A HEALER'S DREAM

A Portrait of a Guided *Ñaka*

Local Medicine in Eastern Caprivi (Namibia)

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Final Fieldwork Report, Cultural Anthropology

Utrecht University

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TRANSLATOR'S NOTE

This English translation was completed in 2026, thirty years after the original Dutch research report (*Een droom van een genezer)* was submitted at Utrecht University. The translation renders the original text faithfully and in full. The language and theoretical framework reflect the academic conventions of 1996 and have not been updated.

This fieldwork report provided the empirical basis for my subsequent literature-based MA thesis, 'Perspectives on the Interaction between Medical Systems' (*Visies op interactie tussen medische systemen,* Cultural Anthropology, Utrecht University, August 1996), in which the interaction between biomedical and local medical systems in Eastern Caprivi was examined within a broader theoretical framework.

The following translation choices require brief explanation:

Ñaka: The term 'traditional healer' carries negative connotations. The Silozi term *ñaka* has therefore been retained untranslated throughout, rendered where necessary as 'local healer'.

Illness and disease: The Dutch *ziekte* is semantically broader than either English equivalent, encompassing both biomedical pathology and the patient's subjective experience of being unwell. Where the text invokes biomedical categories, 'disease' is used; where it refers to indigenous experience or the patient's perspective, 'illness' is preferred. In cases of genuine ambiguity, 'illness' is the default, in keeping with the text's constructivist orientation.

'African' illness and 'modern' illness: The emic categories *matuku a sintu* and *matuku a sikuwa/cipatela* are rendered as 'African' illness and 'modern' illness throughout, retaining the author's own inverted commas to signal their status as locally constructed categories rather than analytical terms.

Reflexive orientation: The searching, provisional quality of certain passages – particularly in Chapter 2 – is methodological rather than incidental. The text was written within the tradition of reflexive anthropology associated with scholars such as Robert Pool and Annemiek Richters, in which the process of knowledge production is itself part of the ethnographic account.

This translation is dedicated to the University of Namibia (UNAM) and to the communities of Caprivi and Makoma, in whose midst the research was conducted and without whose generosity and trust this work would not have been possible. I am grateful to Cletius Mushaukwa, son of Nelson Mushaukwa Mutonga, for his support in making this translation possible.

Photographs are published with the kind permission of Cletius Mushaukwa. Where other people are depicted, faces have been anonymised to protect privacy.

FOREWORD

> (…) rocks on the one hand and dreams on the other – they are things of this world (Geertz 1993:10).

A dream: an illusion, a figment of the imagination, mere fantasy? A phenomenon that is not 'hard', that does not belong to empirical reality, and is therefore subordinate to natural, autonomous matters? Or a phenomenon that forms an indispensable part of human reality? A phenomenon that gives rise to meaningful social behaviour? I adopt the latter perspective and attempt to demonstrate how significant a healer's dream is for his daily practice, serving as a vehicle of communication with the supernatural.

This report presents the findings of my fieldwork project. This research was by no means a solitary endeavour, and I wish to thank everyone who supported me and contributed to making it an unforgettable experience. In particular, I am grateful to Hester van Wingerden and Margo van Ee for many memorable moments; Helga, Willem and Annelie Odendaal for their hospitality and assistance; and Wouter van Beek for his invaluable supervision.

My deepest gratitude, however, goes to the residents of Makoma for their hospitality and for accepting me into their midst – in particular my temporary Caprivian family: Machika and her children; and Victor Mushaukwa, for his friendship and assistance; and, last but not least, Nelson Mushaukwa Mutonga.

* Cover photograph: Nelson Mushaukwa Mutonga (photo: Wouter van Beek)

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INTRODUCTION

Makoma, 15 April 1994, 05:30

In the cool of the early morning, just before dawn, we make our way to the eastern edge of the village, where Mushaukwa is to treat Charles, a man in his late thirties. We walk past the kraal, where the cattle impatiently await the herd boys who will milk them, heading towards the plain – an enormous grassland with scattered clusters of trees, extending southward all the way to the Chobe River, which marks the border between Caprivi and Botswana. The parched plain radiates a yellow-brown glow, and it is now difficult to imagine that during the wet season it is flooded by the waters of the Zambezi and Chobe rivers.

Mushaukwa strides purposefully ahead towards the area where the tall palm trees grow, marking a natural boundary between the village and the plain. He carries a hand trowel, a bowl, and a small cooking pot filled with water containing tusenge – the medicine, consisting of twigs, leaves and roots of trees and plants. Behind Mushaukwa follows Victor, my research assistant, who guides a sledge drawn by two oxen, upon which Charles sits, unable to walk because of his illness. Beside the sledge, Charles's wife and I walk in silence.

Upon arriving at a clearing among the palm trees, Mushaukwa digs a pit with his trowel in the loose sand, approximately half a metre deep and one metre wide. Assisted by Charles's wife, he helps Charles off the sledge. As Charles slowly lowers himself into the pit, his wife supports him, while Mushaukwa fills the bowl with the herbal mixture from the cooking pot and begins the washing. Holding the bowl in his left hand, Mushaukwa uses his right to rub the medicine over Charles's body, working downward from the head. Charles struggles to maintain his balance under Mushaukwa's vigorous rubbing, and the sight of Charles with his wet hair – in which twigs and leaves have become entangled – gives him a somewhat dishevelled appearance. Everyone remains silent during the washing, except for Mushaukwa, who repeatedly utters the following supplications in a raised voice: 'Let this medicine weaken the power of the one who has bewitched this man!', 'Let all evil remain here!' and 'Let this man walk again!'

Each time the bowl is empty, before refilling it from the cooking pot, Mushaukwa throws sand into the pit, which Charles firmly stamps down onto the medicine that has dripped from his body into the pit. In this way, the pit is gradually filled in and Charles is slowly raised upward.

Once Charles's entire body has been washed and the medicinal liquid from the cooking pot has drained into the sand, Mushaukwa helps Charles back onto the sledge and gathers his belongings. The washing is complete; we can return to the village.

In this session, Mushaukwa aims to cleanse Charles of a *silumba* – the soul or spirit of a person stolen by a witch and sent into the patient. As a result of this affliction, Charles had a car accident the previous year and has since suffered from pervasive weakness in all his limbs. By washing him with medicinal herbs, Mushaukwa hopes to liberate him from the *silumba*.

This ritual takes place on the edge of the village, behind the compounds, in the area where the dead are buried. Mushaukwa selected this location because the spirits of the deceased dwell here; the *silumba* feels at home among them and may settle there, so that it will no longer trouble Charles. To increase the likelihood that the *silumba* remains behind, it is buried together with the medicine beneath the sand.

By describing this session, I introduce the central subject of my research: the beliefs and practices of a local healer and the patients seeking his care with regard to illness in Eastern Caprivi. Nelson Mushaukwa Mutonga, the healer observed in action above, is the central figure in my study. I followed him in his work for approximately four months, from the end of March through to July 1994.

My research was conducted within a collaborative framework between the University of Namibia and Utrecht University (as part of the UNITWIN programme). In Namibia, I was affiliated with the Social Science Division (SSD) of the university.

I conducted my research in Caprivi, the district in the far north-east of Namibia. Caprivi has traditionally been divided into West Caprivi – the area west of the Kwando River – and East Caprivi, the part to the east of that river. My research took place in the eastern section.[1]

The report is structured as follows: In Chapter One, I describe the framework within which I conducted my research. I outline the background of the study, set out the research questions, sketch the research setting, and introduce the reader to Nelson Mushaukwa Mutonga. In Chapter Two, I examine in depth the indigenous conceptions of illness. I explain how these conceptions are formed and describe the principal categories of illness causation. In Chapter Three, I discuss the practice of Nelson Mushaukwa Mutonga. I examine how he became a healer and discuss – partly through the description of a number of illness cases – how he diagnoses and treats the sick. In this chapter, the role of the supernatural in his work will become evident. Chapter Four, finally, offers concluding reflections on his practice, in which I address, among other things, his attitude towards biomedical healthcare.

Note: In Eastern Caprivi, Silozi is spoken alongside the indigenous languages of the various ethnic groups – in the case of the Masubia, among whom I conducted my research, this is Cisubia. In this report, I render indigenous terms in Silozi, given its wider currency, with the exception of terms that occur only in Cisubia or whose Silozi equivalents I was unable to ascertain.

[1] Since 1992, the area west of the Kavango River around Andara, which previously belonged to Okavango, has also been classified as part of Caprivi. Prior to this, West Caprivi referred to the area between the Kavango and Kwando rivers: the Caprivi Strip, the narrow, arrow-straight corridor that has the status of a game reserve.

Chapter 1. RESEARCH FRAMEWORK

1.1. Background

In Eastern Caprivi, people who fall ill have several options for seeking help. They may draw upon their own knowledge of home remedies, consult friends or family members, visit a *ñaka* (a local healer), go to the nurse at the local clinic, or travel to the hospital in Katima Mulilo. During an illness episode, several of these options are often drawn upon in combination.

A society such as Eastern Caprivi, in which multiple forms of healthcare coexist, is referred to in medical anthropology as 'medically pluralistic'. The significance of this perspective lies not merely in recognising the coexistence of various forms – often termed 'medical systems' – but also in the comparative study of these systems from a relativist standpoint, treating them as equivalent components of the total healthcare provision, without implicitly assuming the superiority of biomedicine.

The medical pluralist perspective is of relatively recent origin. This egalitarian stance was only adopted in the 1970s. Prior to this, all healthcare practices not grounded in biomedical science – that is, all non-modern practices – were characterised as 'traditional, unscientific, primitive, magical, irrational and intuitive'.[2] A wide variety of healing systems, ranging from lay practices and local traditions to the 'Great' textual medical traditions such as Indian Ayurvedic, Arabic Unani, and classical Chinese medicine, were grouped under a single heading and thus deemed inferior to biomedicine (Richters 1993:98–101). The underlying assumption was a dichotomy between the [bio]medical system and all other forms of healing, which were termed ethno-medical systems, defined by Hughes as: '(…) those beliefs and practices relating to disease which are the products of indigenous cultural development and not explicitly derived from the conceptual framework of modern medicine' (Hughes 1968:88, cited in Slikkerveer 1990:60).

Later, a more relativist perspective emphasised that every medical system is socially and culturally constructed – including the biomedical one – and the distinction between the '[bio]medical system' and other 'ethno-medical systems' was deemed obsolete. In fact, every medical system can be understood as ethnomedical (Yoder 1982:10). Every medical system is a product of culture. In theory, the groundwork for a more equitable comparison of healthcare systems had been laid.

As a basis for comparison, one can take as a point of departure that every form of healthcare seeks to explain, prevent, diagnose, and treat illness. Medical systems differ in the forms these activities take and in the amount of time, energy, and resources devoted to them (following Press 1980, in Yoder 1982:15). A comparable basis is used by Kleinman (1980:24–70) when he divides the pluralistic healthcare of a society into sectors, or 'medical subsystems'. He distinguishes a lay sector, a folk sector, and a professional or formal sector. 'Each sector has its own ways of explaining and treating illness, defines who the healer is and who the patient is, and specifies how healer and patient ought to behave in their therapeutic encounter'.[3]

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[2] This is a manifestation of what Richters (1993:98) terms the 'ethno- and medicocentric contamination' of medical anthropology.

[3] This is a simplification of Kleinman's model, following Helman (1990:55).

The lay sector is the non-professional, non-specialised domain of healthcare. In this domain, illness is first recognised and initial steps are taken to alleviate it. It encompasses self-care, family care, and community care. If no remedy is found within this domain, a specialist from either the folk sector or the professional sector is called upon. The folk sector consists of specialists who do not form part of the official, state-legitimated healthcare system. It is within this sector that Kleinman locates local healers. The professional sector, finally, is the organised and state-recognised healthcare system, typically the Western biomedical model.[4]

My research focused on the folk sector: the indigenous healthcare system rooted in local culture. My study describes the illness conceptions and practices of a local healer and the users of his care. However, the folk sector does not exist in isolation from the professional sector. Despite the considerable differences between the folk and professional sectors on the comparative dimensions outlined above, sick individuals draw upon both sectors, moving back and forth between them in their search for recovery. As we shall see, indigenous illness conceptions provide the legitimating framework for this movement.

The professional and folk sectors come into contact through their shared users. In my research, I have therefore attended to the question of how this indirect relationship manifests itself in the practice of *ñaka*.[5]

1.2. Research Questions

The following questions were central in my research:

- What conceptualizations of illness are held by *ñaka* and care-seekers?
- What factors and symptom interpretations determine the consultation of *ñaka*?
- How do *ñaka* diagnose and treat the sick?

With regard to the relationship between the professional and folk sectors, the following question was posed:

- What is the attitude of *ñaka* towards the professional sector of healthcare?

In addressing the latter three questions, the emphasis is placed on the practice of Nelson Mushaukwa Mutonga.[6]

1.3. Healthcare in Eastern Caprivi

The Professional Sector

Biomedical healthcare was introduced to Namibia at the beginning of the twentieth century by missionaries and German colonists. Today, Namibia is divided by the Ministry of Health and Social Services (MoHSS) into four healthcare regions:

[4] Kleinman also includes classical Chinese and Indian Ayurvedic medicine within this sector.
[5] The biomedically trained health workers in the clinics and the hospital I shall henceforth refer to, following Kleinman's classification, as 'formal healers'.
[6] My research also addressed the interaction between local and formal healers. Describing the illness conceptions and practices of Mushaukwa and the users of his care, however, proved such a substantial undertaking that this second topic receded into the background.

South, Central, North-West, and North-East. The Caprivi district, together with the Okavango district, forms part of the North-East region, which is coordinated from Rundu.

Eastern Caprivi, an area with approximately 79,600 inhabitants, has a hospital located in Katima Mulilo. The hospital has approximately 220 beds distributed across seven wards. According to the head of nursing staff (the matron), an average of 150 people are admitted per month. Five physicians are employed, including the director (the superintendent), all recruited from abroad,[7] alongside approximately 120 nurses. The hospital also has an outpatient department, from which Primary Health Care (PHC) is coordinated, among other activities. PHC is understood as essential healthcare with an emphasis on equitable access to services (both geographically and financially), active community participation, prevention, and the use of relevant and appropriate technology. Furthermore, improvements in healthcare are to form part of broader economic and social development. This strategy was adopted by the national government in 1991.

In addition to the outpatient department, the 21 clinics and three health centres (with limited admission capacity) distributed across the area form part of the PHC structure (see Map 2). A total of 42 community health workers have also been trained, though I was unable to ascertain how many are actually employed. According to a staff member of the PHC, many have dropped out, possibly because they are not paid for their work and because their duties emphasise health promotion and disease prevention, whereas the curing of illness carries considerably greater prestige.

The clinics are staffed by nursing assistants. These individuals have undergone a six-month nurse training programme, supplemented by a short course in midwifery. In addition to PHC activities such as vaccination, maternal and child healthcare, and health education – particularly relating to AIDS, tuberculosis, and the relationships between nutrition and disease and between environment and disease – they are responsible for treating patients who can be straightforwardly diagnosed and managed on an outpatient basis. Serious cases are to be referred to a health centre or the hospital. If a patient cannot be treated at the local hospital either, there is the possibility of flying them to Windhoek for treatment at the State Hospital.

The Folk Sector

The most important male and female medical specialists in this sector are the *ñaka* – the local healers. They treat people through the application of plant-based medicines in various ways, often within elaborate rituals. Within this group, a distinction can be drawn between *ñaka* who have a relationship with the supernatural – such as Mushaukwa – and those who do not. The former category has been called by the supernatural and is guided by it in making diagnoses and treating the sick; I therefore refer to this category as 'guided' *ñaka*. The other category has become a *ñaka* on their own initiative and receives no guidance from the supernatural. The *ñaka* in both categories use divination to establish diagnoses. I did not encounter any healers who diagnose solely on the basis of the patient's symptoms and who do not apply their medicines within rituals (referred to in medical anthropological literature as 'herbalists').

[7] The University of Namibia does not yet have a medical training programme; physicians are therefore recruited from abroad.

Some *ñaka* have specialised in treating particular illnesses, or are known for their particular efficacy in treating certain conditions. A number of *ñaka* have additionally built a reputation as 'witch catchers', who call witches to account in public sessions for the harm they have caused.

Alongside the *ñaka*, there are several women in the area who have specialised in assisting women during childbirth: the local midwives (Silozi: *bapepisa*), officially classified by the World Health Organisation as traditional birth attendants. These women specialise in inducing delayed labour, repositioning the baby during delivery, assisting with the delivery of a retained placenta, and stemming post-partum haemorrhage, using herbs applied in various ways. Their specialised knowledge has typically been transmitted by their mother or grandmother, who was likewise a midwife. Local midwives generally do not have a relationship with the supernatural.

1.4. Course of the Research and Methods Employed

Preliminary Phase and Introduction

Initially, I had planned to conduct my research in the Ovambo region, within the framework of a multi-sectoral development project coordinated by UNICEF. However, following a discouraging conversation with the project coordinator, who was unconvinced of the value of anthropological research in general and of mine in particular, and after attending a national Primary Health Care meeting in Oshakati – where several participants indicated that the Ovambo region had, in their view, been sufficiently studied – I decided to redirect my focus to the Caprivi district, where, according to those in the know, indigenous medicine was a particularly rich area of inquiry.

Having arrived in Katima Mulilo (the capital of Caprivi) at the beginning of March, I spoke with several *ñaka* living and working in and around the town, in order to orient myself on the subject and gain an impression of their accessibility. Although the *ñaka* generally spoke enthusiastically about their work, I quickly became aware of the complexity of the subject and I quickly sensed the risk of losing sight of the broader picture amid an overwhelming wealth of detail. In order to maintain an overview and add greater depth to my research, I decided to concentrate on a single research subject and came up with the idea of going to live in a village with a *ñaka.* But how was I to choose a *ñaka*? And which *ñaka* would welcome such a proposal?

Various people I consulted – including several members of hospital staff – mentioned the name of Nelson Mushaukwa Mutonga, a *ñaka* residing in Makoma, a village in Lusese.[8] By many accounts, he was a highly regarded *mudala* (from Silozi: elder; a term of respect) who might well be receptive to my plans. Struck by the sincerity and respect with which people spoke of this man, I set out to make contact with him and ask whether he would be willing to collaborate with me.

During a visit to the clinic in Lusese with two members of the PHC staff in the context of clinic supervision, I was given the opportunity to be introduced to Mushaukwa. We drove to Makoma but did not find him at home.

[8] Nelson Mushaukwa Mutonga is his full name. He is generally addressed as Mr Mushaukwa, as I shall also refer to him throughout this report.

I was, however, introduced to his third wife, to whom the PHC staff member put forward the proposal. She believed her husband would have no objections and was prepared to take me under her care.

In this way I met Machika – a somewhat reserved woman with an open face, in whose company I immediately felt at ease – and fell in love with Makoma: an idyllic village with a genuine village square, around which the courtyards are arranged, surrounded by swaying palms. I watched children playing with coke cans that they rolled through the sand on sticks, women seated on mats weaving baskets from strips of dried palm leaf, and girls walking upright, balancing buckets of water on their heads. A strange feeling came over me: I could suddenly imagine spending the next four months here.

On the way back to Katima Mulilo, we encountered Mushaukwa, as if by a miracle. He was sitting in the back of a pick-up truck being driven towards Makoma. The PHC staff member signalled to the driver to stop and spoke briefly with Mushaukwa; I shook his hand hurriedly. As we were already on our way again, the PHC staff member told me that he had informed Mushaukwa that this *mukuwa* (from Silozi: a general term for a white person) would be coming to live with him for several months in connection with a research project. Although I was not entirely at ease about whether this manner of introduction was adequate or sufficiently respectful, I hitchhiked the following week to Makoma together with a translator from Katima Mulilo who knew Mushaukwa personally.

The First Days

My premonition proved well founded. Mushaukwa was not satisfied with the way in which I had been introduced by the hospital staff. I was required to return to the hospital in Katima Mulilo to obtain a letter from the superintendent, setting out my intentions. Subsequently, I was to take this letter, together with Mushaukwa, to the *Induna ya silalo* (the area headman) of Lusese, to request permission to conduct research in his area, and to discuss with him what I should pay Mushaukwa in return. This was a setback. I did not want to return to Katima Mulilo, but Mushaukwa proved unyielding: without a proper introduction, there would be no research. And pay Mushaukwa? I had, of course, always intended to give Mushaukwa and his family food and gifts in gratitude for their hospitality and the information they provided, according to my means. But pay in cash? That felt rather too much like a business arrangement. If it had to be done, however, then it had to be done.

