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TROUBLE-SHOOTERS AND TROUBLE-MAKERS:

WITCHFINDING AND TRADITIONAL MALAWIAN MEDICINE

by

ARNOLD PAUL WENDROFF

A dissertation submitted to the Graduate Faculty in Sociology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York.

1985

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1985

This manuscript has been read and accepted for the Graduate Faculty in Sociology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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ERRATA AND ADDENDA

page

- vi, line 24: for "Livingstinia" read "Livingstonia."
- 5, line 7: omit "and."
- 10, line 21: for "thef" read "that."
- 47, line 25: for "are many patent medicines" read "many patent medicines."
- 65, line 37: for "similar them:" read "similar theme:"
- 133, line 44: for "rather an extensive" read "rather extensive."
- 135, line 13: omit "[letter 30762]."
- 138, line 12: add "(Banda, 1973)."
- 153, line 16: for "needs be consulted" read "needs to be consulted."
- 164, line 20: for "in mental ward" read "in the mental ward."
- 169, line 9: for "micro-popitital" read "micro-political."
- 189, line 9: for "been successfully" read "been treated successfully."
- 200, line 8: for "likely" read "possible."
- 208, line 7: for "horse" read "equine."
- 221, line 27: for "much like" read "much as."
- 232, line 20: for "home on Likoma Island]" read "home [on Likoma Island]."
- 243, line 4: for "Education" read "Education]."
- 248, line 15: for "him." read "him. (Statement of Nchimi Lipuka)"
- 263, line 22: for "taht" read "that."
- 266, line 4: for "Nchimi Vwamba]" read "Nchimi [Vwamba]."
- 270, line 14: for "[Nchimi Vwamba" read "[Nchimi] Vwamba."
- 290, line 7: for "[Nchimi" read "[Nchimi]."
- 290, line 29: for "the consults" read "the victim consults."
- 340, line 7: insert the following citation:

Chanock, Martin. "Agricultural Change and Continuity in Malawi." In The Roots of Rural Poverty in Central and Southern Africa. editors Robin Palmer and Neil Parsons. pp. 396-409. Berekeley: University of California Press, 1977.

Abstract

**TROUBLE-SHOOTERS AND TROUBLEMAKERS:
WITCHFINDING AND TRADITIONAL MALAWIAN MEDICINE**

by

Arnold Paul Wendroff

Adviser: Professor Judith Lorber

This dissertation describes and analyzes the system of traditional medicine operating in northeastern Malawi, especially those beliefs in witchcraft and spirit possession which cause people to seek out traditional rather than Western healers. Although a wide range of illustrative material is presented, the discussion focuses on an analysis of client correspondence to traditional herbalists (nganga) and diviner-witchdoctors (nchimi). Such correspondence is apparently the first reported in the anthropological literature of central and eastern Africa, and the letters that comprise it are used to elucidate the role of traditional healers and the nature of the healer-client relationship. An examination is also made of those Western influences which affect traditional medical practice and belief--formal education, Christianity, codified law, scientific medicine. What this examination reveals is that, although a manifest purpose of all these institutions is in one way or another to suppress traditional healing, a latent effect of each is in important ways to encourage the use of traditional healers and to reinforce the claims of traditional medicine. The role of village headmen and of chiefs is considered, with particular

attention to their function as agents of referral and legitimation in those cases of suspected witchcraft sent to nchimi for resolution. Emerson and Messinger's micropolitical paradigm is invoked to furnish a theoretical perspective on complaints attributed to sorcerers and spirits: how such complaints take shape; what means to remedy them are pursued; how the conflicts arising out of them are resolved. The applicability of such a theoretical approach to witchcraft-related troubles is demonstrated, as are the approach's limitations, and suggestions are made how the limitations may be remedied.

PREFACE

The present work is a study of the health-related beliefs and practices of the people of northeastern Malawi, especially the belief in witchcraft and evil spirits as a major cause of misfortune and illness. My focus is on the role of traditional healers in the indigenous health-care system, and I devote particular attention to the diviner-witchfinder or nchimi: Who are his patients and how does he treat them? What are the shared beliefs that underlie his standing and his practice? By what means, official, semi-official, unofficial, are patients referred to him? Do people continue eagerly to seek him out despite the conspicuous presence in Malawi of Western medicine and the government's benign and not-so-benign neglect of traditional healing? Apart from his specifically therapeutic activities, what is his place within the larger context of Malawian culture and belief?

The study can be viewed as an outgrowth of my experience as a Peace Corps volunteer in Malawi during 1967 and 1968, and of a return visit made in 1971. More immediately, it originated in a suggestion made by my academic mentor, Professor Feliks Gross, that I try my hand at ethnographic field work during a second return visit to Malawi in the summer of 1972. It was in the course of that 1972 field trip in the northeastern region that my interest was drawn to local medical practices and beliefs, both traditional and Western. This interest was further stimulated, and occasionally put to some practical use, by Dr. Donald Brownlie, who was then the chief (and usually the only) medical officer at David Gordon Memorial Hospital in Livingstonia, and who is presently on the staff of Mengo Hospital, Kampala, Uganda. As a

missionary doctor, he was aware of the need to learn more about local medical practices, and his encouragement of my research from 1972 to 1979 was vital to my success in carrying it out. I am deeply indebted to him for his kindness, his generous hospitality, and his inspiration.

I am also indebted to many other transient and permanent residents of Malawi whose names are too numerous to mention here. They include my various research assistants, guides, and interpreters, and the many laypersons and traditional healers who, for nine successive summers, consented to answer my unending stream of questions about mankhwala ya fipa (African medicine).

Such specific theoretical knowledge of medical sociology as I possess, and was able to bring to bear on my Malawian researches, has been in great part acquired from my advisor, Professor Judith Lorber. That the long gestation period of this dissertation is now over, is thanks in large measure to her patient services as attending midwife. My three other committee members each aided and inspired me according to their own specialties. Professor Sidney Aronson introduced me to the sociological use of historical documents. Professor Lindsay Churchill extolled the virtues of the ethnomethodological approach, though, alas, I lacked the linguistic command to successfully apply it to my Malawian material. Lastly, Professor Rena Gropper of Hunter College furnished me with the necessary anthropological perspective, suggested numerous sources in the literature, and provided me with much-needed editorial assistance.

To conduct the kind of research I have undertaken is

necessarily quite expensive. Since I was the recipient of neither grants nor awards, all the expenses I incurred in the course of my work have been out of my own pocket. I am nevertheless deeply indebted to my parents, Barnet and Gertrude Wendroff, for their continued support, emotional, moral, and logistic, throughout the time of my field work in Malawi and during the years of paper-shuffling and typing that have resulted in this work. To use my brother's words, they are truly parentes optimi.

Finally, I would like to thank my brother, Dr. William Wendroff, for his manifold services as academic role-model, colleague, and editor.

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CHAPTER I

BACKGROUND

Geography

Malawi, a small landlocked country in southeastern Africa, straddles the 34th meridian of east longitude for 500 miles between the 9th and 17th parallels of south latitude. At its widest point it is no more than 100 miles from east to west. Its land area is 36,000 square miles and it boasts an additional water area of over 9,000 square miles, most of which is comprised by Lake Malawi, which lies in the Rift Valley trench along Malawi's eastern terrestrial border. The lake extends in a north-south orientation for some 350 miles, at an elevation of 1,500 feet above sea level.

Malawi's southern half juts into Mozambique, through which the effluent of Lake Malawi flows via the Shire and Zambezi Rivers into the Indian Ocean. Since the Zambezi is of little use for navigation, Malawi's commerce to the sea runs on two rail lines through Mozambique, to the ports of Beira and Nacala. Malawi's northwestern border is with Zambia, and its northern and northeastern borders are with Tanzania.

Malawi's topography is varied, from the hot damp Shire River valley in the Southern Region, lying only a few hundred feet above sea level, to the high plains of the Central Region, with elevations of some 3,000 feet, and culminating in the extensive Vipya and Nyika plateaux of the Northern Region, with surfaces of over 5,000 and 6,000 feet respectively.

The lakeshore itself varies from broad swampy or sandy plain to steep rocky escarpment, while inland the flat to rolling plains are here and there varied by isolated craggy inselbergs, or by larger ranges of hills and mountains.

For purposes of administration, Malawi is divided into three regions -- Northern, Central, and Southern -- and twenty four Districts. (Agnew and Stubbs, 1972:46-7) The bulk of my field work was confined to the eastern parts of Karonga and Rumphi Districts, located on the northeastern edge of the Northern Region. This area is bounded on the east by Lake Malawi; to the north by the Songwe River which forms the border with Tanzania; and on the west by the Nyika Plateau and its associated uplands. The southern boundary corresponds roughly with the valley of the South Rukuru River, and with the boundaries of Mzimba District on the west and Nkhata Bay District on the east.

The topography of northeastern Malawi is quite varied. There is a littoral of low plain on the north and steep escarpments to the south, while inland the Nyika Plateau, surrounded by dissected foothills, rises to over 8,000 feet above sea level.

The region's climate is tropical, but varies considerably with altitude and proximity to Lake Malawi. Rainfall varies from 40 to 80 inches per year over the area, and is highly seasonal, with most precipitation falling in the wet season which lasts roughly from November through March.

The topography of northeastern Malawi strongly influences its communication routes. The main road from the south naturally follows the valley of the South Rukuru River, from there running along the

lakeshore to the Songwe River. This road has recently been realigned and paved, but during most of the period of my field work it was often impassable during the rainy season to all but an occasional Land-Rover. Bus service is provided along various routes, with periodic interruptions on unpaved roads during the rainy season. Pedestrians comprise most of the road traffic; there are also a few cyclists, and fewer motorcyclists. Automobiles are owned by but a tiny minority of the populace (about 0.2 percent in 1977). The countryside is crisscrossed with a network of footpaths, which is the infrastructure for the primary form of transportation, Shanks's mare. Along the lakeshore dugout canoes are widely used for fishing, but their use for transport has dwindled along those stretches of the shore provided with roads and bus services. Several motor ships provide a regular weekly passenger and freight service along the lakeshore, and are heavily patronized on account of their low fares.

In the northeast as throughout Malawi, there is an efficient postal system, which also comprises telephone and telegraph service. In 1977 there were 21,000 telephones in service nationwide, and the 1978 telephone directory listed almost ninety pages of entries. Post offices and postal agencies or sub-post offices are scattered along the roads or lakeshore at intervals of from five to ten miles, and provide banking, telephone, and telegraph services in addition to postal services. Telegrams are delivered by messenger via bicycle or on foot, and mail is delivered to outlying villages by messengers sent by the local village headman.

Demography of Northeastern Malawi

The Northern Region of Malawi is overwhelmingly rural. Its 1977 population of 643,485 was spread over 10,398 square miles of land, for an overall population density of 62 persons per square mile. It boasts of but seven towns of any consequence, these fall in the range of from one thousand to five thousand inhabitants, mostly clustered around the lesser figure, the sole exception is Mzuzu, the regional capital, whose 1968 population of 8,564 had by 1980 risen to over 16,000. (Crosby, 1980:98)

Karonga District, which borders on Tanzania, has a land area of 1,295 square miles and a population according to the 1977 census of 104,245. Its population density of 81 persons per square mile was the highest in the Northern Region. In contrast, Rumphi District, with an area of 1,841 square miles and a population of 64,110, had a density of but 35 persons per square mile, the lowest in all of Malawi.

Population distribution is of course strongly influenced by topography, climate and soil types. The Nyika Plateau is for both climatic and administrative reasons off-limits, and the national park that occupies most of it and its foothills, is off limits to settlement. And so the scanty population of Rumphi District, which contains most of the plateau, is concentrated on the Nkhamanga Plain to the south, and in the Henga Valley to the east, both of which possess alluvial soils of high fertility. (Pike & Rimmington, 1965) The district's main road follows the Henga Valley with its relatively high population density, and drops down to the lakeshore by way of the Livingstonia and Chiweta escarpments, from there wending its way along

the littoral plain of Karonga District and continuing all the way up to the Songwe River, the border with Tanzania. Karonga District's population is concentrated along this plain, the bulk of the district's land being uninhabited hill country.

The major centers of population in northeastern Malawi are Rumphu, Chilumba, Karonga, and Livingstonia. Rumphu, which lies about twenty five miles inland from the Lake, and is the boma or administrative headquarters of Rumphu District. In addition, it possesses the district hospital, a secondary boarding school, and a small trading center and public market. Chilumba, some seventy miles by road to the north, is a port facility for lake shipping, and also boasts a secondary school, rural hospital, and police post. It is also the Northern Region headquarters of LEPRO, a voluntary organization to combat leprosy throughout Malawi. Karonga, also a port, is a further 50 miles by road north of Chilumba. It is the boma for Karonga District, and is endowed with the usual district hospital, post office, police post, and secondary school, as well as a marketplace. It is the headquarters for the Karonga-Chitipa Rural Development Project, which is attempting to boost agricultural production in these districts and to raise the general standard of living. (Nelson, 1975:252)

In addition to these three secular centers, there is the old mission station of Livingstonia, located about five miles inland from the lake and perched atop the Livingstonia Escarpment at an elevation of 4,500 feet. It is about 50 miles by road north of Rumphu. It too has a hospital, secondary and technical schools, and a post office. Until the late 1970's, it was the headquarters for the Church of Central Africa Presbyterian, or C.C.A.P., the first Christian mission

to this area and important not only for introducing Christianity, but Western education and technology as well.

In 1966 Malawi's population stood at 4,039,583, the average population density being 111 persons per square mile, which in Africa was then exceeded only by Rwanda, Burundi, and Nigeria, and which was about half that of Europe. By 1977 the population had grown to 5,561,821 and was growing at an annual rate of 2.9 percent, and the population density had risen to 153 persons per square mile.¹

The country's population is overwhelmingly African: the 1966 census recorded less than one half of one percent of the people as belonging to another racial group. The 1966 census reported 4,020,724 Africans, 11,299 Asians, 7,395 European, and 165 others.

Malawi's birth rate is one of the highest in the world. In 1970 it stood at 50.5 live births per 1,000 of population. The country's crude death rate at that time was 26.5 per thousand. Population has grown at about three percent a year from 1945 to the present, and during this period has almost trebled in number.

As a consequence of these natality and mortality patterns, age distribution is skewed towards the lower ages, creating the typically broad-based narrow-peaked population pyramid typical of developing countries. In 1970, 45.5 percent of the population was under the age of 15 and only 5.9 percent were over the age of 60. 50.3 percent were in the economically active age group, giving Malawi a high dependency ratio.

Nationwide, life expectancy at birth is 42.2 years. The infant

mortality rate was calculated at 142 per 1000 live births, and is in reality probably much higher. One informal report estimates that between 30% and 50% of those born die before the age of five. About half of all non-infant deaths occur in the one-through-four-year age group, and about three quarters of all non-infant deaths occur among those under the age of twenty-nine. (Jinazali, 1978:57; Nelson, 1975:70)

In 1977 the sex ratio for Malawi as a whole was 926 males per thousand females, with the Northern Region having the lowest ratio of 894. Karonga District had a ratio of 895 and Rumphi District one of 847, the second lowest in the nation. To some extent the sex ratio is a function of differential mortality, as males live for an average of 40.9 years and females for 44.2 years. However, most of the male deficit is a consequence of able bodied men leaving home in search of employment elsewhere within Malawi, or in the commercial, industrial, and mining centers of southern Africa.

Malawi's populace is composed of over a dozen tribal groups, each with its own language. Northeastern Malawi is inhabited mainly by members of the Nkhonde tribe in northern Karonga District, and by Tumbuka-speaking peoples (Henga, Phoka and Tumbuka) in southern Karonga District and throughout most of Rumphi District, with some Ngoni in the southwest and some Tonga in the southeast.

Malawi's population as a whole is estimated to be about 35 percent Christian, 15 percent Muslim, and 50 percent adherents of indigenous religions. (Nelson, 1975:102) However, the people of northeastern Malawi are virtually all at least nominally Christians,

save for a small Muslim population living along the Karonga lakeshore.

Historical and Social Background

Although inhabited for several thousand years, the land today known as Malawi supported but a token population until about six hundred years ago, when the Bantu speaking Maravi people, from whom the country's present name is derived, immigrated from lands to the northeast. They were followed by the politically decentralized Tumbuka people, and by the Nkhonde tribe, both of whom settled in northeastern Malawi and who presently constitute most of the region's population.²

Arab slave traders were the first literate folk to enter Malawi, but it was the Portuguese, long active as traders along the Indian Ocean littoral, who provided the west with its first accounts of the area in the early 1600's. Sporadic Portuguese forays into the region continued through the 1800's from Portugal's bases in Mozambique and Angola. (Johnston, 1897:55-60; Tindall, 1967:81-6) These forays continued until the declaration of the British Central Africa Protectorate in 1891, a declaration precipitated in large part by David Livingstone's exposure of the slave trade conducted around Lake Nyasa (Lake Malawi) by the Arabs, and abetted by the Portuguese. In 1907 the area's name was changed by the British to the Nyasaland Protectorate, and in 1953 the Protectorate was merged into the short-lived Federation of Rhodesia and Nyasaland. This was dissolved at the end of 1963, with independence being granted to Nyasaland. The name Malawi was officially adopted in 1966, when the nation was declared a republic.

Christian missionaries, especially those sent by British missionary societies, were instrumental not only in lobbying for the initial establishment of the Protectorate, but were responsible for

much of the Protectorate's early economic and educational development as well. Their role, later augmented by other European and American missions, remains important, especially in the field of medicine. Missions presently provide about forty percent of the nations hospital services.³

Northeastern Malawi was especially influenced by missionary activity. Missionaries established both primary and secondary schools, hospitals and dispensaries; they fostered road building and steam navigation on Lake Malawi; and they were responsible for many other kinds of modernization. For a variety of reasons, northerners perceived education as being especially of value, and availed themselves of it, in mission and, later, government schools, to a far greater extent than their countrymen to the south. They also adopted Christianity in far greater numbers than their compatriots. The result is that today virtually all of the population of the northeast is nominally Christian,⁴ as opposed to 35% of Malawi's population as a whole. (Nelson, 1975:102)

In 1966, 50% of the Northern Region's population who were over the age of five had some formal education; for the Central and Southern regions, the figures were 35% and 32%. Yet despite these rates of school attendance, Kurian states the national literacy rate for Malawi at only 15%, ranking the country 117th in the world in literacy. (1982:1138) The percentages of those who had at least an eighth-grade education were, for the Northern, Central, and Southern Regions respectively, 4.74%, 1.97%, and 2.27%. In the 1977/78 school year, 21.5% of the Northern Regions total population was attending primary school, as against 10.5% and 11.2% of the population of the Central and

Southern Regions. In that same period, only 7.7% (52,047) of Malawi's 675,740 primary school pupils were in standard eight (eighth grade). During that same 1977/78 academic year, there were a total of 15,140 students in the nations secondary schools, equivalent to 2.24% of the total primary school pupil population. Only 9% of standard eight pupils were admitted to the first year of secondary school during this period. (Malawi National Statistical Office, 1979:41-50)

It will be evident from these statistics that the average Malawian has had relatively little formal education, and this has had a considerable influence on the patterns of utilization of both the Western and the traditional medical systems.

Malawi's government is a one-party-democracy, with most political power concentrated in the hands of the nation's founding father and president for life. Relatively little independent authority is granted to even the highest government officials.⁵ The administration of the various government agencies is highly centralized: the three regional and twenty-four district divisions serve primarily as the local administrative units of the national governments ministries. Each district has its District Development Committee, comprised of laymen, and local government and Malawi Congress Party officials. In addition, the country is divided into 194 chieftanships, each under the aegis of a Chief or Traditional (formerly Native) Authority who presides over his own traditional court.

Malawi's economy is based on agriculture. Most of it is subsistence agriculture, but there are major cash crops of tea, tobacco, and cotton. much of these crops is exported. In the

northeast of the country there is relatively little cash cropping as distinct from strictly subsistence farming, but some smallholder cotton, coffee, and rice is grown for market. There are several rural development projects being implemented in this area, whose aim is to increase agricultural production and so raise the general standard of living.⁶

Only about five percent of Malawi's population is employed, and in 1976 the average worker earned just under \$150 a year. At that time the minimum wage varied between forty eight cents a day in the largest town, to forty two cents a day in the next three largest urban centers, to thirty cents a day throughout the rest of the country. It was estimated that in 1969 an average family had 4.6 members, farmed 3.8 acres of land, and had a cash income of \$48.00. A survey published in 1972 indicated that 50% of households owned a kerosene lamp, 30% possessed a bicycle, 8% had a radio, 6% had a kerosene stove, 2% had a house with an iron roof, and 1% of families possessed an oxcart. (Malawi in Figures, 1972)

Family structure in Malawi is of the extended type, being largely matrilocal among the southern tribal groups such as the Cewa, Lomwe, and Yao, and patrilocal among the northern Tonga, Tumbuka, and Nkhonde peoples. As noted already, there is a relative surplus of women in the north owing to the absence of employment opportunities, and the consequent search for employment by young and middle aged men in the industrial areas to the south. This practice tends to produce various social strains, some of which ultimately result in health problems for those remaining behind.⁷

Villages in Malawi are loosely administered by a headman, who settles minor disputes, assigns land for homesteading and for cultivation, and who keeps the tax rolls. Village headmen are involved in both the Western and the traditional health care systems. They are on occasion required to oversee the general sanitary conditions of their village, a requirement which involves them in such things as refuse disposal and latrine construction. They may act in concert with the local health assistant on these and other health-related matters. Village headmen also figure prominently in the traditional health care system, chiefly in cases of suspected sorcery. The several roles they play in such cases will be described later on.

The Western Belief System

In Malawi as in the West, there is considerable variation in the degree to which a rational-scientific model is used to interpret events,⁸ although there is doubtless some correlation between the extent of its use and the level of Western education, both on an individual, and on an area basis. The people of northeastern Malawi boast a higher-than-average level of education, so that their level of adoption of western ideas might be assumed to be at least as high as that of the rest of the nation, if not more. The number of migrant males who may acquire Western ideas at their workplace is also greater than in the rest of the country. And the percentage of Christians is higher too.

The relationship between Christianity and science in the West has been rather a troubled one. Since the scientific revolution in the seventeenth century, organized religion has gradually been forced to relinquish its near-monopoly as an interpreter of nature. Despite the recent resurgence of Christian fundamentalism and anti-scientific and anti-technological sentiment, religion and science have in the West essentially gone their separate ways. In America, the formal political separation of church and state has fostered this secularization of society.

Most people in northeastern Malawi are at least nominally Christian,⁹ and their religion is, not surprisingly, basically fundamentalist. The events narrated in the Bible are generally interpreted by them as being literally true. Such an interpretation is perhaps natural to a people to whom literacy is recent, and where most of the literate older generation learned to read in mission

schools.¹⁰ In addition, the main utility of literacy for most is to enable them to read the Bible and other religious tracts, there being virtually no other literature available to the general public. (Trelford 1977:15)¹¹ The Church fulfills important religious, moral, social, and intellectual functions for many, and for most people other than school children has no close competition in these areas. Christianity is, in effect, Malawi's state religion. "Religious knowledge" as it is presently termed, or "Bible knowledge," as it was called until a few years ago, is a required subject in all eight standards or grades of primary school, and is offered as an elective subject in all four years of secondary school. It has as its aim "to present the essence of Christian faith through familiarity with the text of the Old and New Testaments." (Malawi Certificate of Education Syllabus 1977:16)

Western science is taught in the same schools and, at the primary level, by the same teachers as western religion. Until the late 1960's there were virtually no teacher demonstrations or student experimentation performed in primary-school science classes. Science was taught in a rote, chalk-and-talk fashion, in much the same way as other subjects, including "Bible Knowledge," were taught. The reality of science was to some extent even more tenuous than that of "Bible Knowledge", for where "B.K." made continual reference to a book, the Bible, which was commonly possessed by many if not most families, there were and are virtually no primary-school science textbooks. A similar situation prevailed among the population of Europe during the Middle Ages, where the "Roman Catholic religion, which touched every corner of their lives, consistently deemphasized reason in favor of the

miraculous, the ecstatic, and the supernatural." (Bootzin et al, 1980:14)

While not taught as "science" per se, Western notions of disease causation and treatment are disseminated not only by the schools, but by such health-service facilities as hospitals, clinics and dispensaries, and by the churches, although such notions may not always be presented strictly as "science." The various health-care institutions have several educational functions. Health assistants go out into the villages in order to instruct people in the elements of environmental sanitation. Other health extension workers hold ante- and post-natal clinics, where mothers-to-be and mothers of children under the age of five are taught the elements of nutrition and child care, and preventive examinations of both mothers and children are made on a regular basis. Health education provided by health workers tends to be quite practically oriented, but does emphasize such theoretical aspects of disease causation as the consequences of poor nutrition and of bacterial and parasitic infection. Women of childbearing age are the prime audience for these efforts at health education.

There is a considerable overlap between instruction in concepts of Western medicine and fundamentalist Christianity. Mission-supported health care personnel who provide almost half of Malawi's health care, engage to varying degrees in Christian proselytization, ritual, and prayer. To the extent that they do so, they introduce and reinforce Biblical concepts of health and disease causation and treatment alongside the bio-medical rationale. The schools, especially the primary schools -- which, as we have seen, use the Bible extensively in teaching -- are the main formal agents charged with the dissemination

of Western concepts of health care.

Yet the science and health science taught in them is at variance with many traditional concepts of disease etiology and treatment, concepts which not only are the norm for the larger society outside the confines of the school, but which are often, if not usually, shared by the teachers themselves. It is probably true to say that a significant number, if not the overwhelming majority of school teachers, subscribe to traditional supernatural notions of disease causation and treatment, and pass these beliefs on to their students, both by word, and far more importantly, by example. Even as they are teaching concepts of Western medicine, they will be found to be patronizing practitioners of traditional medicine.

The thought processes and concepts relating to disease causation and treatment which are inculcated in "Bible Knowledge" classes, are also to a considerable extent antagonistic to those taught in school science classes. Although the new science syllabus attempts to instill a spirit of inquiry and of problem-solving by recourse to observation and experiment, the teaching of Bible knowledge (or religious knowledge, as it is termed in the new syllabus) is like most religious instruction, based primarily, on an appeal to faith rather than to reason. Since much of the supernatural element present in Christianity has a counterpart in traditional Malawian religion, the two to a considerable extent reinforce each other in a syncretistic fashion.¹² By contrast, unfortunately there is little such reinforcement of the Western scientific ideas in the larger society outside of the schoolroom.

The Traditional Belief System:

Throughout Africa, Asia, Oceania, and South America, it is only the exceptional individual who wholeheartedly subscribes to Western rational-scientific ideas of disease causation and treatment. In these areas, where the majority of humankind resides, magical-religious notions are inextricably enmeshed with both the theory and the practice of healing. (Leslie 1976, Middleton 1967) As Parsons notes in reference to Western medical practice,

a really highly developed scientific level in any field is rare among known cultures, with the modern West in a completely unique position. . . . The comparative evidence is overwhelming that illness, even a very large part of what to us is obviously somatic illness, has been interpreted in supernatural terms, and magical treatment has been considered to be the appropriate method of coping with it. (Parsons, 1951:432)

This is certainly true of traditional medical belief and practice in contemporary northeastern Malawi.¹³ Such unreserved belief in magic and the supernatural is presumeably attributeable to the patterns of nonliterate thought so well described and analyzed by Bozeman. (1976:69-99) She discusses the nonliterate African's "comprehensive bent of mind and . . . mythical or magical mode of thought" (1976:75), and further states that this

merger of thought with emotion, behavior, and social structure, and the synthetic approach to all knowledge and experience have combined to foster a metaphysical world view that requires the confounding of all phenomena: the natural world is thus not perceived as separate from supernatural realms. (1976:79)

Although focussing primarily on nonliterate thought, Bozeman (citing Lambo) feels that with their newly-acquired literacy, ideology, and values, modern Africans are particularly vulnerable to the

conflicts inherent in their rapidly evolving societies, and that it is

likely that old beliefs in magic and the power of the ancestors will continue to reassert themselves in all mental lives, at least until a satisfying symbiosis between the two cultures has been attained. In the interim or transitional period--which is of uncertain duration--thought is likely to be controlled by fear and the pervasive influence of the awe-inspiring mystical principle. (1976:78)

In a somewhat similar vein, Chilivumbo, himself a Malawian, writes that:

Man in a traditional society lives closer to nature; his cosmos is entangled with mysticism and bewilderment. The level of technology and the development of the intellectual faculty are relatively low, with the result that individuals lack the ability to grasp their environment on an intricate level. The world is shrouded in mysteries; unknowns and mythology lie at the heart of the explanation of daily events. (1976:77)

Religion has been defined as:

A system of beliefs and practices . . . that formalizes the conception of the relation between man and his environment. It helps explain difficult and seemingly inexplicable events. Religion embodies the ideas of a supernatural power and of personified supernatural forces. (Winick, 1975:454)

Since the disease and misfortune which strike an individual or group are "seemingly inexplicable events,"¹⁴ and since "ideas of . . . personified supernatural forces" are integral to the belief system of northeastern Malawi, it behooves us to scrutinize that belief system in order to ascertain how it affects this population's illness behavior and, in particular, how it influences the role that traditional healers play in the health-care system.

Vestiges of traditional religion persist in northeastern Malawi today, despite the efforts of a century of Christian missionary

activity to modify or eliminate it. One pioneer missionary noted of the Tumbuka people that "their atmosphere is found to be charged with religion [and] their lives are surrounded by spiritual powers . . . which play a great part in their common life." He also observed that "they believe in God [as] an absolute deity. Chiuta [God] is known as the creator, the master of life and death, but he has withdrawn from the world, and has nothing to do with it, beyond sending death and disease." (Fraser, D. 1914:120) Because they conceived of the creator as withdrawn from his creation, Malawians addressed prayers not to Chiuta, but rather to local deities, sub-gods who controlled rain and other natural forces. In addition, ancestral spirits were believed to be everywhere, constantly intervening for both good and ill in the affairs of their relatives on earth. These spirits were believed to live "below" in a great valley where everything was good. Such spirits were thought to be the direct cause of all sickness and misfortune. When misfortune befell, ritual specialists were called on to ascertain which ancestral spirits had been offended.¹⁵

Another man of the cloth, in this case a Malawian, writing more than half a century later than the commentator on Tumbuka belief just cited, corroborates many of the earlier missionary observations. He emphasizes the hierarchy of beings, natural and supernatural, which inhabited man's spiritual realm, with the high God or Chiuta at the top, followed by the vipiri or higher spirits, mizimu or ancestral spirits, and then basofi or priests, who minister to the various spirits on behalf of the people on earth, muntu. Finally, under the earth's surface is the dwelling-place of the dead. (Kauta, 1969:6)

Since misfortune and death were commonly ascribed to offenses

against the ancestral spirits, the basofi prescribed days of atonement, where all brought gifts for the angered spirits and confessed their sins in prayer. The musofi or priest had to be a man who knew everybody in the area over which he officiated. In a time of limited mobility, and of even lower population density than today, this would not have been difficult.¹⁶ The musofi also officiated at sacrifices made to propitiate those ancestral spirits who were thought to have been angered by people violating the established law and custom. Such violations were often believed to cause the guilty party's to incur the wrath of the mizimu, a wrath manifested as disease and misfortune afflicted upon the living.¹⁷

If religion is conceived of as an embodiment of supernatural power and personified supernatural forces which explain the otherwise inexplicable, then the belief in magic may properly be regarded as one of its manifestations. Despite the fact that religion tends to be propitiatory, and magic coercive, the two are inextricably enmeshed. (Malinowski, 1954)

Just as magic and religion are part of a continuum, so do magic, sorcery and witchcraft all belong to the same spectrum of belief. I should emphasize here that although Malawian speakers of English use the word **witchcraft** to stand for the ciTumbuka word ulowe, virtually never using the word sorcery, Witchcraft as it is defined by Evans-Pritchard (1937:9,21) is not meant, and in fact does not appear to occur in the northeast,¹⁸ at least not in Evans-Pritchard's sense of¹⁹ "a supposed psychic emanation from [a] witchcraft substance [found in the witch's body] which is believed to cause injury to health and property." (Evans-Pritchard, 1937:10,21,396)

Whenever the word witchcraft is used throughout this work, it is Evans-Pritchard's formally defined concept of sorcery that is being referred to, that is, doing someone "ill by performing magic rites with bad medicine. (Evans-Pritchard, 1937:21)"²⁰

In the time immediatly prior to European contact, it would appear that in Malawi, the usual explanation for misfortune, disease, and death was that they were brought on by offenses against the ancestral spirits or viwanda, and by sorcery or ufiti. (Fraser, D., 1914:127,140) McCracken notes "that most people in the Malawi region shared three basic religious beliefs: the first in the existence of witches, . . . the second in the spirits of the dead, who functioned as intermediaries between the living and the world beyond, and the third in a High God." (McCracken, 1977:13; Rau, 1972:87) These same beliefs are in fact still current today, having suffered little if any diminution over the past century. Not only do the beliefs still thrive, but McCracken's ordering of these three supernatural powers corresponds with their present order of perceived importance as agents of misfortune, disease, and death.²¹

Today in Malawi as in the past, witches (technically sorcerers) are believed to be the principal agents of serious misfortune. Their motivation for doing evil is usually thought to be jealousy of their victim, a jealousy often excited by some trivial difference in wealth or status.²² Witches desire either to secure something belonging to their victim for themselves, or, more frequently, simply to deny the owner of the envied object any pleasure in possessing it. This type of witchcraft is perhaps the one most frequently complained of in

northeastern Malawi. On the one hand, such cases are difficult to diagnose as there is usually no overt warning given by the sorcerer that he is jealous of his victim, and thus no reason to suspect any individual person of sorcery. On the other hand, almost anyone can be a suspect, and it is relatively easy for a diviner to ascribe virtually any misfortune to the work of a sorcerer.²³ Overt threats of witchcraft are relatively rare, usually arising during the course of heated disputes. It is only in such cases that victims can, without the intervention of a diviner, readily "know" who is bewitching them and why. If the potential victim is convinced that the sorcerer is intent upon, and capable of, doing him or his kin mortal injury by supernatural means,²⁴ he may even go as far as to assault the sorcerer without himself having experienced any symptoms.

Sorcerers perform their necromancy by means of nyanga, evil charms frequently incorporating something that has been in intimate contact with the intended victim. Urine-soaked soil, soil from footprints, (Chilivumbo, 1976:73) nail parings, hair clippings, and articles of clothing are characteristic nyanga ingredients. These may be used in concert with other objects of a symbolic nature, as for example a needle, which is used to induce the pricking or stabbing pains characteristic of pneumonia, symptoms of which are commonly ascribed to witchcraft.

Such nyanga requires that a spell be cast over it, and usually works at a distance from the intended victim. In some cases a bit of nyanga, called mankwala uheni, or evil medicine, may be put into the victim's food or drink; however, it is not intended to replace conventional poisons (which are also known although virtually never

used), but acts rather in a magical fashion. Smith, writing of the Ila of neighboring Northern Rhodesia (Zambia), notes that that:

an evilly-minded person takes advantage of the inherent powers of certain medicines to project his malice upon people whom he hates and wishes to destroy. To the African this is no figment of the imagination. He most firmly believes that it can be and is done. He is convinced that much human misfortune, illness, and death is the effect of malice made effective through the illicit use of the powers of misamo [mankhwala]. Bulozi [sorcery] is the supreme crime in his estimation. (Smith, 1935:477)

Sorcery is generally regarded in Malawi as morally unjustifiable and evil. There is, however, one variety of it which is commonly regarded as justifiable, and which is extensively practiced. This is the fabrication of magical charms whose function is to punish would-be criminals, including those stealing from gardens, and adulterers. Anti-theft charms are occasionally met with in gardens, tied to a stick or tree branch to ward off human freebooters, just as a scarecrow is erected to ward off avian ones. Such charms, and a great many other articles possessed of magical (good as well as evil) and curative powers, all fall under the rubric of mankhwala, which may be loosely translated as "medicine," although it has a much broader range of meaning than the common usage of the term "medicine" in our society.

The other major perceived source of people's troubles in northeastern Malawi are the various denizens of the spirit world, of which there are several types. The first, and conceptually the most familiar, are the mizimu or ancestral spirits, that is, the spirits of one's own departed relatives. These mizimu are rather more feared than revered by the living. In the pre-European past however, God or Chiuta was worshipped via one's mizimu, who acted as intermediaries between

men and the vipiri or higher spirits, who in turn conveyed peoples prayers to Chiuta. (Kauta 1969)

Today in northeastern Malawi, the mizimu are paid relatively little attention²⁵ (de Winter 1972:94) save at funerary rituals, and occasionally, at burials. Bits of white cloth may be draped over a grave to honor as well as to placate the departed spirit, so as to prevent it from harming the surviving members of the family.²⁶ A ceremony, the kupiera, is performed about a week after the burial to help insure that the spirit of the deceased should, as one informant stated, "rest in peace, not that it should come back home and trouble people." A similar ceremony was described by Fraser (1914:159) as being practiced early in this century, so that again we see how persistent these vestiges of traditional religion are. Mizimu act to some extent as upholders of traditional values and morality, by punishing those committing infractions against them either directly, or by causing misfortune or disease to fall on a near relative. The second major category of spirits are those of vimbuza or virombo. They differ from mizimu insofar as they are spirits not of one's own ancestors, but of foreigners, members of tribes elsewhere in Malawi, or even from other countries, such as Tanzania or Zambia. (Fraser, 1914:146; Wendroff, 1982:260) Whereas troubles caused by mizimu can largely be prevented by observing proper behavior towards both the dead and the living, those troubles caused by vimbuza are not so readily avoidable, and once incurred are exceedingly difficult to terminate. They can be controlled by various rituals and medications, but are difficult to dislodge entirely.²⁷ Mizimu are on occasion "seen" by people, in dreams and in visions, whereas vimbuza are not. Vimbuza are

known through the symptoms they cause in those they possess, especially by pains and unorthodox behavior, such as certain stylized groanings, (Fraser, 1914:2) and the desire to dance vimbuza.²⁸

There are two reasons given for spirits of vimbuza possessing people. The first is sheer mischief or malice. The second is just the opposite. It is believed that the vimbuza spirits possess a person when he or she is bewitched in order to combat the witchcraft and thus prevent the would-be victim from being killed by the witch's magic. The possessed's pains are in such cases attributed to the struggle being waged within him or her between the spirits and the sorcerer.²⁹

The Impact of Formal Education on Traditional Belief

Formal education in Malawi was introduced by the various Christian missions. The Protestant denominations have been especially interested in promoting literacy so that the Bible would be accessible to the people.³⁰ In addition, the missions, especially those in the northeast, sought to prepare their students for employment in the nascent commercial economy of Nyasaland and in the mining economies of Central and Southern Africa, which formed the "core" for the "periphery" of northern Malawi. (Chanock, 1977:396)

Although formal education serves to introduce Malawian schoolchildren to Western beliefs and values (as the following section on the Western Belief System illustrates), it may also serve to reinforce indigenous beliefs. Belief in the supernatural in general, and especially in the supernatural etiology and treatment of misfortune is reinforced by the very textbooks used in the schools, both in words and by pictures. A Chewa reader, Khwerero 5 subtitled Nzeru or

"wisdom" and widely used in teaching the Chewa language in schools throughout Malawi, has an illustration of a nganga with his paraphernalia of magical medicines on its cover, and has several stories illustrating the powers of these individuals. Lessons 3 and 4 are entitled "Nganga of the Old Days 1 & 2," (Khwerero 5, 1974:7-15), and have an illustration of the nganga on their first page. The appearance of the nganga in the illustration, as well as the description of his activities in the narrative, are in fact faithful to the appearance and practice of nganga practicing today, and no doubt serve to reinforce the children's belief in the powers possessed by such practitioners. "Nganga Chizoto was a well known person because he was treating many different kinds of diseases. Some of the diseases which he was curing are as follows: headache, rheumatism, coughs, sneezing, backache, madness, fainting, leprosy, abdominal pains, bilharzia, scabies and many others." The story continues in the form of a play, with a chief requesting the nganga's aid in treating his ailing wife. The nganga refuses unless he is rewarded with ten cows and is himself made the chief. Such a demand is certainly exaggerated by today's standards, but the rest of the story is quite contemporary. In the next lesson, the nganga cures the chief's wife, and the chief and his people refuse to reward him and chase him away. In retaliation, he ensorcells the village, making all of the women sick, including the chief's wife. In addition, Pied Piper-like, he causes the village cattle to follow him, leaving the place in poverty and disease. Although exaggerated, the basic lesson of this second part serves vividly to reinforce children's beliefs in the powers of nganga, and in the dangers of crossing such powerful persons.

Another widely used CiChewa reader, Kukula Ndi Mwambo, ("Growing Up With Customs And Good Behavior"), like the "wisdom" text treats of various traditions and customs regarding the supernatural and magic ostensibly as if they belonged entirely to the past. The preparation and use of a love potion is described (Gwengwe, 1975:44), and on the following page another charm to keep a husband's amorous attentions from wandering. Both of these charms are in fact as widely used in today's polygynous Malawi as they were in the past. On page 45-46 are described the preparation and use of a "medicine that can enable you to have much [agricultural] yield." Once again such charms are widely used today. Medicines for strength and for protection against witchcraft are described on pages 45-47: "Kalikokha said that this [medicine] helps to stop witchcrafts to bewitch the people in the house." Page 48 describes medicine for protecting one's body "from the cleverness of a witch, such that they can't come to bewitch you." Although presented as though of historical interest only, these and other beliefs and practices described in Kukula Ndi Mwambo remain current throughout Malawi. In a later chapter entitled "Death Among The People," a grandfather tells his extended family that "All those people who are already dead their spirits stay there at the graveyard; and sometimes when they are angry, they can come in the village and start troubling people through dreams, or sometimes they can bewitch a person and if he does not take precautions in time he can die." (Gwengwe, 1965:92)

A classic case of witchcraft is described in Chapter 23. Nkhondondianansi

had a quarrel with Chiipirawachaje, and after a month Nkhondondianansi was sick, he found that his leg was swollen. At this time he once more called his family.

Look my sons I have been bewitched and I don't know who is my enemy in this village. I once told you there are many people in the world who are jealous, now if I delay to see the one who knows witchfinding I will die."

(Gwengwe, 1965:100) The rest of the narrative tells how the witchfinder finds the witch and administers "medicine that can purify the village and get all nyanga out that the witches put in the village."

(1965:104) The story ends with a description of the mwabvi ordeal, which is the only practice described in this narrative which is outmoded, although its use on surrogates is still reported.

Many other schoolbooks have stories such as these. A play widely used in secondary schools is There Came Mchape In 1930 (Paliani, 1971), which describes a famous witchcraft eradication movement of the 1930's.³¹ The introductory Chichewa grammar for primary schools, published by the Malawi Ministry of Education, makes mention of "medicine for detecting those who have bewitched someone." (Mangoche & Logah, 1971:48) An English cum science reader, The Colours Of The Rainbow, contains a story entitled "Wizards" about an old man who bequeaths his walking stick to his grandson, and how its magical powers save the boy from death.

The first four books of the Malawian Writers Series all contain an appreciable amount of supernatural material. In the forward to the first volume of this series, the joint authors write that "Students despise oral literature because, they say, it is not grounded in reality; it cannot be true, and it has nothing to say to the modern world." (Singano & Roscoe, 1974:7) This may be true for Malawi's few secondary-school and college students, but I am sure that it is not at all the case for the vast majority of Malawian readers. Certainly, as

I have mentioned earlier, much of what is intended by a sophisticated author as historical example, accurately mirrors current reality as well.³² In volume two, Night of Darkness: and Other Stories, the story "The Singing Drum" tells of a girl ensorcelled and incarcerated in a drum in order to enhance its sound, and so gain fame for the drummer. (Zezeza, 1976:160) Such ideas of using humans as magical slaves, or of incorporating human flesh into magical charms, are still current today. The fourth volume of this series is a play on a supernatural theme, The Rainmaker, and includes in its cast of characters a prophet, an ancestral-spirit shrine attendant, and a witch-hunter. (Chimombo, 1975) In "A Note for Schools," the authors note the utility of their tales in "providing a basis for cultural and moral debate." (Singano and Roscoe, 1974:17) No doubt the authors cited earlier have similar objectives for their own works. I believe, however, that the reality of the situation, especially in the primary schools--which, after all, have easily the greatest educational impact on the nation--is that these supernatural tales are frequently taken at face value by the pupils, who have little other literature of a non-supernatural nature to compare them with. The supernatural situations described in these books are an integral part of most Malawians everyday life, experienced either vicariously through someone else's narrative, or at first hand, as at a vimbuza dance,³³ a visit to an nchimi, or in a case of sorcery in one's own village. Outside the schools, the only widely disseminated literature is the Bible, and it too abounds with supernatural references which are taken as literally true by the naive reader.

Murdock notes that "unlike the physical and social

environments, the ideational environment is totally illusory and has no actual existence outside people's minds. (Murdock, 1980:54) He goes on to say that "theories of illness constitute a significant part of the ideational environment." (1980:55) Murdock suggests that it is a society's socialization and child-rearing practices, in conjunction with the individual's "total experience with social control on into adulthood, . . . that provide the source for the projections which generate and maintain fundamental ideational concepts such as theories of illness." (Murdock, 1980:55) In general, the experiences common to inhabitants of northeastern Malawi tends strongly to reinforce traditional theories of illness, theories which are extremely difficult to exchange for Western models, even among those with a Western-style education.

In the Tumbuka tongue, there is no single word for luck, but rather separate terms for good luck, mwawi, and bad luck, or soka. (Sodality of St. Peter Claver, 1957:219; Turner, 1952:129,227) Although Turner cites the word mwawi as the equivalent of the English word chance (1952:185), my research indicates that the concept of chance, as we use it in the West, is lacking in northeastern Malawi, at least insofar as its application to the causality of significant events in people's lives are concerned. Malawians do not subscribe to the notion common in the West, that illness, death, and misfortune frequently occur due to some random process;³⁴ rather they believe that some agency, either human or supernatural, is invariably responsible for such events.

Misfortunes which we might attribute to chance, in Malawi are virtually always believed to be due to either to sorcerers (wafwiti),

to malignant spirits (either vimbuza or, less frequently, mizimu), to God (Chiuta), or to the Devil (Satana). In a questionnaire I administered to an eighth-grade class at a mission secondary school in 1974, 35 of 56 students mentioned sorcery as a causal agent when asked the neutral question, "What makes people get sick?" An identical questionnaire administered concurrently to the eighth graders at a nearby public school found that 18 of the 26 students queried ascribed a supernatural etiology to sickness (13 to sorcery, 1 to vimbuza and 4 to mizimu or ancestral spirits).

In 1973 I sponsored a competition at a secondary school, in which the student entrants had to write "a factual essay on your knowledge of and experience with traditional medicine and Western medicine." A series of twenty-three suggested topics and questions was posted, and 38 students responded. An analysis of their essays showed that 31 of the 38 thought that sorcery was an important factor in making people sick; and 33 of them indicated that vimbuza or spirit possession was a common disease in their neighborhood.

In 1974 I administered a brief essay-type questionnaire on health beliefs to several primary-school classes in Rumphi District. The majority of the seventh- and eighth-graders (16 of 23, and 47 of 56) spontaneously mentioned witchcraft as a cause of disease, a response which indicates that the section of the health-education syllabus meant to debunk such supernatural etiology either was not effectively written, had not been effectively presented, or both.³⁵

A Malawian Presbyterian minister stated to me that he estimated that people in northeastern Malawi attributed 70 percent of disease to

sorcery, 20 percent to God or natural causes, 5 percent to spirits, and 5 percent to the Devil. He himself seemed to believe in the reality of sorcery. Two primary-school teachers whom I interviewed that same day made virtually identical estimates: 75 percent of disease caused by witchcraft, 20 percent by God, and the remaining 5 percent evenly divided between spirits and the Devil. Although other informants give somewhat differing percentages, their overall estimates are in rough agreement, and no other causes than those mentioned are offered to account for mankind's misfortunes. For example, a former student of mine, a graduate of a teacher training-college, thought that people attributed 40 percent of disease to sorcery, 30 percent to God, 10 percent to spirits, and 20 percent to the Devil. He further stated that he thought few teachers taught, or taught effectively, the dangers of using traditional healers, and that virtually none attempted to teach their students to be skeptical of witchcraft. He said that he was afraid that if he himself were to teach students to disbelieve in witchcraft, he would be witched.

Two recent secondary-school graduates, one a Presbyterian, the other a member of the breakaway New Apostolic Church, helped me to draw up the following chart summarizing belief in the causation of misfortune and disease:

AGENT	MOTIVE	ACTIONS
God	Love/Reward	Heaven
"	Punishment	Affliction/Hell
Devil	Innate Cruelty/Hatred	Death/Hell
Ancestral Spirits	Dissatisfaction with family	Warning via sickness

The chart does not include the vimbuza spirits, as my informants were not too clear on their modus operandi. Vimbuza spirits are believed by some to be innately evil spirits³⁶ who delight in harming the person they possess. Other informants state that the vimbuza are benevolent spirits, who enter persons being ensorcelled and attempt to protect them from the evil being perpetrated by the sorcerer. All informants state, as does Luke 8, that many vimbuza spirits may possess a person simultaneously.

The Western Medical System

In order to fully elucidate the role of traditional healers within northeastern Malawi's indigenous medical system, it is necessary to examine the Western medical system³⁷ operating there, so as to afford a perspective on traditional practice. In addition, it is important to trace the mutual impact of the two systems on each other, especially in view of the consideration that their paths may become more convergent in the future.³⁸

Western medicine was first introduced to central Africa by Dr. David Livingstone in the 1860's. However, his was primarily a mission of exploration rather than of healing, and his ministrations were largely confined to members of his own expedition. "Perhaps Livingstone's greatest influence on central Africa came mostly after his death through the missionaries who were swayed by his passionate desire to establish a station" in what is now Malawi. (Gelfand, 1973:189) These "Christian medical missionaries took the first steps . . . [of] introducing modern ways of healing to sick Africans as part of a great campaign to spread the Gospel, [and] brought many converts to the fold by successful cures." (Gelfand, 1964:307)

The usefulness of healing as a means of proselytization was well recognized by those following in Livingstone's footsteps. After the success of the first surgery performed with the use of chloroform, at the south end of Lake Nyasa, by Dr. Robert Laws of the Livingstonia Mission, which was established in Livingstone's honor, and in furtherance of his ideals, "the news spread far and wide, and patients from a distance began to appear, drawn, as those in the time of Christ

were drawn, by the reports of healing miracles." (Livingstone, 1923:93) Laws himself wrote that, "in seeking to evangelise the people, we tried to learn first of all something of their own religious ideas, leading them thus from what they knew or admitted as known, to what was for them unknown." (Laws, 1934:112) One object of this study of traditional medicine was the "overthrowing [of] the empiricism and deceitful incantations of the native doctors." (Jack, 1901:325) This statement gives voice to the inherent conflict between the adherents of scientific Western medicine and those of traditional medicine, a conflict that, with some concessions on either side, continues to this day³⁹ and is by no means limited to Malawi.⁴⁰

The present organization of the Western medical system reflects its historical origins. Although the Malawi Ministry of Health funds most Western-type medical care, almost half of the country's health services are still channeled through eleven Christian missionary organizations operating in Malawi, whose cooperative efforts are coordinated by the Private Hospitals Association of Malawi (PHAM).⁴¹ Government health units provide free service. In part as a consequence of this no-fee policy, as well as of the general shortage of medical facilities, such units are often terribly overcrowded, with long lines at outpatient clinics. This overcrowding often leads to brusque and impersonal treatment by the staff. Mission hospitals, by contrast charge fees for services and medication,⁴² a practice which tends to restrict the number of patients who can afford to patronize them, but which results in better staff morale and more humane treatment. Many people think that what is purchased is better than what is given free, and that medicines dispensed at mission hospitals

are "stronger" than those obtained from government hospitals.

As at traditional hospitals, inpatients are normally accompanied to Western hospitals by at least one helper or guardian. (Winter, 1972:118) Such helpers look after and feed the patient and, when required, act as intermediaries between the hospital and the patient, as in the case of children, the elderly, and the infirm.⁴³ Mission hospitals generally provide no food for patients, and while in government hospitals food is served, it is relatively unpalatable, so that it is always advantageous to have one's food prepared by a friend or kinsman. Hospitals provide cook-sheds and dormitories for the use of guardians, who nevertheless often prefer to sleep in the ward by their patient (most often under his or her bed) so as to be available if needed during the night. At both government and mission hospitals there are no formal visiting hours, the hospital being open to friends and relatives at all times. Ambulatory patients spend most of their time outside of the wards, and often take their meals on the verandah. During the day, the large number of guardians makes for a lively hospital atmosphere, since they interact not only with their own patients, but with others as well. There is a good deal of mutual aid and altruistic behavior among patients and helpers at both Western and traditional hospitals, which makes for a pleasant atmosphere and serves to aid the healing process.

Altruism is fundamental to the process of blood transfusion. No hospitals in the northeastern area have blood banks, and blood must be donated and transfused as needed. Relatives of the patient are first asked to donate, but as only a few are likely to be present at the hospital, they are often unsuitable candidates, due to blood-type

incompatibility, age, or poor health. Many people are reluctant to donate blood, often due to ignorance or superstition.⁴⁴ One informant stated that people believe that if the recipient of the blood is not related to the donors, "he might take all the blood from them while they are asleep. They only give blood if the patient is related to them, otherwise no blood is given." Another wrote that people "fear death . . . by giving away their blood." Nevertheless, blood is usually obtained when necessary, not uncommonly--at least in the case of mission hospitals--from the staff. In hospitals having a secondary school nearby, students are routinely canvassed for transfusions. (Winter, 1972:124)

In general, it seems that the main reason for selecting any particular Western health-care facility, especially an outpatient one, is its ease of access. King (1966:2:6), working in East Africa, asserts that outpatient attendance is inversely proportional to the distance the patient has to travel to the hospital, and that it falls off rapidly beyond a five-mile radius. Similar conclusions were drawn in a more recent study in Nigeria, although various exceptions to this rule of thumb were noted. "In the few cases where a particular approach to treatment is perceived to be essential (i.e. there is no appropriate alternative), or where there is hope for a "miracle cure," "distance seems to have relatively little impact on utilization." (Stock, 1981:10) These findings hold true for Malawi. Winter, for example, found that 79 percent of all outpatients at Nkhata Bay District Hospital came from within a five-mile radius. (Winter, 1972:106) Thus a major consideration in putting into effect a system of Western health care is to make its facilities readily accessible to its

potential clients. One means used to attain this end is the use of mobile clinics run periodically by a team from a distant hospital, who make their regular rounds by motor vehicle, stopping at appointed locations to provide both curative as well as preventive medical care. Unfortunately, such efforts are not very cost-effective in the sparsely-populated areas of the northeast, where operating expenses are compounded by the rugged terrain and poor roads.⁴⁵ All things considered, it is difficult for the Western medical system to provide the ready accessibility that is a prominent feature of the traditional system.

Government and missions coordinate their efforts in providing dispensaries and hospitals throughout the country. Each district has its district (government) hospital, normally headed by a qualified medical doctor or, in some cases, by a "senior clinical officer" who has completed an overseas medical course quite similar to a doctor's but lacking some of the theoretical studies. These doctors and clinical officers are assisted by "medical assistants," who have on completion of secondary school undergone a two- or three-year training in clinical medicine given in Malawi. Medical assistants are in charge of rural hospitals and dispensaries, and often shoulder heavy medical and administrative responsibilities. They provide the bulk of the medical care in hospitals, where they work under the supervision of doctors in a manner reminiscent of American physician's assistants. Medical assistants, who are almost exclusively men, are the mainstay of the primary Western health care in Malawi, as they are relatively easily trained in-country, work for low salaries compared to M.D.'s, and are willing to work in remote areas. "In addition, auxiliaries

[such as medical assistants] are closer to the people being served in thought, culture, and living habits than physicians. Thus, they are more likely to be accepted by the local residents than the latter." (Sorkin, 1976:150) Satow and Lorber (1975) found that cultural congruity was not very important in mental health work in New York City. However, the cultural differences between American blacks, whites, and Hispanics are relatively small in comparison with those existing between European whites and Malawian blacks. As a consequence, there is in Malawi likely to be far greater ease and effectiveness of communication between patient and therapist if the therapist is a Malawian.

In 1974 there were a total of 129 doctors registered to practice in Malawi, which at that time had a population of approximately five million. Of the total number of registered medical practitioners, all but 33 were located in the three major towns of Blantyre, Zomba, and Lilongwe,⁴⁶ and a number of them were engaged in administration. Only a few doctors, practicing in major population centers, were specialists or in private practice. (Malawi Government Gazette, 1974:1; Nelson, 1975:121) Of the remainder, there were nine serving the Northern Region. As for northeastern Malawi, the area in which my research was carried out, there were three doctors and a senior clinical officer. Thus for the Northern Region as a whole, in 1974 the approximate average number of persons per doctor was 15,000, and for northeastern Malawi, or all of Rumphi and Karonga Districts, it was one doctor or senior clinical officer serving 42,000 persons. Some years earlier, in 1969, there were a total of 114 physicians, and 496 medical assistants practicing in Malawi. They were assisted by 178

professional nurses and 306 auxiliary nurses, and by 65 professional midwives and 136 auxiliary midwives. There was also a cadre of some 160 health or sanitary assistants and inspectors, whose duties were chiefly in the field of preventive medicine and environmental sanitation. (World Health Organization, 1972:45) The burden of work which such health-auxiliaries must bear is underscored by Bryant:

Beyond the central hospitals, in the rural areas [of Malawi], there are few professional personnel, . . . and the care of the population of four million people is in the hands of auxiliaries. . . . By default, whatever is done is done by them. The number of out-patient visits received by these auxiliaries is a staggering seven million per year. They have time only for curative medicine. (Bryant, 1969:153)

Winter, (1972:111) quoting King (1966), notes that "the smallest practical size for a hospital is one with two doctors." [Yet] as matters stand, Malawi can hardly afford one doctor per District." Hospitals consume 85 percent of the nation's recurrent health budget (World Health Organization, 1972:23), and the same urban-rural imbalance in the distribution of hospital resources that is to be observed elsewhere, is also to be seen in Malawi. Queen Elizabeth Central Hospital in Blantyre alone consumes 30 percent of the national health budget, though it serves only some seven percent of the population. In that time, Blantyre spent K4.07 (about \$4.88) per annum on the health of each of its inhabitants, while the national average was only K0.73 (\$0.88). "A high proportion of the [Ministry of Health's] resources is spent on patients who do not need specialist treatment but obtain it by virtue of living in or near Blantyre." (Berner, 1976:11)

Having observed the imbalance between curative and preventive

medical practice in the country, one author wrote: "It is apparent that the preventive health services in Malawi are negligible." She went on to state that "only 0.5 percent of the total under-five population attend child care clinics in any one week, and 0.7 percent of women in the child bearing age group are attending ante-natal clinics each week. . . . A majority of these [clinics] are of very low standard indeed, health education and nutritional teaching being minimal or non-existent." (Cole-King, 1968:vii) She identified health education as "probably the most important preventive health measure in this country at the present time," (1968:1) yet noted that both at the rural level as taught by health extension workers, and at formal institutions . . . [it] lacks impetus and is to a large extent ineffective." (1968:vii) My own observations during the decade of the 1970's bear out Cole-King's bleak view of the health education taught in Malawi's primary schools. Pupils come away with little real understanding about illness causation and treatment, and are frequently unable to transfer what they have learned to real-world situations. There has, however, been a considerable increase in the emphasis placed on preventive medicine since Cole-King's report, especially insofar as the provision of ante-natal, post-natal, and under-fives clinics is concerned.⁴⁷

In the whole of Malawi there is but a single mental hospital, located in Zomba in the Southern Region. A World Health Organization mission to Malawi noted that "Rapid industrialization and urbanism is at present taking place in Malawi, and with the attendant stresses and strains to young lives in addition to the effects of disease on the brain, the extent of mental illness will doubtless increase." (WHO, 1972:79) These remarks, and the chronic overcrowding of Zomba Mental

Hospital--which in 1965 had 280 beds and 350 patients (Malawi Ministry of Health, 1965)--have a considerable bearing on significance for the traditional medical sector, whose practitioners are likely to be involved in the care of mental-health patients at one stage or another of their "hierarchy of resort." (Schwartz, 1969:201)

There are three hospitals serving northeastern Malawi. Rumphi District Hospital, with 84 beds and often without a resident medical officer, is situated at the southwestern corner of the area. Some forty miles north is Livingstonia Mission Hospital of about 90 beds, which had the same missionary doctor resident throughout most of the decade of the seventies. At the northern end of the area, some sixty miles by road from Livingstonia, lies Karonga District Hospital, of 105 beds, which has been under the supervision of a Senior Clinical Officer for some years. There are also three rural hospitals, or primary health centers, serving the area, each offering limited inpatient facilities, and under the supervision of a medical assistant. Additionally, there are some half-dozen dispensaries, offering limited medical assistance on an outpatient basis and in the charge of a medical assistant or, in some cases, of a medical auxiliary having but limited on-the-job training. There are two or three small maternity units situated in the area, staffed mainly by auxiliary midwives. Finally, persons seeking western medical aid on occasion betake themselves to distant facilities in their quest for relief, so that residents of Rumphi and Karonga Districts may attend at hospitals in Mzimba District, and vice versa.

