The infancy of Edward Shelonga: an extended case from the Zambian Nkoya

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THE INFANCY OF EDWARD SHELONGA

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Part I

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for Henny

1. INTRODUCTION1

In this chapter I shall present a case history based on the health experiences of a Zambian boy in the first years of his life. The reason for publishing this case is that it sheds some 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. 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 section 2, I introduce the problem, and the method by which I shall approach it. The next section gives some background data (medical, social-structural, cultural) without which the case cannot be understood. In section 4, I present the case history. In the next section I examine the researchers roles in the case, which were so crucial that the story might be considered a research artifact. Having demonstrated that the case is not thus contaminated, I proceed in section 6 to outline the structural principles that can be derived from the case history, as they apply to the specific social setting of Zambian peasants and urban poor belonging to the Nkoya ethnic minority.

Although displaying a seemingly irrational movement to and fro between cosmopolitan and Nkoya medicine, the health behavior 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) 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 by these institutions, set the internal constraints for the social process within Nkoya society, and thus largely determine when and why younger people have 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.

- Most Nkoya (and many other African urban migrants) are in a peculiar socio-economic position. They participate 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 economic of this part of the world has assigned to the village the task of reproducing cheap labor and accommodating discarded labor. Remaining dependent upon the village, even those Nkoya who are committed supporters of cosmopolitan medicine 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 channeled to the village.

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 (1976:4) 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. There are some social-science studies available, both on cosmopolitan medicine in Zambia2 and on some of the alternatives: herbalists,3 priest-healers,4 and African midwives.5 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,6

but these two authors have so far not published an exhaustive 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 healers - WvB] patients had 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 and 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.

Leeson's research was carried out in Lusaka. 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. The majority of these (in fact: all except the private practitioners) are non-fee-paying; also drugs are 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 informants consulted the nganga, at the exclusion of cosmopolitan agencies, for complaints that (cf. table 1) many Zambians today consider amenable to western treatment: they allow themselves to be hospitalized on the basis of these complaints.

Table 1a. The six most frequent reasons for hospitalization in Zambia (source: Stein 1971)

While these data demonstrate the prominence of these diseases in the Zambians' utilization of cosmopolitan medicine, table 1b indicates that the same diseases constitute important reasons for the consultation of non-cosmopolitan healers:

Table 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 paper may sound ethnocentric, even smack of cultural imperialism. Cosmopolitan medicine is just one particular socio-cultural subsystem, peculiar to a type of industrial society that since the nineteenth century has spread over many parts of the world. 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 favor of cosmopolitan medicine. Moreover, despite its achievements and power, cosmopolitan medicine itself is increasingly criticised within the very societies it sprang from; Illich's recent Limits to Medicine, Medical Nemesis: The Expropriation of Health (1977) 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 Pyrrhus 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 and might not be entirely representative for the Lusaka population as a whole. The only other 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: 356f) 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. These reasons overlap with those mentioned by Leeson and throughout the literature on the subject (cf. Lieban 1973: 1056f). Le Nobel's clinical experience in the field of maternity care at the rural district level in Zambia suggested that access to the outlets of cosmopolitan medicine also plays a major part. When a mobile maternity service greatly increased accessibility, utilization increased threefold (1969: 85f); 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 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.

An increasing number of publications in now becoming 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.7 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 paper I shall approach the problem from a different angel: the extended-case method, to whose development Turner himself and his sometime Manchester colleagues (foremost Van Velsen) have so greatly contributed;8 moreover the presentation of my data and analysis has been modelled, somewhat, after Epstein's paper on urban networks (1969). 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; but on the basis of a

carefully studied sequence of social events involving the same interacting protagonists. Applied to the medico-anthropological perspective (cf. Janzen 1975), I shall contend that cosmopolitan medicine and its various local alternatives constitute 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 in the account that follows.

Limitations and possibilities of the extended-case method in medical anthropology will became 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 parts of 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 aspects. 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 to drag off 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 (section 5), I shall briefly consider this ethical question.