When I returned a week later – somewhat uncertain and less enthusiastic – armed with a letter of introduction from the hospital, and explained my intentions to *the Induna ya silalo* (with whom I could communicate directly in English), it emerged that there had been a miscommunication. Mushaukwa had inferred from my introduction by hospital staff that I was working for the hospital. He had assumed that I intended to use his herbal knowledge within the hospital and wished to apprentice myself to him for this purpose. He would only divulge his knowledge of medicines in exchange for payment, and only to the hospital if the superintendent requested it in writing. If I was merely a student who wished to observe how he worked, he saw no objections.

My research could proceed, on the condition that I would ask no questions about the plants and herbs he used,[9] and that Victor – one of his sons by his second wife – would become my translator. I was permitted to come and live in Makoma and could move into a hut that had formerly been used for communal gatherings. Victor, who normally lived with an older brother, kept me company throughout the four months of my fieldwork.

During my Field Work

In the first weeks, I was still deeply uncertain about my position. I had to weigh up whether I was burdening Mushaukwa too much with my questions and my request that he call me whenever he was about to treat a patient, so that I could attend the session. I received signals that he was not entirely enthusiastic about my presence. On one occasion I 'caught' him emerging from the bush having treated a patient there, and he sometimes abruptly brought a conversation to an end – apparently out of boredom, or because he was tired or wanted to eat. I became conscious of the dependent position I occupied as a researcher and recognised that I would have to acquiesce to it. I was requesting his assistance for my research without being able to offer anything tangible in return.

As carefully as possible, I tried to cultivate a basis of trust and to exercise heightened sensitivity in detecting whether I was asking about matters he did not wish to discuss, or whether I was encroaching too much on his time. Gradually, I began to feel that our relationship was becoming less fragile. Mushaukwa seemed to realise that I was there to stay: that I ate 'African' food, walked long distances without complaint, and above all was genuinely interested in his activities. He began calling me more consistently when he was about to treat patients, and conversations flowed more easily – although I noticed he preferred telling stories of his own accord to being questioned or interrupted when I failed to understand something or thought I detected a contradiction. He would also frequently launch into lengthy, enthusiastic monologues in Cisubia when Victor was not present. It was then often difficult to convince him that I genuinely did not understand him and needed Victor to be fetched. During conversations, he would sometimes lament that it was a pity I did not speak his language, as he could then tell me so much more.

Methods Employed

I followed Mushaukwa in his work for approximately four months. I spoke with him regularly about his illness conceptions and various aspects of his professional practice. I also observed dozens of treatment sessions. During sessions, I made notes and subsequently discussed what had occurred with Mushaukwa. I also attempted to speak with the people Mushaukwa treated, though this was not always successful. People were often tired immediately after sessions and not always inclined to speak with me; I felt it was inappropriate to press them.

[9] Throughout the research, he repeatedly reminded me of this agreement whenever he felt my questions were too directly concerned with his herbal knowledge.

Conducting informal conversations – an important method, since informants behave most 'naturally' in the absence of a formal interview situation – was not possible with Mushaukwa directly, as I speak neither Silozi nor Cisubia and could only converse with him via my translator Victor. This necessarily undermined the informal, natural character of the exchange.

In terms of informal conversations, I was therefore limited to those who spoke English – predominantly the younger generation. With Victor and Rafael (a full brother of Victor, sharing the same father and mother), for example, I would often sit and play cards, and we would frequently talk about witchcraft and other causes of illness – as we also did during bicycle rides or walks to neighbouring villages when we were going to interview residents. Cycling across the seemingly endless savanna, Victor on his father's bicycle and I on my mountain bike, we were in our element, and the otherwise invariably reserved Victor would speak openly, covering a wide range of topics – often related to my research, but often also concerning other fascinating aspects of life.

Victor became not only my translator but an important informant: an invaluable source of information who was almost always available. We shared a hut, and when I was writing up my notes in the evenings, I could ask him directly about things I had not understood. This was an ideal arrangement.

In addition to Mushaukwa, I spoke with 12 *ñaka* (ten male and two female) and one local midwife, primarily about their illness conceptions. On this topic, I sought to obtain a somewhat broader perspective and therefore did not limit myself to Mushaukwa's account alone. I also interviewed 11 residents of Lusese from various villages about their illness conceptions and their associated health-seeking behaviour.

These informants were interviewed in an unstructured manner. This meant that questions were not fixed in advance; rather, I guided the interview on the basis of topics I had noted down beforehand or had in mind. Informants were able to introduce new topics and elaborate on issues as they saw fit. Conversations with those who did not speak English were conducted via Victor.

Living in Makoma and participating in daily life proved an effective means of building trust with residents and thereby, as a researcher, minimising disruption to the natural course of events and collecting information that might have remained concealed through the use of more quantitative methods. Nonetheless, I harbour no illusions about having gained an insider's view: 'the understanding of the native's point of view, his relation to life, the realisation of his vision of his world', as Malinowski (1922:25, cited in Zwier 1980:9) has so eloquently articulated the aim of ethnography, is not achievable in four months – if, indeed, it is achievable at all.

1.5. The Research Setting

Namibia

Namibia is situated in the south-western part of Africa and has a surface area of 824,269 square kilometres (approximately 22 times the size of the Netherlands). It borders Angola to the north, Zambia and Zimbabwe to the far north-east, Botswana to the east, and South Africa to the south. The population is estimated at 1.4 million, with an average annual growth rate of three per cent. More than half the population, predominantly Ovambo, lives in the north, close to the border with Angola.

With an average population density of fewer than two people per square kilometre, Namibia is one of the most sparsely populated countries in the world. This low population density can be attributed partly to ecological constraints – no country south of the Sahara receives less rainfall – and partly to the genocide perpetrated by the Germans in the wars against the Nama and Herero in the first decade of the twentieth century, which reduced the population by almost half (Fosse 1992; UNICEF Namibia & NISER 1991).

Namibia possesses enormous natural wealth, including diamonds, uranium, and other minerals, as well as highly productive fishing grounds. The economy is, however, extremely dependent on the export of these commodities, the prices of which have fallen sharply. Furthermore, the profits of the export sector – which is largely controlled by multinational corporations – flow elsewhere. This is compounded by the highly unequal distribution of wealth in Namibia, a legacy of colonial economic structures and apartheid. In 1990, average annual per capita income ranged from US$100 for Black people in rural areas to US$14,650 for the urban White population (Bayer 1990; MoHSS 1993).

The ethnically and linguistically heterogeneous population of present-day Namibia comprises eleven groups: the Bantu-speaking peoples – the Ovambo, Kavango, Herero, 'Caprivians', and Tswana; the Khoisan-speaking peoples – the Damara, Nama, and San; and finally the Rehoboth Basters (of both White and Black ancestry), the Coloureds, and the Whites. Most groups, including the 'Caprivians', can be further subdivided into sub-tribes, clans, or dialect groups.

The original inhabitants of Namibia are the San, better known as the Bushmen. These hunter-gatherers inhabited a vast territory stretching from the Atlantic coast to eastern Transvaal. The arrival of other peoples, however, drove them from the fertile areas into the Kalahari and Namib deserts. These other peoples were pastoral communities who migrated into this part of the continent from the north and east between the ninth and fourteenth centuries: the Herero, Ovambo, Kavango, and Tswana. Later, in the nineteenth century, they were joined from the south by the Nama and, in all probability, the Damara as well.

During the Scramble for Africa at the Berlin Conference of 1884, Namibia was assigned to the German Empire and renamed Deutsch Südwestafrika. The colonisation was to have devastating consequences. By around 1903, more than half of the Herero cattle were already in German hands, and many Herero were compelled to work as labourers on German farms or in the mines (copper and diamond). Resistance by the Herero, supported by the Nama, was met with genocide: three-quarters of the entire Herero population and three-quarters of the Nama population perished.

Following the South African invasion in 1915 and the German defeat in the First World War, South Africa was granted a mandate over South West Africa by the League of Nations in 1920. South Africa was to administer the territory on behalf of the League while simultaneously preparing it for future independence – a commitment which it was ultimately unwilling to honour. Gradually, South Africa tightened its grip on the economy and society. Racial segregation was deepened, most dramatically expressed in the forced relocation of the indigenous population into 'reserves' situated in infertile areas.

The recognition that South Africa would not relinquish its dominance voluntarily gave rise in the 1950s to a period of open resistance – primarily from the Ovambo, who were severely affected by the regime – in the form of protests and strikes, culminating in the founding of the South West Africa People's Organisation (SWAPO) in 1960. This organisation took up an armed struggle against the occupiers, which, after much bloodshed and negotiation, ultimately led to peace and independence. Under the supervision of a UN peacekeeping force, general elections were held in 1989, and on 21 March 1990 Namibia's independence became a reality. SWAPO won the elections and its leader, Sam Nujoma, became president (Bayer 1990; UNICEF Namibia & NISER 1991). In the most recent elections, held in 1994, SWAPO retained its majority and Nujoma remained president.

Caprivi

The curiously shaped district of Caprivi extends across the far north-east of Namibia, between Angola, Zambia, Zimbabwe, and Botswana. The area was originally in British hands but became part of South West Africa in 1890 when Germany claimed a corridor to the Zambezi in order to create a trade route with Deutsch Ostafrika (Tanzania). The Germans named it Caprivi after Count Caprivi, the German Foreign Minister at the time. The Caprivi district has a population of 90,400 people, of whom 79,600 reside in the eastern section (Fosse 1992). Katima Mulilo is the urban and administrative centre, with an estimated population of 15,000.

The eastern part is inhabited by three ethnic groups: the Mafwe (48% of the population in Eastern Caprivi), the Masubia (38%), and the Mayeye (9%). Although various accounts exist regarding the origins and relationships between these groups, all were at some point subordinate to the Malozi as part of the Barotse kingdom, from which they separated only at the beginning of the twentieth century. The Mayeye are considered to be subordinate to the Mafwe and therefore fall under the authority of the Mafwe Chief. However, a growing movement among the Mayeye to break away and install their own tribal authority has already led to some open conflicts with the Mafwe.

The Masubia, under the authority of Chief Muraliswani, inhabit the easternmost part of Eastern Caprivi, which is annually inundated by the waters of the Zambezi and Chobe rivers (the plain). During flooding, people relocate with their livestock to drier areas further west. Some of these locations have become permanent settlements, such as New Lusese.

Lusese

Lusese, often referred to as the 'Lusese area', consists, according to a census conducted by the clinic nurse, of 38 villages or wards – thirty in New Lusese and eight in the older section, situated many kilometres to the east on the plain. According to the same census, Lusese has a total population of approximately one thousand people. Lusese has a clinic, a primary and a secondary school, three churches (communal huts serving as places of worship) – one Roman Catholic, one Sabbath, and one New Apostolic – and two small general stores, which also serve as bars.

The Masubia are organised socially and residentially along patrilineal lines. A village typically consists of a father with his wife or wives, his married sons with their wives and children, and his unmarried children.

Each village has a headman (*Induna munzi*) – normally the male head of the family that first settled at the location in question – who acts as a representative in the *Khuta* (the tribal court) of Lusese, presided over by the *Induna ya silalo*.

Mushaukwa was the first to settle with his family in the area that is now known as New Lusese, founding the village of Makoma. This is the home of Mushaukwa and his four wives, their unmarried children, and three sons of Mushaukwa by his first wife – who are also *ñaka* – with their own wives and children. Each of Mushaukwa's wives has her own courtyard, among which he alternates his residence. The courtyards typically consist of a main hut with several outbuildings, a bathing area, and a cooking hut, surrounded by a reed fence, and are arranged around a central square containing a water well. Here the many dogs that populate Makoma often rest, along with the two pigs whose function it is to dispose of the village's waste and to consume human excrement in the surrounding bush.

Mushaukwa and his extended family live, as do other Masubia, from agriculture and animal husbandry. The main crops are maize, millet, and pumpkins. Maize is the staple food and is eaten as a stiff porridge with meat or fish, sometimes mixed with cooked pumpkin. (The residents of Makoma are not fishers themselves, but fishers from neighbouring villages regularly come to sell their fish, either fresh or dried.) Men are responsible for the cattle and goats and for ploughing the land. The remaining agricultural activities are carried out primarily by women. The women of Makoma are particularly active in weaving baskets, mats, and bowls from strips of dried palm leaf, which are generally sold via the Art Centre, most often to tourists.

1.6. Nelson Mushaukwa Mutonga

Nelson Mushaukwa Mutonga was born around 1922. His exact year of birth is difficult to determine. His identity document records 1922, but Mushaukwa has also on occasion given 1920 as his birth year. Around 1937, he suffered from an illness that proved to be the manifestation of a supernatural calling to become a *ñaka*. Following his recovery, he began treating patients at a very young age – around sixteen – and has since built a career as a *ñaka* spanning more than fifty years, in the course of which he has become widely known throughout the Lusese area as exceptionally skilled.

Mushaukwa has fathered the exceptionally high number of twenty-six children by the four women he has married, of whom seventeen are still living. Although I do not know the average number of children fathered by men in Caprivi, I feel fairly confident in asserting that twenty-six exceeds the norm. It is plausible that Mushaukwa's exceptional fertility functions as a symbol of his power, and thereby contributes to his standing as a respected *ñaka*.

Mushaukwa is a man spoken of with great respect. He is known as a wise man whose counsel is sought in many matters – not only in the domain of health, but also in social affairs such as family disputes and marital problems. He is also politically active. From 1950 to 1969, he served as a representative of Lusese in the (High) *Khuta*, which was then located in Kabbe. He is no longer a delegate, but continues to be consulted for advice by the (High) *Khuta*,[10] now based in Bukalo.

[10] The tribal court at the level of the ethnic group, in his case the Masubia.

Like his family members, Mushaukwa is a Christian. He is affiliated with the Roman Catholic Church and attends Mass almost every Sunday. According to Mushaukwa, Christianity and traditional belief are not in conflict: 'Our God, *Nyambe*, is the same as the God of the white people; we simply call Him by a different name. There is only one God for the whole world. The white people did not bring God to us; they taught us to worship Him in their way.' During his healing work, he frequently prays to *Nyambe*, asking for His support in carrying out his work well.

His vocation as a *ñaka* has proved materially rewarding for Mushaukwa. By the standards of Caprivi, he is prosperous, as is most clearly evidenced by the approximately ninety cattle he owns. Cattle constitute a customary form of payment for his services.[11] He also accepts cash, but since paid employment is scarce in Caprivi, only a small number of people participate in the monetary economy.

[11] Cattle are also used as a medium of exchange in other contexts, such as the payment of bridewealth to the bride's family and the settlement of fines imposed by the *Khuta*.

Chapter 2. CONCEPTIONS OF ILLNESS

> When we study health phenomena or, to take another example, religious phenomena, it is not necessary to proceed from an a priori distinction between what is determined (culture, illness) and what is autonomous (nature, disease). We must critically reflect on our assumptions about what we believe truly exists and what we believe exists only in the imagination of our informants (my translation, Pool 1989a:33).

In the introduction, we observed how Charles, a victim of witchcraft, was treated by Mushaukwa. This gave us a first glimpse of local conceptions of illness. The cause of Charles's accident and the illness that followed was sought in the social world: it was assumed that a malevolent person – a witch – had caused his misfortunes.

In the explanation of illness, the role of the social environment, as well as that of the supernatural, proves to be of paramount importance. This has been observed in virtually all medical anthropological studies conducted in Africa.

People do not, however, confine themselves to these 'traditional' explanations. Clinics and the hospital are also widely used, and most people maintain that individuals suffering from a social or supernatural illness cannot be cured there. Questions that then arise include: 'How, more precisely, do people conceptualise illness, and how do these conceptualisations guide their health-seeking behaviour?'

It will become clear that within the broader system of illness conceptions, space is reserved for illnesses that can be treated in the professional sector and those that can be treated in the folk sector respectively. It will emerge that in the conceptual framework of illness, the folk sector and the professional sector are integrated into a single system, at least in the minds and health-seeking behaviour of the people in the Eastern Caprivi.

In this chapter, I first set out the manner in which illness conceptions are formed, after which I describe in detail a number of the illness explanations that are distinguished. The data derive from various *ñaka* and users of their care residing in Lusese.[12]

2.1. 'Modern' and 'African' Illnesses

People in Eastern Caprivi draw a distinction between 'African' and 'modern' illnesses. 'African' illnesses, or 'illnesses for Bantus' – to use a literal rendering of the Silozi term *matuku a sintu* – are described as illnesses that can only affect black people. 'They are illnesses that belong to our culture' or 'they are our traditional illnesses', as people frequently say.

'African' illnesses are explained through an aetiology in which attention is directed not primarily at the sick individual and the bodily disease process, but at the place of the sick person within 'the larger whole'. The causes of illness are sought outside the patient, in the supernatural and social environment. People assume that those suffering from such illnesses can only be cured by a *ñaka*.

[12] In this chapter I use the masculine personal pronoun as a general reference, applying equally to men and women, in order to avoid the continuous repetition of 'he or she'.

This stands in contrast to 'modern' illnesses (referred to as *matuku a sikuwa*: illnesses of white people, or *matuku a cipatela*: illnesses for the hospital), which can only be recognised and successfully treated by a formal healer. Such illnesses were unknown in the past and, according to some, arrived with the white people.[13] The 'modern' illnesses most frequently cited by informants are malaria, tuberculosis, AIDS, dysentery, pneumonia, and measles.

In order to explain how this distinction is formed in practice, I begin by reproducing a brief excerpt from an interview with a *ñaka*.

> *Ñaka*: 'Some illnesses are for the hospital. African illnesses are for the *ñaka*. If it is a modern illness, it can be treated at the hospital or the clinic.'
>
> Myself: 'What is a modern illness?'
>
> *Ñaka*: '*Ñaka* cannot treat modern illnesses. Doctors cannot treat African illnesses.'
>
> Myself: 'Can you recognise a modern illness?'
>
> *Ñaka*: 'I know that when I begin to treat a patient and there is no improvement, the patient may have a modern illness. Then I send him to the clinic.'

From conversations with Mushaukwa, other *ñaka* (as illustrated above), and users of their care, it quickly became clear to me that people draw a distinction between 'modern' and 'African' illnesses. When I asked what the difference was between the two categories, I consistently received the answer that 'African' illnesses are those that can be cured by a *ñaka*, and 'modern' illnesses are those that can be successfully treated at the clinic or the hospital. When I then asked whether one could specify the different manifestations of the two categories – how one can recognise whether an illness is 'African' or 'modern' – I would generally receive a repetition of the previous answer. This led me to realise that the formation of conceptions about the nature of illness is linked to the evaluation of treatment within one of the two sectors. It became apparent that illness conceptions are not formed on the basis of particular illness manifestations or a considered aetiological explanation prior to the choice of therapy, as I had expected.

The following questions then arose: can the same symptoms belong to both an 'African' and a 'modern' illness? Are there no clinical presentations that are regarded as characteristic of an 'African' or a 'modern' illness? Are conceptions about the nature of illness then not determinative of the choice of care?

Over the course of my research, the following picture emerged: People who, at the onset of an illness episode, are confronted with complaints such as headache, abdominal pain, a cold, diarrhoea, back pain, a painful body, weight loss, palpitations, or a general sense of malaise, initially regard these as illnesses without a clear cause that come and go and are generally transient in nature. These are sometimes described as 'ordinary natural illnesses'.

[13] Mushaukwa draws a connection in this regard between vaccination and the acquisition of 'modern' illnesses: 'Long ago we did not have these illnesses. Then the white people came and told us we had to be inoculated against illnesses whose very names we did not know. After we were vaccinated, some people contracted these new illnesses and had to go to the hospital for treatment.'

Conversations with residents of Lusese indicate that for such complaints – if they have not resolved spontaneously or if treatment within the lay sector has brought no relief – people will generally seek assistance from formal healers. This is often because treatment at the clinic or hospital is less costly than treatment by a *ñaka*, and also because of the perception that modern medicines act quickly and powerfully.

