health Development*, Royal Tropical Institute, Amsterdam, the Netherlands, April 1975, my beloved former teacher of ethnohistory and ethnography, the late lamented Douwe Jongmans, offered me the opportunity of a medical audience; to the passionate and incisive discussions in that connection the final argument has owed a great deal. I am moreover indebted to the following persons and institutions: my fellow-countryman Dr J. Vosters MD, sometime Medical Officer in Charge of the Mangango hospital, Kaoma District, who not only looked after our family's health during our first, traumatic rural fieldwork 1973-1974, but also offered constant advise and supervision which enabled my wife and me, as medical laymen, to run a much utilised, daily medical clinic at Mema Valley, Kaoma District, for the duration of our fieldwork. I also thank the District Medical Officer, Kaoma District, who actively encouraged the medical line in our research. My thanks likewise go to Dr J. Kee MD, sometime Medical Officer in Charge of Luampa hospital, Kaoma District, for adding to our understanding of the area's medical situation and medical history. This piece was first drafted during my first years at the African Studies Centre (ASC), Leiden (late 1970s), when I derived much inspiration and feedback (albeit not in the field of medical anthropology) from frequent institutional interaction with Robert Buijtenhuijs, Henk Meilink, Emile van

Rouveroy van Nieuwaal, and Thérèse Gerold-Scheepers, among others. Outside the ASC circle, I enjoyed the feedback from Dick Jaeger, Robert Papstein and Chet Lancaster as fellow researchers of Zambia. Special thanks (in addition to the above praises) go to Sjaak van der Geest and Klaas W. van der Veen (the stimulating, patient and generous editors of the first printed version of this argument, in 1979); to our sometime family physician, Dr H.C.F. Zwaal MD, for detailed and highly constructive comments on earlier drafts of this argument; and to the members of the Leiden Africa Seminar whose discussion of an earlier version of the argument was most helpful. This piece was originally exclusively dedicated to my first wife, Henny van Rijn, who loyally and lovingly contributed to it with her sweat, blood and tears; of course I have respectfully retained that dedication, but expanded it in connection with the pressing concerns of today.

Meanwhile by far my greatest debt lies with the Nkoya people featuring in this detailed account. In line with established anthropological etiquette I have disguised their names through pseudonyms, but inevitably, their identities can hardly remain concealed in Nkoya circles given the photographs that accompany the present edition. From the bottom of my heart, I thank the Nkoya, who in the course of half a century have effectively become my fellow-Nkoya and my kin, for their trustful acceptance of our little family during fieldwork in both Lusaka and Kaoma District in the 1970s, and during numerous follow-up visits (and family reshuffles). I have tried to live up to their expectations, have sought to answer their most pressing question as to why our children are dying incessantly, have sought to make their lives easier and more secure by arranging for a Rural Health Centre to be established at Mema Valley, by extensively putting the Nkoya onto the map I have served the cause of Nkoya ethnic advancement in Zambian national politics and global science, and in the process I have build Nkoya cultural orientations and worldview into our own European lives. Having found a home where I was least expecting it, I can proudly and gratefully say: *‘Tukukámbirirēko. Niji kankòya’*. (I am even aware that this is a phonetic rendering deviating from standard Nkoya orthography; and a Mashasha, non-standard pronunciation, to boot).

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***THE INFANCY OF EDWARD
SHELONGA***

CHAPTER 1. INTRODUCTION AND SUMMARY

In this argument I shall present a case history based on the health experiences of a Nkoya boy, in Zambia, South Central Africa, in the first years of his life during the early 1970s. This case sheds considerable light on one of the crucial medical problems of the Third World: the interplay between cosmopolitan (*i.e.* Western, modern) medicine, and such other forms of medicine as exist locally; the latter forms usually are part and parcel of the local religion. Use is made of the 'extended-case method', which sees in the relationships between people within one social field, and in the evolvement of these relationships over time, the major key to structural principles, *in casu* those governing the interplay between the various forms of medicine.

In many ways, this argument is at the heart of my Nkoya research and of my Nkoya experience, even though in subsequent decades I have no longer been so focused on the medical anthropology to which this piece has sought to make a contribution. Strong emotions are invested in this book. One does not lightly and cheerfully share the life of a rural community when, for months throughout the (Northern Hemisphere) Fall of 1973, this comes at the cost of one death a week amongst one's close contacts – while in the process one becomes increasingly aware of the health risks for one's own little family in the field. After a year and a half of smooth-sailing urban research among the Nkoya in Lusaka, at the invitation of *Mwene* Kahare Kabambi (no pseudonym) we settled among the rural Nkoya of the Mema Valley (a pseudonym), Kaoma District, Western Zambia. There, when we were accommodated at the village of the client headman Mwene Munethi nicknamed (because of a near-death experience) the Revenant, close to the royal capital, our commoner research hosts were at first at a loss as to what brought us to their rural backwater. Initially, they volunteered the explanation that we wanted to establish a farm

in the area and had come to assess the labour potential. Soon, however, our neighbours more insightfully expressed their own understanding as to what we were doing there: we had come, they alleged, ‘in order to find out why so many children were dying in the village’. Admittedly, that had not been my main initial purpose, but at my interlocutors’ instigation it did become one of the leading concerns of my Nkoya research. The present argument seeks to formulate the answer to our interlocutors’ incisive question. Such an answer has inevitably to be based on concrete, rich data, and these can only show real-life people in real-life situations, revealing their relational and health challenges and dilemmas. For this argument to deliver its message, I have had to present a very detailed picture of the protagonists’ life, and problems and pressures. I hope that they – still my longest-standing, most beloved and closest kinsmen among the Nkoya – will not feel exposed and humiliated, but on the contrary will be appropriately proud of the contribution they are thus making to the description and explanation to one of the crucial aspects of being Nkoya in the modern world.

In Chapter 2, I introduce the problem, and the method by which I shall approach it. The next Chapter gives some background data (medical, social-structural, cultural) without which the case cannot be understood. In Chapter 4 I present the case history. In the next Chapter I examine the researchers’ roles in the case, which were so crucial that the story might be mistaken for a research artifact. Having demonstrated that the case is not thus contaminated, I proceed in Chapter 6 to outline the structural principles that can be derived from the case history, as they apply to the specific social setting of Nkoya peasants and urban poor.

Although displaying a seemingly irrational movement to and fro between cosmopolitan and ‘traditional’ Nkoya medicine, the health behaviour of the people involved in the case will be shown to be rational and understandable in the light of the following principles:

- Health choices are made not only on the basis of cognitive elements (beliefs, concepts concerning health and disease), but also on the basis of an evolving social process, in which social relationships (including those with health agents: doctors, nurses, healers, elders) develop and their effects (in the form of positive and negative experiences and expectations) accumulate.
- Given the indeterminate, ephemeral, extremely flexible nature of Nkoya social groups, the social process among this people revolves around continuous shifts in social relationships, through which individuals try to maximize social, political, ritual and medical support. In this light it

is understandable that people pursue both cosmopolitan and Nkoya medicine, but the extent to which they do so depends on the quality of the evolving social relationships through which they get access to either source of health care.

- Kinship and marriage, and the authority relations defined and evolved in these institutional domains, set the internal constraints for the social process within Nkoya society, and thus largely determine when and why younger people have little option but to submit to the health actions which the elders are continuously imposing upon them.
- For those Nkoya who participate in the multi-ethnic urban environment, modern-sector employment as well as personal relationships and experiences with agents of cosmopolitan medicine largely determine the extent to which cosmopolitan health care is utilized.
- Throughout the 20th century, and in many respects to this very day, the great majority of the Nkoya (and many other African urban migrants) have been in a peculiar socio-economic position.³³ They were participating in urban capitalist structures but their ultimate socio-economic security rests in the village, not primarily because of the so-called 'force of tradition', but because the political economy of this part of the world has assigned to the village the task of reproducing cheap labour and accommodating discarded labour. Remaining dependent upon the village and keeping an important stake there, even those Nkoya who are committed supporters of cosmopolitan medicine (and one of the protagonists in our extended case, Muchati [7], will turn out to be just that) have to abide by the institutions of their rural society, including the medical role of the elders, through which authority is asserted, the group affiliations of junior members are manipulated, and town-earned money is channelled to the village and subsequently appropriated and distributed.

³³ cf. Meillassoux 1975; van Velsen 1960, 1961; van Binsbergen & Geschiere 1985; Gerold-Scheepers & van Binsbergen 1978.

CHAPTER 2. THE PROBLEM AND THE METHOD

In modern Zambia, people's pursuit of health and healing usually takes place on the interface between, on the one hand, what Loudon (1976a: 4) has called *cosmopolitan clinical medicine* (*the bureaucratically-organized realm of public health services and certified private practitioners*) and, on the other hand, a variety of alternatives: self-medication, intra-family treatment, and the services of such African specialists as midwives, diviners; herbalists; priest-healers specializing in the alleged (?) effects of ancestral wrath, sorcery, or affliction spirits; and leaders of certain Christian churches specializing in spiritual healing. Social-science studies are available, both on cosmopolitan medicine in Zambia³⁴ and on some of the alternatives: herbalists,³⁵ priest-healers,³⁶ and African midwives.³⁷ Whatever the merits of these studies, their major shortcoming is that they rarely deal with the crucial problem of the *interaction between cosmopolitan medicine and local alternatives*.

The importance of this problem is certainly acknowledged in the work of Frankenberg and Leeson,³⁸ but these two authors have not published a conclusive empirical study on this point. Close came Leeson's short paper on 'Paths to medical care in Lusaka' (1970), where she found that

'nearly two-thirds of all *ngangas*' [African traditional healers – WvB] patients had

³⁴ Jayaraman 1970; Shattock n.d.; Frankenberg & Leeson 1974; Nur *et al.* 1976.

³⁵ Apthorpe 1968; Turner 1967; Gilges 1974; Symon 1959; Frankenberg and Leeson 1976; Leeson and Frankenberg 1977.

³⁶ Reynolds 1963; Turner 1967b; Colson 1969; van Binsbergen 1977a.

³⁷ Le Nobel 1969: 31*f.*; Spring Hansen 1972; Munday 1945; Barnes 1949; Stefaniszyn 1964: 74*f.*

³⁸ 1974, 1976; *cf.* Frankenberg 1969; Leeson & Frankenberg 1977; and Leeson 1969, 1970.

previously consulted “Western” medical advisers’ (1970: 9).

In a preliminary yet thoughtful analysis, Leeson concludes that

‘to consult [the *nganga*] does not imply a total rejection of Western medicine but instead should be considered an attempt to assess why Western medicine has failed to be effective, or an attempt to try all available paths to health’ (1970: 11).

Extremely stimulating in Leeson’s argument is that, here as elsewhere (1969; cf. Frankenberg & Leeson 1976), she tries to vindicate the African healers, claiming that greater success in public health will not be achieved by needlessly attacking the healers who perform many essential tasks, but by improving the working of the Western health agencies. For a member of the cosmopolitan medical profession (Leeson is a physician), this is quite a courageous statement to make. In passing we note that she still considers the traditional healer and the cosmopolitan doctor to constitute two categories that are totally apart, as if existing in fundamentally different spheres of existence. Within a few years, the World Health Organization would begin to concentrate much systematic attention on traditional healers and advocate their integration in medical care (cf. World Health Organization 1975, 1976, 1978; Bibeau 1979) – a step which Leeson could not yet make.

Leeson’s research (also cf. 1972) was carried out in Lusaka, the Zambian capital. Here the Zambian patient is surrounded by easily accessible cosmopolitan health agencies: the University Teaching Hospital, a number of urban clinics, and an abundance of private practitioners. By the early 1970s, the majority of these (in fact: all except the private practitioners) were non-fee-paying; also drugs were dispensed free of charge. Yet even here, despite the overlap between cosmopolitan and *nganga* consultation noted above, Leeson found that about 40% of the *ngangas*’ patients claimed not to have consulted cosmopolitan agencies. And these are not just patients complaining of illnesses that could be considered the *ngangas*’ special domain: ‘madness’, ‘spirit possession’, etc. A considerable number of Leeson’s interlocutors consulted the *nganga*, by-passing cosmopolitan agencies, for complaints that (cf. Table 2.1a) many Zambians would then consider amenable to Western treatment, allowing themselves to be hospitalized on the basis of these complaints.

While these data demonstrate the prominence of these diseases in the Zambians’ utilization of cosmopolitan medicine, table 2.1b indicates that the same diseases constitute important reasons for the consultation of non-cosmopolitan healers.

	diseases					
	malaria	measles	respiratory disorders	gastro-intestinal disorders	trauma (accident)	disorders of pregnancy and puerperium
in-patient admissions, 1968	19,700	12,000	20,000	15,000	19,100	11,700
in-patient deaths, 1968	330	980	1,380	970	290	280

Table 2.1a. The six most frequent reasons for hospitalization in Zambia (source: Stein 1971)

	diseases						
	malaria	measles	respiratory disorders	gastro-intestinal disorders	trauma (accident)	disorders of pregnancy and puerperium	total
number of Leeson's interlocutors who claimed that, for this disease, they consulted the <i>nganga</i> first and only (at the exclusion of cosmopolitan health care)	9 41%	0 0%	24 33%	39 42%	5 56%	12 41%	89 40%
number of Leeson's respondents giving details on their health actions concerning this particular disease	22 59%	1 10%	72 67%	92 58%	9 44%	29 59%	225 60%
total	31 100%	1 100%	96 100%	131 100%	14 100%	41 100%	314 100%

Table 2.1b. Consultation of *ngangas* for the six most important diseases in Zambia (sample: patients of Lusaka *ngangas*; source: Leeson 1970)

Despite the availability of cosmopolitan medicine, why do contemporary Zambians continue to pursue forms of non-cosmopolitan medicine? Phrased thus, this central question of the present argument may sound ethnocentric, even smack of cultural imperialism. Cosmopolitan medicine may be considered just one particular socio-cultural subsystem, peculiar to a type of industrial society that since the nineteenth century CE has spread over many parts of the

world.³⁹ Wherever cosmopolitan medicine has penetrated, it has encountered local forms of medicine, often of great complexity and antiquity. Rarely is local medicine abandoned overnight, in favour of cosmopolitan medicine. Moreover, despite its achievements and power, cosmopolitan medicine itself is increasingly criticised within the very societies it sprang from; Illich's classic *Limits to Medicine, Medical Nemesis: The Expropriation of Health* (1977)⁴⁰ is an eloquent and convincing example of this tendency. Yet, in a country like Zambia great national and personal efforts and dedication go into the propagation of cosmopolitan health care. The latter does possess reliable therapies or preventive routines for certain endemic diseases (e.g. malaria, gastro-enteritis, measles) which cause great suffering and for which local, non-cosmopolitan medicine has no adequate cure. For these reasons I feel that my question is a legitimate one – particularly if the answers we shall find will not lead to a Pyrrhic victory of cosmopolitan medicine, but to a better understanding and appreciation of the contributions various medical traditions, including cosmopolitan medicine, can make towards the well-being of the people involved.

As regards Zambia, Leeson's answers were not meant to be exhaustive. Moreover, they were based on a possibly biased sample survey: her respondents were found in the *ngangas'* consulting rooms, in other words had already

³⁹ However, considering cosmopolitan medicine (despite this global designation!) *just a North Atlantic ethnosystem* is not the only possible way of looking at it. In much the same way, the bow and arrow, the axe, the plow, the motor car, the airplane, the microcomputer would not primarily be regarded as the culture-specific of just one particular culture, specific in space and time. They may be considered items belonging to the general inheritance of humankind, invented as the result of the convergence of many traditions from many times and places, and foreshadowing the emergence of a globalised world culture. On this vital question of intercultural philosophy, cf. Harding 1997; van Binsbergen 2007c.

⁴⁰ Illich's book has been an important factor why, in juvenile left-wing circles in the modern North Atlantic region, it has become fashionable to be suspicious, even dismissive, of cosmopolitan medicine, its organisational forms, and the huge expenditure it involves. When one is young, healthy and relatively rich (like inhabitants of the North Atlantic regions have tended to be, in a comparative global scale), one can afford such an attitude. As one grows older and serious health problems come knocking on one's door, one learns to be more appreciative of the most elaborate, consistent, and effective systems of thought and action mankind has so far developed for combating disease and furthering longevity. The present book is re-issued, as a token of my immense and daily increasing admiration for the intellectual, professional and especially moral performance of nurses and physicians, in the context of the hospitalisation of my beloved wife, for what approaches half a year, under conditions of intensive care and total isolation for microbiological reasons. The experience has unexpectedly but greatly improved my (never too positive) image of humankind.

openly committed themselves at least in part to traditional health care, and might therefore not be representative for the Lusaka population as a whole. Another author who has explicitly raised the same question in the Zambian context, is Victor Turner. At the end of a general ethnographic inventory of Ndembu Lunda medicine, he quotes (1967a: 356 *f.*) a variety of reasons for the persistence of local medicine. Local medicine is said to rest on the same premises as the total world view of the local society; many illnesses heal themselves irrespective of the real or alleged effect of therapy; the healing cults have an important psychological effect; and illness is so prevalent that the local culture has no choice but to actively confront it.⁴¹ These reasons overlap with those

⁴¹ Whatever the unmistakable merits of Vic Turner as a religious anthropologist, on second thought one would be less impressed with some of the reasons he advances here.

Medical systems travel, and have always travelled ever since Anatomically Modern Humans's expansion across Africa (200-80 ka BP) and then (80 ka BP to present) all across the earth. Only within the presentist, a-historical perspective of structural functionalism does it sound plausible that *the premises of local medical systems, especially in so-called traditional societies, would always coincide with the general premises underlying local society*; but structural-functionalism is an obsolete paradigm, the very Manchester School of which Vic Turner was one of the most glorious exponents, was conceived as a timely antidote to structural-functionalism, and several fundamental objections are called for at this point. For one thing, *probably several contradictory premises* underly local society anyway. *E.g.*, many village societies (I familiarised myself extensively with this type both in North Africa and in South Central Africa) are based on a principle of equality of male adults, yet at the same time organised inequality (*e.g.* aristocracy, royal rule, priestly rule, and these elites's selective recruitment of new members from among the villagers) upset equality and introduce a dynamics that determines much of the local social process. *Secondly, one cannot automatically assume that local medical systems in their totality have exclusively sprung from the local society.* Throughout sub-Saharan Africa, even illiterate diviners in very remote places have been demonstrated to use geomantic divination that has a literate origin in Islamic divination in Iraq around 1000 CE; and that has much in common with Chinese *I Ching* wisdom divination; the same form of divination has been attested for West European courts (*esp.* in the England of Elizabeth I, c. 1600 CE), late medieval (including Byzantine) Christianity, and 19th c. CE Central European peasantry (van Binsbergen 1995, 2012). In Southern Africa, such geomantic divination is particularly used by diviners-healers-spirit mediums of the *Sangoma* cult, which I have demonstrated to have extensive roots in the Buddhism and Hinduism of South Asia (van Binsbergen 2003, 2020, 2021a). The ecstatic cults / cults of affliction of North and sub-Saharan Africa are strikingly continuous with those found all along the Indian Ocean coast in South and South East Asia, and I have the impression that they have one common origin, wherever that may turn out to be (van Binsbergen 2010a, 2010b). Likewise, part of local medicine among the Bamileke of Cameroon turns out to have Chinese roots (van Binsbergen, in press (c)). The world religions such as Buddhism, Christianity and Islam have tended to incorporate, preserve and widely disseminate kernels of traditional medical concepts and practice (*e.g.* those with very archaic shamanic roots)

mentioned by Leeson and throughout the literature on the subject (*cf.* Lieban 1973: 1056 *f.*). Le Nobel's clinical experience in the field of maternity care at the rural-district level in Zambia suggested that the logistic question of sheer access to the outlets of cosmopolitan medicine also plays a major part. When a mobile maternity service greatly increased accessibility, utilization increased threefold (Le Nobel 1969: 85 *f.*); yet even so it could not be prevented that

'only 20% of the regular antenatal attendants reported within a few weeks after the delivery'

for post-natal and under-five consultation. Evidently, besides sheer accessibility there were other factors at work, one of which Le Nobel suggests to be health education – another point emphasized in a vast body of literature on the subject.

In recent decades, an increasing number of publications has become available on the interaction between cosmopolitan medicine and its local alternatives. Like the few Zambian examples quoted, much of this literature uses generalized descriptive data, often of a quantitative nature, to arrive at general but as yet rather preliminary conclusions. Studies based on two types of data are overrepresented: those relying mainly on medical records relating to people already pursuing cosmopolitan medicine (*e.g.* Le Nobel 1969), and those based on speech reactions: on what people say they feel, did, do, or may do in future.⁴² It should be noted that both types of data are artificially restricted to the individual, about whom certain facts (often artefacts) are recorded *without taking into account the social relationships in which that individual is involved, and the development of those relationships over time.*

In the present argument, I shall approach the problem from a different angle: the *extended-case method*, to whose development Turner himself and his sometime Manchester colleagues (foremost van Velsen) have so greatly contributed;⁴³ in particular, the presentation of my data and analysis has been

that were thus distantly displaced in space and time, also into 'traditional' societies (van Binsbergen 2010a, 2019, 2020c).

By the same token, one could wonder *whether culture always actively and explicitly confronts what it cannot simply dissimulate.* Anomia, apathy, alcoholism, suicide, out-migration, have been among the responses to European expansion and conquest in many parts of the world – but these can scarcely be called *cultural* responses – rather their absence or denial. Recent climatic change, breakdown of biodiversity, air pollution etc. are similarly undeniable challenges yet still waiting for their adequate explicit cultural responses.

⁴² *E.g.* Ademuwagun 1974-1975; Leeson 1970; Imperato 1974; Maclean 1971.

⁴³ Turner 1957; Van Velsen 1967, 1964: xxiii *f.* and *passim*.

modelled, somewhat, after a paper on urban networks by Bill Epstein (1969) – another Manchester researcher. In the extended-case method, the fundamental structural features of a social field are identified not primarily on the basis of the participants' statements concerning such enduring cognitive elements as collective beliefs, rule and norms; nor on the basis of other generalized data such as quantitative surveys; nor on the basis of labelling the attending overall social organisation in such aggregating general terms as constitute the anthropologist's conceptual toolkit (*e.g.* patrilineal, uxori-local, etc.; *e.g., cf.* Murdock 1949); but on the basis of a carefully studied sequence of social events involving the same interacting protagonists over time. Applied to the medico-anthropological perspective (*cf.* Janzen 1975), I shall contend that cosmopolitan medicine, on the one hand, and its various local alternatives, on the other hand, constitute two dominant spheres in the social field within which people, through a complex social process, are engaged in the pursuit of health. What form the relations between those two spheres take, and why, shall be tentatively analysed by reference to one extended case, describing in detail the health experiences of Edward, a Nkoya infant. Edward's experiences largely depend on those of his parents Muchati and Mary; therefore, the latter will also play leading parts in the account that follows.

Limitations and possibilities of the extended-case method in medical anthropology will become apparent as my argument proceeds. The health activities of the protagonists, within and outside cosmopolitan medicine and extending over several years, no longer appear as disconnected items but are shown to be *steps in a sustained social process*. The significant health aspects of this social process will be shown to be intimately related to crucial social, economic and political dimensions. But what is thus gained in depth and width, goes at the expense of representativity. We shall therefore have to discuss to what extent the protagonists' situation is unique. Moreover, data of sufficient depth and detail to be amenable to extended-case analysis, can only be collected through intimate and prolonged association between the researcher and the protagonists. In the context of health activities, at the borderline between cosmopolitan medicine and other forms of medicine, is it permissible to use such intimacy primarily for the gathering of scientific data? Or should such influence as the researcher builds up through participation, be used in the first place to drag off, without delay, the patients to cosmopolitan health agencies, thus releasing them from the clutches of non-cosmopolitan healers? When discussing our own role in Edward's case (Chapter 5), I shall have to consider this ethical question.

This argument is an anthropologist's contribution, and makes no claim to

medical competence. When the course of our fieldwork forced us, through massive and insistent popular demand, to diagnose and treat our interlocutors' illnesses, we did so as amateurs, albeit that my wife's long-standing experience with medical research as a biophysicist facilitated our access to medical literature (albeit only such as we had brought with us to the field: a remote village without main, telephone, leave alone Internet – which had not even been invented yet) and to cosmopolitan medical practitioners. The plausibility of such diagnoses as my argument contains has been confirmed in subsequent, detailed discussions with doctors, including three physicians practising in the area itself.

However, as in nearly all cases such tentative confirmation was reached in absence of the patient involved, no medical authority attaches to our diagnoses. In view of the centrality of these diagnoses in my argument this may appear a major weakness, yet it was unavoidable in a rural area where no cosmopolitan doctor was available within 85 kms, there and then a two-hours drive under conditions of local petrol scarcity.

CHAPTER 3. BACKGROUND

The protagonists in this case belong to the Nkoya people, an ethnic group which has its home area in the Eastern part of Zambia's Western Province (formerly Barotseland), and surrounding areas.⁴⁴ My medico-anthropological data mainly derive from the Nkoya of Chief Kahare, a group of peasant cultivators and hunters.

Chief Kahare's is not a healthy area. Situated on the Western Zambia plateau, at the Kafue / Zambezi watershed, the area contains swampy streams and fishing ponds conducive to malaria and bilharzia. Respiratory tuberculosis and gastroenteritis are likewise common. In addition to malaria, almost universal hookworm infestation further contributes to the anaemic condition (*cf.* King 1966: section 24: 64-66) that greatly reduces the resistance of children (measles is a major killer disease here), and of young women in pregnancy and childbirth. Hypovitaminosis is a common condition. With the virtual absence of motor traffic, the major causes of trauma are wild animals, defective bicycles, and human violence. Leprosy and blindness are infrequent but accepted features at the village scene. A massive eradication campaign in the 1950s reduced the rate of venereal disease which before that time was very high.⁴⁵ Infant mortality is high. Moreover, fertility is excep-

⁴⁴ *Cf.* van Binsbergen, my publications on the Nkoya, selectively listed in the bibliographies of this book, and including Doornbos & van Binsbergen 2017; McCulloch 1951; Clay 1945.