To some extent, a health unit's reputation, and hence degree of utilization, depends on the reputation of the doctor, clinical officer,

or medical assistant in charge. That reputation is an amalgam composed of objective and subjective elements. Naturally, the longer a doctor or other health-care professional is stationed at a hospital, the greater the chances for his or her reputation to grow. In the rural areas, it is primarily the mission hospitals which retain doctors for relatively long periods of time, and so allow them to develop their reputations. Government doctors in charge of hospitals in the hinterland tend to stay for shorter periods of time. In northeastern Malawi at the time of my visits, Karonga District Hospital had had the same senior clinical officer for a number of years, Livingstonia Mission Hospital had had the same doctor for a decade, and Rumphi Hospital had had a succession of expatriate and Malawian doctors, with periods of no doctor at all. The next hospital to the south, Ekwendeni Mission Hospital, had retained the same doctor for over two decades. In general, however, the physician turnover rate in Malawi is very high. In both 1972 and 1974 only about 40 percent of all the country's registered physicians had more than four years of experience in Malawi, and fewer than ten percent of physicians registered during these years had been certified in tropical medicine or public health, although an additional five percent or so had studied medicine in Africa. (Malawi Government Gazette, 1972; 1974)

These figures indicate that most doctors practicing in Malawi are initially unfamiliar with the problems of medical practice peculiar to Africa in general, and to Malawi in particular. They have much to learn before they can become as effective as those with in-country experience. This is particularly true of those physicians in sole charge of some remote district or mission hospital, who have a burden

of administrative as well as medical responsibilities. There is much that physicians new to Malawi must learn, and although their learning curve may be steep, most of that gained expertise will unfortunately leave with them after their brief tour in Malawi. (Winter, 1972:111) The problem of continuity is exacerbated in government hospitals, where "as a matter of routine nobody stays at any one place for more than a few years at the most. It is obvious that this often interfered with the proper running of a hospital." (Winter, 1972:112)⁴⁸

The race of the doctor in charge of a hospital has some influence on its utilization. As one medical orderly put it, "people have faith in white skins," meaning that a European doctor is generally perceived as having more medical expertise than an African with the same qualifications. Many Malawians have told me that European doctors (and European officials in general) are favored over Malawians because they are impartial in their treatment. "I would prefer the [European doctor] since he is a stranger and won't have any preferences. The African doctor will be very kind to his own relatives . . . [will] . . . show favoritism towards his relatives."⁴⁹

Each ancillary health unit is, in theory, supposed to refer patients to the nearest hospital in the event that a case is more difficult than it can handle.⁵⁰ There is, however, but little communication between the various health units,⁵¹ and as a rule medical records as we know them are not kept at all, are inaccurate, and/or are not properly utilized.

In 1969 there were a total of 12 medical laboratory technicians and 44 auxiliary laboratory technicians serving throughout Malawi (WHO,

1972:45), and but a single pathologist. Sophisticated laboratory work is out of the question at most hospitals, and the work that is performed is at times suspect. Biopsy specimens are sent to England for evaluation, in a process that takes at least several weeks.

Most Western medical therapy in Malawi involves the use of drugs. These are perforce dispensed at the medical facility where treatment is given, there being only a handful of private pharmacies, all located in the Blantyre-Limbe area and in Lilongwe. Most of nation's medical facilities obtain their drug supplies from the government's Central Medical Stores, located in Blantyre, which purchases and distributes on behalf of both government and mission hospitals. For most government hospitals, the Central Medical Stores is their sole source of medicines. If the Stores are out of stock of an item, there is no alternative supply. Mission hospitals have somewhat more flexibility, since they are able to purchase directly from the commercial pharmacies, whose prices, however, are usually considerably higher than equivalents obtained from Medical Stores. It is not unheard of for a hospital to run out of some necessary item, such as penicillin injection, aspirin, or intravenous fluids, and to be unable to obtain replacement stock for weeks, especially if Central Stores is out of stock as well. (Winter, 1972:119) Disposable syringes and blood-taking sets are routinely sterilized and reused, often until their needles are blunted. In another economy measure, Central Medical Stores compounds various mixtures and dispenses them in recycled beer bottles.

Due to the scarcity of drugs, hospital personnel tend to dispense medication in relatively limited amounts, to check whether the

patient is taking the medication as prescribed, and to evaluate his or her progress.⁵² There is, however, an "endemic chronic disabling hyperprescriptionosis that occurs." (Samuel-Gibbon, 1977:14) This excessive dispensing of medicines is due in part to improper diagnosis and the consequent treatment of symptoms instead of their underlying causes. It is also due to the fact that many patients do not understand the medical assistant's directions, and violate them both with regard to time of administration and dosage. In addition, medicine dispensed for one complaint may be hoarded, used to self treat other complaints, or given to some third party. I observed one nchimi who purchased various pills from a weekly mobile clinic held near his home, and later dispensed them to his own patients without any regard for (and probably understanding of) their intended use.

Such (unsanctioned) prescription of Western drugs by an nchimi is but one example of the informal utilization of Western medicine in Malawi. Traditional healers and laymen alike also use the Western system as a diagnostic tool, citing the failure of a patient to respond to Western therapeutics as a sign that the disease in question is of supernatural origin. But the most common use of Western medicine in northeastern Malawi is no doubt the consumption of the patent and other over-the-counter medicines sold in most small shops. These drugs include various anti-malarials, analgesics, cough preparations, laxatives and antiseptics.⁵³ They are often used incorrectly, one reason being that their labels are usually printed in English and not in Tumbuka or Chewa. There are, moreover, are many patent medicines sold which are irrational mixtures having little inherent pharmacological utility. Prominent in this category are an assortment

of tonics and potency enhancers.⁵⁴ Further contributing to drug misuse are the often misleading advertisements for patent and other over-the-counter medications. Such advertisements often cause people to have an exaggerated belief in the drug's efficacy, a belief which has on occasion led to a patient's death.⁵⁵

Besides availing themselves of patent medicines and the off-prescription ethical drugs, people may use traditional medication, or mankhwala, before, during, or after patronizing some Western facility. Winter remarks that "if a [tuberculosis] patient wanted to use traditional medicine, he was--like all other patients [at Nkhata Bay Hospital]--free to do so." (1972:134) Many patients, in fact, are somewhat ashamed of being rebuked by hospital staff for their use of mankhwala, and attempt to conceal its use from them. Surreptitious or not, its use in-hospital is widespread. A survey of the non-maternity inpatient population at a mission hospital on one day in 1978, revealed that of a total of 75 patients, 35 bore the scars of traditional cutting medicine some of which were fresh--and seven wore some medicinal amulet or charm. On occasion a traditional healer will even minister to a patient in the hospital, and some patients will refuse to be admitted unless they can continue taking their mankhwala.⁵⁶

As noted above, Western medicine may be utilized as a diagnostic aid to traditional traditional medicine. If a patient fails to improve in a Western health-care facility, the patient, or his (or her) traditional healer, may conclude that his complaint is due to a cause not amenable to Western treatment, and that to effect a cure the traditional healing system must be resorted to.⁵⁷

To people with no understanding of its operation, Western medicine often appears a kind of magic. Western diagnostic tools and methods are in fact not generally understood in Malawi, and the x-ray is still regarded with wonder, its repute being such that it is frequently demanded by patients having no indications requiring its use. Surgery, with its attendant anaesthesia, also appears somewhat miraculous. When we consider that most Malawian adults have had at best a primary-school education, that there are in Malawi virtually no mass media save the radio, and that there are few books and virtually no libraries, it comes as no surprise that the populace as a whole is naive with regard to scientific medical technology, and that such naivete even extends to many in the lower ranks of the Western medical profession. A good example of this simplicity is the demand for injections. "To many people the only cure for any illness is a 'jakisoni.' Even many medical people believe that an injection is the best form of medicine." (McNeil, 1973:13) In some cases patients come to a medical facility and demand an injection. A medical assistant at Rumphi District reported that men, especially friends and relatives, came to him for "service," i.e., for injections of procaine penicillin, after having "misbehaved with a lady on the previous night." (Mwenifumbo, 1973:21) Jansen describes a similar desire for injections, and a similar magical belief in their efficacy, in South Africa (1973:74,195), and Bonner writes that "in Sierra Leone you get quacks wandering around offering injections [for sexually transmitted diseases] at L12 for a course to cure you." (1984:19) Paul Ehrlich's figure of a "magic bullet" (De Kruif, 1940:322) is taken literally in Malawi and elsewhere.

One other source of Western-style injections is from retired medical assistants, who may supplement their retirement benefits by setting up practice on their own. Unlike the Thai "injection doctors" described by Cunningham (1970), they generally have no legitimate source of supply and may administer outdated medicines and medicines purloined from neighboring medical facilities. Such individuals (including retired nurses and midwives) constitute a reservoir of medical expertise whose impact on health care has not been assessed. It is an impact which is likely to be a considerable one, having both positive and negative aspects. I myself did not pursue this line of inquiry very far, but it is perhaps worth noting that one of my informants was able to name and locate ten retired medical assistants, some of whom were said to be providing health care.⁵⁸

Like the magic bullet that seeks out germs "within the chemical labyrinth that is the animal body" (Lechevalier & Solotorovsky, 1974:438), Western medicine in Malawi, unlike its indigenous counterpart, ideally tries to reach out into the population at large and treat sick individuals who may pose a threat to their fellows. This case-finding falls on the borderline of curative and preventive medicine, and in Malawi is primarily directed at leprosy and tuberculosis, both chronic diseases caused by related, highly refractory mycobacteria. In 1969 it was estimated that two percent of Malawi's population was afflicted with leprosy (Robertson, 1969:61). The disease's incidence in the Northern Region was in 1977 found to be at least 1.5 percent. (Gjalt, 1977:9) Leprosy-control assistants, travelling by bicycle, Land-Rover, and motorboat, make their rounds on a weekly basis, treating old patients and searching out new cases. The

program is funded and supervised by the British Leprosy Relief Association (LEPRA). Tuberculosis patients are registered at the hospital nearest their home, where they report at tri-monthly intervals for clinical review. They obtain free medication each month at the nearest medical facility.⁵⁹ (World Health Organization, 1972:68)

Legal Aspects of Healing Practice

In Malawi, the practice of both Western and traditional medicine is regulated by several laws, the most important of which is the Medical Practitioners and Dentists Registration Act. This law requires practitioners of Western medicine to be in possession of a medical degree and licence, and to register with the government. However, the law also guarantees traditional healers the right to practice, insofar as it stating that:

Nothing contained in this Act shall be construed to prohibit or prevent the practice of any African system of therapeutics by such persons as are recognized in Malawi to be duly trained in such practice:

Provided that nothing in this section shall be construed to authorize the performance on the part of a person practicing any African system of any act which is dangerous to life. (Laws of Malawi, 1968 Cap. 36:01)

It is noteworthy that the Medical Practitioners and Dentists Registration Act implies that there are "African system[s] of therapeutics" engaged in by persons who are "duly trained in such practice[s]." As noted earlier, such systems and the training associated with them are of a considerably less rigorous, formal, and uniform nature than their Western medical counterparts. There seems to have been no attempt on the part of the Act's framers to sharply define these systems, and such training as may be required is left unspecified by the Act--doubtless on purpose. I have neither heard nor read of any case in which a traditional healer has been prosecuted for lacking adequate credentials.

A second law regulating the provision of health care in Malawi is the Venereal Diseases provision of the Public Health Act. Like the

Medical Practitioners and Dentists Registration Act, the Public Health Act appears on first inspection, to exclude traditional healers from treating venereal disease:

No person, unless he is a registered or licenced medical practitioner, or a State registered nurse, or other person certified by the Secretary for Health to be competent to diagnose and treat venereal disease, shall for reward treat any person for venereal disease or prescribe any remedy therefor, or give any advice in connection with the treatment thereof, whether the advice is given to the person to be treated or to any other person. (1968 Cap. 34:01 section 56)

Neither the Venereal Disease provisions of the Public Health Act nor the Medical Practitioners and Dentists Registration Act prohibits any person from practicing medicine as long as the person receives no reward for his or her services. Yet although section 18 of the Medical Practitioners and Dentists Registration Act expressly allows for the practice of traditional medicine, the Venereal Disease law has no such loophole. Many traditional healers do, in fact, charge for their services, and almost all receive gifts in kind, gifts which would likely be interpreted as rewards under the law. Thus traditional healers treating cases of venereal disease would be liable to prosecution under the Venereal Disease statutes were it not for the contradictory provisions of yet a third piece of legislation.

The opening substantive section of the Pharmacy and Poisons (Control of Patent Medicines) Order at first seems to be in agreement with the Venereal Diseases provisions of the Public Health Act, stating that:

2. In this order, "patent medicine" means any secret, patent, proprietary or homeopathic medicine or preparation.

3. The importation, manufacture, sale or offering for sale of any patent medicine intended for the

prevention, cure or treatment of venereal disease, sexual disorders or impotence, tuberculosis or cancer is hereby prohibited:

However, like the Medical Practitioners and Dentists Registration Act, the Order contains a clause specifically exempting traditional healers from its provisions. The clause in question occurs in a section regulating the sale of medicines for the treatment of venereal disease.

3. . . . this order shall not apply to--- . . .

(b) the sale to any African of any African medicine, compounded or prepared within Malawi and intended for the prevention, cure or treatment of venereal disease, by an African who is recognized by the community to which he belongs as being competent to treat venereal disease. (1968 Cap. 35:01 sections 2&3)

This passage is clearly contrary to section 56 of the Venereal Diseases laws cited earlier, in much the same way that section 18 of the Medical Practitioners and Dentists Registration Act is at variance with the rest of the Act's provisions. All three laws are ostensibly aimed at legitimizing and regulating Western medicine in Malawi, strengthening its hold on health services, and affording it government support, rather than at advancing the interests of traditional healers. Yet the Pharmacy and Poisons (Control of Patent Medicines) Order, and the Medical Practitioners and Dentists Registration Act, though their chief purpose is to regulate orthodox Western allopathic medicine and give it the franchise to the nation's health care, do both in fact make careful and specific allowance for the practice of traditional medicine. In doing so, they appear to reflect a conscious government policy of passively tolerating the existence of traditional healing, while seeking to avoid any appearance of actively encouraging its use.⁶¹

The laws till now cited provide both explicitly and implicitly

for the practice of traditional healing. The Witchcraft Act, the fourth and last law I shall discuss, was drafted specifically to prohibit certain aspects of traditional healing practice.⁶² It was originally promulgated in 1911, and with minor revisions is still on the books today.⁶³ The Witchcraft Act's prohibition of certain fundamental practices of traditional healing relating to the detection and treatment of complaints allegedly caused by witchcraft, has brought about profound changes in that part of the traditional healing system which deals with troubles attributed to sorcery.

The primary objective of "an Act to deal with Trial by Ordeal, Witchcraft and the use of Charms" (the Witchcraft Act) is to prevent innocent people from being wrongfully accused and punished for actions which, by Western-scientific standards, are impossible for them, or any other mortal for that matter, to have committed. This goal is achieved by banning the various witchfinding ordeals, such as that of fire or boiling water (section 2), and especially the mwabvi or poison ordeal (section 3).⁶⁴ Furthermore, the Witchcraft Act generally forbids witchcraft accusation (section 4) and prohibits the employment of witchfinders (section 5). In addition, the "profession or calling of witchfinder or witchdoctor" is made a crime (section 8). Although, as Justice Southworth noted (African Law Reports, 1968:678), it may be difficult to prove a person to be a "professional" witchfinder,⁶⁵ there is far less difficulty in proving that a person has employed a witchfinder and so violated section 5 of the Act. A chief or headman is by the Act (Section 7) further placed under the obligation of reporting any prohibited ordeals within his jurisdiction to the District Commissioner, with stiff penalties being meted out for non-compliance

"unless he shall prove that as a matter of fact he was justifiably ignorant of such trial or intended trial."⁶⁶

Such harsh regulations were earlier in the century no doubt necessary, and were certainly most effective in their goal of putting an end to the use of these ordeals. But they imposed, and continue to impose, a considerable psychological burden on the men charged with their enforcement. Gluckman, writing on the role of village headmen in British Central Africa, which includes present-day Malawi, remarked that:

"The difficulties of the headman's position are enormously aggravated in the modern political system. In the past he and his followers . . . held a common set of values. They do not accept the values of the dominant modern authorities to-day. . . . As he applies these unwelcome and unaccepted rules, his position becomes subject to still greater strains." (1949:93)⁶⁷

The enactment of the Witchcraft Act illustrates this difference in values. "As he [the village headman] applies these unwelcome and unaccepted rules, his position becomes subject to still greater strains." (Gluckman, 1949:94)⁶⁸

Among my informants, several of the headmen and chiefs who were the authors of letters to nchimi (diviners) remarked in some way on the legality of what they had done. Six of seven headmen and chiefs asked, stated that the writing of such letters was illegal, and one headman stated that letters dealing with suspected murder by sorcery need to be stamped by the chief. In reality, any letter written to solicit the employment of a witchfinder is contrary to section 5 of the Witchcraft Act. Several of these men stated that if an nchimi named a person as a witch, the accused would be forced to leave the village. Yet such forcible exile due to witchcraft accusation seems to contravene section

4 of the Witchcraft Act, and most likely is in violation of other statutes as well. Nevertheless, it seems clear that such punishment is on occasion still meted out, especially if it has the support of the village as a whole in collective support of the headman's decision.

Later, I quote a letter written by a headman to an nchimi in which he writes that he is aware that his action of sending a man accused of witchcraft to an nchimi is illegal, and that he fears that the accused had reported him to the authorities. It seems obvious that such referrals, which are common, are known to be illegal by all concerned, and yet, since they are the reflection of the collective will and belief, the practice continues and is seldom reported to the authorities.⁶⁹

Rather than being seen by the public as a benefit to society, these provisions of the Witchcraft Act are generally perceived as aiding and abetting sorcerers and hindering those who would punish their evil-doing. Many informants have stated that the imposition of this law was a significant factor responsible for the present-day increase of witchcraft. Debenham writes that: "When we punish a witch doctor for finding a witch we run entirely counter to their way of looking at the matter; we have punished the wrong man, and their sense of justice is deeply injured." (Debenham, 1955:170)

In the eyes of most people, who believe in the potency of witchcraft, the Witchcraft Act, although generally viewed with disfavor, possesses two saving graces. The first of these is that it forbids persons openly to represent themselves as capable of practicing witchcraft or wizardry (section 6. Unfortunately, this prohibition

seems to have effected little if any reduction in witchcraft suspicion and accusation.⁷⁰ The second provision of the Act that is presumably regarded with approbation is section 9, which prohibits the use of "any lot or charm with a view to the commission of any unlawful act." While this wording makes any attempts at witchfinding illegal and is thus construed as being on the side of the forces of evil, its positive aspect is that it facilitates the prosecution of verbal threats of witchcraft.⁷¹

The drafters of the Witchcraft Act presumably denied the existence of witchcraft in it's Evans-Pritchardian sense, but were well acquainted with attempts to practice sorcery, and so prohibited the pretence of wizardry or witchcraft (section 6) as well as the use of charms intended for the commission of unlawful acts (section 9). The inhabitants of what was then Nyasaland and is now Malawi for the most part still believe in the reality of witchcraft as a cause of disease and death, and of social and economic misfortune. As Justice Cram wrote in his 1967 decision in an appeal case involving the use of mwabvi which resulted in the deaths of four people: (The African Law Reports, 4, 1968:255)

Persons living in a traditional African culture, for whom modern education has just begun to be a reality, have a view of the world which is pre-scientific. They commit acts, logical within the framework of their understanding of natural processes, but which the general criminal law, embodying a totally different comprehension of scientific truth, characterises as criminal. Witchcraft and magic are tenable hypotheses to explain an adverse and sometimes terrifying environment in the absence of modern science, biology and medicine. Indigenous African beliefs, as in every continent before the advent of the scientific era, find supernatural explanations for the events of their world.

The drafters of the laws regulating traditional healing

practice have for the most part recognized and allowed for indigenous beliefs, but have of necessity drawn the line of toleration at those two practices--the mwabvi and other ordeals, and witchcraft accusation--that are not only socially disruptive, but result in injury and death to innocent parties. The law is still somewhat ahead of its time, insofar as its acceptance by the masses is concerned, but is generally effective as a deterrent, and as a tool for effecting, albeit slowly, changes in practice and, even more slowly, of belief.

¹Unless otherwise attributed, all population statistics are derived from the Malawi Statistical Yearbook, 1978, published by Malawi's National Statistical Office in 1979.

²This synopsis of the complex Bantu migrations is taken from Professor Pachai's two books (1972 and 1973) and from Pike's (1968) book.

³The use of the term 'present' refers to the period during which I was conducting my fieldwork, i.e. the 1970's.

⁴The only exceptions being a few Muslims in the area near Karonga on the lakeshore.

⁵See Kurian (1982), and Williams (1978), for more details of Malawi's political situation.

⁶Kurian (1982:1125), assigns a "Physical Quality of Life Index" to Malawi of 31, which was up from 29 in 1976. The index is based "on an ascending scale in which 100 is the maximum," with the United States having a rating of 95.

⁷Such problems include inadequate food for a family at home through loss of an able bodied man's agricultural labor; venereal disease contracted from prostitutes in towns and later spread to a man's wife or wives on his return home; and adultery (by both man and wife) with its various physical and social repercussions, among them witchcraft accusations and what are thought to be sanctions by the ancestral spirits. (Minick, 1976)

⁸By "Western belief system" I mean those features of Western thinking which have to do with causality and the interpretation of events and have been adopted by the residents of northeastern Malawi. Western religion, namely Christianity in its various denominations, and Western science are the main features of the Western belief system that enter into my discussion, but there are numerous other facets of transplanted Western culture which have impinged upon and transformed traditional concepts of causality, especially with regard to illness causation and treatment.

⁹Messenger writes that among the Anang and Ibibio of Nigeria, Lutheran statistics indicate that some fifty percent of the population have been converted to Christianity, although only some ten percent were considered "true believers." (Messenger, 1970:221) I have heard similar ratios spoken of by Malawian churchmen.

¹⁰An illustration of Christian belief in the supernatural is provided by this dream by a middle-aged housewife. She dreamt she was pounding cassava in a mortar to make flour and was bothered by a neighbor's chicken. She flung her pestle at it and it died. She then threw it in a pit-latrine to hide it.

I saw a lady standing by the mortar. She was a middle aged woman. She wore white robes and was smiling at me. I was spell-bound for a moment, because the woman seemed strange to me; and the other reason was that I had a

guilty conscience, I thought she had seen me killing that chicken. The woman said to me: "Daughter, why is it that you have done such a thing? Look at this." She showed me a book and slowly opened it. Then she pointed at my name which was written at the top of that page and said: "Look! If you had not killed that chicken your page would have been spotless. But now . . ." She shook her head, then she said: "Go buy a chicken and give it back to your neighbor. Tell her that you killed her chicken and that you beg for forgiveness. Then your page will be spotless." The mortar was not there anymore, neither the pestle nor the flour. I rubbed my eyes and discovered that I was awake!

The white robes of the woman and the book tallying the dreamers sins are evidently drawn from Christian iconography.

¹¹ Within the borders of northeastern Malawi there were only two of three sources of books, all of them small branches of a mission agency and stocking religious texts and tracts almost exclusively. The country as a whole had at the time of my visits only a handful of bookshops, all located in large population centers. The one closest to the northeast was located in Mzuzu, some forty miles by road from the southern limits of the northeast.

¹² Davis, in his review article "Secrets of the Mormons" (1985:16), writes that

Recent students of Christian and Jewish history have shown that sublime conceptions of divinity were long intermixed with folk magic and cabalistic arts. It was Enlightenment rationalism, Bushman emphasizes, "with its deathly aversion to superstition," that leached official Protestantism of any respect for the miraculous except for the miracles that ceased with Christ's Apostles. As the mainline churches disdainfully dismissed witchcraft, visions, healing, and speaking in tongues, the occult was driven underground or lived on among plain farmers and mechanics who thirsted for some living contact with the supernatural.

Joseph Smith grew up within a rural culture that still combined magic with an unquestioning faith in the Bible as the revealed word of God.

The rural peasantry that constitutes virtually all of the population of northeastern Malawi shares with Joseph Smith and his contemporaries these two varieties of belief, magical and religious. Just as the "clergy" of the early Mormon church believed in the supernatural, as do most of today's Malawian clergy, and virtually all lay adherents to Christianity.

¹³ A Malawian science educator with extensive teaching experience at all levels writes that:

Generally superstitions are part and parcel of all that some Malawians know of the world. Those who should know better however tend to regard "superstitions" as a negative and negligible entity; at the same time one experiences disgust at reports of events in which diverse

excuses are used to embrace superstitions. For example, one hears of a fellow beaten up here for delaying the season's rains, another one there charged with administering drugs to remove witchcraft, still another suspended from his church because he consulted a witchdoctor. Furthermore, our knowledge of what is lawful and what is not is mostly a hotch-potch that we tend to lose ourselves [in] whenever we try to probe the field of superstitions. Despite all this, educationalists ought to lead, and unravel a great deal. . . . The problem of superstitions is regarded here as a non-negligible part of the problems of Malawi education. (Kumbikano, 1968:72)

¹⁴Malone, in his analysis of Weber's concept of magic, points out that the "'disenchantment of the world' and its concomitant rationalization, is by no means a uniform process." (Malone, 1980:6) Weber himself observes that "'the peasants' dependence on nature as a force in their daily existence is conducive to belief in magic.'" (Malone, 1980:7)

¹⁵In 1979 I saw the signs of a sacrifice to ancestral spirits, and interviewed the elderly man, Mr. Kajoroweka, who supervised the ritual, called kusopa viwanda or praying to the spirits. This ritual was called forth by his son's illness some months earlier, when the son dreamt that his grandfather, Kajoroweka's father, requested that he be given beer and meat. Kajoroweka was ill at that time, and postponed the ritual for some months, but finally got round to it, as according to belief, failure to do so could have caused a sudden death in the village. A calf was brought forward. First medicine called viwanda, or "spirits," was rubbed on it, then, while the calf standing, it was killed by chopping its neck from above with an axe. No special incantations were uttered. The calf was skinned and eviscerated, and more of the viwanda medicine, made from the leaves of the kawingawazimu tree, was rubbed over the inside of the carcass. The meat was then divided among Mr. Kajoroweka's six sons, whose wives first boiled it and then cooked it in any way desired. Other folk from the villages nearby attended. The slaughter took place on a Friday, and the meat was boiled then, but it was not eaten till Saturday at noon. The reason for this was to enable the viwanda to come during the night and lick the blood of the meat and drink some of the beer that has been brewed. These were set out in the following way: Meat and beer were placed in a hut and a mixture of maize and millet was spread on the floor for the viwanda to eat. In the morning, when the people saw that these offerings had been taken by the spirits, they knew that the viwanda have accepted their prayer. The ritual was held at a nearby waterfalls, as the spirits were believed to be found there, manifesting themselves as phantom people, goats, chickens, and also as clothes, beads, plates, and other inanimate objects. They were believed to disappear upon one's approach, and to reappear as one retreated.

Mr. Kajoroweka also states that vipiri or higher spirits (Kauta, 1969), which are intermediary between the ancestral spirits and God, inhabit the waterfalls. If twins go near the falls, the vipiri will detain them, awaiting the presentation of some article, such as a white chicken or dove, a white cloth, white beads, or silver coins.

Such relations with the viwanda, and more especially with the vipiri, are rare, and are rapidly dying out with the passing of elders such as Mr. Kajoroweka.

¹⁶Most of today's Northern Region has a population density today of less than 50 per square mile, with a few areas, principally along the lakeshore, of up to 200 per square mile. (Malawi Department of Surveys, Map 1, "Density of Population," 1976)

¹⁷See Minick (1976) for a treatment of this topic among the Cewa of contemporary Malawi and Zambia, and Retief (1940:315), who deals with it as it relates to the Ngoni.

¹⁸Stuart wrote that: "As the Chewa mfiti is dependent upon aids such as horns, gourds, or spells, and so consciously controls his activities, he is a sorcerer rather than a witch." (Stuart, R.G. 1972:3) Gelfand, notes that "The Mashona look upon the muroyi, or witch, as a person endowed with the power to manipulate the forces of Nature to the detriment of mankind, but they do not believe they have witchcraft substance in their bodies . . ." (Gelfand, 1965:43) Gelfand describes Mashona witches as being possessed by an evil spirit, an explanation I am not familiar with in Malawi, but as in Malawi, Mashona sorcerers use medicines of various sorts to effect their evil ends.. (Gelfand, 1965:45-6) Mair cites several Central African societies in which Evans-Pritchard's formal type of witchcraft does not exist, and where sorcery involving the use of medicines is the norm, often with the sorcerer being motivated by some evil spirit. (Mair, 1969:21-2)

¹⁹Other authors suggest definitions of witchcraft somewhat at variance with that of Evans-Pritchard, and there would seem to be a kind of continuum of supernatural evil-doing which encompasses both sorcery and witchcraft. Middleton and Winter define a sorcerer as:

one who is thought to practice evil magic against others. The acts themselves are usually of such a nature that they can be performed by anyone. . . . By contrast the power of witchcraft is a mystical and innate power, which can be used by its possessor to harm other people. Often it is thought that the witch need merely wish to harm his victim and his witchcraft then does this, or it may be enough for him merely to feel annoyance or jealousy against someone for the power to set itself in operation without his being aware of the fact that it has done so.

(Middleton and Winter, 1963:3)

Harwood, using Middleton and Winter's definitions of sorcery and witchcraft for his study of the Safwa people of southern Tanzania, some fifty miles north of Malawi, observed that the Safwa believed in both sorcery and witchcraft. (Harwood, 1970) He attempted to ascertain what social variables were associated with each of the two, and suggested that further research in this area is needed.

Mair suggests simply "that the sorcerer uses material objects and the witch does not" (Mair, 1969:23), whereas, while Mbiti states that in anthropological and sociological usage, "witches . . . are people with an inherent power by means of which they can abandon their bodies at night and go to . . . 'eat away' the life of their victims."

(Mbiti, 1969:202) In Malawi, witches are commonly believed to leave their corporeal selves and travel to their victims, whom they choke, suffocate by sitting on their chests, or otherwise torment, as I have described elsewhere in this work. The use of the seketera or witchkiller is based on this belief, since the witch that the seketera overpowers at his late victim's gravesite is commonly thought to be but a phantasm, with his corporeal self remaining asleep at home. This power of transformation would seem to be a manifestation of witchcraft, according to Mbiti's criteria, if the witch accomplished the transformation by some means inherent to his person. The term "inherent" may be a thorny one to define, and I suspect that most Malawians believe that such necromancy is accomplished by means of some sort of nyanga in the form of a medicine or charm. Even if such witches were to obtain their powers of transformation from evil spirits, one might still argue that their power was not inherent in them, as it is in that Azande witch, with his mangu or witchcraft-substance being inherently a part of his anatomy, and over which he has no control. (Evans-Pritchard, 1937:9) It is perhaps this last-mentioned unconscious and uncontrollable penchant for evil-doing that best differentiates witches from sorcerers. Defined in this way, witchcraft can confidently be said not to exist in northeastern Malawi.

²⁰ Marwick offers "five criteria for distinguishing between beliefs concerning the sorcerer and the witch:"

1. The sorcerer uses magic to perpetuate his evil deeds; whereas the witch is effective by having a special type of personality.
2. People who are sorcerers are conscious of their actions and deliberate in their intentions; whereas those who are witches may not know of the evil life they lead after normal waking hours, and, even if they do, may be driven by an uncontrollable urge.
3. The sorcerer may be driven by anger, envy, or malice of a passing kind; whereas the witch has a permanent addiction to his anti-social actions, one that is rooted in heredity or in early conditioning.
4. The actions of the sorcerer, depending as they do on material substances and/or specific verbal magic, are not as baffling to ordinary minds as are the supernatural machinations of the witch.
5. The ethnographer can usually believe that sorcery is attempted (even though he may not accept allegations regarding its prevalence or its effectiveness); whereas he can only dismiss as fantastic the idea that witchcraft is even practiced, let alone that it is effective.
(Marwick, 1965:23-4)

²¹ The following narrative, by a young man, illustrates how a death may be attributed to a witch in a dream.

I dreamt that after my child's death, I was found

at the graveyard, standing at the head of my child's grave. I saw Mr. Kaunda standing on the bottom of my child's grave, and I asked him, "What are you doing here?" He answered, "Nothing." Then I told him: "You are the one who killed my child!" Then I said: "Stupid go away!" then at the same time he disappeared, and I woke up.

It is believed that witches return to the graves of their victims to partake of their flesh for food and for fabricating nyanga or evil charms used for sorcery.

²²Marwick, writing of the Nyanja central and southern Malawi, observed:

The general opinion among Nyanja informants is that witchcraft is on the increase; and they certainly believe that it operates especially in the new situations arising from modern social changes, e.g. in quarrels between mother's brothers and sister's sons over the ownership of cattle bought with wages earned by the latter at the labour centres. The alleged increase in the incidence of witchcraft is attributed, however, to the fact that the mwabvi poison ordeal, which in the old days was regularly applied as a measure of public hygiene has been suppressed by the Europeans. (Marwick, 1950:101-102)

Such beliefs are as widespread today as when Marwick described them thirty odd years ago.

²³Evidence that the belief in sorcery is very deep rooted is its appearance as a recurring theme in people's dreams:

I once dreamt I was in my brother's house. I was all alone. . . . It was late at night. I wasn't afraid as I went to sleep, until I heard a racket. This sound came from the roof. I started shivering. . . . Then I heard clearly something moving on the roof. There was no doubt it had been sent by a witch. I listened more, then heard clearly the hooting of an owl. Then I knew I was right [in believing it to be a familiar sent by a witch].

Sorcerers are commonly believed to dispatch out their familiars at night, and such familiars often are alleged to move about the thatch roof of the victim's house. Here is another dream with a similar theme:

I dreamt I was sleeping in my home. I woke up because of the noise made by an owl on top of the house. When I woke up I saw shadows of two people. One looked as if it were a man, and the other like a woman. Being afraid I covered my face with the blanket. Just after covering my face I felt something sitting on top of me. I tried to cry out, but I couldn't shout. Then I tried to light a match but it couldn't light. Then after sometime I was being uncovered and the shadows started speaking: "You were the one who said you don't believe in witches. Now have a look, we are here." Hearing this I started to shiver, I was afraid. And then I woke up.

Once again an owl-familiar appears on the dreamer's roof. Another standard mode of behavior of witches is illustrated, namely

that of sitting on their victim's chest; in addition witches are often alleged to throttle their victims, as these next dreams narrate.

I dreamt that someone was bewitching me . . . He pressed my neck so hard that I even failed to cry or speak.

The dreamer, a sixteen year old schoolgirl, stated that:

I don't know why I dreamt this dream, but I think it shall really happen because many people are jealous of our family. They say that we are educated. Three of us are at secondary school, and our brother is at work in Blantyre.

The success of this family is evidently grounds for their neighbors being jealous of them, and therefore ensorceling them.

A middle aged woman narrated this "fearsome dream":

I dreamt I was sleeping in my bed. . . . Then suddenly a man came through the [closed] window as if it was open. He had a very big head and very tiny limbs and body. He came towards me, showing his teeth at me. I tried to shout but I failed completely! The man came and put his tiny hands on my throat and started squeezing my throat! I tried to scream and scream, but I failed. Then my husband woke me up demanding the reason why I was screaming.

The dreamer stated that "I think my dream has no meaning, although I have heard some people say that when you dream such kind of dream, then it means that somebody was really pressing your throat, a wizard."

²⁴An example of such a case is provided by Republic v. Lufazema, heard in Malawi's High Court, on May 1st, 1967. Mr. Lufazema admitted killing his "grandfather with an axe while the latter was asleep," claiming that he had "caused many deaths and insanity in the family . . . by occult means, and had indicated that [he] would be the next victim." Justice Bolt, in his opinion, wrote that "I am satisfied that from a moral, as distinct from a legal, standpoint, the accused person did not know that it was wrong to kill his grandfather. Indeed, I would go even further and say that he passionately believed that it was the right thing to do." However, the Justice found for the prosecution, and Lufazema was convicted of murder on the grounds that although "from the moral standpoint, he may not have known that it was wrong to kill this particular man, or that he ought not to do it . . . from the legal standpoint of responsibility . . . he was capable of knowing, I am sure, that it is contrary to law to take another man's life." (The African Law Reports, Vol. 4, 1968:355-70)

²⁵Elsewhere in Africa the ancestral spirits play a more important role as agents of disease, as in the Ghanaian situation described by Sarpong. (1985:4)

²⁶The following excerpts from dreams illustrate both the fear of ghosts and the association of whiteness with them. The first is from an account by a woman:

I dreamt that I and my mother went to Tanzania where we found ourselves at the graveyard; and there we saw many ghosts and they were in white clothes. One ghost came near us and asked, "What are you looking for?" My mother

answered, "We are looking for our grandfather's grave."
 Then all the ghosts disappeared. Then I woke up.
 The second dream was narrated by a teenage boy:
 I dreamt I was moving past my homeland graveyard.
 I felt very frightened and wanted to run, yet I couldn't
 lift my legs, I could not even walk. I just stood there
 trembling. Then I heard a voice from behind. I could not
 understand what it said but I recognized the voice. I
 looked behind. Then I saw a miracle. My uncle was there,
 smiling at me, yet he looked so strange. He was all
 white. I could not see his arms, nor could I see his
 legs. I just saw his face in a mist of white. My uncle
 had died a long time ago. I was scared stiff, yet I could
 not run. Then I woke up.
 In emphasizing the fear of dead relatives rather than joy at meeting
 them again, this second dream is typical.

²⁷ Although Chilivumbo writes that "with very rare exceptions
 the therapy for Mashawe is the Mashawe dance" (1972:6), my observations
 lead me to believe that many, if not most vimbuza patients take some
 form of traditional medication at one time or another during the course
 of their illness career. Some of these folk take their mankhwala for
 years at a time, a practice which makes iatrogenesis likely. Four of
 six patients interviewed by me at Nganga Nyevya had come to him for
 medicine to treat their vimbuza.

²⁸ Kluckhohn notes that many of those Navaho "fainting" or going
 into a "semi-trance" at "squaw dances" are persons "who are somewhat
 neglected or occupy low status." (1967:83-4) He cites Linton's
 analysis of the neurotic seizures called tromba prevalent among the
 Tanala of Madagascar, which Linton views as "a technique for
 re-establishing the ego of an individual and of providing him with a
 means of escape from the limitations and thwartings which the social
 system imposes on him." (Linton, 1939:303-4; cited by Kluckhohn,
 1967:84) Linton's analysis of tromba in Madagascar reveals many other
 similarities between it and the vimbuza of northern Malawi.

²⁹ The belief that vimbuza combats witchcraft lends support to
 my conjecture that the apparent increase in vimbuza since passage of
 the Witchcraft Act is a correlate of the belief, probably on an
 unconscious level, that it confers a kind of partial immunity to the
 effects of witchcraft. The numbers of nchimi have greatly increased
 since the Act abolished the mwabvi ordeal, but nchimi are not believed
 to be as efficacious as mwabvi was, either in ascertaining who is a
 witch or in punishing the witch, and so in acting as a deterrent to
 witchcraft. Without the mwabvi ordeal as a form of social control over
 sorcery, the perceived incidence of sorcery has risen, as have the
 perceived chances that any individual may become a victim of it.
 Perhaps the belief that vimbuza confers some kind of immunity to
 sorcery is a significant underlying reason why so many people
 unconsciously adopt this syndrome, which is reported to occur
 throughout parts of Malawi, Zambia, Zimbabwe, and Mozambique.
 (Chilivumbo, 1972:6) Chilivumbo has written of some of the secondary
 gains conferred on vimbuza sufferers (1972:7), and the Leacocks
 describe various overtly recognized relationships between possessing
 spirits and sorcerers in Brazil. (1972:277-9) I suggest that the

adoption of the role of being vimbuza-possessed is at least in part motivated by fear of witchcraft, and the belief in the folk theory that vimbuza spirits confer some considerable degree of immunity against witchcraft. When one realizes just how central witchcraft belief is to the general folk-etiology of disease, death, and misfortune, in Malawi and elsewhere in East Africa, it seems not unlikely that this hypothesis may have some merit. The hypothesis seems to be a good candidate for testing by various methodologies.

³⁰The Muslims confined their formal educational efforts to promoting literacy in Arabic and the study of the Koran. Such skills may have enhanced their adherents' spiritual well-being, but were of little economic utility.

³¹See Richards, 1935, for an account of Mchape.

³²In the glossary to Nine Malawian Plays (Gibbs ed., 1976:170-1), various words with supernatural and magical meanings are defined, including ancestral spirits, sacred trees, familiars of witches, and the "Ng'anga: A magician or herbalist. The ng'anga was consulted in cases of sickness. In times of drought or persistent illness, he was an important link between ancestral spirits and the community. He was able to discover which of the ancestral spirits had been offended, and what sort of libations had to be offered." [My underlining!] Note that the work of the nganga is described in the past tense, as if the editor either did not know, or did not wish the reader to know, that these practices are still commonplace throughout the country. It is almost as if he is somehow ashamed to admit that such practices do in fact exist today, but are not merely the romantic stuff of plays. As Singano and Roscoe write in their foreward, "There is a danger, however, that even when due significance is given to oral tradition, it will be given the significance only of interesting relics, shards from a scattered past that antiquarians find quaint and uselessly fascinating, pieces to dream on because they conjure nostalgic images of a former life." (1974:7) I suspect that, in many instances, these nostalgic images are of the authors' former life, before he left his rural home for secondary school, higher education, and employment in the world of the Malawian elite. Certainly any Malawian of rural origin, and most of urban origin as well, would grant that these beliefs are far from extinct, that, indeed, they flourish nationwide and are nurtured, rather than inhibited, by literature such as that cited in this chapter.

³³Chilivumbo writes that:

In the vimbuza dance, there are no passive spectators. In the process of dancing both the dancers and the spectators get emotionally, physically and mentally involved in the dance as the night wears on and the actions increase in intensity and emotional excitement. (1972:8)

I have noticed the same audience involvement myself; and as the spectators include children, from infants on their mother's back to children of school age and beyond, vimbuza dances are loci for the acquisition of belief in the supernatural etiology and treatment of disease.

³⁴I use the word "random" insofar as it indicates the chance occurrence

of some phenomenon, "at haphazard, without aim or purpose or principle, heedlessly;" (C.O.D. 1976:922) in particular as it applies to the cause of misfortune or illness. We all know that misfortune and illness has antecedents that can be traced up to a certain point. Beyond that point we ascribe the event to chance, saying that it occurred at random. For example, we know that malaria is caused by a protozoan parasite, and transmitted by mosquito bite from one person to another. Assume that two Westerners are travelling together through mosquito-infested and malarious country, (northeastern Malawi for example), and both take the same precautions against contracting the disease. Let us further suppose that one of the two contracts the disease, while his companion does not. We would say that it was a case of the random distribution and biting patterns of mosquitoes. Malawians might say that the victim was bewitched.

³⁵ The discussion of traditional medicine and healers is a part of the health education syllabus of standard 7, and is quoted below in its entirety, to show that those responsible for health education are cognizant of the problems raised by traditional medicine.

PUBLIC HEALTH EDUCATION

One of the most painful battles the health centre has to fight is against prejudice and superstition. Too many of the patients who come for treatment do not return for follow-up treatment because they do not trust the medicine that is given to them and they do not understand why they must return several times before the medicine can work well. They go to the village doctor, but he does not have the modern medicines found at the government dispensaries and neither has he the understanding of the ways in which infection can be prevented nor the best ways of giving his medicine. So very often the village doctor makes the sick person worse.

The following are some examples:

(a) Some of the herbs (roots and leaves) which a good village doctor uses, although not as effective as modern medicines, can help a sick person, but unfortunately the village doctor gives medicines to drink in dirty glasses or he mixes them with dirty tools.

(b) He tries to give injections using dirty needles.

(c) The size of the dose of medicine and the frequency with which it should be given needs great thought and care. Some village doctors are very clever in diagnosing what is wrong with sick people and they are very clever at choosing the right herb to help them; but they spoil the good work they could do and they put the sick person in danger because they do not understand the importance of choosing the right size of dose and knowing the number of times it should be given - sometimes medicine should be taken once a day for a week or more, sometimes it should be taken 3 times a day for 2 days.

Activity

Pupils discuss the difference between the good herbalist doctor in the village and the doctor who encourages superstition and deals in "witchcraft". Let the pupils be guided into realising that there is in fact a great difference. Some sickness does start in the mind, e.g.

(a) when we are frightened we may get a bad stomach ache.

(b) when we are unhappy we may get a bad headache.

Help the student to realise that sickness cannot be caused by other people's bad thoughts or by "Spirits". Superstition of this kind causes many deaths and great fear. Educated boys and girls have a responsibility to set their people free from superstition and fear. The teacher should emphasize again the importance of personal responsibility for our own physical and mental well being and also for that of those around us. If any pupils know of good herb medicines their parents know, to cure stomach ache or headache, discuss these and write them in their notebooks. (Malawi Ministry of Education, 1971:127-8)

³⁶One elderly woman interviewed about vimbuza, cited a Biblical parallel: on the other side of Lake Galilee, evil spirits entered a man who then met Jesus, who cast the evil spirits into pigs which went into the lake and drowned. This narrative is evidently taken from Luke 8, "Casting Out Demons," and is an excellent illustration of how Christianity in practice serves to reinforce indigenous belief in the supernatural etiology of disease. The woman likened the beating of drums and violent dancing of those possessed by vimbuza to Jesus' exorcism of the evil spirits.

³⁷What is commonly referred to as Western medicine might perhaps better be described as universal or scientific medicine. Minsky, arguing for the feasibility of communicating with extraterrestrials, reasons that "all intelligent problem solvers are subject to the same ultimate constraints." "Because arithmetic is based on universal truths, alien mathematics will be congruent with our own." (Kirwan, 1985:62; Kirwan paraphrasing Minsky) In a similar vein, human anatomy and physiology are universal to men and women of all nations. In fact, there are enough similarities between man and lower forms of life to make such forms useful models for pharmacological research and development. Gropper notes that "all men belong to a single species and, therefore, . . . share a number of common characteristics, including behavioral and psychological traits." (1967:2)

As a result of its having been brought to an advanced state of development in the West, scientific medicine has been dubbed Western medicine. Western or scientific medicine is, however, geographically bounded neither in its development nor in its application. On the contrary, it is the manifold traditional or indigenous systems of medicine that are parochial and lack universal applicability, largely as a consequence of their having been created in pre-scientific, and generally pre-literate contexts. (Parsons, 1951:432; Bozeman, 1976:75)

Gropper has observed that "anthropologists were biased in favor of Western medicine and . . . this prejudice has colored their research results." (1967:3) I must myself confess to possessing such a bias, insofar as I perceive Western medicine to be the system most congruent with my own perceived reality, and with the reality of those whose opinion I respect, as well as possessing the most universal demonstrated effectiveness. To what extent, if any, this bias has colored my findings I leave the reader to judge.

³⁸ The National Seminar on Primary Health Care, held in Lilongwe in 1978, stressed the importance of cooperation between the Western and traditional health sectors. Dr. Otoo of the World Health Organization, in his report on Health Manpower in Malawi, noted that "after over a century of taunts and contempt, modern medical practice now turns to exploit the paraphernalia and personnel of traditional practice as the best means of effectively and cheaply extending the outreach of health care in African rural communities, because some dictates of healthful living can best be preached and practiced by local leaders." (Otoo, 1978:92)

³⁹ There is a considerable amount of iatrogenesis in Malawi associated with the use of traditional medicine, most of which goes unreported, but which makes members of the Western medical establishment think twice about integrating traditional healers into a unified health-care system. Chimango wrote that of the blinded under-five population that he surveyed, "Most of them [the patients or their kinsman or nganga treating them] applied traditional medicine, [to the eye] which induced a superimposed chemical reaction resulting in a total melting of the cornea." (Chimango, 1977:4) He further noted that the "incidence of 34 cases [of blindness] per 100,000 children is still 10 times higher than it should be. In our estimation, the main causes responsible for the present situation are the still widely used instillations of traditional medicine for the treatment of ocular infections, and the seeking of modern medicine at a very late and advanced stage of the disease." (Chimango, 1977:6) Phillips (1959) writes of the damage done by traditional eye medications in Northern Rhodesia (Zambia); and Robertson states that "In both children and adults, the use of local mankhwala (African medicine) causes severe damage and scarring of the eyes. THIS IS A MAJOR CAUSE OF BLINDNESS IN MALAWI." (Malawi Ministry of Health, 1969:77)

Bullough wrote of the relationship between home deliveries by traditional midwives and the high incidence of cases of ruptured uterus and vesico-vaginal fistula, concluding that "Such cases occur almost without exception in patients who have attempted home delivery." (Bullough, 1979:9) Bierdrager et.al. noted that "there is a high rate of accidents from both traffic and industry, as well as from traditional causes, e.g. the caustic effects of native medicine on the bowels. . . . A large number of cases of proved cancer of the cervix are known to have been associated with the local application of native concoctions which may have a bearing on the aetiology of the pathology. This is certainly an area worth looking into urgently." The authors went on to note the dangers inherent in the "application of ointments and caustic material to the eyes by relatives and native doctors. This problem is widespread all over the country and some intensive health education is needed to remove this hazard." (World

Health Organization, 1972:75-6) Weck made similar observations while working among the Hehe in southern Tanganyika at the turn of the century. He wrote that

The dry powder [of pounded roots] . . . is mixed with spit and painted on the eyes with a hens feather. Abscesses of the cornea with inflammation of the iris and discharge in the front chamber of the eye are always treated in order to bring out the mtoto wa jicho (the child of the eye). In fact, extensive destruction of the cornea and prolapse of the iris soon follow. (Redmayne, 1969:34)

⁴⁰ Trotter reports cases of lead poisoning among Mexican-Americans as a result of the use of lead tetroxide and lead oxide as internal medicine for empacho, a form of indigestion. (Trotter, 1985:64)

⁴¹ In 1977, there were a total of 3,248 maternity beds in Malawi, and 6,369 other hospital beds. Of this total, 1,590 maternity beds, or 49 percent, and 2,730 hospital beds, or 43 percent, were in PHAM facilities. (Malawi Statistical Yearbook 1978, 1979:25)

⁴² Fees levied by mission hospitals were of a token nature, and did not begin to cover the actual cost of service to patients. The public was blissfully unaware of this, however, and tended to berate the missions for making profit from people's misfortunes. At Livingstonia Mission Hospital, some representative fees in 1978 were: 5t (1 Tambala = 1.2 cents U.S.) for one month's registration as an outpatient; 50t inpatient admission for first week of hospitalization, then 5t per day, plus treatment charges; 50t to see doctor without prior OPD referral. The fee for dilatation and curettage with tubal insufflation was K2.00 (1 Kwacha = \$1.20); exploratory laparotomy or hydrocele repair, K2.00; for a major operation, K4.50; for a blood transfusion, K1.50 per bottle; for penicillin injection, K1.00 per course; for intravenous fluids, 75t per liter; for X-rays, K2.00 per 14"x17" film.

⁴³ In Malawi, the criteria for admitting a person as an inpatient vary somewhat from general Western practice; Many patients are admitted who are not very sick, but who live at a considerable distance from the hospital, have no nearby medical facility near them, and must take medication regularly under supervision or have dressings changed under relatively aseptic conditions. In many instances, Western patients suffering from similar complaints would be seen as outpatient, being judged capable of changing their own dressings and of taking their prescribed medication at appointed intervals. In Malawi there are many folk who do not fully share western concepts of cleanliness or of time, and/or who lack clocks and clean conditions for changing dressings. Such persons would be treated as outpatients in the West, but must be hospitalized in Malawi. In addition, due to inadequate transportation and communication facilities, persons suffering from complaints which might suddenly take a turn for the worse are admitted, since it would be difficult or impossible for them to get to a hospital in the event of a medical emergency. This is particularly true of women soon to give birth, who frequently come to the hospital several days to a week or more early in order to ensure that they will give birth at the hospital.

⁴⁴The health education syllabus for standard 7 states that "people are afraid to give their blood because they think they will die." (Malawi Ministry of Education, 1971:128)

⁴⁵Gish's comments about the use of mobile clinics in Tanzania are equally applicable to neighboring Malawi. He noted that expensive four-wheel-drive motor vehicles "are often too expensive for typical health ministry budgets to support" (1975:129), and that "the inefficient ways in which the vehicles are utilised constitute at least as great a problem as their limited number." (1975:130) Transport most certainly is needed, but generally needs to be used more rationally.

⁴⁶Cunningham, working in Thailand, noted that "physicians usually have urban . . . aspirations even before their training which reinforces these aspirations." (1970:5) This certainly seems to be true for Malawi, and, I suspect, for the world in general, as witness the shortage of doctors in many rural areas of the United States.

⁴⁷In 1977 there were a total of 848 under-fives clinics in operation throughout Malawi. The 33 such clinics in Karonga District and the 41 in Rumphi District had respective total attendances of 54,274 and 35,000. (Note how these figures reflect the sparse pattern of settlement of Rumphi District.) During the same period, there were a total of 196,000 new antenatal attendances at maternity units nationwide, and 649,213 subsequent attendances. Of these Karonga District had 3,244 / 14,319 and Rumphi District 3,574 / 10,782. The total number of maternity deliveries nationwide during 1977 was 124,378, with 127,183 children born. That same year, 110,987 expectant mothers had attended at an antenatal clinic. The corresponding figures for Karonga District were 2,428 women delivered, of whom 2,175 had antenatal attention; and for Rumphi District, 2,699 deliveries, of which 2,670 had attended antenatal clinics. (Malawi National Statistical Office, 1978:30-33)

⁴⁸Adair and Deuschle (1970:24-28) make similar observations with regard to the qualifications of doctors serving on Navajo Indian reservations in the American southwest.

⁴⁹Sentiments such as these have been expressed to me about officialdom in general. The former British administration is perceived as having been impartial in dispensing jobs, justice, medical care, and access to education. Since their departure, there has been some perceived lessening of this impartiality. (Williams, 1978)

⁵⁰§Of the hundred-odd common medical complaints covered in Robertson's handbook, fully eighty of them may necessitate referral to a hospital. (Robertson, 1969)

⁵¹Winter mentions a medical assistant who " had stayed for 15 years in succession at Dwambazi dispensary, sometimes without any visit from the District Hospital [Medical Officer] for 3 years." (Winter, 1972:112) This instance may be extreme, but there is relatively little effective supervision of, and communication with, those in charge of remote health units.

⁵²McNeil writes that "Tablets or mixtures can be spit out, vomitted or not taken at all. If you send a patient home with tablets or a mixture, he may lose it, sell it, or only take part of the required dose." (McNeil, 1973:14)

⁵³The following is an inventory of the various medicines in a small African owned shop in Rumph District:

- Sejeso-Idhliso: phenolphthalein-type laxative.
- Phillips Tablets: milk of magnesia.
- Phillips Milk of Magnesia: antacid, laxative.
- Andrews Liver Salt: laxative, upset stomach.
- Vinlax: phenolphthalein-type laxative.
- Dysentone: anti-diarrheal, antacid.
- Digestif Rennie Tablets: antacid, anti-flatulent.
- Diopect: diarrhoea mixture.
- Phensic: aspirin compound for colds, headache, flu.
- Aspirin B.P.: Cafenol: flavored aspirin for children.
- Cafenol: aspirin and caffeine compound.
- Aspro: aspirin for pain, fever, colds, flu, and rheumatic pains.
- Iodoform Dusting Powder: for wounds.
- Chloroquine Phosphate B.P.: anti-malarial.
- Mepacrine Hydrochloride: anti-malarial.
- Vaseline Petroleum Jelly: keeps skin soft, burns, minor cuts, etc.
- Sloans Liniment: relieves aches and pains.
- Amrutanjan Pain Balm: headache, stiff joints, coughs, glandular swellings.
- Vest Nice Rub: "Vicks"-like compound, for a variety of complaints.
- Phillips Gripe Medicine: for infants and young children.
- Good Morning Lung Tonic: a remedy for coughs.
- Hacks Cough Drops: cough remedy.
- Feluna Pills: iron tonic for "maiden, mother, and matron."
- Sex-Ul Pills: yohimbine containing potency enhancer.
- Super Tabs: for rheumatism, backache, stomach, blood, and kidney.

⁵⁴The Health Education Syllabus discusses the misuse of patent and non-prescription medications sold over-the-counter. (Malawi Ministry of Education, 1971:128)

⁵⁵An instance of this misuse of patent medication is given by a medical asistant: "I have seen more than three children brought to our hospital, convulsing or unconscious." The children had been suffering from fever, and their parents had given them Cafenol, a form of aspirin, for symptomatic relief, not realizing that the fever was caused by malaria. "Unfortunately, the children were brought to the hospital too late." In each instance, the child died. (Chongwe, 1976:24-5)

The health-education syllabus asks teachers to "discuss the dangers of using these drugs [patent medications], . . . [and] emphasize that when a person is sick enough to need medicine, he is sick enough to need a doctor's help and advice. (Malawi Ministry of Education, 1971:128)

Bonner (1984:18-9) describes the allied problem of the unscrupulous promotion of ethical drugs in Africa, where many preparations available only on prescription in the West are sold over-the-counter.

⁵⁶One example of such a case was Nyaluwe, an elderly woman living next door to a well-known nganga whose patients I happened to be interviewing. A patient directed me to Nyaluwe's hut, where I found her lying on a mat on the floor, apparently moribund. I was loathe to leave her die there, and suggested to the kin who comprised her "therapy management group" (Janzen, 1978:63) that I take her to the nearest hospital, offering to pay fees. There was heated debate, and at first they refused. Seeing the various pots of mankhwala about, which had been provided for her by her neighbor the nganga, I said that there would be no problem in their bringing it along to the hospital with her, so that she could take both kinds of medicine. At this suggestion they suddenly broke into smiles, and assented to her going with me to the hospital, stating that a helper would carry a pot of mankhwala to her on the morrow. At the hospital she was diagnosed as suffering from heart failure, was prescribed digitalis, and proceeded to make a good recovery.

⁵⁷The following dream, by a 17 year old female secondary school student who was an inpatient at a mission hospital in Mzuzu, the largest town in the Northern Region illustrates such a sequential use of both medical systems:

I was sleeping in a bed in the hospital. I then dreamt I was going for a walk after the afternoon treatment. I took a short cut in order to avoid meeting people; so I walked on a lonely footpath, when all of a sudden right ahead of me appeared a man from nowhere. I wasn't a bit afraid. I proceeded with the same step. Then as I came nearer to him I started to recognise him. He was a nchimi quite familiar [to me]. Then he addressed me. I then started being frightened. He said to me in a low sad voice. "Oh! our girl, why [are you] wasting your time in the hospital? You will never get well [there]. Go and collect your things and come to my house. I will treat you. Someone bewitched you." I ran back to the hospital and packed my things. Just as I was leaving I met the doctor, and he scolded and cursed me for leaving without his approval. I was very angry when I started running to the nchimi's house, for the doctor had really hurt me. The dreamer further stated that she dreamt this "because I had to go and see a nchimi because the disease had been caused by a wizard." "After I woke the following morning a nchimi came to the hospital and told me he would cure the disease; although it was a different nchimi, not the one in the dream."