If a patient does not improve rapidly following treatment at the hospital or clinic, or if complications arise, the treatment is deemed unsuited to the illness, and the understanding of its nature is revised: it is reclassified as 'African'. It is then assumed that a headache or diarrhoea, for example, is not 'merely natural' but that 'there is something behind it'. A decision is subsequently made to consult a ñaka, who will seek out and address the cause of the affliction. It may have been sent by an invisible power or a witch.

In cases where a *ñaka* is consulted first, he may – on the assumption that the illness is 'merely natural' – begin with a treatment directed at the presenting complaints. If these persist, he will seek an underlying cause and direct his treatment accordingly. If this treatment also yields no improvement, then the illness must be 'modern'. All the healers I spoke with told me that in such cases they advise their patients to go to the clinic or the hospital for help. The sick person may, however, also decide to go to the clinic or hospital before the suspicion has shifted towards an 'African' illness. If treatment in the professional sector provides no relief, the illness is 'African' and the sick person consults a *ñaka* once more.[14]

From this pattern of health-seeking behaviour it emerges that during an illness episode the clinic or hospital is visited at least once as a matter of course. If the patient does not recover and therefore consults a *ñaka*, the latter will in practice be unlikely to refer the person back to the professional sector promptly. The earlier unsuccessful visit to that sector effectively rules out the definition of the illness as 'modern'. The *ñaka* will treat the sick person over an extended period until the treatment takes effect or, if it does not, only at an advanced stage of the illness – with the view that it is after all 'modern' – refer the patient to the clinic or hospital.

The evaluation of treatment by a *ñaka* or a formal healer thus forms the basis upon which an illness is characterised as either 'African' or 'modern'. Conceptions about the nature of an illness can therefore change over the course of the health-seeking trajectory. Crucially, illness definitions and therapeutic choices are not determined by the interpretation of specific illness manifestations. In short, the process does not function as a simple formula: 'I recognise these symptoms as characteristic of a 'modern' or 'African' illness and therefore I will go to the clinic or a *ñaka*.' People remain flexible in their interpretation of symptoms, recognising that the same manifestations can be associated with both diagnostic categories.

For certain manifestations, however, this is not the case. These are not regarded as open to multiple interpretations and do guide the choice of care. Of particular significance is the combination of symptoms: high fever accompanied by chills and perspiration, headache, and vomiting – especially of bile (Silozi: *inyoko*).

[14] The conceptions about the nature of an illness and the related decisions about therapeutic choice are, incidentally, generally not formed by the sick individual alone but in consultation with family members and/or friends (the therapy management group).

These symptoms are generally associated with malaria, a readily recognisable 'modern' illness of which everyone is convinced that only the medicines from the hospital are effective against it.

Early in my stay, one of Mushaukwa's sons – who is also a *ñaka* – came to me to ask for tablets for his wife, whom he believed had malaria. He came to me because the nurse had not staffed the clinic for about four days due to a public holiday. I was unable to convince him that I was not a doctor and therefore could not and should not make a diagnosis. According to him, this was unnecessary: he was convinced she had malaria. After he pressed me insistently, I visited his wife, and her symptoms – including a temperature of 41.5°C – did indeed point to malaria. Her condition appeared serious and I decided to give her tablets. After an extremely restless night, I walked on unsteady legs the following morning to the woman's courtyard. When I saw her, a weight lifted from my shoulders: before me stood a smiling, healthy-looking woman – the tablets had apparently worked.[15]

From that point on, I attempted to convince everyone who would listen that I was not a doctor, never would be, and that it was therefore futile to come to me with medical problems.

Other specific manifestations are understood as symptoms of an 'African' illness. These include loss of consciousness, convulsions (often followed by loss of consciousness), singing in one's sleep, having strange dreams, and going mad (Silozi: *kumbulumuka*), expressed through fighting, stealing, excessive talking, and above all running into the bush. If someone dreams, for example, that they are bitten by a hyena and wakes the following morning with a wound on their leg, they will assume that something is seriously wrong and will likely suspect they have been bewitched.[16]

These manifestations share a common character that leads them to be seen as expressions of 'African' illnesses: all involve the (temporary) loss of control over body and behaviour. There is 'something' that appears to overwhelm the person, something that takes over. A cause that exists outside the body, in an invisible reality to which the layperson has no access.

Those experiencing these symptoms will generally consult a *ñaka* exclusively. As one informant remarked: 'You can tell by the nature of your illness: this is a matter for the *ñaka* – they wouldn't know what to do with it at the hospital.'

Within the domain of the *ñaka* there are also social problems – not readily called illnesses (*matuku*) – such as an unhappy marriage, the inability to find a partner, or a lack of success in finding employment. These problems call first and foremost for treatment with ‘lucky-herbs’ to bring good fortune. If these herbs do not produce the desired effect, the *ñaka* will, as with 'genuine' illnesses, seek a possible supernatural or social cause of the problem.

[15] It was an extremely difficult situation. On the one hand, I did not wish to bear responsibility for any complications that might be caused by the tablets, or for the medicine failing to work if it was not malaria. On the other hand, I did not want to be seen as having done nothing if her condition deteriorated – with potentially fatal consequences. I chose to give the benefit of the doubt.
[16] Manifestations that within the biomedical paradigm frequently indicate epilepsy.

In this section I have shown how the medically pluralistic character of this society takes shape in the interpretation of illness through the binary of 'modern' and 'African' illnesses. This labelling of illness is linked to the evaluation of treatment in the professional and folk sectors respectively. The reasoning is used in particular to explain why a sick person does not recover. An illness is 'modern' if treatment by a *ñaka* is unsuccessful.

In short, it is not the *ñaka's* fault that the treatment fails, but the fault of the illness: it is 'modern'. Patients in the hospital who do not recover promptly are there wrongly, since they apparently have an 'African' illness. The logic is internally consistent: the failure of a treatment constitutes proof that a sick person is being treated in the 'wrong' sector. If a patient dies, they were treated for too long in the 'wrong' sector.

By proceeding from the dichotomy of 'African' versus 'modern' illnesses, the professional and folk sectors are incorporated into a single conceptual system in which they are complementary. The literature speaks of an integration of the various therapeutic possibilities 'in the minds' of users. Richters (my translation, 1993:209) notes in this connection: 'Promoting the integration of traditional and Western healthcare, as is currently advocated at policy level, would therefore [on account of this integration in the mind] be unnecessary. People would be rational enough to determine which form of healthcare is best suited to their needs in particular circumstances. Through the market mechanism of supply and demand, a healthcare supermarket would thus naturally emerge that caters to all needs.'

Integration implies, however, a full acceptance of what the respective sectors have to offer. This is not the case in Eastern Caprivi, for people hold conceptions about what the professional sector can provide for them that are not in accordance with the views of formal healers (particularly those of expatriate physicians). Patients frequently leave the hospital on the basis of the conviction that their illness is 'African', while the treating physician – who defines the illness in biomedical terms – is of the opinion that he is able to offer help. For him, 'African' illnesses do not exist. A significant problem here is that people generally expect treatment in the professional sector to be brief and decisive. Long-term treatments, such as those for tuberculosis, and treatments that must be continually repeated but do not remove the illness itself – only its symptoms, as with diabetes and epilepsy – are not accepted, or are poorly accepted. Full acceptance of what is on offer is therefore not present. It is therefore more accurate to speak of a pseudo-integration rather than a genuine integration of the sectors in the minds of users.[17]

In the following section I describe in detail the underlying causes of 'African' illnesses. Much of the information derives from Mushaukwa, reinforced and supplemented by data from other *ñaka* and residents of Lusese. Not all informants have equally elaborated ideas about the causes of 'African' illnesses; the most detailed knowledge resides with the *ñaka*. My description represents the greatest common denominator of the information I collected.

[17] Following Richters (1993:209–220), who critically discusses various forms and levels of integration.

2.2. 'African' Illnesses and their Aetiology

Within the category of 'African' illnesses, it is possible to distinguish three principal aetiological categories. Illness is caused by invisible powers, including the ancestors; illness is sent by witches; or illness is caused by the transgression of a taboo.

Conceptions of 'African' illnesses are inseparably bound up with religion. The causes of illness are sought in influences emanating from a ‘non-empirically verifiable reality'. Attention is directed not, as in Western medical thinking, primarily at biological mechanisms and physiological processes, but at relationships with the invisible world.[18]

At first glance, it may not seem difficult to subsume the categories mentioned under the heading of religion. Witchcraft, too, can easily be accommodated there: witches occupy themselves with matters that are not ordinarily visible or explicable; witchcraft transgresses the boundaries of empirical reality. It is, however, a difficult category to classify. Witches are, in the first instance, human beings: people who live in the earthly world and undertake certain actions with the intention of making others ill or even killing them. Responsibility lies clearly with human agents, unlike other illnesses, which are ultimately all sent by God (*Nyambe*, the 'Supreme Being') – even if they have another proximate cause. The emphasis in witchcraft lies more on the social dimension than on the supernatural.[19]

2.2.1. Invisible Powers

In this sub-section I examine the various invisible powers that are held to be capable of afflicting people. Because they share a considerable number of characteristics, they are often mentioned in the same breath.

First and foremost, they are invisible. People believe that they exist, but ordinarily they cannot be seen. They are sometimes grouped under the collective term *madimona*, a term my interpreter translated as demons. 'Perhaps you could call them spirits,' some people said – often after I had explained what I understood by this: beings that are not ordinarily visible but can nonetheless influence people. What is certain is that they share the capacity to be malevolent.

As noted, virtually any illness manifestation can be a symptom of 'African' illnesses. Among the range of possible complaints, those of a chronic nature – non-fatal complaints that come and go, such as back pain, a painful body, weight loss, palpitations, and a general sense of malaise – are frequently attributed to the influence of invisible powers. Furthermore, these powers make their influence felt by imposing personal prohibitions on individuals, often relating to the consumption of particular foods or the entering of certain places (personal taboos). Their influence is frequently associated with problems within social relationships. In particular, illness caused by the ancestors is often seen as a punishment for family disputes or for failing to treat family members appropriately. The sick person may, incidentally, also be the one who is not being treated properly; their illness then functions to draw attention to what are sometimes latent conflicts or strained relationships.

[18] Based on Van Beek's (1982:14) definition of religion.
[19] God is never seen as the direct cause of illness: 'Whilst he [*Nyambe*] is the ultimate source of power he is generally considered to be remote from petty human affairs' (Reynolds 1963:10).

In addition to directing attention at the sick person, the *ñaka* will seek to bring any underlying social problems to light and act as an intermediary in order to alleviate them.

It proved very difficult to gain a clear grasp of the conceptions people hold about the nature of these powers and the manner in which they make people ill. Can the powers take possession of people? Is this why people fall ill? Do the powers send illnesses to people? One would often hear such expressions as, 'he is *being troubled* by the *balimu* (the ancestors)' or 'she *has Jangula* (the forest being)'.

When I pressed further, asking 'how exactly do the *balimu* trouble him?' and 'does having *Jangula* mean that *Jangula* can enter the body?', the response was frequently: 'I really don't know – they're just names of illnesses.' This was often delivered with an air of impatience, implying that I was overcomplicating matters. Evidently, these questions addressed conceptual frameworks that people themselves do not consider important. More pressing than philosophising about precisely how a given power afflicts a person is the immediate reality: the presence of an ailment and the urgent need to be rid of it.

The names of the powers denote the cause of illness. The powers do not send distinct illnesses with specific names to people. In this sense, they do not cause illnesses as such, but rather illness manifestations. These manifestations are an expression of the powers' influence on individuals. Illness can thus be understood as a medium of communication between the supernatural and the human world.

Three distinct invisible powers can be identified, which I shall discuss separately below.

1. Balimu: The Ancestors

The ancestors are deceased relatives of several generations past who continue to exert influence over the lives of their descendants. They can bring prosperity – such as a good harvest and healthy livestock – but they can also be troublesome and cause illness, often because they feel neglected. They draw attention to themselves by making someone ill. A compelling example is that of an ancestor who is displeased because a particular child has not been named after him. He will then make the child ill until the *ñaka* discovers that it is a 'matter of naming'. Once he has established which ancestor wishes the child to bear his name and the child is given that name, it will recover. People also fall ill because they fail to observe personally imposed prohibitions, particularly on the consumption of certain foods. It is very common for people to be unable to eat certain foodstuffs. They will then consult a *ñaka* who asks: 'Do you become ill when you eat this or that?' If the answer is 'yes', the response is: 'Then you must not eat it any more, because the *balimu* forbid it.' (Other powers may also impose personal prohibitions, but it is frequently the ancestors who do so.) These prohibitions may concern important foodstuffs that form part of the staple diet. Thus Mushaukwa is not permitted to eat a particular species of fish or millet (Silozi: *mauza*), the latter being, alongside maize, the most important crop.

According to Mushaukwa, the ancestors once resided in baobab trees – majestic, hollow structures often referred to as monkey-bread trees. A short distance from Makoma stands one such tree that belonged to the village forefathers, to which people would traditionally go to honour them.

As a gesture of thanks for a good harvest, for instance, a portion of the yield would be offered to them. This was also the place to appeal to the ancestors for help in times of difficulty, such as praying for rain during a prolonged drought. Mushaukwa explained that one could infer the ancestors' presence from certain pure-white birds (*Cisubia: kasangamulela*) that sat in the tree and flew in and out of its opening. He noted, however, that the current generation is no longer greatly interested in the ancestors and pays little heed to their prohibitions. This was reason enough for the ancestors to depart; as they informed him in a dream around 1970, they had relocated to a tree in a quiet, uninhabited area of Botswana close to the Namibian border.

After I had visited the baobab at Makoma, Mushaukwa asked me whether I had seen the white birds. 'No, I didn't see them,' I replied. 'Well, there you are – what did I tell you? The ancestors have left!'

2. Mwendanjangula: The Forest Being

A power about which people have a vivid conception is *Mwendanjangula*, usually referred to simply as *Jangula* – the being that dwells in the forest. It is a being in human form, but with a body of which only one side exists. It has one leg, one arm, and half a head. A slightly different version holds that it does possess all its limbs, but that those on one side are smaller and non-functional. In order to strengthen that side, it has bound it with reeds covered in beeswax.

Beyond the illness manifestations discussed in the introduction to this section, there are specific manifestations associated with *Jangula*, linked to its appearance: problems concentrated on one side of the body, such as a deformed arm or leg, unilateral paralysis, and convulsions affecting one side of the body. Illness caused by *Jangula*, owing to its association with the dangerous character of the bush, is also referred to in Silozi as *mushitu* (forest, woodland).

Jangula is said to possess valuable knowledge of medicinal herbs with which many illnesses can be cured. Its herbs can also bring luck and success (lucky-herbs). To gain access to this knowledge, an encounter with *Jangula* is required. Only those who are fortunate can come across it in the forest. The story goes that a fight will then ensue. The odds are considered slim, but in the event that the human wins, *Jangula* is compelled to yield its knowledge. If *Jangula* wins, however, it can keep the unfortunate person in its forest forever, or at best send the person home no wiser than before the encounter. According to Prins (1992:350), *Jangula*, like witches – whom he terms its 'human brothers' – can enslave the souls of those who encounter it. This may be what people mean when they speak of *Jangula* being able to hold people in its forest.[20]

Supernatural beings in non-literate religions are frequently conceived of as human beings with only half a body (unilateral beings). According to Schoffeleers (1991), people represent the supernatural as simultaneously human and non-human. A human half-being satisfies this requirement: it is human, yet also not, because it is incomplete, asymmetrical, whereas the human being is symmetrical. But with only one half, the supernatural being can do more than the human: move more swiftly, for example, or see more clearly.

[20] See Prins (1992) for a study of the relationship between the 'medical cosmology' of the Malozi and their broader intellectual history.

The absence of one half is therefore not a sign of weakness but of strength – the being can achieve more with less. Furthermore, in human beings there are contrasting forces and values that must remain in balance. For the completion of the human person and the continuation of the human species, men and women need one another. Without a partner of the opposite sex, the individual is, symbolically speaking, only half a person. The unilateral being, by contrast, is a half-person that endures indefinitely and is sufficient unto itself. In short, the unilateral figure inverts and transcends the laws governing human existence. To summarise: '(…) the divine as paradox: not reproducing yet continuing to endure, appearing powerless yet capable of achieving the most impossible things, appearing sub-human yet being superhuman' (Schoffeleers 1991:24).

People generally speak of *Jangula* as a single, all-encompassing being. Mushaukwa told me, however, that multiple *Jangula* inhabit the forest and that there are specific *Jangula* that hold sway over the rivers. These can 'hold people in their river'. The manifestations in people include absent-mindedness, distraction, and excessive drowsiness: they inhabit a murky reality, as though they were underwater.[21]

Mushaukwa also told me that there are *Jangula* of both male and female sex, and that the male *Jangula* afflict only women, while the female *Jangula* afflict only men. When I asked him the reason for this, his answer was: 'It is simply the way things are!' – a response I frequently received and which sometimes left me rather dispirited: what more was there to say?[22]

In search of an interpretation, I was struck by the idea that male and female *Jangula* enter into a relationship with a human being of the opposite sex through illness – a symbolic marriage, in effect. In this reading, *Jangula* is less supernatural, and therefore more human, than Schoffeleers's explanation suggests: he or she is not sufficient unto themselves but requires a human partner in order to endure.

By way of illustration of the ideas surrounding *Jangula*, I reproduce below the text of a song about it, taken from the story collection *Pilaelo ya Noha* (The Worried Snake) by Songiso (1988).

> *Mwendanjangula*! A man with an amazing structure. Head and body are half made. One ear. One leg. Oh ho! you are really an amazing creature. You are frightening.
>
> *Mwendanjangula.* You are known through the whole country. Everyone is eager to see you. You can give people herbs that will make them lucky. There are so many herbs to become lucky. Including some to become rich.

[21] River spirits also occur among the Shona of Zimbabwe, as described by Chavunduka. He describes a case of a man who was pulled underwater by such spirits, was required to remain there for two days, and subsequently left the water as an initiated healer (1978:21).

[22] To many of my questions I received the answer 'it is simply the way things are' or 'because God wants it so', which made me wonder whether he genuinely saw things that way and whether I should not be looking for reasons behind everything, or whether I was confronting him with questions about matters he would otherwise not reflect upon, since they were self-evident to him, and that he gave such answers in order to be done with it. In any case, I noticed that he found it tiresome when, dissatisfied with his answer, I persisted in asking about the same subject. And quite possibly rightly so: is it not typically Western (or typically anthropological?) to seek a reason behind everything?

Mwendanjangula. You cannot be seen. Only those people who are lucky can see you. Stores are built thanks to your lucky herbs. Not saying anything about all the cattle, and the money at the bank. Old wise people failed to answer some questions in mathematics. To see *Mwendanjangula* is like seeing a snake passing water.

Mwendanjangula. Where are you hiding yourself? I've searched in the Bulozi-land valley [south-west Zambia, kingdom of the Bu- or Malozi]. Gone through forests. Searched in the shade of Mizauli trees. I've crossed many rivers. But unfortunately I could not find you. You are only seen by those people blessed by *Nyambe.*

Mwendanjangula wa likondo limweya ngowiye. Mwendanjangula wa likondo limweya ngowiye. Mwendanjangula with one leg, please come. *Mwendanjangula* with one leg, please come.

Mwendanjangula. This is your praising song. Sung by those who drum for *sisongo* and *muba* [alongside *mushitu*, names for illness in which *Jangula* is implicated].

Mwendanjangula. The day I'll meet you. I'll never ask to become a *ñaka.* Because what use is there in weaving a reed skirt to dance in [in public treatment sessions] while others are building shops?

(Translated from Silozi by my assistant, Victor Sipi Mushaukwa.)

According to the author of this song, people today are less interested in *Jangula's* power to make someone a healer than in its lucky-herbs as a means of becoming wealthy: what is the point of dancing in a reed skirt as a *ñaka* when others are growing rich from the shop they run so successfully? An ironic commentary, it seems to me, on a changing society in which traditional conceptions are increasingly being called into question, particularly by the younger generation.

3. Moya/Nzila

Unlike the powers discussed above, *Moya/Nzila* is not generally associated with particular beings or deceased persons. *Moya* literally means air, wind, or breath. *Moya* is everywhere: 'when you breathe, you breathe *moya*'. The association with air is strong. The notion that a power can enter the body is stronger with *Moya* than with the other powers. Mushaukwa told me that *Moya* settles in the chest cavity, and according to him, excessive belching is a sign of *Moya's* presence. And then there is the name *Nzila*, meaning path or road. *Nzila* refers, according to Faber (n.d.:2), to 'the non-personal spirit one meets on the path'.