⁴⁵ *Cf.* Smith & Dale 1920; Northern Rhodesia 1956: 95, 100; Northern Rhodesia 1955: 110; *cf.* Evans 1950, which deals with the Nkoya's eastern neighbours, the Ila. The Ila used to have a promiscuous ceremony conducive to the spread of venereal disease (Smith & Dale 1920; Evans 1950; Callahan 1997). While the Mashasha Nkoya in many respects overlap with the Ila, such a ceremony is to the best of my knowledge absent among the Mashasha; yet before the HIV / AIDS pandemic a high rate of promiscuity was common-place also among them, and major ceremonies (such as female puberty rites, name-inheritance ceremonies, funerals, and from

tionally low.⁴⁶ This may be related to such social factors as high marital instability, polygyny, and labour migration (*cf.* de Jonge 1974) – all being conditions with a negative impact on the frequency of sexual intercourse and enhancing the risk of fertility-reducing sexually transmitted disease; other factors negatively affecting fertility include local practices relating to sex and childbirth.⁴⁷

The unfavourable conditions summarized here contrast remarkably with the picture emerging from the UNDP Nutrition Status Survey (National Food and Nutrition Programme, 1974). Based on a national sample including a large number of rural villages, that study carefully maps out the distribution of such somatic conditions as either indicate, or are considered to cause, malnutrition. For the purposes of the survey, the Zambian territory was divided into a number of ecozones. The twelfth ecozone, to which Chief Kahare's area belongs, compares rather favourably with most other ecozones, in terms of: children's weight against age; arm circumference; most of many serum, haemoglobin etc. levels that were measured (except packed cell volume and ascorbic acid, in regard to which this ecozone scored low); and particularly malaria, where children in this ecozone were found to be least affected

the 1980s on the Annual Kazanga Cultural Festival) constituted standard occasions to meet casual sexual partners and hive off with them in the always nearby bush. This condition of promiscuity, while on the one hand conducive to the spread of venereal disease as a cause of infertility, on the other hand, by enhancing the rate of intercourse hence the chances of impregnation, may have somewhat compensated for very low fertility (which has been reported for the Ila (Tuden 1958: 69 *f.*; Evans 1950), the Nkoya (*e.g.* in the present argument; also van Binsbergen 2012c), and in fact throughout the so-called matrilineal belt of South Central Africa (Central Statistical Office, n.d.; more on these matters, with a map, in van Binsbergen 2022c). Young girls's guardians (although often keen to cash in through the fines which a court of law may impose on a trespassing male lover) often turn a blind eye to their young charges's sexual 'transgressions' because these elders covet, as future politico-residential following, farm hands, and as wage-earners, the offspring which this behaviour may produce.

⁴⁶ *Cf.* Ohadike & Tesfaghiorghis 1975; Central Statistical Office 1975: 6 and *passim*; van Binsbergen n.d. b. The constant competition between kin groups and between villages for the control over children among the Nkoya kin groups must also be seen in the light of this dramatic infertility. Low fertility was also one of the likely reasons for the people of western central Zambia in Early Modern, precolonial times to resort to slavery, especially of war captives and of people indentured as a punishment for man-slaughter (*cf.* Tuden 1958; van Binsbergen 1992a, 2012c).

⁴⁷ On the causal significance of such practices, *cf.* Central Statistical Office 1975: 21; in the Nkoya case they include: intra-vaginal medicine used to ensure a dry milieu for intercourse (the harmful nature of this alkaloid substance is indicated by the haemorrhages it frequently causes); and infanticide under various conditions, *e.g.* when the mother is a girl who has not gone through puberty ceremonies, or when teething of the upper and lower incisors takes place in the reverse order from the local cultural ideal which follows the biological routine among humans (lower incisors first, followed after c. 2 months by the upper incisors).

among the whole national sample. (Malaria incidence in adult males, however, was average, and in adult females even very high).⁴⁸ The report did not attempt a systematic interpretation of these patterns, except for seasonal variation in diet. Given the South East Asian associations of the Nkoya, and the empirical relation between South East Asia, the *thalassaemia* anaemic blood condition, and immunity to malaria (Oppenheimer 1998 and references cited there; van Binsbergen 2012e) it is possible that here lies a background for the children's condition – but that does not explain the higher malaria levels in the adults especially women. The main explanation for the difference between the UNDP's moderately positive picture and the situation I encountered in Chief Kahare's area, becomes clear when we trace the origin of the data in this ecozone (Schültz 1976: figure 30). They derive from four villages in the central part of the ecozone, where not only different ecological conditions obtain (particularly a different hydrography and much greater human encroachment upon the forest), but which is also the region's centre of gravity in terms of medical facilities, cooperatives, communications, exposure to mission and school education, etc.; incidentally, this bias also affects Schültz's own analysis of the area's ecosystem (1976: 103 f.).) For an early yet thorough examination of the health situation in a area adjacent to Chief Kahare's, cf. Newson 1932. Sadly, in the early 1970s health conditions in Chief Kahare's area were still rather similar to what Newson described.

Being located at the periphery of the province and even of the district they belong to, Chief Kahare's Nkoya had to wait a long time for the establishment of a permanent outlet of cosmopolitan medicine in their own area: a Rural Health Centre dating from the late 1960s, at about 25 kms from Chief Kahare's capital village.⁴⁹ However, at distances of 85 kms and more, dispensaries have

⁴⁸ Mosquito nets are hardly used in Chief Kahare's area; there, smack on the Zambezi-Kafue watershed, stagnant waters are in abundance, and the huge discrepancy in recorded malaria incidence between men, women and children simply suggests defective data – such as is common in numerical surveys in Third-World countries (Leach 1967).

⁴⁹ In practice, given the lack of affordable transport facilities in the area, this distance proved prohibitive for many villagers (whose sole means of locomotion were walking or cycling) in the Mema and Mushindi Valleys, and caused such medical deprivation that in 1978 I took the initiative to establish another Rural Health Centre, near Chief Kahare's capital. This was about to be completed in 1989, when I visited the area with my family from Francistown, Botswana, where I was then doing fieldwork. Despite the prevalence of traditional medicine in the area, the whole thrust of the present argument is that it is *not cultural rejection of cosmopolitan medicine* that brings locals to their complex and occasionally puzzling medical choices. One proof of the local population's eagerness to partake of modern medical services, goes back to the 1940s or 1950s (the very period when in Oceania so-called *cargo cults* led to similar initiatives – constructing airstrips so that the ancestors would be able to land their airplanes and deliver the much coveted cargo; Worsley 1957; Cochrane 1970), when prompted by the rumour of flying doctor services extended from the Luampa Mission Hospital, the people of Mema Valley out of their own initiative cleared an airstrip (on an

been available since the 1930s (Northern Rhodesia 1939). From the early 1940s, teachers at the few mission schools in the villages kept some elementary medicaments supplied by the mission. Minor village sanitation requirements as enforced by the district administrative staff on their annual tours; tsetse fly control at the borders of the Kafue Park; sporadic inoculation campaigns, and the habitual medical check-ups when a man would register as a labour migrant at the distant provincial capital: this sums up about all there was of cosmopolitan medicine, and its derivations, during most of the colonial period.⁵⁰ Of the three hospitals found in the district in the early 1970s, one was established in the late 1950s and the other two around the time Zambia became independent (1964). None of these hospitals was within 85 kms from Chief Kahare's Village.⁵¹ Although the number of outlets of cosmopolitan medicine compared favourably with other districts in Zambia,⁵² it is mainly the people living in that part of the district where the three hospitals are concentrated (each within only 50 kms from the others!), who more than marginally benefit from them.

For an understanding of the extended case, a minimum introduction to Nkoya social structure is necessary. Throughout my presentation of the case I shall

spot half a km from the royal capital, where later the government was to build a primary school) in the hope of thus luring an airplane their way. It was never used, of course.

⁵⁰ In addition, migrants returning to the village had often gained considerable experience with cosmopolitan medicine at their places of employment.

⁵¹ The 1968 returns of one of these hospitals corroborate the disease patterns summarized below:

<i>Reasons for admission</i>	<i>cases</i>	<i>deaths</i>
delivery without complications	91	0
genito-urinary infections	71	2
gastro-enteritis etc.	66	6
complications of pregnancy, etc.	59	1
malaria	57	0
respiratory tuberculosis	52	11
measles	51	4

Table 3.1. The seven most frequent reasons for hospitalization and hospital deaths in a rural hospital in Kaoma District, 1968

Source: Republic of Zambia 1972; in order to avoid easy identification in the printed source, I imposed upon the original data a random scatter with mean = 0% and standard deviation = 10% (cf. van Binsbergen 1978a). A further brief summary of the local health situation is to be found in: Republic of Zambia, 1976: 191 f.; Imasiku 1976.

⁵² Cf. Republic of Zambia 1976; Blankhart n.d. [1966]: 6 f.

refer to the principles outlined here. I shall take them up explicitly in my interpretation of the case, in Chapter 6.⁵³

In terms of social structure, the contemporary Nkoya situation must be analyzed at two levels. First we have to look at the relations between this society and the wider social, political and economic structures within which it is incorporated; and secondly we need to study the internal structure of this (part-) society. The two levels complement each other.

In the modern Central African context, 'Nkoya society' forms a social-organizational subsystem: the local results of incorporation into the colonial and post-colonial state, and into the world-wide capitalist economy. The participants in this subsystem are situated partly in the Nkoya homeland and partly in the towns of Central and Southern Africa. The people in these two segments are geographically separated, exist in very different residential environments with varying degrees of multi-ethnic involvement, and specialize in different modes of production. Capitalism dominates urban economic relations, while in the village many pre-capitalist forms still survive, although with difficulty. Yet the two segments are linked by very frequent interaction, making for a constant stream of people, information, letters, money, food, manufactured articles, between the urban and rural segments. Despite the differences in economy and social-structural environment, in both urban and rural segments of the Nkoya ethnic group the same patterns of kinship, marriage, ritual, and medicine obtain, and almost every Nkoya individual is involved in social processes in which both urban and rural kinsmen and fellow-Nkoya actively take part. In this sense it is meaningful to speak of Nkoya society, even though many of its members live outside the Nkoya rural area.

The political economy of the contemporary Nkoya situation can be described with Meillassoux's phrase (1975: 137 *f.*) 'the mode of reproduction of cheap labour' (*cf.* Gerold-Scheepers & van Binsbergen 1978: 25 *f.*).

Capitalism brought not only processes of material expropriation and extrac-

⁵³ A peculiar methodological problem arises here. An extended case is normally used to bring out more general structural principles that presumably have a rather wide application in the society in question. These principles concern, in the present argument, the relationship between cosmopolitan and non-cosmopolitan medicine. However, in order to make the case study amenable to such interpretation, other structural principles must be invoked; these other structural principles, relating to the internal social structure of Nkoya society and its incorporation in the wider world system, can be seen to work in the present case study, but they derive primarily from a much wider set of data, as gathered over the decades and presented in my other publications on the Nkoya, Zambia, and on South Central Africa in general.

tion within the Nkoya homeland (e.g. hut tax, partial closure of the forest area for hunting and collecting); it particularly caused, since the 1910s, a drain of locally reproduced labour force from the Nkoya homeland to the places of capitalist employment in Central and Southern Africa. With low average standards of formal education, and as a small and for many decades despised ethnic minority in towns whose labour market and the informal sector are dominated by other ethnic groups, the Nkoya have rarely been able to become stabilized townsmen who rely entirely on their capitalist employment. Instead, the insecurity of urban employment has necessitated a continued orientation towards the village, and a continued involvement in kinship-dominated social processes focusing on the village. As the village is the place where children are born and raised, and where the old and disabled retire, the urban capitalist sector benefits from a labour force while relegating the costs of its reproduction to rural society. The latter becomes economically (over-) exploited, in fact impoverishes, and its social organization is eroded since its original economic base has been greatly affected by capitalist relations of production. Yet the survival of this rural society is obviously of primary importance within the overall political economy of this part of the world. *Only if rural society remains essentially intact*, can it perform its subservient role *vis-à-vis* the urban capitalist sector. Thus contemporary Nkoya village society reproduces cheap labour, and at the same time provides a niche of economic, social and psychological security outside the capitalist sector, for the many Nkoya who despite their past, present or future involvement in that sector have not been allowed to become anything but peripheral to it.

While in town, Nkoya migrants in great majority engage in mutual hospitality and kin assistance. They participate in Nkoya cults and puberty ceremonies, and send money remittances to rural kin. Thus they demonstrate that they still identify as Nkoya. Only in this way can they ensure their stake in the village, in preparation of their ultimate retirement there. While they live in towns and while the majority of the men are employed in modern formal organizations, in their free time most urban Nkoya pursue a social, cultural, ritual and medical life that is largely that of their rural relatives. The Nkoya therefore, are an example of the fact that economic and political incorporation need not lead to complete destruction of pre-existing social and symbolic structures. These structures may survive as 'neo-traditional' (i.e. deprived of their original base in pre-capitalist relations of production), provided that the incorporated subsystem which they underpin, has been assigned a function within the new, wider system. Under the penetration of capitalism, the Nkoya kinship system has been modified but not destroyed, because Nkoya rural society has been made subservient to capitalist structures.

I shall demonstrate that Nkoya medicine is an essential part of the Nkoya kinship system, and that the continued partial adherence to the former, depends on the continued reliance on the latter.

Meanwhile, it is important to realise that, with these characteristics; the Nkoya of the early 1970s represented already a minority societal variant largely relying on circulatory labour migration, whereas the majority of Zambians contexts by that time had already reached a more permanent state of urbanisation (or ruralisation), cf. Pottier 1968, Watson 1958.

Let us now move on to the internal structure of Nkoya society. The institutionalised principles governing personal intra-ethnic social relationships in the urban segments (*i.e.* outside the domain of participation in formal organizations) largely derive from the rural situation. It is therefore sufficient for our present purpose to describe the latter.

Chief Kahare's area consists of a number of river valleys, separated by extensive light forests where in the 1970s much hunting still used to take place. Each valley derives a separate identity from inconspicuous rain ritual, an unofficial neighbourhood court of law, and concentration of rights to riverside gardens and fishing grounds mainly in the hands of the valley's inhabitants. Each valley contains about a score of tiny villages, whose sizes range from one to twenty households, a minority of which are polygynous. Each village is headed by a headman, whose title and office is ritually inherited at the village shrine; in colonial times, the status of village headman was officially confirmed by his possession of a village register, and succession still requires the Chief's consent. After the death of a headman, a successor is chosen from among a large pool of patrilineal, matrilineal, and sometimes affinal kinsmen of all previous *incumbents* of the office; very often, senior men are attracted from a distant village or called back from town in order to take up the vacant headmanship of a village. Names and titles of persons other than headmen are inherited in a similar fashion – much as among other groups in South Central Africa (cf. Munday 1948; Stefaniszyn 1954). Usually, inhabitants of a village are real or putative kinsmen of the headman. The Nkoya reckon descent bilaterally. By the 1970s, intra-village marriages had become exceptional and were frowned upon; and consequently an individual's maternal kin and paternal kin (either of which he may opt to reside with) tended to be spread over a number of different villages. In addition to real and putative genealogical links, joking relations between pairs of clans⁵⁴ may lead to close personal relationships that

⁵⁴ Nkoya clan affiliation is ambilineally inherited. Every Nkoya belongs in principle to two

in effect contain the same claims and rights as actual kinship, including co-residence in one village.

For all these reasons each junior Nkoya has potential claims to residence and assistance with regard to a large and geographically very extensive set of senior fellow-Nkoya, who all compete for a following of juniors in order to establish themselves as village headman (or to remain successful in that office). In addition to urban-rural migration, intra-rural geographical mobility is therefore very high. All individuals except the aged, continually try to improve their kinship-political position by moving from village to village.

In this extremely *flexible, competitive and conflict-ridden* set up, the village is the main conspicuous unit of the kinship-political process. Yet the village is not a monolithic whole. As inhabitants come and go, they are rarely bound by such conditions as having grown up together or having interacted with each other for many years at a stretch. Usually the village headman spends much of his time and energy to keep together a village consisting, with some exaggeration, of virtual strangers whom only opportunity and calculation have brought together. Bilateral kinship enmeshes and confuses consanguineal and affinal ties to such an extent as to preclude the emergence of stable kin groups above the village level. Clans are now too dispersed and too devoid of corporate interests (apart from matters of chiefly succession) to form enduring social groups. In the course of kinship-political processes of coalition and opposition, *vaguely-defined clusters of kinsmen* tend to emerge beyond the scope of one individual village. Such clusters manifest themselves through the members' repeated yet occasional association, over a few years, for the purpose of marriage negotiations, court cases, ritual, and inheritance to prestigious titles connected with headmanship and chieftainship. Although these clusters have no fixed boundaries nor *ascriptive* recruitment – *i.e.* by birth – of members (*i.e.*

clans: his father's and his mother's. The paternal clan affiliation tends to be submerged, and a Nkoya usually identifies with his maternal clan. In the case of close kin relations, membership of the same clan is often regarded as prohibitive for marriage. Certain chiefly titles are owned by specific clans. Inter-clan joking often forms a starting point for individuals to engage in prolonged dyadic contracts. Today, the membership of the various Nkoya clans is scattered all over the Nkoya homeland and far beyond, sometimes all over South Central and Southern Africa. Before the expansion of political and economic scale, in Early Modern times (which radically altered chieftainship and boosted interregional relationships), Nkoya clans are claimed to have been much more localized, exclusively matrilineal, and with a clan chief (often female) discharging major ritual (*e.g.* rain-calling) and redistributive functions within the clan area. Nkoya clan names constitute an elaborate puzzle, which I have tried to describe and unravel in my book *Before the Presocratics* (2012) – highlighting the transcontinental, South and East Asian associations of the Nkoya clan system.

their shifting composition cannot be predicted just from a genealogy or a village map), they are not entirely *ad hoc* structures. In each cluster, one or two clans tend to prevail, and often a cluster is primarily (but never exclusively) associated with one particular village, also including those of its members who temporarily reside in town. Such a village may even loosely lend its name to the cluster. The definition of such clusters of temporarily solidary individuals is largely *situational* (van Velsen 1964, 1967), in that the present state of any one cluster's composition and internal structure can only be determined when, for one specific social event (particularly conflict), the cluster sets itself off against one or more rival clusters. In the next event, confronting some different cluster over some different problem, the cluster's composition may be different except for a small but firm core membership. In a way, the Nkoya social group dynamics resemble those of a *segmentary* society.

Much of the social process among the Nkoya revolves around the definition, mobilization and confrontation between such blurred, shifting and ephemeral clusters. It is them I have in mind when in the following account I shall speak of the protagonists' 'kin group'. Specifically, our protagonist Muchati's [7] kin group in so far as mobilized in Edward's case, focussed on Nyamayowe Village, which is located in the Mushindi Valley. The kin group of Mary [4], his wife, focuses on Jimbando Village, located in the Mema Valley within 100 m from Chief Kahare's capital. Over the road, the distance between Nyamayowe Village and Jimbando Village is about 8 kms.

Finally, the Nkoya have a richly developed ritual culture, much of which is reminiscent of that of the Ndembu, so eminently described and analysed by Victor Turner (1957, 1961, 1962, 1967a, 1967b, 1968). Most Nkoya rituals have strong medical connotations: they are meant to cure people from illnesses considered to be caused by ancestors, sorcery, the spirits of the wild, etc. Since the early twentieth century CE, *cults of affliction* have established themselves as the dominant ritual complex throughout Western Zambia, including the Nkoya area. The historical conditions under which this happened I have indicated elsewhere (van Binsbergen 1976a, 1977a). Building upon previous authors (foremost V.W. Turner and C.N.M. White, *cf.* White 1949), I have defined such cults of affliction as

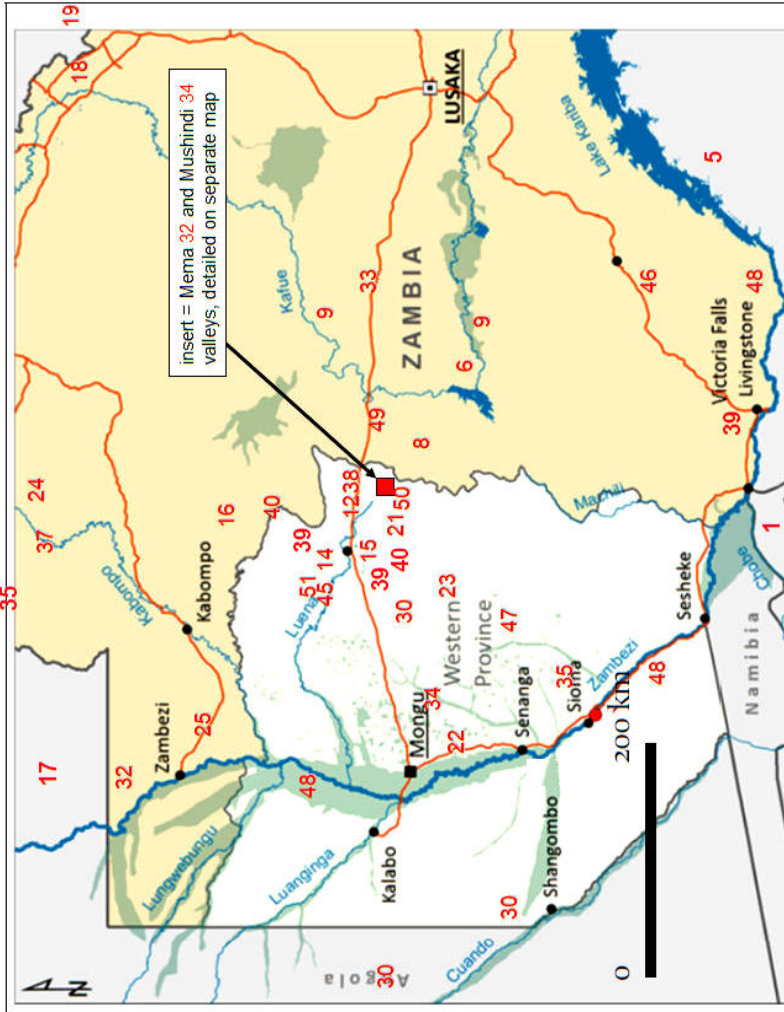
'characterised by two elements: (a) the cultural interpretation of misfortune (bodily disorders, bad luck) in terms of exceptionally strong domination by a specific non-human agent; (b) the attempt to remove the misfortune by having the afflicted join the cult venerating that specific agent. The major ritual forms of this class of cults consist of divinatory ritual in order to identify the agent, and initiation ritual through which the agent's domination of the afflicted is emphatically recognized before an audience. In the standard local interpretation, the invisible agent inflicts misfortune as a manifest sign of his hitherto hid-

den relationship with the afflicted. The purpose of the ritual is to acknowledge the agent's presence and to pay him formal respects (by such conventional means as drumming, singing, clapping of hands, offering of beer, beads, white cloth and money). After this, the misfortune is supposed to cease. The afflicted lives on as a member of that agent's specific cult; [s]he participates in cult sessions to reinforce good relations with the agent and to assist others, similarly afflicted, to be initiated into the same cult.' (van Binsbergen 1977a: 142)

This basic pattern is found in all the many individual cults of affliction of contemporary Western Zambia, including those featuring in the present argument. Most cults of affliction occurring in the Nkoya area have, moreover, in common that their adepts are organized in small factions headed by an accomplished cult leader. Ties of kinship and co-residence are used to reinforce the relationship between leader and adepts; and just like village headmen, cult leaders compete with one another for the allegiance of followers.

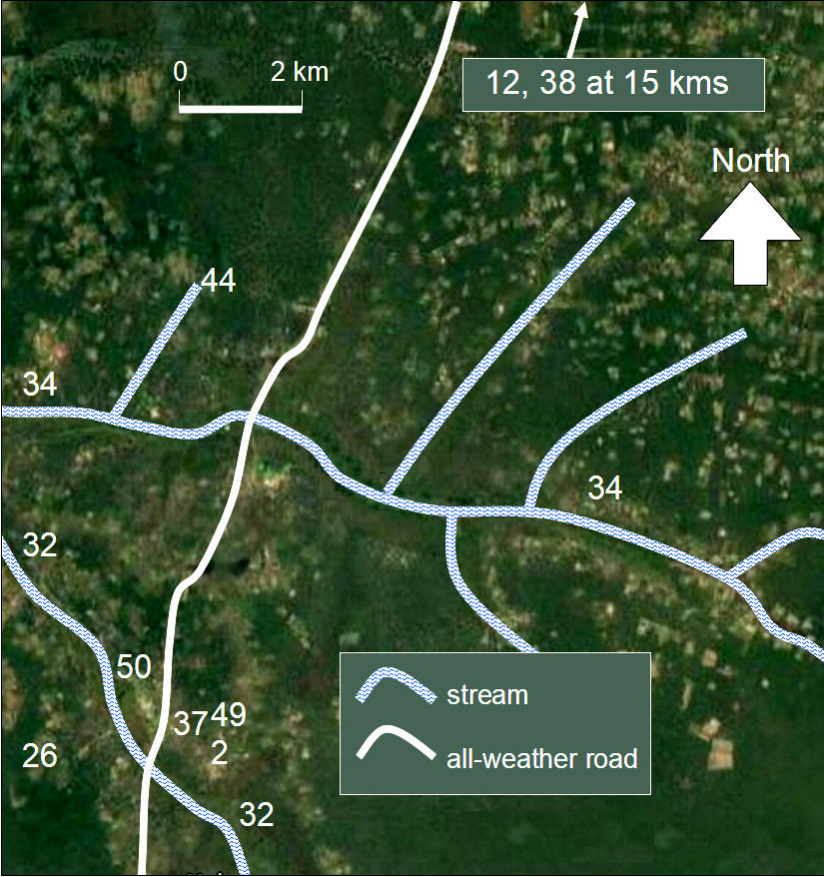
The expansion of these modern cults of afflictions seems to be not unrelated to the introduction of cosmopolitan medicine, at the periphery of Nkoya life. It is remarkable that whenever interlocutors remember these cults' original founder-prophets (*cf.* van Binsbergen 1977a: 155 *f.*), the latter are depicted as having tried, at some stage, cosmopolitan medicine before founding their own healing cult. Oral traditions concerning one such prophet, Shimbinga (not a pseudonym), invariably stress the lack of clinics and hospitals in the district in the 1930s, when severe human and cattle epidemics occurred, and when Shimbinga's cult was founded.

More historical research is needed on this point. But it can be safely stated that, from its first entrance in the Nkoya area, until the much later, fervent competition for the allocation of Rural Health Centres over the various administrative wards of the district (Kaoma Rural Council n.d.), cosmopolitan medicine has been recognized by the local people as highly valuable and desirable. Yet throughout this period it has been forcibly confronted by Nkoya medical alternatives. This book's argument tries to understand why this should be so.