This paper is an anthropologist's contribution, and makes no claim to medical competence. When the course of our field-work forced us to diagnose and treat our informants' illnesses, we did so as amateurs, albeit that my wife's long-standing experience with medical research as a biophysicist greatly facilitated our access to medical literature and to medical practitioners. The plausibility of such diagnoses as my argument contains has been confirmed in later, 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 is available within 80 km, there a two-hours drive.

3. BACKGROUND

The protagonists in this case belong to the Nkoya people, a small ethnic group which has its home area in the eastern part of Zambia's Western Province (formerly Barotseland), and surrounding areas.9 My medico-anthropological data mainly derive from the Nkoya of Chief Kahare,10 a small group of peasant cultivators and hunters.

Chief Kahare's is not a healthy area.11Situated on the central western Zambia plateau, at the Kafue/ Zambezi watershed, the area contains swampy streams and fishing ponds conducive to malaria and bilharzia. Respiratory tuberculosis and gastro-enteritis 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.12 Infant mortality is high. Moreover, fertility is exceptionally low.13 This may be related to such social factors as high marital instability, polygyny, and labor migration (cf. De Jonge 1974); and to local practices relating to sex and childbirth.14

Being located at the periphery of the province and even of the district they belong to, Chief Kahare's Nkoya have only recently seen the establishment of a permanent outlet of cosmopolitan medicine in their own area: a Rural Health Centre dating from the late 1960s, at about 30 km from Chief Kahare's capital village. However, at distances of 80 km and more, dispensaries, and even (just beyond the district's western border) a mission hospital have existed since the 1930s (Northern Rhodesia, 1930). 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; very rare inoculation campaigns, and the habitual medical check-ups when one registered as a labor migrant at the distant provincial capital: this sums up at about all there was of cosmopolitan medicine, and its derivations, during most of the colonial period.15 Of the three hospitals now found in the district, one was established in the late 1950s and the other two around the time Zambia became independent (1964). None of these present-day hospitals is within 80 km from Chief Kahare's village.16 Although the number of outlets of cosmopolitan medicine compares favorably with other districts in Zambia,17 it is mainly the people living in that part of the district where the three hospitals are concentrated (each within only 50 km from the others!), who more than sporadically benefit from them.

For an understanding of the extended case, a minimal introduction to Nkoya social structure is necessary. Throughout my presentation of the case I shall refer to the principles outlines here. I shall take them up explicitly in my interpretation of the case, in section 6.18

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 will turn out to 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 members of this subsystem are based 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 (Van Binsbergen 1978b). 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, medicine obtain, and almost every Nkoya individual is involved in social processes in which both urban and rural kinsmen and tribesmen 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: 137f) 'the mode of reproduction of cheap labor' (cf. Gerold-Scheepers & Van Binsbergen, 1978: 25f).

Capitalism brought not only processes of material expropriation and extraction 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 labor 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 ethnic minority in towns the labor 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 labor force while relegating the costs of its reproduction to rural society. The latter becomes economically exploited, in fact impoverishes, and its social organization is eroded since its original economic base has been greatly affected by capitalist relations of production (Van Binsbergen 1978b). 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 labor, 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 remittances to rural kin. thus they demonstrate 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 at least 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 to 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.

Let us now move on to the internal structure of Nkoya society. The formal principles governing personal intra-ethnic social relationship 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 much hunting takes place. Each valley derives a separate identity from rain ritual, an unofficial neighborhood 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. After the death of a headman, a successor is chosen from among a large pool of patrilateral, matrilateral, 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 to take up the vacant headmanship of a village. Names and titles of persons other than headman are inherited in a similar fashion. Usually inhabitants of a village are real or putative kinsmen of the headman. However, the Nkoya reckon descent bilaterally; moreover, intra-village marriages have become exceptional and are now frowned upon; and consequently an individual's maternal kin and paternal kin (either of which he may opt to reside with) tend to be spread over a number of different villages; and in addition to real and putative genealogical links, joking relations between pairs of clans19 may lead to close personal relationships that in effect contain the same claims and rights as actual kinship.