The two names appear at first glance to point to two distinct influences. According to Van Binsbergen (1979:173–304), this is indeed the case. He describes *Moya* and *Nzila* as two independent 'non-human agents', each with its own history, originating in western Zambia around 1940. Prins (1992:348), on the other hand, maintains that someone who has the illness *Nzila* is guided by the spirit *Moya.* Under this interpretation, *Moya* would be the spirit one encounters on the path.

According to Mushaukwa and residents of Lusese, however, *Nzila* and *Moya* refer to the same power. The names are used interchangeably. According to some, the name *Nzila* is more commonly used in Zambia and Moya in Caprivi.

In any case, in Lusese today *Moya* and *Nzila* are associated with the same phenomena, even if they may originally have been distinct influences. I shall therefore treat them as a single concept for the remainder of this account and combine the names.

Moya/Nzila is associated with 'something that is very clean', symbolised by the colour white and by purity. *Moya/Nzila* is also more closely associated with God, *Nyambe*, than the other powers. '*Moya/Nzila* comes from God,' is a frequent saying, and Mushaukwa began long ago to treat people with this illness simply by praying for them. The Bible remains an important attribute used in the treatment of *Moya/Nzila*. It is also noteworthy that when Mushaukwa was himself afflicted by *Moya/Nzila*, he saw white people in visions. Even now, *Moya/Nzila* comes to him in dreams in the form of white people.

In Van Binsbergen (ibid.) there are indications of the incorporation of Christian and white European elements into the concept of *Moya/Nzila*. In changing societies in western Zambia, cults emerged from the 1930s onwards around new afflicting powers, including *ndeke* (aeroplane) and *bindele* (denoting white people or people dressed in white: Europeans or foreign African traders). Out of the *bindele* cult, the *Nzila* cult emerged in due course. It was founded by a man named Chana who, despite suffering from a typical *bindele* affliction, found no healing within the *bindele* cult but healed himself under the influence of visions in which the power *Nzila* spoke to him. In later visions he was instructed to trust in God, to hold weekly services for Him on Saturdays, and to redirect his activities towards the giving of moral instruction. According to Van Binsbergen, the influence of the Seventh-day Adventists is unmistakeable here.

We observe here how strange new elements in society – such as white people and their Christian Church – were incorporated into the concept of *Moya/Nzila*. The absorption of new elements into traditional religion is a means of gaining a degree of control over societal change. Phenomena that disturb the prevailing order are incorporated into the worldview in such a way that they alter it without overturning it entirely.

2.2.2. Witchcraft

I begin by recounting an experience I had early in my stay in Makoma:

> I am lying asleep in my hut. Suddenly, I am startled awake because I feel something creeping inside. It feels like something heavy, moving with agonising slowness towards my bed. I can tell from the warmth it radiates that it is drawing closer. I am terrified; my heart is pounding in my throat. I want to turn over, but cannot move – my body feels leaden. I seem to be nailed to my bed. Suddenly, the thought flashes through my mind that it must be a lion. A lion, I think – how can that be? Yes, it is possible – this is Africa! I try to shout, but cannot utter a word. When I feel the mosquito net under which I am lying being pressed down onto my shoulder, I feel as though I am about to explode with fear. At that very moment, it is over: the tension snaps. Drenched in sweat, I turn over – there is nothing…

When I told my interpreter the following day about this experience (not Victor, but Moses, my first interpreter whom I had met in Katima Mulilo), he remarked that it was a typical example of witchcraft. Mushaukwa agreed unreservedly: 'A witch transformed into a lion, or sent one to you.'

I was not exactly reassured by this explanation, but comforted myself with the thought that it must have been a nightmare – my subconscious was clearly busy processing all the new impressions and uncertainties. Nevertheless, it was striking that I experienced this, despite having minimal knowledge yet of local ideas about witchcraft.

Could there be another reality, alongside the empirically determined one with which I was so familiar, in which these events can occur? My sober-minded disposition had received a considerable jolt. On the nights that followed, I carefully checked that the makeshift door of our hut was properly shut before going to sleep. Mercifully, that night remained a singular occurrence.

In my research I did not engage further with the ontological status of witchcraft. The fact that it plays such an important role in society – guiding people in actions that have consequences – makes it part of reality: what people believe to exist, exists. Whether it is knowable then ceases to matter.

Witches (Silozi: *baloi*, singular *muloi*) are certain individuals within society who are able to bring misfortune upon others and make them ill through magical acts, with the intent to kill them.[23] They are sinister individuals who fly through the air at night in pumpkins or in the form of balls of light, climb on the backs of people to use them as a means of transport without their awareness, make themselves invisible, and can transform themselves into animals. They behave antisocially, doing things that ordinary people cannot or would not wish to do. They have an ambivalent character: on the one hand they are human beings, on the other they are non-human, displaying inexplicable and barbarous behaviour. Their inhuman side is perhaps most clearly expressed in their need to eat human flesh. The widely used characterisation of *baloi* as 'those who eat others' is not merely a figurative expression for 'those who kill others' but must be taken in its literal sense. *Baloi* gather at night in burial grounds to call up those they have recently caused to die and consume them.

Hunger for human flesh is not their only motive for killing; baloi are equally driven by jealousy, anger, or a desire for revenge. Jealousy, in particular, is frequently cited. For instance, if someone accumulates disproportionate wealth, possesses an impressive vehicle, or has a highly desirable spouse – especially when individuals carry themselves with pride – this is perceived as a direct provocation to a witch.[24]

Baloi are men or women from one's immediate social circle: relatives on the father's or mother's side, spouses, colleagues, or 'friends'. In short, they are people with whom one has a relationship – as must be the case, since people one does not know, cannot be one's enemies.

Just as a thief is not born a thief, people are not born a *muloi*. Their character has been acquired by ingesting certain herbs – 'evil medicines'. A person who wishes to harm another will seek out someone they suspect of being a *muloi*. In exchange for payment, that individual will provide the aspiring *muloi* with herbs to swallow. It is said that these herbs settle in the chest and remain there permanently.

[23] Many of the aspects of witchcraft I discuss have also been observed among the Malozi of the Barotse kingdom, extensively described by Reynolds (1963).
[24] According to Mushaukwa, my presence in Makoma could also be a reason for bewitchment. People in neighbouring villages might, on account of this, be jealous of those in Makoma and seek to bewitch them.

The *muloi* may also make incisions in the body of the initiate and rub the herbs into them, or cause the herbs to smoulder and have the initiate sit in the smoke, in order to transfer the malevolent influence. The initiate is then inducted into the knowledge of magic and 'evil medicines'. A *muloi* may also, to ensure that they will be succeeded, make someone a *muloi* without that person's knowledge or consent, by administering herbs to the chosen individual at night while they sleep in the manner described above. Among those in that person's immediate circle, people will suddenly and mysteriously begin to fall ill and die. The signals that they may be the cause of this come to them in dreams in which they see themselves murdering people and wandering across burial grounds in search of human flesh.

Once *baloi* have become 'powerful', they generally remain so for the rest of their lives. Only exceptionally powerful *ñaka* can treat *baloi* who have grown weary of killing, so that they can once again become ordinary people.

The distinction between witchcraft and sorcery, as it is made in a number of societies – including the Azande of Sudan (so powerfully described by Evans-Pritchard (1976), after which the distinction came into widespread use) – is not made in Eastern Caprivi. No distinction is drawn between persons who possess an inherited, inherent capacity to harm others without engaging in deliberate acts and perhaps even without being aware of it (witches, in the terms of this distinction) and persons who have acquired their power, perform magical acts, and use 'evil medicines' (sorcerers). The concept of the *muloi* encompasses aspects of both witchcraft and sorcery but cannot be subsumed under either category. In short, people do not conform to 'neat' anthropological classifications of reality. It is therefore pointless to adhere to these with undue rigour. I use the term *muloi*, which I translate where necessary as 'witch', as the people themselves do.[25]

Baloi possess the power to harm people through magical acts.[26] Simply by uttering the wish that Mr or Mrs X should suffer an accident or contract a fatal illness – but also through more effective methods, which I discuss below. One frequently mentioned method is the placing of herbs at a spot where the *muloi* expects the victim to pass – for example, at the entrance to their hut – while calling out the victim's name. If the person in question steps over the herbs, illness will befall them (this form is called *muchalela* in Silozi). Furthermore, as noted, the *muloi* can transform into an animal – preferring a snake, hyena, jackal, or lion. In animal form, they visit the victim at night and administer a bite that can have fatal consequences. The *muloi* may also send an animal as an intermediary to carry out the same mission. *Baloi* stand on equal terms with animals and can therefore make them do their bidding.

A device whose use can have swiftly devastating consequences is the *tobolo kaliloze* – literally translated: the magical gun. It is a firearm whose barrel is made from the bone of a human arm, treated with herbs, with which the *muloi* can wound the victim from a great distance.[27]

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[25] In this connection I wish to cite Foster and Anderson, who also wrestle with fitting phenomena into classificatory schemes: '(…) a taxonomy is not an end in itself, something to be admired for its elegance. Its utility lies in clarifying our understanding of relationships among the phenomena with which it deals' (1978:66).

[26] Magic is distinguished from other rituals by its goal-directedness and 'instrumental-technical character'. When the goal is antisocial, one generally speaks of black magic (following Van Beek 1982:39–40).

[27] Several *tobolo kaliloze* are on display in the ethnographic museum in Livingstone, Zambia.

While calling out the name of the victim, the *muloi* fires at the sun. The moment the victim looks at the sun, they will hear the report of the gun, feel a stabbing pain in the chest, and realise with a shock: 'I have been shot!' The consequences are extremely serious: severe chest cramps, blood in the stools, and persistent vomiting of blood – in particular 'bad blood' (Silozi: *mali a maswe*), dark, poisoned blood. It is vital for the victim to consult a *ñaka* as quickly as possible, since otherwise their condition will deteriorate rapidly. Somewhat comparable is *siposo* – the throwing of objects across a distance, such as coins or nails, by the *muloi* into the body of the victim. In the affected part of the body, the victim will feel intense pain.

There is another method that relies on direct physical contact rather than action at a distance: placing 'evil medicines' – toxic herbs – in food or drink that the victim will consume. While other methods operate through supernatural mediation, this form utilizes the immediate physical ingestion of harmful substances.

In these cases, the primary aim is the killing and possible consumption of enemies. The *muloi* can also kill someone with the intention of using that person to harm others. Thus there is the *ilomba mema* – a snake created from blood that the *muloi* has secretly drawn from a person at night, mixed with herbs. From the mixture, a maggot grows that gradually transforms into a snake bearing the head of the victim. As the snake grows, the victim grows sicker. A metamorphosis from human to snake takes place. At the moment the snake reaches maturity, the person dies. The *muloi* can then use the *ilomba mema* – which craves human blood – to kill other people.

The *muloi* can also kill someone by stealing their soul – their last breath – and mixing it with herbs to create a *silumba*. The *muloi* enslaves the *silumba* and sends it out to make others ill. Fainting is often seen as a sign that someone is being given a *silumba*. A *silumba* is an invisible 'something' and is frequently translated as ghost or spirit. Whether these terms adequately capture the concept must remain unanswered.[28]

Although virtually any illness manifestation can be attributed to witchcraft, it is in particular symptoms of an aggressive character – such as hair loss, peeling skin, falling nails, festering wounds, and sudden paralysis – that are associated with it. Acute illnesses in which the patient's condition deteriorates rapidly, the vomiting of blood (attributed to being shot with the magical gun), and sudden deaths are also frequently considered to be the result of witchcraft.

2.2.3. Transgression of Taboo

In the foregoing we observed that invisible powers and witches send illnesses in a directed manner. There is a clear conception of a 'perpetrator' who strikes an unsuspecting victim with illness. In the case of illnesses caused by the transgression of a taboo, the notion of a directing perpetrator is less prominent. Here, illness is caused by a person having come into contact with dangerous, impure things. More so than with the other categories, responsibility lies with the sick person themselves: they have not observed a taboo; they have touched something that must not be touched.

[28] This is, of course, stating the obvious. Concepts must always be translated into the language and culture of the researcher. With any translation of a concept one can in fact ask whether the original meaning is truly being honoured.

The most important prohibition is on having sexual intercourse with family members. The violation of this taboo (incest, Silozi: *sindoye*) results in a terrible illness: strange wounds will begin to form on the body, nails will fall out, and limbs will become deformed.[29] According to Mushaukwa, he is the only healer in Caprivi who can still offer assistance in cases of illness caused by incest. There is also the prohibition on consuming alcohol and engaging in sexual intercourse when a close family member has died but has not yet been buried.

A person who cannot wait until the deceased has been laid to rest (Silozi: *infwanga* – the failure to observe these restrictions) will for the remainder of their life be afflicted in an unhealthy and obsessive manner by alcohol and by the pursuit of women.

Women are considered capable of existing in a state of impurity. It is widely held that women are dangerous to men during menstruation. The idea is no longer so strong that their temporary seclusion is required. The emphasis is primarily on the prohibition against sleeping with a woman who is menstruating. A woman who has had a miscarriage or an abortion is also considered impure. Men can fall ill from the water she has fetched or the food she has cooked. In effect, everything she touches can take on the same dangerous state as herself. The consumption of 'contaminated' food and water does not immediately cause serious illness – it may be limited to a simple cold or a bout of influenza. However, if a man has sexual intercourse with a woman who has had a miscarriage or abortion, a serious illness will befall him (Silozi: *kahomo*). The symptoms are: in some cases paralysis of the legs, and in particular extreme weight loss, so severe that it can lead to death.

The state of impurity in which the woman finds herself must be lifted in order to remove the danger to men. This does not resolve itself spontaneously, as in the case of menstruation. The woman must be treated for this. As a precaution, all men in her immediate environment are also treated, in case they have already come into contact with her in some way. The violation of the taboos on sexual intercourse with a menstruating woman or a woman who has had a natural or induced miscarriage is associated with the contracting of AIDS. It is striking how closely the symptoms of *kahomo* correspond to those of AIDS.

Some people said that *kahomo* is the traditional name for AIDS.[30] Many people, including *ñaka*, are aware that AIDS can be transmitted through blood contact.[31] Because of the blood contact that may occur in the taboo violations mentioned, people have now come to the view that blood contact is in fact the explanation for the illness that follows. The traditional idea of contagion through contact with dangerous, impure things is now given a 'modern' content. Falling ill through the transgression of a taboo is translated into biomedical terms of disease transmission through blood contact.

[29] It is plausible that these symptoms, viewed through the biomedical paradigm, would indicate leprosy.
[30] This is the only clinical picture in which informants themselves draw a connection between an 'African' and a 'modern' illness.
[31] On several occasions the hospital organised meetings for *ñaka* in order to educate them about AIDS, within the framework of the National AIDS Control Programme (NACP).

We observe that taboos apply to precisely those acts that, according to biomedical science, carry an increased risk of HIV transmission. The 'modern' interpretation of these taboos may well strengthen the tendency among people to observe them.[32]

Alongside the taboo transgressions with serious consequences, there are several with less severe outcomes, all of which are connected to animals. There is the abdominal illness *mboma* (Silozi for python), resulting from stepping on a dead python. The sick person must vomit continuously because their stomach is turning like a python. There are also abdominal complaints, often accompanied by diarrhoea, caused by the sick person stepping on a spot along a river where a crocodile (*ingwena*) has rested.

During an interview with an elderly and very eloquent *ñaka*, this illness was mentioned, and I asked him how he identified it. 'The belly of the sick person makes the sound of a roaring crocodile: ‘krrr-gurr-gurr, krrr-gurr-gurr,’ he explained, prompting both the healer himself and the bystanders to burst into laughter at his convincing imitation. Their amusement turned to sheer delight when Victor observed that I had, with complete seriousness, been trying to transcribe the sound in my notes: 'krrr-gurr-gurr, krrr-gurr-gurr,’ the roaring crocodile!' The phenomenon is perhaps best understood simply as a rumbling stomach.

Less well-known illnesses are *tau* and *imbande*. *Tau* (lion) is the result of stepping on the skeleton of a lion. The victim will fall ill in the part of the body corresponding to the part of the lion's skeleton that was trodden upon. *Imbande* (Silozi for eagle) is an illness that can affect young children. If a mother sitting in her courtyard with her baby sees an eagle and says, 'Look, there goes an eagle!', the baby can be 'taken' by the bird. It will begin to make convulsive movements with its body, described to me as resembling the movements an eagle makes when seizing prey: chest forward and wings (in the child's case, the arms) pulled back. To prevent this, every mother should ignore any eagle that flies past. Finally, there is *kanono*: loss of consciousness accompanied by convulsive movements that we would call convulsions, occurring particularly in children. There is an association with a wild cat, possibly because the sudden convulsive movements of someone having an attack resemble those of a startled cat. According to Mushaukwa, a person contracts this illness by eating from a bowl from which a cat has been licking. This view, however, is not widely held; Mushaukwa was the only person who mentioned it.[33]

2.3. Explanatory Models of Illness

In medical anthropology, various classifications of illness explanations have been proposed. Foster and Anderson (1978:53–56) draw a distinction between naturalistic and personalistic explanatory frameworks, using these two types of aetiology to characterise entire medical systems. In naturalistic systems, illness is explained in impersonal terms. Health exists when the inanimate elements in the body – heat and cold, humours or bodily fluids, yin and yang – are in equilibrium, in accordance with the age and condition of the individual in their natural and social environment.

[32] Although no estimates of the number of AIDS cases in Caprivi are known to me, it is generally assumed that Caprivi is the most severely affected district in Namibia. It borders Zambia and Zimbabwe, where the disease is known to be highly prevalent. Many 'Caprivians' have family and friends in those countries, and there is generally a great deal of travel back and forth (Fosse 1992:32).
[33] I suspect that individuals presenting with the symptoms of kanono would frequently be diagnosed with epilepsy at the hospital.

When this equilibrium is disrupted, illness is the result. Naturalistic systems are found in the healing traditions belonging to the Great Traditions, such as the Graeco-Roman, classical Chinese, and Indian Ayurvedic.

In a personalistic system, illness is believed to be caused by the active, purposeful intervention of an animate force. This may be a supernatural being (a deity), a non-human being (such as a spirit or ancestor), or a human being (a witch or sorcerer). The sick person is understood quite literally as a victim – the object of aggression or punishment directed specifically at them, for reasons that pertain above all to their own circumstances.

This classification closely corresponds to the distinction Young (1976) draws between internalising and externalising medical systems. In internalising systems, attention is directed at elements and events within the body, whereas in externalising systems the body is a black box and the causes of illness are sought outside it.

Illness in Eastern Caprivi, once it has been determined to be 'African' in nature, is predominantly explained in personalistic terms. The agents are usually witches or invisible powers. Concurrently, illness may also be understood as a consequence of breaching a taboo. While Foster and Anderson conceptualise taboo violations as separate from pure personalistic intervention – often functioning as an automatic, impersonal reaction – in the Eastern Caprivian context, the boundaries blur, as such breaches are closely tied to the moral disapproval of the invisible powers. Personalistic thinking here is an expression of the importance attached to being part of a larger whole, to being bound to others.

The notion that people are struck by illness against their will is strong. Indirectly, however, one can attempt to exert a degree of control. For example, by refraining from behaviour on which a taboo rests or which is disapproved of by the invisible powers – thus by avoiding disputes or resolving them quickly. In the same way, one can attempt to forestall witchcraft by not carrying oneself with excessive pride and by sharing one's accumulated wealth with others. One can do one's best to ensure that others do not become jealous or angry. Whether one succeeds in exercising this control, however, is ultimately dependent on others: both human beings and invisible powers.

Chapter 3. THE *ÑAKA* MUSHAUKWA AND HIS PRACTICE

> One morning when I have an appointment with Mushaukwa to discuss the background of several 'African' illnesses, Victor comes to tell me that the appointment cannot go ahead because the ancestors came to Mushaukwa in a dream the previous night and showed him a place where he must go and search for certain herbs for the treatment of a sick man, close to the end of the sand track that runs from Makoma to the gravel road – the main road of Caprivi between Katima Mulilo and Ngoma.
>
> Shortly afterwards I see Mushaukwa riding out of the village on his stately black bicycle, his small hatchet fastened beneath the luggage straps. Threading his way between the reed fences of the compounds, he set off on the approximately twenty-kilometre journey along the winding track in search of the designated herbs. Mildly frustrated by my dependence, as a researcher, on Mushaukwa's 'whims', yet simultaneously fascinated by the matter-of-fact way in which the supernatural shapes his daily life, I watch him go from the doorway of my hut, lost in wonder.