- | | | | |
|--------------------|-------------------|--------------------------------|-------------------------|
| 1 Botswana | District | 24 Lunda | 39 Nkoya |
| 5 Zimbabwe | 16 Kasempa | 25 Luvale | 40 Nkoyaland |
| 6 Ila | 17 D. R. of Congo | 30 Mbwela, ≈ Nkoya | 45 Mangango Mission |
| 8 Kafue Park | 18 Kitwe | 32 North-Western Prov. | 46 Tonga |
| 9 Kafue River | 19 Lala | 33 Mumbwa | 47 Western Province |
| 12 Kalale Station | 21 Longwe Stream | 35 Ndembu Lunda | 48 Zambezi River |
| 14 Kaoma | 22 Lozi | 38 Nkeyema Agricultural Scheme | 50 insert, see next map |
| 15 Kaoma (Mankoya) | 23 Luampa Mission | | 51 Tetangimbu Village |

Fig. 3.1. Map of western Zambia, with localities mentioned in the text



map based on TMGoogle Earth, with thanks

- | | |
|---|---|
| <ul style="list-style-type: none"> 2 Chief Kahare capital, see Kahare 26 Mabombola Village 32 Mema Valley / stream 34 Mushindi Valley / stream 37 Mema Rural Health Centre | <ul style="list-style-type: none"> 44 Nyamayowe Village 49 Jimbando 50 primary school area, once self-help airstrip
anticipating on flying-doctors service |
|---|---|

Fig. 3.2. Map of the Mema and Mushindi Valleys, ca. 1973



- 1. Great East Road
- 2. Author's residence, 1971-1973
- 3. University of Zambia (UNZA)
- 4. Kalingalinga informal residential area
- 5. University Teaching Hospital
- 6. Chaisa informal residential area
- 7. Chelston
- 8. Matero
- 9. Mutendere
- 10. Mwaziona informal residential area
- 11. Munali
- 12. House of Chiefs (and National Assembly)
- 13. Institute for African Studies (former Rhodes-Livingstone Institute)
- 14. Roma residential

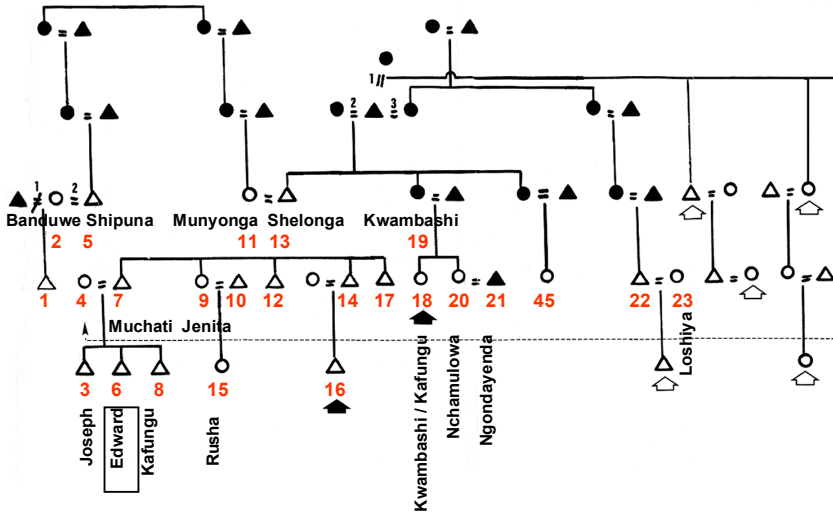
Fig. 3.3. Map of Lusaka ca. 1973, with localities mentioned in the text

CHAPTER 4. THE EXTENDED CASE

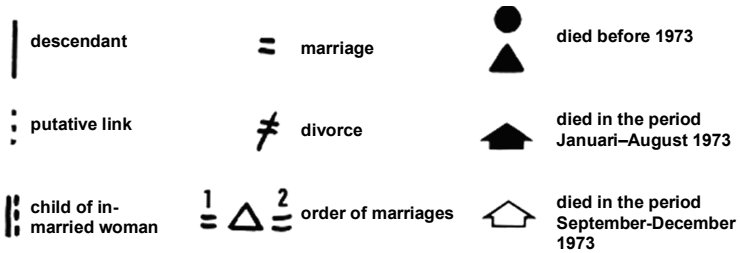
I shall present the facts of Edward's [6]⁵⁵ and his parents' health experiences in chronological order and with such relevant detail as my data allow. Only after this has been done, shall I, in the subsequent Chapters, interpret these facts in the light of the central questions posed in this argument. Fig. 4.1 presents a genealogy of the protagonists in this extended case.

Muchati [7], born in 1946, had left his father's village Nyamayowe in 1961. He had been called to Lusaka by his kinsman Shipuna [5]. The latter had promised to see Muchati through his primary-school education, which in the village had stranded due to lack of money for school fees and uniform. Muchati joined Shipuna's household, but not until almost a decade later (1969) did he find an opportunity to actually continue his education. Meanwhile, Shipuna's urban following waxed over the years, so that by the late 1960s he found himself the leader of a fenced ward in Lusaka's Kalingalinga squatter compound (not pseudonyms). The ward comprised six to eight households of kinsmen of Shipuna, including Muchati. By that time Muchati had found employment as a cleaner with a nearby educational institution. In his spare time he ran a small, informal bar. He had established a stable relationship with a non-Nkoya townswoman belonging to the Mambwe people in the extreme North-East of Zambia.

⁵⁵ Numbers within brackets [] that follow people's names (in fact, pseudonyms) in the text, correspond with the figures in Fig. 4.1. They are not to be confused with the raised footnote numbers, nor with four-digit numbers referring to years. While, in the best anthropological especially Manchester School tradition, proper names in this argument are pseudonyms; unless otherwise stated, the genealogical relations as shown are, to the best of my knowledge, correct. Given, however, the Nkoya's propensity to promiscuity and extramarital sexuality, only the more or less enduring, socially recognised liaisons have been marked.



legend:



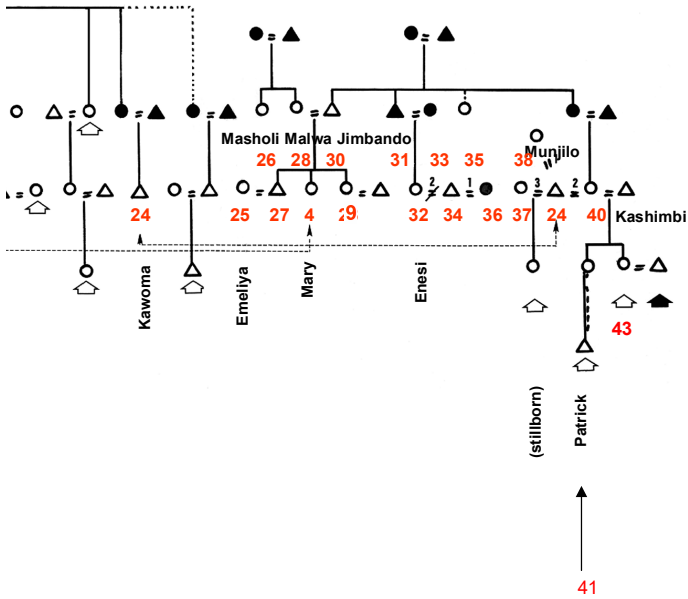


Fig. 4.1. Kin relations among the protagonists (as numbered []) in our extended case.

1969. Muchati's kinsmen in Nyamayowe Village pre-arranged a marriage for him with Mary [4], a moderately educated (grade 4) girl living in Jimbando Village. Under grave pressure from his father Shelonga [13], Muchati terminated his relationship with his urban concubine. Following his father to the village, he reluctantly married Mary there.

Muchati did not know that Mary was his classificatory sister (although too distant to show in Fig. 4.1), and therefore a more or less prohibited partner. Both Muchati's and Mary's parents, however, were aware of this fact. They did not consider it a real obstacle, as marriage prohibitions in similar cases are believed to be a recent innovation among the Nkoya. Muchati's parents themselves were similarly distant classificatory siblings, and their marriage had lasted for over thirty-five years already. Yet the sibling link between Muchati and Mary was kept a secret until after the wedding, mainly in order to deny Muchati a valid argument against marrying Mary.

There was yet another reason why, according to Nkoya standards, the marriage was somewhat unusual. Apart from a consanguineal relationship between Mary and Muchati (which referred to a common ancestor in the distant past), there was a marital link in actual existence between Nyamayowe and Jimbando Village. Kawoma [24], administrative headman of Nyamayowe Village, was married with Mary's cousin Kashimbi [40]. Besides being a headman, Kawoma was employed on Chief Kahare's royal establishment as retainer. He divided his life between Kahare's Village (where the household of his favourite and senior wife was located), and Nyamayowe, where his other two wives lived, including Kashimbi.

Nkoya consider it disadvantageous to contract, within one generation, more than one marriage with the same village. By entering into marital ties with as many villages as possible, the village members maximize the social field where new generations can find residential and economic support, and protection from sorcery. At the same time, avoidance of multiple marital ties with one village minimizes the probability of chain reactions in the deterioration of inter-village relationships, in the (only too likely) case that one of these marriages breaks down. Divorce is frequent in Nkoya society: most adults go through a series of multiple marriages, the average life span of a marriage was about 9 years, in the 1970s, and of all marriages, at least 2/3 ended not in death, but in divorce.

Thus the marriage of Muchati and Mary started out with a number of structural disadvantages. The spouses' personalities and their life spheres (town *versus* village) were not yet attuned to each other. Contrary to many contemporary Nkoya marriages, the affinal relationships surrounding this marriage lacked, even more than usual among the Nkoya, any clear-cut juxtaposition between the husband's

and the wife's immediate kin group. Having been recognized as distant classificatory siblings, both spouses in theory belonged to the far periphery of each other's kin group – and while this may initially have been regarded as a sign of positive integration, it deprived the parties in this marriage from the advantage of well-defined kinship positions from which future marital conflicts might be adequately dealt with in a judicial context.⁵⁶ Nyamayowe Village had already received a wife from Jimbando Village,⁵⁷ and the vicissitudes of this earlier marriage could have repercussions on Mary's and Muchati's own marriage. The accommodation of Mary's and Muchati's initially quite distinct personalities and interests, as well as the development of affinal tensions inherent in any Nkoya marriage but exacerbated by the excessive overlap in affinal relationships and by the multiple inter-village marriages, are to form major specific structural dimensions of Edward's case.

Just how exceptional was Muchati's and Mary's marriage, involving

- remote classificatory siblings and
- multiple inter-village links?

While normative pressures exist against both structural features, I estimate that either feature is present in roughly 10% of all marriages. In the Nkoya kinship system, affinal ties produce classificatory sibling relations in the next generations; therefore the two features do not occur independently, and the probability of their combined presence would be something between 1% and 10%. However, this relatively unusual marriage does by no means disqualify Edward's case as non-representative. Beneath the specific details, a more fundamental and universal principle can be detected: the extremely optional and shifting nature of group formation in Nkoya society, and hence the incessant competition for followers and associates, with both medico-religious and other means, inside and outside the medico-religious sphere.

Immediately after the wedding ceremony in the village, Muchati took Mary to Lusaka. As usual, only part of the agreed bride-price had been paid. The rest was to follow in instalments over the next few years. The couple settled in Shipuna's ward. Now that he was married, Muchati no longer depended on Shipuna's household for the preparation of his food and for other domestic

⁵⁶ For Central African societies, the structural principle involved here was most explicitly argued by Marwick (1965: 199 *f.*).

⁵⁷ On the dynamics of Nkoya *connubia* (enduring, repetitive marital relationships between specific kin groups, villages, or clans), also *cf.* my study of Mabombola Village (van Binsbergen 2014b).

services. He had passed out of the immediate domestic control of Shipuna and the latter's wife Banduwe [2], and no longer submitted to them a considerable portion of his income. Banduwe greatly resented these developments. Soon after the wedding she started a gossip campaign in order to affect Muchati's relations with his in-laws. She alleged that Muchati did not feed Mary well, did not give her proper clothes etc. Alarmed, Mary's mother Malwa [28] came to Lusaka to inspect the situation. She found that the accusations were quite unfounded. Meanwhile Muchati lost his job as a cleaner – a normal occurrence in the Lusaka formal job market at the time, where competition was very high and ethnic patronage (a scarce commodity for Nkoya urban immigrants) the standard condition to get and keep a job.

August 1970. While Muchati was unemployed, their first son Joseph [3] was born without any complications. He grew up without serious health problems.

November 1970. In Kalingalinga, Mary participated for the first time in a nocturnal session of the *Bituma* cult of affliction. She had never been diagnosed as suffering from this particular affliction, but when she heard the drums play she could not control herself and started to dance. As she did not remove her clothes from the upper part of the body (as is obligatory in this and many similar cults, and in funerals – as a sign of respect and of identification, a woman is to meet the sacred with bare breasts; cf. van Binsbergen 2022: section 3.2.1), the cult leader Jilemba accused her of sacrilege and fined her K1. Hoping to incorporate Mary in her cult faction, Jilemba continued for years to harass Mary and Muchati about this offence.

December 1970. Muchati found work again as a domestic servant with an expatriate member of the academic profession.

November 1971. Muchati entered our family's employment: originally as a domestic servant, but soon devoting an increasing portion of his time to research assistance among the urban Nkoya. With his family, he moved to our premises. Thus a period started of 2 years of very intimate day-to-day interaction.

December 1971-January 1972. For several weeks Mary had complained of vague, diffuse ailments.⁵⁸ Finally she proclaimed that she wanted to travel to the

⁵⁸ On re-reading, it occurs to me that at this time, as in March 1973, Mary's moodiness may partly have been due to her being in the early stages of pregnancy. However, at both times her husband and her wider social environment appeared as yet ignorant of her condition, unable to make allowance for it. And whereas in strictly perinatal conditions both mother and infant are treated with circumspection among the Nkoya, I do not think this is also the case for early pregnancy.

village in order to submit to treatment within a cult of affliction. Muchati could not detain her for the reasons to be given below, and she took Joseph with her. Relational problems partly explained Mary's departure. She had been increasingly unhappy in town. She missed her village friends as well as the rural economic tasks in which she has been brought up and which she had learned to regard as inherently meaningful. She found it hard to accept and enjoy her uxorial role in the urban environment, largely because in town her economic power was very limited. The family lived on the husband's income. Mary did not find satisfaction in her very limited domestic chores. She declined any suggestion made by her husband that she could try to engage in some useful activity outside the house (marketeering, making a garden). Frequently she would drive Muchati to exasperation with her sulkiness and her taste for relatively very expensive clothes.

The cults of affliction stipulate actions that the (almost exclusively female) adepts must undertake for the sake of their physical and spiritual well-being. Usually these actions run counter to the short-term interest of their husbands or male relatives. Cult obligations comprise expensive nocturnal sessions, exceptional and luxury foods and clothing, and inconvenient absences from the family home. The expenses of all this are to be borne by men. While the men resent these cultic actions they tend to take the idiom of the cults of affliction as seriously as their wives do, and seldom oppose them. Therefore the women can manipulate their cultic claims as an expression of domestic conflict. Thus the cultic idiom provided a context in which Mary could temporarily retreat to the village without any overt display of marital conflict. Another reason why Muchati was unable to hold her back, was that he still owed her kin group the final instalment of the bride-price.

In Jimbando Village, Mary participated in a session of the *Bituma* cult of affliction, directed by her mother's sister, Masholi [26]. After a month, Muchati went to collect her and paid the outstanding amount of the bride-price.

Early 1972. In Chief Kahare's area Muchati's cousin Kwambashi [18] died. She was one of the leaders of the *Bituma* cult of affliction. Kwambashi's sister Nchamulowa [20], a widow of the cult's founder Shimbinga [21], still fostered the latter's sacred possessions and now intended to succeed to the name of Kwambashi. Thus she hoped to effectuate her latent leadership claims in the cult.

May 1972. Mary participated in a *Bituma* session in Matero suburb, Lusaka, led by her original cult leader, Jilemba. About this time, Mary's second pregnancy became manifest. On instigation of Muchati, she once or twice visited an ante-

natal clinic in Lusaka. These visits were frowned upon by the elderly Nkoya women in Lusaka.

August-September 1972. Two nocturnal mourning rituals were held among the Nkoya in Lusaka: one for a recently deceased Nkoya townsman of Shipuna's ward, another for Muchati's brother's child [16] who had died in the village. Being highly pregnant, it was taboo for Mary to attend. Pregnant women, unborn or small children, and chiefs are not to enter into the sphere of death. However, Muchati found herbal medicine for her that was supposed to lift the taboo and protect her, so she could go mourning.

13 September 1972. Mary's labour had begun in the afternoon, and Muchati went on a quest for herbal medicine which allegedly would ensure a speedy delivery. He sent his younger brother to the Kalingalinga ward, in order to fetch a midwife and her assistants from among his Nkoya relatives there. Soon four women arrived, including Banduwe [2] who was to play the role of principal midwife. My wife and I advocated that the delivery should take place in the University Teaching Hospital, and offered to take Mary there, but the women insisted that they would rather first try for themselves, at home. However, the midwife and her assistants appeared to become unnerved by Muchati's lack of faith in them. He repeatedly pointed out the availability of two allegedly superior alternatives: the hospital, which our car could reach within ten minutes; or, in our main building, my wife, who was however far from eager to interfere and who had, apart from her own delivery of Nezmja, never assisted in childbirth. During the delivery, the women in attendance kept Muchati out of doors – as is the rule in many cultures including that of the Nkoya. Repeatedly he came to request our urgent advice in matters which these women must often have carried out with perfect confidence when on their own, *e.g.* the tying and cutting of the umbilical cord. Finally, around nine o'clock in the evening, an alarmed Muchati urged us to take full control: the child had been born, but the placenta had failed to be produced. Although the women greatly resented Muchati's interference, we were finally allowed to take Mary (still attached to her new baby through the unborn placenta) to the University Teaching Hospital, where she was admitted; here the placenta was born and the umbilical cord severed. She was discharged again early in the morning, *i.e.* nine hours later, without any follow-up appointment; with her newborn baby tied on her back, she walked the entire distance from the hospital back home, well over 5 kms.

Recent newspaper reports had brought out the shortage of school places in Zambia, and the preference given, in the matter of registration of pupils, to children who could produce a birth certificate. Therefore Muchati decided to

formally register the new baby (something he had not done in the case of his first child). Forced to publicly name the newborn child at a moment that this is still premature according to Nkoya custom, Muchati haphazardly gave him the name of Jimbando, the baby's maternal grandfather [30]. 'Mary's family will like that name,' Muchati said. Little could he know what haunting role the child's name, and the attendant affinal relationship, were yet to play. For domestic use, Muchati decided on the name of Edward [6].

After a few days, a Nkoya man was called in from Kalingalinga to ritually cleanse the conjugal bed and to provide birth amulets. This action was meant to terminate the puerperal avoidance between father and child. It was all post-natal care the child received. Despite hospital delivery, the parents refrained from visiting the hospital or, much nearer to their place of residence, the under-five clinic. Elderly women in town, including Banduwe [2], insisted that such visits would be to the child's disadvantage, particularly if taking place before he was three months old. These were the same women, among others, who had assisted in Mary's confinement. We got the impression that, feeling slighted about their failure or humiliation then, they now aimed to assert their medical authority over Mary and her newborn child.

18 October 1972. Edward developed an alarming lump on his head. Although Muchati urged Mary to take the child to the under-five clinic, she was reluctant in view of the elderly women's attitude. Muchati was at a loss: he felt he could not force her to go.

20 October 1972. When in addition to the lump on his head, Edward ran a fever, Mary went to the clinic out of her own will. Edward was referred to the University Teaching Hospital. The doctor there urged her to admit that she had dropped the child on the ground, but this she denied strongly. (A Nkoya mother whose infant incurs serious harm is liable to physical punishment by the child's kin group and by the elders in general. People therefore agreed that Mary could not afford to speak the truth, even if in fact she had dropped Edward.) Edward was admitted to hospital on a diagnosis of pneumonia, possibly related to Mary's habit of bathing the baby out-of-doors in cold water. In addition, the baby was said to have developed 'brain trouble'. Edward was too weak to suck, and was therefore tube-fed. In accordance with general Zambian practice in the case of hospitalized children (*cf.* Boswell 1965), Mary stayed at the hospital premises, in the relatives' shelter, where she was daily visited by Muchati. The frustration of having to spend two weeks without any meaningful activity, in the company of equally displaced and frustrated women whom she had not known before and with most of whom she did not share a common regional, ethnic or linguistic background, in a cramped and

ill-accommodated shelter, added to Mary's worry over the baby and made this a very unhappy episode for her.

The hospital staff did not give the slightest attention to the continuation of Mary's lactation. In combination with her concern over Edward, and the frustrating experience at the relatives' shelter, this resulted in Mary being unable to breast-feed Edward any more, when after two weeks he was discharged. Raised in a culture where breast-feeding is very strongly emphasized as a mother's main link with her child,⁵⁹ the impairment of this function was a very heavy blow for Mary, and a cause of intense feelings of guilt. Mary and Edward were dismissed without anyone on the hospital staff noticing the problem or trying to do anything about it. Alarmed, Muchati and I referred to the hospital. We were anxious to have Mary's lactation function restored. Although bottle-feeding would not be impossible, it would mean an enormous burden in terms of hygiene, expense and maternal role patterns (*cf.* Raphael 1976). At the hospital a doctor told us, rightly, that nothing specific could be done to restore lactation. We were advised to try a protein-rich diet for Mary, as this might have some success. Upon our request we were told that there was no powdered milk available for free distribution to out-patients: neither did we get the feeding schedule we asked for.

With his nearly-completed primary school education (recently, through evening classes, he had reached grade 6), and his extensive experience with expatriates' infants including our own daughter, Muchati was convinced of the necessity of sterilization of feeding-bottles etc., and he conveyed this insight to Mary. With all our modern comforts at her disposal (piped water, kitchen dresser, refrigerator, electrical stove, sterilizing tablets, brushes, several glass feeding bottles, teats, containers etc.), and determined to see her child through, Mary quickly absorbed and accurately performed all the necessary routines. Initially she feared making a fatal mistake in these rather complex operations whose rationale she did not understand in detail. Also was she embarrassed about her nurturative inadequacy and her dependence on members of the opposite gender, and on White foreigners, to rectify this condition. But all this gradually gave way to relief and to a measure of pride. In conversations with friends and relatives Mary would often tell how her lactation function had become impaired and how she could yet manage to feed her child. Yet her dealings with Edward seemed somewhat mechanical, formal, and lacked the spontaneous generosity so typical of South Central African patterns of breast-feeding. An important factor in this was no doubt the fact that

⁵⁹ *Cf.* Turner 1976c: 19*f.* on the culturally closely related Ndembu Lunda.

Mary's bottle-feeding forced her, several times a day, to work in the kitchen of the main house. Here she was doubly an intruder: both *vis-à-vis* us, who lived there, and *vis-à-vis* her husband, whose professional domain it was. In relation with Muchati, Mary's presence may have brought to the fore a typical domestic servants' role conflict: that between being a wife's husband, and doing low-status work of a type commonly reserved for women (*cf.* Tranberg Hansen 1977; Glazer Schuster 1979; Siame et al. 1998; Mulikita & Siame 2005). Inevitably, Mary's preparation of the bottles would often happen to take place under our joint scrutiny, and would very infrequently give rise to such petty friction as may be inevitable in a confined space where so many parental, domestic and employment roles of two families intersect so confusingly. On a deeper psychological level it might have appeared as if Mary was subconsciously reproaching Edward for causing her to fail in her nurturative duties. The lessened affection to which this condition may have led, seems also detectable in Mary's later behaviour towards him, which directly relates to the series of health crises he was to go through.

Edward responded well to be bottle-feeding, and became quite healthy again. Meanwhile, we did put Mary on a protein-rich diet, but (apart from an occasional few drops of milk, which Mary would insist on offering her child) with no other effect than greatly improving her general condition. For the latter reason we yet continued the diet until Edward was about one year old. The costs of this diet and of Edward's powdered milk amounted to over 20% of Muchati's wages, which was much more than he could afford. Therefore we subsidized about 80% of the extra amount needed.

December 1972. Muchati's mother, Munyonga [11], another leader of the *Bituma* cult of affliction, visited Lusaka to look into the marital and religious problems of her daughter Jenita [9], Muchati's full sister. Munyonga staged a *Bituma* session in Kalingalinga, in which Mary, Edward and Jenita were the main patients. We were not surprised to see Jenita feature as a patient. Jenita lived in Chaisa squatter compound, where she and her infant daughter Rusha [15] were extremely poorly provided for by Jenita's husband [10]: a shop assistant in a butchery, he would squander his relatively considerable income on beer and girl-friends. Not only had this state of affairs noticeably affected Jenita's and Rusha's health. Also had the husband (quite exceptionally) refused to pay the fees for the cult leader Kashikashika, to whose treatment Jenita had subsequently subjected herself and Rusha. A conflict with this cult leader had ensued, and Jenita feared that Kashikashika would punish her by making her illness come back.

Treatment by her own mother, Munyonga [11], would greatly reduce that risk,

at the lowest possible costs (for no fee would be required). At the same time it would mean that Jenita would leave the cultic faction of Kashikashika, and join that of Munyonga.

It was however somewhat unexpected to see Mary and Edward appear as the other two major patients of the session. Since Edward was born, Mary had no longer complained of the sort of symptoms that had worried her when she joined in the earlier cult sessions. Her increased domestic tasks as a mother of two, and her much better diet, may have had much to do with this. However, within the idiom of the cults of affliction she, as an adept, was still to be considered a patient. Initiated by her mother's sister [26] in the village, Mary was still a potential member of that leader's cult faction. Moreover, there was still a lingering claim on Mary from the side of the leader of her very first session, Jilemba. Munyonga resented Jilemba's insistence, not only because Mary was Munyonga's daughter-in-law but also because it had been Munyonga who installed Jilemba as a *Bituma* cult leader. Jilemba should yield to Munyonga when told to do so. The fact that Mary now joined in the session staged by Munyonga meant that Mary, too, denounced the claims that her previous cult leaders, Masholi and Jilemba, might have over her, and that she joined Munyonga's cult faction.

On the extra-religious plane this move is another manifestation of a process that runs as a red thread through this extended case: Mary's gradual dissociation from her kin group of orientation, and her increasing incorporation into her husband's effective kin group.

Finally Edward's parents justified his inclusion in the ritual by saying that this initial illness and hospitalization demonstrated his alleged proneness to illness. Among the Nkoya, such proneness is considered the main sign that one is predestined for a leading career within the cults of affliction. Although Edward's health was now satisfactory, an occasional cold and slight cough were stressed as demonstrations that all was not well yet.

Meanwhile, Muchati and Mary had again taken up sexual relations. Mary's ovulation had resumed and, without having menstruated after Edward's birth,⁶⁰ she conceived again.

⁶⁰ Nkoya consider this a very serious negative condition. Menstruation is supposed to cleanse the prospective mother's womb from the pernicious influence of the anti-social blood demon, Kanga (hence the girl novice after menarche is called *ka'Nkanga*, 'Kanga person'). Failure of pre-pregnancy menstruation is one of the principal reasons for a newborn Nkoya baby to be considered an anti-social freak supposed to be killed in the interest of the community. Cutting the

March 1973. Mary claimed that she should go to the village in order to assist her sickly parents, and moreover to seek treatment for her own affliction and that of Edward. Mary's sulkiness had come back, and she was very angry with Muchati for not letting her go immediately. However, an additional reason for going presented itself. Muchati's kin group began to suspect that Edward's initial illness and minor later complaints all referred to his deceased aunt Kwambashi [19]. An ancestral ritual at the village shrine of Nyamayowe Village might need to be performed, in order to confer Kwambashi's name upon Edward.