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 tribesmen, 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 the fact that they have grown up together or have 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 consanguinean 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 association, over a few years, for the purpose of marriage negotiations, court cases, ritual, and inheritance to prestigeous titles connected with headmanship and chieftainship. Although these clusters have to fixed boundaries nor ascriptitious recruitment of members (i.e. their shifting composition cannot be predicted just from a genealogy or a village map), they are not completely 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, 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.

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, Muchati's 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, 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 10 km.

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 Turner (1957, 1961, 1962, 1967a, 1967c, 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, cults of affliction have emerged 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 Turner), I 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 hidden 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; he participates in cult sessions to reinforce his 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 paper. 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 informants remember these cults' original founder-prophets (cf. Van Binsbergen 1977a: 155f), the latter are depicted as having tried, at some state, cosmopolitan medicine before founding their own healing cult. Oral traditions concerning one such prophet, Ngondayenda, invariably stress the lack of clinics and hospitals in the district in the 1930s, when severe human and cattle epidemics occurred.

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 present-day 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 paper tries to understand why this should be so.

4. THE EXTENDED CASE

I shall present the facts of Edward's [6]20 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 sections, interpret these facts in the light of the central questions posed in this chapter.

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. 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. The ward comprised six to eight households of close 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 clandestine bar. He had established a stable relationship with a non-Nkoya townswoman.

1969. Muchati's kinsmen in Nyamayowe village prearranged 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 distant classificatory sister, and thence 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 recent innovation among the Nkoya. Muchati's parents themselves were 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 consanguinean 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], 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. He divided his life between Chief Kahare village (where the household of his favorite 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. 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. For divorce is extremely frequent in this society.

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 the 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 conflict might be adequately dealt with in a judicial context.21 Nyamayowe village had already received a wife from Jimbando village, 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 district personalities and interests, as well as the development of affinal tensions inherent in any Nkoya marriage but acerbated by the confusing 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 explain any Edward's case as non-representative. Beneath the specific details, a more fundamental and universal principle can be detected: the extreme optional 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. Only part of the agreed bride-price had been paid. The rest was to follow in installments 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 services. He has 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 satisfied herself that the accusations were quite unfounded. Meanwhile Muchati lost his job as a cleaner.

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 cult), the cult leader Jilemba accused her of sacrilege and fined her K1.22 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 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 1/2 years of very intimate day-to-day interaction.

December 1971-January 1972. For several weeks Mary had complained of vague, diffuse ailments.23 Finally she proclaimed that she wanted to travel to the village in order to submit to treatment within a cult of affliction. Muchati could not detain her, 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 hart to accept and enjoy her uxorial role in the urban environment. For 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 en 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 very expensive clothes.

The cults of affliction stipulate actions that the (almost exclusively female) adepts must undertake for the sake of their own 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, 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, too, take the idiom of the cults of affliction seriously, 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 over display of marital conflict. Another reason why Muchati was unable to hold her back , was that he still owed her kin group the final installment of the bride-price.

In Jimbando village, Mary participated in a Bituma session, directed by her mother's sister, Masholi [26]. After a month, Muchati went to collect her and paid the outstanding amount.

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 cults founder, still fostered the latter's relics 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 antenatal 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. For pregnant women, unborn of 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 labor 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 Kalingalinga, in order to collect a midwife and her assistants from among his Nkoya relatives there. Soon four women arrived, including Banduwe [2] who was to play 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 point out the availability of 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. During the delivery, the women in attendance kept Muchati out of doors. Repeatedly he came to request our 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, 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 to the University Teaching Hospital, were she was admitted She was discharged again early in the morning, i.e. nine hours later, without any follow-up appointment.

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 immature according to Nkoya custom, he haphazardly gave him the name if Jimbando, his 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 the nearby 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, if in fact she had dropped Edward.) Edward was admitted to hospital on a diagnosis of pneumonia, possible 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, in a crammed and ill-accommodated shelter, added to her worry over the baby and made this a very unhappy episode for Mary.