⁵⁸Mr. Kwiba is a retired medical assistant living about a mile from a hospital. According to one informant, he sees up to five men, women, and children a day, treating them for illness rather than for injury. Treatment is administered at his home, in contrast to the house calls made by the Thai "injection doctors" described by Cunningham. (1970:9) His main treatment consists of injections, and my informant, a secondary school graduate, (naively) thinks that the penicillin injections he dispenses are obtained from the government. The doctor at the hospital thinks that at least some of Mr. Kwiba's supply has in fact "walked" out of the hospital drug store. On one occasion, I was approached by Mr. Soyo, a neighbor of Mr. Kwiba's, who

asked me if I could obtain some penicillin injection from the hospital that Mr. Kwiba could administer to Mr. Soyo's mother. In a related incident, a small boy from the same village was bitten by a snake and carried to the hospital, which happened to be out of antivenin. Mr. Soyo heard of this, and came to the boy's bedside bearing a long-outdated ampoule of antivenom. It was evident that it had been obtained surreptitiously, and it was to his credit that he dared to bring it to the hospital. Needless to say, no questions were asked. The boy recovered uneventfully without the antivenin.

⁵⁹ Establishing the fate of defaulters is not as easy as it might seem. Winter writes: "The only major snag was, that--although absconders were clearly identified--it was hard to trace them back: They often lived up to 60 km away from the hospital and could only be reached over small bush tracks that were too hilly for bicycles, and motorbicycles are not available." (1972:133) He further notes that "If a patient wanted to use traditional medicines, he was--like all other patients--free to do so." (1972:134) One tragic example of such a defaulter who resorted in desperation to traditional healing, was Ruth, an 18-year-old girl blinded as a sequela of tuberculosis. Against the doctor's wishes, she left the hospital where she was undergoing treatment for her infection and resorted to an nchimi some twenty miles distant, with her grandmother as her guardian. She had a month's supply of antibiotic tablets from the hospital, but was not taking them. The woman nchimi told me that the doctor had failed, and that the disease was due to evil spirits or viombo. Ruth stated that she had been given a blood transfusion at the hospital, but that the donor's father was not informed at the time. When he heard that his son had donated blood to Ruth, he became angry, she said, and bewitched her. Despite the fact that the girl was blind, was in pain from her eye infection, had a swollen face and eyes constantly tearing, suffered from headache, had pains in her thighs, and had been amenorrheic for seven months, she and her grandmother both stated that her treatment at the nchimi was the best possible, and refused to return to the hospital even when I volunteered to pay her expenses and fees. She was having traditional medicine instilled into her eyes, which although permanently blinded, were further damaged by this treatment.

⁶⁰ It is interesting to speculate why African healers were allowed to try their hand at compounding medicines and treating venereal diseases, but were not specifically allowed, and therefore presumably were prohibited, from treating "sexual disorders or impotence, tuberculosis or cancer." All of these conditions are, in fact, on occasion treated by some traditional healers. To my knowledge, no traditional healers have been prosecuted for treating cases of cancer or tuberculosis. The difficulties of enforcing such a law are of course, many, not the least being the problem of how the healer is to know that he or she is dealing with a case of cancer or tuberculosis.

⁶¹ Although there has been some mention by government officials of the present and potential value of traditional healers, it has been largely token. Government's only serious attempt to draw on the traditional health sector has been with traditional birthing attendants as described by Bullough. (1978:81, 1979:9)

⁶²Consult the appendix for a complete copy of the Witchcraft Act. See Crawford (1967:appendix II) for a copy of its Rhodesian counterpart, the Witchcraft Suppression Act.

⁶³There were, and in many instances still are, counterparts to Malawi's Witchcraft Act in various other former British African colonies and protectorates. Tanganyika (Tanzania) had its Witchcraft Ordinance promulgated on 28 December, 1928, (and it is still in effect). Rhodesia's (Zimbabwe's) Witchcraft Suppression Act dates from 18th August, 1899. Detailed analyses of its impact can be found in Crawford (1967) and in Mittlebeeler, (1976). Bechuanaland, (Botswana) had a Witchcraft Proclamation enacted on 29th April, 1927. Sierra Leone has a somewhat similar Fangay Ordinance dating from 24th May, 1905.

⁶⁴The mwabvi, or poison ordeal, consisted of administering a decoction of the bark of the mwabvi tree to those suspected of sorcery, as well as other crimes, such as theft and adultery. If innocent, the accused would vomit up the poison, but if guilty of sorcery, he or she would retain the poison and die. Lieban cites a similar practice from the Philippines, where the sorcerers are commonly for hire and function in a manner reminiscent of the nchimi and the mwabvi ordeal combined. "In this system of justice, trial and punishment are one; the death of the victim establishes his guilt." (Lieban, 1967:39) The poison is most frequently derived from the bark of a tree, *Erythrophleum guineense*, which contains cardiac glucosides. (Githens, 1949:26) The ordeal has in Malawi largely been eliminated by enforcement of the Witchcraft Act, but continues to be secretly practiced on such surrogates as chickens and dogs. The mwabvi ordeal was common throughout Malawi, Moggridge (1902:467) describing its use in the vicinity of Blantyre; Werner (1906:171) stating it is used throughout the Shire Highlands; Elmslie (1899:62) describing its use amongst the Ngoni of what was then the northern part of British Central Africa; and Wilson mentioning its use among the neighboring Nyakyusa. (1963:115-16; 1971:21) Marwick reports that mwabvi-drinking "still occurs--in great secrecy--as a family (i.e. matrilineage) affair, especially when an accusation of sorcery or witchcraft is countered by a challenge that all possible suspects, including very often the accuser, should submit to the ordeal" (Marwick, 1963:45)

⁶⁵Justice Southworth, in his decision in *Petros v. Reginam*, High Court December 12th, 1958 (The African Law Reports, Vol. I, 1968:678-81) wrote that "There is no definition in the Witchcraft Ordinance . . . either of 'Witchcraft', 'witchfinding', 'calling' or 'profession.' . . . and the court is accordingly obliged to interpret these terms in their normal meaning. It is clear that the terms 'calling' and 'profession' connote an habitual exercise of some occupation or skill. The court is unable to take the view that, when a single act of witchfinding is established, this is sufficient to constitute an offense within the meaning of s.8 of the Witchcraft Ordinance."

⁶⁶Browne, in discussing the similar provisions of the Northern Rhodesian (Zambian) Ordinance of 1914, notes that this "provision presuming guilt . . . unless the accused [headman] can prove to the contrary [is] an unusual feature in English law." (Browne, 1935:482)

⁶⁷ Crawford, in describing the Rhodesian situation, made similar observations, writing that: "A chief is in a somewhat ambiguous position in that his people see him as representing the tribe in its relations with the Government, while the Government sees him as representing it in its relations with the people. There is clearly, on occasion, a conflict of interests."

⁶⁸ In the late 1970's I interviewed numerous chiefs and headmen in northeastern Malawi, especially those who had written to the several nchimi who had granted me access to their correspondence. One chief made the following remarks (in English) about the relationships between chiefs, their subjects, healers, and witches, remarks which clearly illustrate the which was created in the chief's role.

Chief- "The village headman or a chief, they are the people who live in mankhwala. That is why they want nchimi to be their helper. It means every chief cannot live without some mankhwala in his body; to guard his body against witchcraft. People are too jealous. So once he becomes a chief, he wants those mankhwala to guard his body so that if a witchcraft comes he should be prevented."

APW- "So then, when you took on that job you were having to be very brave, because you were also exposed to this danger?"

Chief- "Yes."

APW- "Then the smart thing to do then will be to get this mankhwala?"

Chief- "Yes. There are two mankhwalas . . . Mbozga, this mbozga means if someone has put his mankhwala, dangerous mankhwala, in this place, if you take mbozga, it means that mankhwala [nyanga] will finish. . . . So there is another mankhwala. That other mankhwala they use to cut the body, you see? Kutema sawu [administer medicine through small cuts in the skin] So that mankhwala should go inside the body. That mankhwala is kukhomerwa. Kukhomerwa means that you have now become very strong. . . . Sometimes we get them [kukhomerwa] from nchimi, sometimes we get them [from] nganga. . . . Some nchimi do not know this mankhwala of kukhomerwa." . . .

"The second way [that nchimi help chiefs] is that, sometimes, you can be witched. Eh! You are suffering. Then you don't know what you are suffering from. Then you can go to nchimi. I am not well. I am suffering, I am feeling pain all over my body. I don't know what is the cause.

Then the nchimi go deep, trying and trying, and he says: 'Oh! yes, I have seen that you are not well of course. There was someone one day did this and this to bewitch you. That is why you are not well at present.' So it needs mankhwala to cure that thing which some person did for you."

In addition to having to deal with their own vulnerable positions, insofar as they themselves are the objects of sorcery, chiefs and headmen must aid those subjects of theirs who suspect themselves to be bewitched.

APW- "I think it is true that many nchimi's, if people are coming to them with disputes or with diseases that they think might be due to witchcraft, then they are needing a letter from the headman or chief so that the nchimi can tell them what is wrong. . . ."

Chief- "This is the habit of all nchimis because they are afraid. Eh, their fear is that, nchimi can tell out that: 'Oh! I have seen that it was someone who did this.' And there are some people who will say, 'Ah! that man. Oh I am going to beat him now. I am going to beat him.' So, this is what they are afraid of. So they want letter from the chief, so that if anything happened, they should simply say, 'Yes, I was authorised by the chief to do this, yes. And what I was telling is true..' This is why they are afraid. They want a letter from the chief. Yes."

APW- "Now, many of the chiefs and headmen are asking the nchimi to write back . . . so that when these people have been searched, then the chief can know what the truth is, what the nchimi has found."

Chief- "This is what they used to do. But, another time came when the government did not want this business. They said it was not right for a person to go to nchimi, no. If anyone wants to go, he can simply go himself, and ask for help, rather than asking for any letter from the chief. That he should carry a letter from the chief, no, that's not good. If anyone wants to go, he can go himself and ask for a help. He will be given mankhwala, that is all. This is what the government said."

APW- "Would it be true to say that as far as dealing with ulowe, catching fwiti, the nchimi's are not of as much use as mwabvi?

Chief- Yes.

APW- If we could have one system or the other today, which would be the better system for most people; the nchimi system that we have today, or the old mwabvi system?"

Chief- "The old mwabvi system was more best because if really you have done something, [practiced sorcery] [and] you are simply refusing . . . you die."

APW- [Paraphrased] Many years ago, during the reign of your predecessor, "do you know the names of any of the nchimis he was using?"

Chief- "By that time, he was using by these ngangas, big ngangas. Because big ngangas used to take mankhwala. But this chief [took mankhwala] so that no one should bewitch him. And we could not do mwabvi."

APW- "Then how would they be finding out who was the fwiti? Were there nchimi at that time?"

Chief- "No, they were doing this with some nganga's. There were some ngangas [who] also were trying with their magic ways."

APW- "What about in the time of Chikanga in the early 1960's; were there many people from here going to Chikanga?

Chief- "Yes, there were very very many people going to Chikanga. At that time, every village headman used to tell his people that 'now it is our time to go. Everyone should go to Chikanga, everyone. If anyone doesn't go to Chikanga, it means it is he who is a fwiti. If you know that you are not mfwiti, well go to Chikanga. It is Chikanga who is going to tell that: 'This man is not a fwiti, this man is not a fwiti, this man is nearly fwiti.'"

Another documented instance of role strain among village headmen is the case of *The Republic v. Donald Gausi*, heard in the Northern Regional Traditional Court in 1973 and reported in Chimango (1974). The accused, a village headman, invited a witchfinder to his village to explain the cause of several deaths. There were 72 people present at this inquest. An absent villager was accused of having caused the deaths by sorcery, and while the witchfinder looked for the evil charms the accused had presumably employed, the police were summoned. It seems evident from the record that the villagers as well as the headman thought that they were doing the right thing by calling in a witchfinder. However, the members of the court, several of whom were chiefs themselves, held, or rather voiced a contrary opinion. They wrote in their decision that

Here the court holds the view that the action taken by the village headman Donald Gausi was a dangerous one because that would lead to his villages destruction after some of his villagers were called wizards.

It is our tradition to call a witch doctor to a village for administering medicines just for the general treatment for cleaning the village, but not to say a witchfinder should say who are the wizards in the village.

This last paragraph is an excellent example of the distinction between what Gross (1964:966) terms ideal and real behavior. "The ideal values [such as those setting limits to the use of witchfinders] represent the norm which the society sets for an individual or group as norms which ought to be observed." Certainly many Malawians in positions of responsibility might subscribe to this curb on the nchimi's actions. However, most persons, including those who officially prohibit nchimi from naming witches, desire nchimi to divulge the names of any witches they have found. As Gross observes, "The real values are those which are actually followed in everyday life, which can be empirically identified in behavioral patterns." I think that the evidence presented in the present work will amply demonstrate just what the real values of Malawians are when the issue is one involving witchcraft.

⁶⁹ Another instance of a crime committed by a collectivity was related to me at second hand. A village headman had died suddenly, and his death was believed due to witchcraft. The alleged witch was killed by the villagers, and buried before the authorities could investigate. The secret was so well kept that no investigation was ever made. Peacock described a similar case, in which a witchfinder divined the

person "responsible" for a series of deaths of children, and the villagers tied her to a post without food or drink, and passersby struck her, till she eventually died. Although members of another tribe brought the case to the attention of the authorities, "on the arrival of the police all the natives were dumb." (1929:122-3)

⁷⁰In early 1984, a man working as a driver at Livingstonia mission had an argument with a female student at the mission secondary school concerning a long-outstanding debt that he owed the girl's parents. An excerpted copy of a court transcript (Northern Regional Traditional Court, 1974, Criminal Case No. 12, The Republic vs. N.Y.M.) in my possession states that the driver said that "I am going to send bees at your boarding house [dormitory] or else I will put medicine on the entrance of the building and anyone entering there will run mad." This threat resulted in twenty-five girls and one boy exhibiting symptoms of mental disturbance. The symptoms which were treated at the local mission hospital, and were collectively diagnosed as an instance of mass hysteria precipitated by the driver's threat. The driver was charged with two infractions, the first of "Intimidation, contrary to section 88(1)(A) of the Penal Code," and the second of "Pretending Witchcraft, contrary to Section 6 of the Witchcraft Act." He was found guilty on both counts and was sentenced to prison.

⁷¹The Concise Oxford Dictionary defines a charm as a "word(s), act, or object supposedly having occult power, spell . . ." (C.O.D., 1976:167)

CHAPTER II

TRADITIONAL HEALING AS AN OCCUPATION

The traditional health care system of northeastern Malawi has a long history, having evolved in conjunction with the indigenous religio-supernatural belief system and consequently being ideologically congruent with it. It has however accommodated itself to many of the newly introduced aspects of western religion, education, science, and medicine. Somewhat surprisingly, and certainly not intentionally, on many planes there seems little fundamental conflict between the introduced medical and religious systems and the indigenous ones; and people continue to use both, either in series, or in concert.¹ Although initially indigenous healing was the unchallenged source of health care, it nowadays shares the field with western medicine, which has assumed the primary responsibility for dealing with acute medical and surgical emergencies, mainly because it is, as well as is perceived as being, far more effective at dealing with these problems than is its indigenous counterpart.²

The indigenous medical system is, however, far from moribund, and "the traditional healer is an integral part of the community," (Kapapa, 1979:1) frequently patronized for minor ailments, serious chronic illness, and for the host of complaints of a social and psychological origin that western medicine is either unable or unwilling to deal with.³

There are several types of traditional healer practicing in northeastern Malawi. Their functions overlap to some degree, and the

extent of their practices varies enormously, from those who treat an occasional relative, to full time practitioners with extensive in-patient facilities.

Types of Healers

The Nganga or Herbalist

The most ubiquitous type of traditional healer in northeastern Malawi is the nganga, the word usually being translated as doctor throughout this part of Africa, (Gelfand, 1961:46; Sanderson, 1954:202; Turner, 1952:197) and is in fact used in that general way, just as the word 'doctor' in the west is used to encompass a broad spectrum of healers from pathologists to psychiatrists. The archetypical doctor whom we think of is, or was, the general practitioner, a species rapidly becoming extinct or perhaps rather evolving into the latter day family practitioner.⁴ The nganga is the analog of our primary care physician and is a traditional healer practicing herbal medicine. He or she provides primary care for a broad spectrum of troubles, prescribing and compounding not only remedies for such complaints as stomach-ache, burns, and snakebite, but also preventive charms and amulets to ward off whooping cough or to ensure steady growth of a child. In addition, nganga also supply charms to ensure success at soccer, to conceal adultery, and for protecting a freshly interred corpse from the depredations of witches. (Retief, 1940:319; Young, 1932) The nganga's divinatory powers are limited, and so nganga can only treat complaints due to witchcraft in a symptomatic fashion.⁵

The practice of traditional medicine is intimately associated with traditional religious and supernatural beliefs, and traditional

healers of all types must deal with various supernaturally induced complaints, not least of which is witchcraft. Since they are so intimately acquainted with the sorcerer's wiles, it is widely believed that nganga may on occasion provide evil charms or nyanga to clients wishing to bewitch some enemy, and indeed such charms are dispensed by some unscrupulous nganga. Such nganga, however, seem to be in a small minority.

Nganga are many and are widespread, so that one is usually to be found in one's own or in a neighboring village. Nganga are normally consulted in person by clientele who live nearby. It is unusual for nganga to be patronized by strangers living more than a few miles distant. Village headmen consult nganga for their own personal troubles but do not refer others to them. Both as a consequence of their localized practice, as well as by their non-involvement in sorcery disputes, nganga generally seem to receive little correspondence of a professional nature.

Virtually all nganga are part time practitioners; that is they spend only a part, usually a small part, of their working day engaged in providing health care, and consequently only a part of their income is derived from their practice. However, considering the small income of most Malawians, the earnings derived from a healer's practice may be relatively great, although quantitatively modest.

Most nganga treat outpatients only, a reflection of their localized practice. Their treatment facilities at most consist of a separate room or corner of their house in which they may consult with patients and store prepared medicines. More frequently mankhwala,

which consists largely of tree roots and other botanical material, is heaped along one side of their house, under the eaves; and patients are seen on the porch or in the shade of a nearby tree.

Many nganga charge for their services, and virtually all will accept a 'thanks' in kind or in cash from a grateful client. Although some nganga give treatment free of charge, most levy a small fee or expect the client to present a gift such as a fowl. The efficacy of a medicine or charm is often perceived as being directly related to its cost, and people are willing to pay what to them are considerable sums for a nganga's services.

Ordinary gardening implements, such as hoe, axe and brush hook, are used by the nganga to collect medicinal plants; and the equally common mortar and pestle or quern may be used in preparing powdered medicine. This apparatus is common to all households and is not specialized or peculiar in any way to nganga. Any specialized equipment that the nganga may possess is confined to certain containers for mankhwala made of gourds or horns and to divination apparatus or oracles, of which there are several kinds; however individual nganga normally restrict themselves to the use of only one or two such devices.⁶

In addition to these divinatory devices or oracles, nganga also make use of another device, the tail-switch or tchoba, which is the de facto symbol of the magical powers possessed by nganga (and nchimi as well). These tail-switches are in use throughout Malawi and in Zimbabwe, (Gelfand, 1967) Kenya and Uganda (Sanderson, 1955:39)⁷

Since most nganga treat outpatients only, they need no

inpatient housing. Their clientele is almost exclusively a local one, save in such cases where a patient coming from a distance may either commute by bus or reside with a nearby relative. I have, however, encountered one nganga in northeastern Malawi (Nganga Tyapula) who regularly keeps from twenty to forty inpatients. He has several buildings used exclusively to accommodate patients, a cook-shed capable of accommodating forty hearths, several pit latrines, bath enclosures, a special shed for storing and preparing mankhwala, and a small consulting room built into one of the patient hostels. His inpatients come from distances of fifty miles and more, and he sees an even greater number of outpatients who come from nearby.

Both inpatients and outpatients receive essentially the same treatment, and just as in America the doctor may prescribe over the telephone, in Malawi the nganga may provide a remedy to some relative of the patient who has come to fetch mankhwala on behalf of his or her sick relative, or on occasion, in response to a request in writing from some distant client working far to the south in a city such as Lilongwe, Blantyre, Salisbury (now Harare) or Johannesburg.

Nganga may be called upon to supply a 'doctor's note,' just as their western counterparts do. Here is an example of one, which is especially interesting since the patient's father was himself a medical assistant in charge of a small rural hospital.

Dear Teacher,

Timothy stayed with me for a very long time [he was out of school for three weeks.] because he had a very bad snake bite. Therefore, I, his doctor, personally give testimony to that young Mhone's illness. And, I had a lot of problems getting him well.

Isaac Mpofwa Chinunka

Nganga

There are several avenues to becoming a nganga. One method is to acquire the knowledge from a relative, usually a parent, and gradually take over the practice as he or she relinquishes it due to advancing age. Alternatively, a person sufficiently motivated may apprentice himself to an experienced nganga. This apprenticeship may require the payment of substantial fees to the preceptor, for such knowledge is the means of his or her livelihood and is not to be parted with for naught. The apprentice begins by aiding the nganga in collecting the roots, barks, and other raw materials of the ethnopharmacopoeia.⁹ At first the apprentice mostly digs, chops and pounds, while keeping an observant eye on his or her mentor's ministrations to patients. This instruction is mostly informal, practical, and highly variable in both quality and quantity, taking from several months to several years until the apprentice has acquired sufficient knowledge to set up his or her own practice.

Perhaps the most common avenue nowadays to becoming a nganga is by means of some form of divine revelation, which may be from God or from some intermediary, such as an ancestral spirit, and which comes to the individual in a dream. Such revelation or dream seems often be precipitated by the illness of a relative, in which case it is revealed to the dreamer what root to dig in order to effect a cure.¹⁰ Once such a dream occurs and the treatment it suggests proves successful, word of mouth takes over and the lay referral network incorporates the new nganga into its panel of recommended healers. Further dreams suggesting other treatments serve to enlarge the new nganga's repertoire. Some nganga continue to treat patients on the basis of

their dreams, but on the whole this practice is more peculiar to nchimi.

The knowledge base on which the nganga's treatment rests varies greatly, as there are no formal qualifications necessary, nor examinations to pass in order to enter the profession. There is no traditional medical literature, the nearest thing to it being those ethnopharmacopoeia compiled by some nganga and nchimi (Young, 1932:229) and on occasion by laymen.¹¹ Such compilations are invariably in manuscript form and are strictly for the use of their authors and close associates or immediate family. They are secrets which are seldom shared, so that any merit that they might possess is not disseminated to the healing community at large. Traditional knowledge of human internal anatomy is extremely rudimentary; and "as far as physiology is concerned they are even more vague about the functions of the internal organs than about their location and structure." (Retief, 1940:313) There is however a sizeable corpus of knowledge relating to herbal pharmacy, but virtually no true understanding of pharmacodynamics. The following excerpt from Fabrega is applicable to the Malawian situation:

The medical knowledge of lay subjects in certain folk or nonliterate settings, thus, may not differ on a group basis from that of healers and medical practitioners. Beliefs about the cause and treatment of illness are simply shared among the members of the culture. (Fabrega, 1974:37)

Fabrega contrasts this case with that of western medicine, with its extensive corpus of knowledge which is not shared with laymen. The western doctor's prestige is in large part a function of his technical knowledge, whereas "in folk settings. [such as Malawi] it appears that the role of the healer (his social and spiritual validation, as it

were) and his charisma are what give him and his actions credibility and stamp him as unique to the culture." (Fabrega, 1974:37)

Diagnosis may be made in a number of ways. It may be furnished by the patient himself, as is often the case with the nganga who practice in the few public markets in this area and whose function is primarily that of compounder and dispenser of mankhwala, rather than diagnostician.¹² Patients or clients may relate their complaints to the nganga and request a remedy for it, or they may simply request the mankhwala which is known to be specific for the complaint, but which they are unable or unwilling to dig up and prepare themselves.

There are also patients of nganga who cannot equate their symptoms with any particular disease entity, and who do not know what remedy is applicable to their condition, nor how to administer it. Such clients require that the nganga make a diagnosis and prescribe a remedy, usually in the form of mankhwala. Nganga may accomplish this in several ways: by dreaming of the patient's trouble during sleep, by experience in treating similar cases, by the use of divination apparatus, or by some combination of these techniques.

The results of the nganga's diagnosis are imparted to the patient with varying degrees of clarity, as here in the United States, a patient may have but a hazy notion of the doctor's findings. In the Western setting this is (ideally), more likely to be the result of inadequate communication between doctor and patient, rather than to the doctors failure to adequately diagnose the case. In the traditional African setting, it seems likely that the patients being kept in the dark is not due merely to lack of communication, but to the fundamental

lack of understanding by the healer of the underlying etiology of the patient's complaint, as well as by lack of effective pharmacological treatment. Another possible impediment to communication between healer and patient is the authoritarian nature of the relationship and its similarity to the authoritarian nature of the family in northeastern Malawi. Patients may be no more likely to press healers for detailed explanations than they are to demand explanations from their parents. This respect for authority is general, and those perceived as being socially superior are generally deferred to. Kleinman noted such deference towards western doctors in Taiwan.¹³ (1980:302) He also mentioned that patients are more likely to follow the prescriptions of healers they regard with awe and fear, such as shamans, than the advice of those healers having inferior social status. "As a consequence, their interpretations are treated as less authoritative, sometimes questioned, and not infrequently discarded in favor of readings of the fortune by healers of higher status." (Kleinman, 1980:246) Waitzkin observes that "information control may reinforce stratification in doctor-patient relationships," as "one person's ignorance is often the basis of another's power." (Waitzkin, 1985:82-3) This seems likely to be as true in Malawi as in America. Waitzkin maintains that, by keeping the patient in the dark as to the prognosis and therapeutic efficacy, the healer enhances his own power.

Of the three basic models of the healer-patient relationship as described by Szasz and Hollender, (Bloom, 1965:40-1) that of activity-passivity is rarely used in its strict sense, as persons with acute medical or surgical emergencies are not taken to traditional healers, but are virtually always brought to a western medical

facility. The guidance-cooperation model is the most common one in Malawi, although the degree of cooperation is generally limited to the patient's taking his prescribed medicine at regular intervals. At the other end of the spectrum, the mutual participation model is also little used, as most chronic complaints are treated simply by the administration of medicine, although the healer may prescribe the avoidance not only of certain foods but of some social interactions as well. Perhaps the most common form of traditional healer-patient relationship involving mutual participation is the vimbuza dancing ritual, where the "patient" or possessed person, actively dances and sings under the supervision of the healer in order to placate the possessing spirits and secure temporary relief from their machinations.

Various forms of treatment are administered, perhaps the most common being a decoction of various roots, prepared by cutting them into finger sized pieces, which are put into a clay pot, covered with water, and boiled. The prescription of but a single ingredient is uncommon, and polypharmacy¹⁴ is the rule, with half a dozen or more ingredients, mostly botanicals, entering into a typical preparation, although medications containing but a single ingredient are dispensed by nganga, as well as being prepared by laymen for their own use. Frequently a kind of catalyst or potentiating agent called a chizimba is added to the pot of mankhwala in a minute amount, in order to enhance its efficacy. These vizimba, (plural), may take the form of a bit of python skin, a cross shaped daub of red ochre inside the bottom of the pot, or a piece torn from an old Federation of Rhodesia and Nyasaland one pound note, to name but a few. (Sanderson, 1955:46)¹⁵

When the roots have had the "goodness" boiled out of them, they are carefully disposed of. In many cases this means returning them to the nganga who prepared them, who dumps them in a discrete pile somewhere on his premises. It is believed that to simply throw out the spent mankhwala would be disrespectful to the nganga and might result in a diminution of its efficacy as a cure. This is no doubt a reflection of the supernatural powers believed to reside within both the medicine itself, as well as within the healer, a concept which is further illustrated by the powers attributed to the vizimba.

A pot of mankhwala may be used from a week to a month or more, with inpatients usually taking their medicine thrice daily. At breakfast, around six in the morning, the pot of mankhwala is boiled, and the liquor is mixed with enough maize or cassava flour to make a thin gruel, bara, which is the usual breakfast in these parts. At noontime and at suppertime (six p.m.), the same procedure is followed, but the decoction is then either drunk by itself or incorporated into sima, the stodgy dough-like staple dish of Malawi, which is usually eaten with a relish of vegetables, fish, or meat.

There are numerous other ways in which mankhwala may be administered. It may be infused into the ear and eye¹⁶ or placed in the rectum or vagina. It may be ingested as a pill or powder or incorporated into a cigarette and the smoke inhaled. The vapors from a pot of boiling medicine may be inhaled. One of the most characteristic avenues of administration is that of cutting the medicine into the patient. Here, carbonized¹⁷ and pulverized mankhwala, usually mixed with a vegetable oil, is rubbed into small superficial cuts made in the skin over the affected area. This results in a series of small

cicatrices which mark the individual for life, providing a sort of permanent, portable, medical history, which can be read by any future healer consulted, traditional or western. Such scars are frequently visible on patients examined at hospitals and dispensaries, oft times so recent that they still bear adherent scabs.¹⁸ It is believed that the medicine enters the body through the cuts, which are referred to in English as "African injections." This method of drug administration is regarded as particularly efficacious and is doubtless in large part responsible for the generally high esteem accorded to the hypodermic injection of western medication,¹⁹ which is recognized as being but a superior version of the traditional method.

There is some specialization of function among nganga, although most are generalists. Surgery is virtually unknown, although rumor has it that it was at one time practiced in such forms as bone setting and wound treatment. This is one aspect of healing which has become the exclusive province of western medicine, in part because of the paucity of indigenous surgical techniques, and mainly, I suspect, to the unequivocal and highly visible success of western-style surgical intervention.²⁰ Some nganga do specialize in particular complaints, snakebite being perhaps the most common, while other's expertise is restricted to the provision of but a single type of mankhwala, such as that used for ritually cleansing the possessions of a dead person so that the surviving relatives can use them without running mad.²¹ Such practitioners are not really doctors according to our conception of the word but do fall under the broader rubric of nganga.²²

The Nchimi or Diviner-Witchdoctor

An nchimi²³ is a man or woman who is adept at divination using only his or her own powers, powers which are universally regarded as emanating either directly from God, or through his intermediaries, the nchimi's ancestral spirits, as contrasted to nganga, who must rely on some form of divination apparatus. Nchimi are not as common as nganga, and as a consequence, they tend to keep inpatients, as clients often must travel considerable distances to consult them. Nchimi tend to see more patients at second hand than nganga; that is to say, patients who have previously consulted a healer, usually a nganga, who has been unable to help them, and so have had to seek treatment elsewhere. Nchimi are especially adept at treating cases of witchcraft, which is often diagnosed as the underlying cause of an illness or other trouble. Suspicion that witchcraft may be at the root of some trouble often arises, when conventional treatment, such as that provided by a nganga, or by a western medical facility, fails to effect a cure. Nchimi are also consulted directly, thus serving as primary care healers, especially when witchcraft is suspected from the outset, when divination is obviously required, as in the case of missing or stolen articles, or when the nchimi happens to be the nearest healer available.

Since nchimi tend to specialize in dealing with witchcraft-related complaints, and since certain of the procedures they employ are at least technically illegal, they frequently require that any prospective client be provided with a letter from his or her village headman or chief, tacitly authorizing the nchimi to perform his technically illegal function of witchfinding. Nganga virtually never receive such letters. These aspects of the nchimi's relationship with

village headmen are dealt with in more detail later in this section.

The nchimi has the same facilities as the nganga, save that, if inpatients are kept, quarters for them are provided. Areas for the storage, preparation and distribution of mankhwala are set aside, as well as in some cases an area for the disposal of spent mankhwala.

Unlike the solitary nganga of my experience who keeps inpatients and has a communal cooking facility, and of western hospitals which provide similar communal cookhouses, patients at all nchimi whom I have visited cook individually at their own quarters. Instead of the communal cook shed, the nucleus of the nchimi's hospital village is the temple or church, typically the largest building of the village, which is used for public divination and healing services.

Inpatients commonly spend from several weeks to several months at an nchimi, and sojourns of over a year are met with on occasion.²⁴ As at other medical facilities, both traditional and western, inpatients are normally accompanied by a helper or guardian, usually a woman relative, who cooks for and otherwise assists the patient. Most nchimi provide separate huts for each patient and his or her helpers, such accommodation usually being built by patients, and refurbished as necessary by subsequent occupants. Newly arrived patients at an nchimi with a burgeoning practice, may have to sleep outdoors until they can construct their own hut.²⁵

Besides erecting and maintaining the various buildings at the nchimi's, patients may cultivate the nchimi's gardens, or if long term patients may even plant their own. Many long term patients weave mats, make baskets or clay pots, or seek part-time employment as agricultural

laborers in neighboring villages in order to support themselves. However most patients simply idle away the time dozing or chatting with their fellows. Many patients purchase their food locally, while others have relatives bring it from home or perhaps have a kinsman living in the vicinity provision them. There is a certain amount of mutual aid between patients, and gifts of food and firewood may be rendered to a fellow inmate who is indigent or without a helper. The healer may on occasion extend charity to such patients.

Those traditional healers of northeastern Malawi who keep large numbers of inpatients, which in practice means certain nchimi and a solitary nganga, have their patients organized to manage and maintain the hospital compound. Patient captains are selected, sometimes one for men and one for women, who supervise the compound's sanitation, receive new patients, and organize healing services in the temple. One nchimi had prominently posted in his temple a list of rules summarizing patient responsibilities and the role of his patient assistants or kapitaos.²⁶ This nchimi had a committee of long term patients who helped organize his compound and who selected the foreman or kapitao.

There is only one path to becoming an nchimi as opposed to the several alternatives open to prospective nganga. In brief, one must be possessed by certain spirits, wanusi, who confer the divinatory and healing powers on those they possess. Although ordinary spirit possession by vimbuza spirits is quite common in northeastern Malawi, with perhaps a quarter of the adult populace having suffered its effects at one time or another, only a small number of persons are afflicted with this 'nchimi disease.'

The initial state of spirit possession results in a disease called wanusi, or vyanusi, which may exhibit a multiplicity of symptoms, thus rendering its diagnosis difficult, save to an nchimi. There are, however, two classic symptoms which even the layman associates with vyanusi; these are the sufferer's "running into the bush," where he or she lives like an animal for some days, and the "death" and "resurrection"²⁷ of the possessed. By the time such advanced symptoms appear, the patient is well on the way to becoming an nchimi. Ultimately an nchimi is found who can correctly diagnose and manage the complaint and, if the sufferer decides to acquiesce to the demands of the wanusi that he or she become an nchimi, he or she becomes an acolyte of the nchimi he is being treated by, assisting him, and gradually being socialized into the role of nchimi, at which juncture he or she undergoes the chilopa ritual²⁸ and so formally becomes an nchimi.

The nchimi possesses virtually the same knowledge of herbal medicine as the nganga, compounding and prescribing similar sorts of mankhwala; in fact nganga on occasion evolve into nchimi although nchimi do not devolve into nganga. The nchimi's knowledge of disease processes other than those caused by sorcery is no greater than that of their nganga colleagues, although nchimis' understanding of traditional etiological concepts is reputedly deeper. Nchimi's reputations rest on their ability to perform divination in order to ascertain who is bewitching a patient and why and in their power to cleanse a person of his or her penchant for necromancy. In addition, less serious, but nevertheless important problems are brought to them for divination. The following quotations are illustrative of the range of divinatory

services sought from nchimi.

Malawi Rifles
Zomba

Dear Father [Nchimi] Vwamba,

. . . I am very thankful for what you did for me the days I stayed with you there. Now the medicine that you gave me, can we drink both of us, I and my wife? How about that news which you said that "you have to come with your wife." It is when you are going to say all. Can you not say now in side the letter? . . .

I have said this because I want to know how the sickness has come into my house. Even if I have started working I do not feel well. . . .

I don't have much to say. Greet . . . all the patients at the hospital.

Thank you father. I am waiting for the reply from you. Please tell me the cause of my sickness. . . .

I end, I am your Child.

Mavunika J.N. Sambo

Mr. Sambo asks Nchimi Vwamba to explain why he is sick. Apparently the nchimi had asked him to return with his wife for further divination, but he is unable to do so. Instead he requests that the information be posted to him, which presupposes that some further divination of his trouble would be performed in his absence. Furthermore he asks if the medicine given him by the nchimi can be used by his wife as well.

Most divination is performed in the presence of the person soliciting it. In the following letter, the person seeking enlightenment is travelling from some fifty miles inside of Zambia, necessitating a road journey of some two hundred miles in order to consult the nchimi.

Dear [Nchimi] Vwamba,

If you are well, it can be fine. With me I am quite well. What you said is understood and I have sent that person Sichali whom his granary caught fire with [the] food completely destroyed. He doesn't know [why] his house caught fire and he asks you if you [can] divine].

V.H. Saulos Chinsali

It was evidently quite important for Mr. Sichali to ascertain why his granary burnt down, or he would not have undertaken such a lengthy journey. It is also indicative of Nchimi Wamba's considerable reputation as a diviner, as is this next letter, in which the author requests a more conventional healing oriented divination.

Nchimi Wamba,

I hereby send Pachunga Msiska and his son Songwani Msiska to you because of their illness. They have visited many hospitals in Zambia as well as at Ekwendeni [in Malawi] and they have failed. That is why they have decided to come over there so that you may tell them how their sickness came to be. . . .

Yours,
Chief Pulikana

It is evident that divination is fundamental to the nchimi's role. Lacking adequate anatomical and physiological knowledge, illness is perforce diagnosed by divination; as are the causes of many social and economic troubles "discover[ed] by inspiration, magic, intuition, or guessing..." (O.C.D., 1976:302) It is logical that troubles thought to be supernaturally induced should be diagnosed by divination, and it is generally recognized that western medicine's scientific methods of diagnosis are largely unable to ascertain the ultimate cause of one's illness. When the causes of non-medical troubles need to be known, there is little competing with divination save for the Church, which runs a distant second.²⁹ Since material taken from lost or stolen personal effects may be used by a fwiti to fabricate nyanga capable of

ensorceling their erstwhile owner, such thefts are regarded much more seriously than their mere economic loss suggests. Furthermore, since incomes are so low, the difficulty of replacing goods is relatively great, and considerable pains may be gone to in order to locate missing items.

Mr. Vwamba Nchimi,

I send that Mary Mhango, She has something to say to you about the lost cloth which she used for carrying her baby. So she needs to know the person who carried it. I've nothing more to say but try to help her.

Yours,
G.V.H. Pulikana

Nchimi Vwamba lived almost sixty miles distant, and the bus fare would have cost more than the value of the lost cloth. It is therefore quite likely that the concern was not for the intrinsic value of the cloth but over its possible use by a sorcerer. It is worth remarking that exactly one year later a similar case of a stolen child's cloth was brought to this same headman. During the course of that year, Nchimi Lipuka, who lives but five miles distant from the headman, had risen to public notice as a successful healer and diviner, and so G.V.H. Pulikana was able to refer this second mother to a more conveniently located troubleshooter.

Many cases of lost or stolen articles have no connection with sorcery but are nevertheless brought to an nchimi in the hope that he can locate them when more conventional methods have failed.

V.H. Chirikizga

Sir! [Nchimi Vwamba],

It is me [the] above, my cow is lost and I looked for it for two months but it is not found. So I have faith

in you that you will tell me where it is. Please tell me Doctor!

I am sending my young brother to hear everything from you.

Yours faithfully, V.H.
Chirikizga

The headman states his faith in the nchimi's divinatory ability, and hopefully such faith did not go unrewarded, although two months is a long time for a footloose cow! Let us hope that the author of this next letter did not wait as long before consulting the nchimi as did his predecessor.

Dear Nchimi Vwamba,

I am sending this boy to you. His blankets are stolen and all clothes. Will you help him in the name of God by finding the person who has taken them in his absence.

Yours faithfully,
G.V.H. Mwenibori

This case originated some fifty miles distant from Nchimi Vwamba, who was unlikely to have had any knowledge of it prior to this letter carried by the unfortunate boy. It seems unlikely that he could have been of much assistance; yet people continue to resort to diviners in such cases, despite their poor track record.

The next case is the only letter to mention the theft of money. It originated on Likoma Island in Lake Malawi, a possession of Malawi only five miles off the coast of Mozambique and some forty miles from the Malawi mainland. It is some 150 miles by ship to Nchimi Vwamba, and yet the case was referred to him.

Likoma Island

Complaint

Dear Sir [Nchimi Vwamba],

(1) In peace I tell you that my boy, Mr. J. Ngoni, has come there to complain because his money has been stolen.

(2) He has also come to you so that you tell him about his troubles.

I finish writing with respect.

I am
V.H. Wumba

The victim has been referred to this distant nchimi for a number of complaints, some of which are likely to be witchcraft related. Likoma has a reputation of harboring many fwiti, a fact seemingly at odds with its having been the seat of Anglican missionary efforts since 1885. A similar situation prevails at Livingstonia on the mainland, which has been the seat of Presbyterian missionary activity in the north for almost a century, yet which is also rumored to have more than its share of sorcerers.

Divination by nchimi is usually performed in public in either of two basic styles. Nchimi use either one or the other style of ritual, but never both. The first is by means of a choir ritual, usually held in the healer's meeting hall or temple. Here the assembled patients and their helpers sing a variety of Christian hymns as well as traditional songs, which serve to put the nchimi, seated at the head of the assemblage, into a psychic state conducive to divination. This is apparently not a trance state, and the nchimi's demeanor is normal. Some nchimi claim that they are in contact with spirits during the divination, while others are not sure of the mechanism directly responsible for their power. However they all

ascribe their divinatory and healing powers to being derived ultimately from God.

The second type of divinatory ritual used by nchimi is similar to that just described, insofar as it involves singing the same sorts of songs and hymns by the assembled patients and helpers. However the singing is accompanied by the beating of drums and the clapping together of hardwood sticks by the multitude. The nchimi, dressed in the paraphernalia of a vimbuza dancer, wearing a belt of tin clappers, and having small iron bells tied to his or her upper arms and ankles, first speaks with the patient and then dances violently to the singing and drumming, which puts him or her into a sort of trance state, during which the divination is performed, and the results imparted to the patient. Although this is done in the midst of the audience, in very crowded circumstances, a considerable degree of privacy is afforded in the micro-environment between healer and patient, as the surrounding tumult makes it virtually impossible for anyone else to overhear their conversation.³⁰

At the end of the ritual, medicine is distributed to the various patients. Some nchimi keep samples of virtually all of their various mankhwala steeping in water in one large pot, making a kind of universal tonic which all patients may drink. Each patient will get his or her individual prescription as well. One practitioner, Nchimi Wwamba, has a large open shed covering a low table containing neat piles of cut up mankhwala. At the end of a divinatory session, the gathering adjourn to this shed, and sit around the table. Each patient, or his helper, places a pot in a line by the nchimi, who takes a pot and asks the owner to signify his or her presence. Then, using a

long bamboo, he points to each pile of mankhwala he desires to incorporate into the finished medicine, and those sitting nearest it pass some down to him, whence he places it into the pot.

Nchimi Vwamba, like all other traditional healers of whom I have knowledge of, keeps no written records of patients' history or progress, although he, and some other nchimi, keep some sort of record of the names and addresses of their clients as well as their date of admission.³¹

In the preceding situation, the nchimi may compound mankhwala for up to fifty patients in the course of an hour or so. Each prescription may have as many as twenty or more ingredients, with an average of perhaps a dozen. My impression is that these prescriptions are formulated on the spur of the moment, primarily at the whim of the nchimi, and have little true ethnopharmacologic rationale, save as placebos. I suspect that this is true of many if not most of the complex mixtures concocted by traditional healers in this area. It seems more likely that the simples prescribed have more basis in ethonpharmaco-logic, than these highly complex, apparently irrational mixtures. The bulk of the inpatient's or outpatient's therapy which I both observed as well as learned of from interviews, consists of taking such mankhwala. The patient's contact with the healer is normally confined to the initial diagnosis or divination and the subsequent brief refilling of prescriptions at approximately weekly intervals.

Two points are apparent from the foregoing description. The first is that there is a strong likelihood that iatrogenic side-effects may occur, considering the irrational dispensing of drugs and the

possibilities of unknown and undetected inter-drug reactions. There is no uniformity of dosage, as neither the amounts of raw material nor their strengths are measured. Furthermore these decoctions are subject to degradation by heat, aerial oxidation, reactions with the walls of the clay pot, as well as with the other ingredients of the mixture. Furthermore, the strength of any such mixture is bound to fall off as the active principles are leached out, so that whatever efficacy the preparation may have initially is rapidly diminished.

The second point illustrated by this description is that the indigenous healer-patient relationship is in practice often rather tenuous. Save for the initial diagnosis and later periodic replenishment of the prescription, there is in most cases virtually no healer-patient interaction. There are exceptions, but these are quite few in number. Patients derive emotional support from other patients and from the periodic divination rituals in which they participate as choir members, but their direct interaction with the healer is quite limited. This lack of contact is in marked contrast with the procedure in western inpatient medical facilities in Malawi, where there are periodic rounds in which each patient's condition is individually assessed by a process necessitating direct interaction between medical personnel and patient.

Many village headmen and chiefs, as well as other officials in a similar position of being officially responsible for the overall welfare of a group of people, have quasi-official relationships with one or more nchimi. The relationship between headman and nchimi centers around the nchimi's witchfinding abilities. Cases of suspected sorcery are on occasion brought to the headman's attention. He is not

generally competent to deal with them on his own, and must therefore seek advice from an expert in these matters, the nchimi. In addition, even if he were to attempt to adjudicate such a case, the parties to the complaint would likely insist that it be laid before an nchimi for investigation and resolution.

The laying of a case before an nchimi by a headman is done only when the special powers of the nchimi need to be utilized, as in cases where divination is required, either to locate the whereabouts of some missing object or person, or, as is the case in the overwhelming majority of cases, in order to find out why a person is sick or why he or she died. In the event that sorcery is found to be at the root of the trouble, the nchimi is requested to name the person who is the sorcerer.³²

Several of the headmen and chiefs who wrote letters to nchimi mentioned the following reasons for patronizing them: to ascertain if a death was caused by witchcraft; to "cleanse" a village of witchcraft when many people are dying; to discover why sickness occurs; to find lost or stolen money and cattle; to find who has bewitched a person, and prepare medicine for the victim; and when one suspects that sickness is due to sorcery. In these events, a headman will refer a patient to an nchimi.

The function of the letter which is often sent in such referrals was elaborated on by each of those headmen whom I was able to interview. They all stated that letters of authorization were sent exclusively to nchimi, (never to nganga), and only in cases of suspected witchcraft, and the occasional request for divining the

whereabouts of lost property or persons.

Headmen stated that the letters serve several functions including: the identification of the patient to the nchimi, including his village of origin; to ask the nchimi for help; to expedite the divination of the patient bearing the letter, as nchimi see them before other patients; and to ensure that the nchimi sends a reply to the headman, informing him of the findings. In addition, and perhaps most importantly, the letters serve the interests of the nchimi, who apparently require them to be produced before undertaking any witchfinding. Nchimi will not accept cases requiring witchfinding without a letter of authorization, as they are afraid of any legal consequences arising out of fights between parties accusing one another of sorcery. One headman stated that "the nchimi is after that [letter] just because the nchimi is afraid of the government."

The initial cycle of correspondence between nchimi and headman is completed by a letter sent by the nchimi, relating his findings to the headman of chief. One elderly chief stated that he began to receive letters from nchimi in the 1920's. These letters may serve several functions, the most common of which is to inform the headman of the nchimi's findings in the case; for in a sense, the nchimi is not only aiding the patient or victim of the particular trouble referred to him by the headman but is also performing a diagnostic and advisory service for the headman making the referral. The headman, whose responsibility is to ensure the well-being of his village, may then act on these findings in settling the problem in his village. On occasion the nchimi may write asking that the headman send other persons party to the trouble to him for divination, usually persons whom he suspects

to be sorcerers. If the nchimi is certain that the person he is sending for is a witch, he may command that person to bring his nyanga with him, so that it may be safely disposed of in the special area of his compound that nchimi reserves for such dangerous articles.³³

The Seketera or Witchkiller

The word seketera is used as both noun and verb, the latter being defined by Turner (1952:123) as "a kind of witchcraft--by medicine the ng'anga [seketera] makes himself [they are invariably men] invisible so as to catch the wafwiti [witches] who come to the grave to take the body for cannibalism." The function of seketera is not merely to prevent the deceased from being devoured by witches. Witches also use portions of the corpse to fabricate potent charms, such as those used to attract customers to a shop or business, and to make various kinds of nyanga.³⁴ In addition, and even more horrible to contemplate, the newly interred body may be magically resurrected in the form of an ndondoska or zombie, which is made to work for the fwiti. The belief in this practice is probably prevalent throughout Malawi, as Sanderson (1954:199) describes a similar practice among the Yao in the south of the country.³⁵ Seketera are engaged, usually at very considerable expense (in the range of \$25 to \$45), when the death of the relative is believed due to witchcraft in order to avenge the family by killing the witch responsible for their relatives death.

Although the seketeras' primary role is to avenge the death of a relative, they are in effect engaged in the diagnostic and preventive (although not curative) aspects of medicine as well inasmuch as the death or severe illness of a suspected witch at their hands provides

proof that that fwiti had bewitched and killed the person recently interred; as well as preventing that witch from causing future illness and death within the community.

A Seketera performs his³⁶ duties by placing certain magical medicines around the new grave, which not only serve to render the seketera invisible but attract the witch responsible for the death and place him under the seketera's power. The seketera is aided in this latter task by his nchoba, or magical flywhisk, which contains powerful mankhwala in its butt, similar to that used in the nchoba of both nganga and nchimi. (Sanderson, 1955:39) The witch (or witches) at the grave is rendered helpless by the seketera and is commanded to bend over so that the seketera can insert a cassava stick up his or her anus and twist it round so as to 'spoil' his entrails. Alternatively, he may pound a sharp wooden spike into the fwiti's anus, using a hammer whose helve contains magical medicine. A latter day method involves driving a six inch spike through the witch's anus or hammering nails into his head.

Some people believe that the witch is actually present at the gravesite, while other informants state that witches appear in some spectral form while their corporeal selves lie in bed at home. In any event, a fwiti unfortunate enough to encounter a seketera becomes acutely ill or dies, either occurrence serving as a token that he or she was the one responsible for the death of the person over whose corpse the vigil was held.

The seketera's practice falls squarely on the borderline of healing and witchcraft. One well known seketera³⁷ had in fact been

named as a witch during an episode of witchfinding, during which the inhabitants of several villages were examined by Nchimi Vwamba; and he was cut with anti-witchcraft medicine by the nchimi. Yet he continued to practice as a kind of nganga as well as performing his seketera. In addition, he was active in community affairs, being chairman of a local political group. Such an individual is both respected and feared, as his ability to detect and punish witches by magical means is itself a form of sorcery; the dictum, 'it takes one to know one,' is generally believed to be applicable in accounting for a seketera's knowledge of, and power over, wafwiti.

The Mzamba or Traditional Midwife

In addition to the nganga and nchimi, there are several other types of traditional healers practicing in northeastern Malawi. The first is the traditional midwife or mzamba, most of whom confine their ministrations to relatives, although a few undertake a more extensive practice. In addition to assisting women in labor, wazamba (plural) provide some ante and post natal care, including treatment to enhance the fertility of women having difficulty conceiving, as well as medicines and charms to facilitate labor, and to ensure the steady and rapid growth of the newborn.³⁸

Christian Healing Services

Although not exclusively of an indigenous or traditional nature, healing services are held in certain Christian churches in northeastern Malawi, especially in those of the various breakaway sects.³⁹ These services include elements of traditional healing techniques, syncretistically mingled with those drawn from

Christianity. I have unfortunately very little first hand information concerning these groups, the one reference that I collected during my fieldwork being the following brief quotation from the notebook of a senior Malawian Clergyman.

Independent Churches take account of witchcraft and sorcery as real issues in people's lives, while mission churches tend to ignore the problem, thus drawing fear of witchcraft underground, but doing little or nothing to combat it. Independent Churches recognise witchcraft and sorcery as realities in the lives of people and combat them through exorcism and faith healing.

There is a broad spectrum of religious belief in Malawi, with indigenous or traditional belief forming one end of the continuum and imported religions, mainly the various varieties of Christianity, constituting the other end. Most people in the northeast subscribe to both and incorporate them into what is basically a pre-scientific, "magical view of nature, the view that events are governed by spirits or demons or other unknowable forces not obeying the normal laws of cause and effect." (Hall, 1981:25) Most people describe themselves as being Christian and apparently have no difficulty in reconciling their belief in the traditional etiology and treatment of disease and misfortune with Christianity, as these letters demonstrate.

Lever Brothers Ltd.
Limbe
12th March, 197_
ANSWER QUICKLY

Dear Brother [Nchimi] Sukutura, I am very glad to write you, no matter [that] I have taken a very long time without writing you. But brother be kind to me. I am your child, as you do always about my health, I am too healthy.

I am on duty here in Limbe - Blantyre and joined on 3rd September, 1975. No matter I had some troubles in getting the job, but because of the power of God and the power of my spirits directed me here and got the job here

in L.B.I. My duties are storeman, supervisor and record clerk in the store where Surf, Vim, and many other items are found. I am the keeper of all thee and then send them -- I have a very big job . . .

This letter shows the author's concurrent belief in Christianity (as illustrated by the reference to God)⁴⁰ as well as in the more traditional ancestral spirits. The next letter shows the client's belief in the nchimi's powers as being divinely inspired.

To Sir Nchimi Vwamba,

I am very happy to write you this letter. Be seeing things well as God has given you this job and the Lord should open your head and your eyes so that you may see even better and do your job better.

The name of the person I've sent you is Carrington Longo. Greetings to all the patients in that hospital of ours.

Goodbye,
Yours:
V.H. E.B. Kaluba

Distribution of Traditional Healers

Nganga and nchimi are found throughout northeastern Malawi. My own far from complete tally listed over 130 nganga and almost sixty nchimi practicing in this area. In addition I counted twenty-one seketera. I made no serious attempt to count the number of wazamba in Rumphi and Karonga Districts, but they are doubtless quite numerous. Of the nganga, only two, or less than one percent, kept inpatients; while of the nchimi, fourteen, or almost twenty percent kept inpatients. The number of nganga is most likely considerably under-reported since there are so many varieties of them, many having very small local practices. The number of nchimi is probably somewhat more representative of their true numbers, as they normally have a wider reputation and thus were more likely to be included by my rough

and ready survey techniques. The difference in inpatient facilities between the two types of healer is a reflection of the more serious nature of complaints dealt with by nchimi as well as of the nchimi's relative scarcity, which necessitates that patients travel some distance in order to patronize them. In addition, many patients suffering from sorcery prefer to leave their villages for the duration of their treatment so as to escape from any malign influence lingering there.

Associations of Traditional Healers

Until quite recently, traditional healers practiced on their own, save for those who had acolytes or apprentices. However, various healers maintain informal relationships of a professional nature, many of which originated as healer-patient relationships. They may consult with one another on occasion, as well as exchange materia medica, or refer patients. Such consultation may be by letter, as the following quotations illustrate.

Dear Mr. [Nchimi] Lipuka,

With respect, I hereby send this daughter together with her mother; they have come for the troubles of Nyagondwe. She is really troubled, she doesn't bear children. She is staying at Salima.

If you are alright we thank very much.

Yours,
[Nchimi] Samueli Sangazingi

The same nchimi, Samueli Sangazingi, wrote to another healer, Nganga Nyevya, not only asking after a patient but requesting some mankhwala as well.

Dear Mr. [Nganga] Nyevya,

With respect I write you this letter. The news is that I have arrived home safely. How is the child there, since I left him still ill? Please tell me whether the sickness is still or not.

The other thing is that you should come here for the child who is suffering here, and you should treat him yourself. Try to find all medicine necessary for treatment as you know yourself, and carry me medicine for fighting and chintembwe [probably a medicinal plant] that you took from Chakaka [Mountain].

Greetings to Nyasongea and Petros. Send me a letter when you are coming.

Yours,
[Nchimi] Sangazingi

Another letter requesting materials for preparing mankhwala was written by Nchimi Lipuka to Nchimi Vwamba.

Dear Father Nchimi Vwamba,

I could be very happy to hear that you are well although an accident occurred at your compound.

I would have come in person, but I am very busy with other things. Now please Sir, Nchimi Vwamba, if you could keep a head of a khuwi and a hyaena's brain for me. Chiefs and people tell me that I should go to the Boma to get documents.

On Wednesday is when I will be going to Rumphu. But about our discussions, I've found one thing; it is thirty feet long.

If it needs me to come there in person tell me; but I have trusted the person I have sent, he can carry everything, without any mistake. The name of the person is Paul Dongo.

I have seen that the walking stick has fallen on the water. Should I take some more of the sticks after coming back from Rumphu? Or [are] you going to fetch the same one?

But father, help me with the trees I have asked you.

Thank you,
I am your son,
[Nchimi] A. B. Lipuka

It seems that Nchimi Lipuka desires the animal heads for use as chizimba; I surmise that he may be reciprocating the favor, as the thirty foot long thing that he has found may be a somewhat exaggerated reference to a python skin, used as a chizimba. In addition, in his closing sentence, he appears to be requesting mankhwala, which is usually made from plant roots.⁴¹

Two nchimi received letters from Chikanga, (his real name,) (Redmayne, 1970:103) a famous nchimi living in exile in Bulawayo, Zimbabwe. Nchimi Vwamba's letter bore no date, but was examined during 1974.

Dr. B. Chikanga
Nchimi of the Nchimi's
Bulawayo

Dear Mr. [Nchimi] Vwamba,

I really fell down when I saw your letter which you wrote me. I praise the Lord our God: His blessings and the blessings of the Holy Spirit which was given to you -- secrets and miracles, authority in his name and the name of the Holy Spirit, Amen. The Lord is my shepherd, I don't fear anything, even if I walk in the path of death -- the Lord is our Saviour.

I bless you child of God -- I have nothing to do here now because I've been stopped there, [in Malawi?] now I just pray to God that we meet if He allows it to happen. You should also be praying that we should meet in future -- I hope we will meet in his power. I am really grateful and I could be more grateful if you could answer me this letter.

I am yours,
Nchimi yazi Nchimi
Chikanga Chunda

This letter, written by the most famous nchimi ever to practice in northeastern Malawi, to the nchimi with the greatest reputation currently practicing in the region, is full of praise for Nchimi Vwamba. It also mentions previous correspondence, and in fact Nchimi

Vwamba was a patient of Chikanga in the late 1950's, who at the time diagnosed his complaint as vyanusi and pronounced him an nchimi. The letter is thus both from a mentor to a colleague as well as from one colleague to another.

The letter from Chikanga to Nchimi Vwamba is in an entirely different vein from this next one addressed to Nchimi Chirembwe. Although Nchimi Chirembwe seems to have initiated the correspondence with Chikanga, the letter indicated that their relationship is rather that of healer to patient rather than collegial.

No. N Flats
P.O. L
Bulawayo
15/6/78

Dear Mr. [Nchimi] Chirembwe,

I have seen your letter, but I can be glad if you're alright. I am alright, but I want you to come here. That is when I can help you in all your complaints. I can be happy if the whole family is in good health.

Yours for ever,
B. Chikanga Chunda
Nchimi of Nchimis

Nchimi Chirembwe never did go to Chikanga for help with his complaints but continued his own practice despite them. He corresponded with at least one other healer, this time Nchimi Sukutura.

Dear Mr. [Nchimi] Sukutura,

I have heard that the child is sick. This has given me sadness. I wish she recovers quickly God knows.

Thank you, I might be coming there when I feel better. Not now, because I am helping a patient, Nyasingapole, [who] is really in troubles, that's why I have failed to come. I can be glad to hear that you are alright. No more to add on this.

Yours,
Sir L.M.N. Chirembwe

[Nchimi] Chirembwe also had a collegial correspondance with
[Nchimi] Lipuka, who lived some thirty miles distant.

Dear Mr. Libwe [Nchimi] Lipuka,

The news is that I want you to come here and this
is what I wanted to say.

I can be very glad if I can hear that you are
well. Please, please, I want you to send me Sandawani and
this is the most important thing I wanted to say.

Greetings to everybody at home.

Yours,
Masida Chirembwe [Nchimi]

Sandawani is a powerful chizimba, hard to come by, and Nchimi Chirembwe
is attempting to tap Nchimi Lipuka as a source. At the time of my
field work, there were no commercial sources of traditional materia
medica, and each healer had to collect and prepare his or her own roots
and other herbal, animal, and mineral substances used as mankhwala.
Since many of these ingredients, especially those used as chizimba, are
so hard to come by, they must be obtained by barter or purchase from
those able to collect them from their source. This naturally leads to
some sort of collaboration between healers, as they are the ones most
likely to collect these esoteric materials.

This spontaneous communication, correspondence, and sharing of
materials has not evolved into any specific healers' organization, at
least not in the northeast of Malawi, although for a variety of motives
some enterprising healers have established healers' associations, at
first in neighboring countries such as Rhodesia, (now Zimbabwe), and
latterly in Malawi as well. Several of the healers I interviewed were

members of one or another of these groups.⁴² The aims of these associations are ostensibly to further the traditional healing profession as a whole and to look after the interests of both patients and healers. The following is a statement of the aims and objects of one of these associations having members nationwide, The Traditional Mediciners of Central Africa, as printed on its membership card.