When told about this, we pointed out that Mary would not be able to keep up her exemplary standard of hygiene and bottle-feeding when on the road or in the village, where there were no modern comforts whatsoever. But this did not deter Mary.

With a supply of powdered milk and sterilizing tablets she set out for Chief Kahare's area. In the village it was publicly ascertained that she was pregnant again. Menstruating women must not cook or handle fire: so a woman of childbearing age who continues to perform her domestic work for over four weeks must be pregnant, and she will be questioned about this by the other women in the village. During this visit, Mary participated again in a *Bituma* session stage by her mother-in-law, Munyonga [11]. No ancestral ritual was performed for Edward, however. Edward's paternal grandfather, Shelonga [13], had formally welcomed Edward at the village shrine, calling him by the name of Kwambashi [18, 19]. But for a proper name-inheriting ritual Kwambashi's only surviving sister, Nchamulowa [20], should have been present. Shelonga had written to her in Lusaka, but she had not replied, as she was still hoping to inherit the name herself.

April 1973. Banduwe [2] went to the village in connection with the prospective marriage between her son [1] and Mary's aunt [35] in Jimbando's Village. Muchati, who was anxious for Mary's return, gave Banduwe money towards Mary's return journey to Lusaka. Although Banduwe's son was from a previous marriage of hers and thus no consanguineal relative of Shipuna [5], as a long-standing member of Shipuna's ward in Lusaka he was yet considered a member of the Nyamayowe kin group when interacting with Jimbando's kin group. Therefore Shelonga [13] accompanied Banduwe to Jimbando Village for the marriage negotiations. However, Jimbando rather unexpectedly began to abuse Banduwe and the whole kin group she represented, claiming that "These people do

upper incisors prior to the lower ones is another such reason. One would expect to see the shadow of the ominous menstrual condition hanging over Mary's next child after Edward, but in fact the expected misfortune came in a different form.

not care properly for the women they marry.’ Not aware of any recent friction, the Nyamayowe delegation tried in vain to pacify Jimbando. Only afterwards it became clear that Jimbando’s anger had little to do with the Nyamayowe kin group’s treatment of the women from Jimbando’s Village but... with the fact that some time before I, personally, had refused to take Jimbando to Lusaka for eye treatment! By that time we had still been strangers to the rural scene, unwilling to commit ourselves to one particular family by bestowing relatively big favours upon them; Muchati, Jimbando’s son-in-law, did not insist at all when we considered turning the request down, and we understood that he was not eager to have his sick father-in-law stay in Lusaka, where he would have to look after him. From Jimbando’s reaction it would appear that (much to our professional satisfaction) he already considered us as members of Muchati’s kin group, at least in so far as confronting his own kin group. Much as we loved Mary and her children (our daughter Nezyma grew up with the latter and it was their language she spoke first), even after we had moved to Nkoyaland and had Jimbando as one of our nearest neighbours, relations never grew to be warm and trusting. Anyway, the marriage negotiations had failed, and Shelonga and Banduwe returned to Nyamayowe Village.

Mary had not approved of her father’s attitude, and very soon after this episode she returned to Lusaka. She brought back a thoroughly weak and emaciated Edward. However, the bottle-feeding routine was resumed in the proper manner, and rapidly Edward got well again. Meanwhile, also in Lusaka, Muchati’s cousin Nchamulowa [20] had found a job as a cleaner. In order to have a free hand she sent her children to relatives in a peri-urban area. She claimed to have taken the job in order to save money for the massive and expensive name-inheriting ritual in which she hoped to take Kwambashi’s [19] name. In anticipation, she persuaded my wife Henny (who had a sewing machine and knew how to use it) to make a splendid white robe for her, to wear during the ceremony.

May 1973. Mary’s mother, Malwa [28], visited Lusaka, mainly in connection with the marital problems of another daughter of hers [29]. Malwa refused to visit with Muchati and Mary. They went to see her at Mary’s sister’s place. There Malwa treated them very coolly. Obviously the relation between Malwa and Mary was still very strained, as a result of the recent events in Jimbando’s Village.

Edward had by now recovered from his stay in the village, but whereas he was physically fit, his motoric development seemed somewhat behind. Edward’s relatives suspected that he was suffering from *shikoba*, the result of a presumed mystical competition between a young child and his next sibling who is still in their mother’s womb; the younger child is supposed to launch murderous attacks upon his elder sibling. (Physiologically, this idea of competition

may be based on the fact that a woman's body does not easily combine the tasks of breast-feeding an older child and building up a new child in the course of pregnancy; but this does not strictly apply here since Mary was not breast-feeding Edward.) On a less mystical plane, the fact that Edward would not walk by the time his next sibling would be born, distressed the elders; still referring to the none too distant past when slave-raiding was common and people had to be able to hide in the forest at very short notice, Nkoya consider having two children who both cannot walk yet, an impossible, dangerous burden for a mother.

In this period, fears of the deceased Kwambashi [19] became increasingly pronounced. There was the idea that Edward, under attack from his unborn sibling and his deceased aunt Kwambashi, would have little chance of surviving anyway. Moreover the restricted, formalized way of feeding Edward which was so alien to Mary's socialization into motherhood, continued to estrange her from her child. In combination, these factors made that Edward's mother was still markedly apathetic and unstimulating in dealing with him, and while he received all necessary material care, the relation between mother and child seemed too deficient for proper development.

Meanwhile we had made two short research trips from Lusaka to Chief Kahare's area. We prepared to move the site of the research to this area. We discussed whether Mary and her children should accompany us, or should stay in Lusaka. Now another fear of Mary manifested itself. She had not menstruated after the birth of Edward and before the new pregnancy. Therefore the new child would be surrounded with all the gruesome properties which the Nkoya (and very many other peoples, in South Central Africa and worldwide) attribute to menstrual secretion. Allegedly, Mary would not be allowed to stay in the village for her confinement, but instead would have to give birth alone in a hut in the forest.⁶¹ This prospect was most terrifying her. (Fortu-

⁶¹ By common Nkoya belief, the village should not be contaminated with tabooed situations and substances. Traditionally, menstruating women retired to a hut in the forest, which is also the ideal place for the elaborate teaching of the *ka'nkanga*, i.e. a pubescent girl immediately after *menarche*. Three decades back, Mary's mother-in-law had to stay in a similar hut in the forest when, newly called to the status of traditional healer, she had spent some days in confusion in the forest and had emerged from there carrying all sorts of common plants which were *not* recognised as medicinal in the standard Nkoya pharmacopea (cf. Symon 1959). And in the late 1980s, Mary's brother-in-law Dickson [12] who in the course of a hunting accident had to fight an attacking lioness and managed to strangle it with his bare hands (!), had to stay in a similar hut for months until his wounds (infested by the accumulated rotten meat in the predator's mouth) had healed. In fact, in South Central Africa (cf.

nately the issue was never raised again; when her time came, she was simply confined in her parent's village.)

July 1973. Munyonga [11] visited Lusaka again. She had been feeling very ill, and this time she came not only as a healer but also in order to seek treatment herself, in the context of cults of affliction similar to *Bituma*. In addition, and despite Munyonga's very strong opposition (which persisted right into the doctor's consultation room), Muchati [7] and Shipuna [5], with our help, took her also to the main urban hospital and to a private physician. Munyonga sought treatment in town because she found the village an unsuitable place for staging the cult session deemed necessary for her recovery. All her surviving children resided in town (except the youngest [17], a mere schoolboy). Moreover her husband, Shelonga, belonged to the recently-emerged syncretistically-Christian Moya cult of affliction (cf. van Binsbergen 1981: *passim*) which was opposed to all medicines, including those featuring in the cults of affliction. Although the two roles of patient and healer merge, and imply each other in the cult of affliction idiom, Munyonga perceived herself primarily as an exceptionally gifted healer, much more than as a patient. Therefore, while seeking treatment from other healers, she felt she had to make up for this painful loss of status (and money!) by organizing a series of extremely successful and massive *Bituma* sessions in Kalingalinga. At these sessions Mary and Jenita [9], among others, appeared again as major patients / adepts. Thus Munyonga tried to strengthen the urban ritual faction she had begun to develop in December, 1972.

Meanwhile it became known that Kwambashi's relatives (by and large Muchati's kin group) had formally decided that Nchamulowa [20] was not to succeed to Kwambashi's name. They pointed out that, with other relatives surviving, it would be a shame if someone were to succeed his or her full sibling – as if left alone in the world. But obviously more was involved, for succession of full siblings is by no means exceptional among the Nkoya. Probably the kin group resented Nchamulowa's independent character and her successful adaptation, as a woman, to urban conditions – having a job where many mature Nkoya men had failed to secure one. This social and financial independence, moreover, largely enabled her to escape from control by her kin group. Yet, without the kin group's consent and ritual cooperation, Nchamulowa was

Marks 1976) any hunter after killing big game is in a tabooed state and (not unlike murderers among the Nuer of South Sudan, or among the Ancient Greeks (cf. Apollodorus / Frazer 1970 / 1921), whom state-of-the art genetics research has demonstrated to have a sub-Saharan background, cf. Arnaiz-Villena *et al.* 2001) first has to be cleansed from inter-species murder before he is admissible to the village again.

absolutely unable to succeed to her sister's name.

August 1973. We gave up our urban residence and in several trips moved our two households to Chief Kahare's area. In the evening, when we reached Chief Kahare's Village after the last trip, Mary's niece [43] died in nearby Jimbando Village. She was a daughter of Kashimbi [40], who in a later marriage had become the wife of the headman of Nyamayowe Village [24]. Her death appeared to be due to extreme dehydration resulting from untreated gastro-enteritis. A young widow, she had only a few days previously settled in Jimbando's Village, having moved from the distant village where her husband [44] had recently died under similar conditions. Malwa [28] and Jimbando [30] had hoped that Muchati and Mary would settle in their village for the duration of the research. But now this was out of the question. In view of this ominous death and the lingering conflict with her parents, Mary absolutely refused to live in Jimbando Village. In Chief Kahare Village (or rather Munethi Village which belonged to the same residential cluster), at barely hundred meters distance, we had to arrange accommodation for Muchati and Mary, next to our own house. Joseph [3] was sent to his paternal grandmother Munyonga in the Mushindi Valley, while Edward [6] for the time being stayed with his parents. Some weeks before, he had been weaned. Therefore his feeding was not likely to cause particular problems in the village, despite the absence of modern comforts.

From our new rural base the research continued as before.

19 September 1973. Mary's labour began in the morning. Muchati went to inform Malwa and Munyonga, who were working in the riverside gardens at considerable distance. The confinement was kept a secret from women in the surrounding villages, for fear of sorcery attacks on the mother or the child.

Malwa, Mary's mother, acted as midwife. Rather against her will, Mary had been taken into her parent's house, where until now she had refused to stay. Munyonga arrived only after Mary had given birth. That was however several hours later, as Mary's labour was to be very protracted. A trusted kinswoman living in a nearby village had given her herbal medicine to speed up the delivery, but without success. Also Muchati's own medicine, allegedly successful when Edward was born, failed this time. Labour took exceptionally long, probably partly as a result of the baby being oversize due to Mary's exceptionally good diet during pregnancy. The relatives began to suspect, first adultery on Mary's part, then (upon her vehement denial while at the paroxysms of labour) a supernatural influence. Mary's sister-in-law, Emeliya [25], married with Mary's brother [27], was asked to divine. Divination took place in the same room where Mary was lying. Emeliya used the friction oracle, by the

standard method of the axe handle.⁶² moving an axe handle to and from on the ground, names are recited of people who may be responsible for the evil influence, and when the correct name is found, the movements of the handle are supposed to halt. Being a member of the family, Emeliya knew all the relevant names. She first recited those of the living, then those of the dead. Kwambashi was found to be responsible. Next the diviner found that Kwambashi [19], though very irate, was prepared to be approached by Muchati [7], for whom she had had a special liking during her life.

Muchati was called and was told to enter the delivery room (which under normal

⁶² Such an axe-handle oracle was also described by Brelsford 1935 for the Sala of Central Zambia. Although now largely separated from the Nkoya by the Ila and Lumbu / Luba groups occupying Namwala and Mumbwa district, the Sala are culturally rather continuous with the Nkoya – as the Nkoya are with the Lenje and the Soli. See the official ‘Tribal and Linguistic Map’ of Fig. 9.16, below. In the 19th c. CE, Nkoya rulers used to maintain diplomatic relationships with the latter groups. Nkoya urban migrants in Lusaka are still very conscious of these links – it is in peri-urban villages of these groups that they prefer to find traditional leaders and diviners close to the city, and makers of musical instruments (xylophones, drums); such instruments may also be borrowed there for Nkoya urban ceremonies.

Meanwhile, the axe-handle oracle is a special form of the *friction oracle*, which is found all over Africa (cf. van Binsbergen 2005b / 2013 for pictures of examples, from the Songye and Kuba of Congo), and in which the postulated invisible forces are supposed to manifest themselves by selectively and perceptively influencing the friction between material surfaces. Friction is a relatively simple, macroscopic natural phenomenon, whose properties have been exhaustively described by secondary-school physics (Anonymous, ‘Friction’, provides a good summary), and are also commonly used in African everyday life, e.g. in the working of the string drum (a most archaic, drum-like musical instrument whose membrane is brought to vibration by pulling along the surface of a rough rope tied to the membrane; its sound is reminiscent of the equally archaic bullroarer, which is not used by the Nkoya), several other musical instruments, the control and release of an arrow on the bow, wielding a spear, tying and untying strings in building, hunting, articles of clothing, the cleaning of a skin, the debarking of wood, etc. etc. My first wife Henny van Rijn, a physicist by training and academic research, was particularly impressed by the keen physics awareness common Zambians showed especially in their approach to friction. For years she intended to do a study of physics concepts of Africans in everyday life, with as working title an explanation which Muchati (one of our protagonists, [7]) had given her about the use of natural wood for domestic purposes: being familiar with friction *‘They Take the Skin Out’* – debark the wood first in order to reduce its friction. Studies of non-cosmopolitan physics explored by accomplished physicists have been very rare (mathematics score better, e.g. the work of the Mozambican mathematician Gerdes, cf. 1981, 1986; of Jaulin’s formal analysis of the mathematics underlying African geomantic divination, 1957, 1966), and Henny’s study would have been a real eye-opener in the field (then only coming into fashion) of indigenous-knowledge systems – but, as these things go, it never materialised.

circumstances a man is never allowed to do). He performed the water ritual of ablution and libation without which the supernatural cannot be approached. Then he implored Kwambashi to take mercy upon her living relatives, and to release the baby. Mary heard her husband pray. Five minutes later the child Kafungu [8] was born.

When they tried to interpret the outcome of the divination, the members of Muchati's kin group arrived at the following view. Kwambashi [19] died between the time of Edward's conception and his birth. Thus Edward had acquired Kwambashi's 'shade' in the most direct way: 'from his father's hands into his mother's womb'. Kwambashi would be his name, no matter what other names might be given to him. This name of Kwambashi had still to be publicly conferred, and confirmed, in a naming ritual; however, that step had until then been postponed. Even had Kwambashi's relatives (except Shelonga [13]) failed to ceremonially welcome Edward as Kwambashi when he had visited their village recently. Kwambashi had sufficient reason to feel slighted, and tried to take revenge on the next baby.

Nkoya individuals have several names. The Kwambashi [18] who died in 1972 had inherited that name when her mother [19] died – her 'own' name had been Kafungu. The name of Kwambashi would be reserved for Edward [6]. Munyonga [11] however, the boy's grandmother, claimed, the day after Kafungu's birth, to have dreamed of a new name for Edward. She argued that the Kwambashi name did not seem to fit Edward. His illnesses and slightly delayed development were cited to substantiate this. She therefore proposed the name 'Heva' [Eve] she had heard in her dream – a (female!) Biblical name (*Genesis 3:20*) which (contrary to many other Biblical names) is hardly used among the Nkoya. Being an illiterate non-Christian, Munyonga may have picked up this name in her dealings with the syncretistic prophet Shimbinga [21], who was also her distant affine (HuSi-DaHu);⁶³ however, in Shimbinga's cult Buddhist elements were rather more conspicuous than Christian ones (van Binsbergen 2017: 394n).

Although Mary and Kafungu were by this time staying in Jimbando Village, Mary's parents had hardly any part in this discussion. Everything revolved around Muchati's kin group. Yet it was a diviner from Mary's kin group who had identified the influence of Kwambashi and thus, not surprisingly, had laid the 'blame' for the difficult delivery on Muchati's kin group.

Next morning, when Muchati, his father Shelonga, and a niece arrived to ceremonially thank their affines for the birth of the new child, relations. were

⁶³ Schematically, part of the relevant genealogy was given in my first paper on the *Bituma* cult (van Binsbergen 1972c: 15). Here Munyonga appears, without her name, in the left-hand side of the figure, as a first-generation *Bituma* leader living in Chief Kahare's area

markedly strained. Under the pretext that all work had been done within the family, and no costs had been incurred, Mary's mother refused to accept the ceremonial payment that the mother's family is to receive on such occasions. Muchati had no choice but to leave the money on the ground in the middle of Jimbando Village, for anyone to take it.

Many present were aware that a similar situation had occurred thirty-five years before, in Munyonga's [u] home village, when Shelonga had tried to pay bride-wealth for his wife. His prospective affines had then refused to accept the money, pointing out that Munyonga was his classificatory sister and could not be married to him; driven to exasperation, he had left the money on the ground, and left. It was an event that many may have recalled at the time when the first three male children of that contested marriage died in quick succession; at the time there were malicious rumours attributing these deaths to Munyonga's alleged ambitions of becoming a great healer – allegedly she had offered her first three sons to the spirits in exchange for therapeutic success. Whosoever knew her for the kind-hearted and morally impeccable woman (widely recognised as the ideal mentrix for pubescent girls's training for *kutembwisha kankanga*, the Nkoya female puberty rites)⁶⁴ would have dismissed such rumours off-hand. Munyonga (depicted in Fig. 9.4, below) was my adoptive mother, so my judgment may be somewhat blurred.

One implication of this refusal of ceremonial payments is the following. By offering money, Muchati and his kin group tried to offset themselves as a distinct social unit against Jimbando's kin group, in a bid to secure disproportionately greater rights over the newborn child. They had already made the proper payments in connection with the child's mother, Mary. The mother's group, on the other hand, in refusing the birth payment, declined such juxtaposition, claiming that in actual fact Muchati's kin group and their own kin group were one, and thus refused to accept the other kin group's exclusive rights over the newborn child.⁶⁵

As the tensions between these two kin groups became increasingly pronounced, Mary had several quarrels with her mother and prematurely left Jimbando Village to join Muchati in Chief Kahare's Village. So rushed was her

⁶⁴ I have written at length on the Female Puberty Rites which Nkoya cherish as one of their central institutions (van Binsbergen 1987c / 2003, 2011c), and I have recently situated them into a worldwide comparative and historical context (2022c).

⁶⁵ Obviously there is a contradiction, in Nkoya social organization, between bilateral descent and payment of bride-wealth, since the indeterminateness of the principle of descent applicable causes the two theoretically distinct categories of bride-givers and bride-takers to be blurred and overlapping.

departure that no medicine had yet been prepared to ritually cleanse Muchati's and Mary's conjugal bed – such as it was improvised at short notice in her dwelling adjacent to ours.

Since Mary could not mind two infants, Edward was sent to Munyonga in Nyamayowe Village, to join his brother Joseph. Under the circumstances it was unthinkable that he should be sent to his maternal grandmother Malwa, in nearby Jimbando Village. Mary stayed behind in Chief Kahare's Village with Kafungu, an adorably plump and healthy baby whom she had not the slightest difficulty to breast-feed. We got the strong impression that, indulging in the delights of this new and splendid baby, Mary tried to forget Edward and the troubles she had had with him.

With Edward's departure, and with Kafungu to replace him, a burden fell off Mary's mind and she entered a period of euphoria. A remarkable change came over her. In town we had always known her as shy and awkward, giving the impression of being lost and uprooted. However, having returned to the village we found that she commanded considerable prestige on the basis of her four years of urban experience. In Mary's case, her urban inclinations could be displayed all the more freely as she lived as a young matron in the village of the chief (her classificatory elder brother), under the relaxed control of her husband Muchati but (contrary to most young women) scarcely subjected to the direct control of her senior consanguineal or affinal kin. The greatest threat in this respect came from her parents in nearby Jimbando Village. But by refusing to reside with them, by quarrelling and ostentatiously siding with her husband's kin group against her father, Mary ensured that she retained her independence *vis-à-vis* her parents. In town Mary had always refused to engage in business, but now, in Chief Kahare's Village, she began to add to her household budget by selling beer and tobacco, attracting and entertaining male customers with her urban ways,⁶⁶ and (with the aid of

⁶⁶ The case appeals to me because both my grandmother by second marriage, my own mother's mother, and my mother's first mother-in-law, had owned and operated pubs; my mother had also received a pub as her wedding gift, but was soon found to be utterly unsuitable for that profession, and turned to the ready-made clothing industry, in which she pursued her own enterprise for 30 years. Mary's entrepreneurship in itself does not in the least imply sexual license and infidelity (even though before the HIV / AIDS pandemic which started in the early 1980s, the Nkoya were scarcely less promiscuous than their neighbours the Ila – cf. Smith & Dale 1920; Evans 1950 – with whom especially the Eastern, Mashasha, Nkoya have also many other traits in common). The socially permitted style of public social interaction between people of complementary genders among the Nkoya (and here they are fairly standard for South Central Africa as a whole) tends to enact the category of the *joking relationship*: frank, provoking, sexually explicit in words, even gestures (sometimes to the point of touching each other's genitals and pubic beads), as much as joyous and yet, essentially, chaste – a socially accepted mechanism to acknowledge but contain and neutralise, instead of enhance and act upon, sexual tension. This relaxed local perspective on sexuality as essentially contained and diffused, instead of pent up and exploding in 'boundary-

a portable grammophone) occasionally turning our corner of the village into a bar!

20 October 1973. Soon after our settling in Chief Kahare's Village the people's insistent demands for medical attention had forced us to establish an informal clinic, where we were seeing dozens of patients a day – with regular and detailed feedback and supply of patent medicines from the district's distant qualified doctors. So Mary called on us when she was worried over Kafungu's slight cough at night. Along with some of the more serious patients calling at our clinic, we took the child to the distant Rural Health Centre.⁶⁷ There we learned that the staff could do preciously little, as they had run out of all essential supplies. (That situation was not to be mended soon. A few weeks later, for a boy with a fractured thigh-bone, no plaster of Paris was available, and we had to drive the patient all the way to the district hospital, another 65 kms away).

23 October 1973. From Nyamayowe, Edward was brought to our informal clinic. His breathing at night was reported to be difficult and noisy; he was weak and apathetic, and had a slight *conjunctivitis*. After our earlier experience with the Rural Health Centre, we decided to apply our own patent medi-

transgressing behaviour', is so very different from the quasi-liberated, yet essentially sex-obsessed perspective on sexuality in Northwestern Europe around the year 2000 CE, that for today's Europeans it is very difficult to appreciate the Nkoya perspective without Eurocentric cultural bias. The very different approach to women's breasts especially when unclad is a related topic.'

⁶⁷ Table 4.1 gives the clinic's official returns for the 1972. The data were scrambled in the same way as those presented in Table 3.1. This leaves the order of magnitude of the figures intact. The original figures appear to be fairly reliable. The majority of the patients must have come from the immediate vicinity of the clinic, within a radius of a few kms. Participatory and quantitative evidence have convinced me that, at 20 to 30 kms distance, the population of the Mema and Mushindi Valleys contributed very little indeed to these figures.

A. number of beds	2
B. in-patient admission (persons)	23
C. total in-patient days	98
D. in-patient daily average (persons) ($D = C / 365$)	0.27
E. average stay in clinic (days) ($E = C / B$)	4.3
F. deaths	2
G. out-patient first attendances	6,801
H. out-patient total attendances	9,694
I. average attendances per out-patient ($I = H / G$)	1.4

Table 4.1. Official annual returns of the Rural Health Centre in Chief Kahare's area, 1972; source: Republic of Zambia 1976.

cines. We urged Edward's relatives to bring him along daily for eye treatment: we were so short of *Terramycin* antibiotic eye ointment that we could not afford to give each patient a personal tube to take home. However, we did not see Edward back before three days later, and again four days later.

Early November 1973. In Nyamayowe Village, Edward's health deteriorated steadily. As soon as Muchati had left to accompany us for a week's work in Lusaka, Edward was immediately declared critically ill by his kin group. Shelonga sent a letter to Muchati urging him to come back – through the usual, quick and efficient channel of cycling to Kalale Village at the main road to Lusaka (some 20 kms from Nyamayowe Village) and asking bus passengers stopping there to take a letter to a common relative or friend in Lusaka. From Nyamayowe Village the Rural Health Centre is also at a distance of c. 20 kms, *i.e.* two hours of cycling along the bush paths. And there were bicycles available in the village. Moreover, Muchati had left some money to cope with eventualities like this. Yet for two reasons Edward was not taken to the Centre. First, recent experience had shown that, however useful perhaps at other times, the absence of supplies made it now futile to go there. And secondly, after the events surrounding Kafungu's birth it was so overwhelmingly obvious to his kin group that the determinants of Edward's illness were not primarily somatic but supernatural, that it was considered a waste of precious time to refer to the outlets of cosmopolitan medicine. Instead, Edward's kin group decided to invoke the help of a Nkoya healer who happened to visit a neighbouring village. This healer lived far away and was, in Chief Kahare's area, primarily perceived as a member of Jimbando's [30] kin group. Muchati's kin group felt that this was advantageous as it meant that the responsibility for Edward's well-being in this critical situation was not exclusively carried by themselves but shared with Edward's maternal kin.

At the same time, in another village, a cousin [45] of Muchati's reported dreams in which she was harassed by Kwambashi crying 'My relatives do not respect me. Even if my name comes to Muchati's child they do not accept it.' Therefore, despite Nchamulowa's [20] absence, the Nkoya healer staged the long-awaited naming ritual for Edward. In addition he gave him herbal medicine to cure the concrete, somatic manifestations of the affliction. Mary came to attend the ritual. As the rains had started, she proceeded to make a garden on the land of Nyamayowe Village. Later she returned to Chief Kahare's Village, leaving Edward in the care of his grandmother, Munyonga [11]. By that time we had returned from Lusaka.

22 November 1973. From Nyamayowe, Edward was again brought to our informal clinic. He ran a slight fever, had diarrhoea, and showed initial signs of

dehydration. We sent him back to Nyamayowe, with a supply of powdered milk and with drugs to cure his suspected gastro-enteritis.