The hospital staff did not give the slightest attention to the continuation of Mary's lactation. In combination with the worry over the baby, 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,24 the impairment of this function was a very heavy blow for Mary, and a cause of intense feelings of guilt. Mary and Edward were sent home 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 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 previous experience with expatriates' infants including our own daughter, Muchati accepted the absolute necessity of sterilization of bottles etc., and he conveyed this insight to Mary. With all our modern comforts at her disposal (pied 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 nurtural inadequacy and her dependence on members of the opposite gender 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 fee her child. Yet her dealings with Edward seemed somewhat mechanical, formal, and lacked the spontaneous generosity so typical of Central African patterns of breast-feeding. An important factor in this was no doubt the fact that 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 here 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 commonly reserved for women. 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 would appear as if Mary was subconsciously reproaching Edward for causing her to fail in her nurtural duties. The lessened affection to which this condition may have led, seems also detectable in Mary's later behavior 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 cold 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 here infant daughter Lusha [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 Lusha'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 Lusha. A conflict with this cult leader had ensued, and Jenita feared that Kashikashika would punish here 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 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 here 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 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 and demonstrated his 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, she conceived again.

March 1973. Mary claimed that she should go to the 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 [18]. 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, calling him by the name of Kwambashi [18]. 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 consanguinean 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 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 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 be bestowing relatively big favors upon them; Muchati, Jimbando's son-in-law, did not insist when we turned 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 the latter considered us as members of Muchati's kin group, at least in so far as confronting his own kin group. 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, 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 [18] name. In anticipation, she had my wife 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 retarded. 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 the 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 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 Kwambashi became increasingly pronounced. There was the idea that Edward, under attack from his unborn sibling and his deceased aunt, 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 locally attributed to menstrual secretion. Allegedly, Mary would not be allowed to stay in the village when giving birth, but instead would have to give birth alone in a hut in the forest. This prospect was most terrifying her. (Fortunately the issue was never raised again; when her time came, she was 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, 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 cults 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 Moya cult of affliction 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 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 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] die din 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, 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 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 labor 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 labor 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. Labor 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 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 standard method of the axe handle: 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. Begin 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, though very irate, was prepared to be approached by Muchati, for whom she had had a special liking when alive.

Muchati was called and was told to enter the delivery room (which under normal circumstances a man is never allowed to do). He performed the water ritual of ablution and libation without which the supernatural cannot be approached; the he implored Kwambashi to take mercy upon her living relatives, and release the baby Mary heard her husband pray. Five minutes later the child [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 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 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 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, had dreamed of a new name for Edward, the day after Kafungu's birth. She claimed that the Kwambashi name did not seem to fit Edward. His illnesses and retarded development were cited to substantiate this. She therefore proposed the name 'Heva' she had heard in her dream - a biblical name 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 Ngondayenda.

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 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 another child, relations were 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 [11] home village, when Shelonga had tried to pay bridewealth for his wife. His prospective affines had then refused to accept the money, pointing out that Munyonga was his classificatory sister; driven to exasperation, he had left the money on the ground, and left.

One of the implications 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 disproportionally 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.25

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 departure that no medicine had yet been prepared to ritually cleanse Muchati's and Mary's conjugal bed.

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, a pathetically 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 features 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) outside the direct control of her senior

consanguinean of affinal kin. The greatest threat in this respect came from her parents in nearby Jimbando village. But by refusing to stay with them, by quarreling 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 augment her household budget by selling beer and tobacco, attracting and entertaining male customers with her urban ways, and (with the aid of a record player) 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 improvised bush clinic. 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 Center.26 There we learned that the staff could do previously 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 a district hospital, another 60 km).