As the above fragment illustrates, Mushaukwa is a healer who maintains a close relationship with the supernatural. In this chapter, which places Mushaukwa and his patients at the centre, the importance of this relationship in his daily practice will become apparent. I preface the description of Mushaukwa's practice with an account of the manner in which his relationship with the supernatural came to be.

3.1. How Did Mushaukwa Become a *Ñaka*?

A distinction can be made between *ñaka* who have been chosen by one or more of the invisible powers and those who have not, but who have instead voluntarily acquired their qualities by undergoing initiation and training under an experienced *ñaka*.

Mushaukwa is a *ñaka* of the first category – whom I refer to as guided *ñaka* – and was compelled by the ancestors, *Moya/Nzila*, and *Jangula* to devote himself to the vocation of healer. He describes his power as 'something that was given to him'. It was not, however, a gift he could accept or refuse at his own discretion. The powers coerced him by afflicting him with illness.

Below I reproduce the account, as Mushaukwa told it to me, of the manner in which he fell ill and the powers first revealed themselves to him.

> Mushaukwa was approximately fifteen years old (around 1937) when he was suddenly surrounded by brilliantly white light. He was the only one who could see it, and it frightened him greatly because he thought it was fire that might burn him. The light appeared irregularly and without warning, shining for around fifteen minutes at a time. While the light was visible, Mushaukwa was unable to speak and felt a powerful urge to run into the forest. One morning, as he was sitting in his parents' courtyard with his younger brothers – his parents having gone to their fields to plough – he saw the white light again and suddenly ran out of the courtyard in a state of agitation and into the forest. His brothers ran after him and tried to restrain him.

Mushaukwa was, however, too strong for them, and in the white light he saw white people calling out: 'Come to us, run away from them, they want to kill you, come to us!' His brothers could not overpower him and called for the help of pupils from the nearby school, and together they managed to seize hold of him. Mushaukwa then lost consciousness and was carried home by his brothers in that state. When he came round shortly afterwards in his parents' courtyard, he saw his parents, brothers, and the other people gathered around him as wild animals that wanted to kill him. 'Go away, go away, you want to kill me!', he cried, and he tried to run away again. To prevent this, his parents decided to lock him inside the house.

His parents consulted a *ñaka*, who concluded that Mushaukwa had been bewitched. When they later entered the house where Mushaukwa was staying, carrying the herbs they had obtained from the *ñaka*, he immediately lost consciousness. Only when the herbs were removed did he regain it. Mushaukwa's parents consulted several other *ñaka*, and every time their diagnosis was witchcraft; yet each time they tried to treat Mushaukwa, he lost consciousness.

Meanwhile, Mushaukwa's condition remained unchanged: during his solitary confinement he periodically saw the white light again, and was still afraid of people, who transformed into wild animals in his eyes whenever they came near him. Only his mother and brothers were permitted to enter the house briefly in order to bring Mushaukwa food and drink. All told, Mushaukwa remained locked in the house for a year with no improvement in his condition.

Mushaukwa's parents continued to consult *ñaka*, and at some point they encountered one who was of the opinion that Mushaukwa had not been bewitched but was being troubled by *Moya/Nzila* – a new *idimona* [Silozi, singular of *madimona*: see 2.2.1.] that had arrived from Zambia. This *ñaka* knew of a *ñaka* in Zambia who had been ill in the same way and could cure *Moya/Nzila*. That *ñaka* was consulted and came to see Mushaukwa. When he entered the house where Mushaukwa was sitting, Mushaukwa began to weep. The *ñaka* said: 'Yes, it is clear, it is *Moya/Nzila*.' He then prayed to God, *Nyambe*, on Mushaukwa's behalf, and told Mushaukwa that he too must pray, for *Moya/Nzila* comes from God, and gave him a Bible. After a few days the white light disappeared and Mushaukwa was once again able to tolerate the presence of others.

Then Mushaukwa received a message in a dream that he must go and treat others who were also being troubled by *Moya/Nzila*, by praying for them with the use of his Bible. Mushaukwa accepted his calling and began to treat people of whom he was informed in dreams that they had *Moya/Nzila*. By his own account, this made him the first person in Caprivi who could cure *Moya/Nzila*.

Mushaukwa told me later that after he had recovered, the ancestors also began to come to him in dreams, recognisable as old people. They gave him information about sick individuals whom he should go and help, told him where to find the right herbs, how to prepare them, and in what manner and how often he should treat the sick person with them. It was like a film, in which he was shown precisely what to do. Sometimes the images were absent and he would hear voices during his sleep conveying messages to him.

The ancestors were the ones who later gave him his divination instrument, with which he could identify the cause of illness. It was then that he began to treat illnesses other than *Moya/Nzila* as well.

With the knowledge in mind that the powers compel people to become *ñaka* through illness, I asked Mushaukwa whether the revelation of the ancestors was also accompanied by illness. Mushaukwa replied that he suspects it was partly the ancestors who made him ill. During his illness episode he had dreams which he did not understand at the time, but which he now recognises as the ancestors' attempts to identify themselves.[34] However, the meaning of these dreams only became clear to him after he had recovered from *Moya/Nzila*. He was later also ill with *Jangula*, who likewise appeared to him in dreams, unmistakeably as the half-being. (*Jangula* can thus either make someone a *ñaka* following an encounter in the bush – see 2.2.1. – or do so through a calling expressed as illness.)

Mushaukwa's account is consistent with the generally recognised manner in which a person is chosen to become a *ñaka*. The invisible powers compel a person to take up the vocation of healer by making them ill. If the person is unaware of the calling or fails to accept it, the illness manifestations will increase in severity and death may ultimately follow. The powers afflict the chosen one with ever-greater persistence until the calling is recognised and accepted.[35]

Behaviours that are generally regarded as manifestations of 'madness' often prove to be signals of a calling. This was clearly the case with Mushaukwa. Under the influence of confusing phenomena such as the white light and the white people, he felt the urge to flee into the forest, away from the people around him, who had transformed into wild animals in his perception. This can be interpreted as follows: his familiar environment was reflected back to him as life-threatening – a place where Mushaukwa no longer belonged; he was different. He would be saved if he submitted to the will of the supernatural, if he accepted his otherness. It was only after he had accepted his calling and recovered that he understood the white light and the white people to have been manifestations of *Moya/Nzila*.

The illness episode is typically accompanied by dreams in which the power attempts to make its calling clear and to indicate how the person should act. These dreams are often unclear and confusing, and the sick person does not grasp the message until they enlist the help of an experienced *ñaka*. That *ñaka* will recognise that the person is not simply being 'ordinarily' troubled by one of the powers, but that the illness is the consequence of a calling. The dreams the sick person is having constitute a clear sign of this for the *ñaka*. The *ñaka* may also receive a message in their own dreams from the power troubling the person, conveying that the sick individual must become a *ñaka*. A further unmistakeable sign of a calling is when a person, during a treatment ritual, suddenly runs distraught into the forest and returns after a time carrying herbs. The *ñaka* will then identify and use these herbs in the treatment.

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[34] Mushaukwa generally spoke of the ancestors, the *balimu*, in broad terms, without drawing distinctions among them. Only during one of our last conversations did he tell me that it is usually his paternal grandfather – who was also a *ñaka* during his lifetime – who comes to him.

[35] The compelled election to healer by the supernatural, accompanied by serious illness, is a near-universal phenomenon. The term 'shaman', Siberian in origin, is frequently used to denote the chosen healer (Foster and Anderson 1978:107-108). For a remarkable autobiography of a contemporary shaman from Burkina Faso, see Somé (1994): Of Water and the Spirit.

As a rule, the aspiring *ñaka* is treated and initiated by an experienced *ñaka*, in exchange for payment. During the typically slow healing process, the secrets surrounding the correct treatment rituals and the herbs to be used are revealed to the aspiring *ñaka*. In this way, they learn from the manner in which they themselves are treated how to treat others afflicted by the same power, while the power in question provides the novice with further information about treatment through dreams. We observe here that the power is simultaneously the cause of the illness and the instrument of its removal. It is therefore said that a *ñaka* can only treat effectively those who are being troubled by one of the invisible powers if they have themselves at some point been ill through that power (see also 3.2.4., the case of Leonard).

Mushaukwa, incidentally, did not undergo apprenticeship with other *ñaka.* With the exception of his treatment for *Moya/Nzila*, he never required the assistance of other *ñaka*. He told me, not without pride, that he applied the knowledge he received from the powers in his dreams to himself and to others without assistance.[36]

3.2. The Practice

Mushaukwa is one of the oldest *ñaka* in Caprivi. He has a career of more than fifty years. He is, however, in the twilight of his career. He no longer treats as many sick people as he once did, and tiring nocturnal public treatment sessions he leaves to the younger generation of *ñaka*. On average he treats around four people a week. Mushaukwa is known throughout Eastern Caprivi and people come from villages well beyond Lusese to seek his help.

In this section I explain when and in what manner Mushaukwa is consulted, and describe how he establishes diagnoses and treats the sick. The treatment of people with 'African' illnesses is discussed by means of a number of detailed case descriptions.

3.2.1. Consultation

Following Chapter 2, I recognise three different situations in which a sick person may call upon Mushaukwa's help: a sick person has already been treated at the clinic or hospital without satisfactory results; a sick person presents with specific symptoms that point to an 'African' illness; or a sick person is confronted with illness manifestations initially regarded as 'simply natural'. The majority of people whom Mushaukwa treated during the period I lived in Makoma stated that they had already been to the clinic or hospital for treatment.

In the first two situations, suspicion points in the direction of an 'African' illness; in the third it does not, at least not yet.

When a sick person and/or their family members suspect that they have an 'African' illness, a family member will typically seek out Mushaukwa and ask whether he can help. That person informs Mushaukwa about the sick individual and asks him to investigate the cause of the illness.

[36] See the studies by Chavunduka (1978), Staugard (1986), and Hammond-Tooke (1989) for descriptions of the chosen healer among the Shona of Zimbabwe, the Tswana of Botswana, and various ethnic groups in South Africa respectively. Reynolds's (1963) study of healers and witches among the Malozi bears strong similarities to mine – not particularly surprising given the historical influence of the Malozi on the ethnic groups of Caprivi.

A suspicion about the cause is usually already present at this point, linked to certain relationships and events. Perhaps the ancestors made the person ill because he recently quarrelled with his father, felt the young man was not caring for his own wife adequately? Or perhaps it was that man from Katima Mulilo who made that strange remark the other day about the sick person's new vehicle – could he be a witch after all? Or the nephew to whom the sick person recently refused to give money for beer? Or could it have something to do with the woman from a neighbouring village about whom rumours are circulating that she recently had a miscarriage – might the sick person's body have been 'contaminated' by her?

The sick person and their family may deliberate about these possibilities, but Mushaukwa will need to provide a definitive answer through his divination instrument – often without the sick person being present, as they may still be in hospital. If Mushaukwa is away, one of his sons who is also a *ñaka* will perform the divination. Mushaukwa will then decide – usually on the basis of approval from the invisible powers conveyed in dreams – whether or not he will treat the sick person. The patient can then come to Mushaukwa to be treated. Mushaukwa will, as a precautionary measure, consult his divination instrument once more. Acute cases that indicate the involvement of an 'African' illness – such as a girl who had fainted, a witch having sent a silumba into her – are brought to Mushaukwa immediately. If the patient's condition is serious, Mushaukwa will visit them at home.

People with 'natural' illnesses come directly to Mushaukwa. My research indicates that it is primarily his family members from Makoma who come to him with such complaints, sometimes in combination with a visit to the clinic. It appears that the fact that Mushaukwa is so 'close by' – being a family member – is the decisive factor here. People naturally seek help first within the family. In this context, Mushaukwa functions more as part of the lay sector than the folk sector (Kleinman's classification; see 1.1.).

Before turning to divination and the treatment of people with 'African' illnesses, I devote some attention to the treatment of 'natural' illnesses.

3.2.2. Treatment of 'Natural' Illnesses

In treating these illnesses, Mushaukwa does not require the assistance of the supernatural. He is guided in diagnosis and treatment by the patient's symptoms, and knows from experience which herbs to use. For diarrhoea and abdominal pain, for instance, he administers an herbal decoction to be drunk or mixed into maize porridge; for skin problems, a mixture that the patient must apply to the skin. He generally gives the patient the herbs ready for use, to be applied at home. Unlike with 'African' illnesses, they are not administered within the context of a ritual.

In his interpretation of illness manifestations and in his treatment approach, certain ideas about illness and the functioning of the human body are discernible. Mushaukwa, for example, regards vomiting as a means through which illness can leave the body. When Victor once had diarrhoea and had been given an herbal decoction to drink by his father, and vomited as a result, Mushaukwa said: 'Good – perhaps the illness has now left.' I also encountered, in Mushaukwa and in other *ñaka*, the notion that illness is localised in bile (Silozi: *inyoko*). A person who is vomiting bile must keep vomiting until all the bile has been expelled.

Mushaukwa sometimes induces vomiting, for example in people who have been bitten by a venomous snake or by a dog suspected of being rabid (Cisubia: *umbwa u mbulumuka*, 'mad dog' – whether dogs in the area have the disease we know as rabies is difficult to determine, though it appears they might: the dog becomes completely wild with foam around its mouth and dies within a few days). He gives such patients herbs that cause vomiting, on the understanding that the body is thereby cleansed of the venom. Mushaukwa told me that he has in this manner successfully treated, among others, people who had been bitten by a black mamba – an extremely venomous snake that is abundant in the area. For bites from a non-venomous snake, Mushaukwa rubs saliva into the wound. He also treats people who have been attacked by a spitting cobra – this snake typically aims at the eyes – with his saliva.[37]

When a sick person discharges blood – for example, in stools or urine – this is taken as a sign that the person has too much blood (or that it is 'bad blood'). The body restores the balance by expelling the excess.[38] I was confronted with this idea one evening when I was sitting with Mushaukwa and Victor eating in Machika's courtyard and I suddenly had a severe nosebleed. I quickly pinched my nostrils shut and tilted my head back. Mushaukwa exclaimed in astonishment when he saw me do this and addressed Victor, who then said to me: 'You must not stop the blood, let it go, it wants to come out! Perhaps you have too much blood, or it is bad.' When I continued to pinch my nose, Mushaukwa shrugged his shoulders in resignation, his expression reading: 'suit yourself, then, stubborn *mukuwa*!'

3.2.3. Diagnosis through Divination

When it is suspected that someone has an 'African' illness, Mushaukwa identifies the cause through divination. Divination involves the manipulation of certain objects through which the human being attempts to discover what the supernatural has in store for them. It is a means of communicating with the supernatural and finding concrete answers to specific questions (following Van Beek 1982:23-25).

Mushaukwa uses a specialised instrument for divining: his *litaula* (Silozi). This term is the general designation for the instrument used by *ñaka* to perform divinations. It takes various forms, but in Mushaukwa's case it is a small hatchet. The principle is that, depending on whether or not he is able to lift the handle of the hatchet, Mushaukwa receives answers to his questions about the cause of an illness. Other *ñaka* divine by gazing into a magic mirror, by having someone hold a stick that begins to write in the sand – after which they interpret what has been written – or by throwing small bones and interpreting the configuration that results.

Mushaukwa communicates through his *litaula* with his ancestors, who were the ones who gave him this power. This came about as follows: they told him in a dream that he should use his hatchet as a *litaula*, and showed him the herbs with which he should treat himself and the hatchet in a smoke bath. To do this, he mixed the herbs with hot embers and sat in the smoke that rose up, while holding the hatchet.

[37] Bites from animals are initially considered 'natural'. If they prove fatal, they are generally assumed to have been an act of witchcraft.
[38] In these conditions we can detect elements of naturalistic illness explanations: the notion of bodily elements, including bile and blood, that must remain in equilibrium (see 2.3.).

In order to convey how divination works, I describe below how Mushaukwa performed a divination on me and what the occasion for it was.

I should note a caveat here. The divination could take place because Mushaukwa had told me that his *litaula* can identify not only 'African' but also 'modern' illnesses. I have the impression, however, that this would not ordinarily occur in practice, since divination is only undertaken when there is already a suspicion that an 'African' illness is involved. Mushaukwa will therefore not put questions to his *litaula* concerning 'modern' illnesses, which means the outcome can never point in that direction. This account therefore serves more to illustrate the manner in which divination is performed than to demonstrate its outcome.

> For several days I have been feeling unwell. I am feverish, have a raised temperature and diarrhoea. I am sitting somewhat withdrawn together with Machika in the courtyard, listening to the always loud radio. The news bulletin from the local radio station has finished and, although the newsreader's Silozi is almost entirely incomprehensible to me, I find it a pleasant pastime to listen to the familiar sounds and guess the topic of conversation from the words I recognise. I tell Machika, who is weaving a basket for a competition organised by the Art Centre in Katima Mulilo, that I am not feeling well, and name my symptoms, whereupon she says: 'Maybe you have malaria, go to the clinic for some tablets.' I tell her I don't believe I have malaria, since I have no chills or headache. A little later Mushaukwa enters the courtyard, and after a brief exchange between Machika and him, from which I can only pick out the words malaria and *cipatela* (hospital), Machika tells me that Mushaukwa also thinks I have malaria and should see the nurse. It occurs to me that Mushaukwa told me his *litaula* can identify modern illnesses, and I ask him – via Machika – whether he might not be able to make the diagnosis.
>
> A little later we are sitting together in Mushaukwa's second wife's courtyard, in a sheltered spot between the main hut and the reed fence. Mushaukwa produces his *litaula* and bites firmly into the handle before bringing it towards me. Not knowing whether I am supposed to bite it as well, I simply hold the handle for a moment.[39]
>
> He speaks the following words: 'I wish to examine this sick person; tell me the problem.' He presses the *litaula* into the sand with the blade facing towards him and begins to ask his questions. While asking a question he draws the thumb and index finger of his right hand through the sand around the handle. After each question he attempts to lift the handle of the hatchet. If the handle rises, the answer is 'no'; if the handle remains fixed to the ground, the answer is 'yes'. He puts the following questions to the *litaula*:
>
> 'Has a witch sent a *silumba* to Jan?' Without difficulty Mushaukwa lifts the handle – the answer is no.
>
> 'Has he been bewitched in some other way?' Mushaukwa lifts the handle: a 'no'.
>
> 'Has he perhaps eaten something wrong?'[40] The handle rises: again a 'no'.

[39] Mushaukwa told me later that the biting serves to activate the *litaula*.
[40] 'Wrong' in the sense of taboo – something that might be forbidden to me by one of the invisible powers.

'Is he being troubled by *Moya*?' That is not the case either – the handle rises.

'Does Jan have malaria?'

Mushaukwa tries to pick up the handle. He cannot. The hatchet is firmly fixed to the ground. Mushaukwa tries with both hands. No difference. He rises from his chair and, with a look of grim concentration, his eyes and mouth clenched shut, he hangs his entire body weight from the handle. There is no movement. His fingers slip free and Mushaukwa is thrown backwards. He tries once more. He shakes his head – he cannot do it. Mushaukwa frees the *litaula* by striking the blade hard with his fist. The handle springs up. Mushaukwa looks in my direction with beaming eyes. A certain triumph radiates from him – apparently because he had assumed that a white person like me would not really believe in the existence of such magical matters. Now he has provided proof that it is not trickery.