15 December 1973. Still in the care of his grandmother at Nyamayowe, Edward gradually developed unmistakable symptoms of malnutrition.⁶⁸ His worried relatives declared him ill once more, and had the illness diagnosed by a diviner. However, this time the diviner, Loshiya [23], through marriage and subsequent incorporation, belonged to their own kin group. She was the wife of Muchati's cousin [22]. The outcome of this divination carried out by Edward's paternal kin was strikingly different from the divination his maternal kin had carried out at Kafungu's birth. This time it was again a deceased relative who was declared responsible for Edward's illness, but now not a member of Edward's patrilineal kin, but of his matrilineal kin! Jimbando [30] was generally known to seriously neglect Enesi [32], the young daughter of his deceased brother [31]. Enesi had settled in Jimbando Village after a divorce, and there had been treated as mad and as an outcast.⁶⁹ None of her fellow-villagers had bothered to improve her

⁶⁸ Despite the generally unhealthy nature of Chief Kahare's area, malnutrition has been a rare occurrence there – the eminently skilful, frequent but responsible hunting by the Nkoya (since the creation of Kafue National Park, effectively since the 1950s, painfully redefined as 'poaching'), right up to the 1980s guaranteed a steady supply of valuable animal protein for the benefit of locals of both genders and all ages; moreover besides hunting the ancient 'gathering' component of the hunting-and-gathering mode of production had partly survived, and especially women were skilled in picking all sorts of valuable additional, seasonal food sources (berries, mushrooms, herbs) from the well-watered forests. From the 1980s on, regional strangers (mainly from warring Angola, and attracted by the lucrative Zambian market for dried bush meat) began to hunt with machine guns and upset the delicate ecological balance in the forest. The Kaoma local branch of the World Wildlife Fund, under the dynamic and resourceful leadership of my adoptive cousin the late lamented Dr Stanford Mayowe, has been trying to curb this development. Likewise, the establishment of the Nkeyema Agricultural Scheme (Hailu 1994; Nelson-Richards 1988), which rapidly grew into a considerable, ethnically and culturally heterogeneous rural town, negatively affected the forest ecology and brought both locals and regional strangers to appropriate considerable stretches of bush, and turn them into farms. In the 1970s, the very few cases of child malnutrition which I encountered among the Nkoya, all had in common that the affected child had been the victim of a *chance breakdown of its kinship network* – as a result of a series of recent deaths, other demographic vicissitudes such as the exceptional paucity of siblings, uncles and aunts in adjacent generations, outmigration of vital close kin to other rural areas or to town. Given the lack of children and therefore the eagerness of kin groups to extend their patronage over a child, in most cases such bad luck was accommodated within the wider kin network, but in very exceptional cases it was not. Soon, from the mid-1980s on, the HIV/AIDS pandemic would totally upset this time-honoured and effective system, and many more children would find themselves without resources essential for survival.

⁶⁹ This had nothing to do with her divorce as such. Chief Kahare's area abounded with young

ramshackle house of to build a kitchen for her. On a recent occasion the headman of a neighbouring village had been allowed to beat her after she had allegedly insulted him. (Instead of taking the law into his own hands, the headman should have sued Enesi before the Neighbourhood Court or the state's Local Court).⁷⁰ Now the diviner Loshiya alleged that Enesi's deceased mother [33] had

female divorcees. Enesi, however, made a nuisance of herself by defying male elders' control and engaging in verbal abuse – besides having spells of apathic pondering. Her condition was locally explained as follows. She had married her former husband [34] shortly after the latter had become a widower. However, upon his first wife's [36] death the latter's kin group had refused to ritually cleanse the widower, since they blamed him for her death. In the emic view, the husband's dangerous state of pollution was sexually transferred to his new wife, Enesi, upon their marriage. When Enesi's condition of (what was emically interpreted as) madness became manifest, her husband divorced her, and she settled in Jimbando Village. I did not get to know Enesi well and have no idea how cosmopolitan medicine would diagnose her condition; nor do I have the detailed sociological data to interpret the failure of her marriage. But in general, far more Nkoya marriages end in divorce than in death.

⁷⁰ We cannot go here into a detailed discussion of the various parallel judicial regimes attending to Nkoya rural society in the 1970s, and the resulting forms of legal pluralism. Cf. van Binsbergen 1974, 1977b, 2011h. In the few centuries before the colonial conquest, jurisdiction was in the hands of kings (*Myene*), and at the valley level minor cases would be delegated to lesser authorities, notably valley chiefs and village headmen. The power of jurisdiction was a major privilege; the local Lozi chiefs who after the incorporation of Nkoyaland into the Barotseland Protectorate (outgoing 19th c. CE) came to be stationed all over the Nkoya area, were particularly resented for their *judicial* role – and they administered a law system (Gluckman 1943, 1955) often deviating from Nkoya tradition, to boot. Nkoya resistance to specific local Lozi chiefs, often violent, persisted well into the 21st c. CE. Especially in the eastern, Mashasha area of Kaoma (formerly Mankoya) District the judicial situation had crystallised out by the 1970s, in the sense that the *Myene* (now encapsulated in the postcolonial state as 'Chiefs') were no longer adjudicating cases, but instead formal Government Local Courts, in modern buildings and bureaucratically co-ordinated by an extensively educated Court Clerk (normally a regional outsider), existed scattered across the district (their distribution was comparable to that of Rural Health Centres, which often were in their proximity). At Local Courts, regional notables with close links to the Nkoya royal establishments (as kinsmen of the Chief, and as members of the Chief's Council) would, as *assessors*, and clad in culturally estranging gowns (see Fig. 9.18, below), adjudicate cases on the basis of a mixture of ancient local law, and national-level 'customary law' as divulged to them through formal state application courses. Local Courts attended to adultery cases, divorces cases, assault, insults, etc. Since this system turned out to create a considerable legal vacuum (the Local Courts were few and far between, and not all plaintiffs could afford to absent themselves from their productive and domestic activities at home, travel to the Local Court, and wait there for legal action), Chief Kahare's area from the 1980s onwards saw the gradual return of more or less informal, local legal alternatives – i.e. the *mabombola* or 'palaver' court variants – in the hands of the Chief (who would not face the litigants directly but through the intermediary of his *Mwanashihemi*, 'Prime Minister'), his councillors, valley

made Edward ill, in order to revenge the suffering of her own child, Enesi, at the hands of Enesi's patrilineal kin, who were at the same time Edward's matrilineal kin. Edward was now again subjected to an ancestral ritual, this time directed at Enesi's mother (Edward's classificatory grandmother). People claimed however that this ritual could only lead to an improvement of Edward's condition if at the same time Jimbando would actually put an end to Enesi's suffering. For Mary, who accepted the pronouncements of this diviner, new fuel was added to her conflict with her parents. She was furious that her father's shortcomings should cause harm to her son Edward. It is possible, however, that Mary accepted this interpretation of Edward's misfortune, and eagerly joined in the general indignation *vis-à-vis* Jimbando, because in doing so she would not have to admit that she herself had been neglecting Edward since Kafungu's birth.

The subsequent events must be placed against the background of a high incidence of sudden deaths among adults and children in Chief Kahare's area during the second half of 1973. Mortality always soars high in this area after the onset of the rainy season, when food is scarce and bodily resistance low. Most of the children involved in this mortality crisis died in the course of a measles epidemic which ran through the district. Although measles immunization was propagated at the district's under-five clinics, in this remote area virtually no children had been vaccinated. Our informal clinic (where such preventive measures were beyond our means and skills) was frequented by mothers who wanted treatment for the secondary infections their children had contracted while having measles. I have no reliable comparative data to indicate that in this period a truly exceptional number of adults died – but many recent deaths have been marked in the genealogy of Fig. 4.1. The population had become virtually paralyzed with fear. Coupled to the prevailing interpretation of death as being invariably caused by sorcery, this rate of mortality had a downright paranoiac affect. For several weeks parents refused to send their children to the village school for fear of the alleged presence of murderers hiding in the forest. A massively attended public sorcery trial was staged at which Chief Kahare and members of his royal establishment were accused (*cf.* van Binsbergen 1975a) of having caused the recent deaths, so as to procure powerful chiefly medicine. The Mema and Mushindi Valleys were in the grip of unsettling rumours, a state of dramatic insecurity which was also related to the national general elections on 5 December, 1973.

I have pointed out how beyond a small core the composition of kin groups is extremely flexible. This enables people anxious to detect a meaningful pattern be-

headmen (offering something of a Neighbourhood Court), and village headmen.

hind common misfortune, to rearrange recently deceased members of the local community in such a way that many of them appear as close relatives – even although they would rather be reckoned as members of rival kin group when still alive. Thus it becomes possible to interpret many sad events as a direct attack from some other kin group (to be identified by divination) upon one's own. Now with the spate of sudden deaths, this mechanism was particularly manifest among the members of the kin group focusing on Nyamayowe Village. As indicated in Fig. 4.1, this kin group, after substantial losses already in the years 1972-73, literally within a few weeks saw itself deprived of seven of its members. In addition, the third wife [37] of Nyamayowe's headman, Kawoma [24], was confined of a stillborn child in mid-December 1973. Fig. 4.1 shows that, though scattered over various villages, the people who died in the last quarter of 1973 were actually rather closely related to our protagonists. The resulting paranoia, therefore, was not merely due to an optical illusion. The surviving members of Muchati's kin group felt deeply and personally threatened and continually feared for their own lives. Proceedings were set in motion to divine the identity of the rival kin group that would have caused the deaths. All this against the background of the common belief among the Nkoya (also widely distributed throughout the eminently immanentalist⁷¹ cultures of South Central Africa) that natural death does not exist – in other words, that most deaths are due to deliberate human malice, *i.e.* to sorcery (Nkoya: *wurothi*).

⁷¹ I call an emic world-view eminently *immanentist*, if there is hardly allowance for a transcendent reality considered to be fundamentally different from the here and the now of human interaction. The distinction has played a considerable role in my emerging approach to religion and its long-range cultural history – which I see largely as a process of the invention, installation, and unfolding, of notions of transcendence. There is a contradictory dynamics to be appreciated here. On the one hand a modicum of transcendence is already doubtlessly inherent in the use of articulate language – for this is the instrument *par excellence* to deal with the not-here and the not-now (or else words and meanings could not have an application beyond the context in which they were employed for very the first time; yet such application is the essence of language, it is, in Reichling's (1967) words, 'vicarious action'). By the same token, the concept of *the social* which Durkheim has placed at the centre of our thinking about society, requires a relative permanence and unaffectedness in space and time, in other words transcendence, which (as was Durkheim's (1912) highly illuminating view) may particularly be brought about by sacred, eminently immutable and enduring rituals. We cannot assume that all, even the simplest, human social forms only came into being with the advent of articulate speech; the latter would seem to be restricted to Anatomically Modern Humans (the variety of humans to which all people now living belong, and which probably only emerged in Southern or Eastern Africa c. 200 ka BP), whereas the species *Homo* is at least twenty times older. On the other hand, the elaboration of transcendence seems largely a process of the most recent period of humans's existence – the Upper Palaeolithic and later periods, roughly the last 40 ka. These are momentous themes, to which we cannot do justice here. I must refer the reader to: van Binsbergen 2005c, 2005d, 2012d, 2018b, 2022d, 2022e, 2022f.

26 December 1973. For over a week, Patrick [41] had suffered from measles. He was a four year old boy in Jimbando Village, a grandchild of the second wife of Kawoma [40]. His condition had not prevented him from taking active part in the Christmas celebrations, which form a major social event in the area. On the morning of Boxing Day Patrick was very sick, probably because of eating too much on Christmas. However, against the background of recent losses, his relatives were convinced that Patrick was dying; they panicked, and as a result he did die. Only immediate injection, people claimed, might save Patrick's life. They did not refer to us, for several reasons. Although people had very often asked us for injections (which here as elsewhere are considered the most powerful technique in cosmopolitan medicine), we had never given any, for the simple reason that we had none to give. Moreover, only a few days previously we had returned from Mangango hospital, where my wife and I had been found to be so seriously ill ourselves (I with hepatitis-A, my wife with a particularly virulent *mononucleosis*, and with *bacterial conjunctivitis* which made her temporary blind for two weeks) that we had been referred to the University Teaching Hospital hospital in Lusaka; we had only stopped at the village in order to collect some personal effects, and were not in a condition to see patients. So we were not told about Patrick's condition until it was too late.⁷²

⁷² I have never been keen to rub shoulders with fellow-Dutchmen abroad, least of all in Africa – where I found their habitual collective, obliquely racist, grumbling unbearable. Yet the fact that I am a Dutch poet means that my heart lies with the Dutch language and national culture far more than I may admit. In time of need, ethnic support is low-threshold and has a semblance of self-evidence, not just for Nkoya labour migrants, but also for Dutch academics. In Lusaka in 1974, our shared Dutchness mobilised the indispensable loving support (especially to the benefit of little Nezmja, and my additional research in the Zambia National Archives) from our fellow countrymen Leo and Aafke van den Berg, when very severe illness had curtailed our rural fieldwork and Henny had to spend months in hospital. The geographer Leo had been my UNZA colleague and a fellow-researcher of Lusaka's urban life. Henny, who was an excellent amateur pianist, had already worked with him (a *ditto* violinist) on Franck's famous *Sonata in A Major*, which after numerous weekly rehearsals (it had not been Beethoven's *Kreutzer Sonata*, and most certainly not in Tolstoy's version; cf. Velikovskiy 1937) was successfully performed in the Spring of 1973 in our Lusaka drawing room before a mainly UNZA audience of some 20 people; and our two families (our own family still without a valid driving licence) had jointly spend a delightful vacation in Malawi in 1972, also looking for spare parts for Leo's decrepit *Daihatsu* car. On this solid basis, Nezmja found a trusted part-time refuge with them. In the same trying period we found similar support, as throughout our stay in Zambia, and likewise on the basis of ethno-linguistic (but not religious, nor political) identification, with the South African but largely Netherlands-born staff of the Theological College of the Reformed Church of Zambia; and (at the other extreme of the political spectrum) with the South African exiles the Simonses, as well as with our departmental colleague, Italian-born Dario Longhi and his American wife

The headman of a nearby village possessed an old syringe, which in the recent past he had wielded with sad results. At least two people were known to have died under his hands in recent years. Yet Patrick's relatives were prepared to take the risk. The boy's grandfather, Kawoma, was absent, but in his locked suitcase inside his house he was keeping a carton box containing vials of chloroquinphosphate, bought at the black market during a visit to Lusaka where he had accompanied Chief Kahare for one of the latter's meetings at the House of Chiefs. Kawoma had recently quarrelled with his senior wife, Munjilo [38] (*i.e.* the co-wife of Patrick's grandmother [40]). Eager to help and thus in ingratiate herself with her husband, Munjilo now broke open the suitcase and took the medicine to the headman-healer, who instantly injected several vials (a manifold overdose).⁷³ The boy went into a coma, and the healer fled. Patrick was already considered dead, many people had streamed to Jimbando Village and had started mourning, when Muchati told me what had happened. He had finally called on me because he was puzzled by the fact that the 'dead' boy still had a pulse and felt warm. In vain I tried to revive Patrick from his coma, and he died in my arms. His mother wailed: 'The witches have waited to kill him until after the injections, so that now everyone will say that he died because of the injections, but I know it is not true...' A day after this episode, I drove our little family back to Lusaka, leaving Muchati behind.

Patrick's was the second sudden death in Jimbando's Village within a few months. As was to be expected, the standard, stereotypical rumour started that the senior members of the village, Jimbando [30] and Malwa [28], were sorcerers seeking to further enhance their sinister powers by killing off the younger inhabitants. Moreover, these deaths involved the stepchild and stepchild's child of Kawoma, *i.e.* potential members of Muchati's kin group, which had already suffered so many losses recently. It was now no longer possible even to pretend friendly affinal relationships between the two kin groups associated with respectively Nyamayowe and Jimbando Village. Realizing this, and fearing an

Pamela. Jaap van Velsen had meanwhile been succeeded in the directorship of the Institute of African Studies by my dear friend and colleague the Zambian linguist Mubanga Kashoki, and (since after completion of my UNZA contract I had been privileged to join the Institute as an affiliate) I was were comfortably and without delay accommodated, with my little family, at that Institution's spacious premises when having prematurely returned from Chief Kahare's Village.

⁷³ Even with proper dosage and under adequate clinical conditions, the great dangers of such an injection are well-known (*cf.* King 1966: section 13: 6). However, and to further enhance the biographical ironies attaching to our central extended case, when during field-work in Guinea-Bissau in 1983 I was myself suffering from life-threatening cerebral malaria and practically at death's door, my co-researcher the psychiatrist Dr Joop de Jong MD (we were investigating local psychiatry) overnight saved my life by a similar injection.

outbreak of violence, Malwa urged her daughter Mary to leave neighbouring Chief Kahare's Village and fly to Nyamayowe Village, in order to bring herself and Kafungu into safety. Thus Mary rejoined her sons Edward and Joseph. This move dramatically completed the process, extended over four years, in which Mary gradually dissociated herself from her parents' village and became more and more closely incorporated into her husband's kin group.

January 1974. Edward's condition worsened again, and again a healer from elsewhere was consulted, a woman this time. She staged a divining ritual and began pointing out the responsible person – who, she insisted, was not a deceased relative but a living sorcerer. When she claimed that this sorcerer lived in the neighbourhood and was a full sibling of Edward's paternal grandfather Shelonga [13], the latter told her that she could stop, collect her fee, and go: his last surviving siblings had died a few months previously (*cf.* Fig. 4.1).⁷⁴

⁷⁴ The episode was to have (van Binsbergen 2015c) a remarkable sequel in the early 1990s, when Kaoma District was the scene of massive witch-hunting (and witch-killing) under the aegis of the Luvala witchfinder Tetangimbu (whose actions were apparently condoned by the district authorities – hence my great difficulties in investigating the case).

Shelonga [13] was a aging man of impeccable integrity and great prestige (and another one of my adopted fathers). Not only was he the hereditary Royal Drummer to accompany Mwene Kahare during the latter's royal dance. His hereditary status had nothing in common with that of members of Nkoya royal orchestras, usually poor commoners of slave descent. Also (and this only transpired at Kahare Kabambi's death end of 1993) Shelonga and his sons (including Muchati [7]) were the Royal Undertakers, by virtue of the South Central African institution of so-called *funerary friendship* (Stefaniszyn 1950). Clans locked in a mutual joking relationship (which usually reflects a combative confrontation in the past) would be obliged, and privileged, to bury each other's members. The special link between Shelonga and the Kahare kingship derives from the fact that until just before 1900 CE (when the Kahare kingship had been appropriated by the warlord Shamamano, Kabambi's grandfather, under the aegis of the Lozi king Lewanika whom Shamamano had served during the campaign against the Ila) the Kahare kingship had belonged to the Kambotwe ('Frog Person') kin group to which Shelonga and his cousin Mwene Mulimba belonged; *cf.* van Binsbergen 1992a.

Now against this background, in the early 1990s Shelonga had been accused by a – none too close – male junior relative, of being a sorcerer, and in good faith Shelonga travelled to the distant witchfinder's village under the smoke of Mangango, to have his innocence established there. An entrance fee was charged before the witch-funding procedure could be initiated. Cash has been eternally wanting in Nkoya villages, and Shelonga was a small amount short to pay the fee. In confidence he approached a nearby relative to help him out, but the latter, familiar with the witch-killing practices staged in Tetangimbu on a daily basis (the witchfinder had his own private cemetery to bury his victims in considerable numbers; after it had been deserted and burned down, I visited the place in mid-1995), beseeched him to relinquish his plan and return to the Mushindi Valley, since once submitted to the witch-finding procedure he had not the slightest chance of coming away with his life. Shelonga

February 1974. Edward's condition seemed critical and his parents, themselves now suffering from malaria, took him to the district hospital. There Edward was found to suffer from pneumonia and malnutrition. After initial treatment, and instructions as to diet, Edward returned to Nyamayowe. Muchati was now caught in a role conflict as a father and a research assistant. Although he saw that Edward needed to return to town, he did not want to abandon the field while my wife lay seriously ill in Lusaka. However, when hearing of the situation we wrote a letter urging him to collect his family, return to Lusaka and take Edward to hospital there. This he finally did.

March 1974. After the usual hours of queuing, referral, queuing again, completing forms, etc., Edward was admitted to the University Teaching Hospital in Lusaka. The two medical officers (one European, one Indian) who successively examined Edward prior to admission, were reluctant to hospitalize him. One said: 'What is the use of trying to fix up this child, as with *these people* he will be the same within a few months?' (*italics added*) The other doctor tore at Edward's hair and squeezed his limp cheeks and leg muscles, shouting at Muchati with histrionic indignation: 'Look what you have done, you stupid man. Is this the way you people raise children?' Utterly shocked by this humiliating confrontation with the health agency whose excellence he had always advocated among his people, and to which he was now applying as a last resort, Muchati rushed out of the ward, to the parking lot where I was waiting. For the first time in the several years that we had already worked together (dozens and dozens were yet to follow), he cried out my first name, without the usual titles of address, and not even the Nkoya version but like my parents had given it. '*Wim!*' Finally he was an equal who in his distress appealed to his friend, his brother. He told me to explain to the doctor Edward's complex medical history, including his earlier hospitalization in the same hospital and its disastrous effects on his mother's lactation, the trouble and expense of bottle-feeding, the health hazards of village life, etc. This I did, throwing in such weight as my ethnico-somatic ('White') and academic status happened to carry in Zambia at that time. Apparently (and embarrassingly) my intervention did much to improve the doctor's attitude towards the case. Edward was well looked after in the ward, and we received regular reports on his progress.

Once again Mary stayed at the hospital's relatives' shelter, in order to help with the feeding of Edward. As she was still breast-feeding Kafungu, she had to bring the latter as well. Muchati asked a girl from his family in Lusaka to come and assist Mary at the hospital shelter, since the hospital staff did not

heeded this advice, did not return to Tetangimbu Village, and lived on for several more years only to die of natural causes.

offer her any assistance. However, this girl could not be spared from home, for she had to attend to her sick mother who claimed to be suffering from *Bituma*.

Children other than patients were not allowed in the children's ward. Therefore those mothers who had both a child patient in the ward, and a suckling baby on their backs (a very common situation), were required to leave the baby outside in the porch on the ground. Here, at the ward's entrance, no accommodation was provided (yet hardly any mother would possess a perambulator to leave her baby in), nor any supervision. So within a short while Kafungu caught pneumonia and thus earned a passport to be admitted too. It was a time of agony for Mary.

After a few weeks the two children were discharged and the family joined Muchati in his Kalingalinga house. Over one and a half years old now, Edward still showed no signs of beginning to walk or to speak. But at least he showed more motor activity than ever before, and had started to crawl.

When she had both children safely at home again in her Kalingalinga house, Mary vowed that never again would she go and live in the rural areas. 'Now I know that I can only keep them healthy in town. The village is no place fit for children,' she said. Of course, personal experience and conviction is not strong enough to defy a deeply seated social-structural pattern, and in fact she was to continue, with her children, to shuttle back and forth between village and town for the rest of her life.

This complex and detailed account of Edward's infancy, while pertinent to the medico-anthropological questions I raised in the introduction to this argument, at the same time offers a picture of the wider social dynamics that set the framework within which Edward's health experiences must be understood. Edward's case brings out recurrent themes that dominate the health situation of contemporary Nkoya society, in both its rural and urban effects; and in fact may be largely generalised for the whole of Zambia, even South Central Africa at large.

But before analysing the data presented here, let us first consider those aspects of the case that render it not only unique, but also, to some extent, non-representative. And by this I mean our own involvement, as expatriate and temporary members of the Zambian elite, in the lives of Edward and his family.

CHAPTER 5. EDWARD'S CASE: A MERE ARTEFACT RESULTING FROM THE RESEARCH SITUATION ITSELF?

Contrary to standard ethnographic conventions, I have refrained from making ourselves (my wife and me) invisible in the preceding account – not (I hope) out of undue self-indulgence, but because we were major actors. Repeatedly we offered alternatives that helped to shape the course of event.

An example of this is our intervention at the birth of Edward: but then our role was not different from that of most elite employers of domestic labour in Africa. By subsequently providing the means to put Edward onto bottle-feeding we contributed to his survival, but also to his vulnerable nutritional status and indirectly to the inhibitions that surrounding Mary's relationship with him. However, short of letting the child starve to death there was no real alternative for us on this point.

The next major intervention was the move of Muchati's and our own household from Lusaka to the village. Many urban Nkoya families occasionally return to the village for longer or shorter periods. This is especially the case after the husband has lost his urban job. However, it also occurs while urban employment lasts. In the latter case not directly economic reasons prevail, but reasons such as local leave, family visits, healing, attendance of life-crisis ceremonies. Especially since the completion of the tar road into Western Province (1972), movement between Lusaka and Chief Kahare's area has been frequent and relatively cheap: there have been several daily bus services. Before our moving to the village, Mary had twice gone there on her own initiative, both times taking an infant with her. Therefore Edward's prolonged stay in the rural area (September 1973 – March 1974), even if ultimately instigated

by our research, was not really a-typical. What was a-typical was that, due to Muchati's position as a research assistant, he and Mary should be living at Chief Kahare's capital, *i.e.* outside direct day-to-day scrutiny of and control by their senior kin. However, in Chief Kahare's Village Mary lived within earshot from her parental home, where after Kafungu's birth Edward might have been looked after, had it not been for the increasing friction between Mary and her parents. Edward's dismissal to distant Nyamayowe, and the dramatic decline of his condition there, had very little to do with our presence in the area.

Finally, our operating an informal clinic in Chief Kahare's Village introduced an additional non-fee-paying health agency in Chief Kahare's area. The characteristics of our clinic included its proximity, novelty, availability of simple but essential medicines, our informality, use of the local language, attention for social and relational aspects of the patients' complaints, our keeping of efficient patient records, our considerable lack of knowledge and experience, yet our considerable success in the treatment of the most frequent complaints. For these reasons our activities amounted to unintended competition with other health agencies, particularly *banganga* / herbalists in the surrounding villages, and the more distant Rural Health Centre. Soon we were seeing about forty patients a day. Naturally, however, we frequently referred people to the district's hospitals and (until this proved useless) to the less distant Rural Health Centre. Often we would take the patients there in our car, which was for most of the time the only serviceable motor vehicle within a radius of over twenty kms. Just as our medical activities did not prevent Edward's kinsmen from consulting local healers, they did not really block the way to the distant, more formal cosmopolitan health agencies. Therefore, although we were major actors in Edward's case, I do not think that our intervention was such as to wholly distort the picture of the health situation among the Nkoya peasants and urban poor. I would rather describe our influence as catalytic, or perhaps as a not too well controlled and none too successful social-science experiment, forced upon us by insistent popular demand, and rendered somehow permissible by the feedback we constantly sought from qualified doctors in the district.