- (a) The Medicinary shall endeavour to follow the most up to date methods in the care and treatment of patients.
- (b) It should also see that all who practice as Mediciners must be members approved by the Traditional Mediciners of Central Africa.
- (c) The Executive shall seek the power to contact any person not a member of the Medicinary practicing as Mediciner.
- (d) Any Mediciner who comes to Malawi with the intention of selling or practicing as Mediciner should contact first to the Mother Body for recognition in the Medicinary before selling or practicing, and without that the Executive will seek the way to contact this Mediciner who sells Herbs or practices as Mediciner having not reported to Mother Body first.
- (e) Any Mediciner must send or carry a patient who is seriously sick to the nearest Hospitals, on co-operation with the Ministry of Health.

Despite the high sounding nature of these manifest objectives, I suspect that it is in all probability the various latent objectives which spurred both the initial organization as well as the subsequent membership of the traditional healers. The first of these latent functions is that this association and others like it is a business for the person or persons running it, for whom turning a profit is a main objective. As it turns out, anyone who sends in the requisite fee of K5.00 [\$6.00] for membership and K4.50 [\$5.40] for a membership card,

could become a member. This was ascertained by my sending in an application to this organization, under a pseudonym, as well as to the rival African Herbalists Association,⁴³ (which wanted dues of only K3.00 [\$3.60]) which originated in Rhodesia and formed a branch in Malawi. Both organizations wrote back to me accepting me as a member without attempting to ascertain my qualifications, if any. One even asked me to become the chairman of the local chapter and furthermore stated that "We are going to send you an authority note so that you can show it to the D.C. [District Commissioner] in your District and to the M.C.P. [Malawi Congress Party] Chairman in the District."

These latter references reveal the underlying reasons why healers join such associations, namely to increase their prestige in the eyes of their clients. This is accomplished primarily by their possession of the membership certificate, which may be framed and displayed, much as a western medical professional's diploma may be prominently displayed on his or her office wall. Both serve to confer legitimation on their possessors. Prior to the formation of such associations, traditional healers sought to obtain letters from their local district commissioner or chief stating that they were recognized as traditional practitioners.⁴⁴ Here is one such letter written in 1959.

To whom It May Concern

This is to certify that . . . [Mr. Msiska] S/C Kayere, N.A. Mbura has been authorized to run with his Native medicine as a Native Doctor. I have examined him and he is fit to open the above mentioned duty.

Your devoted,
J. Nyirenda for S/C Kayere

This letter was addressed to all chiefs and sub-chiefs in the northeast

of Malawi and was marked with the sub-chief's official stamp. The nganga, Mr. Msiska, had a local practice. It is unclear as to what is meant by "I have examined him ..." as the Chief's competency is not likely to extend to this area; yet the Chief recommended him to the public.

The next somewhat similar letter of authorization was also written by a third party, probably a scribe or secretary, on behalf of a sub-chief.

1956

The bearer nchimi Wilson Marata is hereby authorized by me that he knows to treat sick people by the native medicine. Anyone who wants a help should see him at anytime.

Signed,
Saulosi Harawa for [S.C. Singini]

In both of the above letters, the sub-chiefs who wrote them state that the healers know their job, implying explicitly in the first letter and implicitly in the second, that the chief has somehow tested their knowledge and abilities. This requirement that legitimation be sought for outside of the specialist healers' group is somewhat antithetical to one of Friedson's criteria of professionalism, namely that "The occupational group, . . . must be the prime source of the criteria that qualify a man to work in an acceptable fashion." (Friedson, 1970:10) In each of these cases, the healer has attempted to secure legitimation from officials outside his occupational group, as fellow healers are unable to grant such legitimation in a legally meaningful way. However, since Friedson writes that "the occupational group, . . . must be the prime source . . ." rather than the sole source of such

qualifying criteria, our traditional healers may yet qualify for professional status. The development of associations of traditional healers which set some sort of standards of qualification and treatment is one step towards attaining this goal.⁴⁵

Other Forms of Healer Legitimation

Many people believe that there is some kind of examination administered by the district commissioner which tests the supernatural powers of the healer. A commonly held belief is that some object is hidden and the healer must rapidly find it. I doubt that there is any substance to these beliefs although they are widely held, and several nchimi have told me that they have taken such tests. One village headman, who referred cases in writing to both Nchimi's Vwamba and Lipuka, stated that:

The most well known nchimi's are the ones that have been recognized by the Government. The nchimi has been recognized by the Government by the certificate... There is an examination for that. They might hide something somewhere, and ask the nchimi to find it. Then if the nchimi really gets at it, that means he has passed the examination. He will be given a certificate for that.

The following two letters of legitimation were both written on behalf of an nchimi who had a large practice with many inpatients. Notice that these letters are somewhat more objective in tone than the first, merely stating that Nchimi Msofi is authorized to practice but not mentioning that he has passed any examination.

TO WHOM IT MAY CONCERN

This is to certify that Nchimi Msofi is a citizen of Rumphu and that he operates his job as Nchimi without troubles.

W.N. Vimbo,

DISTRICT COMMISSIONER

This letter and the following one were written about two years apart in the early 1970's, during the office of two different district commissioners. Both letters were on official letterheads.

AFRICAN SYSTEMS OF THERAPEUTICS ALLOWED:

CAP. 36.01 SECTION 18.

MEDICAL PRACTITIONERS & DENTISTS REGISTRATION.

Section 18 of Cap. 36.01 states that African systems of curing diseases is allowed provided that such practice of African system of curing diseases is not dangerous to life.

This letter serves to inform everybody to know that Nchimi Msofi is acting in accordance with the existing law.

J.S. Kaligu DISTRICT COMMISSIONER

The letter to me from the Traditional Mediciners association stated that "we are going to send you an authority note so that you can show it to the D.C. in your District and to the M.C.P. [Malawi Congress Party] Chairman in the District." Presumably this was to enable the recipient of such a letter to obtain letters similar to those quoted above from their district commissioners. The reference to the Malawi Congress Party is interesting, as it is the only political party in Malawi and is de facto a branch of the government. The Traditional Mediciners association claims to be "affiliated with the Malawi Congress Party..." which "we accept and recognize as our political Mouthpiece." Perhaps they are working through the party to lobby for increased recognition? In any event I have not heard of any Party official being solicited to give his or her imprimatur to a traditional healer in the manner of the chiefs or district commissioners quoted

above.

It is evident that district commissioners must realize that most nchimi engage in witchfinding, as virtually any person growing up in Malawi knows that witchfinding is fundamental to the nchimi's role. It follows that district commissioners must to some extent condone such activities among those nchimi they provide such letters to. Certainly there are many persons in places of influence who patronize nchimi and no doubt recommend them to the district commissioner as deserving of such a letter of recognition and authorization. It is not unlikely that district commissioners themselves patronize nchimi on occasion, as the higher a person's attainments, the more likely he is to perceive himself as being an object of jealousy and hatred, and therefore sorcery.

¹A good example of this lack of perceived conflict between the use of traditional healers and Christianity is provided by a young woman patient at an nchimi. She had been a member of the Student Christian Organization at secondary school, and continued to be an active churchgoer afterwards. Her father works for a Christian charitable organization, and is an elder in the Presbyterian Church. Her mother is a member of the Umanyano, or Church woman's organization. It would appear that both she and her parents are solid, active Christians. She had been ill since 1965, and when I met her in 1979, she was an inpatient at an nchimi, where she had with her an English bible and numerous Christian pamphlets and newsletters. In the years since the onset of her illness, her parents had taken her to a total of eleven western medical facilities, one Christian religious healer, twelve nchimi, and two nganga. Most of the traditional healers all told her that she was being bewitched by her grandfather, a statement she seemed to believe. She stated that both the nchimi's and the Church are doing the same thing. "They are praying for me." She has never seen or heard of any actions of nchimi's that could be termed un-Christian.

²Although much writing has extolled the virtues of traditional medicine, both African as well as that indigenous to other continents, much of that praise is, I suspect, motivated more by sentiment than by fact. The following description of seventeenth century European medication is an apt commentary on the traditional medical system as it is being practiced today in Malawi (and elsewhere). Certainly Malawian traditional healers are no further advanced in the twentieth century than their European counterparts were in the seventeenth. In fact, they are probably less so.

Empiricism alone does not make experimental science.

Most conspicuously is this true in seventeenth century medicine, at once high conservative and high empirical. Ringing ther changes on drugs, setons, bloodlettings, baths and dietary rules, the treatment of patients was an unceasing experiment. Many physicians would claim that their preferred method in a particular disease was experimentally proved -- patients were cured by it. One might expect that by selection the better remedies would drive out the worse, but nothing of the kind happened. Random experiments by thousands of doctors on millions of patients, conducted with an air of great professional assurance, produced no positive results. Did bloodletting cure fevers? No one knew, though everyone supposed it did. In the absence of any relevant theory, or the use of statistics, experiment with this theory or that was meaningless. (Hall, 1963:125)

Hall earlier writes that there was "much produced by fantasy, from Kenelm Digby's weapon salve, . . ." applied not to the wounded man but to the weapon that struck him. (Hall, 1963:26) Such examples of sympathetic magic "assume that things act on each other through a secret sympathy. . . ." (Frazer, 1957:16) This belief remains fundamental to the practice of sorcery in Malawi as well as being

invoked for certain medicinal uses as well. Men such as Digby, although propounding theories that were controversial in their own time and preposterous in our own, nevertheless were able to communicate their ideas and the rationales for them in writing, so that they could be scrutinized by their fellows. (Willey, 1953:193) Traditional healers in Malawi and the associations of such healers that have recently sprung into being make no such attempts to disseminate their ideas.

³In addition to the many part time and full time traditional healers, traditional medicine is used for much of the self treatment which presumably deals with the greatest number of illness episodes.

⁴See Thomas (1983) for a brief but illuminating description of the role of the family doctor in the years prior to the introduction of antibiotics.

⁵A dream illustrating one nganga's efforts on behalf of a victim ran as follows:

I dreamt I was talking with a ng'anga whom I know. [Dreamer refused to identify the nganga.] He told me he knew the reason why I got my pricking pains. He said: "There is a friend of yours who is jealous of you. He is the one who is bewitching you. Now take this medicine and when you see any of your friends you hold it tight and you will see what happens." He gave me some kind of roots. I took them, and I walked toward my house, and inside there was my father talking to one of my friends. There were only two of them in the house. I greeted them and I held the root tight. Then I saw that my friend's eyes turned white, and he was in some sort of a coma. I also saw that he was carrying a big needle in one hand. My father looked at me, then down at my friend, and without saying anything he started kicking my friend. I started feeling dizzy, and I let go the root. My friend was normal again. He wanted to run away, but I held him by the arm and slapped him hard in the face. I kicked him again. He then wrestled away from my arms and ran out of the room. I got hold of my root and pressed it. My friend fell on his face in a coma again. I told my father that the boy was the one who was bewitching me. Then I woke up.

The dreamer, a twenty year old secondary school student, stated that he "felt very angry in the dream, because I learned about a person bewitching me being my best friend." The pricking pains referred to in the dream are typically believed to be caused by sorcery. A needle, such as that held by the "friend," is often actually incorporated into nyanga prepared by a sorcerer. I am unclear if the healer described was in fact a nganga, as the word is often used to mean a healer in general, such as an nchimi. Certainly, the provision of medicine to enable the victim to see the witch, is theoretically within the ken of a nganga, although I have not heard of ngangas' providing such charms.

⁶The four most common forms of divinatory apparatus are the mchembo, mpichi, nyisi and senga. All four of them are used in conjunction with a technique in which dichotomous questions, often of a

yes or no variety, are presented to the oracle, and it responds by some supernatural power conferred upon it by mankhwala of one sort or another. The mchembo consists of an empty tortoise shell, filled with mankhwala, and with a cord running through it, making a sharp bend inside the shell. One end of the cord is looped round the nganga's toe, as he holds the other in his hand. As long as the cord is held taut, the shell remains still. If the tension is relaxed, the shell descends. The oracle is asked yes or no type questions by the diviner, and if no the mchembo remains immobile, while a descent indicates a yes. The strength of the affirmative may be indicated by the amount of the descent.

The mpichi is made of a wooden stick about a foot and a half long and three inches in diameter. It is lightly grasped by the nganga with his fingertips and rubbed back and forth in a groove made in the ground. It is asked yes or no questions. A yes is indicated by the mpichi apparently sticking to the ground, as the diviner's fingertips slide over it, unable to move it.

Both the mchembo and mpichi may contain mwabvi as their active principle, according to one reliable informant. Presumably its' powers of ascertaining the truth are capable of working in this indirect, oracular application, as well as in the more direct method where it is ingested.

The nyisi or runyisi consists of three parts. The base is a flat round winnowing basket, about two feet in diameter and one inch high. It is inverted, and on its bottom is placed a small iron bell, such as is placed round the neck of a dog, or tied to one's arm for a yimbuza dance. Over the bell is inverted a small porcelainized steel bowl, of about eight inches' diameter. This bowl is given an eccentric motion by the nganga, as he asks the oracle the same yes or no type questions addressed to the previously described oracles. A no answer is indicated by silence, but a yes answer is heralded by the ringing of the bell, as it is caused to roll about by the action of the eccentrically moving bowl.

The senga consists of a small duiker horn, sometimes decorated with white and colored glass beads and filled with mankhwala. A cord about a foot and a half long is affixed to the basal end of the horn. The senga is operated from a sitting or squatting position. The nganga holds the string so that the tip of the horn rests on the ground, with the horn making an angle of about sixty degrees to the ground. The operator addresses yes or no type questions to the senga, which responds by spinning around the point resting on the ground to register an affirmative answer or remain still if the answer is negative.

I have personally experimented with each of these four forms of divination apparatus and experienced little difficulty in mastering the manipulative technique necessary to operate them. Of course the real skill lies in the clever questioning technique used by the nganga in order to elicit the information he requires from his client.

⁷The use of the tail-switch is not limited to healers alone. Various presidents of African states carry such switches as symbols of their powers. Both the presidents of Malawi, and Kenya, to name but

two, carry such artifacts, which are widely regarded as having the same magical properties as those possessed by nganga and nchimi.

⁸I once observed an adolescent girl who was either bitten by a snake or stung by a scorpion not a hundred yards from the rural hospital of which Timothy's father was in charge. Instead of availing themselves of the hospital, the girl's family at first attempted to treat her with a herbal remedy prepared from plants freshly collected near by their dwelling. This proved unsuccessful, and so they carried her on their backs, not to the nearby hospital, but some half mile distant to a nganga specializing in snake-bite. He then went out to collect mankhwala from a tree some quarter mile distant, returned, and compounded a medicine which seemed to be no more effective than that prepared by the girl's kin. There was evidently little confidence in the ability of the hospital's staff to deal with this sort of complaint.

⁹A number of the nganga and nchimi whom I had to good fortune to meet, had written ethnopharmacopoeias for their own use. Young (1932:229) reported this same practice some fifty years ago.

¹⁰The following dreams illustrate this phenomenon, at least as it applies to laymen. The first was dreamt by a 27 year old man:

I dreamed that I went to a certain country. This was the time when I was sick. There the people told me that I should look for African medicine, and the tree is called mulangali. Then I woke up.

The next dream is from a 21 year old male secondary student:

One night I dreamt that I was at home. When it was about three o'clock, I went to go and cut rafters in the bush. I went there silently. When I was busy looking which to cut, I saw a black faced old man standing straight in front of me. When I saw him, he came to me and greeted me. It was down by the ant hill where there were many trees. He touched one tree and asked me if I knew its use to man's life, and I told him that I had no knowledge of it. He laughed deeply, and told me that that was a tree used as a medicine when a snake has bitten a person or animal from a village. I came close to see it's features, so I could keep it in my mind, but I could not know it's name. He was beginning to tell me how it is used. The name was told, but soon I forgot when I woke up.

The dreamer went on to say that "I was very sorry to have missed the chance [to learn how it is used], because many people have known African medicine through being told in dreams."

This next dream was related by an eighteen year old woman, who was teaching in a primary school.

I dreamt that I was with my mother who left my father before he died. We stayed around my late father's house near a fire. While sitting I saw some lumps of wound starting to come out from the whole body. I told my mother that some lumps are coming out, and she told me to ask from my father who died sometime back, but [who] was sitting on

the veranda showing his back. When I talked to my father about the lumps of wound he became very angry, and told me to go to my sister ... who could show me the medicine. when I went and asked my sister, she told me to go in the bush and dig the roots of miduzu and wash using the milk [sap] on the lumps of the wounds.

¹¹I collected two ethnopharmacopoeia written by laymen during the course of my fieldwork. The first, a relatively recent compilation, contained medicines for conjunctivitis, pains of pregnancy, snakebite, trachoma, heart disease, food poisoning, Bilharzia, toothache, and ear infection. In addition, there are several medicines for men who have slept with women during their monthly period, medicine against sorcery, and a charm for raising pigeons. The second, a much more extensive compilation, had been copied from a much older manuscript, written during the first few decades of this century, by one of the most prominent Malawians in this area. Unfortunately the original work was lost, and only these transcribed fragments remain. The medicines described include those for asthma, whooping cough, heart pains, gonorrhoea, night blindness, stomachache, cough, chest pain, menorrhagia, excessive urination, snakebite, madness, sleeping sickness, wounds, swelling of legs, syphilis, dysentery, and rheumatism. In addition there were medicines for catching fish, to make infants learn to walk quickly, for preventing mudulo, a disease caused by committing adultery, (see Drake, 1976, for an elaboration of the illness complex known as mdulo among the Chewa) for pleasurable intercourse, and for making a woman become pregnant.

¹²A description of such a nganga practicing at Rumphu Market was obtained from an informant, a recent secondary school graduate. He wrote that "Kavukani had been allowed by the government to cure people, or to sell any medicine which people want for their own needs."

¹³As a secondary school teacher in Malawi, I observed at first hand the reluctance of students to question their teachers. As an observer at both western and traditional healing establishments over a considerable period of time, I noted a similar reticence to question the person in authority.

¹⁴Thomas' description of American medical practice at the beginning of this century seems in some ways similar to traditional herbal medicine as practiced in contemporary Malawi, at least insofar as its use of medication was concerned.

These were fantastic formulations containing five or six different vegetable ingredients . . . [which were] . . . intended to be a mystery . . . [to the patient.] The purpose of this kind of therapy was essentially reassurance. A skilled, experienced physician might have dozens of different formulations in his memory, ready for writing out in flawless detail at a moment's notice, but all he could have predicted about them with any certainty were the variations in the bitterness of taste the color, the smell, and the likely effects of the alcohol used as solvent. They were placebos, and they were the principal mainstay of medicine, the sole technology, for so long a

time--millenia--that they had the incantatory power of religious ritual. (Thomas, 1983:15)

¹⁵ Roberts describes the theory, preparation and use of vizimba in Zaire, which seems quite similar to its use in Malawi. (1983:119-33)

¹⁶ The practice of instilling mankhwala into the eye has been the cause of considerable grief in Malawi and surrounding areas. Numerous cases of blindness have been caused by such treatment, as caustic agents are not infrequently used as eye medication. (Chirambo, 1977:2) (Phillips, 1959) Janzen (1982:183) notes the use of tobacco juice instilled into a patient's eyes by a Zairean nganga.

¹⁷ Since the mankhwala used for these sawu or cuts is almost invariably first carbonized, there can be but little if any active principle left besides the inert carbon.

¹⁸ Patients at western hospitals are sometimes a bit defensive and ashamed of these signs of their having recently patronized traditional healers. In 1978, a survey of all inpatients at a mission hospital in northeastern Malawi disclosed that 41 of the 75 inpatients had visible signs of traditional medicine on their persons, either as scarifications (34 of 45) or amulets (7 of 45).

¹⁹ Many western medical personnel have mentioned this desire for injections to me, and I have myself oft times observed it as well.

²⁰ Livingstone, (1923:92) describes "the first chloroform case in Central Africa," performed around 1880 by Dr. Robert Laws on a young man with a cystic tumor near the eye. "The Doctor felt that the whole future of the work depended on [his] success... His desire was fulfilled; the news spread far and wide, and patients from a distance began to appear, drawn, as those in the time of Christ were drawn, by the reports of healing miracles." Jack (1901:130) also alludes to the near miraculous view of surgical intervention, which "to the simple natives . . . were apparently miraculous."

²¹ This ceremony, the kupiera, is held a week after the deceased's burial. In the ritual that I observed, mankhwala of roots was placed in a pot which had chizimba of ochre daubed on its rim as well as the blood from a live chicken, obtained by severing a toe and dripping it into the pot. (The chicken, minus a toe, will be presented to the elderly woman mzamba cum nganga who furnished the mankhwala.) Some mud from a river-bank is added as well. The mixture is boiled, and the liquid is sprinkled on the deceased's belongings, as well as being given to each relative to drink, the first mouthful being spit out, and the second swallowed. Sima or stodgy dough is made with the medicinal liquor, and small balls of it are thrown in the direction of the homes of those relatives unable to attend.

²² The following are brief sketches of several of the nganga who gave me entree to their correspondence.

Nganga Tyapula is a man in his early forties. He is of average height, and dresses neatly, but unostentatiously. He obtained his skills as a healer from his late father who also was a well known

nganga. He speaks good English and is an elder in the local Presbyterian church. He is active in local government and has close ties with various government employees. His primary source of income is a small general store. He also has a small canteen at his hospital village, staffed by a patient, where soda, sweets, and soap are sold to the patients.

Nganga Tyapula's practice is atypical since he has many inpatients, whereas most nganga have none. His hospital village is located hard by the main road, where he keeps between twenty and forty patients in several buildings. He has a small shed for storing and preparing the herbal medicines which are the mainstay of his treatment. He initially sees patients privately in a small office built into the corner of a large patient dormitory, often making use of a magical mirror for divining the patients' trouble. He has but one wife, as befits a church elder.

Although having a large number of inpatients, as well as seeing numerous outpatients, Nganga Tyapula's practice differs significantly from that of Nchimi Vwamba, insofar as none of Tyapula's patients are referred to him by village headmen.

Nganga Parapaska is about 60 years of age, short, paunchy, and balding. He is a poor man who lives several miles from the nearest main road. He keeps no inpatients, and although literate speaks no English. He has been practicing as a nganga for many years and is widely reputed to dabble in sorcery, both for evil as well as good. He has written an ethnopharmacopoeia, the contents of which, while mostly curative in nature, contain various charms and formulae which tend to confirm his neighbors suspicions that he practices sorcery.

Nganga Nyevoja is in his mid fifties. He speaks English and has worked as a cook for various European missionaries. He has at various times run a small tea shop, contracted to make bricks, and run his own light truck for hire. He lives by a tertiary road, in a substantial western style house, with a front room used as an office or consulting room. His practice is limited to outpatients. At the time of my fieldwork he was practicing as a nganga and used the senga type of divining apparatus. However he was aspiring to become an nchimi and needed only to undergo a chilopa ceremony in order that he be an nchimi. He treats vimbuza or spirit possession, having the necessary drums, bells, and jangle belts for the ceremonial dancing employed for that purpose. He prepares many medications by powdering them, storing them in glass bottles. His clientele is mainly local.

Nganga Mwetuka is in his early thirties, married with one wife, and speaks some English. He was working as a cleaner at a mission hospital when I first met him, living in hospital housing and seeing his clients there during his off hours. His practice was limited to outpatients. Interestingly a near relative of his is a medical doctor. Mwetuka is a very devout Christian and quite active in church related affairs. He continually exhorts patients, both his own and those at the hospital, not to fear witches. He has tried unsuccessfully to get a letter of authorization from his District Commissioner, such as that possessed by Nchimi Vwamba. He has a small ethnopharmacopoeia.

²³The following brief descriptions, are of several of the nchimi who provided me with samples of their correspondence.

Nchimi Wwamba is perhaps the best known healer in northeastern Malawi. He has been practicing his calling for over twenty years and has a hospital village of about one hundred huts in various states of repair. He has had on average perhaps sixty inpatients, on each of the occasions that I visited him. His great status and wealth is evidenced by his many wives. He is a tall handsome man, about forty years of age, well dressed, and with a dignified air. He has become well to do as a consequence both of his healing skills and from his various business ventures, which have included farming, fishing, and the operation of a maize mill. He is quite a progressive individual, as illustrated by his being a branch chairman of a nationwide herbalists association, by his (unsuccessful) attempts at advertising his healing services, and by his availing himself of governmental aid in mapping his land and counseling him as to what crops to plant in his various fields. He frequently wears a white coat, similar to those worn by western medical personnel, on his rounds through his hospital village and when conducting healing rituals. He professes to be a devout Catholic and seems quite familiar with his Bible, which is well thumbed and frequently consulted. Nchimi Wwamba spoke a bit of English when we first met in 1974 and had learned enough to engage me in conversation of a limited nature by 1979. He had completed but a few years of primary school in the 1950's, and has had no other formal education.

Nchimi Wwamba has two letters of authorization from his District Commissioner, authorizing him to practice; both were drafted in the early 1970's. The relevant part of the earlier of the two reads as follows:

AFRICAN SYSTEMS OF THERAPEUTICS ALLOWED:

CAP. 36.01 SECTION 18.

MEDICAL PRACTITIONERS & DENTISTS REGISTRATION

Section 18 of Cap. 36.01 states that African Systems of curing diseases is not dangerous to life.

This letter serves to inform everybody to know that Nchimi Wwamba is acting in accordance with the existing law.

A copy of this letter was forwarded to the Police Officer-in-Charge of the District. The second document authorizing Nchimi Wwamba to practice, was written several years after the first, by the new District Commissioner:

TO WHOM IT MAY CONCERN

This is to certify that Nchimi Wwamba is a citizen of ____ and that he operates his job as Nchimi sincerely without trouble.

These two letters, as well as many other documents in his correspondence, indicate that Nchimi Wwamba is well known to local government officials, who are familiar with the details of his practice

and approve of it.

Nchimi Vwamba is frequently consulted by village headmen, who refer numerous patients to him, by various other officials, and by laymen. Since much of this consultation is either initiated by letter or involves written communication during its course, and because his volume of clients is greater than any of the other healers in this area, Nchimi Vwamba has the most extensive correspondence of any of the healers I have visited and who permitted me to examine their correspondence. It is possible that one or possibly two nchimi practicing in this area have an equally voluminous correspondence, but have denied me access to it. Since his correspondence is so voluminous, he employs a secretary to assist him in his letter writing. He often uses a rubber name stamp on his letters, and is in the habit of assigning a 'reference number' to correspondence, similar to that used in bureaucracies elsewhere, save that, being unfamiliar with its overt utilitarian function of expediting the retrieval of filed correspondence and seemingly cognizant only of one of its latent functions, namely that of enhancing the visual dignity of the letter's appearance, all of his reference numbers are the same!

Nchimi Vwamba performs his divinations with the assistance of a choir composed of his patients and their helpers. Divination occurs during the healing services held in the nchimi's church, a building some fifty feet long, originally of wattle and daub construction, but slated for replacement in late 1979 by a burnt brick structure with a sheet iron roof.

The hospital village is some distance from the main road, along which runs the bus line bringing most patients. The day to day administration of the hospital village is overseen by several trustees or capitao, who assign huts to new patients, supervise the sanitation of the compound, and organise daily prayer meetings in the church. In addition new patients are registered in a notebook, and a fee of a few tambala is levied on them in order to pay for kerosene to light the church during evening services.

Nchimi Vwamba has had several apprentices. At the time of our first meeting, two young men were in residence, who had been suffering from vyanusi, a form of spirit possession which, if recognized and properly treated, results in the sufferer becoming an nchimi. These men were formerly patients of Nchimi Vwamba and were assisting him in diagnosing and treating patients, administering the hospital village compound, and in the collection and preparation of herbal medicines. Eventually they are likely to establish their own practices.

Nchimi Lipuka is in his late thirties, has a primary school education, and speaks fair English. When I first met him in the early 1970's, he had far more in-patients than he could accommodate; it being the dry season, they simply slept outdoors. His patients erected about thirty temporary grass huts that rainy season as well as a large wattle and daub church where a choir assisted him in his divinations. His practice was then at its height but was prematurely diminished due to an outbreak of cholera along the lakeshore where his hospital was located. The government perceived the large numbers of patients with inadequate sanitary facilities as a potential health hazard and closed

down his facility. He continued to keep a few inpatients the following year and then seems to have abandoned his home-based practice, attending to odd cases here and there for several years as an itinerant healer making housecalls. On occasion he visited the nearby western hospital to treat patients there. He kept an ethnopharmacopoeia in which he wrote down some of the medicines he used for different complaints, along with their composition.

Nchimi Chirembwe is a young man, in his late twenties, slender, of average height and neatly dressed, but wearing his hair in long matted coils. He began his secondary education, but fell ill and left school; stating that he was then taken to the District hospital, where he died. His corpse stayed there for two days, and on the third day he returned to life. He then ran wild in the bush for six months, subsisting on wild foods, and dreaming of mankhwala. These are the classical symptoms of vyanusi, or that form of spirit possession which leads to the sufferer becoming an nchimi. He claims to be able to eat certain poisonous fruits and several times demonstrated this ability during the course of my visits to him.

In 1979, Nchimi Chirembwe had a hospital compound consisting of some thirty huts, mainly of wattle and daub construction, situated near a main road. Most were for relatively short term patients, although several former patients, afraid to return to their homes for fear of again being bewitched, had homesteaded near him. He has two wives.

Nchimi Sukutura was in his late twenties at the time I met him. He is a short muscular individual, who dresses casually, frequently wearing shabby clothing and going barefoot. He has a primary school education and speaks passable English. He is the first in his family to be a healer, his father having been a primary school teacher. He had suffered from vyanusi in his early twenties, which was treated by Nchimi Suku, who lives but a few miles away. Like Nchimi Chirembwe, he claims to be able to eat certain poisonous plants. On one occasion, during the course of a nocturnal healing ritual in his temple, Nchimi Sukutura took a bite out of a branch of the toxic Candelabrum tree, (Euphorbia sp.) and then surreptitiously spat it out in the semi-darkness, while pretending to chew and swallow it. He has erected two signs proclaiming his availability as an nchimi by the main road running past his hospital village, which has about a dozen huts for inpatients, and typically had around fifteen patients in residence. Many more come as outpatients to attend his healing rituals, which are dominated by the beating of drums and clapping of hardwood sticks to which he dances, the music and dancing serving to potentiate his divinatory and healing powers. One such healing session involved searching or examining twenty one clients, who paid five tambala apiece for the service. He had compiled a rather an extensive ethnopharmacopoeia and prescribed and dispensed considerable mankhwala to his patients.

²⁴ Many of the patients at an nchimi or at a nganga with inpatient facilities are physically well, but fear to return to their village. Many have minor or seemingly trivial physical symptoms but fear that, as their complaint is due to witchcraft, they had better stay until all signs are normal. Most such patients are fully ambulatory and otherwise apparently normal.

²⁵Huts are usually of wattle and daub construction, with a thatch roof, and last for several years if looked after and rethatched. Temporary shelters of reed and grass may be more rapidly erected but are soon consumed by the ubiquitous termites.

²⁶Nchimi Vwamba had the following rules hung on the wall of his temple:

Rules of Nchimi

1. Be active and keep your location clean.
2. I want everyone to love one another in this location.
3. This is an Independent location, prayers to God should be given.
4. Please obey the helpers, don't be rude to them.
5. No one should commit adultery in this location. I don't want it. I have completely refused anyone from doing it.
6. Don't steal and don't lie in this location.
7. Come with all your complaints to the helpers. Don't fear them.
8. There is no other way to come to me apart from through the helpers because they are your head.
9. Give all the complaints, whether you have quarrelled with somebody, to the Chairman or Vice Chairman so that the Committee should look on it first.
10. The Committee has the authority on all patients, and, therefore, it can do anything it likes with rude people. You should do all the gentlemanly things at your home, here you have come looking for medicine.
11. A person who has not been divined should not enter the location. When greeting your relative who has not been divined, take the permission first from the helpers. Have faith in the Lord whom you have come with here with your troubles. Thank you.

Your Nchimi

²⁷The symbolic "death" and subsequent "resurrection" of persons destined to be seers or divines is not limited to Malawi but is found elsewhere in Africa as well. Mbiti mentions its occurrence among tribes in Dahomey, Nigeria and Tanzania. (1969:175-7, 191-2)

²⁸The chilopa ritual is common to both forms of spirit possession, vyanusi and the much more common vimbuza or virombo. It involves the ritual slaughter of some animal, such as a chicken or

goat, by the possessed. This is accomplished by biting the animal's throat, suffocating it, and tearing it open and drinking some of its blood. It is normally performed under the supervision of an established nchimi. Its completion at least temporarily cures the vimbuza sufferer and ends the initiation phase of the proto-nchimi suffering from vyanusi.

The following excerpt from a letter written to Nchimi Vwamba asks him to administer a chilopa. "I have so many things for you to do, that is why I want you at my home. I want you to give me a chilopa. I have no one in mind who could give me this, as it is said that only a person who can foretell is the person who can give me a chilopa, but tell me in advance that you are coming so that I buy a goat before your arrival." [letter #0762] Reference is made to the nchimi's powers of divination as being necessary for conducting the chilopa ritual, as well as the need of a sacrificial animal, in this case a goat. (Chilivumbo, 1972:8)

²⁹ Religious tracts such as WHY ME? A Study in the Problem of Suffering (Cox, 1973) attempt to provide a Christian rationale for troubles, although relatively little preaching is done to refute the utility of traditional divination.

³⁰ The degree of privacy desired will vary to an extent, depending on the type of complaint. However the degree of privacy desired is culturally determined, and in Malawi it is generally far less of a requirement than in middle class America. Bloom (1965:85-6) citing Sigerist, notes that in Hippocratic Greece there "was very little privacy in the relations between doctor and patient. The doctor's shop, the iatreion, like other craftsmen's shops, was open to everybody, and medical questions were discussed publicly in the market place." The same situation generally prevails in Malawi today, with exceptions including the patronizing of healers, especially nchimi by church members who are fearful of suspension for consulting false prophets; men with embarrassing sexual problems; and those desiring the nchimi to perform sorcery on their behalf.

³¹ Several of the nchimi whose hospital villages I stayed at had record books in which they registered new patients. These were ordinary notebooks, which were kept by one of the capitao or patient trustees. The entries in Nchimi Vwamba's record books, from October 3, 1972 through May 20, 1974 register a total of just under eight thousand (7,946) people. They seem to be a mixture of outpatients, inpatients, and possibly some helpers as well. Most seem to have paid a small fee, usually two tambala (about 2.5 cents) which was levied in order to pay for paraffin (kerosene) used to illuminate the temple during evening divination and healing sessions. At another nchimi who kept patient records, fees were levied in order to pay for both paraffin and for the razor blades used both for making incisions for administering 'cutting' medicine and for cupping.

³² One sub chief told me that, as far back as 1894, nchimi foretold the people of the coming of the missionaries to Livingstonia.

Whenever there was something wrong in the village, the spirits would possess them, and tell them that the village must be cleansed, and maybe tell the chief that the

spirits were annoyed with the moral situation of the village. And so the chief had to do something. So they acted also as spirit mediums.

The village needed to be cleansed whenever it was attacked by nduwi, or thowi, which is a kind of diarrhea, or katukutesia which meant a sudden death of a man who had not been sick, people just dying without being sick. [If that happened] then you would suspect [that] there was something wrong with the village, and therefore it had to be cleansed. These things would be caused, most of them, by witchcraft. And he says adultery would also cause such diseases. It seemed the nduwi killed the people who had actually indulged in sexual intercourse because they had not confessed their immorality. So they would ultimately die.

When he was a young boy, and the missionaries arrived, about 1894, 1899 or so, he says at that time there was a certain man known as Kapika Msiska, at Fuliwa. He was a chief whose village had been beset by several diseases. And so he invited a nchimi to find out what was the cause of that problem. A nchimi to find out who was bewitching who, and what was wrong.

And so the nchimi came there, and performed the work, and then, when the government heard of that, they arrested Kaphika and kept him in custody at Karonga. And then he died in prison and was buried at Fuliwa. And so, since that time, the government insisted on having witches judged by the government or courts, instead of [by] these chiefs, whereas earlier on, it was the chief who administered mwabvi after getting a message, through a messenger, from the nchimi [that a person was a witch].

[But the nchimi's powers were not perfect, so that the ultimate test at that time was mwabvi?]

Mwabvi, yes, administered by the chief himself. The chiefs had the power to decide who was a witch or not, but, when the government said mwabvi was an obnoxious type of thing, it had killed many people ... they stopped using mwabvi, and so depended more on the judgement and findings of the nchimis'.

[At the time what did people think of the government's suppression of mwabvi?]

Actually, people were not happy, because they knew that now a witchcraft would not be well discerned, and so they will die from witchcraft. . . .

Prior to the introduction of literacy, they depended on messengers to transmit the message about who was a witch from the nchimi to the chief. But later on, about 1920 or so, that was the time when literacy had been

introduced into the country well enough for many people to write letters. And so he postulates that it was about that time that he started receiving letters from the nchimis about witches.

The original tradition was that a chief invited the nchimi to his home. And so he did all his business there and kind of directly conveyed his message to the chief in person. But later on, when the nchimis were suppressed, and then they were not officially invited to chiefs' palaces, it became necessary for such type of communication as letter writing. So it was after the suppression of nchimis as official judges, as it were, that this business of letter writing and messengers being sent in between [headmen and nchimi] was actually founded.

[Who actually initiated the writing of the letter to the nchimi?]

The chief, who wanted to know about the affairs of his people. First of all, if people suspected one another, they went to their chief, and then he sent them to the nchimi because he was powerless as far as judging who was a witch and who wasn't. And so, since they had been sent by the chief, the nchimi felt it incumbent to reply, and so it was the nchimi who wrote the letter.

[Could he estimate how many witchcraft cases he dealt with a year as chief?]

He says there were more than forty people he would send per year.

³³The correspondence concerning any one case is generally concluded by the nchimi's reply to the headman's letter, i.e. it consists of two letters in toto. If the nchimi requests that additional persons be sent to him, the correspondence may grow to a total of four letters: the initial one authorizing the victim to see the nchimi; the nchimi's request for further suspects; the headman's authorization of such suspects to go to the nchimi; and finally, the nchimi's presentation of his findings to the headman. The second and third letters are generally omitted, and the correspondence typically consists of two letters only, the first and last of the series just described.

³⁴On December 29, 1973, the president of Malawi, in his Christmas broadcast to the nation, discussed the steps taken to apprehend those guilty of a series of grisly murders. He said that:

The man who was arrested . . . stated that these murders had been committed because there is a man in Lilongwe who wanted medicine in which human flesh was necessary for that medicine to be effective. In other words, there was a man in Lilongwe who wanted "chizimba" [Chichewa for backbone] for his medicine. Those of you who know your Chichewa know what the word "chizimba" means. It means something which must be mixed with medicine, if the

medicine is to be effective. As a rule, this means human flesh and human flesh which comes from certain parts of women or sometimes men but chiefly women, babies or even fetuses . . . It was for this man who wanted "chizimba" for his medicine that these murders were being committed in Kasupe, and the arrested man gave the name of the organizer of the murders in Kasupe who was killing women for human flesh to be taken to Lilongwe. When the police reported this story my mind went back to 1966, 1967 and the beginning of 1968. In that period, we had a series of murders in Lilongwe committed by men for the sake of "chizimba."

Parrinder devotes a section to "Medicinal Murders" and writes of cases similar to that described by Banda occur periodically in Basutoland. "The purpose of the ritual murders is to obtain ingredients for a medicine of invincible power. . . . Chiefs, in particular, feel the need of obtaining for themselves such strong magical medicines, which will defend them from all ills and give them success and importance." (Parrinder, 1958:153) Such a desire on a chiefs' part is echoed by the narrative of the Chief in endnote 8 of the section on the legal aspects of healing.

³⁵ Sanderson (1954:199) defines ndondoca as practiced amongst the Yao of southern Malawi as:

"a dead person brought to semi-life by witchcraft and employed by an msawi [witch] as a 'familiar.' On the night following a funeral the msawi goes to the grave and summons the occupant with the words, 'Arise, your mother calls you', whereupon the grave gapes and the corpse, still inert, is extruded; he carries it away and after amputating the legs at the knees, brings it to life by the fumes of his medicines so that he can send it on his evil errands bewitching his enemies. As it creeps along it can be heard in the silence of the night, mewing like a cat.

In the north of Malawi, ndondoska are allegedly put to more mundane tasks, such as doing field work for their masters.

Mair relates that in the Dahomean, Voodoo, and Ndembu traditions, "familiaris are dead men brought back from the grave, called zombies." (1969:236)

³⁶ Seketera are invariably men.

³⁷ This man was the only seketera whom I was able to interview. He was remarkably frank about the details of his calling and demonstrated the use of all of his paraphernalia. In addition to his seketera work, he is consulted as a nganga, providing a wide variety of mankhwala, such as that used to: attract a lover, to enable a barren woman to conceive, and to cure pneumonia (chilaso). He also finds articles that have been lost or stolen by the use of the senga or runyisi forms of divination apparatus. He is also patronized by people who desire nyanga in order to bewitch their enemies.

People are coming here asking for nyanga because they just hate someone, and they want to kill him, because

that is just as Africans are accustomed [to do], that when he hates someone, he wants to kill him. He says he just cheats those people. "I cheat him. I charge him a lot of money, maybe L40, L30 or L50. Then after that I make a nyanga which is not going to work to him, and give him that nyanga. Then he is going with that nyanga, trying to use it. It doesn't work, and he cannot go anywhere and complain that: 'That person has just cheated me.' The government doesn't allow people to make nyanga, and he cannot take me to court, because I am not going to be accused.

Later on in the interview, after better rapport had been established, he admitted to occasionally making real nyangas. "We Africans, I can make a nyanga if someone has eloped [with] my wife because, if I was loving much that wife and someone has eloped [with] my wife, then I'm going to make nyanga so that person should die, so that [I am having] a chance to marry back, to get back my wife." "If someone can ask me to sell a nyanga to him, when someone has witched his relative without reason, he comes to me so that I should [sell him a nyanga to] kill that person who has witched his relative." People often pay him with cattle, rather than cash. "As one [Cebuano] sorcerer expressed it, 'My conscience is clear because this is done only against those who are guilty of wrongs against their fellowmen.'" (Lieban, 1967:39)

³⁸ A listing of medicines found in the ethnopharmacopoeia of one mzanba, NyaMayuni, serves to illustrate some of the kinds of trouble she dealt with and contained the following: medicine that makes the vagina big when giving birth, medicine that a woman takes to attend the monthly period after giving birth some months earlier, medicine for a man to take after having intercourse with a woman during her menstrual period, medicine for curing gonorrhoea and syphilis, medicine given when a woman "fails to give birth." In addition, it contained formulae for medicine for making witches not visit the house, an antidote for sorcery, and a charm for good luck with people and on the job. It is evident from this listing of mankhwala that this mzamba's practice was not strictly confined to midwifery and overlapped into the nganga's province. NyaMayuni's mother was also a well known mzamba, and her daughter has evidently followed in her footsteps.

A study conducted in the south of Malawi in 1974, (Bullough, 1979:9) found that most women delivering at home, who at that time constituted 85 percent of all confinements, were attended only by female relatives, who did not consider themselves 'professional' wazamba. Bullough noted that such women "must be very limited in experience, in view of the limited number of deliveries that can occur within one family, even an extended family." (1979:11) A similar situation seems to prevail in the northeast, although a considerably larger proportion of mothers bear their children at western maternity units and hospitals than in the south of Malawi. (Malawi National Statistical Office 1978:33)

In 1978 an experimental training course for selected traditional midwives was held in the Central Region (Bullough, 1978:81) in an effort to upgrade their skills. The outcome was deemed

satisfactory, and it was recommended that the program be expanded. This has been the only official attempt to enlist traditional healers into the western medical system, although there have been several mentions of possible similar integration of ngangas.

One such mention was made as early as 1972, at a weekend seminar on traditional medicine held by the Medical Association of Malawi, in Blantyre, (see The Society of Malawi Journal, Vol. 36, No. 2 July, 1973 for further details), where the then Minister for Health suggested that there be some liaison between western and traditional healers. Six years later, at a National Seminar on Primary Health Care held in Lilongwe, it was noted that "the herbalists' contribution to curative medicine is not recognized at Government level;" and once again it was suggested "that there is a need for studies to be carried out in order to regulate their [traditional healers'] practice and integrate them into the health system particularly at community level." ([Malawi Ministry of Health], 1978:17)

It is evidently considerably easier to integrate traditional midwives into the officially recognized health care system, probably because their practices are well defined, involve a minimal resort to magical agencies, and possibly because they are invariably women, and therefore more likely to conform to the standards imposed by the officially sanctioned system.

³⁹ Peltzer writes of the therapeutic functions of the Zionist Christian Church in central Malawi. (n.d.[ca. 1984]) Hastings writes that:

the quest of the independent church was the quest for a ritual . . . through which immediate human needs, social, psychological and physical could be appropriately be met. . . . Prayer for healing became the central activity of the spiritual churches in West, Central and Southern Africa. While the missionary approach of scientific medicine was only partially rejected, it had reached far too few people and excluded too many problems to fulfill the needs of the common man. Rituals of healing were among the most important of those in traditional society, and the most characteristic motivation of the new Christian movements in Africa was . . . the establishment of accessible rites of healing with a Christian reference. . . . (Hastings, 1979:72)

⁴⁰ My reason for equating the reference to God with a belief in Christianity is because the God [Chiuta] of traditional religion was virtually never referred to directly by the people, who instead directed their prayers through their priests to the various spirits who acted as intermediaries between man and God. The idea of a personal or directly approachable God is a Christian (or more rarely Islamic) innovation. (Kauta, 1969:6)

⁴¹ The word kuni means "a tree, a piece of wood." (Turner, 1952:56) Since most mankhwala is made from tree roots, bark or leaves, it seems likely that this reference to "trees" was for such medicinal raw materials.

⁴² Chilivumbo notes the existence of a "category of [Malawian] ng'anga [who] are trained herbalists, holders of certificates from herbalists' associations of either Rhodesia or South Africa." (1976:70) However, whatever training they may possess is idiosyncratic. Frankenberg and Leeson, describing traditional healers in neighboring Lusaka, Zambia, write that:

These traditional healers could not be said to belong to a school of medical practice, unlike some of their counterparts in other parts of the world, such as those who practice Ayurvedic medicine, or acupuncture and moxibustion. There is no written body of knowledge or beliefs (cf. Horton 1967:180), no systematic means of instruction; they are in fact a heterogeneous collection, with no unanimity of theory or practice, although of course they share some common features. (1976:239)

⁴³ Chavunduka (1978:127-130) reproduces the constitutions of three Rhodesian traditional medical associations in the appendix of his book. In addition he discusses the "modernization of traditional medicine," and interprets their role in his country as "a form of rearguard action against the advance of modern health programmes." (1978:80) He sees Rhodesia's traditional healers as being "confronted by a powerful Medical Council of Rhodesia which is making attempts to squeeze them out of the medical profession." There is no such pressure as yet in Malawi.

⁴⁴ Katz and Katz observed similar practices in Kenya, writing that "Many [healers] have trade licences or are licensed under the Business Names Act, [and] several carry letters (some very old) from government officials which vouch for their integrity." (Katz and Katz, 1981:18)

⁴⁵ Several other of Freidson's criteria of professionalism are met by Malawian nchimi. In essence they "have gained command of the exclusive competence to determine the proper content and effective method of performing some task;" (Freidson, 1970:10) insofar as nchimi are recognized to be the only persons capable of performing witchfinding, cleansing witches of their penchant for evildoing, and administering chilopa to sufferers of vimbuza or vyanusi. Lastly, "what is also needed, is general belief in the consulting occupation's competence, in the value of its professed knowledge and skill." (Freidson, 1970:11) Such belief in the competence of both nchimi and nganga is attested to by the letters from a wide range of clients, presented in the latter half of this dissertation.

CHAPTER III

THEORY AND METHODOLOGY

Paradigms of Illness and Deviance

Although Emerson and Messinger's (1977) paradigm is applicable to virtually any sort of trouble, the following chapters demonstrate its particular relevancy to those sorts of complaints which in Malawi are taken to traditional healers for their resolution, especially (although not exclusively) troubles of a seemingly interpersonal nature, which are suspected of being caused by witchcraft or the machinations of malignant spirits. Such troubles of supposedly supernatural etiology, together with the efforts made to resolve them, constitute an important fraction of the illness behavior observable in northeastern Malawi, and, as a consequence, are of considerable applied as well as theoretical importance to the medical sociologist.

Other sociologists, including Goffman (1959), Mechanic (1968), and Parsons (1951), have addressed themselves more specifically to such health-related troubles. I shall briefly excerpt certain of their theories, especially insofar as they are applicable to Malawi's medical systems and to troubles such as witchcraft and spirit possession that are more peculiar to contemporary Malawi rather than to the industrialized countries of the West.

Parson's "The Case of Modern Medical Practice"

Parsons (1951) remarks in his discussion of "the functional setting of medical practice and the cultural tradition" (429) that

illness is socially dysfunctional and therefore that the sick role is a deviant one insofar as it prevents the effective performance of social roles. It is therefore in society's interest to control and minimize illness. In Malawi and the Third World in general, morbidity is considerably greater than in the West, and there is therefore a greater incidence of such illness related deviance.

The sick role itself according to Parsons carries with it not only exemption from various normal social duties but also the responsibility to take whatever steps are necessary to get well. The assumption of the sick role for any length of time requires some form of legitimation, provided most often in the West by a physician¹ functioning in the role as agent of social control. In Malawi such legitimation may be provided by a physician, but, due to the dire shortage of such professionals, some other western health worker such as a medical assistant is most likely to provide the patient with the proverbial doctor's note. Additionally, in Malawi, there are the several varieties of traditional healers who can and do, in one form or another, legitimize their patients' sick role, not only to their families but to various official agencies and employers as well.

This legitimation of the sick role and the patient's exemption from normal social obligations carry with them an obligation to get well, using those methods which his or her culture prescribes. In the West, this usually means consulting a doctor. The patient who does not make such an effort may be accused of malingering. (436) In Malawi, society, being in a state of flux, may dictate the use of a western healer for one set of symptoms, as a traumatic injury, and the use of a

traditional healer for a chronic complaint.

According to Parsons, a crucial obligation of the sick role is to seek technically competent help. Naturally this term is subject to manifold interpretations, depending on one's cultural frame of reference. Here in the West it generally, but not exclusively, means "see a doctor." In Malawi it is even more subject to choice, and several different types of healer may be consulted, either concurrently or sequentially, for the same complaint.

In Parsons' paradigm, an important aspect of the physician's role is as an agent of social control, his or her societal mandate being to eliminate the patient's deviance by effecting a cure and so eliminating the cause of the deviance. This notion is reinforced by Sigerist's statement that medicine's "primary target must be to keep individuals adjusted to their environment as useful members of the society, or to readjust them when they have dropped out as a result of illness." (cited in Gropper, 1967:1)

Parsons notes that the sick role "channels deviance so that the two most dangerous potentialities, namely, group formation and successful establishment of the claim to legitimacy, are avoided." (477) This observation is broadly true of the Malawian situation, although there are two exceptions to it that I am aware of: the first is the case of long-term patients, especially those resident at nchimi, and the second type is the set of those suffering from vimbuza in its various forms. In both cases, "the sick are tied up . . . with other deviants to form a 'sub-culture' of the sick." Long term patients, have legitimation by virtue of being patients, and constitute a

definite sub-culture, as I have mentioned earlier, with respect to inpatient organization at both nchimi and nganga.² Although such inpatients live together at a traditional hospital for long periods of time, their tendency to form a "solidary collectivity" (477) is somewhat reduced by virtue of the fact that in most cases they have non-sick relatives living with them as helpers or guardians.

The case of vimbuza sufferers is somewhat different, as they live at their homes, remote from one another. However they congregate at intervals to reestablish their contacts with one another and with their community, at which time their legitimacy as sufferers cum patients is reestablished by contact with their healer and with the community at large, which actively participates in the more palliative than curative vimbuza dance ceremony. (Chilivumbo, 1972; Leacock & Leacock, 1972) Vimbuza sufferers in effect constitute a deviant subculture in the Parsonian sense.

Various authors have written on the social functions of sorcery and spirit possession (Marwick, 1965; Leacock & Leacock, 1972) and how they serve to relieve certain social strains. Parsons is concerned not only with social strains of an affective origin but also with social strains produced as a consequence of organic complaints and how these organic, as opposed to social and emotional troubles, are addressed by the medical profession and its patrons.

Parsons recognizes both biological as well as social factors of illness causation, (431) these latter being of considerable importance in such phenomena as spirit possession and sorcery, which are common complaints in northeastern Malawi. He further states that: "Illness may

be treated as . . . one way of evading social responsibilities."³(431)

This seems to be a central factor in the case of vimbuza or spirit possession and may also be of importance in explaining the residency of certain inpatients (usually diagnosed as suffering from sorcery) at traditional healers for periods of from several months to more than a year, when they suffer either from seemingly trivial symptoms or admit to being physically well. In these cases, deviance is transformed into a legitimized sick role. It should be noted that in one sense the greater the number of patients an nchimi possesses, the greater his or her status is likely to be, so it is to some extent in the interest of these healers to keep patients as long as possible. On the other hand, just as hospitals and physicians in the West are judged, an astute patient in Malawi may question the efficacy of a healer who takes too long to effect a cure. On the whole, however, it would appear that Malawians are used to long hospital stays, both traditional and western, and that an institution's reputation is not diminished by what to us seem excessively lengthy stays, nor is the client's claim to the sick role challenged by long delays in recovery.

Although most traditional healers are, to use Parsons' nomenclature, collectivity-oriented and apparently try their best to heal their clients, their methods are frequently of little utility, especially in cases of serious organic illness. This is in large part due to the fact that "what to us is obviously somatic illness, has been interpreted in supernatural terms, and magical treatment has been considered to be the appropriate method of coping with it." (432) If the diagnosis is not in accord with the etiology and if the treatment is based on the erroneous diagnosis, there is little likelihood that

the treatment will be efficacious, especially if the underlying complaint is a somatic one, the placebo effect notwithstanding. Parsons notes that "in non-literate societies there is an element of empirical lore which may be regarded as proto-scientific, . . . but the prominence of magic in this field is overwhelmingly great." (432) In present-day Malawi, much of the population is illiterate, and although considerable folk medicine is based on "empirical lore," such largely herbal medication is of the folk variety which is common knowledge and which is largely self administered or obtained from a family member. Such medication may be taken for a particular effect, which is readily observable and immediate, as a laxative, vermifuge, or abortifacient. The more esoteric complaints and medications seem to have a shakier claim to any empirical foundation, and are often compounded by some revelation seen in a dream by the healer. Apropos of the aforementioned magical treatment, Parsons observes that:

Science is of course a very special type of cultural phenomenon and a really highly developed scientific level in any field is rare among known cultures, with the modern West in a completely unique position. It may also be noted that scientific advance beyond the level to which the Greeks brought it is, in the medical field, a recent phenomenon, as a broad cultural stream not much more than a century old. (432)

These observations are certainly true of Malawi, where Western medicine was first introduced at the turn of the century and where it is at present still practiced on what is frequently a rather rudimentary level.

In his discussion of the social structure of medical practice, Parsons delineates the attributes of the physician's role, assigning it to the general class of professional roles, which in our culture have

become functionally specialized as full-time jobs. He notes that such full-time employment at one's profession is not necessarily the case in societies other than our own, (434) and such part-time practice is in fact the norm for most traditional healers of northeastern Malawi.

Like professionals in the West, the occupational role of the nchimi or nganga is "institutionalized about the technical content of the function which is given a high degree of primacy relative to other status-determinants." (434) The definition of technical competence is obviously subject to a considerable degree of cultural relativity, as the technical competence of a nganga to successfully treat pneumonia would be questioned by a physician, and the competency of a physician to effectively treat vimbuza would be questioned by a nganga.

In sum, Parsons' description of the sick-role is directly applicable to the Malawian situation. Exemption from normal social responsibilities is a secondary gain of the sick role, and after several days of illness it must be legitimated by a healer, which is illustrated by this letter from a schoolmaster to an nchimi, referring to what in effect must have been a doctors-note previously written by the nchimi to the headmaster.

Vumba Primary School 13 September, 1975

Dear Sir [Nchimi E]

TRANSFER FOR PETE NZERU

Thank you for your nice letter about the ill health of Pete Nzeru. I am glad to hear that you have detained the boy for further treatment.

I was only told by him that he needed transfer

letter to go back to Muhuju. I had no objection on this.
As you have said, I will keep the child and give him his
examination number.

Best wishes to you all.
F.C. Khowe
Headmaster

Such notes are presumably necessary primarily for those persons who are in some way employed in the Western sector of the economy and are little used by those following more traditional pursuits. Furthermore, the patient must be treated in order to return him to normalcy, not merely to change his or her attitude. This is generally the case in Malawi, although there is at least one exception, the case of vimbuza, as has already been alluded to. Patients suffering from this syndrome are frequently assumed to be permanently afflicted, and the treatment neither returns the sufferer to normal nor changes his or her attitude, but in fact serves to reinforce the deviant behavior by virtue of the secondary gains vimbuza confers.⁴ Nonetheless, as with the chronically mentally ill in our society, it is a legitimate sick role.⁵ Other forms of chronic illness are treated as best they can be by traditional medicine but, in contrast with vimbuza, they confer only minimal secondary gains on their victims.

In Malawi as in the West, the sick role is a contingent one; but when illness does befall one, the victim is obliged to seek technically competent help and to cooperate with the healer. As discussed previously, the definition of technical competency is to an extent culturally relative. In the long run, technical competency is a function of the healer's perceived success, i.e. is empirically determined.⁶ However there are many subjective elements that enter into a perceived cure, and it is therefore possible for healing practices

having little or no scientific efficacy to be perceived as affording relief or a cure. We need merely to examine the pre-scientific history of western medicine to realize this.

Achieved status, specificity of function, affective neutrality, and collectivity-orientation are, according to Mechanic (1968:112) the structural features of greatest importance in Parson's analysis of the physician's role. These traits are to a considerable extent congruent with those of traditional healers practicing in northeastern Malawi. The status of nganga or nchimi is an achieved one, having a "minimum standard of technical proficiency." (Mechanic, 1968:112) Medical doctors practicing in Malawi are required to possess a diploma from a recognized foreign medical school and to register with the government. Similar uniform standards of training are not specified for traditional healers; however, the Laws of Malawi, Medical Practitioners and Dentists Registration Act, Cap.36:01, specifically allows "the practice of any African system of therapeutics by such persons as are recognized in Malawi to be duly trained in such practice: . . ." In addition, the Pharmacy and Poisons (Control of Patent Medicines) Order, Cap 35:01, allows

the sale to any African of any African medicine, compounded or prepared within Malawi and intended for the prevention, cure or treatment of venereal disease, by an African who is recognized by the community to which he belongs as being competent to treat venereal disease.

Thus the law provides for some definition of the technical competence required of traditional healers but leaves it to the communities they serve to define (or not define) just what those competencies are. Traditional healers are in this sense at least in partial compliance with Parsons' dictum.

The specificity of function Parsons ascribes to latter-day physicians is in part a consequence of their high technical competence, and "the physician is not, by virtue of his modern role, a generalized 'wise man' or sage--though there is considerable folklore to that effect." (435) The range of "expertise" of traditional healers in Malawi, especially that of nchimi, is considerably greater than that of any Western physician, including family practitioners and psychiatrists. Nevertheless nchimi are recognised as having the requisite technical skills to undertake this broad spectrum of troubleshooting, the "specific sphere of his [the nchimi's] technical training and experience," (435) being far broader, albeit oft-times shallower, than that of the physician.

Traditional healers, like their physician counterparts, are generally perceived to be affectively neutral, although some selectivity of patronage is exercised by certain clients who perceive a particular, usually nearby healer, as being biased in some respect significant to that prospective patient's case. Such bias is frequently a consequence of the close-knit social web of village life, with its strong relational bonds and many primary relationships. This affective partiality is most often sought out in cases when it is the healer's micro-political prowess rather than his or her healing powers that are desired.

In general, Malawians view their traditional healers as having a strong collectivity-orientation, and they are respected for it. Individual traditional healers are, however, on occasion accused of being self-oriented, generally for some profit-making motive.