It is clear: according to the *litaula*, or more precisely according to the ancestors, I have malaria and must therefore go to the clinic for tablets.[41]

In many societies, including Western ones, it is normal for a sick person to provide the doctor with information about the illness: the symptoms, the duration and intensity of the complaints, previous episodes, and other details needed to make a diagnosis. In Caprivi, however, a ñaka asking for such information is seen as exhibiting weakness. At most, the sick person simply points to the affected area. A ñaka who is 'strong' – possessing a direct relationship with the supernatural – identifies the cause of illness through spiritual means. That is what he is paid for. It is also the case that the *ñaka* is often already aware of the strained relationships and particular events in the sick person's life, either because he knows them personally or because a family member has whispered this information to him beforehand. He therefore knows in which direction to look: perhaps there are reasons for the invisible powers to afflict this particular person with illness – a family dispute, for example. Perhaps certain events and remarks by people give rise to the suspicion that witchcraft is at play, or rumours are circulating that the person has transgressed a taboo – for example, that they have had sexual contact with a woman who has had an abortion.[42]

The *litaula* is sometimes compared to the X-ray machine at the hospital. Without asking questions, it identifies the cause of illness in a mysterious way – the X-ray sees things that are not ordinarily visible. This causes people to hold physicians in higher esteem, since physicians normally make their diagnoses in a ‘weak’ fashion. One woman expressed this as follows: 'They ask you endless questions.

[41] I was taking a malaria prophylactic and had a curative remedy of my own. I therefore did not feel it immediately necessary to visit the nurse. In any case I did not take the medicine, as I was already feeling considerably better by the evening. Whether I actually had malaria remains an open question for me.

[42] It is also possible that Mushaukwa, on the basis of his own knowledge of relationships, may suspect one of the family members who has been informing him about the sick person's background of having caused the illness. It should also be noted that Mushaukwa does not put questions to his *litaula* about the identity of a possible witch – the finding of witchcraft is, in the first instance, sufficient.

What kind of doctors are these, if you have to tell them yourself what you have? If I knew that, I wouldn't go and see them!'[43]

3.2.4. Treatment of 'African' Illnesses

In identifying and treating 'African' illnesses, Mushaukwa is guided by the invisible powers. To this end, they enter into communication with Mushaukwa, and he with them. We have already observed one such form: divination, through which he receives concrete answers from the ancestors to questions about the cause of illness. Another important vehicle of communication is the dream. In dreams he receives direct information from the powers about how to treat the sick. They indicate which herbs he must use, show him the exact location where they can be found, how they should be prepared, and in what manner and how often the sick person should be treated with them. It is like a film in which he is shown precisely what to do. Sometimes the images are absent and he hears voices during his sleep conveying messages to him. During a treatment period, the powers may indicate that Mushaukwa should use different herbs. They may also, before Mushaukwa has even been consulted, announce that on a certain day a person who has for example been bewitched will come to ask Mushaukwa for help, and that he should go in advance to a designated place to gather herbs. When he goes in search of the herbs the powers have shown him, he can feel when he is drawing close. The powers draw him, as it were, towards the right shrub or tree. It is impossible to resist this compulsion. If he were to try to walk away from the tree or shrub in question, he would be pulled back to it just as forcefully, in reverse.

Mushaukwa is guided by the ancestors, by *Jangula*, and by *Moya/Nzila*. According to Mushaukwa, the ancestors and *Jangula* can provide him in dreams with information about all possible 'African' illnesses. They provide insight not only into how to treat those whom they themselves afflict, but also with regard to illnesses caused by other categories of powers or resulting from witchcraft. By contrast, according to Mushaukwa, *Moya/Nzila* provides guidance exclusively on removing the symptoms she herself has caused. Although Mushaukwa is guided by all categories of powers, the ancestors appear to play the most important role. During the period I lived with Mushaukwa, virtually all the dream messages he told me about came from the ancestors.

In the remainder of this section we encounter yet another form of communication that Mushaukwa uses exclusively in treating people made ill by the invisible powers: making contact with the powers by bringing the sick person into a trance state through the use of a bell.

The treatment of 'African' illnesses can last several weeks to several months – as long as it takes until the sick person feels better, or until no improvement occurs and the sick person, in consultation with their family and Mushaukwa, decides to go to a clinic or the hospital. During the treatment period, Mushaukwa provides accommodation for sick persons and their families (usually the sick person's spouse) who have come from far away. Payment is made only if the person recovers from the 'African' illness (no cure, no pay) and takes the form of a cow, or the equivalent monetary sum of 200 Namibian Dollars.

[43] This may be a contributing factor to the problem that hospital patients frequently do not respond to direct questions from physicians and nursing staff about their illness: based on their experience with *ñaka*, they do not expect to be asked questions.

Mushaukwa generally treats people in the courtyard of his second wife, where he also stores, under a reed shelter, the plant material for his medicines. He uses exclusively plant-based material, ranging from roots, twigs, and leaves of trees and shrubs to tree bark and parts of certain cactus-like plants – collectively referred to by Mushaukwa as 'herbs'. To prepare them as medicine, he crushes the herbs and mixes various types together. Once the medicine is ready for use, it is called *tusenge*.

During the time I followed Mushaukwa in his work, divination had not indicated in any of his clients' cases that they had transgressed a taboo.[44] In every case the *litaula* had indicated that they were being troubled by invisible powers or had been bewitched.

1. Invisible Powers

The majority of people were ill through the influence of invisible powers, in particular *Moya/Nzila* or *Jangula*, and sometimes both powers. In none of the cases I witnessed being treated were the ancestors involved, with the exception of a man who was to become a *ñaka* – a calling they were partly enforcing. (The treatment I witnessed was not, however, directed at the ancestors themselves; see below: the case description of Leonard.)

Mushaukwa explained that in these modern times people are no longer so interested in their relationship with the ancestors and no longer maintain it. This may be the reason why the ancestors make their influence felt less: they no longer bring prosperity, but neither do they cause illness.

The sick persons mentioned the following complaints: having no energy to work, loss of appetite, weight loss, a painful body or part of the body, headache, dizziness, back pain, and palpitations. These are in general 'nagging' problems – complaints that come and go and do not appear to carry an immediately life-threatening character. Most of the sick persons who came to Mushaukwa had already received a series of treatments from him on earlier occasions, sometimes for the same complaints. According to Mushaukwa, the powers often continue to trouble people on and off over an extended period of their lives. After a series of treatments, the powers will remain quiet, only to resurface again sometimes years later.

Mushaukwa begins by attempting to communicate with the powers, in support of the divination and in order to establish in what manner the sick person should be treated. He does this by performing a ritual in which he attempts to invoke the powers by ringing a bell close to the sick person's head (Cisubia: *kalangu ni kumbelela*, 'asking with the bell').

If the person is indeed being influenced by one or more of the powers, they will enter a kind of trance when Mushaukwa, while ringing the bell, asks after its presence. The sick person begins to tremble across the entire body and indicates through intense bodily expression which power is causing the complaints – by striking or pressing on the part of the body in which it is localised.[45] Mushaukwa then asks what treatment is required.

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[44] I mean here the group-based taboos (see 2.2.3.), not the personally imposed ones laid upon people by the invisible powers.

[45] *Ñaka* who do not possess a *litaula* use the bell for making the initial diagnosis (some use a mug or teacup which the person in trance picks up and brings to the part of the body where the complaints

Whether or not the sick person responds to questions about the various possibilities determines which treatments Mushaukwa will carry out. Crucially, *Moya/Nzila* also responds through Mushaukwa himself by means of belching; a belch signals confirmation that *Moya/Nzila* – which is associated with air – is present (see Section 2.2.1).

After the conclusion of a 'bell ritual' with a woman who was being troubled by *Moya/Nzila* and *Jangula*, I attempted to gain some insight into Mushaukwa's ideas about what happens when the person begins to tremble. A brief fragment of the ensuing conversation is reproduced below. (The conversation was conducted via Victor, but I present it as a direct dialogue between Mushaukwa and myself.)

> Myself: 'What questions did you ask?'
>
> Mushaukwa: 'I asked the following questions: Is it *Moya*? Is it *Moya* that is giving her problems? Is it *Moya* that is causing her back pain? And I also asked whether she has *Jangula*. She trembled in response to the questions about *Moya* and *Jangula*.'
>
> Myself: 'How does the sick person know when to tremble?'
>
> Mushaukwa: [with a slight laugh] 'She doesn't know.'
>
> Myself: 'What makes her tremble?'
>
> Mushaukwa: 'It is the illness that is inside her body.'
>
> Myself: 'Is *Moya* inside her?'
>
> Mushaukwa: 'Yes, *Moya* makes her tremble.'
>
> Myself: 'Is *Jangula* also inside her body?'
>
> Mushaukwa: 'Perhaps. He responds by making the sick person tremble.'

The sick person does not tremble consciously. According to Mushaukwa, it is the powers that take over control. Whether they actually enter the body is less clear. This idea is strongest in the case of *Moya/Nzila*. In any case, the point is that through the influence of the powers, the sick person exhibits certain behaviour that yields information for the *ñaka* about the illness and its treatment.[46]

It frequently emerges from the bell ritual that the sick person should be washed with the blood of a white or black chicken. The illness is believed to localise itself in the chicken. The chicken may therefore not be eaten by anyone. In addition, the series of treatments typically consists of a number of steam baths. A steam bath involves the sick person sitting under a blanket and inhaling the steam from a boiling mixture of water and *tusenge* in a cooking pot placed between their legs.

Another method of treatment, which Mushaukwa applies only for *Moya/Nzila*, is washing using a broom.

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are localised). If the sick person does not respond to the ringing, the illness has another cause, to be identified by a *ñaka* who does possess a *litaula*.

[46] This is behaviour that Helman terms 'controlled abnormal'. It is only to be displayed within the prescribed context of the ritual, governed by hidden cultural rules about its form, intensity, and duration. Outside the ritual, it constitutes 'uncontrolled abnormal' behaviour (Helman 1990:215-220).

He does this by dipping a reed broom into a cooking pot of hot water containing *tusenge*, striking it against his hand, and thus spraying the water over the sick person, who sits on a number of laid-out poles at a distance of approximately 1.5 metres.

In both methods of treatment, the sick person generally sits facing east – the correct direction because it is where the sun begins its daily course. Both methods also proceed in six rounds: Mushaukwa brings the cooking pot back to the fire six times. When I asked him the reason for this specific number, he answered: 'The number six belongs to the *madimona* – it is simply the way things are'.

A standard element of the treatment for *Moya/Nzila* and *Jangula* is the construction of a small courtyard in which Mushaukwa places on a dish the herbs with which the sick person must wash themselves every day until they feel better. During this period, the sick person may only speak with people who are also receiving treatment for the powers or who have recovered from them. Once the person feels better, the courtyard is dismantled.

The aim of these treatments is to free the sick person from the *madimona*. The powers themselves indicate what treatment is required. By doing precisely what they wish – by appeasing them – they lift their influence. The person is then no longer troubled by them.

The invocation of the powers through the bell ritual, followed by treatment with a steam bath or washing with a broom, can also take place in a public session. The sick person's family decides to hold a session and consults a *ñaka.* These sessions are often announced on the radio in order to attract an audience.

In this type of session (called *ngoma*, Silozi for drum), the first step is to attempt to bring the sick person into a trance through the stimulating drumming of large drums and the clapping and singing of the audience. The audience sings specific songs for the powers, led by the *ñaka*, who is simultaneously ringing the bell – songs such as: '*Mwendanjangula* with one leg, please come!' The power to whose songs the person begins to tremble is identified as the one making them ill. Treatment can then begin, likewise supported by drumming, singing, and clapping from the audience.

These sessions often last the entire night – sometimes because it takes a long time before the sick person begins to tremble (or it does not happen at all, indicating apparently that the person has a different illness), and sometimes because members of the audience also enter a trance and must in turn be treated. Mushaukwa no longer participates in these sessions, considering himself too old for them. He has left them to his son Alexander (see Appendix 1 for a description of a *ngoma* session).[47]

[47] This type of public session has been described by Turner (1968, in Janzen 1982:12-13) as drums of affliction. The phenomenon is of sufficient complexity to merit a dedicated study. See, for example, Janzen (1982) for a study of the Congolese drum of affliction, the Lemba cult. Janzen regards this cult more as a political institution than a healing institution. In brief, the individuals who were the object of their relatives' jealousy – typically because they belonged to the elite – were those who suffered from a Lemba affliction. The Lemba therapy was aimed at inducing this group to place their wealth and power at the service of the community (following Richters 1993:177-179).

** Leonard:[48] a man sent by the 'senior doctors'*

A particular case of someone being influenced by invisible powers is that of Leonard. This man has been chosen by the powers to become a *ñaka* and is now apprenticed to Mushaukwa.

> Leonard is a middle-aged man who lives in Katima Mulilo. He has had health problems since a young age. It began around the age of five with a period of six months during which his behaviour was so strange that those around him labelled him as mad. After this period, problems continued to come and go. From approximately 1969 onwards he has suffered from heart complaints and 'problems in the chest'. He has also been temporarily paralysed on the left side of his body.
>
> Over the years he consulted various *ñaka*. In dreams, however, he was told that none of the *ñaka* he consulted was 'good'. According to the messages he received, the ñaka he consulted were *ñaka* who use medicines to kill people – in short, they were witches: 'Do not take medicine from those *ñaka*, they are bad!'
>
> At some point Leonard suddenly fainted while he was in Katima Mulilo. He was taken to the hospital and admitted. When he regained consciousness he was told that he had high blood pressure, which needed to be brought down with medication. Leonard took the prescribed medicines and had to remain in hospital for some time so that his response to them could be monitored. His condition deteriorated, however: he slept for three consecutive days and became paralysed in both legs. While in hospital he had a dream in which he was told not to take the hospital's medicines, because they were dangerous for him. From this he understood that he was not suffering from a 'modern' illness but most probably an 'African' one, whose treatment would need to be entrusted to a *ñaka*.
>
> He obeyed the prohibition and told the doctor treating him that he wished to be discharged: 'I want to leave this place, people are dying here!' His nephew fetched him from the hospital and took him home.
>
> Once he was home again, he received a message in a dream that he was to become a *ñaka* and should go to Mushaukwa to be treated by him. At the end of January 1994, he visited Mushaukwa for the first time, and Mushaukwa proved willing to help him.
>
> Mushaukwa established that it is the *madimona* who are causing his complaints in order to compel him to take up the vocation of *ñaka*. According to Mushaukwa, the ancestors, *Jangula*, and *Moya/Nzila* are all troubling him for this reason.

Leonard has accepted his calling. In a series of treatments by Mushaukwa, beginning in January, the secrets surrounding the correct treatment rituals and the herbs to be used are being revealed to him. He is learning first, through his own series of treatments, how to treat people made ill by the powers, after which Mushaukwa will explain to him how to treat people with 'natural' or other 'African' illnesses.

[48] Names are fictitious, to protect the privacy of the informants.

In this process he is already being guided by the powers, who come to him in dreams. 'The spirits told me in my dreams that I should become a chief in traditional healing.' Each time the powers – whom he calls the ‘senior doctors’ – give him a directive to that effect, he calls upon Mushaukwa's help.

The powers are putting him through a considerable ordeal. He still has heart complaints and pain on the left side of his body. They have also imposed various prohibitions upon him: he cannot tolerate the water from the borehole; all food prepared for him by others is forbidden to him; he may not go into the forest; and he may not sleep in the same room as his wife.

> 'The spirits forbid me to drink water from the borehole and eat the food that people prepare for me. I can only drink water from rivers and lakes and eat the food that I prepare myself. When I ignore these taboos I have to vomit. I feel it in my heart if the water I intend to drink is not right. As in a reaction my hand paralyses and I will drop the cup. Also the spirits forbid me to go into the forest. When I enter the bush, I just panic and will run out, very scared. Once I entered the bush with my hat on. The spirits told me that I should show them respect and not leave my hat on while being in the bush. I panicked and rushed out. I lost my hat, it is still there in the bush.' [Leonard himself made no distinction between the various powers. He spoke consistently of 'the spirits'.]

According to Mushaukwa, the prohibitions will be lifted once Leonard begins to treat people – when he starts to put into practice what he has learned. The *madimona* will then cease making him ill.

Leonard recently had another dream and has therefore come back to see Mushaukwa, bringing with him a piece of paper on which he has written down his dream: 'The day before yesterday the senior doctors told me to get a new chair, a white doctor's coat and three pigeons. Actually they asked for turtledoves, but they were too difficult to get.'

The intention was that Leonard should be treated together with these objects. The pigeons were specifically to allow him to sleep with his wife again (the symbolism of turtledoves: the traditional emblem of conjugal love).[49]

Before Mushaukwa proceeded with this, however, he verified the accuracy of the information by making contact with the powers through his bell. The bell ritual took place in the privacy of a hut in the courtyard of Mushaukwa's second wife.

> Mushaukwa has directed Leonard to sit in a chair facing east. Opposite him is a chair draped with a white cloth upon which lies an open Bible. Mushaukwa opens the session with a brief prayer to *Nyambe*. He stands behind Leonard, who has bowed his head with his eyes closed and his hands stretched out before him, places the index and middle fingers of his left hand on Leonard's head, and asks *Nyambe*: 'Please grant me the strength to do what is right.' Mushaukwa begins to ring a bell with a wooden handle, held in his right hand, close to Leonard's head. He rings the bell – which produces a penetrating, high-pitched sound – in a monotonous, driving rhythm, while invoking the powers in a high voice.

[49] The pigeons and the white doctor's coat are, of course, not indigenous symbols but adopted Western ones.

After a few minutes, Leonard responds. With a contorted expression he begins to shake violently across his entire body. He lets out deep sighs and begins to groan. Mushaukwa continues to ring the bell and begins to ask questions about Leonard's dream. Leonard responds intensely to the questions. He pushes and strikes with his right hand at the left side of his chest, and slaps the back of his right hand into his left palm. He continues to convulse wildly across his body, nodding his head, and repeatedly bringing his hands to his chest and the left side of his body.

After some fifteen minutes, Mushaukwa stops the ringing and closes the session as he began it, with a brief prayer to *Nyambe*.

This time it proved to be *Moya/Nzila*. This power had responded affirmatively to the questions about its presence, as well as to the questions about the directives Leonard had received. The treatment of Leonard with the objects could proceed.

That same evening at 18:30, as dusk has already fallen, Mushaukwa goes to wash Leonard using a broom in the courtyard of his second wife. Mushaukwa has just selected the right herbs, chopped them finely, and measured out the correct quantities. He has set out a cooking pot and now proceeds, together with Leonard, to put the herbs into it. Mushaukwa takes two handfuls of the herbal mixture and places it in Leonard's outstretched, cupped hands. He presses Leonard's hands firmly shut and takes another two handfuls himself. Together they carefully place the herbs in the pot, after which Mushaukwa adds several cups of water and places the pot on the fire. Leonard takes his place on the new wooden folding chair he has brought with him. Mushaukwa has meanwhile fetched the white doctor's coat and helps Leonard to put it on. He then marks a white cross on Leonard's forehead with ash. All of this is done unhurriedly, with Mushaukwa explaining patiently to Leonard – who sits motionless on his new chair with his hands stretched out before him – what is about to happen. Mushaukwa takes the three pigeons out of their box and plucks several feathers from them, which he tucks into Leonard's hair and under his coat. Before Mushaukwa begins the washing, he traces a cross with his fingers on Leonard's back and asks in a brief prayer to *Nyambe* to give him the strength to help this man.

Mushaukwa takes his broom and begins to spray the hot water from the cooking pot over Leonard. One round consists of approximately sixty 'sprinklings' applied to both the back and the front of Leonard's body. During the washing, Mushaukwa addresses the following requests to the powers: 'Let this man tolerate all the food that is prepared for him'; 'Let him drink the water from the borehole'; 'Let him have a good marriage again'; and 'Give him permission to enter the forest once more.'[50]

After the third round, Mushaukwa suddenly realises that he has not added sugarcane to the herbal mixture and stops the washing at once. Leonard immediately bows his head and begins to weep.

[50] It has not become clear to me whether *Moya/Nzila* was responsible for all these prohibitions or whether Mushaukwa was directing the request to all the powers.

I ask Victor what might have prompted the sudden weeping, and he says he suspects it is the *madimona* making him cry because Mushaukwa has not prepared the correct medicine. After Mushaukwa has added sugarcane to the mixture and resumes the washing, Leonard tells Mushaukwa that he had been confused about whether he was suffering from an 'African' or a 'modern' illness, but is now convinced that he has an 'African' illness. After the sixth round, Mushaukwa puts down the broom and prays to *Nyambe* to close the washing.

When Leonard is sitting by the fire shortly afterwards in his soaking wet coat, drying off and warming himself, he tells me that he will sleep outside tonight, because the left side of his body is burning: *Jangula* is troubling him. It is too hot to sleep indoors.