23 October 1973. From Nyamayowe, Edward was brought to our bush clinic. His breathing at night was reported to be difficult and noisy; he was weak and apathetic, and had a mild conjunctivitis. After our earlier experience with the Rural Health Center, we decided to apply our own medicines. We urged Edward's relative to bring him along daily for eye treatment: we were so short of Terramycin eye ointment that we could not afford to give each patient a package 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. From Nyamayowe village the Rural Health Center is only at a distance of 20 km, i.e. only 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 at other times (cf. note XXX above [was 14]), the absence of supplies made it now useless 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 neighboring 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 bush clinic. He ran a slight fever, had diarrhea, 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. 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 patrilateral kin, but of his matrilateral 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.27 None of her fellow-villagers had bothered to improve her ramshackle house of to build a kitchen for her. On a recent occasion the headman of a neighboring village had been allowed to beat her after she had allegedly insulted him. (Instead, the headman should have sued her before the neighborhood court of the local Court; cf. Van Binsbergen 1976b: 51f). Now the diviner Loshiya alleged that Enesi's deceased mother [33] had made Edward ill, in order to revenge the suffering of her own child, Enesi, at the hands of Enesi's patrilateral kin, who were at the same time Edward's matrilateral 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 not possible, though, 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 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 bush 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. At any rate, 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 of having caused the recent deaths, so as to procure powerful chiefly medicine. The Mema and Mushindi valleys were in the grip of unsettling rumors, a state of dramatic insecurity which was also related to the national general elections which took place 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 behind 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 (which then has to be identified 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 diagram 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. Diagram 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.

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 the food he had eaten 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. Moreover, only a few days previously we had returned from one of the district's hospitals, where my wife and I had been found to be so seriously ill that we had been referred to the Lusaka hospital; we had mainly stopped at the village 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.

The headman of a nearby village possessed an old syringe, which in the 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 once more. The boy's grandfather, Kawoma, was absent, but in his locked suitcase inside his house he was keeping a box containing vials of chloroquinphosphate, bought at the black market during a visit to Lusaka. 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 injected vials (a manifold overdose).28 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...'

This was the second sudden death in Jimbando's village within a few months. The rumor started that the senior members of the village, Jimbando and Malwa, were sorcerers intent on killing off 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 outbreak of violence, Malwa urged her daughter Mary to leave neighboring 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 neighborhood and was a full sibling of Edward's paternal grandfather Shelonga, the latter told her that she could stop, collect her fee, and go: his last surviving siblings had died a few months previously (cf. diagram 1).

February 1974. Edward's condition seemed critical and his parents, themselves now suffering from Malaria, took him to one of the district's hospitals. 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 and I were very 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?' 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 excellency 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 all the years that we had worked together, he cried out my first name, without the usual titles of address. Finally he was an equal who in his distress appealed to his friend. 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 racial and academic status happened to carry in Zambia at that time. Obviously 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 related girl in Lusaka to come and assist Mary, since the hospital staff did not 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 have a perambulator to leave her baby in), nor any supervision. So within a short while Kafungu caught pneumonia and could 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 motoric 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.

This complex and detailed account of Edward's infancy, while pertinent to the medico-anthropological questions I raised in the introduction, 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.

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.

5. EDWARD'S CASE: AN ARTIFACT?

Contrary to current 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 labor in Africa. By subsequently providing the means to put Edward onto bottle-feeding we contributed to his vulnerable nutritional status and indirectly to the inhibitions that surrounding Mary's relationship with him. But short of letting the child starve to death there was no real alternative.

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 is frequent and relatively cheap: there are 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 in 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 a bush clinic in Chief Kahare's village introduced an additional 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, and considerable success in the treatment of the most frequent complaints. For these reasons our activities amounted to unintended competition with other health agencies, particularly 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 Rural Health Centre. Often we would take the patients there in our care, which was for most of the time the only serviceable motor vehicle within a radius of over twenty km. 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 social-science experiment.

Obviously, our personal involvement and commitment did not stop short at the limits suggested in some handbooks on participant observation. This raises the question of ethical responsibility, which always 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 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 accompanied 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. In view of strategies of participatory research, it was of course absolutely necessary to give that impression. But 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.29 Did our admiration encourage Edward's relatives to look 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. More likely, such an attitude (which would moreover be contrary to our own awareness of the limitations of cosmopolitan medicine) would have estranged us from Edward's relatives, would have deprived us of such limited means as we had of intervening in his health situation, and would have made us utterly impossible as participant researchers.