Additionally, there are those few nganga and nchimi who allegedly put their knowledge of necromancy at the disposal of evilly-disposed persons so as to harm some individual or group. Such healers seem to constitute but a small minority of the profession.

Mechanic's "The Study of Illness Behavior"

Mechanic (1968) writes of illness behavior as a "culturally and socially learned response," (117) which is of course a central theme of my dissertation. He defines illness as "any condition which causes, or might usefully cause, an individual to concern himself with his symptoms and seek help." (115) He continues:

If we are to understand the process of illness, it becomes necessary to consider what goes on even before a person sees a doctor or some other health worker. Thus the study of the patient's perspective is an indispensable aspect of the analysis of health and disease. (115)

The symptoms that prompt a person to seek help from a culturally defined healer are far broader in Malawi than they are in America. This is perhaps due to the broader mandate that such traditional healers possess as well as to the greater variety of environmental threats that Malawians perceive, especially threats posed by witchcraft and malignant spirits. Mechanic remarks that in America Spanish speaking and Amerindian patients are more likely than Anglos to rely on folk medicine, as it is more consistent with their cultural expectations. In Malawi, the native population has grown up and been acculturated to perceive environmental threats which are culturally defined as being curable only by traditional medicine. This need not preclude their being treated by Western medicine, but, for any cure to be fully and finally efficacious, the services of a traditional healer

are necessary. In practice this often means that the underlying why of the complaint must be ascertained by some form of traditional divination, and any malignant influences of a supernatural nature discovered by the diviner must then be dealt with.

Mechanic writes that "manageable" difficulties may be ignored, (Mechanic, 122) which is similar to Emerson and Messinger's statement that "a problem ignored may fester; or it may disappear." (E&M, 122) The key word here is "manageable," a term which is culturally relative. Mechanic implies that, if the course of an illness is predictable, the victim is not as likely to seek medical help as when suffering from an unfamiliar complaint with an unpredictable outcome. In Malawi, any complaint attributable to sorcery is perceived as having an unpredictable outcome. It therefore behooves any person possibly suffering from such trouble to seek the services of one competent to adequately diagnose such complaints. Operationally this means that a diviner, usually an nchimi, needs be consulted. Once this happens, as Emerson and Messinger have pointed out, the complaint becomes a public matter requiring an extrinsic remedy, and is subject to redefinition by the third party or troubleshooter. In Malawi, such redefinition most often occurs in cases of intrapersonal troubles, most commonly illness of one sort or another, which are redefined by nchimi as interpersonal troubles, with the second party or troublemaker being a sorcerer or spirit.

Mechanic lists ten "factors affecting the response to illness" (130) which are worth dwelling upon insofar as they are applicable in the Malawian context. The first five of these deal with the perceptions of the patient and significant others as to the seriousness

of the symptoms. There are some symptoms which are painless but potentially serious, which would alarm a Westerner, but cause no qualms in the average Malawian; and conversely there are symptoms which would be ignored by Westerners, that would be viewed with alarm by Malawians. The perceptual factors are to a large degree dependent on Mechanic's sixth factor: "available information, knowledge, . . . cultural assumptions and understandings . . .", which collectively affect the individual's response to illness. (130) Mechanic's next two factors both deal with the patient's needs and their tendency to distort perception. The case of vimbuza would be a good example of the victim's needs coloring the symptoms and channelling the person into adopting the vimbuza cult. The penultimate factor is especially salient to Malawi in light of the rapid social change and implementation of western ideas and technology, namely, "competing possible interpretations that can be assigned to the symptoms once they are recognized." (131) Symptoms can be interpreted under the guidelines of one or both of the prevailing health care systems and frequently are. Lastly, but not least importantly in a poor area of a poor nation, are the economic constraints on treatment, such as cost and availability, as well as any social stigma or humiliation attendant on utilizing one health care system or another. Such humiliation may occur when a person bearing fresh medicinal scarifications made by a traditional healer appears at a Western health care facility, and the medical staff remark on them in a disparaging way.

Mechanic (135) cites Freidson in constructing a brief summary of help-seeking behavior. First self-medication is tried: next the trouble is discussed with kin and acquaintances, and their advice is

sought on what course of action to pursue and on what healer to consult, this latter interaction constituting a lay referral system. The victim may then consult the doctor on a trial basis and compare the diagnosis with that made by significant others. This schema is generally descriptive of the Malawian as well as of the American situation.

Mechanic again quotes from Freidson, who writes that if "diagnostic authority is based on . . . divine 'gift'. . . professional authority is unlikely to be recognized at all. . . . And, insofar as the cultural definitions of illness contradict those of professional culture, the referral process will not often lead to the professional practitioner." (136) This is the case in Malawi insofar as complaints suspected of supernatural etiology are concerned. If such etiology is suspected, the complaint is deemed untreatable by Western medicine and must be taken to a traditional healer for diagnosis and treatment.

There is a bit of confusion in using the next sample of Mechanic's quotation from Freidson, insofar as the concept of the term professional is concerned.

With an extended lay referral structure, lay definitions are supported by a variety of lay consultants, when the sick man looks about for help. Obviously, here the folk practitioner will be used by most, the professional practitioner being called for minor illnesses only, or, . . . by the sick man grasping at straws. (Freidson, 1960:377-8 in Mechanic, 1968:136)

This passage was written from the contemporary American perspective, where allopathic medicine with its professional practitioners is the overwhelmingly dominant medical system. In contemporary Malawi this is not the case, and there are professionals

practicing Western and traditional medicine, with both being extensively patronized, although to different degrees and for differing complaints. In Malawi and other Third World countries, folk practitioners provide a significant, if not major proportion of overall health care, and so must come under the heading of "professionals."

Mechanic introduces the terms "self-defined" and "other-defined" illness, noting "that in the latter, the person tends to resist the definition that others are attempting to impose upon him . . ." (139) Although other-defined illness is mainly of the mental variety, it may be physical, especially in the case of children. In Malawi, one might perhaps use the term other-defined illness to describe the phenomenon of a patient with a rather innocuous complaint consulting an nchimi and being told that it is due to sorcery, is quite serious, and requires radical therapy. From the etic perspective, most illness attributed to sorcery may be of this other-defined variety, insofar as its attribution is concerned. In addition, the seriousness of symptoms are to an extent magnified by such diagnoses, which are of a suggestive nature and may have profound psycho-somatic repercussions on the patient.

Although Mechanic, Parsons, and Goffman, primarily, if not exclusively, refer to troubles in the form of illness, physical and/or mental, the sorts of complaints which are taken to traditional Malawian healers are often of an economic nature as well and involve no illness as we commonly define it. Mechanic writes that "many symptoms leave a person little alternative but to recognize that he has a medical condition, and that medical care is essential." (141) In northeastern Malawi, the inability to secure a job, a wife, or pass an examination

may lead one to seek help from a healer, who may attribute these difficulties to supernatural agencies and in effect may medicalize the troubles, with the etiologic agent being a sorcerer or spirit, rather than a microbe or toxin.

Hearkening back to his earlier listing of factors affecting the response to illness, Mechanic expands on that theme, analyzing each factor in terms of both "other-defined" and "self-defined" illness. His first such factor is the **visibility, recognizability, or perceptual salience of symptoms**. In other-defined illness, the deviation from social expectations increases the victim's social visibility and so constrains others to seek to ameliorate the aberrant behavior. (142) This is basically true of Malawi, although in the village situations prevalent there non-violent aberrant behavior is much better tolerated than it is in our urban environment. Persons with significant aberrant behavior are often capable of being economically integrated in a peasant society, whereas they would be much more of an economic liability in industrial society.

In self-defined illness," . . . individual symptoms may vary from those that can be detected only indirectly to those that develop in an evident and unequivocal fashion." (143) In terms of what choice of medical system to utilize, it is the former type of illness, i.e. the insidious type, that is nowadays more prone to be taken to traditional healers, with the acute type of complaint, such as traumatic injury and other medical emergencies, being virtually the exclusive province of western medicine. There is of course a wide overlap of complaints which are taken to both Western and indigenous healers.

The second factor postulated by Mechanic is the **perceived seriousness of symptoms**, which he defines as "estimates of present and future probabilities of danger." (144) Although a complaint causing minor inconvenience and of a trivial nature would likely be ignored, if it is perceived as being possibly caused by witchcraft, its import is magnified, its future probabilities of being dangerous are greatly enhanced, and it is taken to a traditional healer for divination. Such a course of action is essentially similar in both self-defined, and other-defined illness, save that it is the "others" who take action on behalf of the victim in instances of the latter.

The extent to which **symptoms disrupt family, work, and other social activities** constitutes the third factor determining response to illness. In both self-defined and other-defined complaints, "perceived seriousness and disruption of activities are highly correlated with one another," (145) such disruption being a potent inducement to seek medical attention.

Closely related to this last factor is the fourth one, namely the **frequency of the appearance of symptoms, their persistence, or frequency of recurrence**. In other-defined illness, the more frequently aberrant behavior is exhibited, the more likely is it to draw attention and be defined (or labeled, if you will). In self-defined illness, the more frequently the symptoms recur, the greater the incentive to seek help.

The **tolerance threshold of those who are exposed to and evaluate the deviant signs and symptoms** make up the fifth factor in Mechanic's schema. He cites the Hutterites of the northwestern United

States and adjacent Canada, whose apparent rate of mental illness was considerably less than their neighbors, until research showed that it was the Hutterite response of integrating their mentally ill into the community, rather than any lower incidence of morbidity, which was at the root of their seemingly lower incidence of mental illness. (147) The Hutterites, like most Malawians, are an agricultural people, and when afflicted by mental illness "they are looked after by the immediate family. . . . They are encouraged to participate in the normal life of their family and community, and most do some useful work." (Bloom, 1963:101, quoting Eaton and Weil, 1955:235-6) In cases of self-defined illness, "an individual's tolerance for pain and discomfort, and his values about stoicism and independence, may also affect how he responds to symptoms and what he does about them." (148) My impression is that in Malawi a considerably greater amount of discomfort is often tolerated before action is taken, in part due to the greater difficulty of taking appropriate action and perhaps the perception that such action will not result in the prompt relief of the discomfort. Furthermore, in some instances, a culturally fostered stoicism is at work, as in the case of childbirth, where women are not supposed to cry out and show their pain.⁷

"It is evident that the amount of pain people are willing to tolerate will depend on the significance and meaning they attribute to the painful event." (149) This significance is in turn a function of the sixth factor, namely the available information, knowledge, and cultural assumptions and understandings of the evaluator. In many of the cases I cite, cultural assumptions strongly color the evaluator's reaction to the symptoms and therefore the course of the therapy.

Sorcery and spirit possession are essentially outmoded concepts in the West, although once widely subscribed to. These and other beliefs in supernatural etiology are still current in many other parts of the today's world, including northeastern Malawi, and are a major factor fostering the utilization of traditional healers.

Traditional supernatural beliefs aside, there is still a dearth of scientific medical knowledge among the Malawian population, who in general "have only very naive notions of bodily functioning." (Mechanic, 1968:151; see also Retief, 1940:313-14) This ignorance negatively affects the utilization of Western medicine, as patients present themselves for treatment with diseases in advanced stages normally unseen in the West, due to lack of appreciation of the severity of the symptoms; moreover, they are unable or unwilling to adhere to medication regimens, as they fail to understand their *raison d'etre*.

The next, and seventh factor, **perceptual needs which lead to autistic psychological processes**, raises an interesting point, namely, the nature of reality. Earlier on, Mechanic defines autistic psychological processes as "perceptual processes that distort reality." (131) As social scientists know, reality is in part a social construct, and my dissertation centers around the phenomena of witchcraft and spirit possession as social realities. From the etic perspective, the native perception of these phenomena is indeed distorted, and we have only to review our own history to see the folly of such beliefs. Malawians, however, have not yet passed through this particular historical phase, in effect living in the past. From the emic perspective these are very real and dangerous phenomena, which

must be dealt with according to the prevalent folkways. In the case of both other-defined and self-defined illness, anxiety and fear that prevent the recognition of symptoms and seeking of effective care may have disastrous consequences.⁸

Mechanic describes his eighth factor as **needs competing with illness response**. If work needs to be done in the fields or at home and there is no one to be spared, attending to medical problems will be postponed for as long as possible. This is coupled with his tenth factor, namely the **availability of treatment resources, physical proximity, and psychological and monetary costs of taking action**. In Malawi, Western health care is relatively hard to obtain, due both to the few health-care facilities and to the relatively high fees charged by mission-operated facilities, which are generally perceived to provide a higher standard of service than government facilities. Mechanic notes the persons living in close proximity to a mental hospital are more likely to have a relative hospitalized than those living at a distance from such a facility, since they find it easier to visit the hospitalized relative. (154) In all of Malawi there is but a single mental hospital, located in the Southern Region, and those living remote from that facility must be faced with a difficult decision, as contact is hard to maintain unless some relative travels with the patient and resides nearby the hospital. This aforementioned practice, is, as was mentioned earlier, a common one, and when patients are referred to the large hospitals to the south, a relative frequently accompanies them in the capacity of guardian.

The ninth, and last to be cited of these factors affecting the response to illness, is the **competing possible interpretations that can**

be assigned to the symptoms once they are recognized. In the case of other-defined illness, there is a tendency for relatives to cope with their sick kin's aberrant behavior and to attempt to "normalize" it or explain it away. There is perhaps less stigma relating to mental illness in Malawi than in the United States, due to its almost always being attributed to sorcery and therefore not the fault of the victim or kin. In the case of self-defined illness, a similar interpretation may be made, and sorcery of spirits may be invoked at various stages in the illness career as alternative etiologies to natural causes. Such attribution may be suspected by the victim and kin or may be initially suggested and later confirmed by the healer treating the patient.

In reality, of course, all of the above factors interact with one another in determining the course of a particular illness career. In the case of other-defined illness, as deviant behavior becomes more frequent and persistent, the problem becomes more evident and the initial tolerance of the family ebbs. The therapy management group seeks information as to what course of action to pursue and acts according to its perceived seriousness of the illness, tempered by any stigma it perceives as being associated with its action or inaction. (156) In the case of self-defined illness, the person experiencing symptoms is more likely to attend to them if they are persistent; if the sufferer's tolerance wanes, the symptoms, although the same, are perceived as being more serious, and medical aid is sought.

In sum, Malawi illness career patterns and help-seeking behavior can be analyzed using Mechanic's conceptualizations, since they incorporate the social and cultural elements in the construction of the sick role to a high degree.

Goffman's "Moral Career of the Mental Patient"

Goffman's "The Moral Career of the Mental Patient" (1959, reissued 1961) describes other-defined illness from a natural history perspective. He discusses both the internal or personal aspect of the illness career as well its public or official aspect. Goffman's main concern is with the moral aspects of the illness career, which he defines as "the regular sequence of changes that career entails in the person's self and in his framework of imagery for judging himself and others." (1961:128) He refers to "social anthropological work on ceremonies of status transformation" for material on moral career, (128) and my own researches in Malawi have uncovered several such instances of ritual status transformations. The ritual of chilopa is performed for patients suffering from ordinary vimbuza and the closely allied vyanusi, both forms of spirit possession. Partaking of the chilopa marks the status transition from patient to being cured in the case of ordinary vimbuza (Chilivumbo, 1972:8) and in the case of patients suffering from vyanusi, that form of spirit possession that confers divinatory and curative powers to those it afflicts, the administration of the chilopa is a kind of graduation or commencement exercise, marking the transformation from patient to nchimi. Both varieties of chilopa are administered under the aegis of an nchimi.⁹ Another rite of status transformation is called kusinka and is similar to the chilopa insofar as it signifies the cure of a patient. However the etiology in this case is sorcery rather than spirits, and the symptom is insanity rather than the varied, mainly physical complaints exhibited by most vimbuza patients.¹⁰

Goffman's analysis is centered around "the heavy machinery of mental-hospital servicing," (129) which is not very applicable to the Malawian situation, in which mental illness is dealt with in a way similar to that adopted by the Hutterites described by Mechanic. Goffman notes the wide variation in symptoms and their severity among mental patients, observing, however, that, once they have begun, the careers of mental patients tend to be similar. He attributes these similar careers not to their mental illness per se, but to the situations they find themselves in and the social forces that are common to such situations. (129)

Goffman suggests that students of the social aspects of mental illness adopt an emic perspective, mentioning its utility in the study of non-literate societies, where what is initially seen as barbaric and distasteful by the observer from his etic perspective becomes less so as one acquires familiarity with it. He claims that "craziness or 'sick behavior' is by and large a product of the claimant's social distance from the situation the patient is in, and is not primarily a product of mental illness" (130) and that the mental inpatient community is basically similar to other communities. Goffman recognizes that in mental ward as in any community, there will always be a minority who will be unable to follow the rules of social organization.¹¹

Most mental patients are unwillingly admitted to hospital, and it is the career of these that Goffman concentrates on. They come because they have been implored to or even threatened by their families, because they have been forced to by the police, or because they have been talked into it, not realizing the full implications of

being committed. I suspect that this description is essentially characteristic of Malawian mental patients.

Most mental patients have committed "offenses against some arrangement for face-to-face living," (133) which has incurred the wrath of some complainant, the first person whose actions lead to the prepatient's hospitalization. This defines the social beginning of the patient's career, irrespective of the psychological origins of his illness. (134) Most mental patients have had a long series of ineffective complaints lodged against them before finally being admitted to a mental hospital. In a somewhat similar vein, those accused of sorcery may be initially absolved of their crime. They become, however, the object of suspicion; and, if they later are suspected of perpetrating sorcery, their punishment is likely to be much more severe.

Goffman next discusses career contingencies, those factors that actually determine when the patient is hospitalized, and concludes that in a sense "mental patients distinctively suffer not from mental illness, but from contingencies." (135) To some extent these contingencies are similar to Mechanic's listing of factors affecting the response to illness. They occur during the prepatient's circuit of those agents and agencies that transform his status from prepatient to that of patient. (135)

The agent roles specified by Goffman are, first of all, the next-of-relation, who is defined in terms of being the most accessible and dependable in times of trouble. The next-of-relation is usually, but not necessarily, the patient's next-of-kin. The next agent role is

that of complainant, the person who in retrospect was responsible for initiating the patient's admission to the hospital. Complainants are usually lay persons, as opposed to the final category of agents, the mediators. These consist of those agents and agencies, including medical practitioners, lawyers, clergy, and police, to whom the prepatient is referred during the career leading to his hospitalization. Mediators tend to be specialists with "experience in handling trouble" (136) and correspond most closely to Emerson and Messinger's troubleshooters. Goffman's complainant is similar in many ways to the complainant of Emerson and Messinger, while the patient corresponds to Emerson and Messinger's victim. Emerson and Messinger, as we shall see, do not provide a special place in their schema for their victim's next-of-relation, as does Goffman.

The next-of-relation is in what from the prepatient's perspective is an "alienative coalition" with some mediator or mediators, where the relation is established as "the responsible person to whom pertinent findings can be divulged, while effectively establishing the other as the patient." (137) The prepatient is thus made to feel an outsider to these proceedings and may feel the object of some conspiracy. At the time of admission, when the role changes from that of prepatient to inpatient, there is often a feeling of betrayal and abandonment on the patient's part, as the next-of-kin leaves with the assurance the stay will be short and the treatment effective. (139) Mediators as well see mental hospitals as short-stay institutions. A somewhat similar situation exists for tuberculosis patients in contemporary Malawi, save that the time of inpatient hospitalization is much shorter, due to effective chemotherapy. The

problem is to ensure that the patient will continue to take his medication over a course of many months, and that he or she will report back to the hospital periodically for therapeutic evaluation.¹²

Prior to hospitalization, the prepatient is in possession of civilian rights and privileges, largely stripped away on admission. This is another aspect of the patient's "betrayal." From the prepatient's perspective, the circuit of agents functions as a sort of "betrayal funnel," with each stage resulting in a diminution of his adult free status, yet with each agent attempting to "maintain the fiction that no further decrease will occur." (140) The prepatient's consideration for those mediating his case allows them to show consideration, thus providing a positive incentive for his doing so. (141)

The circuit of mediators tends to define the prepatient's situation for the next-of-relation, which may result in the patient's further losing his trust in the next-of-kin or even hating him or her for a time. (143) This hatred may be deflected away from the patient's spouse, who is often the complainant as well as next-of-relation, by pressing one of the adult children into the role of mediator and so focussing the patient's animosity on the child. After admission, the hospital staff may assume this guilt-carrying function and so facilitate a rapprochement between the next-of-relation and patient. (144)

Goffman's final remarks about the prepatient's career point out "its peculiarly retrospective character." Until the patient is actually admitted and held against his or her will, neither the patient

or others may have conceived of him or her as becoming a mental patient, nor is there any way of knowing that he or she is destined to become one, "given the determinative role of career contingencies."

(145) A somewhat similar situation confronts persons accused of sorcery by an nchimi, save that, in their case, there is often no history of aberrant behavior.

Goffman's new inpatients may avoid having to ratify the grounds for their incarceration by attempting to withdraw into themselves. This attempt at anonymity is slowly given up as they settle down and assume the patient role, in which the routine is similar to other total institutions, "jails, concentration camps, monasteries, work camps, and so on." (147) Such total institutions, while present in Malawi, are not characteristic of most health care facilities. Patients at both traditional and western hospitals are free to leave the hospital wards and grounds if they are physically able to and normally do so, the sole exception being certain patients at the Zomba Mental Hospital.

Thus, while Goffman's prepatient phase, with its contingent and retrospective character, is similar to the illness career of a Malawian accused of witchcraft, the inpatient phase, with its emphasis on control and isolation from outsiders, is not applicable to Malawi.

The new inpatient is largely stripped of his former rights and is initially mortified and humbled by his institutionalization. He is punished by loss of privileges if he refuses to comply with the "pervasive house rules." (149)

Emerson and Messinger's (E&M) article, "The Micro-Politics of Trouble,"

. . . proposes a natural history framework for analyzing interactional processes through which personal difficulties or troubles are identified, reacted to, elaborated, and perhaps transformed into a specific form of deviance. These processes center around efforts to do something about or remedy the trouble, and are critically shaped by the nature and direction of the intervention of some outside, usually official party. The form a trouble ultimately assumes is in large part a product of micro-political struggles for the support and legitimation of such official agents. (E&M, 1977:121)

Emerson and Messinger's paradigm is generally applicable to the sorts of troubles taken to Malawian traditional healers for resolution, and I have used it in my analysis of certain of these cases, particularly those involving suspected witchcraft. However some sorts of troubles prevalent in Malawi are not adequately described by Emerson and Messinger's paradigm, and I have therefore amended it in order to encompass them. Both their original theory and my modifications to it are presented in some detail in Chapter VII.

Emerson and Messinger's Roles

Emerson and Messinger have delineated four roles fundamental to the micro-political processes involved in the resolution of troubles. The first of these roles is that of the victim, who is the person afflicted with the trouble. The second role is that of the complainant, who is the person who makes the trouble known to the agent who will hopefully resolve it. The victim and complainant are usually one and the same person, although the complainant may be a separate party, such as a relative, friend, acquaintance, or village headman acting on the victim's behalf. The third role is that of the troubleshooter who is the person to whom the trouble is taken for resolution. In the troubles described in this dissertation, the troubleshooter is a traditional healer, either a nganga, or, especially

in witchcraft cases, an nchimi. The fourth role is that of the troublemaker, who is the person who allegedly is responsible for the trouble. In the context of the cases from northeastern Malawi which I present here, the troublemaker is typically regarded as some form of sorcerer.

Emerson and Messinger's Concept of Careers of Troubles

Troubles, according to Emerson and Messinger, begin when the victim recognizes that something is wrong. That is to say, there is a definitional aspect to troubles, with such definitions being to a considerable extent culturally determined and culturally relative. This is not only true of interpersonal troubles, but of intrapersonal ones as well. An example of the former case of cultural relativism might be the ascription of witchcraft to an illness one contracts after having engaged in an argument with a neighbor. In contemporary Malawi or seventeenth century Massachusetts, this would be a popular rationale, although it would not be subscribed to by many in contemporary New York. In the case of intrapersonal troubles, many rural Egyptians would view bloody urine (caused by chronic schistosomiasis) as normal, as rural Nepalese view chronic diarrhea, while most Americans experiencing either of these symptoms would be alarmed and seek immediate medical attention. This takes us to the second stage of a career of trouble, namely, the remedial phase.

Remediation may begin with negotiations between the two parties (victim and troublemaker), to an interpersonal trouble. This interaction will not only help to determine the outcome of the trouble but also affect its perception. Such intrinsic remedies are doubtless

the most desirable as well as the most common form of resolution of most minor and many major interpersonal troubles. However many troubles, both interpersonal, as well as intrapersonal, necessitate the intervention of some outside troubleshooter to aid in their resolution. The victim may act on his or her own behalf in soliciting the troubleshooter or may relate the trouble to some third party who in turn, acting as a complainant, engages the services of the troubleshooter. In any event, the trouble is rendered a public affair by the enlistment of the complainant and troubleshooter to its ranks, and, as a corollary, the remedy imposed by the troubleshooter will be to a greater or lesser extent an extrinsic one.

As mentioned earlier, the enlistment of an outside troubleshooter presupposes an extrinsic remedy of the trouble. Whether this remedy will be perceived as a fair one by the parties will to a considerable extent be determined by the initial stance taken by the troubleshooter, that is, whether he or she responds to the trouble as conflict or as deviance.

In the case of many of the troubles discussed in this dissertation, the initial troubleshooter is frequently the village headman, who, by the nature of his position, is likely to view impartially any interpersonal complaints brought to him for resolution, i.e. to regard them as conflict. He may attempt to resolve the complaint himself, or, if as is likely in cases of overt witchcraft accusation, he will refer the case to an nchimi for divination. The reader will observe that in many of the letters dealing with such referrals, the headman remains neutral in his language, as is correct in cases of conflict.

If, on the other hand, the victim/complainant succeeds in convincing the headman that the troublemaker is indeed guilty of sorcery, the headman's language becomes less circumspect, and he describes the alleged troublemaker as a deviant in his letter of referral to the nchimi. It is then up to the nchimi in his capacity as troubleshooter to weigh the various "evidence" and arrive at a decision. In earlier days and on other continents, public opinion had considerable impact on the outcome of sorcery cases,¹³ and its ability to cause contemporary nchimi to treat troubles as deviance rather than as conflict should not be underestimated.

Once it is referred to an nchimi, the outcome of a trouble may be quite variable, since the nchimi may interpret the complaint as his spirits guide him. In this fashion, an overt interpersonal complaint between two disputants accusing each other of sorcery may be interpreted as conflict by the nchimi, who may ascertain that neither is a witch and instead find some more mundane cause of their trouble, which both parties will be equally urged to address and resolve. Alternatively, the nchimi may interpret the trouble as a case of deviance, finding one party to be the victim and the other the troublemaker and commanding the latter to relinquish his nyanga and cease his evildoing.

It appears that most of the cases taken to nchimi for troubleshooting have their beginnings as what we would term intrapersonal troubles, the victim suffering from some physical, mental or economic complaint which is not (at least initially) overtly attributable to any other person, but rather seemed due to bad luck,

nature or God's will. It is such troubles whose careers are most often and most radically altered and transformed by the intervention of nchimi and to a lesser extent by nganga. What begins as an intrapersonal trouble is transformed into an interpersonal one and attributed to the deviance of some troublemaker.

The next stages of such a career of witchcraft trouble typically involve the nchimi identifying the troublemaker, obtaining his confession and coercing him into relinquishing his nyanga, and making him drink mbozgya or cutting him with dekano, both medicines being able to prevent the confessed sorcerer from engaging in further evildoing. In the meanwhile, the victim is given various medicines, in an effort to treat the symptoms of the witchcraft induced complaint as well as to neutralize the sorcerers power over him. Finally, the victim and troublemaker return to their village and inform their headman of the nchimi's findings, and the headman takes whatever measures he deems necessary to punish the confessed witch.

If it is not already obvious to the reader it will soon become so, that the above synopsis of a career of trouble of supernatural etiology (in this case witchcraft) is but one of many possible alternatives, such alternatives being illustrated and discussed in the following chapters.

METHODOLOGY

A. Types of Data Collected

I collected a wide variety of information on medical practice and related belief during the course of my fieldwork in northeastern Malawi, including the following:

1. Observations of medical practices at both traditional and western medical facilities, and in diverse other settings, such as funerals, villages, and markets.
2. Narratives of dreams, both of patients and non-patients, which illustrated some of the unconscious manifestations of supernatural belief.¹⁴
3. Traditional names and their meanings, many of which illustrate belief in supernatural forces.
4. Autobiographical illness histories, and logs of daily events written by patients at traditional hospitals.
5. Essays on a wide variety of topics related to medical practice and supernatural belief.
6. Inpatient and outpatient records from western and traditional hospitals.
7. Maps of traditional hospital villages.
8. Songs sung during spirit-possession and healing ceremonies.
9. Ethnopharmacopoeia compiled by both healers and laymen.
10. A glossary of Tumbuka words relating to disease, healing, witchcraft and religion.
11. Letters written to traditional healers.¹⁵
12. Commentaries on the above letters by their authors, in which I asked them to explain the significance of their own letters, as well as the general function of such letters.¹⁶
13. Letters written by traditional healers to their clients, primarily village headmen.
14. Primary and secondary school textbooks, and syllabi.
15. Printed and documentary materials on traditional religion, medicine, and sorcery belief.

Methods of Data Collection

Information was obtained utilizing a variety of techniques, so that there were often several sources of similar data on any given research topic. This multi-faceted method of data collection was coupled with a series of nine field trips to northeastern Malawi, over a period of nine years, which added an invaluable longitudinal or temporal dimension to my study, greatly enhancing its reliability.

The methods of data acquisition included observations made at a variety of social settings of a medical or religious nature, both western and indigenous, including facilities of both traditional and western healers, funerary rituals, villages, markets, gardens, and schools.

In addition to these observations made by me as a bystander with varying degrees of conspicuousness, I was fortunate in being able to work as a participant observer at several western medical facilities in northeastern Malawi. I lived with various medical doctors and medical assistants and contributed my services to the medical facilities they administered in a variety of ways, which gave me entree to, and empathy with, their operations in a way difficult for an outsider to have obtained. I repaired hospital equipment ranging from operating tables to microscopes, sharpened surgical instruments, helped design and equip laboratories and an x-ray darkroom, drove the ambulance cum hearse, assisted at numerous operations, went on rounds with the medical staff, inventoried and reorganized several pharmacies, dispensed drugs to staff members, and purchased supplies. In addition, I taught a week-long course in elementary anatomy and physiology to the

staff at one remote medical outpost. These experiences, which extended over a period of eight years, provided me with considerable insight into hospital operations and utilization.

Another important method of data gathering I used over the years was interviewing a wide variety of persons in a wide variety of settings on all aspects of medical belief and practice. All interviews were of an open-ended nature, although many were initially focused.¹⁷

There was some difficulty in arranging interviews with the authors of the letters, due both to the intrinsically sensitive nature of such correspondence as well as because the letters were often in obvious violation of the Witchcraft Act's admonition against witchcraft accusation and the employment of witchfinders. I managed, however, to interview about twenty of the authors, mostly village headmen, but also a chief, a sub chief, and several laymen.¹⁸ Additionally, I held numerous interviews with ordinary folk who had not to my knowledge written to any of the healers who had provided me with their letters in an attempt to ascertain the general public's view as to the function of such correspondence. I assumed that if an individual had not written such a letter or had no reason to believe that I knew he or she had, he or she would be less likely to have any inhibitions about divulging to me the function of such letters. The information gleaned from these interviews with authors was generally consistent with the results of the content analysis performed on the letters, as with the numerous other interviews, observations, and written statements I obtained during the course of my field work.

Unlike a questionnaire with its generally narrow focus on

preselected specific information, these letters contain a wide range of raw data, much of which is implied or alluded to, rather than directly stated. In numerous instances, the author writes to the healer on matters that they have discussed before, either verbally (directly or through an intermediary) or in writing, and references to such prior communications are often largely unintelligible to the outside reader. Nevertheless a considerable amount of information can be gleaned from most of these letters, not only from their manifest content but also from what is known of the particular healer addressed, and from the cultural patterns that define such correspondence. For example:

My Dear Sir Nchimi Lipuka,

I was very happy when I received your letter. Now, Nchimi, please do me a favor, I've sent two people to you: Aliki Bwana and Nelson Lambya. Divine them accordingly. Then tell me whether they are good men or not. Please do it. I know that you know everything.

Yours,
G.V.H. Wolo

In this case, Group Village Headman Wolo states that he has received a letter from Nchimi Lipuka which implies that he had written an earlier letter to the nchimi. Thus, this letter represents at least the third exchange between the two, although not necessarily on the particular topic dealt with here. The request that the nchimi divine the two men sent by G.V.H. Wolo, in order to ascertain "whether they are good men or not," is given deeper meaning in light of the information garnered from interviewing, namely, that such referrals are invariably made only in cases of suspected witchcraft. Therefore, this request by G.V.H. Wolo can be interpreted as his requesting Nchimi Lipuka to engage in witchfinding. While the details of the case can not be ascertained from a perusal of the letter alone but would require interviewing one

or more of the parties involved, the letter itself provides data strongly suggesting that it is a case of witchcraft suspicion requiring the services of a diviner, such services necessarily being sought through the aegis of a headman.

Closely allied to interviewing was the administration of questionnaires by my research assistants to various members of the community. Since illiteracy is widespread, it was necessary to administer the questionnaires orally, which allowed them to be relatively open ended in nature, although several written questionnaires were administered to upper primary school pupils in the area.

I solicited written narratives from literate Malawians, whom I provided with writing materials and a list of topics I was interested in. Some of these narratives were of an autobiographical nature, especially illness histories and diaries or logs kept by inpatients at traditional healers. In addition, I sponsored an essay competition at a local secondary school, with cash prizes for the best essays on traditional belief. This proved to be extremely rewarding both for my research as well as for the participating students.

I did some mapping of the hospital villages of several traditional healers, in order to ascertain their extent, form, and similarities. In addition a crude census was taken of the patient population at various healers.

The analysis of the letters obtained from traditional healers deserves some special mention, as they are so central to my dissertation. These letters totaled approximately 1,500. They were

photographed and then translated into English by local secondary school graduates who were fluent in English as well as in the various indigenous languages the letters were written in, for the most part the Tumbuka tongue, but with a few in Tonga, Chewa, Sukwa, Nkhonde, and English.

Representativeness of the Letters

Although the letters I collected were neither a universe nor a random sample of such correspondence to traditional healers, I believe that they are representative of the written documentation of types of troubles brought to nchimi and nganga for resolution, as well as providing a reasonable indication of the proportion of witchcraft-related cases healers deal with and of the role played by village headmen in such cases. The letters were collected from over a dozen healers, although only ten collections of correspondence were ample enough to be included in my analysis. These healers were located over a wide geographical area and had a wide variety of practices. Furthermore, many additional healers in this area were visited, and my observations of them lead me to believe that those nchimi and nganga who volunteered their correspondence represent a cross section of their profession.¹⁹ The letters were collected over a period of six years (1974-79) and were written over the course of a decade (1970-79). There seems to be considerable uniformity of content and style among letters written to the same healer over a period of almost a decade, which would indicate the stable role of the healer and a stable function for the letters.

The collections of correspondence from the several healers are

of varying degrees of completeness. None of the healers had a well-organized chronological filing system for their letters, and many either discarded some letters in a random fashion, used the paper for wrapping powdered medicine, or for fashioning cigarettes. Those letters that were retained are typical of the types of complaints treated by these healers. I often obtained a corpus of correspondence with no advance warning, and the healers generally made little or no effort to sort through their materials, merely fishing the letters out of the box or other container they happened to be in and presenting me with them. It is evident from reading the letters that several of them are potentially embarrassing or even incriminating, and yet they were lent to me. If the healers had selectively edited their materials prior to letting me examine them, such matter would most likely have been removed. In addition, some of the collections of letters contained other documents, which were mixed together with the client's correspondence and which would not have been included if the healers had sorted through the material prior to allowing me to examine it.

In short, all evidence leads me to the assumption that these letters are representative of the wide variety of the more serious troubles that are taken to nchimi and nganga for resolution and for which such letters are written. I recognize that less serious complaints, which constitute the bulk of the average nganga's practice, are not adequately represented by these letters, as letters are not normally written in such cases, the client going directly to his or her local nganga for treatment.

Explanation of the Variable List

Of the approximately 1,500 letters collected, 1,233 were translated and coded, although only 805 proved relevant and were sufficiently intelligible and complete to be included in the analysis. I had performed a preliminary analysis of the first lot in 1974, using peripheral-punch (McBee) cards and coding for about a dozen variables. Additionally, having hastily read the newly collected letters as they were translated, I had some prior familiarity with the correspondence when I ultimately performed a more exhaustive, computer-assisted content analysis of the letters, which coded for forty-eight variables, falling into four broad groups: provenance, authors, type of help desired, referrals.

Provenance

Twelve variables deal with the provenance of the letters. First is the **type of healer**, nchimi or nganga the letter was addressed to, and next was the source from which I collected the letter, that is, the **name of the healer** to whom the letter had been addressed and from whom the correspondence was obtained. There was one exception to this, a group of five letters that was obtained from an established healer, an nchimi, but which were actually addressed to an apprentice of his. Each letter was assigned a **serial number**.

The other provenance variables are: the **author's name**, and the **day, month, and year the letter was written**. Some of the letters lacking dates were in envelopes bearing date stamps, and this date was coded as the date of the letter. Where a letter had no discernable date, the year that it was collected was coded.

Five variables all spatially locate the authors of the letters

in order to facilitate plotting them on a map and thus indicate the geographical distribution of each healer's practice. These variables are the **author's post office** and **postal agency** (or branch post office); the primary, or rarely, secondary **school nearest the author**, schools often being used as mailing addresses in Malawi; the name of the **author's village**, and the name of the **author's village headman**, again often included in an address.

Authors

Twelve variables describe the authors and their relationship with the healers they wrote to. The **author's sex** was normally deduced from his or her first name, from the prefix Nya which is appended to a married woman's last name, from the occasional use of Miss or Mrs., and to references to husbands within the text. All chiefs and headmen are male.

The **author's occupation**, or status as a chief or headman, was determined both from the text of the letter, as well as from the address, such as a mine in Zambia, or a factory in Blantyre. Chiefs and headmen normally include their titles in heading and signing their letters. There were about fifty occupational categories.

The next set of variables categorized included the **author's status as a patient** of the healer addressed or of some other healer, the **author's kinship relationship to the healer**; and any evidence of **prior communication** between the author and the healer.

I was interested in the degree of **Christian religiosity** prevalent among patrons of traditional healers. Numerous members of

the clergy and other churchmen and women of my acquaintance in Malawi, had voiced the opinion that the patronization of traditional healers, especially diviners, implies a lack of Christian faith. I therefore noted any reference to God, Jesus, angels, the Holy Spirit, and the Devil, as evidence of some degree of Christian religiosity.

Greetings sent by the author to the healer were coded as evidence of esteem and relationship. Related to greetings, were the categories of **praise** and **thanks** to the healer, which to some extent indicated the esteem in which he was held by the author. Any **payment** or **gift** giving to a healer was coded, as was any request for the healer's **forgiveness** or pardon. These variables indicated the value of the treatment to the patient and the deference with which the healer was held.

Lastly, if the letter contained a significant amount of **personal or non-healing related business** it was coded, with those exclusively of such nature being excluded from the statistical analysis.

Type of Help Desired

Fifteen variables describe what it is that the author desires of the healer. The first such entry codes for the **specific type of help desired** by the author, and notes when there were requests for several types of help. The next several variables describe certain specific troubles of the author or of those persons he refers to the healer. The first codes for any **mention of death** in the letter. The next deals with any allusion to **spirit possession** or reference to spirits. Lastly, any **reference to dreams** was coded.

Disease was coded as **traumatic, acute, and chronic** states, and the **specific disease entity**, or its location on or within the victim's body, was also coded. **Sexual or reproductive complaints** were thought likely to be major aspects of the traditional healers practice, so they were recorded separately. Similarly, any references to **marital strain or discord** were coded.

Other miscellaneous variables encoded were the social-spatial **site where the trouble manifested itself**, such as the home, village, school, or workplace; any reference made to the use of **western medical treatment**; and any proposal on the author's part that he or she **visit the healer**, or that the healer visit him or her.

The remaining four variables in this group form a kind of specialized subset, which link as a whole with the next and final group. All four, while dealing with other troubles of a general nature and with the sort of help solicited from the healer, are in addition heavily, if not exclusively, oriented to problems associated with witchcraft.

The first codes for overt or implied **accusations or disputes**, which in the context of these letters, are almost invariably announcements of suspected sorcery. The second, denotes any explicit or implicit **reference to witchcraft**. **Requests for divination**, which again are usually made in cases of suspected sorcery, were coded separately. These are usually accompanied by a request that the healer communicate his²⁰ findings to the headman initiating the request for divination, and such **requests for a reply** were also coded separately.

Referrals

Nine variables deal exclusively with the referral process initiated by the author, usually a headman or chief. Any such **referral** or **introduction of a third person** to a healer was coded, as was the **number of men, women, and children** referred to the healer by the author. The **total number of persons referred** was included as a catch-all category, since the ages and sexes of those referred were not always apparent from the letter. I also coded both for the simultaneous **referral of both a husband and wife**, or wives, or when such spouses planned to visit a healer on their own.

In witchcraft cases, a witness or witnesses are commonly sent by the headman to the nchimi, along with the supposed victims in order to provide the headman with an unbiased account of the diviners findings. In addition, an escort would normally attend any inpatient, either of a traditional or western healer, in order to provide custodial and nursing care as well as companionship. The presence of such a **witness or escort** was coded.

In many cases, the troubled person is too sick to make the journey to the healer or is otherwise unable to do so. In such instance a **surrogate** may be sent to describe the victim's symptoms to the healer, to be divined in his or her stead or merely to collect medicine for his or her relative. Finally, I coded whenever a **person refused to go to a healer**, since such refusals, especially to go to a diviner, are usually associated with witchcraft accusations, often with the person refusing to go being a suspected sorcerer.

Variable List

Variables Describing Provenance

1. Type of healer (nchimi or nganga).
2. Name of healer.
3. Author's name.
4. Day letter written.
5. Month letter written.
6. Year letter written.
7. Author's post office.
8. Author's postal agency.
9. Author's school address.
10. Author's village.
11. Author's village headman.

Variables Describing Authors

1. Author's sex.
2. Author's occupation.
3. Author's patient status.
4. Author's kinship relation to healer.
5. Author's prior communication with healer.
6. Authors degree of Christian religiosity.
7. Author's greetings to healer.
8. Author's praise of healer.
9. Author's thanks to healer.
10. Author's payment or gift to healer.
11. Author's request for forgiveness from healer.
12. Author's reference to non-healing-related business.

Type of Help Desired

1. Specific type of help requested.

2. Death mentioned.
3. Spirit possession mentioned.
4. Dreams mentioned.
5. Illness type (chronic, acute, traumatic).
6. Disease type.
7. Sexual and reproductive complaints.
8. Marital strain or discord.
9. Location where trouble manifested itself (home or workplace).
10. Western medical treatment mentioned.
11. Author suggests a visit to healer, or visit from healer.
12. Accusation or dispute.
13. Witchcraft mentioned.
14. Divination requested.
15. Reply requested.

Referrals

1. Referral of some third person by the author.
2. Number of men referred.
3. Number of women referred.
4. Number of children referred.
5. Total number of persons referred.
6. Simultaneous referral of husband and wife.
7. Witness sent.
8. Surrogate sent in lieu of patient.
9. Refusal of person to visit healer.

¹In the United States, in addition to the practice of conventional **Allopathic Medicine**, there are a variety of competitive systems of healing, based on a greater or lesser degree of scientific rationality, and enjoying a greater or lesser degree of legitimacy. These include, but are not confined to the following: **Chiropractic**, which is covered by Medicaid in 27 States, and by Medicare as well, when subluxation of the spine is demonstrated on X-ray; **Christian Science**, "a religion, and system of healing through prayer and the control of mind over matter." Some of its services are covered by health insurance programs including Medicare and Medicaid; **Homeopathy**, once popular, but now largely used as self treatment; **Naturopathy**; **Osteopathy**, now virtually synonymous with allopathic medicine; **Structural Integration or Rolfing**; and **Scientology**, "a religious movement . . . which claims a sure psychotherapeutic method for . . . speeding recovery from sickness, injury and mental disorder. (U.S. Congress, House. 1976)

As can be seen from this list, some twentieth century Americans patronize systems of healing scarcely more rational and scientific than those provided by traditional Malawian healers, and the United States government recognizes the validity of such therapies. See Wallis & Morley (1976) for a discussion on various types of marginal medicine as practiced in the U.S.A., including several of the aforementioned varieties.

²See Chapter II for a description of inpatient organization and the social stratification that takes place with long stay patients, who eventually move to the top of the inpatient hierarchy, thus providing them with an additional secondary gain.

³See Chilivumbo (1972) for a description of the social norms that are violated during the vimbuza dance.

⁴See Leacock & Leacock (1972) for a detailed discussion of this phenomenon.

⁵This seems to have been a theoretical problem which proved refractory to Parsons analysis. See his piece on motivated illness (Parsons, 1964:112-26).

⁶Interestingly enough, the Concise Oxford Dictionary uses one sense of the word empiric to mean a "quack doctor." (1976:339)

⁷To what extent this stoicism results in at-home deliveries resulting in obstetric emergencies is worth speculating on. One factor for such stoicism may be attributable to the widely held belief that difficulty during labor is due to the woman having committed adultery. If she is having difficulty, she is exhorted to reveal the name/s of her lover/s. A woman not wishing to be put to such indignity, may attempt to put on a brave face and repress her urge to express her pain. Another illustration of this stoicism is provided by an incident in which a European woman of my acquaintance gave birth in a rural Malawi hospital. She was not reticent about verbally expressing her labor pains and became the butt of numerous, albeit good-natured jests and imitations of her groanings, by the Malawian mothers and

mothers-to-be in the maternity ward.

⁸I remember the case of one old woman, who had never been to a western medical facility, although she lived not far from the site where a weekly mobile clinic was held. She had been suffering from a large ulcer on her thigh for several years, and traditional treatment proved ineffective. She was afraid to try western treatment, but was finally forced to do so by her relatives. Unfortunately, the ulcer had become malignant, and she died from its metastases. Had her fear of western medicine been less, the ulcer could have been successfully, and she and her family could have been spared much suffering.

A similar case was that of a middle aged woman with a tumor of the knee about the size of a volleyball. She had no use of her leg for some time but was loathe to have it amputated. She too died of the cancer, fearing the loss of her leg more than the loss of her life. Both of these women were sane, as we commonly use the term.

In another case, coincidentally also involving the lower extremity, but this time afflicting a young man, who was not sane. He suffered from a severe fungal and bacterial infection of the foot, which by any standards required hospitalization. He was, however, incapable of appreciating the gravity of his condition, and, although he was for a time forcibly sedated, he eventually wandered off.

⁹The ritual itself consists of taking a live chicken or goat, (Chilivumbo reports that cows are also used) and biting its throat so as to sever the large blood vessels and drink its blood. The Leacocks' report a similar form of ritual sacrifice to spirits among an Afro-Brazilian spirit possession cult. (Leacock & Leacock 1972:247,73,98)

¹⁰The salient features of the kusinka ritual were explained to me by Nchimi Chirembwe shortly after he had invited me to observe him administering it to a young woman in her twenties. She had been bewitched by a watchman at her job site, where she was a community development instructor. She was said to be suffering from kuzweta mutu or "turning of the head." (It is worth noting that her superiors granted her leave to seek traditional medical care.)

The function of kusinka is so "a person never suffers from madness again" and assumes a calm demeanor. It consists of the ritual slaughter of a sheep, which is used because a sheep when moving always keeps its head down, symbolizing its heart is good. It is quiet. The sex of the sheep should be the same as that of the patient. Only the sheep's heart is used in the ritual. This is because the heart helps the person to be "alright." A quiet heart. The heart is excised from the sheep and eaten by the patient, either raw or cooked, as the patient prefers. Prior to this, a mankhwala prepared from pounded leaves called muzura or nyauhango is prepared, some of which the patient washes with, drinking the remainder. "Even a cruel person can become quiet with that kind of medicine." Additional mankhwala is made by preparing sima or porridge and mixing it with some of the sheep's heart, which the patient then eats. The ritual itself is performed at dusk, by the bank of a river. At its finale, the patient's hair is shaved, mixed with mankhwala, and buried in the river bank. This has

the function of making the heart ever quiet because the river is ever cold and ever flowing. The various pots and calabashes used in preparing the mankhwala are then thrown into the river, symbolizing that the disease has finished forever, because when they go into the river they can never return. Finally the patient and her father walked back to the nchimi's hospital village with the admonition not to look back, symbolizing that she has left her disease behind her. The patient is now cured.

¹¹The list of rules posted by Nchimi [Vwamba] cited in Chapter II, was an attempt to minimize such infractions. The patient capitaos serve a similar function.

¹²Goffman alludes to the similar situation in the moral career of the tuberculosis patient (Parsons, 1972:144) in the days prior to effective chemotherapy, when T.B. patients had to spend long periods in hospital, just as mental patients did.

¹³In 1692, John Proctor, hanged as a witch during the infamous Salem witchcraft trials, wrote that "judge and jury hav[e] . . . condemned us already before our trial. . . ." (Graubard, 1984:76)

¹⁴Professor Deborah Offenbacher, of Brooklyn College, sponsored my collection of some 2,000 odd dream narratives for a comparative study that she had undertaken, (Offenbacher, 1976) and graciously shared her material with me.

¹⁵My initial discovery of such correspondence was made during the course of an interview with a well known nchimi who had an extensive inpatient practice, when during the course of an interview he happened to mention that his clients often wrote letters to him. Upon my asking him if I might see them, he produced two termite-riddled cardboard boxes full of unsorted letters and other documents. I asked my research assistant to roughly translate a few of the letters. His reading of them confirmed my initial feeling of pleasant anticipation, and I knew then that I had the kernel of my doctoral dissertation before me. I was also somewhat overwhelmed by the sheer volume of material to be dealt with, as I had but a short time remaining before having to leave Malawi. I therefore hesitantly asked the nchimi if I might borrow the letters for a week or two, so that I might examine them, and much to my relief he consented.

¹⁶I soon discovered that I was at a considerable disadvantage in not having the original copy of the letter, which I naturally returned after its translation, because many authors either could not, or more probably would not remember the letters they were being queried about. I therefore photographed all letters collected subsequent to 1974 and affixed a facsimile of each to the back of the translations I worked from, in order that the author when interviewed would have a direct means of refreshing his memory, as many of the letters were already several years old when I first obtained them.

¹⁷In general interviewing went smoothly, but there were occasions when I found it rough going. Lofland has written that "some researchers, . . . have remarked that contradicting and arguing may be quite productive, at least in some circumstances." (Lofland, 1971:90)

I certainly found this to be the case on many an occasion, especially when an informant gave a garbled account or was reticent about divulging the true course of events, which I had already ascertained from other sources, but wanted further confirmation or clarification of. The ease of taking notes recorded as the informant relates his or her narrative is one of the few advantages of conducting interviews via an interpreter, as I generally did. Such notes enabled me to refresh my own, as well as the informant's, memory on points needing clarification.

¹⁸ The total number of authors was 651, of whom 199 were headmen and chiefs. The authors interviewed were selected after consultations with my field assistants, who generally had some knowledge of the author. We only attempted interviews with individuals whom we felt would not take offense at such inquiries. I usually began such interviews as if I assumed that the subject had no first-hand experience in such matters but was familiar with the general function of such letters. I would initially ask the author to talk in general terms about his knowledge of the role of traditional healers and the function of letters written to them. When I felt that sufficient rapport had been established, I directed the conversation to the specific healer to whom the subject had written and then introduced the author's letter for discussion. The reactions were mixed, but generally satisfactory, with most of the authors approached admitting to having written the letter and explaining the circumstances prompting their correspondence. There was occasional embarrassment and one or two rather overt refusals to discuss the letters.

¹⁹ The sole exception to this representativeness seems to be Nganga Tyapula, whose practice is unique among the nganga of my experience.

²⁰ All of the ten healers whose letters I present here, were male; however, there are female nchimi who undertake such witchfinding cases, one of whom I was able to interview although I could not obtain any letters from her.

CHAPTER IV

THE ROLE OF THE NCHIMI

Nchimi as Witchfinders

The role of the nchimi is generally perceived to be that of troubleshooter, to use Emerson and Messinger's nomenclature. (1977:126) In northeastern Malawi, nchimi are sought out to troubleshoot a wide variety of troubles, most especially those that are suspected of being caused by witchcraft. The two healers with the largest practices and with the greatest reputation as witchfinders, Nchimi's Vwamba and Lipuka, were the ones with the greatest total number of referrals. It appears that their reputation as witchfinders was in large part responsible for their overall popularity.

One way in which suspicions of witchcraft may be generated is if an illness fails to be successfully treated at a western medical facility (or by a nganga). This failure is seen as a token that the complaint is of supernatural etiology, and the patient is likely to seek succor from the traditional health sector, especially from an nchimi.

The following excerpts from healers' correspondence illustrate this use of the nchimi as a provider of secondary (or later) health care, when western medicine has been unable to resolve an illness related trouble.

In the hospitals, a way is not seen. Thus why she has thought before, to come to you Nchimi Vwamba.

We have failed in the hospitals and we think you [Nchimi Vwamba] will help her.

I have been given two injections at Roman Catholic Hospital, but no improvement, so please Nchimi Sukutura give me some medicine together with the children.

They have been attending the hospital here, and after finding the hospital wasn't helping them, I told them to come and see you Nchimi Vwamba ... (1) For you to know what disease they are suffering from (2) [For] medicine that would make them not bewitched.

In each of the above instances, western treatment was sought but was of no avail, and so traditional healers were resorted to.

Western and traditional systems may also be used concurrently, as the following letter illustrates.

Dear Mr. Nchimi Lipuka,

This letter is to inform you that we are here at Chiwawani [Mission] Hospital. When we reached Rumphu is when we heard that Dr. Scott is back from holiday and then we thought of coming here. Sorry for this was unforeseen.

The disease is still [with us] and now they have changed the medicine trying the other type. The truth is it is really witchcraft.

When we have been discharged we shall be coming there without failing if God can give us the opportunity to come. ...

Wishing you the best of living.

Yours Sincerely,
Chapasi Mwale

It seems that the author and his entourage were on their way to consult Nchimi Lipuka when they heard that Dr. Scott, a missionary doctor with long experience and high reputation in northern Malawi, was back from leave abroad. They thus modified their plan and decided to consult him first, rather than proceed directly to Nchimi Lipuka. Apparently Dr. Scott was unable to treat the complaint to their satisfaction, and as so often occurs, this was taken as a sign that the trouble was due to

sorcery. (Wendroff, 1983:266) The victims state their intention of seeking help from the nchimi upon their discharge from the hospital, as they evidently have lost their faith in the ability of the hospital to cure the disease, which had evidently been ascribed to witchcraft. The failure of the hospital's treatment was perceived as confirming such diagnosis. In many cases, patients are discharged without having been cured or even adequately diagnosed, at least by their own lights, which may in fact be in agreement with state-of-the-art medical opinion, which although capable of providing a diagnosis and possibly a cure, is unfortunately unavailable to the majority of Malawi's (and the world in general's) population.

The following letter illustrates how the two systems of healing are used concurrently or in parallel by the two principal parties to a trouble--the victim and the troublemaker. Note that in this instance there are two troubleshooters, one Western and one indigenous. In all probability, the western healer/troubleshooter is working in ignorance of his traditional counterpart's contribution, although as the letter indicates the nchimi has been apprised of the role of the western healer.

Dear Chimi Vwamba,

Herewith [is] Chidongo Mwafulirwa who has been accused of witchery by Chalwita Msonthi. The bewitched is now at the hospital at Karonga.

You know everything what is to do with him as [you are] a real witchfinder.

Yours, V.H.
Kankhusi

The village headman has referred the alleged malefactor to the nchimi for divination and possible exorcism of his evil. Meanwhile the victim

has resorted to the hospital for what according to the letter must be envisaged as merely symptomatic treatment and will presumably consult the nchimi on his discharge from the hospital.

An individual may also resort to the western medical system for one complaint, while at the same time utilizing the traditional healing system for some other unrelated need. Unfortunately there is no letter in my possession illustrating this point, but I have often noted it during interviews at western medical facilities. Examples include: protective charms and amulets worn on the person, medicine for vimbuza, and house and garden magic; all being used while a person is receiving western medical treatment for some unrelated complaint.

This next letter illustrates an unusual use of the nchimi, namely to clarify the findings of the western medical system in a non-supernatural context. A worker for some unspecified employer is apparently ill enough (possibly with an occupational disease?) to retire and claim his retirement gratuity, which in Malawi is often given in lieu of a pension. His employer is not satisfied with the diagnosis made at the local government hospital and is having him seek a second opinion at another, more sophisticated facility. The author is puzzled and requests the diviner to somehow clarify matters.

Dear Father [Nchimi Vwamba],

. . . Now I want you to tell me about what you already know about the gratuity, because now they are sending me to Lilongwe [General] Hospital to be examined. But here it is where I don't understand, because at Mzimba [District] Hospital they already examined me, and they found disease; and they have said that I should leave the job and have to receive my gratuity. Now they [my employers?] don't agree with the Doctor at Mzimba, that is why I say these things to you, to look into them; because I myself they have broken my head [confused me]. Please I have begged you. Please go over these things. . . .

Yours,
D. Fumpira

The general lack of adequate communication between western medical personnel and their patients may necessitate many such requests made of traditional healers to elucidate western diagnoses. In all fairness, however, it should be noted that traditional diagnoses are often equally confusing, and communication between traditional healers and their clients may on occasion be even less informative than that between western health care personnel and their patients.

There is considerable trust and confidence placed in traditional healers, particularly in nchimis, and they are frequently consulted by patients who have obtained a diagnosis at a Western health-care facility to explain the "why" of the Western healer's diagnosis. The opposite, however, is generally not the case; and, although Western healers may be consulted after having consulted a traditional healer, it is not to ascertain "why" or "who" caused the complaint, but rather to treat its symptoms on a somatic level, with any supernatural ramifications later being taken to an nchimi.

Officialdom's Use of Nchimi's Services

In order for traditional healers, particularly nchimi, to continue practicing their technically illegal witchfinding, they must have the tacit approval not only of the populace in general but of those who hold the reins of political power. The following letters are illustrative of the faith of such functionaries in the powers of nchimis. The first letters are from officials in Malawi's sole political party, which, together with the Life President, is the real

center of authority in Malawi. (Nelson, 1975:153. Williams, 1978:230)

Malawi Congress Party
Chizungu District Headquarters

Dear Nchimi Vwamba,

See this young man as quickly as possible because he has a lot to do at the Party. He is the District Chairman for the Party. He is wanted here in Chizungu on Friday because we are having District elections . . .

In the name of the Party,
Amosi Mvula
District Clerk
for District Chairman

This letter shows that the services of an nchimi were urgently solicited on behalf of the Party. In this case the nchimi resided some one hundred and twenty miles distant from the author of the letter, so there must have been a rather pressing need for the consultation. The next letter leaves less to the imagination as to what services are requested of an nchimi by Party members as well as by the public at large.

Kafukule Branch [M.C.P.]
Kalulu Area

To Nchimi Sir Vwamba,

This letter is to inform you according to the call you gave Mr. J.K. Sukwa. The letter we received from you is the second one. Now, I, Branch Chairman of the Kafukule Branch, went into action and I went to the man you were calling for, Mr. Godfrey Dwangwa the younger. I found out that you have accused him of being a witch. He, Mr. Sukwa, is accusing his brother of being a witch -- and he continued to say that he has got witnesses who can agree with him that his brother said that he is going to kill him. When I read your letter in which you said that the brother of Sukwa (who is accused of being a witch by his brother) should accompany him to your place. I did not understand that and I would like you to explain more on this matter than before.

I now inform you that as you have called that man to your home as a witch, I suggest that the best thing to do is for you to come here and take the nyanga from Sukwa in the presence of everyone so that it should be known that he is a witch by everyone. Sukwa too is suggesting the same thing. I hope he wrote you about it. He would have come in person to tell you that but he's busy with some other business.

I would be glad to learn about [your] health.

Goodbye you,
Branch Chairman of Kafukule
Mbembe Songwe

In this case, the local chairman assumed a role similar to that of a village headman. My conjecture is that the problem was so locally notorious that the Party was called in as an unbiased adjudicator. The local branches of the Party frequently engage in community affairs, including road and school construction. The resolution of witchcraft accusations are apparently another area in which they occasionally involve themselves.