In this ritual, Leonard was initiated by Mushaukwa on the instruction of *Moya/Nzila*. The new chair, the white doctor's coat, and the cross on his back and forehead are symbols of the healer's vocation. Symbolically, Leonard was 'reborn' as a *ñaka* through this ritual.

Leonard returned to Mushaukwa on several further occasions, usually to ask for his help in finding certain herbs. During the time I lived in Makoma, he had already begun treating people himself.

** Georgina: a woman troubled by Moya/Nzila and Jangula*

Georgina is a middle-aged woman from a village in Lusese who was first treated by Mushaukwa for *Moya/Nzila* in 1980. She is now experiencing complaints again. She has strange dreams, back pain, and a painful left leg. She is unable to work.

Three weeks ago she went to the hospital, where the doctor could find nothing wrong but noted that she had a fever and gave her tablets, then sent her home.

When she attended a drum session by Alexander, she 'trembled' in response to the songs for *Jangula*. Alexander consulted his *litaula*, the outcome indicating that she was being made ill by *Moya/Nzila* and *Jangula*.

Her husband asked Mushaukwa for advice a few days ago, and Mushaukwa had considered visiting the woman at home because she could barely walk. In the end she managed to reach Mushaukwa unaided.

Mushaukwa first performed the bell ritual, in which the outcome of Alexander's divination was confirmed. *Jangula* is specifically responsible for the pain in her left leg.

Georgina responded intensely to Mushaukwa's questions. She fell trembling from her chair, and Mushaukwa had to calm her by stopping the bell-ringing and placing his hand on her head, saying: 'Stop! Stop! Stop!' Mushaukwa also asked questions about the treatments to be carried out. She was to receive a steam bath for *Jangula*, and for *Moya/Nzila* she was to be washed with the blood of a black chicken, after which Mushaukwa would wash her using his broom.

Before this could take place, Mushaukwa had a dream in which the ancestors told him that the woman had *Injimo* – a specific 'direction' of *Moya/Nzila* that causes people to have no energy to work. This new insight called for a particular variant of the broom washing:

> Before Mushaukwa begins the washing, he takes a hoe and turns it twice around the neck of Georgina, who is sitting before him, while whispering something. He hangs the hoe around her neck with the blade resting in the back of her neck and the handle running over her left shoulder towards her chest. He prays to *Nyambe* and begins the washing. After washing with the broom, Mushaukwa taps Georgina gently on her back and whispers a few words. Suddenly she seizes the hoe from around her neck and begins making convulsive movements, hacking into the ground beside her.

When Mushaukwa whispered, he was asking *Moya/Nzila* whether Georgina had been treated in the correct manner. Georgina's hacking was a confirmation by *Moya/Nzila* of this question: *Moya/Nzila* is satisfied and lets Georgina work again.

* Margret: the drowsy woman

> Margret is a young woman who has come to Mushaukwa accompanied by her mother. She is troubled by excessive sleepiness and is consequently unable to carry out her tasks. She lies dozing on a reed mat throughout the day in the shade of a tree outside the courtyard of Mushaukwa's fourth wife. According to Mushaukwa, she has been 'taken' by the river *Jangula*, who is holding her in his river. Because she is being kept under water, her reality is murky.

The day after her arrival she was to be washed in the small river called the *Sanzwe*, a few kilometres from Makoma. Mushaukwa planned to hold her under water and then free her from the river *Jangula* by lifting her out of the water and washing her with herbs. But the following day Mushaukwa told me that the ancestors had told him that night that he must not hold her under water! He was only permitted by them to wash her in a shallow part of the river. Mushaukwa did not know why this was the case, but he would honour their wishes.

> It was a long walk of almost two hours across the plain to the river. Margret could not keep pace with Victor, her mother, and myself, and arrived last. Mushaukwa had let us go on ahead because he still had something to arrange and caught up with us on his bicycle. After arriving, Margret visibly exhausted drops into the shade of a tree and sighs deeply several times. She stares ahead with a desolate look. Mushaukwa gives her only a brief rest, for once he has mixed the herbs with water from the river in a bowl, she must prepare herself for the washing. She takes off her clothes, leaving on only her *chitenge* [a wrap-around cloth], and takes her place before Mushaukwa in the shallow part of the river. He takes a handful of the mixture from the bowl and hurls it with great force against Margret's body, then rubs it in. In a commanding tone he says: 'Go, *Jangula*, go! Let her do her work properly again!' The herbs slap against Margret's body as she bows her head and looks at the silent water of the Sanzwe. 'Let her not be sleepy! Let her rise up from your river! Let her go free!' Halfway through the washing, Mushaukwa hangs a *bulungu* – a white beaded necklace – around Margret's neck. At the end of the washing he takes the *bulungu* and tears it apart.
>
> The white beads fall one by one into the river, and Mushaukwa throws the remaining string after them. 'Trouble the *bulungu*, instead of this woman!', he adds. Mushaukwa then holds out his right arm like a gateway and pushes Margret through it.

> He briefly rubs one more handful of herbs over her body. She walks out of the river towards her mother, and together they walk away from the river to rest a little further along. Finally, Mushaukwa washes his own feet with the last herbs from the bowl and jumps out of the river.

The other case descriptions showed Mushaukwa appeasing the powers by washing the sick persons with the appropriate herbs. In this session there was no question of appeasement; instead, the treatment was clearly aimed at driving the power away. Mushaukwa hurled the herbs against the sick person's body and threw the *bulungu* – which was intended to absorb *Jangula's* influence – into the river after tearing it apart. To ensure that all his influence remained in the river, Margret had to slip through a 'gateway' out of the river, and Mushaukwa leaped from the river after cleansing his own feet.

2. Witchcraft

Witchcraft cases represent the most serious end of Mushaukwa's practice. Unlike illness caused by invisible powers, where the aim is to appease or expel, witchcraft demands that its effects be actively undone – the poisoned blood purified, the *silumba* freed. The treatments are accordingly more aggressive, and the process longer. The case of Charles illustrates this in full.

> On 13 April, an ox-drawn sledge is led into Makoma carrying a middle-aged man from Nakabolelwa, a village approximately thirty kilometres south-east of Makoma. The hospital collar he is wearing revealed part of his health-seeking trajectory. He is unable to walk without support. His movements are slow and laboured – resembling a marionette operated by someone who has yet to master the puppeteer's art.

This was Charles, whom we already encountered in the introduction – a man who, according to Mushaukwa, has been bewitched, and as a result suffered a serious car accident. He was treated by Mushaukwa for approximately three months, during which time he and his wife lived with his sister, the fourth wife of Mushaukwa. He is the principal witchcraft case in my research. Before I give a detailed account of him, I first describe the typical course of a witchcraft case.

When the outcome of divination indicates witchcraft, the treatment is initially directed at removing the malevolent influence of the witch. Attention is not directed at the witch themselves, even if the sick person has a suspicion about who the perpetrator is. Mushaukwa will treat the sick person without using his *litaula* to identify and call the perpetrator to account. He gave as his reason for this that the victim may be contemplating revenge and wishing to mount a counter-attack – responsibility for which he is unwilling to bear.

Many of the treatments Mushaukwa employs have, like the illness itself, an aggressive character. The sick person is often given a number of 'smoke baths' to drive out the evil. Mushaukwa also makes incisions in the body into which he rubs the ash of herbs in order to purify the blood, if the witch has 'corrupted' it.

If the treatments prove ineffective and the patient's condition deteriorates, a decision may nonetheless be taken to call the witch to account. In a public session, a *ñaka* will attempt to identify the perpetrator. For this purpose, Mushaukwa's son Alexander is frequently consulted – the renowned witch catcher.

This *ñaka* will interrogate persons under suspicion – both his own and those of the sick person and their family – in order to find reasons and evidence for witchcraft, for instance the possession of 'evil herbs'. The aim is for the witch to confess publicly to having attempted to kill the victim. If this occurs, they are left in peace thereafter: everyone now knows who the witch is, which compels them to stop their activities.

If the suspect does not confess, they or the *ñaka* may take the matter to the *Khuta* for a ruling. If the *Khuta* finds the *ñaka's* evidence insufficient, the *ñaka* must pay three cows to the falsely accused person and one to the *Khuta*. If the suspect is found guilty, they must pay five cows to the victim or their family and one to the *Khuta*. Such proceedings are particularly initiated in the case of a suspicious death in which a *ñaka* has subsequently determined that witchcraft was involved. As a general rule, *ñaka* are not particularly eager to accuse people of witchcraft, owing to the damages they must pay if they lose the case before the *Khuta*. Nonetheless, witchcraft cases constitute a significant proportion of the matters dealt with by the *Khuta*.[51]

* Charles: a victim of witchcraft

> Charles had a car accident the previous year and sustained serious injuries. Near Katima Mulilo he lost control of the steering wheel and came to a stop against a tree. Gravely injured – he had lost strength in all his limbs – he was taken to the hospital in Katima Mulilo where X-rays of his back were taken. These revealed that his spine had been dislocated in the accident. He was then admitted to the State Hospital in Windhoek for treatment. He spent three months in traction to realign his spine. [Charles told me that his spine had not been fractured.] According to Charles, however, the treatment was not very effective, and he was discharged from the hospital because the doctors could do nothing more and told him he could go home.
>
> Charles then decided to consult Mushaukwa, who is known to be highly experienced and very skilled. One of Charles's sisters went to Mushaukwa to ask whether he could help her sick brother. Mushaukwa consulted his *litaula* and established that Charles had been bewitched. As a further precaution, his son Alexander also consulted his *litaula*, arriving at the same diagnosis. Mushaukwa sent the woman back home with the message that he was prepared to help her brother.
>
> When Charles arrived in Makoma, his condition was poor. He had little strength in his limbs and a weak neck and back. Initially he was unable to sit or stand without help. Mushaukwa complained that his condition was so poor because the doctors at the hospital had 'held' Charles too long. From the fact that he was not recovering, it could, after all, be inferred that he had an 'African' illness. Charles should therefore have come to Mushaukwa sooner. It would now be more difficult for him to cure Charles.
>
> The witchcraft had, according to Mushaukwa, permeated his entire body. He was nonetheless willing to treat Charles, although he thought it would take considerable time to cure him.

[51] Based on personal communication with Hester van Wingerden, a fellow researcher who in 1994 conducted research among the Masubia on the position of women in family law.

Mushaukwa explained Charles's illness as follows: the witch had ensured that Charles suffered an accident by poisoning his blood. As a result, while sitting in his vehicle, he had suddenly been unable to move his limbs properly, causing him to lose control of the car. The illness manifestations Charles experienced after the accident were caused by the continued influence of the witch. (Mushaukwa considered it plausible that *Jangula* was also involved and therefore had Charles wear a *bulungu* to absorb *Jangula's* influence. Only if the treatments against witchcraft proved ineffective would he direct further attention towards *Jangula*.)

The series of treatments consisted, among other things, of a number of steam baths, carried out in the same manner as those for the invisible powers, except that they comprised five rounds rather than six (the number five belongs to witchcraft). Under the influence of dreams, Mushaukwa frequently altered the composition of the herbs. Another important treatment Mushaukwa performed was freeing the *silumba* that the witch had sent into Charles, by washing him with *tusenge* in the dwelling place of the spirits of the deceased (this session is described in the introduction).

Charles also received smoke baths on several occasions. This involved Mushaukwa placing an iron plate on which herbs had been mixed with glowing embers between the legs of Charles, who was sitting on a mat, and then draping a blanket over the plate and Charles, leaving his head free, so that he was exposed to the smoke that rose. The smoke bath was always administered by Mushaukwa in combination with the *kusala* ritual – the 'incision ritual' – in which he rubbed the ash of the herbs into incisions made in Charles's body:

> In a sheltered spot in the courtyard of Mushaukwa's fourth wife, Mushaukwa, Charles, his wife, Victor, and I have gathered for the *kusala* ritual. Charles stands undressed, apart from his shorts and hospital collar, his back to Mushaukwa. He supports himself by holding on to two poles of the fence. Mushaukwa takes a razor blade and begins to make small cuts in Charles's lower back, along the line of his spine. He pinches a piece of skin between his thumb and index finger and then quickly makes a cut with the razor blade. He works his way around the upper body at hip level and then covers all his limbs. Charles makes no sound, but from the small jerks he gives each time Mushaukwa makes a cut, I infer that it is quite painful. Drops of blood begin to form and soon run in rivulets down his legs. Mushaukwa points to the blood and says: 'Look how black it is – it is as black as a cooking pot!' This blackness, in his view, indicates that the blood is ‘poisoned’. Charles's wife uses a strip of palm leaf to wipe the blood from his legs into the sand. She rubs the ash from yesterday's smoke bath into the cuts, while Mushaukwa continues making incisions. Once she has rubbed ash into all the cuts, she digs a hole with a small hoe, into which she sweeps the bloodied sand.

This ritual served to remove the poisoned blood from Charles's body and to purify the remaining blood by rubbing it with herb ash.[52]

Charles was treated by Mushaukwa approximately every other day, alternating steam baths and smoke baths in combination with the incision ritual.

[52] Despite the fact that Mushaukwa performed this ritual no fewer than seven times, Charles's cuts rarely became infected. This can be attributed to the sterility of the herb ash.

We noted that when treating people troubled by the invisible powers, Mushaukwa prays to *Nyambe* to request His support. In treatments against witchcraft he does not do this: illness caused by human beings has nothing to do with Him.

When not being treated by Mushaukwa, Charles spent his time lying on a mat in the shade of a tree near the courtyard of Mushaukwa's fourth wife. I would often go and sit with him to keep him company, and would try to steer the conversation towards the background of his illness. His English was unfortunately very limited, and as I had observed with others before him, he spoke freely about witchcraft but primarily in general terms: 'I have heard that they do this and that' or 'There was once someone who was bewitched and then…', not about his personal situation. I had the impression that he was afraid of provoking or angering the witch by voicing suspicions about the witch's identity or motives. Charles told me that he believed he had been bewitched. He even knew who the witch was: a man who lived in his village. He was afraid of the witch because this individual was very powerful and difficult to combat. 'The witches know where you go, they follow you without you seeing them. They travel through the night, sometimes you see them as a kind of flash of light.' He believed that the witch had sent a *silumba* into him: 'I have been given a ghost', and suspected that the witch had placed herbs in his path over which he had stepped. Charles believed that Mushaukwa could cure him, although it might perhaps take a long time.

After a few weeks his condition began to show visible improvement. He was able to sit up unaided and carefully get to his feet. With his wife supporting him and a large stick that Mushaukwa had cut for him, he began to walk short distances. The improvement continued, and after a total of three months of treatment by Mushaukwa he was able to return home. He could then walk cautiously without support, though he still appeared to me to be very weak. Mushaukwa subsequently visited Charles's village on several occasions for additional treatments. In Charles's case, it therefore proved unnecessary to call the witch to account. Mushaukwa succeeded in removing the witch's malevolent influence.

Figure 1. The storage place of Mushaukwa's medicinal herbs (photo: JdB)

Figure 2. Mushaukwa preparing a medicine (photo: JdB)

Figure 3. Mushaukwa attempting to free Margret from the river-*Jangula* (photo: JdB)

Figure 4. Mushaukwa making small incisions in Charles's legs with a razor blade (photo: JdB)

Figure 5. Charles's wife rubbing herb ash into the incisions (photo: JdB)

Figure 6. Charles practising walking, accompanied by his wife (*identities protected*) (photo: JdB)

Chapter 4. CONCLUDING REFLECTIONS

4.1. The Essence of Mushaukwa as a Healer

The source of Mushaukwa's power as a healer resides in his relationship with the supernatural. This relationship encompasses the invisible forces that brought it into being by subjecting Mushaukwa to a period of intense suffering. This period may be understood as a symbolic death, following which Mushaukwa was reborn as a *ñaka.* In practice, the relationship is expressed through communication – by means of dreams, divination, and the interpretation of trance states induced in the sick through the use of a bell. Unlike practitioners within the shamanic tradition, Mushaukwa does not himself enter a trance in order to travel to another realm or to serve as a medium for supernatural forces.[53]

Mushaukwa may be seen as an instrument through which the supernatural operates. He does not appear to act on his own initiative, but rather at the behest of the invisible forces. At the same time, however, a trial-and-error approach is nonetheless apparent.

When he suspects that a person is suffering from a 'natural' illness, he will initially attempt to treat it on the basis of his accumulated experience, with no recourse to the supernatural. He then waits several days to observe whether the treatment has had any effect. If it has not, a 'second plan' is set in motion. The suspicion then arises that the illness is 'African' in character, on the basis of which Mushaukwa will decide to invoke his relationship with the supernatural. He consults his *litaula*, awaits dreams, and combines this with the interpretation of trance states in the sick, should the invisible forces be at work. If, following what is usually an extended period of treatment, the patient fails to recover or complications arise, it becomes apparent that the supernatural has been mistaken: the person has a 'modern' illness and is advised by Mushaukwa to seek care at a clinic or hospital. In short, pragmatism and the supernatural go hand in hand.

4.2. Conceptions of Healing

Although I can speak of Mushaukwa's healing efficacy only on the basis of Charles's case – whose condition seemed to have improved following Mushaukwa's treatments (the other patients were in the midst of their course of treatment and were not yet expected to have recovered) – I nevertheless wish to offer some observations on *why* he heals, particularly in relation to 'African' illnesses. I begin with the *emic* perspective.

The treatment of 'African' illnesses is directed at influencing the underlying cause, regardless of the patient's presenting symptoms. Healing occurs because the *ñaka* intervenes in both the supernatural and the social environment. He neutralises the influence of the invisible forces by appeasing them, often in conjunction with removing the source of their malevolence: quarrels must be reconciled, and family members who have been treated poorly must be dealt with more fairly. A victim of witchcraft recovers when the harmful influence of the witch is eliminated, or – should this prove unsuccessful – when the witch is called to account and revokes that influence.

[53] For a descriptive study of shamans and their 'shamanic journeys', see Ceriez (1994).

But how, from 'our' vantage point, does a person actually recover? What does the *etic* perspective reveal?

It is frequently argued that local healers are particularly effective in treating illnesses that we would classify as psychological or psychosomatic. The explanation commonly advanced is that healers share the same cultural background as their patients and therefore possess insight into their psyche – functioning, in essence, as a kind of indigenous psychologist. I would argue, however, that whilst patients do recover through the influence of psychological processes, the *ñaka's* intervention is not explicitly directed at these processes. Attention is directed not at the patient, but outward onto the supernatural and social environment. The *ñaka* locates the cause of illness within these environments, thereby offering an explanation that accords with the worldview of his patients. In this way, meaning is conferred upon the illness – a function that carries significant reassurance and therapeutic value. The persuasive force of the *ñaka* rests upon his authority: the image of infallibility and power he projects, which is itself a consequence of his relationship with the supernatural.

I would further suggest that the power of ritual plays an important role. The patient is able to surrender to the situation and give him- or herself over entirely. This is particularly evident in rituals in which the patient is permitted to enter a trance state under the influence of the *ñaka's* bell – most especially when this is encouraged by an audience during a public session. In these rituals, the patient is supported by a group of family members and friends, and finds him- or herself at the centre of a caring community (see further Hammond-Tooke 1989:148).

4.3. The Ambivalent Position of the *Ñaka*

> (..) it is not unreasonable for people to believe that the specialist who can control and fight sorcery also has the requisite knowledge to practise it himself when it suits his needs (Foster & Anderson 1978:115).

In English-speaking contexts, *ñaka* are frequently referred to as 'witchdoctors'. This is a term widely recognised across Africa and one that was most likely coined by colonial administrators. In its original usage, the designation denoted the presumed convergence of doctor and witch in a single person, with emphasis placed upon the sinister dimension. So-called witchdoctors were portrayed as malevolent, cunning figures – the very embodiment of evil. Since the recognition that these individuals are, in fact, typically highly respected and indispensable members of their communities, whose role is precisely the combating of evil, the term witchdoctor has been avoided in medical anthropological literature, or retained but stripped of its negative connotations. Some authors invoke the term only to swiftly dismiss it as inapplicable (see, for example, Hammond-Tooke 1989:103).

Notwithstanding this more positive shift in the attitudes of outsiders towards local healers, many people in Caprivi hold decidedly ambivalent views about them. (It is not entirely clear to me whether people in Caprivi always use the term witchdoctor to express negative ideas about *ñaka*, or whether it is sometimes employed out of habit.) It is said, for instance, that a *ñaka* can only heal a victim of witchcraft if he is a more powerful *muloi* than the one seeking to cause the victim's death. This idea manifests most concretely in the belief that a *ñaka* who has freed a person from a *silumba* cannot simply release it without directing it at a target.