At the time we did not consciously develop this attitude and weigh it against alternatives. Frankly, we felt as if we had no choice in the matter. Our main guidance lay in a professionally cultivated sense of trans-cultural humility which (being the main stock-in-trade of anthropologists in the humanist tradition) may well be the greatest contribution anthropology could make to cosmopolitan medicine in Third-World settings. Ours was not a research project in applied anthropology. We tried to gain understanding of the nature of Nkoya contemporary 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 not prepared to extend our intervention in their lives beyond the limits that had implicitly been agreed, and gradually extended, in our interaction with them. 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 field-work roles as researchers, spouses, parents, and finally as patients ourselves, we felt that it was not primarily on our

shoulders that the responsibility for Edward's well-being lay.

On the other hand it should be 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 greater knowledge, and higher status in the wider Zambian society), we were in a position to take away some of the barriers that hindered their access to cosmopolitan medicine. In Edward's case, the protagonists' pursuit of cosmopolitan medicine was not really dependent upon us: at several crucial moment we were not available, or not consulted.

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.

NOTES TO PART I

1This paper is a product of my research into religious change and urban-rural relations in Zambia, in which I have been engaged since 1972. Field-work was undertaken alternatingly in Lusaka and Western province, Zambia, from February 1972 to April 1974, from September to November 1977 and in August 1978. A research grant from the University of Zambia covered initial research expenses in the period February-April 1972. In 1973-74 and 1977-78 I was a Research Affiliate of the University of Zambia's Institute for African Studies, in which capacity I greatly benefitted from the intellectual exchange and research facilities offered. The Netherlands Foundation for the Advancement of Tropical Research (WOTRO) provided a writing-up grant for the period 1974-75, when the first draft of the present paper was prepared for the 11th International Course in Health Development, Royal Tropical Institute, Amsterdam, April 1975. The final version was written under the stimulating conditions of my current appointment as Research Officer at the African Studies Centre, Leiden; this institution also financed my 1977 and 1978 research trips. While registering my indebtedness and gratitude vis-à-vis these various institutions, the Zambian authorities and my informants, I wish to thank in particular the following people: Henny van Rijn, my ex-wife, with whom I shared the traumatic experience of studying the Nkoya medical situation, and to whom consequently this paper is dedicated; Muchati and his wife Mary for reasons which my argument will make sufficiently clear; D.G. Jongmans for offering me the opportunity of presenting my data and views before a medical audience; the students of the International Course in Health Development, to whose passionate and incisive discussion the argument owes a great deal; J. Vosters, sometime medical officer in charge of a hospital in Western Zambia, to whose constant advise and supervision we, as medical laymen, owe much of our clinical experience with the rural medical situation; the District Medical Officer, Kaoma district, who actively encouraged the medical line in our research; J. Kee, sometime medical officer in charge of a hospital in Western Zambia, for adding to our understanding of the area's medical situation and medical history; S. van der Geest, K.W. van der Veen and H.C.F. Zwaal (M.D.) for detailed comments on earlier drafts of this paper; and finally the members of the Leiden Africa Seminar whose discussion of an earlier version of the paper was most

helpful.

2Jayaraman 1970; Shattock n.d.; Frankenberg and Leeson 1974; Nur et al. 1976.

3Apthorpe 1968; Turner 1967; Gilges 1964; Symon 1958; Frankenberg and Leeson 1976; Leeson and Frankenberg 1977.

4Reynolds 1963; Turner 1967b; Colson 1969; Van Binsbergen 1977a.

5Le Noble 1969: 31f; Spring Hansen 1971; Munday 1945; Barnes 1949; Stefaniszyn 1964:74f.

61974, 1976; cf. Frankenberg 1969; Leeson and Frankenberg 1977; and Leeson 1967, 1970.

7E.g. Ademuwagun 1974; Leeson 1970; Imperator 1974; Maclean 1971.

8Turner 1957; Van Velsen 1967, 1964: xxiiif and passim.