The courts are another locus of power which in theory should be at odds with nchimi, at least insofar as their witchfinding practices are concerned. This next letter indicates that the author, a court official with various outside business interests, was not above patronizing the nchimi for various magical charms.

S.N. Misuku
Vumba Court

Dear Nchimi Vwamba,

I am here, work is really plenty; I've got sixty cases at hand and I know I am going to knock off when it is dark.

How about our things? Are you preparing them? Especially the store thing. The grinding mill can wait. I don't want my store and my grinding mill to finish. . . .

I am yours,
Misuku

This official had presumably earlier requested the nchini to prepare magical charms to ensure the success of his outside business interests, a store and a grain grinding mill. These are common business ventures undertaken by those employed in both the public and private sectors. They invest their savings in them and operate them with hired labor and/or with the help of family members. Such ventures are often risky, and the prudent person takes whatever steps he can to ensure their success. One commonly used method of soliciting patrons is by the use of magical charms which will entice customers to one's business, which is probably what the official was referring to in his letter. Although innocuous sounding, such charms are sometimes fabricated from human flesh, often infants killed specifically for this purpose.¹ It is likely that one who solicits such charms from an nchimi is cognizant of the nchimi's role as a witchfinder. It certainly does the nchimi no harm to have friends and clients in these positions, who can put in a good word for him in the event that his circumventions of the Witchcraft Act are prosecuted.

Perhaps even more useful in such an event is to have the police on one's side. During the course of my fieldwork I observed several police officers patronizing traditional healers. The following letter illustrates such a case.

Police Station

Thank you Sir [Nchimi Vwamba],

I am Mr. Zgambo here at the Police Station, and I have sent my wife to come to you and see what is stopping her from bearing children. I would have come but because I

am on duty, I have failed.

Please do your best.

Yours,
F.N. Zgambo

Since police officers, like members of most other occupations, are clients of nchimi, they are loathe to interfere with their work even though they know it is frequently of a technically illegal nature. In this case, it is quite likely that the barren wife will be diagnosed as ensorcelled, and the policeman might then become a party to such an accusation.

There can be little doubt that most people believe in the reality of sorcery and are prone to overlook the provisions of the law that forbid witchfinding. Other letters from officialdom to nchimis emanate from the employees of the prison system, army, and Malawi Young Pioneers.

A prison employee wrote several letters to Nchimi Vwamba, including the following plea.

Mskambo Prison Farm

Dear my Doctor [Nchimi] Vwamba,

Excuse me for taking time in letting you know about my journey from your place. I was too busy to write.

My doctor, I'm pleased to note that you have accepted my request to visit my home [so] that you perform your witchery miracles on my family, and do all you can to keep away witches out of my home. So anytime should a witch try to come for something evil, such have to be reversed to himself . . . He must die himself.

I have explained the whole situation to my young brother who's at home, who is ready to come and take you there. He's also in favor of the idea. At the meantime I'm getting ready for your journey . . .

- 200 -

The prison official is requesting that Nchimi Vwamba supply him with lethal medicine against witches troubling his home. The provision of such charms would appear to be illegal under Sections 8 and 9 of the Witchcraft Act.

Another branch of the uniformed services to patronize nchimi is the army. There is obviously considerable scope for the application of magical powers to military operations, as this next letter clearly indicates.

Kamuzu Barracks
Q. Company
Lilongwe
-By Forces Mail-

Dear Mr. [Nchimi] Vwamba,

I am happy to have time of writing you this short copy . . .

The main point of writing you again is that I want you if you can help me with medicine that when I use it I should not be seen to the enemies during the war, and [also] that one [medicine] for [protection against] snakes.

I have sent K10.00 for that purpose and I will send you again K2.00 soon after the coming month. I have done it so because I am having a problem of [buying] charcoal for ironing [my uniforms]. Please forgive me for being busy of the problem.

Yours,
Geoffrey Musirikari

I will tell you next time if I have collected the two things we were talking about.

The role of the nchimi in this letter is that of a purveyor of magical charms.² The allusion in the post-script seems likely to be to some ingredients desired by the nchimi for making mankhwala of some sort. It seems likely that the large scale use of such charms by

members of the armed forces is common throughout the region.³

Officers in charge of Malawi Young Pioneers⁴ settlement schemes find themselves in a position analogous to that of a village headman insofar as they are responsible for the welfare of those living in their settlement, and they therefore have to deal with the various interpersonal problems that arise in such situations.

Malawi Young Pioneers
Chiweta Settlement Scheme

Mr. [Nchimi] Vwamba,

Here we have a lot of troubles in our camp. People steal things which belong to our friends, and now the famine has taken place because of stealing. Help us our Nchimi, who do these [things] including witchcrafts. There are others who [are] complaining very much. Many things have been stolen, like foods and goods and these are the owner of the goods. . . . Find out who steals their things by magic or African medicine. 1. Mr. F. Zunga. 2. [Mr.] Jere. 3. [Mr.] Msiska; and [Mr.] Lungu is a witness.

Yours,
N.K. Kumera
Officer-In-Charge

It is interesting that the author correlates the famine with stealing. Ancestral spirits are often thought to be offended by immoral actions such as theft or adultery and show their displeasure by punishing the community as a whole, as by a crop failure or making innocent children ill rather than the individual offenders. (Drake, 1976) The status of the first three men is unclear from the letter, but they seem to be involved in some sort of accusation, either theft or witchcraft. The nchimi will divine them, and Mr. Lungu, the witness, will relay his findings to the Officer-In-Charge. This letter is essentially indistinguishable in style from similar letters penned by village

headmen.

The next letter from an officer at a M.Y.P. settlement scheme is likewise similar to what his counterpart, the village headman, would draft under similar circumstances.

Malawi Young Pioneers
Chisimi Settlement Scheme

Dear Honourable [Nchimi] Vwamba,

I have sent another stranger to you, who is named Samson Nyirenda, in connection with words between them. Honourable Vwamba, I have not many words to say, but find out. We know that you have already searched him, but a letter must be provided to the boy so that he stays there freely. I end as your everyday son of M.Y.P.

L.S. Mwenecho

This letter implies that there is an ongoing case, probably of witchcraft accusation, as indicated by "words between them" and "you have already searched him." The provision of a letter to the boy, who is likely the party suspected of sorcery, "so that he stays here freely," is to furnish written proof to the officer who authored the letter that the boy is innocent of the charges or that he has been cleansed of his witchcraft propensities and is thus fit to reside at the settlement scheme. Without such clearance from the nchimi he might be banished from the scheme.

Nchimi specialize in witchfinding. Such complaints are traditionally first taken to a headman, who most often refers or authorizes the case to an nchimi, which accounts for the majority of the referrals emanating from headmen. The village headman in effect assumes the role of Emerson and Messinger's complainant, (1977:126)

albeit in a secondary capacity, while the nchimi ostensibly serves as a troubleshooter.

Who is Referred to Nchimi

As we shall see from analysis of letters of referral, use of nchimi is widespread throughout northeastern Malawi and includes politicians, police, army and Young Pioneer officers, educators and church officials. Nchimi are consulted concurrently and immediately following the use of the Western medical system and are even asked to interpret Western medical diagnoses. In sum, the nchimi's role for Malawians is that of a highly respected, widely used specialist for chronic, stubborn, puzzling, or conflict-producing problems.

More healers receive referrals of women than of men because of the dependent status of women in Malawian society. Referrals are not required by nganga, but women often must obtain their husband's or other male relative's permission before seeking treatment from a healer of any kind, traditional or western. When men are referred to nchimi, it is likely to be witchcraft-related. Men would ordinarily not need to secure permission from anyone in order to consult a healer, save in witchcraft-related cases. In general any referral by a headman or chief to an nchimi for a problem not otherwise specified is witchcraft related.

Children are rarely referred by letter. Although it is the child who is ill, it is frequently the parent who is referred, as it is the parent who must deal with the healer. Another reason why children may not be mentioned in these letters is possibly due to a "cultural belief that the family is a single social entity with interchangeable

parts, as it were. This belief is reflected in the statements that the ancestral spirits send illness as a punishment to any member of the family, not simply the actual culprit."⁵ The language of many of the letters of referral written by headmen is laconic, due in some cases to a combination of being ill at ease with pen and paper as well as at times being intentionally reticent for fear of committing too much to writing in cases where witchfinding is covertly being sought. This serves to further eliminate reference to the child's sickness as being the primary reason for the consultation. Furthermore, children suffer from high morbidity and mortality rates, and their illness episodes, especially among infants, are far more likely to be acute, and so they are more likely to be taken directly to western medical facilities than are adults.⁶ Finally, the widespread network of well-baby and under fives clinics results in many cases of illness being detected and treated by the western system, before any resort is made to the traditional system. Indeed, nchimis themselves occasionally refer acutely sick children to the Western system. The following letter illustrates how one nchimi referred an acutely ill child suffering from malaria to the nearest hospital.

Ministry of Health Malawi
District Hospital

Dear Nchimi Vwamba,

I have received your letter and I thank you for sending the child back here. I have found that he has been bitten by mosquitoes, that is why he is feeling pain from the whole of his body [i.e. has malaria]. He has been injected quite alright and I have given him tablets. If you are well it's alright. Here we are a bit fine.

Yours,
Doctor Mpoto

In this case, the western doctor has taken pains to explain what his diagnosis and treatment were, possibly in an effort to encourage the nchimi to continue his referrals of such common but serious cases of childhood malaria.

Economic Factors Affecting Nchimi Utilization

There are several economic factors influencing the utilization of traditional healers. Perhaps the most important such factor is whether the healer charges for services and medication and, if so, how much. Since healers tend to be somewhat reticent about discussing their fees, the letters specifying fees for particular services and medications are rather illuminating, although they are for the most part atypical of charges made to the general patient population.⁷ However they do indicate that certain types of charms command a high price indeed.

[Nchimi Sukutura]

Dear Brother Mr. Lamba,

I am very happy to receive your letter though we have never met before. I have understood all that you have said and I will try to prepare the medicine as you have said. I have sent medicine (1) for [increasing one's] rank (2) for not getting diseases (3) for [attracting] girls. For all these send me Rand 25.50. This cash is for all medicine and not for each of them.

If you want some more, tell me, but tell Mr. Chimpepo that a Doctor wants vizimba: (1) Sandawana (2) Njoka (3) Sumbata. The last thing is that I want a black Tchoba and send it in a parcel. Please, please!!

Such high fees are not charged for ordinary treatment but rather for charms that confer magical powers on their possessor. The man addressed by Nchimi Sukutura was resident and presumably working in

South Africa and no doubt could well afford the steep fee of twenty five Rand. It should be noted that the nchimi requests his distant client to obtain three kinds of vizimba for him in turn as well as a black horse's tail, used to make the magical tail switch or tchoba used by traditional healers and practitioners of magic. (Sanderson, 1955:39) Such horse tails are not readily obtainable in Malawi, but are common in South Africa, with its more abundant horse population.

An additional list of magical medicines, together with their costs, was found in Nchimi Sukutura's records, and once again was evidently destined for a client resident in South Africa.

	R	c
Medicine for safeguarding the body	25	50
" " making a person vomit	25	50
" " wounds	15	50
" " making penis erect	15	50
" " preventing getting diseases	15	50
" " girls	<u>12</u>	<u>50</u>
	110	00

Whoever this consignment of medicine was destined for must have had an ample bankroll by Malawian standards, perhaps even by South African standards as well. The "medicine for making a person vomit" sounds as if it might serve some nefarious purpose, as ordinary emetics are locally available for far less money.

Even clients of traditional healers within Malawi may pay stiff fees for magical medications and charms. One young patient of Nchimi Vwamba who suffered from epilepsy was temporarily cured for a small fee, but medicine for a permanent cure was priced at more than K10, which was well beyond the patient's ability to pay. In another case, the wife of a man working as a cook died, and he spent more than two

month's wages, K30, on hiring an nchimi to divine who had bewitched her.⁸

Status of Nchimi

Traditional healers, especially nchimi, are highly respected and sometimes feared by their clients. These sentiments are expressed by the authors of the several letters presented thus far and by these next few that I have selected to specifically demonstrate this point. The first is a letter alluding to the healer's fame.

Millsell Chrome Mine
Rustanberg
[South Africa]

Dear Brother [Nganga] Parapaska,

In the first place I would like to ask you about your health. How are you? I am a bit okay. Brother your fame has gone very far, very far up to a person with troubles. You are famous in the nganga business. I have hope that what I am looking [for] can be found through you and can be perfectly done. I'm asking for medicine: (1) Medicine for [making] change [come to me] when in a bank or store. (2) If you don't have this change medicine, I want medicine for [winning at] playing cards. Please reply quickly.

Yours, Lameck
Khondowe

The requests in this letter are for magical charms similar to those quoted in a South African catalog.⁹ It seems as if the author may have heard of Nganga Parapaska from a fellow mine worker.

In addition to praising them, and extolling their virtues, several of the authors asked them for forgiveness.

Dear A Chimi [Vwamba],

Firstly I would like to say that I am very sorry and that you should forgive me for I've spent a long time

since I came here, without writing you. Secondly: I am very sorry indeed because I've taken all this time without giving back the money I borrowed from you. . . .

In some cases this request for the healer's pardon was no doubt a polite formality, but on occasion it is a reflection of a real fear of offending and thus incurring the wrath of a person with potentially dangerous powers.¹⁰

Educated and high-status Malawians respect, trust, and make use of nchimis. This letter from the headmaster of a primary school is illustrative of the headmaster's concern for his student and of his evident belief in the nchimi's expertise in the case.

Rwatizi Primary School.

Dear Sir [Nchimi Sukutura]

TRANSFER FOR PETROS NJAKWA

Thank you for your nice letter about the ill health of Petros Njakwa. I am glad to hear that you have detained the boy for further treatment.

I was only told by him that he needed transfer letter to go back to Chitipa. I had no objection on this. As you have said, I will keep the child and give him his examination number.

Best wishes to you all.
G. Domasi
Headmaster

This letter implies that the headmaster had sent Petros to Nchimi Sukutura, who lives in the same village as the school. The formality of writing a letter is indicative of the semi-official standing possessed by the nchimi, which is further indicated by the reference to the nchimi's earlier advice concerning the student's examination number allocation.

Nchimi Lipuka was the recipient of this next letter, also from the headmaster of a primary school.

Vunguvungu Primary School

Dear Mr. Nchimi [Lipuka],

Mr. Jackson Mweso a teacher here at Vunguvungu lost his money on 20/10/73, yesterday. He has come there so that you should tell him the one who found this money or where it is.

Thank You, K.T.L. Nyirenda,
Headmaster

It would seem that both the headmaster and the teacher have faith in the divinatory powers of the nchimi, despite their relatively advanced education. Such patronization of traditional healers is observed by the students perpetuating and reinforcing their use.¹¹ It is not surprising, then, that students at all levels of education write to healers requesting a wide variety of services.

Kondowe Full Primary School

Dear Father [Nganga] Tyapula,

... Now Father I want to tell you how those things have gone on. I did all what you told me and as how I got four subjects I have just passed one only. ... Therefore I am sorry because I have bad luck. What can I do Father. Please. Please, I trust you now to help on this case. . .

Yours,
Kondwani Msiska

Apparently Kondwani had earlier obtained mankhwala of some sort to aid him in passing his examinations. This charm was evidently not as efficacious as he desired, and so the student implores the nganga for further assistance.¹² Students, especially those in secondary school,

may be the objects of jealousy of their neighbors whose children were unable to secure entrance to the few available openings. Such jealousy is widely thought to be grounds for bewitching the unfortunate student. Legson Kayira writes;

Then came another problem. My father began to feel uneasy about my well-being. During his beer errands he would meet a good many people, his beer partners. These partners would whisper into his ears that if he would let me go on to [primary] school, some people in the village [in northern Nyasaland] would feel jealous and bewitch me.
...

One day he called me to him. Sitting on his stool he began thus: "I fear they are going to kill you, my son, because you are passing all your examinations. Do you know what you should do?"

What?

I am telling you that you should go and fail your forthcoming examinations. Write all the useless things you can and ... you will fail and nobody will bother to think of you [and bewitch you] anymore." (Kayira, 1965:33-4)

Kayira's narrative took place about 1950, but similar sentiments are expressed to this day.

This next letter, from a secondary school student to an nchimi, is a further illustration of the pressures on students taking examinations and of a culturally acceptable way of alleviating those pressures by attempting to magically influence the examination's outcome.

Junju Secondary School

Dear Sir [Nchimi Sukutura],

I thank you very much for the good work that you did to me that day and that you will be doing, for up to now [I] am not yet alright.

To repeat, I was very much contented to hear all that you told me about my sicknesses. . . . I forgot to

ask you whether those sufferings came to me because of some body, or [if] I am born with them?

Doctor your boy is very sorry to write this to you for he knows he may come and fail the exams . . .

Please Doctor try to find me the best of your medicine that can help me clear out all these sufferings so that during exams I should come and write what will be needed to make me pass. I shall be very happy if you work very hard to find my medicine.

I read but things can't just get stick in my mind and headache starts. I don't know what I can talk because what you said was really the problem I am facing.

Too many complaints Sir, but please try to help the poor fellow . . .

Thanks you very much.
Yours sincerely,
Brighton

Here again a student has consulted an nchimi beforehand with only partial success. He asks if his trouble is due to witchcraft or is of natural causation; "[do] those sufferings come to me because of some body, or am I born with them?" Brighton seeks help for a common complaint of secondary school students headaches induced by studying under the stress of imminent examinations.¹³

Students may also bring troubles not directly associated with their student role to traditional healers for solution as this next letter illustrates.

Nyungwe Technical Training School

Dear Mr. [Nchimi] Vwamba,

I let you know of my complaint. Up to now I'm a little fine. I still have pains on my penis, where pus still comes out of there. Please I request you send me that medicine you promised me.

May God be with you to continue with your doctorate duties without fault and failure. And the suppression of

witches and [those] who let others die in vain.

Pass my greetings to patients and all. . . .

Another letter was from a headmaster of a school, requesting the nchimi addressed to ascertain the whereabouts of missing money belonging to one of his students.

In the light of this use of nchimi by church officials and divinity students, it is not surprising to find dual interactions of the Christian God and the nchimi's magic in letters from ordinary laypeople:

Chingola Zambia

. . . And also [Nchimi] I want to ask a big thing if at all it can happen. Here in town we do lottery in which we write numbers of horses. If your horse has come out the first then you have won. Now can you not help me. If it is so please try to see it at Choir and tell me the . . . horse which can come the first. . . . Please brother do that, because perhaps God can help us.

Another gambler, this time from Rhodesia, sent a list of the names of eighteen horses, for the nchimi to choose from. It is in such towns that the new customs of wagering are learned as well as where the loose cash necessary for serious gambling is readily come by, but the old traditions of using the divinatory powers of nchimi remain.¹⁴

Bulawayo
Rhodesia

Dear Nchimi,

. . . I will write you the names of the horses so you should see to it, and if God helps us, I may be able to send you the money which we have gained. Please, you should know the name which has won and even the second one too, and even the third and fourth . . . [A list of eighteen horses was attached.]

W&C French
P.O. Lilongwe

Dear Father [Nchimi] Vwamba,

I am glad if you and the whole family are alright. I firstly say may God bless you. I keep going by saying that God himself said that there are going to be nchimi's among your children saying the truth. And the one looking for it shall find it. Father, I have spent a lot of money in lottery that I do play in Germany without winning. These are the numbers: (1) (2) . . . (49). We are told to choose only six numbers which we think are the right numbers. . . . So Father help me. Which are the right numbers that are to be picked in 17th April 1976 for the draw? I am going to post the numbers that you are going to tell me. Tell me before the date so that I also post them in time. I am your slave. Help please.

Yours,
Peter B. Kumwenda

All of these gamblers invoke God's help in their requests for aid from the nchimi. Their God seems much more amenable to magical forms of activity than the Protestant or for that matter, even Catholic missionaries would like to admit. Nevertheless, it is the very same Diety introduced or rather reintroduced and rendered more familiar and approachable by the missionaries.¹⁵ The role of the nchimi, in light of these references to God, is quite reminiscent of the nchimi's precursor, the msofi or priest, whose function was as an intermediary between man and the spirits, who would in turn put the case to God.

In addition to headmasters and students, members from all ranks of the western medical establishment wrote to traditional healers. All but the medical doctors requested some professional service of the healers they wrote to. In one instance, a nurse at a District Hospital drafted the following appeal to Nganga Tyapula:

Tafwakali District Hospital 11/5/76

Dear Father Tyapula,

I can be glad if you are well and I am also well. Perhaps you still remember me. I am Nyanthenda and I work at the hospital. I came there on 10/3/76. I came with two complaints. First it was transfer, and second it was that I don't find marriage. . . . The medicine for cutting is already done and medicine for washing I am doing it . . . I am still troubling you with marriage because every person . . . should marry, that is what is said... Please father help me. . . .

Greet everybody Yours Eness
Nyanthenda

I had the opportunity of interviewing this woman. She was a very attractive and well-spoken registered nurse. As her letter indicates, she retained her belief in the efficacy of traditional healing in its broad sense despite her western medical training. Neither of her complaints is of an organic or even of an emotional or psychological, nature. They are basically of a relational nature, problems which individuals in Western society might take to psychiatrists or mention in the course of consultation to a primary care physician. (Cartwright & Anderson, 1981)

This next letter provides valuable insights into the broad spectrum of traditional healing and its patronization by western medical personnel.

Junju Hospital

Dear Mr. [Nganga] Tyapula,

I am very glad to write you this letter because I just hear your fame many times from people about how you cure people, because if a person is in troubles [he] starts asking about the ngangas. Now Mr. Tyapula in the early days of September, I will come to you. I have been very much worried about what troubles us. Now that I have been told by Mr. Boddington Khondowe from Thunduti, the father of Bernard who has been operated [on] and is here at the hospital. I am ready to come there for my troubles. My

home is Hara and I have a garden of rice which is three acres; and if I have farmed I sometimes get six or five bags of rice. I am now disappointed with the produce I find in my garden, I don't see well my produce. Here, we have different tribes of people. I now fall on your legs Mr. Tyapula so that you hear my cry. Do your kindness to me. Perhaps you can know the medicine which I can put in my garden and produce reasonable produce. Please, I am under you.

There are many things which trouble me in my house. I have my elder wife whom we have bore five children, but all are dead, except only two girls, and because of this my wife has stopped bearing children. Some people have bewitched her and put something in her stomach which has stopped her from giving birth to children. And in 1968 when I was staying at Misuku it started troubling her, and the doctor at Misuku [Hospital] sent her to Lilongwe Hospital and there it is where they took out the thing that was troubling her in her stomach. It [is] in January 1968 since that she doesn't bear children. We have approached many ngangas and they say she can no longer bear. Maybe at Lilongwe [Hospital] they cut together with the intestine. I will therefore come with my wife there so that you help her with some medicine. I am working in the above mentioned hospital and I am responsible for the dressing room. If you are alright it can be better. Greet everybody at home.

Yours, Kalulu
Fufu

Members of the western medical establishment are no different from their lay counterparts in their continued belief in the value of traditional medicine. Most of the medical orderlies who constitute the bulk of the staff of many of the health care facilities in this area have little formal education in general and even less in medicine. However, as we have already seen, there is little correlation between amount of education and the level of belief in the supernatural aspects of traditional healing. Medical personnel tend to communicate their beliefs to their patients and together with school teachers are role models for their neighbors and for children in particular insofar as the utilization of traditional and western medicine is concerned. Their continued patronage of traditional healers serves to undermine

their advocacy of western medicine, as people are more likely to follow their example of using traditional medicine than their exhortations to patronize the western medical system.

Several individuals with church-related jobs also wrote to the healers from whom I obtained letters. It is common knowledge that many of the clergy themselves believe in the efficacy of traditional medicine and the underlying supernatural philosophy upon which it is based, specifically the role of witchcraft as the major etiological agent of trouble and disease.¹⁶ The belief in Christianity in no way precludes belief in other aspects of the supernatural, specifically the existence of witchcraft and of various malignant spirits. This letter from a divinity student is illustrative:

Balaka Bible School,
17th April 1979

Dear [Nchimi] Lipuka

. . . I can't forget you for what you did for me.
. . . I was well welcomed by masters who are teaching us now here. For that thing you helped me really works. Each and everyone are very happy with me. They always respect me.

I have now proved exactly that your medicine you gave me was true. I don't face any trouble of provocation from my friends. When they see me, they are just trembling themselves through what you gave me.

While I am here, I am always praying for you to God that He must add some more days [for you] to live on earth.

I can be very glad if you can reply to my letter soon.

I think I will hear more from you.

With constant remembrance,

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David Luhanga

The next letter is from a more senior church official, an educational administrator.

Dear Father [Nganga Tyapula],

Keep cool if I did not tell what I exactly wanted. The main thing is that I want your help as always. The help is that I want to be lucky with the life.

[He relates three instances in which he was passed over for promotion and for advanced studies overseas]

All these have forced me to ask you so that you should help me with the medicine for good luck. Even if I have that, everything is in the power of God.

I will be there on the 16th of July.

I am yours,
Edward S. Gombwe

Church members are often secretive about their utilization of traditional medicine, especially of its magical aspects. The attempt to use magical charms to further his career would have earned Mr. Gombwe severe censure if not downright suspension from his church if it had been detected.¹⁷

The "Cooling-Out" Function of Nchimi

In an area with a high mortality rate, such as Malawi, death is a commonplace event, and people frequently attend the funerals of kin or fellow villagers. Although under prevailing socio-economic circumstances there is little that they can do to prevent these excessive deaths, people want to know why their loved ones have died, i.e. whether by "natural" causes or due to sorcery. If suspicion is

focussed on sorcery, further steps may be taken to deal with the sorcerer.

There are a number of different scenarios involving death which prompt people to seek the aid of an nchimi (or nganga, acting in the same roles). Some of these are illustrated in the following letters, the first category of which deals with the death of children, the group with the highest mortality rate.

Dear Nchimi Vwamba,

I would be glad to learn about your health. I send Fred Ndozi to you because he wants to know the cause of his troubles: his child just died without falling ill at all. Help him, Doctor. Tell him everything which has happened to him and tell me also please. I am very sorry.

I am,
V.H. Munthali

In this case the troubled party, Fred Ndozi, received a letter of referral or authorization from his headman, as he was dealing with an nchimi who was known to require such a protocol.

The next letter is from a layman to a nganga who does not require a referral although he is being consulted in a divinatory capacity similar to that of the nchimi in the last letter.

Blantyre

Dear Father [Nganga] Mwetuka,

...I am really in trouble Father. The time I got your letter all my children were seriously sick [and now] these two children are dead. I am crying as I am writing this letter.

All of them died in the same week, a thing which I have never witnessed on Earth. Father . . . I am coming there to know what has killed my children. . . .

The next letter is from a chief who desires to know who killed his child and promises a present to the nchimi if he reveals the name of the witch. He sends a messenger or witness to bear the tidings from the nchimi and assures him that the matter will be kept secret, presumably because both know that such proceedings are expressly at odds with the provisions of the Witchcraft Act.

To Dr. [Nchimi] Vwamba,

I am writing you this letter so that you should tell me the one who has killed my child. I shall be very glad if you tell me the one who killed my child.

If you will tell me, I will give you a present. What I would also like to tell you is that I have sent Mr. Bara to hear every thing which you will tell him. I really trust the man and therefore don't hide anything from him according to what you see about this matter. I know that the man will keep everything secret.

I shall be very thankful if I hear that you are also fine.

Yours,
Chief Linthipe

The last letter relating to the death of a child was written by a layman to a nganga who was widely reputed to himself be a witch, and has sinister implications:

My Dear Brother [Nganga] Parapaska,

If you are alright that can be good. With us here [it is] not really good. Please Brother, I am in troubles here. My grandchild passed away; the death of the child is too sorrowful.

Brother, see if at all this death is caused by people or by God, but if it is by people, I have an ox here to make sure that who[ever] made my grandchild die should also die. Please Brother.

I bow down to your legs Brother. I can give you anything you may like. If it is the disease by God, that means I have failed. Please, please, I plead for help. The death of my grandchild is too sorrowful. No more words.

Yours,
Matambula Mkwate

Here the author asks the nganga to ascertain whether or not the death was due to witchcraft and, if it was, offers to pay him an ox if he will magically kill the witch. I was able to secure several ethnopharmacopoeia written by Nganga Parapaska, and they contained formulae which tended to confirm the widely held opinion that he dabbled in necromancy and might be consulted not only to ascertain the cause of a persons's death but also, to avenge it as well.

Although western medical facilities furnish their patrons with diagnoses, their primary function is to treat the complaint. It is often difficult (for a variety of reasons) for the western healer to adequately convey a diagnosis to the patient, and as a consequence many patients fail to understand the western healer's etiology of their complaint and thus the rationale for treatment. The result is often poor compliance with prescribed treatment procedures, which themselves may not be adequately explained. Resultant slower healing or complete failure of the therapy, plus lack of communication, has a negative impact on confidence in western medicine¹⁸ and tends to further induce people to seek an explanation of their trouble from traditional healers whose diagnoses may be more culturally congruent, "understandable," and therefore acceptable. Nchimis may do nothing more in these instances but serve to speed acceptance of the inevitable.

Summary

In Malawi, nchimi serve in the combined role of healer, psychiatrist, priest and fortune teller. They seem to be used as general practitioners of "trouble," much like local primary care

physicians are used in systems of Western medicine, and with similar parochial respect and status. This aspect of the nchimi's role is the benign side of their behavior. As we shall see, their work as "troubleshooter" is not always helpful or harmless.

¹Reference to this practice is made in Chapter II.

²Such charms in effect allow the nchimi to perform his or her troubleshooting in absentia or perhaps to prevent a trouble before it actually manifests itself.

³Bozeman, citing Mungo Parks' experiences in West Africa in the late 1700's, mentions charms to "guard the bearer against snake bites, or, in time of war, against hostile weapons." (1976:87)

⁴The Malawi Young Pioneers (M.Y.P.) recruit young men and women and train them in agricultural, self-help, and citizenship skills. On completion of their training most are placed in agricultural resettlement schemes. The M.Y.P. was based on Ghanaian and Israeli models, and has a secondary paramilitary role as well as a primary agricultural one. (Crosby, 1980:116. Nelson, 1975:98)

⁵Suggested in and quoted from a letter from Professor Rena Gropper of Hunter College, City University of New York.

⁶Considerable use is made of western medical facilities for treatment of small children. In 1977 there were respectively a total of 12,781 and 8,795 first attendances at under-five clinics in Karonga and Rumphi Districts. There were a further 41,293 and 26,205 re-attendances. Under-fives clinics offer primarily preventive health care. Insofar as utilization of western curative medical services is concerned, in the same year, 1977, there were 95,828 and 57,453 outpatient registrations of under-fives in these same two districts. (Malawi National Statistical Office, 1979:29-31) There is evidently considerable use made of western medicine in treating children. Unfortunately the statistics at my disposal do not give the under-five inpatient admissions, but these too are considerable, based on my own observations.

⁷The reason that these fees are atypical is that they are for special charms from nchimi, rather than the mankhwala for the commonplace complaints normally treated by nganga, which constitute the overwhelming bulk of medication prescribed and dispensed by traditional healers.

⁸Healers have other sources of income as well. One itinerant woman nchimi fabricated and sold protective amulets in the form of necklaces which warded off a variety of diseases of both adults and children. She charged K1 per necklace and sold many of them. Nchimi Vwamba and other nchimi charge a small admission fee, usually a few tambala, to purchase kerosene to illuminate the divination rituals and prayer meetings held in the evenings as well as to purchase razor blades used in administering cutting medicine and for cupping. However when large numbers of patients are seen in a short period of time, these small individual fees mount up to a substantial sum. In the early 1970's Nchimi Vwamba saw several thousand persons a year and collected from two to five tambala from each just as an admission fee.

⁹Malawians also obtain magical medicine from a variety of sources outside the country. I have seen listings from companies

purveying such materials which were located in South Africa, Nigeria, and the United States. One such outfit, Noa's Ark & Co., located in Natal, R.S.A., sold a variety of charms, which in 1976 were quoted in Rhodesian, Zambian, and Malawian currencies. Some of the categories of medicines they advertised in their catalog are listed below: Medicines for Attracting Good Luck. These included: "4. JOB SEEKERS. This will help you to find the job you want anywhere." "5. Liked By Boss. Yes you'll certainly be. Even if he's cheeky he will treat you like his own child. K5.00" "RIVAL. To remove anyone from your work or position, he (she) will be sacked and you will remain in your work. K5." "11. SECURITY. At work you won't be sacked unless you want to leave. K6" For Luck in Money Matters "18. LOTTERY. You'll win on Lotteries and Sweepstakes and Raffles. K5" "21. MONEY MAGNET. It attracts a lot of money to you in many ways... K3" "23. EXAM SPECIAL. You'll pass any subject or test easily with full marks. K4" Medicines For Protection "40. PROTECTOR. You'll be safe from bad people, spirits, & medicines wishing to harm you. This is your shield. K7" "44. BOOMERANG. Any medicine sent to you will go back and harm the sender. K6" "46. SWEEPER. The charm which destroys all medicines placed on your house so that they don't affect you. K6.50" Medicines for the Homestead "50. HOME GUARD. For your home security against evil spirits & medicines so they don't affect you. K6" "51. SUCCESSFUL FARMER. Your fields will yield plenty of crops all the time. K5" "54. BIGAMIST. To make your wives to love one another & stay peacefully. K5" Medicines for Love Attraction "66. LOVE BAIT. Once she (or he) eats that medicated food, she (or he) will fall in love without knowing it. K4" "71. LOVE LOCK. Is there anyone trying to take your beloved one away? Then order this before it's too late. K5"

Many of these medicines have their indigenous Malawian counterparts, but some folk obviously prefer to acquire their charms from abroad. One such party of my acquaintance was a former politician, Mr. Mpofwa, who was engaged in commercial farming and ordered a variety of charms from the DeLaurence company of Chicago, Illinois, U.S.A. DeLaurence quotes their prices in American, British, Nigerian, Jamaican, Caribbean, and French currencies; indicating that they do an extensive overseas business. My acquaintance ordered: #777 A magical handkerchief "impressed with seven talismans of MONEY, HEALTH, VICTORY, SUCCESS, LOVE, KNOWLEDGE and PROTECTION.(\$2.25) #825 "Write your examinations with DeLaurence's 'PSALM' ball point pen. Inscribed with blessings from DeLaurence. Instructions for use include prayers for success in life and love. If you want to pass that examination we suggest you order this pen today.(\$3.50) #763 MEMORY PERFUME "Embarrassed by a poor memory? You need a good memory to get through school and succeed in your job. Use this associative perfume in your work." With instructions from DeLaurence. (\$1.00) "Money! Come to Me. DeLaurence MIDAS TOUCH BILLFOLD has a secret pocket for accumulating high denomination money. With it you receive special suggestions and your choice of parchment paper talisman for Money, Love, Success, Protection, or Health. State your preference." (\$3.50) #591 CRUCIFIX RING "Will you have help and protection in the dangerous days ahead? Christ will probably mean more to you if you wear this ring." (\$20.00)

A year after his receipt of the above articles, which at his request I helped him to obtain, I asked Mr. Mpofwa whether they had

been efficacious, and he wistfully replied that his money would have been better spent elsewhere. If a man of some sophistication and experience can be gulled into purchasing these charms, there is an enormous market to be tapped in areas such as Malawi, for selling similar goods. I am sure that an investigation into the markets of the DeLaurence [company] and its counterparts would prove a fascinating project for an enterprising researcher. It should provide materials for several dissertations!

¹⁰ An example of such a fear of offending the healer is provided by the case of a young man in his mid twenties, who suffered from a mental disorder while employed in neighboring Zambia, and was admitted to a Zambian mental hospital for two weeks. He was discharged without being cured and returned to Malawi, where he consulted a nganga who told him he was witched. The nganga treated him with medication but failed to effect a cure. He next resorted to a woman nchimi where I found him after a two month residency. The nchimi told him he was witched because he was educated. She told me that "Only God knows how much longer he is going to have to stay here. He told me that he wished to be discharged, but feared to press the nchimi to release him. "I sleep well, and moreover I don't dream too. ... The disadvantage of this woman is that she has no proper instant to examine one. ... Why is she punishing me by keeping me here?" He wanted to leave and get a job, but the nchimi wanted him to remain, even though he felt cured. "If I'm leaving her, it's better to leave her in peace, that's the only solution. Eeel, dodging it won't be good, it won't help me." He believed that if he left without her permission she would bewitch him. "You know these people work by magic."

¹¹ This is especially the case in rural village society, where the teacher is almost as visible outside the confines of the classroom as he is inside them, unlike the urban teacher who assumes anonymity once he or she leaves the pupils at the end of the school-day.

¹² This letter indicates elsewhere that the student is advanced in years, as is not uncommon in the upper grades of primary school in Malawi. Students must pass a series of written examinations in order to earn their primary school leaving certificate. It is not uncommon for students to sit the exam several years in succession until they do pass or pass with a high enough score to secure entrance into secondary school. In the 1977-78 school year, 34% of the standard 8 students of Karonga District and 47% of the standard 8 students of Rumphi District were repeaters. (Malawi Statistical Yearbook 1978:42,45)

¹³ Bieliauskas (1982:16) notes several studies in which elevated "17-hydroxycorticosteroid levels in the plasma and urine of college students have been shown to be significantly related to examination stressors."

¹⁴ See Powdermaker, (1962:15,19,95) for a discussion of the impact of the money economy on urban dwellers in neighboring Zambia.

¹⁵ See Msiskas's paper (1969:3-11) for further details on the early Tumbuka concept of God.

¹⁶ One Malawian clergyman of my acquaintance had embarked on a

master's thesis dealing with this very topic. Its title was to be "The Influence and Extent of Witchcraft Belief Within Livingstonia Synod, 1924-1977" The author writes:

The general belief in northern Malawi and eastern Zambia where the Synod of Livingstonia operates is that witchcraft is real. Those who deny it have either been influenced by the West or masquerade their involvement.

The author states elsewhere that:

The [early] missionaries were mistaken in not giving the fear of witchcraft so much attention. This superficial and contemptible treatment of this problem was one of the reasons that gave rise to the Independent Churches. It also engendered hypocrisy amongst the Christian ranks. . . .

Then I would like to conclude by pointing out that this missionary error left the fear of witchcraft intact, though not condoned. For an African Christian still fears witchcraft and has not been made to trust only the greater power of Jesus Christ.

Reverend X___, continues with a discussion of "sacred specialists."

By Sacred specialists I refer to the witchdoctors such as Mchapi, Bangeya, Chikanga, Nchimi X___ (in Malawi) and Lenshima (Eastern Zambia) claim to have been sent by God. Some open their meetings with Christian songs and accept no stipend for their work (except gifts). Since they claim to be the servants of God they confuse Church members and consequently retard the growth of Christianity.

For we need to recall that before the introduction of Christianity there were religious figures who were highly respected in African societies known as seers [i.e. nchimi]. And so these sacred specialists, or call them witchfinders (witchdoctors) [today] command respect in their own right.

I have heard that there is some very important correspondence between Chikanga and [Nchimi] X___, which was consulted by an American doctoral research student [Wendroff]. From such letters we can clearly see what the claims of these specialists are. They insist that they are God's people sent to cleanse the villages of all witchcraft substance (stuff) [nyanga].

They further claim to possess power from God and that they give someone protective medicine. Both non-Christians and many Christians alike flock to them in search of their lives, property, power (unless one has ghosts), work and for success in business. The most important ingredient to such medicines given or dispensed is nothing less than human flesh or anything to do with human beings.

The author, a senior Malawian churchman, cites many specific instances of witchcraft belief among Christians in general and churchmen in particular.

¹⁷ Graubard cites the case of a fourteenth century abbot who was condemned to life imprisonment for engaging a magician to find his stolen money. (1984:40)

¹⁸ Western medicine, like its traditional counterpart, relies to a considerable extent on the placebo effect. Any diminution in patient confidence is likely to have a deleterious effect on the placebo effect.

CHAPTER V

THE ROLE OF THE CLIENT

Introduction

To use Emerson and Messinger's terminology, the client of a traditional healer is most often the victim of some trouble, who is utilizing the healer in his or her capacity as troubleshooter. (1977:126) Although this chapter concentrates on the client as victim, one should be cognizant of the fact that in a sense, the village headman who referred the victim is also a client of the healer, as I shall show in the following chapter. As I discuss at length in Chapter VII, the victim's role may be construed as that of troublemaker, although the illustrative material presented here makes no mention of this alternative.

This chapter will concentrate on the role of client as help-seeker for problems suspected of being caused by witchcraft or because of a witchcraft accusation itself. The previous chapter indicated the myriad reasons for use of nchimi by clients; this chapter will focus on the witchcraft aspect and indicate how a client may be a victim in a two-fold sense: as the recipient of witchcraft or as the recipient of a witchcraft accusation.

Marital Troubles

Marital troubles by their very name have an inherent relational factor, in addition to any symptoms of an organic, usually reproductive nature. Healers utilize their counseling skills as well as resorting

to mankhwala in dealing with such marital troubles. As in numerous other troubles previously cited, village headmen may refer cases of marital discord to an nchimi as in the following case:

Dear Nchimi Vwamba,

I have sent these two people, the husband and wife to you so that you divine them; because the husband is accusing his wife to be moving about with other men.

Yours,
V.H. Kaphwata

This letter does not seem to overtly implicate witchcraft as the source of the trouble, although such involvement may be uncovered by the nchimi's divinations, as perhaps some magical charm was used by the wife to mislead her husband or by the wife's lover/s to seduce her. The couple's village headman is generally charged with settling disputes and maintaining order in his village, but apparently his talents as a troubleshooter were inadequate to settle this dispute, and he has referred the case to Nchimi Vwamba. Although it is the couple who are the primary clients of the nchimi and would be responsible for any fees incurred, the headman is also a client of sorts, as he is ultimately responsible for the well being of his village. Headmen frequently request a written or verbal message from an nchimi in cases that they refer, so as to know what course of action to pursue vis a vis the parties to the trouble. Such requests are further evidence of the headman's client relationship to the nchimi.

Another letter deals with adultery in a straightforward manner.

Dear Dr. [Nchimi] Sukutura,

Henry is my name. I am writing you and ask you about your health. . . . Sorry I have sent you the money

but it is very little. . . . I . . . hope . . . in future . . . you can be buying soap for washing after cutting the medicine. . . . For a person to know mankhwala it is a big job. As you said about the pregnancy of my wife Nyamnyirenda, she told me that she had slept with Kumwenda only once, but you told me [that] Kumwenda played [had intercourse with] her three times a day. Without you she would have told me lies only. Thank you Dr. Sukutura, we shall meet in future. Stay well, but if you have received it you tell me.

Yours,
H.J. Lengwe

There are other causes of marital discord which are more peculiar to Malawi and which are taken to traditional healers for solution or amelioration. Among these are the inherent tensions between co-wives in polygynous marriages, as the following excerpts illustrate:

Dear Mr. [Nganga] Mwetuka,

. . . That time we had a quarrel and [I] left my husband because he got married again to a Tonga, but now we are together again . . . If it can be possible I want these: Medicine for mtima [heart], chizgumbo [dizziness], and medicine that can make the other woman leave the place. I don't want polygamy. . . .

About a month later, the same author again wrote to Nganga Mwetuka:

Friend,

Haven't you received the letter that I wrote before . . . ?

About my condition, I am feeling better. About that medicine I had told you, I want medicine that could make my friend divorced so that I remain the only wife.

In a situation such as that described in this last letter, the complainant is both a victim as well as a potential troublemaker. In fact, the nganga whom she is patronizing as troubleshooter will be cast in the role of de facto troublemaker if he supplies her with the desired medicine, and the second wife would then become the victim.

Other women wrote with varied requests. This next complaint is not specific, but the letter of interest as it illustrates the functioning of a lay referral network.

Dear Uncle [Nganga] Tyapula,

You'll be surprised to read from me. I'm very tortured with my husband's attitude towards me. I came to know [of] you from friends to whom I was asking for help. And somebody introduced you to me.

I intend to come there personally that I tell you of my longstanding problem. . . . Please answer me urgently. . . . I herewith enclose an envelope and stamp and paper, that you write to direct me the way, urgently.

Nothing more,
Yours,
Mrs. S.L.M. Msiska

The following letter is from a young woman whose lover, having impregnated her and thus forcing her to withdraw from secondary school, left her.

Dear Uncle [Nganga] Tyapula,

. . . He promised he would marry me. Yet up to now he doesn't make up his mind. At first I thought I'd do without him. But this seems a failure now. I think of him night and day. It pains me to recall failing to go through for school for nothing. I am sorry indeed.

What I want is to create a marriage with him. . . . What can I do to make him love me for marriage? Please help me to succeed because all my love is on him. I failed to tell you all this [when I saw you last time] because I came with mother who was ever present that I couldn't talk freely. I tried to get some [magical] herbs from my uncle for writing letters. [Presumably to make the reader love her.] I wrote him one and he answered, but [he] hasn't (up to now) answered my second one. Can you tell if at all he received it or not? . . . I'm desperately worried. I'm getting thinner with the boy I love. Is he married or not? His name is Godfrey Phiri. Does he think of me as I do [of him]? Please try to find out what is wrong with my blood that I'm unfortunate. The child I have is Godfrey's . . . The child is always sick, you can also check on the cause of this sickness.

Janet Rutonga

Note the allusion to her inability to fully divulge her problem during her earlier visit to the nganga due to her mother's presence. This problem is probably not uncommon since a relative commonly accompanies a patient on any visit to a healer that is likely to necessitate an overnight stay. Furthermore, traditional diagnosis is often performed in a public setting, which may serve to dissuade the shy individual from fully divulging his or her complaint for fear of embarrassment, as already seen in the several letters dealing with sexual problems, where the authors were embarrassed to relate their problem directly to the healer. This underscores the importance of the letter as a vehicle for communication in such cases. Letters are particularly apropos in the traditional medical context since healers are believed capable of divining the cause of a trouble without the physical presence of the victim.

Just as women have difficulties in retaining the fidelity of their husbands, so men may also experience trouble in keeping their women, as this next letter attests:

Dear Father [Nganga Chirembwe],

. . . My wife doesn't love me. She goes to her home on Likoma Island] perhaps four times a year. ... Please sir help me on what I am going to say here. I want medicine which would make us love one another. I love my wife for these reasons:

No. 1 She doesn't take long to bear.

No. 2 She is very strong at all works.

No. 3 She doesn't go about [other] people's houses.

I want her planted at my house, not thinking about her home any more nor talking about her home now and then.

Please father when she comes there for medicine treat her there so that she should become a lizard of my

house. [Allusion to a house lizard or gecko.] I paid K50 for her in 1970.

Yours, Golie Ngombe

The reasons given by the author for "loving" his wife seem fairly typical, the first two being of an economic nature (as was his allusion to having purchased her, this referring to lobola or bride price), and the third being her mannerly behavior, keeping herself to herself as it were, a highly desirable trait in a wife by Malawian standards.¹ The jealous husband wishes to reinforce this latter trait by means of a magical medicine. It is common for a married woman to leave her virilocal residence and visit her kin on occasion. Such trips may be cause for alarm to a jealous husband such as this man seems to be.

Recourse to a healer may be made by a spouse, not only to retain one's partner, but, as this letter illustrates, to do away with him or her.

Dear Father [Nchimi Vwamba],

. . . Another story which I would like to tell you is that I have separated from my wife, so what can you say about this? I just pray to God that you should kill her. Only God will help her because I did not know that my wife would behave like that. I know that you were given that job by God, so [that] being the case, help me. . . .

Tennyson Muhango

Once again the fine line separating the healer from the sorcerer is alluded to. As Bibeau mentions with reference to the Ngbandi of Zaire: "The art of healing is born from witchcraft . . . This shows a fundamental ambiguity . . . derived from the potential of medicine to kill as well as to heal." (Bibeau, 1982:51) In this instance, the nchimi is being resorted to for his knowledge of witchcraft, to injure rather than to heal.² To what extent healers acquiesce to such requests

is not clear, but it is certain that some do, although with varying degrees of efficacy. This last letter illustrates again the possibility for both the victim and the troubleshooter to become troublemakers and for the troublemaker, at least in theory, to become a victim.

A cuckolded husband appealed to an nchimi for aid in his misery:

Dear Father [Nchimi Vwamba],

. . . I am a little bit fine but we [have] a very big problem here. . . . My wife has run away from me with the whole house properties. Would I find any help if I can come there? Sir I have run out of words by this action done by my wife . . .

Your Slave,
Godfrey M. Mkandawire

P/S Sorry Sir, I am crying very much. My wife got rid of the pregnancy which was eight months. Later on she ran away with her new husband and all my properties and my money, wireless and wristwatch. Sir, I am failing to find what to do with these people. Sorry sir for you have never seen me before, but I will be coming there in any way I find.

God should be with us so that we should meet one day.

You will have all my complaints when I come there.

Thank you, Thank you, Thank you,
Your poor son.

It is interesting to speculate on just what function such a letter has, that is to say, what does the author seek to accomplish by writing it? He relates his troubles to the healer, which very likely has a cathartic effect. He asks if there is any point in his visiting the nchimi and presumably expects a reply. However, he seems to have already made up his mind to come.

The final illustrative letter in this series deals with ancestral spirits and their malign influence on a marriage⁴ and the role of the diviner in countering that influence.

Father [Nchimi Sukutura],

. . . my wife and I believe there is something wrong.

What I want you to do is to sit down with Father and all people who were present on the marriage and discuss the procedure it went through since it was not a good one. Now the spirits are angry with us. . . .

If you don't do this, she will never get married because the spirits are angry. That is true Father. Don't think that my wife doesn't want to be married, but the only problem is the spirits, and if you can sit down with Father at Matala there, then everything will be fine. I have already discovered that the marriage did not go in the right order.

Please Father do as I am asking. I believe that some of the rules for marriage were skipped and it is up to you to make them right again. If that is not done [we] will continuously be troubled with these spirits and she will have no chance of staying with her husband, and since the spirits are very cheeky, she will not have good health. . . .

Please Father sit down with all people there at home. . . . If you can leave your friends and speak to the spirits yourself, still my wife will not be settled. . . .

Your Son,
Gamba

The nchimi is expected to meet with the people present at the marriage, presumably in order to make an informed diagnosis and then to intercede with the spirits. The author suggests that merely speaking to the spirits without prior conference with "all people there at home" would be of no avail. This reference to the nchimi's role is very much like that of the basofi or traditional priests described by Kauta, (Kauta, 1969) who acted as intermediaries between man and the spirits.

Referrals of Husband and Wive/s

Less conflicted spouses may jointly visit a healer, even though only one of them is troubled, for logistical support, with one acting as helper or guardian to the other. Alternatively, both may be afflicted with the same or different troubles, as shown by this first letter.

Dear Nchimi Lipuka,

I hereby write this letter to you with great respect. I have permitted this man so that you help him in his troubles about his home and about the illness of his wife. The names of these people are Mr. L. Khondowe and his wife Nyausiska.

Thank you, we hope they will tell you everything they have come for.

Greet everyone at the house.

Yours,
V.H. Chikororo

In this case the wife is ill and the husband is apparently acting as her helper as well as taking his own troubles to the nchimi. The allusion to troubles around the home is often mentioned in these letters and in most cases is probably but a euphemism for suspected witchcraft.

Dear Sir, Nchimi of Chimi's [Vwamba],

I am V.H. Mwenikwacha. Father, Sayton Sifukwa and his wife Nyakandulo are hereby coming to you. They are many times falling ill and they have accused some people. Check them all please.

Yours,
V.H. Mwenikwacha

Here the couple's troubles, illness, are overtly blamed on "some people," most likely fellow villagers, and they take their case to the nchimi for divination.

Spouses may not only accuse in concert, but may as well be accused together, as demonstrated by the following letter.

Nganga [Nchimi] Vwamba,

Mr. Mkandawire and his wife are said to be fwitis [witches]. Please see them.

Answer my letter soon.

V.H. Kazumba

Quarrelling husbands and wives may on occasion accuse one another of witchcraft and so be referred to an nchimi by their headman, as demonstrated by this next letter.

Please Nchimi of the Nchimi's Vwamba,

Those two people Binrat Nyaluhango and her husband Nyirenda have accused each other of witchcrafts. Nyaluhango has accused her husband of witchcrafts.

I therefore have sent them to you so that you divine them. And I have sent Nyangwira to be my witness.

Thank You,
Yours,
V.H. Kuruska

Disputes between spouses need not manifest themselves as witchcraft accusations in order for them both to be referred to a traditional healer.

Dear Nchimi Vwamba,

The one who is writing this letter is me Kanyota. I have sent those children because they have divorced each other, so please act according to your uchimi business. In so doing you will save them.

I have sent Chalwita Banda to act as their witness.

Yours,
V.H. Kanyota Chisanga

It is of course possible that sorcery accusation is the source of this divorce, but I think it is likely that there are numerous cases where nchimi and nganga are jointly consulted by a man and wife or wives in disputes not involving sorcery. For example, divorce may be initiated by a man if his wife is not fertile, and such cases are commonly treated by traditional healers. It is however quite possible that these letters of referral written by village headmen have been inspired by sorcery suspicion or accusation, since my various informants are well nigh unanimous that such letters of referral to nchimi are only written in such cases. Thus the "misunderstanding" mentioned in the following letter may be of a sorcery nature.

Dear Sir Nchimi Vwamba,

I can be happy if you are in good health. Sir Nchimi I have sent the mother and the father. They have [a] misunderstanding between them and you are the only person who can help them in solving the problem.

It would be good if you can start dealing with these people as soon as you get the letter because the man is the Chairman [of the Malawi Congress Party] here and he is to welcome the President to Mtaka. Pass greetings to everyone and to all patients.

Yours,
V.H. Wafawafa

Troubles at the Workplace

Workers in Malawi are subject to occupational diseases not only from the physical and environmental hazards peculiar to their employment but from the social aspects as well, namely the malign actions of colleagues. Jealousy is most often at the root of such complaints, which take the form of sorcery suspicions and accusations. Traditional healers are resorted to both in order to prevent such sorcery from being initiated as well as to counter it once begun. In

addition, healers may be solicited to furnish charms to further a client's position at the expense of his fellows.

Uncle [Nganga Tyapula],

I've gone to Karonga and will return tomorrow. The situation is okay now. But people have started consulting witchdoctors that they act against me.

I request you prepare me all that is necessary remaining [so] that I don't suffer the loss of my position; and that those in rank above me have to favour me like their own son.

I'll stop on my way back. I [understand] you've gone to a funeral.

With thanks, Yours,
C.F. Magaga

The author does not state that he is suffering from any ailment. Rather he fears that he will lose his position presumably through his colleague's machinations and so asks the nganga to prepare a charm to counter this threat. Powdermaker observed in neighboring Zambia that "a man who was fired sometimes placed the blame on the witchcraft of an envious fellow worker." (1962:319)⁵ This next excerpt describes a similar complaint.

Bulawayo,
Rhodesia

Dear Father [Nganga Parapaska],

. . . don't forget the medicine that I wrote you [about], because my job assistant has gone on holiday to look for medicine that I should be sacked so that he can take my place. That is why I wrote to you [so] that you should post me the medicine because people of this place do not fear; they think we are so simple. . . .

I remain your son, T.D.K
Ngwira

This next excerpt describes a similar complaint, although in

this case it is the worker's wife who makes the plea to the nchimi.

Dear Brother [Nchimi Chirembwe],

. . . I have a very hard problem which I would like you to help me [with]. . . . Mr. Mumbo's death won't be known because of the job that he is doing. I am pretty sure that his fellow workers are going to kill him. Even [he] himself now knows that there is someone who is after his life and his position at work. . . .

Brother, Mr. Mumbo is a very shy person to tell you what is happening at his place of work. So please help him. . . . I have no more to add but answer me. I am going to be waiting for it. . . .

Yours,
Mrs. Iris Mumbo

This letter is especially significant insofar as it is quite unusual for a woman to write on behalf of a man. It is usually the husband or male relative who writes on behalf of his female relative.

The next letter demonstrates that the fear of death by sorcery by one's co-workers is not limited to the aforementioned example and is in fact widespread.

Dear In-law [Nchimi Lipuka],

. . . At our job, my friends do not like me very much, since they say the European manager loves me. And now my friends are jealous of me, and they say: "We should kill this Tumbuka man." And I wonder if I am going to stay alive.

I am fine here and I can be glad if you can tell me that you are also fine and mainly if you can tell me that you want to come and chat with us here at Lilongwe. I want an answer from you so that I should also know what you have in your heart.

Yours,
Yoram Msiska

The normal tensions existing within the workplace are here exacerbated by intertribal tensions. Tumbukas and other northerners

are disproportionately represented among the employed, their numbers being in excess of their percentage of the nation's population due to their generally superior educational attainments. There has been considerable discrimination against them, some of it being fostered over jealousy of their economic attainments. This general discrimination against northerners, coupled with the man's being favored by his manager, may very well have led to efforts by his "friends" to do away with him. More likely, however, is the fostering within him of suspicion and fear without any actual attempt on his life. The same author, Yoram Msiska, wrote another letter to Nchimi Lipuka some three months later about his co-worker's jealousy.

Dear Father [Nchimi Lipuka]

I don't have much to say by this time, but what I want to say is as follows:

1. I do work here but my friends do not like me and they are jealous of me.

2. And what surprises me is that since I came here [to Lilongwe,] I have never come back there [home in the northeast]. When I take my holiday I decide to come home but I find that I change [my mind] suddenly.

3. The last thing is that since my coming here, I have never cut medicine in my body, and therefore my friends are out-weighing me very much. . . .

But I will come there during the holiday. . . .

Yours,
Yoram Msiska

He additionally makes two statements that indicate his suspicion that he is being ensorcelled. The first is his puzzlement at not returning home when the opportunity arises during his holidays; instead he suddenly changes his mind and does something else, although his initial intention is to return. The second is his noting that his "friends are

out-weighing [him] very much" in their use of cutting medicine. Such medicine which is administered by cutting it into the skin generally is of a defensive nature, although its use may indicate that aggressive sorcery techniques are being utilized as well.

In this last letter referring to trouble at the workplace, the author also mentions a variety of other complaints.

Chileka Estate
Lilongwe

Dear In-law [Nchimi Lipuka]

I am glad to know that you are well though it is not true a person always stays clear from diseases.

I have many troubles here and I sometimes lose desire for work. In-law I want to ask for assistance from you and I hope you will help me.

(1) My wife is ever in troubles with fwiti. When she is asleep, she dreams that the fwiti feed her at night while asleep and she doesn't stay well when she wakes up. There are many happenings here which you are going to know when you come.

(2) I am doing a heavy job but I earn little money, therefore I want you to carry me medicine for the increment of money.

(3) I want promotion. They, in my presence, say that I am doing my job very well, but they give me little money and no promotion. I wrote a letter asking to be an officer. There is a place [position] quite alright, but they don't answer me.

(4) People are hating me very much including staff members and farmers. They say I am very young and not supposed to lead them at work. So I want medicine so that whoever sees me, he should be happy with me. When they make secret meetings speaking against me, they should come and ask for forgiveness after telling me what they had been discussing.

I have started buying tobacco but people turned against me because they said I lower the prices of tobacco. The company told me to continue buying tobacco and get transferred after the closure of the market. But I

am afraid that people are going to trouble me again where I will go.

(5) I want to sit for G.C.E. 'O' level [General Certificate of Education] in April 1978. I wrote this examination at first but I failed. I don't know why I failed the examination. Now, I want you to prepare the medicine so that I pass this examination in all five subjects at once.

In-law, there are many troubles but the drawback is that we don't correspond. I will send money shortly so that you come here. How are you at the moment together with the children and sister?

We are a bit fine here.

Yours,
C.A.B. Mwandovi

Employment is hard to come by in Malawi and there is great competition for the few available jobs. Belief in sorcery is well nigh universal, and whether or not junior colleagues attempt to ensorcel their seniors, such action is likely to be suspected when job related difficulties arise. Such troubles are generally relational rather than organic, although there may be physical complaints as well, some of which are attributed to witchcraft. There is additionally a much higher per capita incidence of occupational disease and injury in Malawi than in the United States, which may be attributed to sorcery, when it is in reality due to poor management practices.⁶

The following is another instance of such a workplace related complaint, which like most others of its genre, refers to the fear of future trouble rather than to any past injury.

My Dear Father [Nchimi Vwamba],

How are you? I was working at Chengera sugar factory, . . . but white men have transferred me to here in Blantyre, and I am now at Mzungu rest house. I am the one who is welcoming white visitors and even black bosses. I am the supervisor. I have a garden boy [and] three cooks, that makes four under my supervision. But one of them

wants my post so he is bringing his medicine [to] the place of work. I have been told by workmates that he washes medicine in the rest house's toilet. . . .