Malicious tongues maintain that a *ñaka* must redirect the *silumba* either towards the witch or towards another innocent person – usually a child. This act, in their view, renders the *ñaka* himself a *muloi*.

Suspicions that *ñaka* are witches are strongest in relation to those who possess a divination instrument but have not been called by the supernatural. Rumours circulate that such *ñaka* have their *litaula* driven by a *silumba*: 'If you don't have the spirits from God you have to use a human being.' The *ñaka* in question deny this, asserting that they have empowered their *litaula* by treating both themselves and the instrument with medicinal plants – often through smoke baths or by rubbing them into incisions in the body. This is the same method by which Mushaukwa obtained his *litaula*, with the important distinction that he found the plants in the bush following instructions from the ancestors, whereas the non-called *ñaka* purchase their plants from another, more experienced, *ñaka*.

These rumours are, of course, difficult to substantiate. Nevertheless, I find it striking that the manner in which people become *muloi* is analogous to the manner in which *ñaka* empower their *litaula*: through treatment with medicinal plants in smoke baths or by rubbing them into incisions in the body.

Ñaka themselves also entertain the idea that other *ñaka* engage in harmful practices ordinarily associated with *baloi*. I encountered this dimension of the fieldwork in the following way: I had interviewed an elderly *ñaka* from a remote village in Lusese and, immediately upon my return, Mushaukwa asked whether the man had offered me anything to eat. 'No, only something to drink,' I replied, somewhat taken aback. 'What kind of drink?' Mushaukwa pressed. 'A coke, from a can,' I said. 'Did he give it to you sealed?' Mushaukwa continued. 'Yes – but why?' 'No, no, nothing. In that case it's fine.' I later learnt from Victor that Mushaukwa had posed these cryptic questions because he suspected the other *ñaka* of being a *muloi* who might have intended to poison me by introducing 'harmful' medicinal plants into my food or drink.[54]

I never caught Mushaukwa in any suspicious statement or practice. Yet during one of our final conversations, he suddenly revealed that he was capable of controlling snakes – a power conferred upon him by the ancestors. I listened carefully and asked what purpose this serpentine control served. He explained that, on his command, snakes could bite people, and he offered the following anecdote: 'Once I had two pairs of shoes, which I always kept in the hut of my first wife. One day I came home and found that a pair was missing. Furious, I said to my wife: 'Let whoever stole my shoes be bitten by a snake!' The next day, one of my sons came running to me in a panic – he had been bitten. And, sure enough, he soon brought back the shoes he had borrowed from me without asking! After that I stopped controlling snakes. If they start biting your own family...' I cautiously suggested that this capacity for snake-control bore a striking resemblance to the control that *baloi* are believed to exercise over animals for the purpose of killing people. Mushaukwa, however, rejected the comparison: his intention had never been to kill anyone. He merely wished to punish wrongdoing. (See also Appendix 2, and particularly section [1.], for a fictional illustration of how witchdoctors engage in practices that border upon those of witches – a story featuring a *ñaka* who employs a hyena as a mode of transport.)

[54] The reason for this was not immediately clear to me at the time; I now suspect that I may have been caught up in a competition between the two practitioners.

It appears that *baloi* and *ñaka* draw upon the same magical forces, but deploy them towards opposing ends. This observation is echoed by Reynolds:

> The witchdoctor makes use of the same magical forces as does the sorcerer [*muloi*, translated by me as witch]. In fact, the difference between them has often been stated as the difference between white and black magic. In many cases, the instruments with which the doctor handles these forces are the same as those of the sorcerer. The analogy to be drawn is one of the spear, whose point and blade are dangerous either to malefactor or policeman, depending on who is wielding the weapon (Reynolds 1963:55–56).

Of course, I cannot say with certainty whether *ñaka* are simultaneously *muloi*. What remains clear, however, is that people hold ambivalent views towards them – views that colour the relationship between healer and patient. It is conceivable that the authority of the *ñaka* derives in part from the widely held perception that he is capable of wielding his mastery over magic and medicinal plants for malevolent ends as well.

4.4. Attitudes Towards Biomedical Healthcare

Mushaukwa holds a positive view of the work of formal healers. He believes they play an indispensable role in society, given that he observes patients recovering in the clinics and hospital. In his view, the two types of healer each operate within their own domain, thereby complementing one another: 'they do their work and we do ours.' This position is grounded in the distinction between 'African' and 'modern' illnesses: formal healers address 'modern' illnesses, whilst *ñaka* attend to 'African' ones. On this basis, he is aggrieved that physicians often fail to refer patients who present with what they – sometimes with the support of their families – identify as an 'African' illness to a *ñaka*, and that physicians do not permit *ñaka* to treat patients within the hospital: 'People are dying there in the hospital from illnesses that we could treat.'[55]

Mushaukwa is receptive to information provided by the hospital. He participated, for example, in workshops on AIDS in 1993, organised by the Primary Health Care (PHC) department within the framework of the National AIDS Control Programme. Following these workshops, the Caprivi branch of the national healers' organisation – the Namibia Eagle Traditional Healers Association (NETHA) – was established. Mushaukwa chairs a committee of senior, experienced *ñaka* that advises the younger generation. The organisation convenes irregularly in the hospital's meeting room, sometimes at its own initiative (for instance, when a new board member must be elected), and sometimes at the invitation of the PHC department, typically for educational purposes.

Mushaukwa's interest in the formal healthcare sector was also apparent during my fieldwork. Following a treatment session with a woman suffering from *Moya/Nzila*, he suddenly produced a piece of paper on which the names of several 'modern' illnesses were written: malaria, measles, AIDS, and tuberculosis. 'So, I have some questions for you,' he said. 'Tell me – where do these illnesses come from?' I attempted to answer, though it proved difficult to persuade Mushaukwa that these conditions could be caused by factors to which he was exposed on a daily basis:

[55] It is worth noting that some nurses at the hospital do allow *ñaka* to treat patients in the hospital—or temporarily take them outside for treatment—before and after the physicians' official working hours. They believe the doctors would not approve and therefore act without their knowledge.

‘How can malaria be caused by mosquitoes? I’ve been bitten by mosquitoes my entire life and have never once visited the hospital!’

Mushaukwa does refer patients whom he suspects of having a ‘modern’ illness to the clinic. His response to my own episode of illness offered a clear illustration of this. Guided by the ancestors, Mushaukwa was firmly convinced that I had malaria and therefore needed to visit the nurse at the clinic. In his broader practice, however, referrals to the formal sector are infrequent, because – as was noted in Chapter Three – his clients have typically already been treated at the clinic or hospital, thereby ruling out the classification of their illness as ‘modern.’ Mushaukwa expressed this directly: ‘Once a patient has already been to the hospital, a *ñaka* is permitted to treat him over an extended period.’

The dichotomy between ‘African’ and ‘modern’ illness is not shared by formal healers – at least not by the expatriate physicians at the hospital (see also section 2.1.).[56] These doctors do not proceed from the premise that ‘African’ illnesses exist as a distinct category. In their view, such conditions are biomedically definable and, in principle, amenable to treatment within the formal healthcare system. This frequently gives rise to a confrontation between competing illness explanatory models. By way of illustration, I describe how such a confrontation can unfold in practice.

> A resident of Makoma, who is also a *ñaka*, had a three-year-old boy who was experiencing spasmodic contractions on one side of his body and occasionally losing consciousness. This was interpreted as an indication of *Jangula’s* influence, and the *ñaka* set about treating his son accordingly. The child’s mother, however, brought him to the hospital, where the paediatrician diagnosed him with diabetes. Furthermore, the convulsions pointed to a neurological problem – possibly a tumour or a tuberculosis abscess. The child required further investigation and potentially treatment at the State Hospital in Windhoek. The *ñaka* refused to consent to his son being flown to Windhoek and decided to discharge him from the hospital in order to resume treatment himself. To do so, he was required to sign a Refusal of Hospital Treatment (RHT) form, since the discharge was contrary to the advice of the paediatrician. By signing this form, responsibility for the subsequent course of events passed from the hospital to the father.[57] The *ñaka*, however, interpreted the RHT form as a kind of ‘collaboration agreement.’ He understood it as written confirmation that the paediatrician consented to his taking over the treatment.
>
> He continued his treatments directed at *Jangula* and appeared to achieve some success – his son’s episodes became less frequent. One day, however, the child fell into a prolonged state of unconsciousness, and the father brought him to a renowned Mafwe *ñaka*, his own treatments having ceased to have any effect. It seemed as though his son had contracted another illness ‘on top of’ *Jangula*. Under the care of the other ñaka, the boy regained consciousness and his condition appeared to stabilise. Somewhat reassured, the father left his son in the care of this *ñaka* for further treatment and himself departed for Katima Mulilo.

[56] Some nurses do make the distinction. The nurse at the clinic in Lusese, for example, advises patients whom he suspects of having an ‘African’ illness to consult a *ñaka*.
[57] Based on conversations with the paediatrician.

> That same night, however, the boy again lost consciousness and died towards morning. The *ñaka* later told me that had he been present, he would have brought his son to the hospital.

This account illustrates dramatically how the same clinical manifestations are subject to fundamentally different explanatory frameworks. Convulsions and loss of consciousness are interpreted by *ñaka* and residents of Lusese as expressions of 'African' illnesses, whilst formal healers read them as symptoms of epilepsy or as sequelae of conditions such as tuberculosis or malaria. The two explanatory frameworks are grounded in distinct models of reality. One is rooted in biomedical science and focuses on the patient and somatic processes; the other is an environmental model that foregrounds the supernatural and interpersonal relations.

From a relativist standpoint, both models are valid. This returns us to section 1.1. of this report, in which I proceeded from the premise that every form of healthcare attempts, in its own way, to explain, prevent, diagnose, and treat illness. There is no value-neutral frame of reference that would permit comparison and allow one to determine whether one medical system is more successful than another in achieving its objectives. Every frame of reference is necessarily a product of culture and is, accordingly, never value-free.

AFTERWORD

In this report I have focused on describing the medically pluralistic character of the society as it emerges through the thought and practice of Mushaukwa and care-seekers. That world, and its uneasy coexistence with the biomedical system, points towards questions that lie beyond the scope of this report – questions that will form the starting point of a literature-based thesis into the interaction between medical systems, in which this fieldwork will serve as the central case. This study will be called: 'Perspectives on the Interaction between Medical Systems'.

* * *

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APPENDIX 1. *Ngoma* Session

In Masikili, a village in the south-east of Caprivi on the border with Botswana, a *ngoma* is held on the night of 20 to 21 May 1994 for a young man and woman who have *Moya/Nzila*. Several family members have consulted Alexander, who has agreed on this date and announced the *ngoma* over the radio.

Around ten o'clock people begin to gather around the large fire that has been lit at the place where it will happen, in the middle of the village. Two narrow, elongated drums lie close to the fire to warm up. Alexander sits on a reed mat with a blanket around him and is busy preparing the medicine. He produces a can of cola, opens it and adds some herbs. The cola fizzes out of the can; he quickly brings it to his mouth and drinks it empty. Whistling a tune nonchalantly, he continues his preparations at a leisurely pace.

It is cold that night. People have dressed warmly and try to position themselves as close to the fire as possible. Alexander has put the medicine into a cooking pot with water, placed the pot on the fire, and then disappeared into the darkness of one of the courtyards. The approximately thirty people wait for what is to come and begin to grow impatient. It is not until quarter past twelve that he reappears. He takes his place on an upturned wooden mortar (in which women pound maize) in the middle of the circle that has formed, and strikes up several introductory songs. The sick have by now entered the circle and sit wrapped in a blanket on a mat. The women have positioned themselves behind them, opposite the fire, on either side of the two boys operating the drums. The boys hold their drum clamped between their knees and concentrate on Alexander, who gives them instructions about the kind of rhythm they should play. The women sing Alexander's songs back to him and tap empty cans together in time.

Alexander is not satisfied with the choir and, with a short downward movement of his hand, orders the women to stop singing. He moves several women from one side to the other of the drummers and tells them they must try harder. He feels too few women are participating: 'When there is a *ngoma*, no woman should remain in her courtyard!' He resumes his singing and blows on a shrill whistle from time to time to urge on the drummers and the singing women. As if struck by lightning, he suddenly straightens up and peers into the audience with his hand on his chest – on an old man [he has a mysterious *litaula* in his chest]. He addresses the man and says: 'You have been troubled by pain in your stomach, have you not?' The man looks surprised and does not know what to say, but Alexander has already turned back to the circle and continues singing. Repeatedly he addresses the audience, in expressions that Victor says are difficult to translate into English [idioms]. Among other things, something along the lines of: 'When I ask an old man to give me his 'tail' [a magical instrument made from the tail of a wildebeest] to make rain, he had better do so, had he not?' and 'Who here wants to be the ox of the herd?' [the leader of the community, possibly used negatively to mean witch].

It is now two o'clock and he has barely paid any attention to the sick, who are still sitting in the circle. Alexander begins to complain again that people are not taking the *ngoma* seriously enough and walks away. The drumming and singing falters and for a moment there is complete silence. Here and there murmuring breaks out and suddenly the mother of the sick young man turns to the women: 'Why are you not singing better – are you jealous of me or something?'

This makes an impression, for the women begin to sing noticeably more enthusiastically, and around three o'clock Alexander runs back into the circle. He takes a mug of medicine from the cooking pot and hurls the liquid into the fire. Great clouds of steam shoot hissing into the air and people start back in fright. The *ñaka* is back.

He begins to dance wildly, lifts a man onto his back, blows hard on his whistle, and urges the drummers to increase the pace of the rhythm. He also picks out several more people from the audience, informing them via his *litaula* that they are ill. He keeps one hand on his chest and the other on the shoulder of the person in question. Alexander then has the sick take a steam bath and washes them with the herbs from the cooking pot. The drumming and singing continue unabated. The sick have not trembled. This is probably unnecessary, as they have already done so in an earlier session, and this *ngoma* is primarily directed at treating them.

Victor and I are by now struggling to keep our eyes open and decide to sleep for a few hours in the courtyard of an acquaintance of Victor's. In the morning we wake at six o'clock when the sun is already high enough in the sky to cast its rays just over the edge of the reed shelter. Half-asleep, we walk to the middle of the village. Although the sick man and woman are nowhere to be seen, the women are no longer singing, the drums lie silent under a tree, and a smouldering heap of ash is all that remains of the crackling fire, Alexander is still at work in a small group. It emerges that a young man who cannot find work and therefore suspects he is being bewitched is trying to convince Alexander that he must find out who is responsible. After some back and forth, Alexander tells the young man that he knows perfectly well that he only makes private arrangements to organise sessions to identify witches, and considers the matter closed. He gathers his things and gets into the car of an acquaintance who is already waiting impatiently. They must drive today to a village in Botswana, where Alexander has another *ngoma* this evening.

APPENDIX 2. The Hyena and the Witchdoctor: a Story from Caprivi

(From Davis, n.d.)

[1.] Kalundu the witchdoctor, sat beside his fire smoking his pipe. It was full moon and the sky was aglow in its light. All at once he jerked up straight and listened. Yes, he could hear his hyena calling him! It was time to go. He picked up his bag of herbs and bones and made his way to the tall Marula tree on the banks of the Zambezi river. There he found Mia, the great hyena, waiting impatiently for his master. 'Now, Mia go carefully! I have important medicine in my bag. We must go to Linyanti [a place in Mafwe territory, where their *Khuta* is located] at once.' The hyena laughed with pleasure, for he had friends in Linyanti and he enjoyed going there. He leapt into the air and a strong current bore them both high into the glowing sky. 'Not too near the moon!' warned Kalundu, 'I don't want to be blinded!' Mia laughed with excitement as he chased a shooting star. 'Behave yourself!' shouted Kalundu, 'Don't go so fast!' The hyena slowed down and then dived towards earth again. Soon he landed outside the Kraal of Nzehengwa. As they landed, Kalundu saw the chief approach with another witchdoctor. They greeted each other, clapping their hands and crouching to the ground as was their custom. 'Greetings, Kalundu. I see you have had a safe journey. My friend, Sankas, wishes to borrow your hyena.' 'You see my hyena died last night and I have an important meeting in Bagani tonight,' explained Sankas. 'Certainly you may use Mia,' replied Kalundu, 'but see that you are back before dawn for I must return to my home then.' 'Thank you, you are very kind,' and Sankas climbed on the back of the hyena. Mia was disappointed because he had wanted to see his friends but he had to obey the witchdoctors. Kalundu and Nzehengwa walked quickly to the place in the forest where all the people of the village had gathered.

[2.] Nzehengwa addressed the people: 'Two men have accused one another of killing a man named Kamwi. I have asked Kalundu the witchdoctor from far away to help us find out which one is really the murderer. You are the witnesses. The culprit will be taken to the Kuta for trial in the morning. You must obey the orders of Kalundu.' Nzehengwa called for the two men to stand before Kalundu. Singongi and Simana, an older man, stepped out before Kalundu, looking very frightened indeed. Kalundu turned away from them for a moment and called upon the drummers. He told the people to clap to the rhythm of the drums. The drummers started slowly and Kalundu began his dance. He lifted his arms, swayed his body and stamped his feet to the beat. The rhythm began to get stronger and faster and the sharp clapping kept up with the drums. Kalundu swayed and swirled, faster and faster. He threw his head back and his whole body writhed with the rhythm. The fire crackled and shot sparks into the air. Kalundu's muscles shone in the firelight and the whites of his eyes gleamed. Faster and faster he swirled and then suddenly stopped. The drummers and clappers stopped too. For a moment there was silence in the firelight. Kalundu held in his hand a small mirror. He looked into it and gasped. 'I see a terrible deed!' his voice boomed out like the sound of floodwaters. 'I see Kamwi on his knees, pleading for his life.' Kalundu stopped. A murmur rippled through the crowd as the people watched him. The witchdoctor suddenly turned and threw the mirror into the fire. The crowd gasped in amazement. 'It is not I who should reveal the culprit!' cried Kalundu. 'These two men must search their hearts.

The one who has committed this dreadful crime must confess. No man can live with sin in his heart. It will eat him, like a disease. He will destroy himself.' The crowd murmured and nodded in agreement. This was indeed a wise man! 'If you are a true man, you will confess your sin, take your punishment and only then can your soul be free — if you sin no more. Come, my brothers, search your hearts!' Kalundu faced Singongi and Simana and looked deeply into the eyes of each man, searching his face and waiting for the truth. The crowd was hushed, waiting expectantly.

Suddenly Singongi sank to his knees and held his arms out towards Kalundu. 'I have done wrong!' he wept. 'I killed Kamwi because I was jealous of him.' The people gasped and stared at Singongi. 'What made you jealous?' asked Kalundu quietly. 'Simana has a beautiful daughter. Both Kamwi and I wanted her. Simana chose Kamwi to be her husband. I killed Kamwi in a fury and then told everyone that Simana was angry with Kamwi because he'd stolen the cattle for payment for the bride, so I told the people that Simana killed Kamwi. I have lied! I have sinned! Forgive me!' Singongi put his head on the ground and wept, digging his fingers into the earth in despair. The crowd was quiet and all that could be heard above the crackling of the fire was the anguished weeping of Singongi.

After a long while Kalundu spoke again: 'You have confessed two wrongs. You have killed a good man and you have accused an innocent father. It is good that you have confessed — that takes courage. It also takes courage to accept punishment. You will be tried tomorrow at the Kuta. Take him away!' he commanded. Two men stepped forward to take Singongi away, leaving Simana looking relieved but still shaking with fear. The people began to talk excitedly to one another. This was an unusual witchdoctor! Kalundu called for quiet and told everyone to leave. Slowly the people returned to their homes and once again peace returned to the forest.

Kalundu and Nzehengwa sat by the fire smoking their pipes, discussing the events of the night. Then from the darkness came the bark of a hyena. 'Haau……my friend Sankas has returned,' remarked Nzehengwa. 'I am glad he isn't late,' replied Kalundu. 'I must go now, Nzehengwa, but I shall come again at the next full moon.' 'Thank you for your help,' said Nzehengwa, rising to his feet. 'I shall send you an ox with my nephew.' The two men greeted each other and Kalundu walked into the forest to his waiting Mia.