Obviously, our personal involvement and commitment did not stop short at the limits suggested in standard anthropological handbooks on participant observation. This raises the question of ethical responsibility,⁷⁵ which always

⁷⁵ I addressed these questions in an article (van Binsbergen 1987g; reprinted in my recent book *Van Vorstenhof tot Internet*, 2022i), which so far however only exists in Dutch. In general, my approach to intercultural philosophy has concentrated on epistemological, knowledge-political and philosophy-historical questions, and has so far overlooked the unmistakable ethical side of

pervades social research in the domain of illness and death; as it does clinical medical research. Let me try to make our position clear. It was certainly not as if we cynically allowed Edward's health to decline in order to study his parents' and kinsmen's reactions in relation to various Nkoya and cosmopolitan health agencies. *But could we not have done more to prevent the near-fatal outcome?* Throughout our association with Muchati and his family we had advocated the use of cosmopolitan health agencies including under-five clinics. We warned against the use of black-market drugs and we emphasized that in serious cases, consultation of Nkoya healers should always be complemented by visits to cosmopolitan health agencies. Yet by continually discussing Nkoya medicine; by making cults of affliction a pivotal element in our research; by helping to organize cult sessions and participating in them – by all this we conveyed the impression that we took Nkoya medicine seriously, considered it eminently valuable, and did not want to see it wiped out entirely by cosmopolitan medicine. This impression correctly reflected our past and present views of the matter, and in the long run it foreshadowed my becoming a traditional African healer (a capacity in which I have also been active in the Nkoya context, from 1992 on) and my serious defence of African science and healing in international scholarly publications (van Binsbergen 2003c, 2007c, 2009a, 2021a). Therefore, although in view of strategies of participatory research it was absolutely necessary to give that impression, it was not merely a façade. From our first confrontation with them, we could not help taking Nkoya cults seriously, both as amazing psycho-therapeutic achievements, and as powerful and creative symbolic configurations, betraying great musical and dramatic virtuosity, and expressing suffering and remedy in a very moving way. My appreciation of cults of affliction in Lusaka and Western Zambia was related to the fact that I was no newcomer to this class of religious phenomena: before coming to Zambia I had spent some years studying regional cults and cults of affliction in rural Tunisia – and throughout my academic career I have pondered on the correspondences and possible historical and transcontinental continuities of the North African and South Central African materials. Did our admiration encourage Edward's relatives to look (more than they would have, or should have, out of their own

intercultural interaction and knowledge formation. The dilemmas in this field are immense. Are cosmopolitan (*i.e.* Western!) ethics universal? Is their claim to universality merely hegemonic hence unjustified? In my recent book *Africa Intercultural* (2022) I have defined hegemonic as: 'the frame of mind, and the resulting practices and institutions, that take for granted, and seek to perpetuate and to reinforce, the existing geopolitical inequalities in the world at large'. What about the ethical premises underlying local, non-cosmopolitan medicine? I have examined some of these in my studies of Nkoya law (1974, / 1977b, 2011h), but have never come around to explicitly enumerate them in the medical-anthropological context.

impetus) to these cults for a solution of their health problems? I hardly think they needed any encouragement on this point. Might a more negative attitude of ours, particularly if militantly propounded in conversations and advice, have helped to keep them on the straight path to cosmopolitan medical care? I very much doubt it – apart from the fact that such discouragement would have run against my own convictions in favour of these cults and our own awareness as to of limitations of cosmopolitan medicine. More likely, such a dismissive attitude would have estranged us from Edward's relatives (several of them were themselves established healers of the first magnitude), would have deprived us of such limited means as we had of intervening in his health situation, would have made us utterly impossible as participant researchers, and would have fatally undermined our efforts to understand Nkoya traditional medicine.

At the time we did not consciously develop this attitude and weigh it against alternatives. Frankly, we felt we had no choice in the matter. Our main guidance lay in a professionally cultivated sense of transcultural humility which (being the main stock-in-trade of all anthropologists in the humanist tradition; *cf.* Kluckhohn 1949) may well be the greatest contribution anthropology could make to cosmopolitan medicine in Third-World settings; the final scene of Edward's extended case, of ignorant and high-handed cosmopolitan doctors humiliating Muchati, is very eloquent in this respect. Ours was not a research project in applied anthropology. Self-initiated and self-funded in the first place, it resulted from three challenges neither of which made for a very well-defined methodological or theoretical stance to begin with:

- my determination to underpin my social-science teaching as lecturer at the University of Zambia, with first-hand up-to-date research;
- the insistence from our rapidly increasing Nkoya network that, ethno-historically and ethnographically, I should put their people on the intellectual and publishing map
- the unexpected shipwreck of my North African PhD project, which forced me to make the best, career-wise, of my years in Zambia.

Against this somewhat muddled background, we tried to gain understanding of the nature of Nkoya society. In the process, we were confronted head-on with its economic and medical misery. We did not allow the temptation of easy answers and solutions to wedge in between ourselves and our Nkoya friends. For better and worse, we were hardly prepared to extend our intervention in their lives beyond the limits that had implicitly been agreed, and

gradually extended, in our interaction with them.⁷⁶ That yet we set up an improvised local outlet of cosmopolitan medicine is no paradox: it was an action forced upon us by the people's continued appeal to us for drugs and medical advice. Within the very narrow limits of our resources and skills we accepted such responsibility as they entrusted us with; but as we struggled along in our own difficult fieldwork roles as researchers, spouses, parents, medical workers *malgré nous*, and finally as patients ourselves, we felt that it was also, but not *primarily*, on our shoulders that the responsibility for Edward's well-being lay.

On the other hand, it should also be very clear that the interest in cosmopolitan medicine among our urban and rural Nkoya contacts was not exclusively or primarily due to our intervention. The interest was there; but we intensified this interest, and by our own action (facilitated by our somewhat greater medical knowledge and access, greater financial means, and much higher status, hence privileged access, in the wider Zambian society), we were in a position to take away some of the barriers that hindered our Nkoya associates' access to cosmopolitan medicine. In Edward's case, the protagonists' pursuit of cosmopolitan medicine was not really dependent upon us: at several crucial moments we were not available, or not consulted.

Whilst recovering from our fieldwork, in Lusaka in the early months of 1974, my then wife and I decided that the shocking experiences we had gone through left us no choice but to stay on permanently in Zambia and devote the rest of our lives to furthering health conditions in that country. As to the

⁷⁶ Yet, especially in medical matters, we did not always stick to the dominant professional rules of non-intervention in fieldwork. Several times (*cf.* van Binsbergen 1987g) we have taken especially young rural patients, suffering from trauma or about to go blind because of neglected inflammation of the eye) to a distant hospital against the will of their parents or wardens. On those occasions we deliberately, and with fear and trembling lest this would mean the end of our fieldwork, defied the warden's authority because, in our eyes, they happened to be too biased (as Watchtower adepts rejecting all state intervention in medical matters), or too irresponsible (riding, and falling with, a bicycle with a child on the backseat when far too drunk), to determine the health action of their charges. On these occasions, we were saved by a simple Nkoya viewpoint: *despite the incessant competition over children (which are surprisingly rare) as kinship-political following, ownership of and responsibility vis-à-vis children can never be considered the unique monopoly of one person, but lies with the entire community, in fact with the whole of humankind.* Thus, by sinning against the abstract rules of fieldwork, we affirmed our incipient Nkoyanness, and in the public opinion this spoke enough in our favour to protect us from the slighted wardens's wrath. On one occasion, two decades after the 1973-1974 rural fieldwork, one of these wardens – the father himself, accompanied by his now adult daughter – even went out of his way to thank me and my former wife for our high-handed intervention, which had saved his child's eyesight.

literal fulfilment of that self-imposed obligation, fate decided otherwise: in the Lusaka University Teaching Hospital, Henny's health faced such further challenges that we had no option but to give up and return to Europe. In fact, our political conscience in the person of Jack Simons implored us to do so, and we felt we had to oblige. Back in Holland, I continued to pursue what others have called 'a transcontinental distinguished career' as an Africanist, anthropologist and philosopher, increasingly and with increasing success living up to our calling to put my intellectual powers at the service of the African cause. Predictably, my marriage with Henny (who was eleven years older than I) did not survive the ordeal we had gone through, nor did her career as a biophysics research; she never returned to Zambia, and – not without justification – blamed me for having stolen Zambia from her by engaging with Zambian women. Her contributions to the present study have been immense, and deserve our greatest gratitude. She died, aged 82, in 2019. May her soul rest in peace.

Having thus dealt with our own place in Edward's case, I shall now proceed to derive from it such medico-anthropological insights as it has to offer.

CHAPTER 6. INTERPRETATION OF THE EXTENDED CASE

Now that the details of our extended case have been sufficiently presented, let us proceed to a systematic, theoretically inspired interpretation of the material. Let us first consider the role of cosmopolitan health agencies.

Both at the beginning and at the end of my account of Edward's infancy stands the Lusaka University Teaching Hospital; in between, the protagonists move to and for between various other cosmopolitan health agencies and time-honoured, local Nkoya alternatives. *When and why, therefore, do people utilize cosmopolitan health agencies?*

Obviously, *accessibility* is a first condition for such utilization. In the urban situation (*cf.* Shattock n.d.), urban clinics tend to be within walking distance from the homes of the majority of the population. With the exception of private doctors, Zambian cosmopolitan health agencies had become non-fee-paying in the late 1960s; and that is what they were at the time of our extended case. Therefore, the main determinant of accessibility came to lie in the *time* factor (*cf.* Zeller 1974). Limitations of staffing and equipment usually cause long waiting hours, which have formed such a common and perennial feature of cosmopolitan medicine in Africa that patients have become prepared to accept them – provided no third party is making an equally urgent demand on their time. In many cases however there is such a third party: children, husbands or elders waiting to be fed at home and to see the household chores attended to, an employer anxious for his employee's return to work (or anxious to replace the employee who is absenting herself or himself for medical reasons, by one who is available for work), one's own business that needs attention, etc. Should the urban clinic refer one to the central hospital, not only a further loss of waiting time is involved, but also the distance to be

covered often requires use of public transport, which means further expense of time and money. Among the urban poor, lack of transport money often means that a visit to hospital has to be postponed or abandoned.

In the rural areas the access factor weighs even more heavily.⁷⁷ Here a visit to a rural health centre or hospital usually involves travelling over considerable distances. In Chief Kahare's area in the 1970s, motor transport was very seldom available. The long journey and the long waiting hours frequently necessitated an absence of several days, which many people could not afford (particularly young women, who under the tight control of their senior consanguineal or affinal kin carry the lion's share of domestic and agricultural tasks). Such prolonged absences require that one carries blankets so as to avail oneself of the cheapest possible sleeping arrangements, food and kitchen utensils to prepare for on the journey (in the very likely case – especially given the Nkoya's increasingly peripheral position in a Kaoma District flooded with newcomers from all over Zambia and from Angola – that, near the hospitals, one cannot expect to enjoy kin hospitality), or that one has money to buy food on the way. As a result, rural utilization of cosmopolitan health services falls steeply with increasing distance, and on the longer distances (exceeding 10 kms) tends to show a bias against those who are particularly busy, poor, or junior.

In Edward's case, the Lusaka data do not suggest that the accessibility factor is very important in the urban environment. Mary remained on the outside of cosmopolitan medicine, irregularly went for antenatal care, gave birth at home, and did not attend the under-five clinic⁷⁸ (except when Edward was obviously ill) – not for reasons of access, time or money. However, in the rural data the effect of these factors was demonstrated by the fact that, while visiting the distant Rural Health Centre (and *a fortiori* the even more distant hospitals) was a major decision, and one which people would not take except in very serious cases (when it was often too late), they would daily flock in considerable numbers to our improvised clinic. Even at our clinic the impact of

⁷⁷ King 1966: section 2: 6 and 2: 9; Fendall 1965; Sharpston 1971; Stein 1971: 100.

⁷⁸ Stein reports (1971: 127) that around the time of our extended case only 9% of the under-five population of Zambia is brought to clinics, while re-attendance averages only 3.4 visits per child. Mary's health action in this respect was therefore fairly representative in the Zambian context at the time; understanding of her choice of alternatives is likely to have wide applicability even for more recent periods. However, Nur *et al.* (1976) quote much higher figures for the Lusaka municipal township of Matero with its typical upper-lower class connotations.

distance made itself felt. Our patients were mainly from Mema Valley, where Chief Kahare's capital is located. Even from the adjacent Mushindi Valley, where e.g. Nyamayowe Village is located, markedly fewer patients would come: and those who did come would tend to have more serious complaints. It proved impossible to have Edward brought in daily for eye treatment, across a distance of only half an hour of cycling. Considerations of accessibility also form an obvious explanation for the common phenomenon of black-market medicine (cf. Patrick's death) – although we shall find additional explanations when discussing the health role of the elders.

While largely economic factors underlie the effect of accessibility, time and money, Edward's case clearly brings out the role of non-economic factors. In the literature these are often discussed in terms of local, culturally shared modes of conceptualizing health and disease. Authors in this connection often speak of the force of 'tradition' and the persistence of 'traditional' medicine, as if that would explain anything.⁷⁹

As we have seen, the same person (Mary) may in the course of a short period repeatedly shift between cosmopolitan and Nkoya health agencies; yet her ideas on health and disease remained the same, throughout the process. Why was Edward dragged to and for between the various outlets of cosmopolitan medicine, and a variety of local alternatives such as ancestral ritual, cults of affliction, diviners, etc.? Why did Mary achieve overnight mastery in hygienic bottle-feeding, yet allowed Edward to go through a musical chairs of Nkoya treatments, which by delaying effective, cosmopolitan clinical action nearly cost him his life? The health concepts in her mind are not likely to explain the variability of her actions – except perhaps for this one notion, so fundamental in Nkoya social structure, that potential support and remedy is never limited to one exclusive source, and that one may safely look for alternatives if one way is blocked. But given the options present in Edward's health situation, what principles governed that certain options were finally taken, and others were not?

The typical Third World medical situation today is that of a person surrounded by various alternative health agencies, all off them in principle accessible (albeit not at equal costs). Given this situation, *the data suggest that such a person's actual pattern of utilization will to a considerable extent result from the social process in which he is involved in his immediate social environment.*

⁷⁹ For early, general criticism of the notion that 'tradition' or 'culture could serve as an explanatory in the study of health action, cf. Lieban (1973: 1058) and Erasmus (1961).

In the years covered by my data, Muchati and Mary (and by consequence their child Edward) did not significantly change their class position, level of income, educational status, etc. All these individual attributes which surveys have tried to link up with health agency utilization, here remained constant, and for that reason are incapable of explaining the variation in Muchati's and Mary's health activities. But what did undergo perceptible and significant changes was the pattern of crucial relationships by which each of them was surrounded. *It is in the evolution of these relationships that their health choices become understandable.*

In these relationships, four major spheres can be identified, which I shall now discuss one after the other.

6.1. Formal-sector employment

One such sphere was the relationship of Muchati's nuclear family with the families of his employers (not just us). Here Muchati was thoroughly exposed to cosmopolitan health concepts, and obliged to apply them at least in his professional work as a domestic servant. He could enhance his employment security by pleasing his employers. The latter would expect him to observe basic cosmopolitan hygiene, and would normally make his visit to a cosmopolitan medical agent a condition for granting paid sick leave. Moreover, expatriate members of the Zambian elite became a reference group for him; he would attempt to selectively adopt their life-style. Largely for these reasons Muchati absorbed modern hygiene and applied them in his personal life. As is repeatedly demonstrated in Edward's case, this made Muchati a strong advocate of cosmopolitan medicine. He struggled to have Mary attend the urban clinics and to have Edward be born in hospital; he supervised Mary's bottle-feeding; upon departure from the village he left money for visits to the rural cosmopolitan health agencies, etc. At our informal clinic, in his greatly enhanced status of research assistant, Muchati would often take the initiative of lecturing the women and youths on elementary hygiene (use of boiled water for drinking, washing hands after toilet use, etc.).

However, the impact of formal-sector employment was inevitably set off against that of other social spheres, in shaping the health actions of Muchati's family.

6.2. Elders

While living in town, Muchati's and Mary's frequent interaction with fellow-

Nkoya meant a continuous confrontation between Nkoya medicine and cosmopolitan medicine. Nkoya medicine, in this context, was not offered in the form of advice that one could either take or leave. Rather, the idiom of illness and healing provided a major context to shape interpersonal relations within this ethnic group. Propounding advice in health matters, dreaming up new therapies for sick kinsmen (even when the dreamer has not yet been informed that they are sick!), dispensing herbal medicine and other therapies – all this forms an integral and central part of dealings between kinsmen and between fellow-Nkoya, in town as well in the village. Seniority and authority imply protection and care, and the most common form in which these are offered is a medical one. Most Nkoya adults over forty years of age claim specialist knowledge of certain aspects of local medicine. It is no exaggeration to claim that, in recent decades, health action has been the Nkoya elders' main task – now that their productive, managerial, judicial, and political tasks have largely fallen away due to the imposition of the colonial state and of the capitalist mode of production. At the same time health action is also the elders' major prerogative, by which they assert their authority over their junior relatives and fellow-Nkoya at large. This is particularly the case with the village headman. Therefore a headman's failure to protect his village from illness, death and sorcery is a terrible shortcoming, which will greatly lessen his authority in local-political and judicial matters. On a less exalted scale, the relationship between parents and children, and even that between husband and wife, calls for explicit health intervention from the party (parent; male) that is culturally defined as being dominant.

In the past, the medical dimension of the elders' role among the Nkoya was accompanied by very considerable power in the marital, political and economic domain. Together, these aspects made for a marked dominance of the old over the young. Now that political incorporation of the national state and the penetration of capitalism, have largely destroyed the elders' political and economic power, mainly two domains have survived in which the elders can expropriate the products of the labour of their juniors: affinal relationships, and health action. In the field of affinal relationships, recent decades have seen the evolution of marital payments from trade goods or labour (bride services), to high and standardized monetary bride-prices in the order of magnitude of K80, *i.e.* what an unskilled labourer, if he manages to secure full-time employment, can *earn* (not: save) in about three months.⁸⁰ In general it

⁸⁰ Reference is to recent urban immigrants in Lusaka in the early 1970s. Today, half a century later, the relative orders of magnitude have remained more or less the same, but the

is the juniors who pay and the elders who receive these payments. Thus a major inter-generational flow of town-earned cash is maintained. In the domain of health action, the elders' medical services not only drive home the juniors' fundamental dependence on the elders; no matter how economically independent the former may have become, such health action invariably also involves the transfer of money from the young to the old (and / or from men to women). In the case of cults of affliction, relatively high fees of K20, amounting to a few weeks' full-time work as a general worker, are no exception.⁸¹ Where the symbols of economic and political excellence have declined, the elders seek recourse in new medical symbols to express and assert their uncertain dominance. Not only do they deal in historical forms of Nkoya medicine, or in such recent derivations as the cults of affliction – they also appropriate and dispense modern medicine obtained in dispensaries or the black market. Patrick's death illustrates to what tragedies this can lead.

6.3. Kinship and marriage

The third major sphere in the social process surrounding Edward's health experience is that of kinship and marriage. Edward's story reflects two main processes in this respect. First there is the development, against many odds, of a mature, stable, trusting conjugal relationship between Mary [4] and Muchati [7] (cf. Fig. 9.9, below). And secondly there is the increasing juxtaposition between their respective kin groups, with Mary being more and more drawn away from her parental kin group and into that of her husband. It is largely from elements derived from these two processes that the elders (taking temporary precedence over the cosmopolitan health agencies championed by Muchati) shaped their healing activities with relation to Edward. The elders' health action (which sometimes amounts to illness-provoking action), is primarily a means to assert their kinship-political claims over juniors such as Mary and her child Edward. Conflicting supernatural interpretations are advanced in order to bring out the imperfections of the rival kin group, and ritual is undertaken to incorporate the juniors more fully into one's own kin group.

Judged exclusively within the framework of cosmopolitan medicine, it would seem as if the relatives cynically let the child suffer, merely using its critical condition as a pretext to pursue their own kinship-political interests. However, a less ethnocentric interpretation is called for. Kinship dominates the Nkoya community, as it is the fundamental organizational set-up by which rural production and reproduction are organized. Bilateral kinship creates the specific structural problem of several kin groups competing, with virtually equal force and legitimacy, and with uncertain outcome, for the allegiance of

absolute figures have greatly increased due to inflation.

⁸¹ This refers to the 1973 situation. Ever since, the Zambia Kwacha has known a constant and formidable inflation.

junior members. This competition is a major structural theme in Nkoya society. It makes for a very high rate of inter-village migration, and is closely connected with the considerable degree of marital instability. The competition for juniors is further acerbated by the fact that offspring is so very scarce due to an extremely low fertility. This seems to be the background of the Nkoya's obsession (even more than among other mortals worldwide) with illness and death. Reproduction is a major concern in any society; it is a centre of gravity in all societies organized around the domestic community (Meillassoux 1975). But among the Nkoya, with their impaired fertility coupled (since more than a century) to a continuous emigration of young labour power to the capitalist places of work, reproduction has eclipsed most other concerns, perhaps even production, which is at a low level involving severe annual shortages. In this context, even a child's minor health complaints activate, in the consciousness of that child's kin, the whole predicament of their society, and drives them into panic and into rash action. A child's death is in the most literal sense what the frantic mourners claim it to be: an assault on the survival of their group. Name-inheritance ritual (van Binsbergen 1990b; meant to tie the child more closely to the kin group and its ancestors) and ritual contests (*cf.* the two competing divinations of the causes of Edward's illness) with other groups that extend rival claims over the child, may not constitute the most effective way of curing a sick child, yet they do form a meaningful attempt to get to the roots of the child's condition and its paramount social significance for the various groups that lay a claim to its membership.

6.4. Cosmopolitan health agencies

A fourth major sphere in the social process shaping our protagonists' health behaviour, is formed by the cosmopolitan health agencies themselves.⁸² Once the problems of access have been overcome, what kind of interaction actually takes place between patients and medical staff at rural health centres, clinics, hospitals and private practices? Edward's case suggests repeatedly (*cf.* negligence of Mary's breast-feeding while Edward was in hospital; the rural health centre lacking essential drugs; the doctor's high-handed attitude towards Muchati when he brought Edward in for admission; Kafungu's pneumonia) that this interaction is often of a very deficient nature, both in social and in technical-medical respects, and especially in those cases that require more than quick and simple administration of

⁸² It is remarkable that, as late as 1962, patients' experiences with and reactions to health institutions etc. had to be discovered as a forgotten factor in the utilization of cosmopolitan medicine and its alternatives; *cf.* von Mering 1962; Polgar 1962.

medicaments.⁸³ In terms of social relations there is often little to reinforce and consolidate a patient's initial attraction to cosmopolitan medicine, and there may be much to deter him. The immense pressure of work (*cf.* Leeson 1970), the cultural and linguistic barriers (*cf.* Conco 1971), the conflict-ridden internal structure of institutions of cosmopolitan medicine,⁸⁴ and the difficulties involved in keeping up medical supply lines in a huge, empty and poor country like Zambia (Hage-Noël 1974), may all be quoted in vindication of individual health workers. However this does not take away the fact that often health action along the lines of cosmopolitan medicine is frustrated by the very institutions that claim to have scientific furtherance of health as their major aim. Cosmopolitan health agencies have a great influence on peoples' health behaviour – but often this influence may be of a kind to encourage them to take their health problems elsewhere.

Alternatively, Edward's case offers sufficient examples (Mary's bottle-feeding; our informal clinic; my patronage in the event of Edward's final hospitalization) of the fact that, given adequate social relations between Nkoya individuals and the advocates of cosmopolitan medicine, the effect of cognitive or kinship-political barriers to adequate health action can be minimized. In a South Central African society like that of the Nkoya, where 'shopping-around' (for kinship support, followers, co-residence, medico-ritual attention within the context of Nkoya medicine, religious denomination, etc.) is a fundamental structural theme, one should hardly expect that such a powerful source of support as cosmopolitan medicine would be ruled out for reasons of principle! Just as in the choice of a headman or a *nganga*, much depends on one's ability to enter into a satisfactory relationship with that agent. The manifestly low standards of performance in both medical and social respects, among some agents of cosmopolitan medicine, deter Nkoya patients, no matter how much the latter are prepared to admit, at the cognitive level, the superior power of cosmopolitan medicine.

Of the four major structural domains distinguished in my interpretation of the extended case, two (elders, kinship) belong to the internal structure of Nkoya society, and two (modern-sector employment, cosmopolitan health agencies) to the wider society into which Nkoya society has become incorporated – largely as a result of what we would now call *globalisation* (the term was not yet *en vogue* when this argument was first published, but of course the phenomenon is much older). An important problem in analyzing the social proc-

⁸³ The same point is made by Leeson 1970: 10 *f.*; for a Nigerian parallel, *cf.* Ademuwagun 1974-1975: 72 *f.*

⁸⁴ *Cf.* de Craemer & Fox 1968; Jayaraman 1970; Frankenberg & Leeson 1974.

ess out of which Edward's case exists, is that it *continuously links these two entirely different structural settings*. The theoretical and methodological difficulties which this situation (yet so common in the modern world) poses, constitute one of the central themes of recent globalisation studies.⁸⁵ Meanwhile Muchati's [7] role can be appreciated as that of one who, due to an increasingly successful yet still very vulnerable position in the wider society, could, slightly better than his fellow-Nkoya, afford to ignore the claims of the internal Nkoya social structure, such as it is expressed through the elders' health action. At Edward's birth he tried to wrench the initiative from the hands of the Nkoya women he had himself called earlier in the evening. A year later, when Edward's health declined, his relatives dared enlist the services of a healer only after Muchati had left for the town. Yet the pressures channelled through his wife, parents, affinal kinsmen and urban fellow-Nkoya left him little choice but to accept Edward's extensive exposure to Nkoya medicine. Although Muchati's close personal relationship with his elite employers make him somewhat exceptional, this *reluctant compliance* is surely one of the main characteristics of contemporary Nkoya youths and young adults in relation to the elders. Of great structural significance, it reflects the indeterminateness of the social-structural position of modern Nkoya, who are caught between two totally different social systems. The rudiments of their pre-capitalist rural society can no longer fully provide an adequate material life for them. Alternatively, in the modern capitalist urban society they used to be lowly-educated newcomers with only a very insecure footing. Ultimately, therefore, such economic, social and psychological security as they enjoyed by the time of our extended case, had to come from the village. *For this reason they have been forced to adhere to the social and symbolic arrangements of the village society, including their medical aspects.*

Having thus identified some main and often conflicting spheres of relationships

⁸⁵ A blatantly arbitrary selection from the voluminous literature might include: Appadurai 1986, 1990; Beaujard 2012; Doornbos 2001; Geschiere *et al.* 1995; Kapferer 2000; Korff 1995; Meyer & Geschiere 1998; Rasing 2018; Strathern 1995; van Binsbergen 1994b, 1999a, 1999b, 2001b, 2021a; van Binsbergen & Geschiere 2005. A particularly seminal collection in this connection has been: Featherstone 1990. African scholars have been particularly vocal addressing globalisation, *e.g.*: Forben 1995; Hountondji 1997; Nyamnjoh 2000, 2004; Obi 1997; Onwudiwe 2001; Sichone 2007; Sawyer 1999. In this connection, my own work on virtuality may make some slight contribution; *cf.* van Binsbergen 1997, 1998a, 2001a. Specifically on the interplay between tradition and modernity in the medical sphere in Central Africa, we have been fortunate to have been inspired, for decades, by such excellent pioneering analyses as Spring Hansen 1978 and particularly Janzen 1978.

that among the contemporary Nkoya intersect around specific individuals in their pursuit of health, it is important to realize that these relationships are not static structural arrangements. They constitute a veritable social process – in the very specific, illuminating sense given to this concept by the Manchester School (Werbner 1984; van Binsbergen 2007a). ‘Historicity’, in the sense of the *serial, consecutive nature* of events and the *accumulation of effects along a time axis*, is the key to an understanding of the specific health actions of individuals at a specific moment of time. This historicity pervades Edward’s case from beginning to end. Without the mounting tensions between Jimbando and Nyamayowe Villages (the struggle over Mary’s social and ritual allegiance, the abortive marriage negotiations concerning Banduwe’s son, the death of Kashimbi’s daughter, and of Patrick, in Jimbando Village) – without such tensions it is unlikely that the struggle over Edward would have been enacted at such an early stage, when the child was barely one year old. It is more usual for such struggles between affines over a child’s allegiance to begin when the child is in his tens. Without the truly traumatic outcome of Edward’s first hospitalization (the impairment of Mary’s lactation), and without the repeated recent disappointments at the ill-supplied Rural Health Centre, Edward’s kin would also have looked to cosmopolitan medicine, and not so exclusively to Nkoya medicine, to deal with the decline of his health from October 1973.