Yours, H.L. Mkandawire

The author was working far from his rural home in a large town in the south of Malawi. Ordinarily such an accusation of sorcery made to an nchimi would be channelled through one's village headman, who would most likely be acquainted with both accuser and accused. However, in a case such as this, with the (incipient) victim living at a distance from home and with the alleged troublemaker unknown to the victim's headman and not subject to him, there is little recourse but to complain directly to the nchimi. If the incident had occurred in a rural area with a local village headman in authority, the victim would likely have put the complaint before him. However, in an urban environment such as the author finds himself, village headmen are non-existent, and the community is frequently loose knit and impersonal. Many of the inhabitants are transients, employed in town, but with their primary orientation to their village, to which they sooner or later intend to return. Rural folk working in town normally retain close ties to their native villages. They may resort to the healers that they know of from their homes and with whom they have had prior experience, for troubles such as the one under consideration rather than patronize a local healer of another tribe, speaking another tongue, and with unknown credentials. The distance involved is not a problem since much of the healing takes place with the client in absentia.

The Use of Surrogates in Divination and Treatment

Unlike their western counterparts, traditional healers are

believed to be capable of diagnosing a complaint and prescribing for it without the patient having to be physically present. This is true to some extent of both relational as well as organic complaints. It is widely believed that some third party, usually a relative, may go to a healer on behalf of the victim, and be both a complainant as well as in some unspecified fashion a kind of surrogate on whom the healer does his divination. Since healers having a high reputation may be consulted by patients living far away and since transportation is both relatively expensive and inconvenient, it is not surprising that some seriously ill persons will attempt to secure help in this fashion. There are several varieties of surrogates mentioned in the various correspondences, the first occurring when the troubled author sends someone to be divined in his stead to learn what ails him.

Father [Nchimi Vwamba],

I am ill but I have failed to come alone because of the illness, therefore I've sent that child to come and see of my illness. And I am looking forward to hearing from you.

Yours,
Acting V.H. Chifukwa

Unfortunately, I have little information on how healers go about making a diagnosis in the patient's absence however, in light of the rather arcane diagnostic methods used when patients do present themselves, diagnosis in absentia requires but little more faith on the part of both practitioner and patient. The next example suggests a request that two people be divined in absentia.

Dear Brother Mr. [Nchimi] Lipuka,

I have sent these children so that you should search me and my daughter who is married at Chilumba by Mr. Mhango. I, myself am failing to walk because my legs seem as if tied, and my daughter is very sick and I want to see

what is wrong here at the village. You know it is difficult for a person to take out a log [splinter] in his eye, but his friend will do it for him, and that is why I have put all my trust on you. And look upon these children also according to their complaints. This is all that I have [to say] but I would like you to answer my letter.

Yours,
V.H. Monire

The second type of surrogate referral is when the author sends a surrogate on behalf of some third party who is troubled.

[Nchimi Vwamba,]

I have permitted Mr. V.H. Chunga to come and see the illness of his son's wife who up to now is still in the hospital at Kazuni.

yours,
B.V. Dambo
Acting Chief Kwavya

In this instance since the author is a village headman and has written to give his permission to a divination in absentia, there is probably a suspicion that witchcraft is at the root of the daughter-in-law's illness.

The last and most common form of surrogate consultation occurs when an author sends someone in his stead to fetch medicine for him. The author's request is not merely that the third party collect medicine as one would pick up a prescription for a sick relative at home here in America, but rather that the healer diagnose the complaint on the basis of the scant information contained in the letter as well as upon any narrative the messenger is able to furnish.

Dear Ntchimi Vwamba,

My in-law Fraction Nyungwe has come there because of his illness and because of my illness. Had it been that I had transport money, I could have come there already, but I am not in a good health because I was seriously sick in 1972.

I can be very grateful if you will give medicine to my in-law so that he should give me here so that I can get better a bit in order to come there alone.

If God can permit you to come here, I can be very glad, but my aim is [to] come there in order to get energy.

May God bless us so that we may meet. Greetings are due to you and your family. My in-law knows all my troubles pretty well.

Yours,
Kondwani Kupakata

This author, a once powerful political figure now out of favor, was diagnosed as a hypochondriac by several western doctors who could find nothing organically wrong with him on repeated examination.⁷ He apparently expected his in-law to supply the nchimi with the details of his condition in order that he might diagnose and prescribe for it.

In a number of letters the author describes his own or some relative's complaint and requests that the healer prepare a suitable medicine to be collected by a messenger who does not appear to have any other mission. The healer is apparently expected to be able to diagnose and prepare a remedy solely on the basis of the brief written description of the complaint.

Dear Mr. [Nchimi] Vwamba,

I have sent this person to come and get medicine for my aunt. She is suffering terribly from stomach-ache. She doesn't eat at all. If she tries, she vomits. I came there yesterday but I missed you, you went to the Police Station. I have sent this person today because I am on duty [at the bus depot] and I will be leaving for Rumphu with the bus.

Please help me sir.

Thank you,
Yours,
[Bus] Driver E. Nyirenda

The author has penned a sketchy account of his aunt's symptoms, expecting that it is sufficient for the nchimi to divine what is ailing her and dispense some remedy for it.

In addition to sending relatives to fetch medication to be taken by their sick kin, at least one nchimi (Nchimi Lipuka) administered mankhwala to the wife of the victim, who acted as a kind of surrogate for her husband, as the following excerpt indicates.

His wife was eating some powdered medicine, and drinking some medicine, because she is with one blood with her husband; because you know, they have children together, and that his disease, Mr. Nkaza's disease, is not just a natural disease. He has been bewitched, and therefore it was magic, and therefore the medicine also should have a bit of magic. And that's why the wife should take it and it would heal him.

I have been unable to find other instances of this practice in my field notes, but it is unlikely that the practice is peculiar to Nchimi Lipuka.

Requests for Healer to Visit Author

Although clients of traditional healers generally come to the healer for consultation and treatment or send their surrogates, healers on occasion make house calls, such visitations being made by both nganga and nchimi. In addition to visiting clients at their homes, healers on occasion minister to inpatients at western hospitals. Clients who live far from a healer may request that he or she come to them at their expense, as the following letters attest.

Mobil Oil Malawi Ltd.
Blantyre

Dear Father [Nchimi] Lipuka,

. . . What I wanted is that you should come here in Blantyre for the following reasons:

(1) I find I don't have strength in my body, but I don't know the reason why.

(2) My wife is nearing to give birth but at the hospital they say they are not sure when she will give birth.

As you said that when you are coming you will bring the medicine with you ... Come with your medicine for cutting. ... We have failed to find money quickly for your transport. You can get money out of yours, so that when you come here, we shall replace it back. If you have set off [on] your journey, send us a telegram. . . .

Yours,
Matthew Kutondora

In this case it would appear that the nchimi is requested to come since the author is employed and cannot conveniently leave his job, nor is his wife capable of making a tiring journey some five hundred miles to the north.

In the next letter, although the author lives but a few hours walk from the healer, he requests his presence at his village since his family and house are bewitched.

Dear [Nganga] Mwetuka,

Friend, I am really in troubles. I am being troubled by the witch people. Please I am asking you to come here and help me with some medicine. I would have come there but I haven't come because I want you to come and give us medicine so that the witch does not play [like a cat with a mouse] with me, my two wives and children, together with my house. Please friend, I have hope that you are coming. Answer me quickly. . . .

Yours,
David Mwenivumo

The Search for Explanation

Patients and their relatives frequently resort to traditional

healers in order to ascertain the why of their complaint. It is even more important to learn the cause of an individual's death, or, if the death occurred at a western medical facility, to verify the hospital's diagnosis, that is, to determine if the death was due to God, i.e., natural causes, or to witchcraft. Death certificates are not normally issued, and autopsies⁸ are even more rarely performed, even in those cases when a person dies in a hospital. Most deaths occur in the absence of any western medical supervision, and so an informed western style rationale for a death is not often available. The following letter illustrates this quest for an explanation of death, even when the deceased met his end in a hospital.

Chizumulu Island,
P.O. Likoma Island

Dear Nchimi of the Nchimis Vwamba

I have permitted these two men, Mr. Isiah Kanjera and Baza Nkanga to come and ask about the death of their relative who was found along the lake and was taken to the hospital and died there. We therefore want the truth if this death was caused by people or God the Lord.

If it was caused by people, tell us their names, and if it is God himself you can also tell us. We have trusted that the whole truth will come from you since you are the Nchimi of the Nchimi's. We were very happy with the journey of Fumbani Bowe, at least the whole village was happy. We hope to receive a letter from you. These men have been sent by the mother and father of the dead person.

Yours,
V.H. Jwanthi

Often, a person's death is immediately attributed to witchcraft, and some person or persons are suspected from the outset. In such cases a diviner is consulted in order to confirm or deny the suspicion, as this letter demonstrates:

Chief [Nchimi] Vwamba,

I am sending this person, he is suspecting some in this village to have killed his wife by magic. So I have allowed him, and give him this letter as evidence.

I should be grateful if you will be so kind to help him.

Yours faithfully,
G.V.H. Kwahare

On occasion, instead of one person suspecting another of having killed a third party by means of sorcery, there is a mutual suspicion or accusation.⁹

In rare instances, a person accused of having caused a death appeals to the healer for aid in clearing his name or seeks protection from possible retribution, as this letter illustrates.

Dearest Brother [Nganga Tyapula],

Thank you very much for the medicine you sent me. Thank you very much indeed. I've seen another animal skin [used as an ingredient for magical medicine] and I shall buy again and bring it before schools close. [The author is apparently a primary school teacher.]

Furthermore I wanted very much to come there alone and explain how people hate us here, especially those who stay near us. There is a certain woman whose home is Likoma, and her child died. So the Likoma woman and another woman, again whose house is near us too, tell people that I'm the one who killed her child. What can I do with this Cousin? You know that I'm just a simple woman, ... Sometimes I simply pray to God so that He, the Almighty can reveal the truth. What I do is simply to keep quiet.

Now these days, I dream very bad dreams as if one of my children will die. I fear that they might kill my children. Find out if there is something bad, so that I come there for help. Please answer me. Whatever you shall tell me I shall do, for I trust you very much Cousin. Especially there is a certain woman who comes from Nkhata Bay, she is the one who says I'm a witch. But I just overlook her because she isn't an employee, so I know that it's jealousy.

Greetings to everybody,

Your Sister
Mrs. Lunda

This next letter dealing with death falls into yet another category. In this instance, the client dreams that a witch attacks him during the night but is repulsed. He later learns that a neighbor dies and so suspects him of being the witch in the dream.

To Father [Nganga] Mwetuka,

How are you? We are okay here but for a bit of coughing. This is so because of the coldness. How is the job going on? With me the job is going on well, but the truck is in the garage. . . .

About our sleep at night. It is very nice. I had a dream of trucks for three days. The other day I had dreamt of a man sitting on my chest, and I did bite his testicles and he did run away. And then two days passed and the death happened 500 yards from my house. This chap was our fellow driver, and I think he was the one who had come to my house and is the one I did bite. And he has failed.

Yours,
Henry Msuka

More important for our analysis than the fact that the deceased was a neighbor is that he was a co-worker. It is likely that the author was living away from his home, probably at some construction site. Rivalry among workers for promotion or other favors often results in witchcraft accusations, and this is such an example. Mr. Msuka might well interpret the sequence of events as the co-worker trying to bewitch him by pressing on his chest while asleep. This is a common enough description of how witches harass their victims. However the dreamer reacted aggressively to the co-worker's shade and bit him, causing the shade to return to its corporeal self, which later succumbed to the injuries sustained by being bitten.¹⁰

Dreams of various kinds may be taken to healers for

elucidation. In addition, nchimi are apparently requested to supply medicines that will facilitate dreaming, as the following excerpts illustrate.

Johannesburg

Dear Nchimi Lipuka,

. . . Another thing is that I want you to send me some medicine known as njilizi so that I should be dreaming. Send it quickly.

Phillip

Swaziland

Dear Mother,

. . . I have sent this money for Mr. [Nchimi Vwamba] for medicine. . . . Please Mother, tell him to send me the medicine that I left there. Two njilizi which he refused me to take because I had not enough money. These two njilizi, one is for dreams and one is for staying in my pockets so that it should help me sell my goods effectively. Mother try to find me medicine for defending the house so that the fwiti should not see or witch my house. . . .

John

The main agent causing disease, death, and misfortune in Malawi is believed to be sorcery. Dreams are believed to provide information on possible threats to one's health and happiness caused by sorcerers, and those who have such dreams may on occasion consult a healer to interpret them as well as to aid them in combating any sorcery indicated by their dreams.

Dear Mr. [Nchimi Lipuka],

. . . The main trouble here is the people who are troubling me very much. I dream my friend whom I am working together with [is] visiting me every night together with his wife, and sometimes eating unnecessary things. I sometimes tell them that though they do such things they

won't do [accomplish] anything. Am I being wrong when I say so? Please brother tell me although I know you are ever busy. . . .

My heart here does not settle down as you are already aware that we are both innocent people knowing nothing about medicine. Greetings to everybody there at home since they are friendly to us and no one has a grudge towards us. God be with you and He should lead you in all your activities.

We also greet you.

Yours,
Robert Nganda

Apparantly the author suspects that his co-worker is witching him and so seeks advice on how to deal with this situation.

In another letter, an author is given things to eat which do not agree with him and relates his trouble to an nchimi.

Dear Father [Nchimi] Chirembwe],

. . . At night I dreamt that some people were giving me some things so that I should eat. When I waked up early in the morning, I wanted to vomit. Later on, I started feeling abdominal pains. Up to now, I am still not better. That's what happened to me . . .

Yours,
M.L. Lungu

It should be noted that although this dream narrative mentions what in effect is the administration of a poison, in reality, there is virtually no true poisoning practiced in this area. The substances used as nyanga to effect sorcery all act at a distance, rather than directly, and toxic substances are not normally placed in people's food or belongings.¹¹

References to spirits are found in letters dealing with both dreams and death, the three phenomena being intimately related. Both nganga and nchimi may deal with spirits, although nchimi allegedly have

the edge on expertise.

Help-Seeking for Spirit Possession

One would have expected a much larger number of letters dealing with problems associated with vimbuza or spirit possession, considering the number of persons complaining about it at both traditional and western medical health care establishments. Perhaps the reason for the conspicuous absence of such letters is due to vimbuza being such a commonplace and generally non-threatening trouble, having many secondary gains. It might well be argued that it is assumed voluntarily, in order to take advantage of these gains. Furthermore, since vimbuza is most often treated locally, in a setting that involves the participation of both the possessed and the community, (Chilivumbo, 1972:6) distant healers need not be consulted, nor need letters be drafted to them.

On occasion, problems attributed to vimbuza are of a more serious nature, and some distant healer may be consulted in order to solve them. Another reason for clients' writing about vimbuza to a healer is illustrated by the following letter.

Blantyre

Father [Nchimi] Chirembwe,

I am informing you that the mother of Hastings is coming there at Muhoni so that you can see the troubled Hastings. The mother also is not well with the head; she is suffering from vimbuza. Please try to help her when she comes there. ...

Please try to let me know all what is wanted on her troubles before month ends.

I'm coming there in the dry season.

Yours,
David Shawa

In this case, the author is the husband of the woman suffering from vimbuza. He is working for a government agency in Blantyre in the south of the country and so must manage his affairs by mail. He expects that Nchimi Chirembwe will be able to aid both his wife and child.

As with other sorts of complaints, an individual suffering from spirit possession may seek aid directly from a healer, as this next letter indicates.

My Dear [Nchimi Vwamba,

I hope to come there, but I am coming very far . .

I have one thing that is troubling me a lot, this is vimbuza. This disease is making me lose weight. But this month I dreamt that vimbuza is making me not to have a pregnancy, and the disease did attack my breasts and the breasts did swell. I am coming very shortly.

Yours,
Agnes

Here the symptoms of vimbuza were serious enough to cause the sufferer to seek help from a healer with more than a local reputation, who in this case was about twenty miles distant.

Instead of going to the healer, one may request that he send medicine to treat the disease, as does the next author.

Dear Nchimi Vwamba,

I ask you if you could send me some medicine of virombo. That medicine you were talking about, so that I should come and drink with my children together with mbozga.

I trust you very much that you will send me, and I promise to send all the people in my village so that you divine them.

Yours,
Goli Mbiri

P/S Give my medicine to the one who has carried the nyanga.

In this letter, the author makes two statements that tend to connect virombo, or spirit possession, with witchcraft. The first is his reference to drinking medicine for virombo together with mbozga, which is a general name for anti-witchcraft medicine. The second is in the postscript, in which a messenger carrying nyanga is to fetch the medicine. Nyanga is the medicine used by sorcerers to effect their evil-doing. It is unclear how the nyanga got into the author's hands, as it is normally handled only by witches or nchimi, but in this context it tends to lend support to the interpretation of vimbuza as being caused by an interaction between spirit possession and witchcraft, as mentioned earlier in this thesis.

Another case in which spirit possession and sorcery are somehow linked is illustrated by the following letter.

Lakeshore F.P. School
By Hand

Dear Mr. [Nganga] Nyevoja,

I have heard about your father. The grandfather who healed my father was Mr. Chenje and now I have heard that you know everything that Mr. Chenje had. Father I fall before you. What I want from you is not just my doctor, but even forming relationship.

They have fed me something that is inside my flesh and not [merely my] intestines. It bites me and sings a lot. I fail to come there since I fail to walk long distances. Legs and virombo trouble me, and again I and my wife are both teachers, therefore try to come here please. You will carry a lot of fish from here. I kill a lot of fish here. If you have failed to come please give some medicine to father according to my complaints. Please give him medicine.

Your Son,
Reuben Khondowe

The relationship, if any, between the sorcery being practiced upon the author and his virombo troubles is not clear. They may be envisaged as two separate troubles or as having a causal relationship, as suggested earlier. It is worth remarking that the author and his wife are primary school teachers yet evidently give credence to both sorcery and spirit possession.

Sufferers of vimbuza sometimes undergo the chilopa ritual when they are cured of their malaise. (Chilivumbo, 1972:8) This entails the ritual slaughter of a goat or chicken, and drinking its blood, as this next letter refers to.

Hello Father [Nchimi] Vwamba],

If you are in good health it can be good. I am a little better, but only troubles are here, very much, and there are a lot of people [patients]. I am still here a little bit. I will cook medicine for [those] who want to dance vimbuza and suck the blood of an animal. . . .

I am Nchimi
L.M.N. Mtembolibwe

It seems likely that the author of this letter is a former patient or acolyte of Nchimi Vwamba, who is now practicing in a small way on his own. The mention of sucking the blood of an animal is a reference to the chilopa ritual.

Whereas Nchimi Mtembolibwe is administering the chilopa ritual to his own patients, the next author is requesting that Nchimi Vwamba administer the ritual to him.

Dear Mr. [Nchimi Vwamba],

I am alright here, but I did wait for a long time

but did not see you as you had said that you were coming. I would have come but failed because I heard you had gone to Lilongwe.

I have so many things for you to do, and that is why I want you at my home. I want you to give me a chilopa. I have no one [else] in mind who could give me this, as it is said that only a person that can foretell is the person who can give me a chilopa, but tell me in advance that you are coming, so that I buy a goat before your arrival.

Yours,
Chizirachi Kamwenye

The author is presumably suffering from some sort of spirit possession, most likely vyanusu, the form leading to the possessed person becoming an nchimi. He correctly remarks that "only a person that can foretell [i.e. only an nchimi] ... can give me a chilopa," the administration of which is the culmination of the therapy, marking the transformation of the vyanusu sufferer into an nchimi.

In addition to dealing with vimbuza spirits, healers also act as intermediaries between man and the ancestral spirits or mizimu.

Father [Nchimi Sukutura],

I also have known that you are aware about the troubles of my wife, and I believe there is something wrong.

What I want you to do is to sit down with father and all people who were present at the marriage, and discuss the procedure it went through, since it was not a good one. Now the [ancestral] spirits are angry with us.
...

If you don't do this, she will never get married because the spirits are angry. That is true father. Don't think that my wife doesn't want to be married, but the only problem is the spirits, and if you can sit down with Father at Kalowe there, then everything will be fine. I have discovered that the marriage did not go in the right order.

Please Father do as I am asking. I believe some of the rules for marriage were skipped and it is up to you to make them right again. If this is not done my [wife] will

continuously be troubled with these spirits and she will have no chance of staying with her husband, and since the spirits are very cheeky, she will not have a good health.

. . .

Your Son,
Nyirenda

Apparently certain of the protocols of this man's marriage which dealt with the mizimu were either neglected, or were incorrectly performed. The result was that the spirits were angered although the way in which they manifest their anger is not described. In any event the problem is taken to the healer, in this case an nchimi in his traditional role as ritual expert and intermediary between men and spirits.

The next two letters are to a nganga who evidently also deals with spirit related troubles.

Dear Father [Nganga Tyapula],

It is me Edith Moyo. . . . Father, I didn't know that I would be alive, but because of you, I now respire very well. Since I got married . . . I haven't borne a child [without getting] sick, . . . When I came there to ask for medicine temwanene [a love potion used by women,] I failed here at home and we got divorced . . . I have sent K1 [\$1.40 in 1974] so that you clear away all my ghosts that trouble me. I want to see the goodness in you with all the power, love, kindness, glory should be with you together with the freedom.

Thank you,
Yours,
Edith Moyo

Although the love potion she requested from Nganga Tyapula failed to retain her husband's affections, she still has confidence in his powers to influence the ghosts or spirits that trouble her.

Another woman wrote to this same nganga complaining of her own and her children's troubling dreams of spirits.

My Dear Brother [Nganga Tyapula],

I am writing to let you know that I'm having a very hard time because of these three children. . . .

- (1) Alan . . . He is awakened during the night calling out as in sight of a creature. "A creature! A creature!" He looks very frightened. Please help us Brother. I don't know whether he sees witches.
- (2) Binrat also fell sick last month, she was vomiting . . .
- (3) Jane is also sick with her usual headache, dreaming of spirits.
- (4) I'm also dreaming of dead people, sometimes talking to [the] late Priscilla, and last week I dreamt her saying "I want a chicken," so I chased her away. Someone was talking to me through a dream saying I should go and put money on her grave. . . .

The usual nightmares of childhood, which in our culture are generally accorded little significance, have greater import in Malawi, where the supernatural beings, such as ghosts, vimbuza spirits, and witches which populate such dreams are often regarded as real and are dreamt of by adults as well.

Summary

It would appear from these letters that contemporary healers have largely supplanted the former priests or basofi as intermediaries between man and the indigenous (as opposed to the introduced Christian or Muslim) spirit world. This function enhances their power, and adds to the list of reasons for becoming an nchimi's client.

The material presented above illustrates the client as victim. This is, as I stated at the beginning of the chapter, the commonly accepted interpretation of the client's role in Malawi. The only straightforward way in which a client of a healer is himself the

instigator of a trouble is in the event that the healer is patronized in his capacity as purveyor of nyanga, as is briefly discussed in Chapter IV. From the perspective of a non-believer in the powers of sorcery, clients may be seen as troublemakers when they accuse a person of sorcery. However, judged from an emic perspective, such an accusation is fully compatible with the role of the client as victim.

¹Evans-Pritchard remarks upon the absence of sentimental or romantic love in primitive societies, noting however that the concept of love was introduced by the Europeans. (1965:47) Love is making inroads in Malawi, especially among the educated and those living in towns.

²Graubard writes that "such professionals [European "herb-women" of the 1600's] walked a most delicate tightrope. Everybody believed in these practices and approved of their use so long as they served what was regarded as a legitimate purpose. Should . . . that purpose cease . . . to be approved of, the very same practices became evil . . . (1984:53)

³Note the allusion to a very late abortion made by the author. Abortion is highly illegal and very much frowned upon, yet abortifacients are readily available, either from healers or home made, and induced abortions do take place, albeit clandestinely, mainly on unmarried women, especially students and the employed. All three medicine-men studied by Young listed abortifacients in their ethnopharmacopoeia, (Young, 1932:229) and at least two nganga that I am acquainted with list such medicines in their ethnopharmacopoeia.

⁴Gelfand, writing of the Shona people of Rhodesia, states that "any neglect of a rite or religious practice may offend one of these spirits." He specifically notes that "in the complicated marriage formalities, any omission of part of the dowry would anger the spirits concerned." (1969:376) Perhaps some similar problem is believed to be at the root of the trouble described in this next letter.

⁵Powdermaker also wrote that: "My strong impression was that education continuously increased the number of those who replaced witchcraft-thinking with the empirical thinking of science. The intelligentsia, particularly those with secondary education, schoolteachers, and men learning new skills of advanced jobs were gaining a view of the universe in which witchcraft was not a principle of causation." (Powdermaker, 1962:319) My experience, and the documentary evidence presented within this thesis, indicates that Powdermaker erred somewhat in thinking that education would supplant witchcraft as a viable explanation of causation of misfortune. Many of my informants were secondary school students, who both orally and in writing indicated that they firmly believed in sorcery. The various professionals whom I have quoted, including nurses, clergy, administrators, and teachers, all believe in the reality of witchcraft and are, I believe, a representative cross section of the population. It will be a very long time before western scientific notions of causality, particularly as it applies to misfortune, are as common in northeastern Malawi and its environs as they are here. Perhaps by that time, the rising tide of Christian fundamentalism, Creationism, and similar phenomena, will have brought our two hemispheres to some sort of causational parity?

⁶The high incidence of industrial accidents seems due to limited awareness of both workers and management, inadequate regulation and enforcement and limited economic resources. An illustration of this is an observation I once made at a government sawmill in southern

Malawi, where the men working a wood pressure impregnation autoclave were not wearing gloves and were walking barefoot through puddles of spilled creosote wood preservative on the floor. This material is both toxic as well as carcinogenic, and any symptoms that might show up in the years after they had left their employ would not likely be reported as being of industrial origin. (Goldwater & Omran, 1974:339-42) In 1977, there were a total of 276,126 persons employed within Malawi, and 1,590 injuries or deaths severe enough to result in the award of workmen's compensation payments. The rate of worker fatalities was 21.3 per 100,000, and the rate of worker injuries sufficiently great to be granted workmans compensation was 554.7 per 100,000. (National Statistical Office, 1979:76,80) The total number of job related injuries was presumably considerably greater. These very high rates are likely to provide grist for the mills of both western as well as indigenous healers.

⁷ Several doctors acquainted with this case thought that Mr. Kupakata's symptoms were psychogenic manifestations of his underlying depression, which was precipitated by his fall from power. Kiev (1974) and his fellow authors discuss the somatic effects of depression, and their theories may have broad applicability to many cases of illness currently ascribed to sorcery. If a person is depressed due to some sort of interpersonnal conflict, such depression may produce organic sequelae, which will only disappear when the underlying psychological complaint is successfully treated. This may explain how nchimi and nganga with their relatively physiologically ineffective medications can cure some of their patients, since it is the patients faith in the healer and his medications, i.e. the placebo effect, which by treating the underlying depression, effects the somatic cure.

⁸ Janzen writes that "One nurse's aide and pathology assistant in a mission hospital, ... sold small pieces of cadaver as a powerful fetish, reinforcing the fear that in performing autopsies (i.e., tampering with the dead), the missionaries "ate" parts of the body to strengthen themselves." (1978:216) See also the discussion of chizimba, and Dr. Banda's comments on chizimba in Chapter II.

⁹ The type of letter written in such cases is illustrated in Chapter VI.

¹⁰ See the description of the seketera for an explanation of how witches may be killed.

¹¹ Graubard, writing of European witchcraft circa 1600, states that "The distinction between a magic-working herb and a poisonous one was not too important to sorcerers aiming at incapacitating a victim by spells, charms, images, or chants." (1984:49) I suspect that such distinction is made by contemporary Malawians.

CHAPTER VI

THE WITCHCRAFT CAREER

Witchcraft as a Career

Just as persons afflicted with an organic or mental disease follow an illness career, so do those who are victims of troubles allegedly caused by witchcraft. Emerson and Messenger's description of the stages of such a career of trouble are generally applicable to witchcraft cases occurring in northeastern Malawi. There is an initial recognition that something is wrong, necessitating a definition of the trouble, which is, however, subject to further clarification and perhaps redefinition as the career unfolds.

In Emerson and Messinger's parlance, the role of village headmen is most often that of complainant. (1977:126) As official referral agents, they formally, yet frequently non-specifically, state the victim's trouble to the nchimi or nganga who is expected to be the troubleshooter. In some instances, however, headmen are overtly partisan and assume the role of accuser. (Marwick, 1965:105)

Witchcraft cases may originate as somatic complaints, initially indistinguishable from any other illness; such symptoms may be preceded by some intrapersonal conflict, making their definition as witchcraft all the more "obvious." On the other hand, the trouble may be of an economic or emotional nature, and there need not have been any evident interpersonal conflict preceding it for sorcery to be suspected as its etiology. One criterion for such a suspicion is a long standing chronic complaint, which has proven refractory to more conventional

treatment, both traditional and western. Those suffering from such chronic ailments may suspect sorcery, and so secure a referral from their chief or headman to a healer. For example:

Nchimi Vwamba],

I send Mainess Nyakhwawa so that you divine her on her illness that she has, for she has been troubled for a very long time.

According to how you're going to see and find, you should tell her how her illness came into being.

Yours, Chief
Kambola

One can assume that in a referral of this nature witchcraft is suspected as possibly being at the root of Nyakhwawa's trouble. The consultation with the nchimi is to ascertain what his or her opinion is, with the hope that some other agent other than witchcraft is responsible for the complaint.

The next letter illustrates another stage of such a career of trouble, in which a chronic illness which fails to respond to treatment is definitely attributed to sorcery by the victim or his therapy management group, without the necessity for it being formally suggested by a troubleshooter. In this case the victim is the complainant and is asking Nchimi Vwamba "if you could tell me those who trouble me so that I go and take them." However, there is no guarantee, even with such a definite suspicion by the victim, that the nchimi will in fact attribute the trouble to sorcery, or, if he does, that he will name the sorcerer.

Dear the Honourable Father [Nchimi Vwamba],

I have written the letter crying in your face. I am here, just for the night. I shall not sleep for the cough has taken place. And where I am surprised is on that I have the cough, my wife has the cough, and so does my

younger brother - all of us in the house. And with me now it catches the throat and it gets dry up Father, all my legs fail to walk and both my eyes don't see up clearly.

I therefore have this belief that it must be of magic Father. And as I am here, I don't even sleep at night and I am much surprised because all of us at the house have the same type of cough. And as I am now I don't take the medicine because it is now worn out Father. And as I am here I cry Father and pray that may God enter into you so that you find me some medicine for this magic cough. Father I've cried very hard and inside my stomach burns as though there is fire. And I don't even go to the toilet. Father when I walk, I just insist myself to do so but I am not alright.

And I would very much like to hear how my illness came into being at my house or to other people outside for I know that you're the only person who knows of every illness of someone, where it heads or where it has come from Father. Indeed, I cry hard for I don't find a good life and I agreed on what you said because if the x-ray fails, therefore I know that you are the only one who can help me Father.

I am no where as I am here now. But I cry to you that please aid me on this cough. Although you say it is just a disease, yet it is with everyone of us at the house. Perhaps they have done it deliberately to put it at our house Father. I have written all this because it is the sufferer who complains father. I therefore fall on your knees and want you to know all what troubles me. Perhaps there is something wrong that I've done at home and so that they have put this cough on me. We all don't sleep as I have said earlier, and to my great surprise, yesterday as I was coughing, I found a hair in the sputum. And today the same thing has happened Father. And now my throat dries and I even fail to breathe out. Please help us Father, everyone else is ill at home and I was the only strong person, but then I am dying. I beg you if you could tell me those who trouble me so that I go and take them. I fall on your knees so that you help me, although it doesn't show respect in writing a letter. I cry to you father for now things that come out of my stomach are like porridge.

Your child,
I. Chitindi

The author attributes several commonplace events to magic or witchcraft, whereas an outside observer might see nothing unusual in an entire family, especially one living in relatively crowded and unhygienic conditions, coming down with the same type of cough.^{1A}

sinister connotation is also given to the appearance of a hair in the sputum, although there are many possible non-magical avenues for such an event occur. The author interprets these phenomena as manifestations of sorcery and thus is logically forced to take his troubles to a specialist in such supernatural matters, an nchimi.

Letters of Referral

Nchimi may be approached directly, but custom frequently dictates that in serious complaints, particularly those in which sorcery is suspected, the patient obtain a letter of referral to the nchimi from his or her village headman or chief. Such letters may be genuine referrals, in which the author, the headman or chief, is the person suggesting that the patient see some particular nchimi chosen because of his own experience as a patient, or, more frequently, on his knowledge of the nchimi's successes with other villagers. While the headman is technically a layperson as far as the native medical system is concerned, the referral is made in his official capacity. The headman is to some extent responsible for settling disputes and keeping order within his village. (Gluckman, 1949) If a villager is experiencing a trouble which may have a relational cause, i.e. sorcery, it traditionally falls within the headman's responsibility to deal with it. Nowadays this means initially referring the case to an nchimi, who may be chosen by the troubled party, by the headman, or possibly even by the alleged troublemaker, if he or she has been named. The headman's referral of the victim to the troubleshooter, to use Emerson and Messinger's (1977:126) terminology, is normally effected by means of a letter, which serves the overt functions of requesting that the nchimi see the victim, ascertain what is wrong,

cure the complaint, and finally, communicate the findings to the headman.

The latent function of such letters is in part a function of the headman's role of official complainant, once again borrowing Emerson and Messinger's terminology. This function is in effect to authorize the nchimi receiving such a letter to practice witchfinding in his attempt to divine the cause of the victim's trouble. Since witchfinding is illegal and since arguments are likely to erupt when witchcraft accusations are made by an nchimi, the letter serves to guarantee that any ill effects resulting from such witchfinding will be attributed to the headman who authorized the divination in the first place as well as to discourage any argument and fighting by showing that these investigations have been officially sanctioned.

Instead of requesting a written reply or often in addition to expecting one, the headman may send a witness or witnesses along with the victim. The witness, who may be chosen by the alleged sorcerer or by either the victim or the headman, has the responsibility of communicating the nchimi's findings to the headman, who will then take whatever steps, if any, are indicated by these findings. In cases where there is an alleged sorcerer initially suspected, that person is often sent along with the victim for divination, with or without an additional witness.²

The following is a typical letter accompanying two complainants, each of whom has accused the other of sorcery, and a witness.

Please Ncimi of the Ncimis Vwamba,

Those two people Talina Nyaluwe and her husband

Msiska have accused each other of witchcrafts. Nyaluwe has accused her husband of witchcrafts.

I therefore have sent them to you so that you divine them. And I have sent Mkandawire to be my witness.

Thank You,
Yours,
V.H. Mizimu

Note that the headman refers to Mr. Mkandawire as his witness, implying the function of the witness is primarily to relay the nchimi's findings to the headman. A witness may also serve to protect the interests of the parties to a dispute, who may both select an impartial observer to carry the results of a divination back to their village, as in this next example.

My Dearest Chief [Nchimi Vwamba,

Sir! How are you going on with the job? And how are you? As for me I am well and fit.

I have one thing to talk to you about, and that is, I am sending Mr. Mzumara and [Mr.] Mwamale. They are arguing with one another and they have been in this state for a week. Their witness is Mr. G. Mwandevu.

Nothing more,
Yours faithfully,
V.H. Mfuni

The usage of the term "witness" thus differs from its commonly understood sense in western legal cases, as the role is generally not to make any statement during the factfinding phase of an investigation or trial, i.e., the divination, but rather to act as a messenger in bringing the nchimi's findings back to the headman so that he may decide what steps to take. Although the headman or chief is not directly involved in judging witchcraft cases, he still has the responsibility to decide on the disposition of the case, based on the nchimi's findings.

In addition to witnesses' reports, headmen request written replies to their letters to nchimi. Several stress the importance of a letter written by the nchimi to the village headman as the formal indication that the accused party is indeed guilty. If such a letter is not forthcoming, the accused may question or reject the nchimi's findings.

Dear Nchimi Vwamba],

I have sent this child to you. This child has accused Mr. Ngwalo and his wife that they are witches and they are refusing because he doesn't have a letter from you mentioning about their witchcraft. Please Nchimi Vwamba help me in giving the boy a letter. I trust that you will help me. Many people appreciate you because you have got letters from the government allowing you to do your work. They say I should organize my people and call you to come to my village.

Greet your child Mwana, Bye bye
its me, V.H. Njala

The next letter is similar to its predecessor, but with one significant addition.

Dear Nchimi Vwamba,

I have sent Mr. Anderson Ngwira with the people you wanted. They are three and are the people you said they killed that boy. Their names are Jonasi Ndirande, Katalia Mlanje, and Andrea Viphya. Mr. Nchimi Vwamba, please tell us the duties they are doing. I say this because when they come here, they refuse, [saying] that they are not witches since you don't write us a letter of information. You should write us about their badness so that we know. Please, write their names and the badness they were doing on this dead person.

V.H. Lambarara

Both of the last two letters, but especially the last, place the nchimi, at least in theory, in a double bind. If no letter is sent, his findings may not be taken seriously and acted upon. If, on the other hand, he puts the results of his divination into writing, he has

created a potentially incriminating document insofar as the provisions of the Witchcraft Act are concerned. Many, if not most, of the healers engaged in witchfinding seem to ignore or be ignorant of this aspect of the law, but at least one nchimi that I interviewed stated that she took pains to send such letters through the mails unsigned, so as to preserve her anonymity should they ever get into the wrong hands and render them useless as evidence against her.³

Verbal replies were requested in some cases where the letter was delivered by the person seeking aid or by a messenger or witness especially provided, as a double-check. The following letter illustrates the lengths that may be gone to in order to secure both types of reply from a healer.

Dear Nchime of Nchimis Vwamba,

Please, Miss Lincey Nyalongo came there and carried a letter from me Mr. V.H. Pyumpyu. The letter contained my troubles. I think the troubles which you found there you had written on the letter but it has been found that the daughter of Lincey has lost the letter. Here at home there are a lot of troubles. We have also [again] given the letter to Lincey Nyalongo so that she should deliver it to you and in return we beg you to write another letter so that I should know the troubles.

Yours,
V.H. Pyumpyu

I was able to collect a few of the replies from healers to headmen and chiefs. In all cases, they were from nchimi.⁴ The first such letter to be presented is from an nchimi who was practicing in Rumphi District in the early 1970's.

The Sub Chief Tirimura,

I am answering, and telling you that Nyalungu is a dangerous person [great witch], and she killed so many people. She did not agree that she is a wizard, but the truth is that Nyalungu is a bad person [wizard].

I now remain, but watch out, she is too dangerous.

Your Nchimi
Nyakofya

This letter was written in reply to a case that the sub-chief had presented to the nchimi, who is accusing the woman in no uncertain terms of being a witch. The nchimi lived only a few miles away from the sub-chief, and the results of her divination could have easily been conveyed in person or by a witness. Nevertheless, a letter, doubtless hand-carried, was chosen as the medium of communication, making the judgement an official written record.

Even more formality surrounded the next letter, obtained from Nchimi Vwamba, who retained a copy of it in his files.

Dear V.H. Chikoti,

With great respect I write this letter to you asking this favor: Please send to me this person whose name is Lameck Mtowa; he should come here and settle his disputes with a person who is here.

I have not got much to write you.

Yours,
African Doctor,
Nchimi Vwamba

This letter was drafted during the course of the nchimi's divination, apparently one dealing with a witchcraft accusation. Presumably the nchimi had more to relate at the conclusion of his investigation, and he did so in his next letter, written to the same sub-chief.

Dear The Honourable S.C. Tirimura,

With much respect to answer the note that you had written together with the diseased.

I have divined them and found out that Mr. Mkandawire has bad medicine in his body. The very same medicine has been given to Mother Nyausiska. This medicine

[nyanga] was given to Nyausiska by Mr. Samson Chavula.

And I badly want Chavula and the two diseased to come here so that Chavula can take away all the medicine [nyanga] in her body.

I remain yours,
Nchimi Vwamba

It is evident both from the analysis of these letters as well as from numerous observations and interviews that referrals from headmen to nchimi is the common second phase in the witchcraft career. This phase defines the trouble as witchcraft related and formalizes the situation.

Witchcraft Accusation

By documenting through divination that the source of the troubles is witchcraft, the nchimi officially brings into the case another person--the accusee or fwiti. In Malawi, people are accused of witchcraft in several ways. An accusation may be made at or shortly after the onset of a trouble by the victim or, in cases where the victim has died, by his kin who suspect some person or persons of having a motive for ensorceling the victim. Accusation of witchcraft may also be mutual, occurring in the heat of an argument. Witchcraft accusation is also made by a witchfinder, usually an nchimi; such divination is either the result of an accusation which is prompted by the victim's stated suspicions or is an accusation of some person who is wholly unsuspected by the victim and who may have a tenuous motive for doing harm to the victim. In the witchcraft career, the entry of the nchimi into the case not only formalizes the attribution of witchcraft for the victim but also for the person accused of causing the trouble.

Most of the preliminary accusations in the letters in my possession were made by village headmen and chiefs, on behalf of their subjects.

Nchimi Lipuka,

Mr. Msiska and Mr. Mkandawire have come there so that you divine them, because Mr. Mkandawire is suspected of witching Mr. Msiska. Divine them so that there should be no hatred in this village. Do your job without favour.

Yours,
V.H. Mwale

The nchimi is requested to impartially ascertain which of the two (if either) is the sorcerer. It appears that Mr. Msiska is the complainant who has taken his case to the headman, as it is Mr. Mkandawire who is named as the suspected troublemaker.

The following letters are more typical representations of sorcery accusations made before village headmen, and relayed to nchimi:

Dear Nchimi Vwamba, We have sent these two, Hangson Tembo, and Trywell Mkandawire. They have accused one another of witchcrafts.

Trywell who is the son, has accused his father Hangson Mkandawire.

It is only you the Nchimi who can know more of their dispute. Skangali Mkandawire is there to witness their dispute.

Yours,
V.H. Chambwiwe

Dear Nchimi of the Nchimi's [Vwamba],

With great respect I send Mr. Mowa to you, he has been accused by his wife that he is a witchcraft. It is said that he killed his father-in-law, mother-in-law, and the child of his mother. I therefore, send him to you so that you divine him. I can be glad if you send him back soon.

Yours,
G.V.H. Mwangonde

P/S I hope you will tell me the result after you

have divined him.

In the following letter of sorcery accusation, the accused is merely rumored to be a witch and is desirous of clearing her name. The request for divination is hers, on her own behalf, rather than the headman's. Her headman has couched his letter in a supportive vein, stating that, if she is found innocent, she will live amicably with her family. The letter is thus a request for a formal "bill of health." Village headmen may more actively make accusations on their own behalf, as in the following letter.

Sir, Nchimi Vwamba,

Help this woman please. She is failing to cope with the situation in her village. There are rumours that she is a mhawe [witch] and she has given herself in to you that you check if it is really true that she is a mhawe as the rumours say; if she has not got anything, then she will stay well with her relatives.

Yours, V.H. Ngombe

In the small villages that characterize northeastern Malawi, most accusations are lodged by some specific person; however, rumors leading to a sorcery accusation may arise with no specific accuser being mentioned in the complaint. In such cases, the help-seeker is the village headman or alleged troublemaker.

In the next letter, the accused "are said to be the fwitis who have killed many people." There are no accusers named, but the headman seems to impute guilt.

Nchimi [Vwamba], we don't stay well here because of the problems of nyanga. Because of this, we have just decided to come there so that you should check who fwitis are. There is nobody who is worrying because we have all agreed to do this. We have all signed about this, and we believe that there will be no violence among us. The names listed below are said to be the fwitis which have killed many people in our area. These people are really very

dangerous so please check them. Here are their names:- [a numbered list of 16 names.]

The[se] are the witness[es] of the people without fear.

V.H. Chenjera IV
on behalf of my people.

What influence the headman's negatively biased statement of dangerousness would have on the nchimi is hard to state, but it is likely to have some effect on the nchimi's official disposition of the case. It is unclear whether any of the persons named was sent to the nchimi or if he was to attempt his divination on the basis of the information contained in the letter. While there is no mention of his being invited to visit this village in the letter, during the course of my field work, I learned that Nchimi Vwamba had visited this area in connection with similar requests.

Dear Nchimi Vwamba,

I have sent Mziwa to you so that you divine him because he has been accused by me V.H. Chembere that he is bewitching [six men, all of the same surname] and the witnesses for this accusation are Mr. E. Mkandawire and Mr. M. Nyondo. We should know from you who is bad and who is good.

yours,
V.H. Chembere

This letter, like several of its predecessors, while in clear violation of sections 4 and 5 of the Witchcraft Act, which forbid "Charging a person with witchcraft," as well as the "Employment of [a] witchfinder," are written by village headmen in their official capacities. Thus, the headman and the nchimi's are both "professionals" in the witchcraft career. The headman, who is the first source of help for troubles, functions as a "primary care generalist." The nchimi is a specialist, referred to for suspected

witchcraft-related troubles.

Remedies for Witchcraft

Most witchcraft is believed to be effected by the use of evil medicine, mankhwala uheni or nyanga, and it is the healer's job to remove or neutralize it in order to cure the victim.

My Dear Sir [Nchimi] Vwamba,

Please, I've sent this man to you. Doctor, in one of his houses people have put some mankhwala. Now, you have to know that it is really serious because one of his children is now dead because of the mankhwala [nyanga]. Please, Sir, look into the matter.

Yours,
G.V.H. Golera

Another method of dealing with such sorcery is to return the nyanga to its creator, as the following two letters attest.

[Dear Nchimi Chirembwe,]

. . . Please father I have a lot of complaints to you, . . . Another type [of medicine] that I want is that if a person wants to witch me his nyanga should go back and strike him down. . . .

Father [Nganga] Parapaska,

. . . At our home father, our friends are jealousy with us. Many times they think of destroying our lives only, and they always want fortunes to fall on their way only. So father, if it can be applicable, I would like you to help us by doing something with us so that whenever they send something to destroy our lives, it should return to themselves, and I want our village to be safeguarded, and where I work I should have good luck. . . .

The treatment or remedy may involve direct action against the witch. One way to deal with fwiti is to use a magical medicine to trap them. The job may be done by a seketera or by a layman, using medicine obtained from an nchimi.

Viphya Pulpwood Project

Dear Sir [Nchimi] Chirembwe,

I have sent K10-00 according to our agreement to the job that you did to me. Sir, I am now sleeping the right sleep. I now owe you K20-00 about the medicine you gave me. If you have received it let me know.

When I have finished the remaining amount you gonna help me again Sir with the medicine that could hold the witch who come to my house at night till day break. Answer me Sir.

Thanks,
Yours,
Wellington

Just what will be done with the witch come daybreak is not specified but is likely to be quite unpleasant if it is anything like the punishment allegedly meted out by seketera.

A letter making a similar request was sent to an intimate of Nchimi Lipuka to be relayed to him.

South Africa

Dear Friend,

What is the problem since you don't send me letters. Please tell [Nchimi] Lipuka (1) That chikamuzume is still troubling us at home. (2) The other thing is that you should send us medicine so that . . . people should not come to us so please prepare the medicine so that such people should suffer themselves. (3) ... Now try to find us medicine and tell me the price quickly, and the medicine should lead to the dismissal of some people from work. . . . Also find me medicine to safeguard the house so that the fwiti should not go away if he comes to the house until day light. These things are useful to me here mainly because they help in living. Has [Nchimi Lipuka] received the money? Ask him because it is bad manners that he is doing. . . .

Yours, S.B. Chambo

In this letter, Mr. Chambo requests several types of magical medicine which range from defensive to offensive. Medicine is requested that would make witches coming to his house "suffer themselves" or be unable to leave the premises till day light, when they will presumably be caught and punished. Inserted in this plea for defensive magic is a request for medicine to "lead to the dismissal of some people from work," indicating that the witchcraft victim is not above using witchcraft himself.

In a more active form of intervention, nchimi are summoned by laymen, headmen and chiefs to rid their villages of witchcraft.

Dear Nchimi Vwamba,

I am writing to you this letter with great respect because I have heard that you are coming to Kanyunya very shortly. I am really very glad about that. Please when you come here, remember to visit my home. I would like you to visit my home because our village is completely spoiled with witchcraft. Please feel pity with me, I trust you very much because I know that it's God who directed you to start this business.

I do not have much to say, but please remember to come at my village.

Your Servant,
Thompson Citamba

The author was a minister of the African National Church (an indigenous church) as well as being an nganga. It is therefore again worth noting that most inhabitants of this area see no inherent contradictions between these several roles, and Mr. Citama writes that "it's God who directed you to start this business" of being an nchimi.

The next letter is from a sub-chief who is writing on behalf of a group village headman and with the authorization of the chief to summon Nchimi Vwamba to deal with a case involving several witches.

Call for Nchime

I the Sub Chief Lisanga, I have been told by Chief Suci. I am calling you, so that you should come here in my village [of] G.V.H. Nyongo at Covico so that you should come and see the troubles of teachers at Covico Primary School together with their families. I can be very glad if you could come.

Yours,
Sub Chief Lisanga

I was able to interview or collect statements from several persons who were either directly involved in the case or who lived in the vicinity and witnessed some of the proceedings. Teachers at Covico Primary School had been troubled with sorcery for some ten years prior to the incidents which precipitated the preceding letter calling Nchimj. Vwamba. According to an informant: "The wizards and witches used to come at night to spell teachers and their children. The children were found away from the bed where their mother slept [with them]." Subsequently, the headmaster found witches in his house and discovered that it was some villagers who were the malefactors. The headmaster was also a seketera and is alleged to have beaten at least one of the witches at the time of their discovery.

The next reported instance of sorcery occurred some years later, once again to the child of a teacher, who was found vomiting in bed and was taken to a nearby hospital. The school acquired a bad reputation as a consequence of these incidents, and some teachers left, while those assigned to replace them threatened to resign rather than teach there. In one informant's words: "Many teachers were leaving the place because of the suffer[ing] of themselves, their wives, and children. . . . These were wonderful things . . . which were found . .

. in the houses of the teachers. One day in the morning one teacher found . . . blood at the door of his house without knowing where that blood has come from. . . . One day in the evening it was found that [a] child of one teacher was found at the door while the child was so young that [it] did not yet start [to] walk. This was a surprise to the teacher and his wife." In addition, students were failing to pass their examinations for entry into secondary school. Said an informant: "It was believed that they [witches] [had] planted a horn [commonly used as nyanga in front of the standard eight [classroom], which had [magical] medicine in it, so that it prevented the students from keeping the things they learned in their heads."

Finally, there were only three or four teachers left at the school, which normally had a complement of about a dozen teachers for its almost three hundred pupils. As a consequence of this dearth of faculty, the incumbent headmaster (the previous one had left) had to go to the District Education Office to ask for help. The District Education Officer visited the Covico School Committee, composed of prominent members of the community, to discuss the problem and later met with the several headmen whose villages were served by the school. This meeting was also attended by the Native Authority or Chief who was the head of the traditional government of the entire District, by the local Minister of Parliament, and by another senior parliamentarian who lived in the vicinity.

Suspicion was focused on several people, and the community demanded that action be taken to find any other malefactors, cleanse them of their evil ways, and restore the school to normalcy. The village headmen were unanimous in their desire to summon an nchimi, and

they proceeded to make their request through the proper channels. One of the headmen is reported to have asked his District Commissioner to contact Nchimi Vwamba's District Commissioner and authorize him to come to Covico, which apparently was granted. Transportation was provided by the community, which raised money for the hire of a truck to transport the nchimi and his choir. It was reported that while en route "a big stone was rolled on the road, and it was not known where it came from, but Nchimi Vwamba put some medicine on it and it melted away. And after a short time all the road was covered with fog, but, when Nchimi Vwamba spat some saliva, where they were going got cleared. Nchimi Vwamba knew who caused this; he knew they were great wizards. They did this so that they should stop him from coming to Covico."

The nchimi was welcomed by the village headmen, and was given a house in which to conduct his divination. He called for the people of each headman in turn, first stating that all those having nyanga should go to their homes and return with them, promising dire penalties if they failed to comply. He went to the teacher's houses located near the school. An informant said, "As he entered . . . one of the houses he found nyanga, as [the] nyanga saw Vwamba it tried to run but it was too late, so Vwamba caught it; . . . this made people to be amazed." He then searched the school and found more nyanga inside the building.

In all there were over two hundred persons named by Nchimi Vwamba as being witches, and I was able to collect information on some fifty of them. The method of witchfinding was for the headman to call his people into Nchimi Vwamba's house one at a time. I was told that: "As soon as they were coming in the Nchimi could just predict whether

he or she was good. . . . If he or she was good, he or she was told to leave the room, but, if found to have some bad medicines, then the Nchimi decided that he be cut [scarified] and given some medicine to drink in order that he be no more able to bewitch people." [Many] "people . . . brought different nyangas, some had baskets full, . . . some had white thread balls, some looked like sewing needles, and some, which looked like small roots covered with cloth, . . . he said were planes, which they flew when they went to visit other friends [witches]." There were many more nyangas collected, with attendant confessions being made by their owners.

Nchimi Vwamba stayed at Covico for several days and cleared the area of witches to the general satisfaction of the community. The school has not been bothered by sorcery since that time and presently has a full complement of teachers.

In cases such as the one just described, the community in general may be pleased with the work of the nchimi, although those branded as fwiti are likely to be displeased, especially so if they were subjected to unpleasant treatment. In recent years, although belief in witchcraft remains strong, the harshness of the punishment meted out for such infractions has considerably mellowed, especially on the official level. The following two letters illustrate this point. The first objects to beatings, but not to other remedies.

To Nchimi Vwamba,

Ba Nchimi Vwamba, according to the big job that God has handed over to you, for curing the spirits of people, it has really impressed us. And it has also given fame in our area of [the] Northern Region.

But the sorrow is that the grief of people has greatly spread out to people that they are being beaten by

your men. And now they don't agree to come there with fear of being beaten.

And now my appeal in my youth is that you have been given this job of curing people and that people should not be killing one another. And that's why you are there and also to save people from illnesses and deaths. Is beating also curing or killing someone?

Try to stop your boys not to beat people in this way, otherwise they spoil the job which God has given you. Pardon me if I have cursed you for I fear that we might spoil our job. That place is holy and that there shouldn't arise a bad rumour. Please I plead, teach those boys so that they have the good behaviour in running that job.

What is important is this, that a witchcraft must get some medicine either that to drink or the cutting medicine on the body so that the strength of the bad medicines he had is unable to do anything bad.

Pardon me father, we are going to meet after having entered the New Year.

Yours,
V.H. Fukuzi

The second headman objects to almost all remedies for witchcraft but grants permission for the nchimi to visit the headman's village for what can be little else but witchfinding.

Chief Wombeza

Dear Mr. [Nchimi] Vwamba,

V.H. Gonka came to me and said that I refuse you to go out from my area to help people in their suffering.

I tell you now quite clearly that I do not do that. If you decide to help people outside my area, you may go to Chief Nchesa, Myanga, and Dompeka. But in my area, I do not want you to check the witchness from people and bite them or make some marks on their faces or to put out their clothes so they are naked and then put a severely medicine in the private parts of their bodies. I will never ever allow these mentioned things above. If you do them, the Government will deal with you. I warn you because I love you. I do not want you to fall into troubles!

So you are allowed to go to this Village Headman

Gonka but do not do any thing bad there.

Yours faithfully,
H.C. Wombeza [Chief]

In most instances, given the widespread belief in, and official condoning of, divination and accusation, the person accused of witchcraft becomes as much a victim of trouble as the original troubled person.⁶ It is the reaction of those accused of witchcraft that we turn to next in the analysis of careers.

Reactions to Witchcraft Accusations

It is usual, at least at the onset of the divination process, for the alleged fwiti to refuse to admit to practicing sorcery and certainly not to having ensorcelled the victim. Some may state that appearing before an nchimi is contrary to their Christian principles, (Irvine, 1973:20) as illustrated by the following letter.

Dear Sir, Nchimi Vwamba,

I would be glad if you are in good health. Mother Nellie Nyakabungo refuses to come there because she says she is a Christian, in the Free Church of Scotland. Now what should we do with this woman. You can decide anything in connection with the way we should bring her to you, Sir, and I, V.H. Marata, say: Please tell me some more people who come in your head, I will bring them all. . . . Please, if there [are] some more people you would like to see, tell me.

V.H. Marata

In the next letter, a village headman has instructed his subjects not to go to the nchimi, despite a request from the author, himself a headman, that they should go.

Beloved Nchimi Vwamba,

I sent my man to the V.H. Samueli, so that he tells Paul and Jailousi that they were being called by you, Vwamba. Samueli Village Headman told his people not to come

there.

I hope this matter is in your hands now. Thank
you.

I am,
V.H. Kutumpura

Apparently, the accused parties were under V.H. Samueli's jurisdiction, although the victim or complainant was a subject of the author, V.H. Kutumpura, who expects that Nchimi Vwamba will be able to break the impasse and divine Paul and Jailousi.

An accused person may consent to go to an nchimi for divination and then have second thoughts en route, as the following letter indicates.

My Dear [Nchimi Vwamba,

Thanks father. We arrived safely home. We didn't write you a letter because that man Mfuni we failed to bring him because he ran away on the way. But that help you gave to us we told the chief and the people about it. The people have refused to come there, they say they have no nyanga. They have refused completely. They say they cannot bring their child. . . .

Your son forever,
Walaya Mvula

Other accused people refused to go at all, stating that they have no nyanga, the possession of which is a sine qua non of being a sorcerer. Another instance of an accused sorcerer absconding prior to appearing before an nchimi is described in the following letter.

Dear Nchimi Vwamba,

. . . We are hereby informing you that we the Village Headmen of Sub Chief Gurura held a meeting about the illness of our Sub Chief. Our Sub Chief told us that there were three people who bewitch him, two men and one woman. All this was heard from different Nchimis who were telling out those who were troubling our Chief. These are the people who are troubling our Chief: Katalia Msonthi, Edson Mwandira and [Ms.] Sekanayo Lungu. Mr. Edson Mwandira deserted sometime back and is not seen up to this time. We

have sent Katalia Msonthi and Sekanayo Lungu so that you divine them. We are looking forward to you. Tell us the result.

It's we the Village Headmen
of S/C Gurura

Those accused and summoned before an nchimi may decide to take the offensive, as illustrated in the following letter, in which the accused threatened to have a village headman arrested for accusing him of being a witch.

Nchimi Vwamba,

I am very happy to write you this letter; but people are scaring me, they say I will be arrested because I send people to you. Please, tell me if I will really be arrested. I believe in you, Nchimi Vwamba.

Father, listen to this: Samuel Sepetura and his wife Nyakwiza are refusing to come to you. They have gone to lodge a complaint against me. They have gone to N.A. [Chief] Pungu. They complain that I have pointed out that he is a mhawe [witch]. He has by now given the complaint already. I think I will be called after the N.A. has come home, for he is not home now.

Yours,
V.H. W.D. Kutuka

In another defensive strategy, the nchimi's abilities are questioned by the accused party.

Sir [Nchimi Vwamba],

I have seen your letter and the person you want, I called him and he has refused. He has denied you saying you don't know your job as a nchimi.

I called for advocates from both the male and female families and they were all present at the case. And he said all of you have just been talking nonsense. "You say I have a nyanga. If you see me going to the Nchimi cut off my neck with a knife." He aroused a fight at my house, I who prevents people to come to you.

This person has denied us so I beg you to give a hand. What can you do to help. My plead [is,] please help me with this rude person. The other thing is that boy who has come to you with his wife, please help him with his

troubles with his wife for his child.

The person who has refused to come there I know him and his ways pretty well. He has killed many people, boys and girls and many people have been killed. Please Sir, help me with my problems.

I don't have much more to say.

Yours,
V.H. Fundumuka

This case presumably began with some party being sent to the nchimi and being divined. The nchimi apparently has come to a strong preliminary finding that the party referred to in the first paragraph of the letter is the sorcerer and has sent for that man together with his nyanga. The accused not only refuses to come before the nchimi, but he denies having the nyanga and states his doubts as to the nchimi's competency. However, refusal to be divined can be turned into evidence of guilt.

The headman, who may have been circumspect in his initial letter of referral to the nchimi, states in the last paragraph that the accused "has killed many people," implying that he is indeed a witch. Any doubts that he may have had are dispelled by the man's refusal to appear before the nchimi. When someone states that a person has killed many people in such a context, it is understood that the killing was by magic, as any conventional overt murderer would not likely go unpunished by the authorities. Death which superficially appears to be by natural means is generally presumed to be so by the police, and redress of such "murders" attributed by the community to sorcerers must perforce come via the powers of the nchimi.