9Cf. Van Binsbergen 1975; 1976a, 1976b, 1977a, 1978b, and n.d. (b); McCulloch 1951; Clay 1946.

10People's personal names and titles have been altered in this paper, as have those of localities in Western Zambia.

11The 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 ecozones, to which Chief Kahare's area belongs, compares rather favorably 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 well volume and ascorbid acid, with regard to which this ecozones scored low); and particularly malaria, where children in this ecozones were found to be least affected among the whole national sample. (Malaria incidence in adult males, however, was average, and in cult females even very high). The report did not attempt a systematic interpretation of these patterns, except for seasonal variation in diet. The main explanation for the difference between this moderately positive picture and the situation in Chief Kahare's area, becomes clear when we trace the origin of the data in this ecozones (Schültz 1976: figure 30). They derive from four villages in the central part of the ecozones, 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. (cf. Van Binsbergen: 171f; incidentally, this bias also affects Schültz's own analysis of the area's ecosystem (1976: 103f).) For an early yet thorough examination of the health situation in a area adjacent to Chief Kahare's, cf. Newson 1932. Sadly, present-day health conditions in Chief Kahare's area are still

rather similar to what Newson described.

12Northern Rhodesia 1956: 95,100; Northern Rhodesia 1955: 110; cf. Evans 1955, who deals with the Nkoya's eastern neighbors, the Ila.

13Cf. Ohadike & Tesfaghiorghis 1975; Central Statistical Office 1975: 6 and passim; Van Binsbergen n. d. b.

14On 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 substance is indicated by the hemorrhages it frequently causes); and infanticide on various occasions, e.g. when the mother is a girl who has not gone through puberty ceremonies.

15In addition, migrants returning to the village had often gained considerable experience with cosmopolitan medicine at their places of employment.

16The 1968 returns of one of these hospitals corroborate the disease patterns summarized above (table 2):

Table 2. The seven most frequent reasons for hospitalization and hospital deaths in a rural hospital near Chief Kahare's area, 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: 191f; Imasiku 1976.

17Cf. Republic of Zambia 1967, 1968, 1976; Blankhart 1966: 6f.

18A 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 presented in my other publications on the Nkoya and on Central Africa in general.

19Nkoya clan affiliation is ambilineally inherited. Every Nkoya belongs in principle to two 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. Finally 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. Before the expansion of political and economic scale, around 1800 (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 discharging major ritual and redistributive functions within the clan area.

20Numbers within brackets [ ] that follow people's names in the text, correspond with the figures in diagram 1. They are not to be confused with the raised footnote numbers, nor with four-digit numbers referring to years. While the names are pseudonyms, the genealogical relations as shown are, to the best of my knowledge, correct.

21For Central African societies, the structural principle involved here was most explicitly argued by Marwick (1965: 199f); cf. Van Binsbergen 1977b.

22K. Kwacha, the Zambian currency. K1 equaled about £ 1.30 in 1973.

23On 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 were as yet ignorant of her condition, and could not make allowance for it.

24Cf. Turner 1976c: 19f on the culturally closely related Ndembu.

25For the contradiction, in Nkoya social organization, between bilateral descent and payment of bridewealth, cf. Van Binsbergen 1977b: 43f, 56f; and n.d. (b).

26Table 3 gives the clinic's official returns for the 1972. the data were scrambled in the same way as those presented in table 2. 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 km. Participatory and quantitative evidence (cf. Van Binsbergen, n.d. (b)) have convinced me that, at 20 to 30 km distance, the population of the Mema and Mushindi valleys contributed very little indeed to these figures.

27This had nothing to do with her divorce as such. Chief Kahare's area abounds with young female divorces. Locally Enesi's conditions was 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: they blamed him for her death. The husband's dangerous state of pollution was transferred his new wife, Enesi, upon their marriage. When Enesi's condition of 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 specific sociological data to interpret the failure of her marriage.

28Even with proper dosage and under adequate clinical conditions, the great dangers of such an injection are well-known (cf. King 1966: section 13:6).

29My 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.

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