This historicity is implied in the extended-case method, and constitutes one of its great advantages. When we concentrate on the action aspects rather than on the cognitive or cultural aspects of health dynamics, some recurrent findings of medical anthropology in Africa can be placed in their proper perspective.

Africans have been claimed not to make too rigid a distinction between cosmopolitan and local medicine.⁸⁶ Along the same lines, it is claimed that they do not consider themselves as defaulters to one side or the other when they shop around for health assistance. On the purely cognitive level these findings are hard to explain. Hardly would one assume that Africans fail to perceive the enormous differences between cosmopolitan medicine and the various African systems of medicine. But if one sees such cognitive elements as primarily shaped, and given meaning, in a specific sequence of actual interaction in the context of a *network of social relations involved in a social process*, then the practical fusion of the various spheres of medical care in the social processes in which people are involved, explains the absence of neat compartmentalisation between these spheres in their thinking and attitudes.

Such a complementary relationship between cosmopolitan medicine and local

⁸⁶ Frankenberg & Leeson 1974: 261; Ademuwagun 1973: 73f.

alternatives as my analysis suggests, lies not primarily in the fact that they are so very different (or so very similar to each other, for that matter), but in the fact that *both are involved in the same social field, and utilised by the same actors*. The social process, within the various spheres that in mutual rivalry determine it, takes people now to cosmopolitan medicine, now to local healers, kin therapy, or self-medication. This is a rather horizontal view, which looks at cosmopolitan medicine as one among many alternatives, neither (at least, in their concrete practical implementation, of which our extended case contains a few alarming examples) incomparably superior to Nkoya medicine, nor rigidly separated from the latter by impassable cultural or social boundaries.

This raises the much debated issue of the *functional complementarity of cosmopolitan medicine and local alternatives*.⁸⁷ Do people

- refer to local alternatives, mainly for emotional relief and social redress,
- whereas they refer to cosmopolitan medicine mainly for sheer somatic treatment?

Complex as the issue is, I have a feeling that this kind of reasoning erroneously projects into the participants' minds the distinctions and evaluations common among members of North Atlantic society, and *a fortiori* among the latter's doctors. Could they afford to admit that local, non-cosmopolitan medicine is *anything more* than just emotionally and socially relevant, in other words can they admit that it primarily entails *medical* actions by fellow-doctors, however exotic? As I have tried to demonstrate, the oscillation between cosmopolitan medicine and Nkoya medicine in Edward's case was primarily the outcome of the evolving struggle between various major foci in the social process of the people involved. It was not as if at one stage emotional or social concerns or needs began to prevail over the desire for somatic cure, and that *therefore* cosmopolitan medicine had to yield to healing ritual etc.

Non-cosmopolitan medicine does not have the monopoly of social and emotional aspects. Would not the following aspects of cosmopolitan medicine upon closer analysis reveal major parallels with the symbolic and social content of African medicine: the period of seclusion that Mary underwent at the escorts' shelter while her child was in hospital; the fixed routine of daily rounds through the wards; the rigidly defined role expectations in the interaction between patient and staff. Just as local healing ritual may reveal crucial

⁸⁷ Gonzalez 1966; Lieban 1973: 1056 *f.*; concerning Zambia, e.g. B. Quintanilla, as quoted in Grollig & Haley 1976: 450.

aspects of the village society,⁸⁸ the patients' enforced submission to anonymous structures of formal organisation is eminently significant in a urban capitalist society dominated by formal bureaucratic organizations both within and outside the medical sphere. Thus, the *absence of sociability* in the sphere of cosmopolitan medicine, may be just as much of a socially relevant fact, as the unmistakable 'social' element in local African medicine. It could even be said to constitute an 'ideological state apparatus' enforcing submission to the modern state, in the sense of Althusser (1976) and Gramsci 1950 / 1985 (cf. Geschiere 1986). Hitherto, perhaps, social scientists interested in health action have too readily accepted our doctors' own definition of the cosmopolitan medical situation, thus taking for granted what most needs elucidation (cf. Loudon 1976: 33*f.*).

Does my analysis imply, then that medico-anthropological analysis is to lose itself entirely in the tracing of petty families histories, without any prospect of producing structural insights that can be generalized and thus applied in public-health policy?⁸⁹ Such a view would ignore the lessons I have tried to derive from Edward's case. However complex, and however unpredictable in details, yet the social process that surrounds individuals in their pursuit of health shows a systematic pattern such as explained throughout my argument in this book, and summarized in its introduction. In this pattern, cosmopolitan health agencies play an integral but often far from ideal part. The better this pattern is understood, the nearer Third-World cosmopolitan medicine may come to the realization of its lofty ideals, and to the justification of the comfortable social privileges of its professionals.⁹⁰

⁸⁸ Turner 1957, 1967c, 1968; however, cf. van Binsbergen 1976b, and my critical footnote on p. 49*f.*

⁸⁹ Let it be understood that I do not consider such extended-case analysis an alternative to sophisticated quantitative analysis. Far from being incompatible, quantitative analysis should follow at a later stage, once the fundamental determinants of health agency utilization have been identified qualitatively. Many quantitative studies in this field, however, seldom reach this advanced stage, and often remain crude, 'fact-finding' exercises, prone to produce artefacts by solely considering the speech reactions of individuals while ignoring the complex and constantly evolving social processes in which they are involved; and usually without first establishing a basis of communicative trust and commitment, on the strength of which respondents may make an effort to tell the truth.

⁹⁰ Meanwhile it must be clear that the structural conditions surrounding the interplay between cosmopolitan and local medicine, as analysed here for the Nkoya case, are very specific; the Nkoya findings are not likely to apply, lock, stock and barrel, to other societies, that have different internal structures and different forms of incorporation in the modern economic and political world system.

CHAPTER 7. CONCLUSION

When I presented, in 1975, a first and admittedly less balanced version of this argument to an audience of North Atlantic physicians working in (what was then called) the Third World, their main reaction was one of disbelief and irritation. Was not the implication of my argument that even if the accessibility factor was taken care of, yet people like the Nkoya would not, and *could* not, embrace cosmopolitan medicine overnight and wholeheartedly? The reaction of the audience was:

‘So much of unique and unquestionable value we as agents of cosmopolitan medicine come to offer them – and you are telling us that they may have reasons for rejecting it?!’

It is not with impunity that one can present a more relative view of cosmopolitan medicine; nor it is easy to explain anthropological data and insights in a manner that makes sense to medical professionals.

Edward’s case suggest how complex the situation really is, and how difficult to alter. Nkoya, both in town and in the village, do consult cosmopolitan health agencies. As elsewhere, this utilization increases with increased accessibility. The Nkoya are not deaf to the persuasions of non-Nkoya outsiders, or of enlightened fellow-Nkoya, who advocate cosmopolitan medicine. Rather complex hygienic routines, such as bottle-feeding, may be mastered within an amazingly short time, and adequately performed provided the logistics of the situation allow this. Cultural notions play a relatively limited role in this set-up, and certainly do not create insurmountable barriers against cosmopolitan medicine. Yet two main factors turn out to militate against people becoming *exclusively* committed to cosmopolitan medicine. First, their own medicine may be so central in their social process (both in the village and in town), that they cannot afford, as yet, to do away with it; their structure of authority, kin-

ship, competition between kin groups over scarce members, largely revolves on it. And secondly, the version of cosmopolitan medicine offered to them tends to be of clearly inadequate standards.

These standards can only be improved if more funds become available *and* if medical performance is re-assessed and continually evaluated against the social, political, ideological and ethical priorities of the local community, of the national state which administers cosmopolitan medicine, and of the world community at large. Ultimately this means a political process in which the elitist and consumptive tendencies inherent in the cosmopolitan medical professions, and the de-humanizing tendencies inherent to all modern formal organizations including medical ones,⁹¹ are radically checked in favour of the people's interest (medical and otherwise) at the grass-roots level. Humanitarian compassion alone is not likely to bring about such a change – it has to be brought about by the organized political demands of the people themselves. Thus the evolution of public health becomes an aspect of a much more general class struggle.

Alternatively, the centrality of Nkoya medicine in their society is not likely to decline unless a profound transformation takes place in their political and economic situation within the wider society. By the 1970s, Nkoya society was not really disappearing. It lived on in a greatly modified form as a handmaiden of urban and global capitalist structures, nursing future labourers and sheltering discarded labourers. Even in this neo-traditional form Nkoya society could only survive provided its basic social and ritual institutions, including Nkoya

⁹¹ Cf. Frankenberg & Leeson 1974 for similar views. Africanists generally do their work within modern formal bureaucratic organisations such as universities and research institutes, most of their lives in cosmopolitan society (in terms of residence, formal education, health care, religion, consumption, recreation, etc.) is also regulated by formal organisations, self-reflexivity is not a common virtue among Africanists (as I found out to my detriment), hence the formal organisational format of Africanists's own society tends to remain invisible to them like the very air they are breathing in. I appear to be one of the few Africanists that have expressed amazement (e.g. van Binsbergen 1993b, 2004) at the fact that within less than a century, the formal organisation has managed to impose itself as standard upon African life, governing both the state (politics, administration, education, health care, the judiciary, culture), the economy, and even forms of self-organisation as in churches, sports and other forms of recreation. The emphasis on the literature has been rather on the *failures* of African formal organisations to stick to the letter of their blueprints, and failure to deliver what their formally stated goals are. Be this as it may, given the wealth of pre-conquest forms of African organisational forms, no one could have predicted that the Weber / Parsons / Etzioni model would be so triumphant in Africa in the course of the 20th c. CE. Cf. Weber 1985 / 1919; Parsons 1949; Etzioni 1993, 1995.

medicine, remained more or less intact. Nkoya medicine underpinned the elders' authority, articulated group processes especially at their most dramatic stages, and provided a mechanism of redistribution through which some meagre revenues of labour sold in the capitalist sector could be channelled back into Nkoya rural society. Other forms to legitimate authority, and other mechanisms of redistribution, are conceivable, and their substitution in the place of Nkoya medicine can be expected to pave the way for fuller adoption of cosmopolitan medicine. Our extended case from the 1970s revolves on the reality of exploitative incorporation within the 'mode of reproduction of cheap labour'. If this reality could be overcome (for instance through the class struggle of the Nkoya and other Central African peasants and urban poor; or through a rather different structuring of inequality and urban-rural relations under conditions of globalisation and the digital media revolution of the 1990s-2010s) Nkoya society would be transformed (both internally and as regards its place in the world system), and Nkoya medicine would no longer need to serve the functions which now make it indispensable.

There are indications over the past two decades that changes in this direction are actually taking place. Cosmopolitan medicine is now more readily available at the village level, and is more readily utilised as a matter of course.

When I revisited Nkoyaland for the last time in 2011 (ever since, my return has been prevented by my own ill health in combination with writing obligations, and by the fact that since my formal retirement in 2012 my travel expenses are no longer refunded by an institution) the villages turned out to be overtaken by the personal cellphone, and ingenious solar solutions had to keep these devices serviceable, 85 kms from the district capital, even in the persisting absence of a mains network of electrical power. Circulatory migrancy had become far less common. The royal drums has been all but abolished. In town, cults of affliction no longer offered a lucrative source of income to the ritual leader such as my sister Jenita [9], and even in the villages syncretistic Christian movements were taking their place. Even my elder brother Muchati [7] in his old age had become a leader in one such movement, one that had a strong healing aspect (*cf.* Fig. 9.7, below); for the first time in our extensive and dramatic experiences together across 40 years we would spend time on Christian (as distinct from ancestral or affliction-cultic) prayer, at Muchati's initiative. But lacking my own means of motor transport and hence being captive more or less of the urban middle-class concerns of the Kazanga Cultural Society which was hosting my return visit, I could not stay long enough to detect with any certainty significant shifts in the structural factors determining health behaviour in the Nkoya rural area.

Walking back from Chief Kahare's royal compound, where my adoptive father's successor had acknowledged and privileged me by playing the royal bells in recognition of ancestral presence, I stopped at the nearby Mema Rural Health Centre, and (with an hopefully forgivable sense of accomplishment and pride) set myself in its porch. A faintly familiar woman was confidently sitting next to me. She was puzzled by my command of the Nkoya language, then – realising that I must be Tatashikanda, on whose lap she had often played as a small child, even occasionally and on her own initiative repeating the affectionate gesture as a teenager – she covered me with the wild kisses Nkoya reserve for close kinsmen thought lost. It turned out to be Rusha [15], the daughter of our sister Jenita [9]; an infant in the early 1970s, Rusha was now a proud and healthy mother 40 years of age, while her aging mother (whom I was to visit soon) was suffering in a poverty-stricken Lusaka ward, unable to find patients anymore for her *Bituma* practice, and desperately attending to her second husband who in their very one-room accommodation was dying of open tuberculosis; after my return to Europe, I paid for this visit by weeks of medication and qualified quarantine as a tuberculosis suspect, but I had no choice.

Clearly, the status of the traditional *nganga* has markedly declined over two decades. In 1992, when I returned to Zambia from Botswana with all the paraphernalia and certificates of a traditional healer recognised both by the professional guild and by the state (*cf.* Fig., 9.11, below), the enthusiast comment of my close Nkoya associates was 'you see now, he is a real Nkoya'. Meanwhile, however, traditional healers have become far less conspicuous in rural social life, claiming to be a traditional healer is no longer even an admissible topic for polite conversation, several traditional healers active in the 1970s-1990s are now complaining that they have lost nearly all their customers to healing churches, and such traditional healers themselves now tend to adopt syncretistic Christian forms in a bid to avoid the sorcery connotations that, of old, adhered to their profession. This can only mean that Nkoya society is fundamentally changing, and that, under altered conditions of the state and the world economy, globalisation, the digital media revolution, etc. the village is no longer so vital for the upkeep of Nkoya society as understood and functioning today. But these changes require much new research, for which the present book can only be a stepping-stone.

CHAPTER 8. POSTSCRIPT: THE ROLE OF COGNITION

In his introduction to the collection *In Search of Health: Essays in Medical Anthropology* (1979), where the present study appeared for the first time, Sjaak van der Geest points at what he claims to be a major weakness in my contribution: the fact that I have ignored the role of cognition as a determinant of the selection of specialist healers. I am grateful for this opportunity to explain my position more fully.

When, like in the contemporary Nkoya situation, patients and their sponsors are confronted with a plurality of medical systems, the problem of which specialist healer they select, when, and why, is of obvious theoretical and practical interest. Many medical anthropologists⁹² have dealt with this selection problem as follows. Participants are said to impose their cultural classifications upon the diseases they suffer from. These classifications interpret the nature of each disease, and stipulate the specialist agent (if any) thought to be capable of curing it. Where cosmopolitan health care is available along with forms of indigenous medicine, people allegedly tend to classify some diseases as 'suitable for hospital treatment', and others as 'to be treated by non-cosmopolitan healers'. In my own analysis I did largely ignore this cognitive approach, and instead interpreted the participants' switching forward and backward between cosmopolitan and other healers as the outcome of a sustained, complex social process – a process which had little to do with the specific nature of the diseases involved, and which could be understood retrospectively but could hardly be predicted.

⁹² Cf. Lieban 1973: 1056 *f.* and references cited there. Lieban is rather critical of the accepted views.

The data as presented in this argument provide support for my view that among the Nkoya there is no one-to-one relationship between certain somatic (or mental) symptoms, and the choice in favour of cosmopolitan or non-cosmopolitan medicine. In the case of Edward, the same few symptoms (coughing, fever, emaciation, lack of appetite, inflamed eyes, retarded motoric development), which recurred over a period of 1½ years, were subject to a shifting labelling process. Sometimes his relatives imposed cognitive categories such as *shipèlo* ('usurper', an unborn child's attack on his immediately preceding sibling), *jithina* ('name', i.e. illness springing from a name which the bearer's ancestors do not approve of), or *mpáshi* ('ancestor, "one who is below, i.e. in the ground" ') illness caused by an ancestor who is angry because of a violation of kinship obligations between living kinsmen). I have suggested how in each instance the particular labelling could be understood as the result of the ongoing social process in which the boy and his relatives were involved; and I have described this process in detail. When the labels mentioned were applied, the boy's condition was not considered amenable to cosmopolitan treatment, and local, ritual cures were pursued instead. At other times the relatives accepted the possibility that the very same somatic symptoms, in the same boy, might be within the realm of cosmopolitan medicine. They took the boy to hospitals and clinics, where such cosmopolitan diagnostic categories as '*pneumonia*', '*malnutrition*' and '*conjunctivitis*' were pronounced, without the relatives opposing these diagnoses or rejecting the modern treatment that was indicated.

Edward's case does not stand on its own. Our fieldwork involved us deeply in the health problems of our Nkoya interlocutors. Not only did we collect people's statements on illnesses, their categories, and explanations – in many cases we also examined the patients and tried to treat them. Malaria, gastroenteritis, respiratory tuberculosis, bilharzia, hookworm and various forms of eye infections are among the most frequent diseases in Chief Kahare's area. The attendant somatic symptoms are (with the exception of hookworm), fairly unmistakable, and (once one has learned the Nkoya language) as easy to discuss in that language as they are in English. However, when it came to labelling a particular combination of symptoms with a Nkoya category, it turned out that different vernacular diagnostic labels were applied to the same set of symptoms, and likewise, different symptoms might be identified under the same label. Moreover, these labels had again widely different implications as to the alleged illness-causing agent, and as to the healer to be selected. Similarly, the same diagnostic labels, such as *wurothi*, 'sorcery'; *mashika*, 'cold'; and *mulútu*, '(hot) body', were used to describe such different disease patterns as malaria, gastro-enteritis, and respiratory tuberculosis. This finding is rather at

variance with Symon's (1959) description of the medical system of the Nkoya and neighbouring groups: without any semantic analysis or methodological discussion, Symon's crude listing of local disease names and treatments suggests a one-to-one relationship between local diagnostic terms and those of cosmopolitan medicine. I think Symon is utterly mistaken.⁹³

However, *Nkoya diagnostic categories constitute, in the first place, an idiom to discuss, in a more or less coded and symbolic form, the social relationships surrounding the patient.* For instance, if these relationships are currently in a state of intense conflict, and if in the patient's social environment there is a strong interest, among one faction or another, to bring this conflict out in the open and force the issue, then the diagnosis of *wulothi* ('sorcery') is likely to be made, by that faction. (For a case in point, cf. van Binsbergen 1977b: 50 f.). Rival factions thus implicitly accused of evil practices, or those parties that have an interest in playing down the conflict, will instead propound alternative diagnostic labels: e.g. *Bituma* (a spirit affliction unrelated to human aggression); *wulwēji ya Nyambi* ('illness sent by God', i.e. regardless of human action); *wulwēji wa Bamukuwa* ('Europeans' illness', i.e. amenable to cosmopolitan treatment); etc. Typically, the various parties involved try (through their display of formal authority, gossip, and rumours) to influence the patient, sponsors, and public opinion in general, so as to have their own interpretation of the disease prevail. This struggle is in itself part of the social process in which the patient, and the surrounding parties, are involved, and its outcome depends on their relative strength. Once the patient and his sponsors have accepted one diagnostic category as the most applicable one, they thereby commit themselves to a particular type of healer⁹⁴ until further developments take place in the social process, necessitating a new interpretation of the same patient's complaints, and a new choice of healer. Edward's case provides several illuminating examples of this.

Thus it would seem as if, in the Nkoya case, the cognitive approach cannot in itself throw light upon the selection problem. There is no denial that Nkoya medicine, like any other medical system in the world, is also a cognitive system; and I could have described this system more systematically and in

⁹³ Apart from this one obscure publication, nothing is known of the author Symon, and his or her original profession can no longer be ascertained.

⁹⁴ My emphasis is on the cognition of the patients and their sponsors; the specialist healers each use a diagnostic system that tends to be more technical, elaborate, idiosyncratic, and orientated towards somatic symptoms, than are the laymen's diagnostic categories on which the patients and sponsors base their choice of healers in the first place.

greater detail. This cognitive system, with all its partly obscure symbolic and religious implications, full of contradictions and *double ententes*, sets the boundaries within which Nkoya health action can take shape, and defines basic fears as well as the possibilities for mutual identification within the community and across the urban-rural divide. For this reason cognition constitutes one of the pivotal elements of Nkoya society. But between the emic cognitive system, and actual health action, stands the ongoing social process, which determines which elements in this cognitive system will be selected for action. Where medico-anthropological studies have so far tended to ignore the social process, I still feel justified in concentrating on it.

***ADDITIONAL AND REFERENCE
MATERIALS***

CHAPTER 9. PHOTO ESSAY



Fig. 9.1. In the setting sun, in a yard at the newly created Nkeyema Agricultural Scheme, 25 kms north of the Mema Valley, a woman adjusts her head scarf while sorting *kandoro* tubers, 1977; note the combination of time-honoured elements (e.g. calabashes) with cosmopolitan market items (e.g. oil drums, enamel dishes, plastic buckets)



Fig. 9.2. In the rising sun, a white debarked forked branch planted upright (in itself probably a solar symbol; it is in North American cultures (Hultkrantz 1980) whose continuity with South Central Africa I have argued at length, e.g. 2012a) serves as a shrine for the *Bituma* cult in a Nkoya village, Mushindi Valley, Kaoma District, 1973; similar branches, but more usually living shrubs, are in use as village shrines among the Nkoya (van Binsbergen 1979b: ch. 3).



Fig. 9.3. At the Annual Kazanga Festival, 2006, near a temporary shrine erected for the occasion, the hereditary headman and royal councillor Mwene Shelonga [13] (Muchati's father), a traditional Owner of the Land and prominent member of the Kambotwe descent group that owned the Kahare royal title until the late 19th c. CE, exerts his historic privilege of playing the drum for the Royal Dance of Mwene Kahare; by virtue of the same historic condition, he is also, with his sons, the hereditary Undertaker of the Chief.



Fig. 9.4. In a clearing near Nyamayowe Village, Mushindi Valley, the senior *Bituma* leader Mrs Munyonga Shelonga [11] (Muchati's mother) poses in her all-white ritual uniform (recently made by my wife Henny) and wields her ritual flyswitch, standing near her *Bituma* shrine which is hung with strings of white beads; she is seconded by her granddaughter Rusha, my adoptive sister's daughter [15], who, four decades later, appears as an adult and mother on the cover of this book.



Fig. 9.5. The time-honoured, standard form of celebration among the Nkoya has been *ruh̄n̄wa*, a nocturnal dance around the xylophone and drums, which in the 1970s was still young village girls's principal form of recreation; name-inheritance (*ushwana*) celebration, Mabombola Village, Mema Valley, 1977; cf. van Binsbergen 1990b.



Fig. 9.6. In the early morning after the same nocturnal *ushwana* ritual and festive dance as shown in the previous photograph, a drum is brought back to the festive circle for the final, liberating dance in which the heir is to present herself to the community in the identity she had just inherited; in the right-hand feaster we recognise Muchati [7].



Fig. 9.7. In recent decades the role of traditional healers (*banganga*, ‘African doctor’ in Zambian English) among the Nkoya (and throughout Zambia) has taken on more and more syncretistic Christian elements. Here, in the centre of Nyamayowe Village, 2011, many years after the events described in this book, we see the surgery (marked, in Zambian English CHECHA AFLICAN DOKOTA, ‘Traditional Healer’s Church’) by means of which Muchati [7], now approaching 70 years of age, has sought to continue the spiritual specialities of his mother’s family – contrary to his mother Munyonga [11] he was never active as a *Bituma* leader but has sponsored many *Bituma* sessions for his wife Mary [4] and his sister Jenita [9].



Fig. 9.8. Forty years after the inception of their close relationship, this picture shows Muchati [7] and Tatashikanda (the author, left, in one of his more athletic poses) waiting for an audience with Mwene Mutondo, one of the three other royal Nkoya chiefs besides Mwene Kahare, in the temporary royal court erected for the occasion of the Kazanga Cultural Festival, Kaoma District, Zambia, 2011.




Fig. 9.9. A few days after the occasion shown in the previous picture, this photograph shows Muchati [7] and Mary [4] as an aged couple meeting Tatashikanda at the road junction of Karare, Kaoma District, 2011.




Fig.9.10. Against many odds: this book's protagonist, Edward [6], alive and kicking, at a restaurant in Kaoma township, Zambia, 2011, nearly forty years after the events described in this book.

22/100



THE KWAME (LEGWAME) TRADITIONAL
ASSOCIATION OF BOTSWANA



Mr./Mrs./Miss
M. J. Van Binsbergen

has been examined by our most qualified committee and found fit to practice as a traditional doctor and is hereby appointed a qualified member of the Kwame Traditional Association of Botswana

President G. Phiso 05.09.90


Chairman.....

Secretary.....

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**KWAME (LEGWAME)
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This is to certify that Mr. M. J. Van Binsbergen ~~of~~
has been examined by our most qualified committee and found fit to practice as a traditional doctor and is hereby appointed as a qualified member of the KWAME (LEGWAME) TRADITIONAL ASSOCIATION OF BOTSWANA.

G. Phiso 05.09.90
President

Chairman
KWAME (LEGWAME)
TRADITIONAL ASSOCIATION
OF BOTSWANA

Fig. 9.11. My 1990 membership certificates of the Kwame (Legwame) Traditional Association of Botswana, by virtue of which I am recognised as a qualified traditional doctor throughout Southern Africa.



Fig. 9.12a,b,c. My principal teacher of herbalism, and *Hakata* (four-tablet) divination, Dr Smarts Gumede, Somerset informal residential area, Francistown, Botswana, 1989, throwing his divination tablets in his surgery (top left); interior of his surgery (top right; cf. van Binsbergen 1998b); and outside his surgery at his vending stall offering firewood and fat cakes (bottom)



Fig. 9.13. The author in a regrettably narcissistic pose in full *Sangoma* regalia in his study in the Netherlands (2006).



source: <http://www.medanthrotheory.org/article/view/4594/6250>, with thanks

Fig. 9.14. Photographed against his native typical Dutch landscape of canals, meadows and cows, so dear to him, Sjaak van der Geest (ca. 2015), emeritus professor of medical anthropology at Amsterdam University, and a major catalyst towards the medical-anthropological work of Wim van Binsbergen.



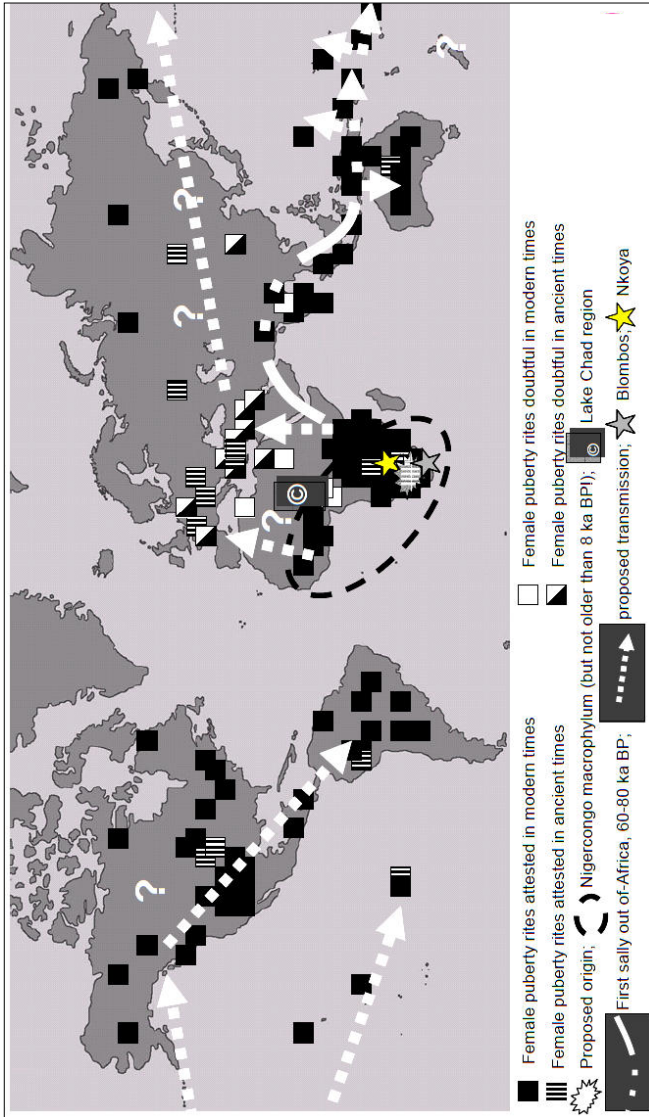
Note the ominous withered plant on the bookshelf in the back; a symbol of the young alumnus's anthropological career? Of Köbben's? Of his Amsterdam School of Anthropology? Of the West's hegemonic etic subjugation of non-ocsmopolitan knowledge systems?

Fig. 9.15. André Köbben (right), leading anthropologist at Amsterdam University at the time, congratulates Wim van Binsbergen (left) after the latter's gaining, *cum laude*, the degree of Doctorandus of Social Science at the end of the then mandatory seven years of full-time study (1971).



in the background the surroundings of Chief Kahare's capital in Mema Valley (2011); in horizontally rotated form, the same photograph serves as this book's cover illustration

Fig. 9.16. Four decades after the events described in the present book, our minor protagonist Rusha ([15]; who as a baby had often played on my lap) waiting with her own latest baby in the porch of the Mema Rural Health Centre, built 1978-1990 in local self-help at the initiative, and on the strength of the national and international resources, of her adoptive mother's brother Tatashikanda, who also took this picture when accidentally running into Rusha during his 2011 return visit to the area.



source: van Binsbergen 2022c; also cf. 2021a : 187n.

Fig. 9.17. Against the background of the world distribution of Female Puberty Rites as attested in historical times, this diagram seeks to reconstruct the long-range history of such rites over the past 200 ka, from a putative origin (at least as far as Anatomically Modern Humans are concerned) in Southern Africa.

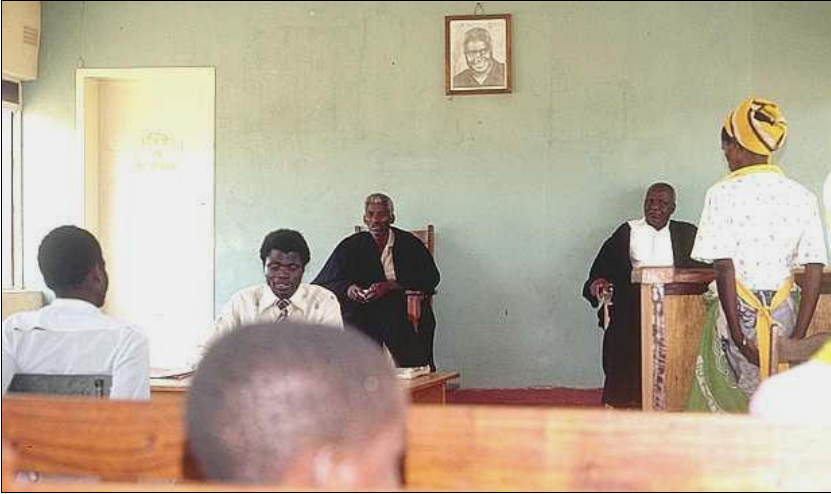


Fig. 9.18. The Local Court as a contested intercultural space (1977): The state-instituted 'Local Court' at the royal capital of Mwene Mutondo, one of the royal chiefs among the Nkoya. The seats, gowns, the court clerk (a formally trained outsider in control of all procedure and documents), the picture of the state president Dr Kaunda, the upright stance of the lady giving testimony, are all cosmopolitan / transcontinental manifestations, yet the two assessors are traditional royal councillors, mainly applying a largely local, oral, time-honoured and recognisable form of family law in an emphatically modern and state-controlled setting,



Fig. 9. 19. Today's digital media revolution reaches Nkoyaland: my adoptive cousin the late lamented Dr Stanford Mayowe, in 2011 (after retirement as director of the parastatal *Lake Fisheries*) active as district councillor, local representative of the World Wildlife Fund (operating from the distant Kaoma District capital), administrator of an organisation dispensing farmer's loans, office-bearer of the Kazanga Cultural Society, and sometime unsuccessful pretender for the throne of Chief Kahare, uses his cellphone in front of his house at Nkeyema, Kaoma District, under the disc antenna that keeps him connected to the wider world (2011); the house is also equipped with solar electricity



Fig. 9.20. The late lamented Mandanésima (Henny van Binsbergen née van Rijn), the infant Nezmja, and the dog Lisa, Lusaka, 1972



Fig. 9.21. Mandashikanda / MmaSara (Patricia van Binsbergen née Saegerman) in conversation with Mr Sunarta, local politician and family head, in a Hindu family temple during fieldwork in Sanda, western Bali, Indonesia, 2010 (van Binsbergen 2010d).

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11. BIBLIOGRAPHY OF WIM VAN BINSBERGEN'S WRITINGS WITH RELEVANCE FOR THE FIELD OF MEDICAL ANTHROPOLOGY

After the 1980s, Wim van Binsbergen has seldom explicitly identified as, specifically, a medical anthropologist. Even so, many of his later writings have had relevance for the field in question. The list below brings together both his explicitly medical-anthropological writings, and a wider selection of writings in the fields of magic, shamanism, possession, mediumship, divination (including geomancy and astrology), healing and healing cults (including cults of affliction), incubation and pilgrimage, (bodily) symbolism, life crisis ritual (including puberty rites) that contain materials or discussions that are relevant in the present context. Often, especially for the works deemed to be only peripherally relevant to medical anthropology, we have added a summary indication of that relevance. We have structured the bibliography into the following sections

1. Fully fledged works centrally relevant to medical anthropology
2. Fully fledged works peripherally relevant to medical anthropology; often containing chapters of medical-anthropological relevance as listed separately elsewhere in this chapter's bibliography
3. Ephemera and other minor texts centrally relevant to medical anthropology

q.v. = 'see there', reference to the full bibliographic listing of the publication in question elsewhere in this bibliography

Nearly all publications listed here are freely accessible on the Internet through the clickable links offered below; exceptions involve mainly texts of a confidential nature such as reader's reports and external examiner's assessments – which yet often contain points of a much wider applicability.

This bibliography stands on its own and is (contrary to the preceding LIST OF REFERENCES CITED) not a key to the Shortened Harvard references (*e.g.* Evans-Pritchard 1952a, 1952b, etc.) employed throughout the main text and footnotes of the present book – it deliberately lacks the appropriate year letters.

1. Fully fledged works centrally relevant to medical anthropology

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the medieval Islamic textual background of the principal geomantic divination systems in sub-Saharan Africa

van Binsbergen, Wim M.J., 1976, Ritual, class and urban-rural relations : elements for a Zambian case study, *Cultures et développement*, 8, 2: 195-218; incorporated in: van Binsbergen 1981, *Religious Change in Zambia*, q.v.

how healing cults link town and countryside

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the bodily symbolism of orifices

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ecstatic cults compared

van Binsbergen, Wim M.J., 1971, 'Muziek en dans in het Atlasgebergte', *Dansbalans*, March 1971: 2-5; also at: <http://www.quest-journal.net/shikanda/Berber/muziek%20dansbalans%20otekst%20ogescand.pdf>

also music and lyrics of the Islamic ecstatic cult

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contains a detailed quantitative analysis of the sociological background of local fuqra (members of an Islamic ecstatic healing cult), and qualitative analysis of

the world view within which local conceptions of health and illness are situated

van Binsbergen, Wim M.J., 1971, 'Muziek en dans in het Atlasgebergte', *Muziek en Volkenkunde*, Jan./May 1971, no. 109-113; identical to van Binsbergen, 1971, 'Muziek en dans in het Atlasgebergte', *Dansbalans*, q.v.

includes musical score and lyrics from the local Islamic ecstatic cult

van Binsbergen, Wim M.J., 1972, '*Bituma*: preliminary notes on a healing movement among the Nkoya of Kaoma district and of Lusaka, Zambia', paper read at the University of Zambia/University of California Los Angeles conference on the history of Central African religious systems, Lusaka, 16 pp, incorporated in unpublished set of conference papers: Conference on the history of Central African religion (1972), Los Angeles: University of California Los Angeles, p. 30-43; fulltext at: <http://www.quest-journal.net/shikanda/publications/bituma%201972%20ofor%20PDF%20def.pdf>

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healing cults

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Edith Turner (the famous religious anthropologist Vic Turner's widow) sweepingly claims the material reality of spirits as conceived in non-cosmopolitan diagnostic and therapy systems; my argument seeks to expose the naivety of such a view and also dwells on the trancontinentality of many related knowledge systems

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2006; greatly revised and expanded January 2011; draft version), http://www.quest-journal.net/shikanda/ancient_models/crosshatching_FINAL.pdf; also as a Powerpoint Presentation: http://www.quest-journal.net/shikanda/ancient_models/crosshatch/index.htm

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akin to magic and sorcery, and triggering diagnostic and therapeutic action, evil is a potential focus of medical anthropology

van Binsbergen, Wim M.J., with the collaboration of Lacroix, Jean-Pierre, 2000, Cupmarks, stellar maps, and mankala board-games: An archaeoastronomical and Africanist excursion into Palaeolithic world-views; provisional version at: http://www.quest-journal.net/shikanda/ancient_models/gen3/starmaps_3_2000/cupmarks_o.html

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van Binsbergen, Wim M.J., 1979, 'Explorations in the History and Sociology of Territorial Cults in Zambia', in J.M. Schoffeleers, ed., *Guardians of the Land. Essays on Central African Territorial Cults*, Gwelo (Zimbabwe): Mambo Press, pp. 47-88; incorporated in van Binsbergen, 1981, *Religious Change in Zambia, q.v.*

sorcery, murder, and incest as the three traditionally distinguished plagues that affect the land and its fertility

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novel on fieldwork with major ritual aspects, whose therapeutic relevance is touched on in passing

van Binsbergen, Wim M.J., 1990, 'The state and African Independent churches in Botswana: A

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touches on divination, shamanism, female puberty rites, their traces in prehistory, and their significance for the foundation and continuity of human society

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van Binsbergen, Wim M.J., in press (c), *Testing the Sunda hypothesis: Provisional report on the proto-historical transcontinental connections of the Bamileke people of Cameroon: In two vol-*

umes, I. *Data and theory*; II. *Photo essay*, Hoofddorp: Shikanda Press, Papers in Intercultural Philosophy / Transcontinental Comparative Studies (PIP-TraCS) No. 19

contains a discussion of the Sunda thesis, demonstrated (e.g. in van Binsbergen, Sunda, 2020, q.v., p. 210n) to be illuminating for the rise of medicine (and shamanism) in the Ancient Near East - see more extensive discussion below under the 2020 Sunda book ; short discussion of traditional medicine and its principal agent at a modern Bamileke court; suggestions of transcontinental continuity notably with China

van Binsbergen, Wim M.J., in press [projected for 2023], 'Our drums are always on my mind': *Nkoya history, culture, and society, Zambia*, Hoofddorp: Shikanda, Papers in Intercultural Philosophy and Transcontinental Comparative Studies, 11

van Binsbergen, Wim M.J., & Peter Geschiere, 2005, eds, *Commodification: Things, Agency and Identities: The social life of Things revisited*, Berlin/Muenster: LIT, at: <http://www.quest-journal.net/shikanda/ethnicity/commodif.htm>

van Binsbergen, Wim M.J., & Wiggermann, F.A.M., 1999, 'Magic in history: A theoretical perspective, and its application to Ancient Mesopotamia', in: Abusch, T., & van der Toorn, K., eds., *Mesopotamian magic*, Groningen: Styx, pp. 3-34; also at: http://www.quest-journal.net/shikanda/ancient_models/gen3/magic.htm ; reprinted in van Binsbergen, 2017, *Religion as a social construct*, q.v., pp.. 293-325

van Binsbergen, Wim M.J., with the collaboration of Jean-Pierre Lacroix, 2000, *Cupmarks, stellar maps, and mankala board-games: An archaeoastronomical and Africanist excursion into Palaeolithic world-views*; pre-publication version at: http://www.quest-journal.net/shikanda/ancient_models/gen3/stamaps_3_2000/cupmarks_0.html ; definitive, greatly shortened definitive version in: van Binsbergen, 2018, *Confronting the sacred*, q.v.: section 8.2.2. 'Burial as an indication of Neanderthal star-orientated religion?' , pp. 277- 283; the latter also as: van Binsbergen, Wim M.J., 2021, 'A Neanderthal stellar map? The La Ferrassie burial 6 block as a testimony of Neanderthal astronomy and star-orientated religion', at: http://www.quest-journal.net/shikanda/topicalities/neanderthal_short_article_def_better.pdf

potentially relevant for medical anthropology: a decapitated infant buried under an unmistakable stellar map of the Sirius region of the heavens, maar kan dat niet vinden ; the 2021 except mentioned a few lines up both dramatically strengthens the argument and reduces it to a few pages

van Binsbergen, Wim M.J., & Doornbos, M.R., 1987, eds., *Afrika in spiegelbeeld*, Haarlem: In de Knipscheer, also at: http://www.quest-journal.net/shikanda/literary/Afrika_in_Spiegelbeeld_1987.pdf

van Binsbergen, Wim M.J., 2020, *Sunda Pre- and Protohistorical Continuity between Asia and Africa: The Oppenheimer--Dick-Read--Tauchmann hypothesis as an heuristic device, with special emphasis on the Nkoya people of Zambia, Africa*, Hoofddorp: Shikanda, Papers in Intercultural Philosophy / Transcontinental Comparative Studies, no. 25; also at: <http://www.quest-journal.net/shikanda/topicalities/SUNDA%20BOOK%20FINALFINALDEFDEF%20lulu5-gecomprimeerd.pdf>

contains an important indication of Sunda effect on therapy systems in the western Old World: p. 210:. Apart from having been the patron god of exorcists, Ea was

a master craftsman, patron of all the arts and crafts, and endowed with a wisdom and cunning that myths and stories do not tire of extolling

The accompanying footnote reads [p. 210, note 173]: This could be an important detail. In the Ancient Near East, the rise of the crafts of the Asu and the Ašipu, ritual specialists of healing and divination (Ritter 1965), marks the arrival of shamanism on its expansion into Western Eurasia and possibly into sub-Saharan Africa. But below [i.e. in the 2020 Sunda book] we shall also identify such ‘cults of affliction’ (as they are known in the study of sub-Saharan Africa, by a term coined or at least propagated by the great anthropologist of religion Victor Turner) as potential tell-tale signs of Sunda influence. The Persian Gulf / Sumer is the most conspicuous candidate for Sunda influence to have landed in Western Eurasia. The term ašipu has no ready Austronesian antecedents, but asu straightforwardly means ‘dog’ in Proto– Austronesian – and the dog in the Ancient Near East is mainly conspicuous for its close association with healing cults (Edrey 2013). It is still too early to draw further conclusions, but the coincidence of these indications is intriguing, and may also cast a new light on the emphatic veneration of the Dog Star, Sirius (α Canis Majoris) in the Ancient Near East including Egypt’. So far the footnote. I cannot begin to discuss here the extremely rich Ancient and modern literature relating to Sirius, however relevant. For other relevant themes, cf. Ritter, E.F., 1965, ‘Magical-expert (-ašipu) and physician (-asū): Notes on two complementary professions in Babylonian medicine’, in: H.G. Güterbock & T. Jacobsen, 1965, eds., *Studies in honour of Benno Landsberger on his seventy-fifth birthday*, April 21, 1965, Chicago: University of Chicago Press for Oriental Institute of the University of Chicago, pp. 299-322; Edrey, Meir, 2013, ‘Dog Cult in Persian Period Judea’, in: Phillip Ackerman-Lieberman & Rakefet Zalashik, 2013, eds., *A Jew’s best friend: The image of the dog throughout Jewish history*, Bridgton etc.: Sussex Academic Press, pp. 12-35. In this canine connection it seems most significant that both the Ancient Greek and the Ancient Irish god of medicine, Aesculapius and Bran respectively, are standardly accompanied by a dog (Graves, R., 1988, *The White Goddess: A historical grammar of poetic myth*, London/Boston: Faber & Faber, reprint of 1961 edition, first published 1948, pp. 52 – and so is the great healing god demi-god Herakles / Hercules (also known as σωτήρ ‘the Saviour’, like Jesus of Nazareth in the Christian tradition), who has much in common with Aesculapius. In South Central Africa, where Zambia, and within it Nkoyaland, are situated, dogs mainly carry a rather different and from a human perspective often pejorative connotation. The Lozi used to call the Nkoya people ‘dogs’, and did not mean that as praise of the Nkoya’s unmistakable expertise at medicine; as is clear from many oral and written documents throughout the 20th c. CE, it is a designation with which the Nkoya took great offence. The circumcising people of Northwestern Zambia (among which the Nkoya in principle belonged right up to 1900 CE, when circumcision was discontinued; cf. van Binsbergen 1992 and 1993) used to eat dogs, perhaps in reminiscence of the extensive Chinese influence South Central Africa underwent in the course of the last two millennia (cf. van Binsbergen 2010 (Buddhism, Taoism...), 2012 (Presocratics), and 2020xx I have not specifically made enquiries into canine consumption among the Nkoya; I would be surprised if it ever was a major trait, for one thing because I did not come across it at all in fieldwork, for another thing because at least the Eastern Nkoya / Mashasha identify primarily as hunters, and for them a dog is an indispensable friend and ally, not a meal. This throws a rather more positive and less embarrassing light on the opening anecdote of this book, where I depict our relationship with the protagonist Muchati [7] as developing out of our need of a watchdog. The story ramifies in all directions. In 1971, when joining the University of Zambia, we came from Europe with our beloved dog Jinn, which was my wedding gift to my first wife Henny. When we gave up our Lusaka urban residence for Nkoyaland, Jinn still accompanied us, and at the end of our rural fieldwork he stayed on in the loving hands of Muchati, who with the application of patience, skill, and special secret

dog medicine, turned Jinn into a formidable hunting dog. The dear animal ended its glorious days heroically, on the horns of an irate buffalo which Muchati had shot but not killed; Jinn's being my wedding gift to my first wife Henny, this held ominous but correct forebodings for the future of our marriage. Overlooking the entire dog theme in this book we can only suggest that (for murky reasons; perhaps reality emulating the order imposed by our own mind? cf. my book *Sangoma Science*?) there is poetic justice in fieldwork, even transcontinentally and interculturally.

van Binsbergen, Wim M.J., 2011, 'Sri Lanka fieldwork 2011: Provisional photo essay', at: http://quest-journal.net/shikanda/topicalities/srilanka_fieldwork_webpage/SRI%20LANKA%20FIELDWORK%202011%20WEB.htm

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13. GENERAL INDEX

Exhaustive listing of all proper names in this book, including authors. Names (*i.e.* pseudonyms) of the protagonists in our central extended case are followed by a number between square brackets [], facilitating their identification in the genealogy of Fig. 4.1 and elsewhere in this book

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- Seventh Day Adventist Church, 20, 55
- Sexual Revolution, 20th c. CE, 25n
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- Shapiro, W., 11n
- Sharpston, M.J., 106n
- Shattock, F.M., 105, 45n
- Shelonga [13], 70, 79, 82, 85-86, 89, 96, 129-130, 31n, 96n-97n; and Kahare, 96n; - and Banduwe, 80
- Shelonga, FaWiSiDaSo of -, [22], see Fig. 4.1
- Shelonga, sister's son of - , [45], see Fig. 4.1
- Shikanda Press, 6
- Shikanda, transcontinental designation spanning the three continents of the Old World: Queen, incumbent of the Kahare royal title, ca. 1790 CE, named after the Hindu god of war Skanda, whose name in turn derives from Alexander the Great, king of Macedonia, N. Greece, ca. 300 BCE; cf. van Binsbergen, Shikanda, Mandashikanda, Tatashikanda, Shikanda Press
- Shimbinga, Luvale syncretistic prophet among the Nkoya, 62, 73, 85
- Shimunika, Rev. J., former diviner-healer, the first Nkoya Protestant pastor, 22n
- Shipuna, [5], 67, 71, 74, 79, 82
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- Soli, Zambian ethnic group, 84n
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- Spaarne Gasthuis, hospital, Haarlem / Hoofddorp, Netherlands, 6, 48n
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- Tempels, Placide, 23n
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- Terramycin*, antibiotic eye ointment, 88
- Terray, E., 11n
- Tetangimbu, witchfinder and mass murderer, 96n-97n; Tetangimbu Village, 63
- Thailand, Thai, 25n
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- Third-World, 102, 116, 55n
- Thoden van Velzen, Bonno, 28, 12n
- Tolstoy, L., 94n
- Tonga, Zambian ethnic group (among a handful of South Central African groups bearing that name, cf. van Binsbergen 2020c: Index, s.v. Tonga), 63
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- United Nations Development Programme, UNDP, 54-55
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- Verdaasdonk, Hugo, 13n
- Vicarious Reflections* (van Binsbergen), 4, 34n
- Volkswagen* van, 10
- von Mering, O., 11n
- Vosters, Dr, 35
- Vrijeleide* (van Binsbergen), 26n
- Wales, Welsh, Welshmen, UK, 29
- Walhalla, Germanic heaven, 10
- Warner, W.L., 11n
- Watchtower, Christian religious movement in the North Atlantic and Southern Africa region, in the latter region often with syncretistic (notably witch-finding) accretions, 21, 103n; - Bible and Tract Society of Pennsylvania, 21n
- Watson, W., 59
- Weber, M., 118n
- Werbner, Richard, 29, 34, 114, 31n
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- Zambezi District, 17n
- Zambezi River, 53, 63; Zambezi-Kafue (*q.v.*) watershed, 55n
- Zambia National Archives, Lusaka, Zambia, 94n
- Zambia(n(s)), *passim*; Central - 83n; - Northwestern, 14n; - Western Province, 53; - Tribal And Linguistic Map, 143, 84n; Western - , 41, 61-62, 101; Post-Independent - , 143; Western - Plateau, 53; Zambian English, 133; Zambian Ministry of Health, 20
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- Zimbabwe(an(s)), 63
- Zulu, ethnico-linguistic group in South Africa, 18n
- Zuster, Dochters / Sisters, Daughters* (van Binsbergen), 26n
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14. LIST OF PROTAGONISTS IN OUR CENTRAL EXTENDED CASE

See the genealogie of Fig. 4.1.

person	no.		person	no.
son of Banduwe	[1]		brother (b) of Mary	[27]
Banduwe	[2]		Malwa	[28]
sister of Malwa	[3]		sister of Mary	[29]
Mary	[4]		Jimbando	[30]
Shipuna	[5]		brother of Jimbando	[31]
Edward (central protagonist of our extended case)	[6]		Enesi	[32]
Muchati	[7]		wife of brother of Jimbanda	[33]
Kafungu	[8]		ex-husband of Enesi	[34]
Jenita	[9]		sister of Malwa	[35]
husband of Jenita	[10]		deceased wife of ex-husband of Enesi	[36]
Munyonga	[11]		third wife of Kawoma	[37]
brother (a) of Muchati	[12]		Munjilo	[38]
Shelonga	[13]		<i>not attributed</i>	[39]
brother (b) of Muchati	[14]		Kashimbi	[40]
Rusha	[15]		Patrick (a)	[41]
child of brother (b) of Muchati	[16]		<i>not attributed</i>	[42]
brother (a) of Mary	[17]		daughter of kashimbi [40]	[43]
Kafungu	[18]		husband of [43]	[44]
Kwambashi	[18, 19]		sister's son of Shelonga	[45]
Nchamulowa	[20]			
Ngondayenda	[21]			
FaWiSiDaSo of Shelonga	[22]			
Loshiya	[23]			
Kawoma	[24]			
Emeliya	[25]			
Masholi	[26]			