A person accused of witchcraft or of some less serious infraction may reluctantly decide to go to an nchimi as his accusers and headman demand and yet proclaim himself innocent of any wrongdoing,

as the following letter indicates.

Nchimi Vwamba,

This man Nyasulu has come to you because of troubles at his home. He is troubled by some other people at his home who are keeping things which should not be kept by people at all [nyanga].

At first they went to Mr. [Nchimi Lipuka at Chinthi, where the dispute was not settled. The accused wouldn't listen to what Lipuka the Nchimi was saying. Help us now, Vwamba, so that the dispute is settled.

I am,
V.H. D. Kuchizga

This letter illustrates a kind of "shopping around," both by the victim Mr. Nyasulu, as well as by the alleged troublemaker who refused to listen to Nchimi Lipuka's findings. The village headman, probably on behalf of both victim and troublemaker, has referred the case to a second nchimi in the hope that he can settle the dispute.

Summary: Stages of the Witchcraft Career

The career of a victim of witchcraft may begin with some overt interpersonal conflict in which the threat of sorcery is made. Symptoms of trouble may manifest themselves after the altercation and be attributed to it by the victim.

Alternatively, and far more frequently, there is no obvious interpersonal conflict, and the trouble, once perceived, is taken to a healer, usually a nganga or Western dispensary for treatment. If treatment is ineffective, sorcery may be suspected. Even if treatment is effective, if the complaint is sufficiently out of the ordinary, witchcraft may be suspected.

Once the suspicion of sorcery exists the consults with his or

her village headman, who provides the victim with a letter of referral to an nchimi.

The case is brought to the nchimi, who may divine it to be due to natural causes, to malignant spirits, or to sorcery. If the trouble is attributed to sorcery, ideally the nchimi will ascertain who the witch is, force a confession, and confiscate any nyanga he or she may possess. The witch is then treated with dekano in order to prevent any future necromancy.

The results of the nchimi's findings and treatment are reported to the village headman who may take whatever action he deems appropriate.

The accused fwiti in most cases seems to accede to the nchimi's accusation. Occasionally, persons accused of witchcraft may refuse to heed the nchimi's summons for witchfinding, may run away, or on rare occasions may lodge a legal complaint against the accuser, the village headman or the nchimi, under the provisions of the Witchcraft Act.

¹See Rosenberg (1978:61) for a description of similar conditions in New York City during the 1860's.

²The only healer to receive letters mentioning witnesses is Nchimi Vwamba, and these were in the main written by village headmen in the context of a referral of some person or persons to the nchimi for a witchcraft-related trouble. I suspect that this is but one more reflection of his extraordinary reputation as a witchfinder, as witnesses are produced only in witchcraft cases. However, other sources consulted during the course of my fieldwork suggest that the practice of sending witnesses along on witchcraft complaints is not uncommon, and it is likely that other nchimi engaged in witchfinding have witnesses occasionally sent along on the cases they handle. The witness is frequently enlisted by the headman to hear the nchimi's findings and impartially relay them back to the headman. He may additionally carry a written message from the nchimi, as many headmen request, although this may be posted instead.

³Village headmen may be aware that their referrals to nchimi are often illegal. The following rather cryptic letter was from a chief, in reference to what I suspect was a case of suspected adultery. The author seems intentionally circumspect in his language, since the government had been voicing its displeasure at chiefs and headmen for referring cases to diviners rather than to the courts.

From S/C Chasefu
To the Nchimi Chirembwe
3rd August, 1977

1 Corinthians 14 v. I ---- Nchimi Nkesho

[This verse of the New Testament deals with prophesy and speaking in tongues, which is essentially what a latter-day nchimi does.]

Leviticus 18 V [line] 14

[This verse from the Old Testament is entitled "Marriage," and the line states: "You shall not uncover the nakedness of your father's brother, that is, you shall not approach his wife; she is your aunt."]

Leviticus 20 V [line] 20

[This reference states: "If a man lies with his uncle's wife, he has uncovered his uncle's nakedness; they shall bear their sin, they shall die childless."]
It appears likely that the sub-chief is circumspectly describing a case that he wishes Nchimi Chirembwe to divine, one involving suspected adultery between nephew and aunt.

The letter also shows the headman (and probably the nchimi as well) to be well versed in the Scriptures, implying the likelihood that he was a reasonably devout Christian.

⁴Such letters from healers are far harder to lay one's hands

upon than those written to healers, simply because few headmen or chiefs are likely to amass a very large correspondence of this sort over the course of his working lifetime; whereas at least some healers are the recipients of extensive correspondence from many headmen and chiefs. I also have the sense that chiefs and headmen may be somewhat more reticent about allowing outsiders to examine such material, but this may be an erroneous impression.

⁵ A work of fiction which gives us Westerners the flavor of such events, as are described in the two preceding letters, is furnished by M.R. James short story, "Casting the Runes," which describes the return of an evil spell to its maker. "That it must be returned to the source whence it came they were agreed, and further, that the only safe and certain way was that of personal service. . . ." (1975:233)

⁶ Goleman notes that such victims are seen "as having brought on their own plight, as deserving what has happened to them." Such victims are perceived as members of "an evil group who pose a tangible threat to the social order." (Goleman, 1985:C5)

CHAPTER VII

THE CONCEPT OF TROUBLE AND ITS APPLICABILITY TO WITCHCRAFT

The paradigm proposed by Emerson and Messinger (1977:121-134) is applicable to the analysis of emotional, social and physical sorts of trouble, including troubles attributed to sorcery. It is generally of broader applicability than the paradigms of Goffman, Mechanic and Parsons described earlier. However, although satisfactory for the analysis of sorcery of certain types, it has certain flaws that become apparent when one attempts to apply it to that form of sorcery most prevalent in contemporary northeastern Malawi as well as to other areas around the globe where similar troubles manifest themselves. In addition, there are limitations in its applicability to other forms of trouble having a supposed supernatural etiology, such as spirit possession.

I shall first illustrate the applicability of Emerson and Messinger's paradigm to certain troubles of a supernatural nature common to northeastern Malawi. Next, I shall point out certain types of supernaturally attributed trouble that are not amenable to analysis by their theory; and lastly I shall suggest certain modifications of their paradigm which will extend its applicability to the aforementioned types of trouble.

Preliminary Considerations of Troubles and Remedies

Cases of sorcery or witchcraft, like most troubles, "originate with the recognition that something is wrong and must be remedied." (E&M, 121) They thus "involve both definitional and remedial

components." (E&M, 121) If no definition is imposed on the trouble, it is in essence ignored. In that case it "may fester; or it may disappear." (E&M, 122) This is frequently the case with both somatic, (Gould, 1983:12) emotional, and economic troubles,¹ any of which may be, and frequently are, ultimately attributed to sorcery in Malawi.

Once the trouble is recognized, some initial remedy is tried. If the remedy succeeds, the case is closed; but, if it fails, the trouble assumes a cyclical form, in which the symptom prompts the quest for a remedy, which is applied and found sooner or later to be ineffective, thus leading to the search for a new remedy. Within this framework, the "trouble is progressively elaborated, analyzed, and specified as to type and cause," (E&M, 122) a cycle quite common in cases of chronic illness, which are often attributed to sorcery.

According to Emerson and Messenger, "The effort to find and implement a remedy is critical to the process of organizing, identifying, and consolidating the trouble." (E&M, 122) This process frequently emerges in cases of suspected sorcery, where the feedback generated by the failure of a remedy reinforces the ever present suspicion that sorcery is at the root of the trouble. Then the initial interpretation of the trouble is recast in order to bring it into congruence with a diagnosis of witchcraft.²

In other words, "any initial formulation of what the trouble really is is conditional upon the subsequent effects of the attempted remedy. The . . . remedy . . . simultaneously serves as a test of that definition." (E&M, 123) In the traditional treatment of disease and other troubles in Malawi, if the remedy works, it substantiates the

diagnosis that indicated its use.³ If the remedy fails, it may be seen as an omen that more sinister forces are at work and that stronger measures must be taken to combat them.

The initial ". . . definition of what a trouble is affects what is done about it, . . . prefiguring some solutions and removing others." (E&M, 123) For example, if sorcery is suspected from the outset, an nchimi is likely to be consulted immediately. If the same symptom presents itself in a less threatening context so that sorcery is not initially suspected, a nganga may be the first healer patronized. Thus there is in Malawi (as elsewhere) an intimate relationship between treatment and diagnosis, successful treatment lending credence to the diagnosis and failure often indicating not that the remedy was at fault, but that the diagnosis itself was in error. In short, as Emerson and Messenger state, "conceptually, the definition of a trouble can be seen as the emergent product, as well as the initial precipitant, of remedial actions." (E&M, 123)

Relational Troubles and Intrinsic Remedies

Sorcery is an interpersonal trouble, but many troubles which may eventually be ascribed to sorcery are seen initially as being of an intrapersonal nature. 'Classical' sorcery, as exemplified by Marwick's studies of the Cewa, (Marwick, 1952, 1965) as well as Mitchell's description of Yao sorcery, (Mitchell, 1956) is practiced either between relatives or between people whose frequent contact with one another results in some readily recognizable interpersonal tension. The resolution of these tensions requires that the rights and responsibilities of the relationships they are embedded in be

examined.

As Emerson and Messinger point out, "what begins as a personal trouble can be redefined and treated as a relational one, and vice versa." (E&M, 124) In sorcery cases of the 'textbook'⁴ or 'classical' variety, interpersonal tension is immediately perceived as being a potential major factor in a trouble. However, in the geographical area under consideration, most sorcery cases are not of this variety and are initially dealt with as intrapersonal troubles, only later being redefined as relational troubles.

Such "movement of a trouble from an individual to a relational frame . . . is often propelled by the remedial cycle . . . and both intrapersonal and relational versions of the trouble may be entertained sequentially, or even simultaneously." (E&M, 124)⁵ Thus a chronic cough may be initially diagnosed as a disease caused by God, i.e. due to natural causes, (Janzen, 1978:8; Yoder, 1982:13) and so treated with herbal medicines by a nganga and, on the failure of such treatment, the complaint is chalked up to sorcery, and the case is put in the hands of an nchimi. In addition, as predicted by the Emerson and Messenger paradigm, the sufferer may attend a western hospital while under the care of either of the traditional healers.

Interpersonal troubles, as exemplified by 'textbook' sorcery, involve initial remedial actions of one party attempting to influence the other's behavior. "Such corrective actions can be termed intrinsic remedies, since they can draw upon the interpersonal resources inherent in that relationship." (E&M, 124) In those sorcery cases where there is an immediate suspect, there is frequently direct negotiation between

the troubled party and the alleged malefactor in an effort to moderate the behavior of the offender. These negotiations may be of an overt face to face nature or may assume implicit forms, such as joking. Alternatively, no negotiations may be engaged in, and the incipient victim may instead avoid all contact with the suspected sorcerer. As a consequence of the potential gravity of even minor troubles suspected of being caused by witchcraft, the management strategies employed in such cases more frequently involve the ". . . accusation that the other's behavior is wrong and must change," rather than "we need to have a talk about it." (E&M, 125) Such a direct complaint made to the suspected sorcerer by his or her victim serves to consolidate the trouble, as well as defining or labeling it as an interpersonal matter.⁶ However if the initial interpersonal remedies prove ineffective, this initial complaint is likely to be but the beginning of an extensive remedial cycle, and other strategies, such as seeking the services of an nchimi, are required.

In sum, the possible sequences are 1) the initially offended party learns to live with the problem and ultimately comes to ignore it; 2) the trouble continues unresolved, with neither party subscribing to the other's allocation of blame; 3) the initial complaint and reply are sufficient to satisfy the troubled party; or 4) both parties to the trouble mutually accuse one another of sorcery and an nchimi is consulted. Given the gravity with which sorcery is held in this region, there is relatively little tendency to ignore or attempt to live with a trouble which has come to be defined as due to sorcery, and so the majority of cases end up in the hands of nchimi.

The following is an example of a typical sequence. A poor aunt

of a man recently returned from a job abroad demands some part of his newly acquired wealth. In line with the emerging economic individualism, he is reluctant to share his hard-won earnings with her although he realizes that he is defying custom in denying his aunt's request. She, whose frame of reference is more traditional than his, feels that she is only asking her due and makes veiled threats of sorcery in an effort to secure what she feels is rightfully hers. Even if no threats are made or implied, if the man has a minor illness or misfortune befalls him subsequent to her unfulfilled request, he may well assume that the trouble is a consequence of his contravention of the sharing norm and that either the ancestral spirits or his aunt herself are offended and have caused his trouble. At this point, the troubled man may decide to modify his behavior to bring it in line with customary notions of sharing with relations, realizing the relational rights of his relative and his own responsibility towards his aunt. If he does not, he may interpret any further misfortune he incurs as being due to his aunt's ill will, and seek assistance from traditional healers who may confirm his fears. He might then decide to placate her by acceding to her economic demands. On the other hand, if the trouble she has fomented is sufficiently serious, such a case might end up as a full blown witchcraft accusation, with an nchimi being engaged who may summon the aunt to be "searched" and to force her to confess, relinquish her nyanga, and in future desist from troubling her nephew.

Complaints and Third-Party Intervention

If intrinsic remedies to a sorcery dispute fail, outside parties are likely to be brought in. These may initially include relatives, but sooner or later specialists such as nganga and

especially nchimi are resorted to, the latter often engaged through the efforts of the village headman. If such parties merely advise and support, the trouble remains essentially private. If the outside parties actively intervene, the trouble undergoes significant change.

As Emerson and Messenger put it, "With the request for third party intervention, the following roles become differentiated in the remedial process." (E&M, 126) The first role to manifest itself in most cases of trouble ultimately attributed to sorcery is that of victim, who is the person believed to be troubled by sorcery. He or she may also play the role of complainant, the individual who announces the trouble's presence by seeking a remedy, or this function may be performed by some kinsman. The complaint is registered with a troubleshooter, a party external to the trouble whose role is to remedy it. The nchimi is the most important troubleshooter of sorcery cases, although the nganga is frequently consulted as well, especially in the early stages of cases where sorcery is not immediately apparent. Additionally, various practitioners within the western medical system may be engaged as troubleshooters, especially in the initial stages when the trouble is still perceived as an intrapersonal one. The troublemaker is the party deemed to be responsible for the victim's trouble and in the Malawian context is the muhaw or sorcerer. If the sorcerer is known initially before symptoms manifest themselves, then the troublemaker would be the first role to materialize. This is the case in threats of sorcery, as when during an argument (a form of conflict) one of the protagonists threatens the other with sorcery. This threat immediately recasts what began as a case of conflict to one of deviance, in which the party who uttered the threat or curse is the

deviant and the object of his wrath the (incipient) victim.⁷

The decision to seek outside intervention and the type of intervention sought are intimately connected with earlier attempts to remedy, isolate, or avoid the trouble. If the trouble (illness) is a minor one and is initially deemed to be of an intrapersonal nature, it is likely to be self-treated by home brewed herbal remedies, if it is not totally ignored.⁸ If such treatment is effective, the matter is dropped. If the trouble is perceived as an interpersonal one, in particular as being possibly due to sorcery, it is less likely to be self-treated or ignored, although trouble of a minor, non-threatening nature (such as might be attributed to having stolen fruit from a garden protected by anti-theft charms) may be simply tolerated or avoided.

As we have said, the failure of a trouble diagnosed as being of an intrapersonal nature to respond to the initial treatment is frequently interpreted as a sign that the diagnosis was mistaken rather than that the therapy was at fault. The possibility that the trouble is of an interpersonal nature, or to put it bluntly, is caused by sorcery, is raised; and steps are taken to ascertain if that is the case, and if so, who is the malefactor or troublemaker. In overt cases of sorcery, where there are mutual accusations or unilateral threats from which the trouble proliferates, outside troubleshooters, primarily nchimi, are engaged without prior resort to self-help.

According to Emerson and Messenger:

"Such factors as the kinds of controls available in the particular social situation, the availability of and limitations on their use, the presence and strength of ties with outside parties and possible troubleshooters, and the

degree of legitimacy accorded each outsider's potential involvement in the troubled situation, all shape not only the nature of initial efforts to respond to the trouble within the relationship, but also the occasion and nature of outside intervention." (E&M, 126)

In the case of troubles due to sorcery, the forms of control available include direct representations made by the victim to the alleged sorcerer as well as the marshalling of public opinion on the side of the victim, an appeal to the village headman being one avenue towards this end.⁹ The final step is to resort to a troubleshooter specializing in these matters, preferably an nchimi, although on occasion nganga, especially when nearby, are utilized instead.

Certain considerations govern the choice of troubleshooter. In the case of mutual sorcery accusations or of an overt unilateral accusation, the case is likely to be taken immediately to an nchimi. Insofar as "the presence and strength of ties with . . . possible troubleshooters . . ." (E&M, 126) is concerned, although it is more convenient to patronize nearby nganga and nchimi, they are often intentionally bypassed, especially, but not exclusively, in cases of mutual sorcery accusation, as being potentially biased in favor of one or the other of the participants to the trouble. Thus, although local nganga are usually familiar with their clients, they are not the troubleshooters of choice in troubles where sorcery is suspected from the outset. Their involvement in troubles rests on their perceived expertise and their geographical proximity, with its attendant familiarity with the victim. However, such proximity may be a hindrance if the troubleshooter is perceived as being partisan to one of the parties in a case of sorcery.

According to Emerson and Messenger, the definition of trouble

evolves with the utilization of official, licenced troubleshooters, with "specific troubleshooters . . . sought out . . . because of their expertise or neutrality . . ." (E&M, 127) In Malawi both of these qualities are important to victims, (and the latter to alleged troublemakers,) who are prepared to travel long distances and undergo considerable hardship and expense in order to patronize healers meeting these desiderata.¹⁰

The Evolution of the Definition of Trouble

In Emerson and Messenger's model, "the initial choice of troubleshooter . . . may . . . impose a definition on a trouble previously open or contested. . . . This selection [of troubleshooter] may expose the differences between the troubled parties as irreconcilable." (E&M, 127) In the case of a trouble which has the potential of being attributed to witchcraft (which in practice means almost any trouble) and which may be diagnosed and treated by a variety of troubleshooters, each one provides his or her own definition of the trouble. For example, if a 'stomach-ache' is taken to a nganga, it would most likely be diagnosed as caused by God (that is, to 'natural' causes) and some herbal concoction prescribed as a remedy. The same complaint presented at the local dispensary or hospital might result in a diagnosis of constipation (again due to "natural" causes) and a laxative given as the remedy. But if an nchimi is consulted, the same symptoms might be defined as a relational trouble, i.e. witchcraft, with the remedy involving an attempt to divine who the sorcerer is and why he or she is causing the stomachache.¹¹

There are two major options available once the etiology of the

complaint as being due to witchcraft has been established. The first is to treat the victim, usually with a regimen of herbal medicine. The second is to deal directly with the alleged witch, by the nchimi summoning him or her, frequently with the cooperation of the village headman, if, as is usually the case, both victim and alleged sorcerer live in the same village.¹² The process of divination, accusation, confession and surrender of nyanga, and medication with anti-witchcraft medicine is then carried out, as I have described in detail on previous pages. In short, an overtly interpersonal trouble such as a dispute over the rights to a garden plot is adjudicated by a headman as a case of conflict, the opposing parties being reconciled with a compromise. But, if the same problem is recast as a form of sorcery by an nchimi, it becomes irreconcilable, with all right being relegated to one party to the dispute, the 'victim,' and all wrong to the other party, now recast as the deviant 'troublemaker.'

In addition to defining the trouble and providing appropriate remedies, the effect of the initial choice of troubleshooter frequently determines whether, where, and how a trouble enters subsequent referral networks." (E&M, 127) Intractable problems are often passed along to other "often more specialized troubleshooters," (E&M, 127) and the trouble enters a "circuit of agents" (Goffman, 1961:135) in which it is shifted to increasingly more specialized agents whose ministrations often result in increasingly coercive and punitive outcomes. Although the total number of agents patronized may be quite large¹³, there are essentially but two basic types of troubleshooter at work in Malawi, so the variety encountered in any "circuit of agents" is relatively limited. The definitions of trouble and the remedies

prescribed are consequently also limited. Intractable intrapersonal problems and irreconcilable disputes are thus likely to manifest themselves ultimately as sorcery accusations.

The Process of Defining Witchcraft

Outside interventions and transformations of previously private troubles illustrate "the negotiated (rather than intrinsic) nature of problems." (E&M, 128) An initially defined interpersonal trouble moves from dyad to triad with the involvement of a troubleshooter, who may, in sorcery cases, initially be the village headman, but who eventually is likely to be an nchimi. The original participants can no longer orient exclusively to one another, but must present their case to the troubleshooter. Each party to the trouble attempts to influence the troubleshooter, and "in the process relational assumptions, claims, and expectations previously taken for granted will have to be openly proclaimed and justified." (E&M, 128) If the troubleshooter's standards for weighing relational claims differ from those of the disputing parties "new grounds for asserted rights and responsibilities may have to be provided. . . . Indeed the parties may learn to their surprise and dismay that some behavior on which they founded their claim of being troubled are seen as 'normal' or even 'desirable.'" (E&M, 128) For example, a magical medicine is commonly used to prevent or punish adultery. Such mankhwala is frequently employed by a husband forced to leave his wife at home while he is working in the towns to the south or abroad in the mines of Zambia or South Africa. The charm may have the effect of causing the wife's lover's body to swell. The lover may seek the aid of a nchimi, realizing that he has been ensorcelled by the cuckolded husband's charm but feeling wronged by the

result. The nchimi however, may sternly reprimand him for his adultery and remind him that such magic is of the protective or defensive variety and that he has basically brought the trouble upon himself.

Alternatively, taking the problem to the troubleshooter may for the first time focus and formulate the trouble through reinterpretation of earlier incidents. Emerson and Messenger say that

" . . . the need to account for past actions and to justify desired remedial responses to the third party may generate more closely documented histories of the origin, causes, and persistence of the trouble, along with the new and extended accusations of wrong doing." (E&M, 128)

The use of official troubleshooters turns the trouble into a "case" which accumulates an official history as it moves through the referral system.¹⁴ Troubleshooters of an official nature (official in the sense that they have governmental sanction or licensure) who deal with witchcraft-related cases include western medical practitioners, village headmen and chiefs, and on occasion police and court officials. Official troubleshooters in the non-governmental, but formal, societally approved sense, include the various traditional healers, especially the nganga, and the nchimi, and occasionally the seketera as well.¹⁵

To summarize, intervention by nganga and more especially by nchimi tends to clarify and specify the nature of the trouble of witchcraft and its potential seriousness. The type of intervention undertaken by these traditional healers "may fundamentally shape what the trouble will become," (E&M, 128) in particular whether or not it will be interpreted as a manifestation of witchcraft.

Dealing With Complaints: Contingencies in Intervening

If trouble is perceived as interpersonal, it poses an issue of alignment to the troubleshooter, who may respond to it as conflict, an issue involving two or more people each legitimately struggling to achieve some goal, or deviance, an issue involving wrong-doers and innocents. In general, it is the nchimi who makes these differentiations since interpersonal troubles are normally taken to them. Nganga are not normally involved in treating overtly interpersonal troubles and so are less often likely to classify complaints as due to conflict or deviance, i.e. witchcraft.

In pre-colonial times, troubleshooters adopted stances of "nonalignment" toward the two parties to a sorcery accusation. The village headman of today, who is usually the first agent to be contacted in such disputes (although more as an official complainant or referror than as a troubleshooter), frequently retains this impartiality, as does the nchimi to whom such a case is ultimately taken. In earlier days, the mwabvi and other ordeals were often administered symmetrically to both the accuser and the accused or to both parties in a mutual witchcraft accusation. These ordeals have long been outlawed, and latter day sorcery cases are overwhelmingly of the latent variety, with no overt suspect. As a consequence, today's troubleshooters of witchcraft cases most often deal with but a single victim, and a witch who is initially unknown, it being their task to find, create or label the malefactor. Such intervention is by definition asymmetrical, and their alignment is on the side of the victim who has engaged their services.

Various factors determine whether the troubleshooter's

intervention will be symmetrical or asymmetrical, that is, whether the trouble will be ascribed to multi-party conflict or to one-party deviance.

First, "on the structural level, the assertion of certain types of rights and claims may be legally proscribed . . ." (E&M, 129) In fact, in Malawi, the Witchcraft Act prohibits most witchcraft accusations and all witchfinding as well as prohibiting witchcraft itself. This does not mean that the framers of these laws recognized the reality of witchcraft; indeed, the courts have ruled on several occasions that there can be no such thing as witchcraft.¹⁶ "Such denial of legitimacy to the assertion of particular claims, of course prescribes one-sided intervention against the illegitimized claimant." (E&M, 129) That is, what may be a case of two-sided conflict in the courts ends up a case of deviance, with the accuser as the deviant. The courts are concerned with upholding the tenets of the Witchcraft Act, which in most of its sections is directly at odds with the interests of those believing themselves to be suffering from the unwelcome attentions of a witch. The courts punish not the alleged witch, but rather the accusers. In addition, because of the illegality of witchcraft, in most contemporary witchcraft cases the victim either fails to confront the suspected assailant directly or has no well founded suspicion of sorcery. The trouble is defined as an interpersonal one but with only one party seeking aid (on his or her own behalf) from the troubleshooter, who has little incentive to treat the case as anything but deviance on the part of the alleged sorcerer, who, if not called to appear before the nchimi, has no means of protesting his or her innocence until long after his or her guilt has

been established in absentia.

"Second, [according to Emerson and Messenger, (129)] troubleshooters often operate with a distinctive theory of trouble and interventional ideologies which require symmetrical or asymmetrical responses." Village headmen are duty-bound in most cases to be even-handed in dealing with witchcraft accusations, especially in cases where the accused party has no prior history of necromancy. However, once a person acquires a reputation as a witch, he or she is no longer given the benefit of the doubt, and the headman is likely to immediately take the side of the victim.¹⁷ The various ordeals, especially mwabvi, were often administered in an even-handed manner to both the accused and the accuser, victim and alleged troublemaker or witch. Nchimi, as substitutes for the ordeals, are seen as impartial in cases of mutual accusation and are often patronized by people living at great distances from them, specifically for their impartiality as strangers, rather than taking their case to a nearby diviner, who knows the parties personally.

Unlike western careers of trouble, few cases of witchcraft ever acquire a dossier or an official record; first, because few cases reach the attention of the relevant governmental authorities, second, because there is little communication between the various healers, both traditional as well as western, regarding individual cases; and, last, because of the lack of a tradition of literacy and recordkeeping. Thus, the patient who makes the circuit of agents bears no accompanying baggage of records, nor are such records either requested by the present healer or forwarded by the former healer. The last troubleshooter to be consulted is thus free to act either impartially

or to take the patient's side. However although the advent of literacy has not resulted in the compilation of patient dossiers, the widespread use of letters of referral or authorization does allow village headmen to provide some input into the nchimi's decision-making process, as does the practice of requesting the nchimi to visit the afflicted village and perform his witchfinding in situ; thus enabling him to acquire such local knowledge as he deems necessary or that any partisans to the case may wish him to obtain.

The rise in importance of the nchimi as a replacement for the relatively impartial mwabvi results in an attendant rise in the asymmetrical disposition of witchcraft cases. In contrast, the medicalization of troubles in Malawi almost invariably results in their being categorized as intrapersonal, with the victim having no one else to blame in most cases although responsibility for some cases of transmissible disease and childhood malnutrition is occasionally placed on others. Village headmen or chiefs, to the extent that they function as troubleshooters of witchcraft cases rather than complainants, are committed to dealing with these cases in an evenhanded way.

To revert to Emerson and Messenger again, "the form of intervention is affected by the power of the troubleshooter relative to that of the original parties to the trouble." (E&M, 129) Troubleshooters dependent on their clients' (often their neighbors') support tend towards symmetrical interventions and cannot impose their solutions. The village headman falls into this category of troubleshooter, as do most nganga having a strictly local practice. Nchimi, on the other hand, are more likely to draw clients from greater distances than nganga and village headmen. They are usually strangers

to their clients and are not beholden to them in any way. Their power is derived from their reputed ability to resolve witchcraft-related troubles and is enhanced by the semi-official status some of them enjoy as a consequence of possessing their letter from the local District Commissioner authorizing them to practice. Nchimi are also often reputed to possess powers akin to witches, it being widely believed that "it takes one to know one." The public tends to stand in awe of nchimi and therefore accepts their decisions, thus confirming Emerson and Messenger's statement that "many official troubleshooters possess the power to impose one-sided solutions through adjudicated decisions even in the face of opposition from one or both parties." (E&M, 129) The courts and the nchimi fall into this latter category insofar as witchcraft accusations are concerned, and village headmen tend to act in concert with nchimi as executors of their judgements.¹⁸

Most typical contemporary witchcraft cases initially involve no overt suspects. The nchimi not only diagnoses the trouble as witchcraft but identifies the witch as well. The witch has no input into the adjudication process until after his or her guilt has been determined. At this point, the witch is called to the nchimi's presence to confess and relinquish his nyanga. Any attempts made at that time to clear his name are likely to prove futile. Overwhelming social pressure is on the accused witch to confess, surrender his or her charms, and be "cleansed" of his or her predilection to sorcery. Failure to conform to this scenario means remaining under suspicion or perhaps even exile from the village. The easiest way out of this "no-win" situation is confessing.

In cases of mutual accusation, a more evenhanded treatment is

accorded by the nchimi¹⁹ to both parties to the trouble, with the village headman enlisted as a mediator and playing a non-partisan role in such cases. However, Emerson and Messenger predict that "when one party's accusation is made from a position of greater power, the likelihood of one-sided intervention on that person's terms increases." (E&M, 130) If one of the two accusing parties has a history of being accused as a witch, that person's reputation tends to erode whatever forces he or she is able to muster in his or her favor. Whether or not the nchimi adjudicating the case is familiar with the two protagonists, the opposing party is likely to bring such history to his attention in an effort to impugn the adversary's reputation. Thus, nchimi are likely to favor an asymmetrical solution to the problem.

According to Emerson and Messenger, it is outside intervention, especially of the official variety, "that produces the forms of alignment distinctive of deviance and conflict, and which ultimately constitutes the trouble as one or the other of these forms." (E&M, 130) In order for conflict to exist there must be at least two parties who consciously oppose one another, and the incidence of such situations seems no less common in northeastern Malawi than elsewhere. What is different about their culture, as contrasted to our own, is the strong tendency for such interpersonal struggle to be couched in terms of deviance or wrongdoing, specifically sorcery, rather than conflict. One of the main avenues through which conflict is transformed into deviance is through the diagnostic efforts of traditional troubleshooters, especially nchimi. Nganga and nchimi have an even greater impact on the constitution of trouble by their tendency to transform intrapersonal troubles into interpersonal ones, which are

invariably ascribed to deviance or sorcery rather than to legitimate conflict. This transformation is especially characteristic of nchimi since their professional stance in these cases is that of witchfinder and exorciser rather than as healer of internal complaints or adjudicator of multi-party disputes.

In summation, "those committed to relational treatments [as most nchimi are,] may find themselves stymied in efforts to work out a mutually acceptable solution, [which nchimi are not since they can in most cases either find or construct a "straw man,"] and may have to resort to onesided responses as a practical expedient," (E&M, 131) which is in fact the response taken by nchimi in most cases. Thus, "particular forms of trouble, including deviance and conflict, are produced procedurally by the responses of troubleshooters, and not simply by their definitions of the trouble." (E&M, 131) The divination process, as performed first on the victim and later on the witch, is a good illustration of this procedural production of deviance.

Cases Where the Paradigm is Inapplicable

"The Micro-Politics of Trouble," by its very title, deals primarily with interpersonal troubles, that is, with troubles resulting from the interaction between two or more persons. The Malawian cases of witch-finding call into question Emerson and Messinger's use of the term troublemaker. This is not surprising since, of the four terms describing the roles of the participants to a trouble, that of troublemaker is the least precisely defined. In fact it is not properly defined at all, the relevant sentence reading: "Finally, one party to the trouble may come to be designated the troublemaker"

responsible. (E&M 126) It would be misleading to label as troublemakers those alleged to be witches and sorcerers, who although actual persons, in reality are quite incapable of causing the troubles attributed to them; and it is even more inappropriate to apply the term to various sorts of spirits, viwanda and vimbuza, for example, who have no physical existence at all. If such agents are indeed the only etiology of some trouble, then that trouble is a candidate for being described as an intrapersonal trouble from our etic perspective.

In Malawi, as in most other societies, people frequently attribute their troubles to a variety of supernatural beings such as gods and spirits as well as to humans alleged to possess supernatural powers such as witches and sorcerers. Such troubles are conceived of as interpersonal by those experiencing them, and a troublemaker is assigned as the cause. However, a scientifically trained outside observer would in many such cases assign the cause of the trouble elsewhere. Thus, from an insider's perspective, the Emerson and Messenger terminology is appropriate, but, from an etic point of view, it is not.

The viwanda are people's own ancestral spirits who are capable of troubling their living kin in a number of ways and from a variety of motives. Such troubles are often recognized to be a consequence of one's having misbehaved in some way, as by failing to adequately honor an ancestor's spirit or by violating some societal norm. The other major denizens of the spirit world, the vimbuza, are the ethereal residuum of the dead of distant places. They trouble people for a variety of reasons, none of which are the fault of the victim. In the case of trouble attributed either to viwanda or vimbuza, the

troublemaker is not a person as we normally use the word, but is dead, often long dead, and is therefore not a good candidate for the title of troublemaker, as defined by Emerson and Messinger.

Sorcerers are perhaps the most frequently cited troublemakers in Malawi. Not only are people accused of sorcery, but alleged sorcerers on occasion confess to having caused the trouble that they have been accused of. In many, if not most, cases of alleged sorcery, the sorcerer is either not named, or if named, is not confronted. In most sorcery cases, the alleged sorcerer probably has not attempted necromancy against the victim and may not even harbor animosity towards him or her. In fact, the alleged sorcerer may hardly even know the victim and may have no real motive for, nor intention of, sorcery. Under any circumstances, sorcery has little physical reality although possessing a marked social and psychological impact. It may be easy to convince a troubled person that a sorcerer is at the root of his or her trouble, but that does not necessarily infer that the alleged sorcerer is a "troublemaker" as defined by Emerson and Messinger.²⁰

Witchcraft is another form of trouble which is defined as interpersonal by those among whom it is prevalent and which would logically be categorized as an interpersonal trouble, as defined by Emerson and Messinger. Viewed from the scientific perspective, however, witchcraft is an even less realistic phenomenon than sorcery. The victim of what is alleged to be witchcraft believes that the troublemaker has bewitched him or her without consciously intending to. The power to wreak such evil is thought to reside in some supernumerary organ in the witch's bowels over which he or she has no control. There seems to be no valid evidence for such supernatural

claims although the notion of a "witchcraft-substance" may have some underlying physical basis.²¹

Complaints attributed to gods, spirits, sorcerers, and witches are conceived of as interpersonal troubles by most Africans and superficially appear to conform to Emerson and Messinger's definition of "relational troubles--that is, those in which remedial efforts are addressed to another in a recognized relationship with the troubled person." (E&M, 123) Applying a more rigorous definition to relational troubles, complaints attributed to supernatural causes are eliminated from the interpersonal category, at least insofar as it is defined both conventionally as well as by Emerson and Messinger. Realistically, such troubles are either intrapersonal or perhaps what I would term iatrogenically interpersonal in that it is the process of diagnosis or treatment which is responsible for the trouble being labeled interpersonal rather than any intrinsic aspect of the trouble itself. In other words it is the troubleshooter who is responsible for defining the trouble as interpersonal, and, in so doing, the troubleshooter becomes a kind of troublemaker. If a troublemaker is "a deliberate fomentor of disagreement," (C.O.D. 1976:1245) then the witchfinders are the troublemakers, for when they name a person as being a sorcerer or witch and responsible for a victim's trouble, they perpetuate the dissension instead of resolving it. People recognize that nchimi and on occasion nganga are frequently de facto troublemakers when they engage in witchfinding, and such blame is not infrequently laid at the door of the nchimi by irate alleged troublemakers who have the gumption to stand up for their rights.

There are numerous instances of one individual threatening to

ensorcel another and, less frequently, actually attempting to carry out such a threat.²² Such intimidation in and of itself may initiate within the victim a stress related reaction resulting in mental and/or physical distress (Bielauskas, 1982) and may legitimately lead to a person's being branded a troublemaker by an nchimi. However, when there is no such overt threat and when no real grounds exist for blaming a trouble on any particular individual, the nchimi often conjures up a scapegoat on whom the victim's trouble is blamed. The troubleshooter in such a case may succeed in explaining to the victim why the trouble began and who was responsible for it, but he is unlikely to be able to remedy the trouble if it is disease of physiological origin or if the trouble is of the socio-economic variety and one in which the alleged troublemaker has no controlling input. If the problem is in actuality organic or not the accused's fault, the naming of an alleged sorcerer as scapegoat indeed creates social trouble. In these cases, the nchimi both creates and remedies the trouble, that is, makes it and cures it. Indeed, creates it in order to cure it.

In a similar vein, a troubleshooter may interpret a troubled person's symptoms as being due to some sort of spirit. In these cases, the trouble is quasi-interpersonal, as the spirit is both referred to and related to as if it has a human personality. In such a case the troubleshooter, (usually an nchimi) is not quite the same "deliberate fomenter of disagreement" as in sorcery accusations, solely because the alleged troublemaker is now a disembodied spirit rather than in corporeal form. The basic principle, however, remains the same, and one might justifiably label the nchimi who blames some poor unsuspecting spirit for the troubles of an unrelated mortal as a

troublemaker. Such is the case in vimbuza and vyanusi, where unrelated spirits are allegedly responsible for the victim's trouble. In cases of trouble caused by one's own ancestral spirits, the blame is often more logically assigned to the victim, for some act of commission or omission by which he or she has offended an ancestor. In either case, the nchimi remedies the problem by neutralizing the troublemaker he himself has created, just as the sorcerer he named as troublemaker is neutralized.

The troubleshooter is charged with remedying people's troubles. Nchimi and nganga treat both inter and intra personal troubles after first having defined them. If what is in reality an intrapersonal trouble is defined by the troubleshooter as an interpersonal trouble, the troubleshooter may not only be doing a disservice to the client (the victim) but actually fomenting trouble between the victim and the wrongfully accused troublemaker.

The term victim must also be modified to be applicable to the Malawi situation. A victim is "the person held injured, harmed, or wronged," (E&M, 126) whose trouble is perceived as being due to some outside agent. The victim (and frequently the troubleshooter) assigns the cause of the interpersonal problem to this outside agent or troublemaker and assumes no responsibility for it even though the alleged victim may be the instigator or at least the mutually responsible party to a conflict, as in the case of adultery.

Being a victim of an interpersonal trouble presupposes that some other person has caused the trouble that one is suffering from. Being a troublemaker assumes that one has caused some victim's trouble,

and being a troubleshooter requires that one attempt to resolve trouble rather than exacerbate it. Emerson and Messinger's parties to trouble conform to these criteria. However in Malawi (and elsewhere), it is frequently the case that those playing these three roles are in reality playing them in a manner exactly opposite to how they are defined in Emerson and Messinger's paradigm.

Modifications to Emerson and Messinger's Paradigm

Several important albeit commonsense precautions need to be taken when applying Emerson and Messinger's model to cross-cultural situations. Three of the four primary types of role postulated by the authors as party to any trouble, complainant, victim, troubleshooter, and troublemaker, are capable of diametrically opposed interpretations. The victim can be an instigator; the troubleshooter a troublemaker, and the alleged troublemaker an innocent victim and incapable (from a western perspective) of having caused the trouble at issue.

The folk ascription of the role of troublemaker to supernatural beings such as gods and spirits and to humans with supernatural attributes such as witches and sorcerers may be perfectly legitimate from an emic perspective, but social scientists are not likely to use the term troublemaker in describing such ethereal entities, save in certain cases of sorcery where the alleged sorcerer is known to have threatened the victim. From an indigenous point of view, Emerson and Messinger's concept of troublemaker holds, but not from an outsider's perspective. Spirits (both ancestral viwanda and foreign vimbuza and vanusi) and ghosts (mzguka) cannot in good conscience be termed

troublemakers by the social scientist even though they are so labeled by the population under study. Troubles which are attributed solely to such agents are in reality likely to be purely intrapersonal troubles, having no troublemakers save perhaps the victims themselves.

In a case of sorcery accusation, the troublemaker may be the alleged sorcerer. However in most cases of this nature, the party labeled as sorcerer-troublemaker is in reality himself or herself a victim, as the courts in Malawi and elsewhere in Africa have ruled. Thus, in analyzing sorcery cases, one must exercise a modicum of discretion when using the term troublemaker to describe a sorcerer. In general, one is safer in using the more cumbersome, but more accurate, appellation, alleged-troublemaker.

The role of the victim is similarly likely to be misinterpreted since Emerson and Messinger have defined the term in rather an ambiguous way: "victim, the person held injured, harmed, or wronged." (E&M 126) The sociologist's problem is, "held injured, harmed, or wronged" by whom? Their paragraph defining these crucial terms (victim, troubleshooter, and troublemaker) is rather too succinct, and their brevity, although stylistically admirable, may prove troublesome to those attempting to apply their paradigm to cultures different from our own.

Emerson and Messinger's use of the term victim implies a person whose trouble is due to some outside agency, not of his or her own causing, this being the most common usage of the word. However, people may equally be victims of their own actions of commission or omission and have no one to blame for their troubles but themselves, as: "fell a

victim to his own avarice." (C.O.D., 1976:1296) Troubled people have a tendency to blame their trouble on some external agency, even if it is their own fault, or is attributable to what we in the west call chance or accident. This external agency is frequently anthropomorphized or conceived of as having a personality, not only by the victim, but by other parties to the trouble as well as the public at large. Even in the case of troubles which are obviously interpersonal, it is often possible for both parties to regard themselves as victims, and Emerson and Messinger recognize this. The sociologist describing troubles attributed to supernatural forces by those party to them should therefore err on the side of caution and precision of language when using the term victim in Emerson and Messinger's technical sense, as it is frequently the case that the victim's trouble has been caused not by some other person, but by either some impersonal agent such as a microorganism or by the victim's own actions. The trouble may thus be of an intrapersonal nature, rather than an interpersonal one.

The concept of troubleshooter is the one most likely to be misapplied when using Emerson and Messinger's model in the analysis of trouble. The troubleshooter's overt role is to unravel a trouble and eliminate it. However, in so doing, troubleshooters such as nganga, and more especially nchimi, may play the latent role of troublemaker insofar as their cure frequently depends on wrongly ascribing blame for the victim's trouble to an innocent person who is branded a sorcerer as a consequence of their spurious divinations. The troubleshooter or traditional healer is patronized by the initial victim to remedy his or her trouble. However, if the healer indulges in witchfinding and names an innocent person as the sorcerer responsible for the victim's

trouble, it is the alleged sorcerer who has been victimized by the healer. In short, the troublemaker is the victim, and the victim may be the troublemaker. But the troubleshooter is always the troublemaker, either realistically in the creation of victims, or sociologically in the definition, evolution, and institutionalization of trouble.

¹Although Emerson and Messenger do not directly deal with them, in Malawi, economic complaints are often interpreted as having an interpersonal origin and so may be analyzed within their logical framework.

²Several letters quoted in Chapter IV are illustrative of the first stage of such a rediagnosis.

³Although the success of a particular treatment is often assumed to prove that the underlying diagnosis was correct in western medicine, the objective criteria used in arriving at such a diagnosis are quite different from those relied upon by nganga and nchimi. In any event, Western doctors practicing state of the art medicine are aware of the possibility that their therapeutic interventions, although successful, may not prove that their diagnosis was correct, but were merely of placebo value or perhaps of no value at all. They realize that many patients will spontaneously recover with or without their intervention, although they may not always pass on such knowledge to the patient. Traditional Malawian healers, on the other hand, do believe, or at least state that they believe, that their successful treatment is a sure indication of the accuracy of their diagnosis. If witchcraft is diagnosed and the alleged sorcerer is made to confess and the patient recovers, it proves the symptoms were due to sorcery.

⁴In a witchcraft case among Brazilian Indians, the Kuikuru, (Harris, 1971:381) the initial overt trouble was the setting afire of two houses by lightning. The local shaman attributed the trouble to a villager who had moved away some years previously. He was selected not at random, but because he fulfilled the criteria of having a reputation as being quarrelsome, having a motive for doing harm, and having relatively weak kinship relations. The shaman himself lived in the village and thus was thoroughly familiar with the absent man's history.

In northeastern Malawi, the nchimi patronized in cases of serious trouble is extremely unlikely to be a member of the disputing parties village or to have any intimate knowledge of the trouble prior to it being presented to him by one of the parties to it, said party initially being almost invariably the victim. Harris goes on to note that the shaman is not in full control of the divinatory situation but is constrained by public opinion. "A shaman abuses his supernatural gifts if he accuses people who are well liked and who enjoy strong kin-group support. If he persists in making such mistakes, he himself will be ostracised and eventually murdered." (Harris, 1971:382)

In the Malawian situation that I am familiar with, the nchimi may exercise more control over the outcome of his divination than the aforementioned shaman, as he is a stranger to his patients, who have relatively little social control over him. In many cases, the primary client of the nchimi appears to be the village headman who refers clients to him, rather like a medical specialist here in America who depends primarily on professional referrals for his patients.

⁵There is a very strong tendency for intrapersonal troubles of the somatic as well as economic variety to be cast as interpersonal

troubles, specifically as due to sorcery, or to the unwanted attentions of spirits.

⁶This is a good example of the labeling theory of deviance, in which the deviance, in this case the alleged use of sorcery, "is the outcome of a social process which involves conflicting values of social groups, a social language of labels, social reactions and expectations." (Lorber, 1972:414) The clinical interpretation of deviance has been to concentrate on the characteristics of the deviant, who, in the case of the witch and even the sorcerer (both in the Evans-Pritchardian sense), is in reality merely an artifact of the labeling process. "The labeling approach concentrates instead on the characteristics of the controllers--the formal and informal agents of social control who ferret out, define, and do something about a certain kind of activity." (Lorber 1972:414-5) The term controller can be taken as the equivalent of Emerson and Messinger's troubleshooter, who in the Malawian situation is the nchimi or nganga.

⁷The case of Nyasaland v. Jackson illustrates such a state of events.

The accused had had an altercation with the deceased, an elderly female cousin, regarding certain rites which should have been observed at the funeral of the accused's brother. Certain remarks of the deceased [Jackson's cousin] were construed by the accused to mean that a spell had been or would be cast upon him which would result in his death. Believing his life in imminent danger, he killed the deceased. (African Law Reports, Vol. I 1968:490)

In such a case, there are two sequential troubles, both having the same players but with their roles reversed. In the first instance, the elderly female cousin was the troublemaker and Jackson, the potential victim who killed her in what he deemed to be self defense. This act of his resulted in his being cast as troublemaker, both from the perspective of the law as well as that of the deceased, who logically became the victim.

⁸In rural Malawi, the threshold level of physical discomfort tolerated (rather than perceived) before palliative action is taken seems considerably higher than the norm for many western communities. Read writes that "In some societies people are trained from childhood to endure pain or even to deny its existence." (Read, 1966:36) She particularly discusses this denial of pain by women in labor. (1966:36,67) This is very similar to the situation prevalent in northeastern Malawi. Jansen, a doctor working in rural South Africa, noted the role of culture in pain tolerance and implied that his rural African patients had a relatively high tolerance of pain as well as requiring fewer pethidine injections for post-operative analgesia than their urban counterparts. (Jansen, 1973:90)

⁹The village headman may be an interim troubleshooter in cases of sorcery, but his role usually changes to that of complainant, or more precisely of referror, when he sends the case to the nchimi for divination.

¹⁰ See Redmayne, 1970, for an account of how clients traveled from as far as Rhodesia and Tanganyika to visit Chikanga, an nchimi practicing in Malawi in the early 1960's.

¹¹ The complaint might possibly be laid at the feet of some spirit. If it was caused by a chimbuzza, the fault would be the spirits and the trouble an interpersonal one. If the trouble was caused by a mizimu or ancestral spirit, the fault might lie with the victim for some act of commission or omission on his or her part, and the trouble would be envisaged as an intrapersonal one.

¹² A case in which both of these options were pursued simultaneously is illustrated by the following letter.

Dear Chimi Vwamba,

Herewith [is] Chapasi Mwandosia who has been accused [of witchcraft] by Chembe Mkandawire. The bewitched is now in the hospital at Karonga.

You know everything (what to do with him) as a real witchfinder.

Yours,
V.H. Vikuyu

In this case the victim was taken to the troubleshooters at the hospital, while the village headman in his role as official complainant refers the alleged troublemaker to the traditional troubleshooter, the nchimi, who, interestingly enough, is overtly referred to as a witchfinder.

¹³ See Chapter II, endnote 1 for an account of the use of many healers by one patient.

¹⁴ The written aspect of the case history in the traditional medical system seems to be exclusively confined to the sort of correspondence that I presented earlier. In the western medical system there are patient charts of varying degrees of completeness, and the court system keeps its own records. As Bozeman states, "writing, then, affects fundamentally the nature and quality of thought and its expression." (1976:71) Keeping written records of traditional sorcery cases would not necessarily alter their outcomes, as witness the many witchcraft trial narratives of earlier times. However, I believe that committing the findings of traditional healers to writing would, in the context of the competing alternative system of western thought, considerably speed up the evolution of traditional medical practice, most likely bringing it into greater congruency with that of the western system.

¹⁵ Although the seketera is not really a healer, he may be categorized as a type of troubleshooter, one providing a "final solution" to witchcraft cases that have resulted in someone's death. Seketera kill the witch responsible, thus not only have revenge but also prevent the witch from causing any future trouble.

¹⁶ See Justice Cram's decision which I have quoted in Chapter I, for support of this statement.

¹⁷ An example of this bias on the part of a village headman is provided by the following excerpt from a letter to Nchimi Vwamba.

Sir,

. . . The person who has refused to come there I know him and his ways pretty well. He has killed many people, boys and girls, and many people have been killed. Please, Sir help me with my problems.

I don't have much to say.

Yours,

V.H. Fumbo

¹⁸ In the past, mwabvi would have fallen into this category as well, due to its perceived impartiality and its likelihood of finding either or both parties guilty or innocent.

¹⁹ As mentioned elsewhere, the nchimi consulted may dwell at a considerable distance from the parties to the trouble. That such a diviner is consulted is due to several factors, first of which is probably the fact that nchimi who deal with witchcraft disputes that result in letters of referral from healmen are relatively few, and so parties to such a trouble are likely to have to travel some distance to the nchimi. The other reason is that many people feel that a distant diviner is inherently more impartial than a nearby one, as he or she does not know the parties to the case and is unlikely to be influenced by local opinion.

In the event that a distant nchimi is consulted in a case of suspected witchcraft and he finds one of the parties to the trouble to be a witch, his findings are relayed by means of a letter or by messenger to the village headman who initially referred the case to him, who then acts on those findings in exerting sanctions on the offender, the most serious being banishment from the village. The nchimi himself may punish the alleged witch by forcing him to confess as well as by cutting dekano medicine on his or her forehead.

²⁰ Marwick observes that:

The third character in any sorcery drama, the accuser, is of great sociological importance. While from the investigator's point of view the relationship between sorcerer and victim is an imaginary one, that between sorcerer and victim is a real, observable one, and so, for that matter, is the affiliative relationship between accuser and victim. Sorcerer-victim relationships may thus be regarded as representing peoples' estimates of interpersonal tensions; and accuser-sorcerer relationships, as actual expressions of them. (Marwick, 1965:105)

Marwick's accuser is in some ways similar to Emerson and Messinger's complainant although the two roles are far from being congruent. The victim may be the accuser and in fact may make a self accusation or may, as a client of a diviner, prompt the diviner to so accuse him. (Marwick, 1965:106) The complainant may be the accuser although it seems that, in most but by no means all cases of suspected sorcery in northeastern Malawi, no overt accusations are made by either victim or complainant, it falling to the nchimi as troubleshooter to make any

formal accusation.

²¹The discovery of a dermoid cyst or other tumor on autopsy of a suspected witch might have led to the belief in such an organ, which one author described as "found in the belly . . . a round hairy ball, which may have teeth, and is very dreadful to look at." (Evans-Pritchard, 1937:22 quoting Larken) This is a good description of a dermoid cyst, a rather spectacular form of teratoma.

²²Young, (1932) who examined and analyzed the ethnopharmacopoeia of three traditional healers of northern Nyasaland, noted the existence of several medicines designed to effect some nefarious purpose, i.e. sorcery. These include medicines: "To get rid of enemy; For introducing disharmony between man and wife; To prevent woman from giving birth", as opposed to causing an abortion, and "For one who has interfered with one's wife." The results of this latter preparation are not specified but are likely to be unpleasant. Young writes that "It will also be noted that medicine of the charm or spell category has hardly, if at all, been ousted from its leading place by education. And I may, I think, use the word education more correctly of Nyasaland than of any other territory known to me. We find here this category including items of a sort that one might easily, but wrongly, imagine as having been banished as knowledge grew." (Young, 1932:231) Some half century later, my field work indicates that little change in this area of belief has occurred since Young's time. An illustration of this is provided by the following formula which I collected during the course of my fieldwork. The author of the ethnopharmacopoeia in which it was written was a nganga practicing in northeastern Malawi. "Medicine for vilasi [pneumonia]: bwitizi -- put blood to it (by rubbing) and then take a needle and pierce at the middle. Say the curse. The enemy should die."

APPENDIX 1

LAWS OF MALAWI
CHAPTER 7:02
WITCHCRAFT

An act to deal with Trial by Ordeal, Witchcraft and the use of Charms 12th May, 1911 [1911, 1929, 1946, 1963, 1964, 1968]

1. This Act may be cited as the Witchcraft Act.

2. Trial by the ordeal of muabvi or other poison, fire, boiling water, or by any ordeal which is likely directly or indirectly to result in the death of or bodily injury to any person shall be and is hereby prohibited.

3.—(1) Any person who directs or controls or presides at any trial by ordeal which is prohibited by this Act shall be liable to imprisonment for seven years.

(2) Any person who within Malawi instigates or conspires or confederates or agrees to hold a trial by ordeal which is prohibited by this Act, whether the same is to be held within Malawi or elsewhere, shall be liable to imprisonment for seven years:

Provided that where any such trial as mentioned in the two foregoing subsections results in the death of any person, the person directing, controlling or presiding at such trial and the person instigating any such trial or conspiring, confederating, or agreeing to hold any such trial shall be liable to imprisonment for life or for any shorter term.

(3) Any person who is present at or takes any part in any trial by ordeal which is prohibited by this Act shall be liable to a fine of L5 and to imprisonment for one year:

Provided that no person shall be punished in respect of the same trial by ordeal under this and the last preceding subsection.

(4) Any person who collects, makes, sells, or assists or takes part in making or selling, or has in his possession any poison or thing which is intended to be used for the purposes of any trial by ordeal which is prohibited by this Act shall be liable to a fine of L5 and to imprisonment for one year.

An African found in possession of muabvi or other poison commonly used for the purpose of trial by ordeal shall be deemed to have committed an offense under this section unless he shall prove that such poison was not intended for such purpose.

4. Any person who, otherwise than in laying information before a court, a police officer, a Chief, or other proper authority, accuses any person with being a witch or with practicing witchcraft or names or indicates any person as being a witch or wizard shall be liable to a fine of L25 and to imprisonment for five years.

5. Any person who employs or solicits any other person to name or indicate by the use of any non-natural means any person as the perpetrator of any alleged crime or other act complained of shall be liable to a fine of L25 and to imprisonment for five years.

6. Any person who by his statements or actions represents himself to be a wizard or witch or as having or exercising the power of witchcraft shall be liable to a fine of L50 and to imprisonment for ten years.

7. Any Chief or Headman who directly or indirectly permits, promotes, encourages or facilitates any trial by ordeal which is prohibited by this Act, or who knowing of such trial or intended trial does not forthwith report the same to the District Commissioner of the District in which such trial has been or is intended to be held, shall be liable to a fine of L25 and to imprisonment for five years.

Every Chief or Headman within whose territory or village any prohibited trial by ordeal takes place shall be deemed to have committed an offence under this section, unless he shall prove that as a matter of fact he was justifiably ignorant of such trial or intended trial.

8. The profession or calling of witchfinder or witchdoctor or of professional maker or mixer of poison is hereby declared to be an illegal calling and every person exercising or pretending to exercise such calling or profession shall be guilty of felony and shall be liable to imprisonment for life.

9. Any person who shall use or assist in using any lot or charm with a view to the commission of any unlawful act shall be liable to a fine of L5 and to imprisonment for one year.

10. Nothing in this Act shall affect the liability to the death penalty of any person who under a pretence of trial by ordeal or of using any lot or charm commits wilful murder.

11. The Minister shall have power to make Rules for the better carrying into effect of this Act and such Rules may impose fines not exceeding L5 and imprisonment not exceeding one year.

APPENDIX 2

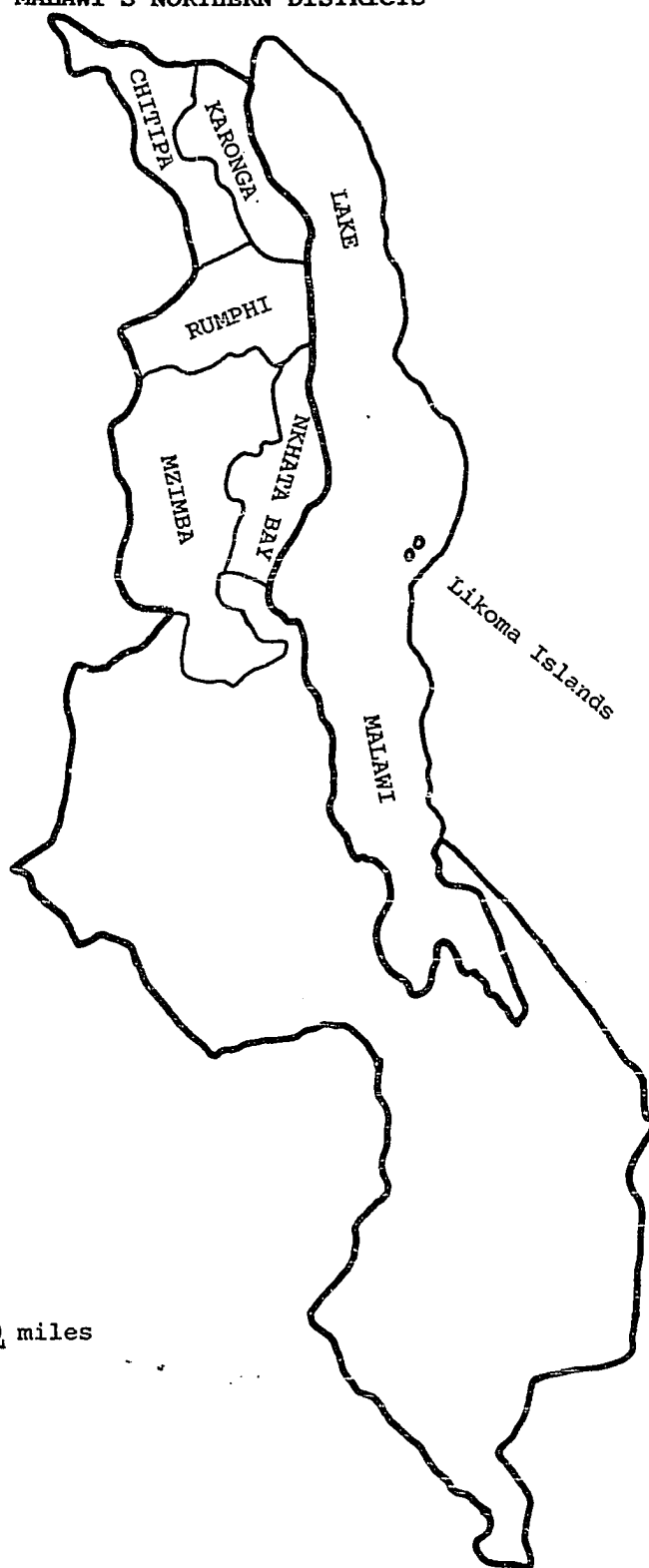
MAPS

The first map shows the four northern districts of Malawi. Most of my research was conducted in Karonga District, and in the eastern part of Rumphi District.

The remaining maps show the distribution of authors of letters collected from several of the nchimi and nganga included in this study. They plot only the distribution of those authors whose letters I was able to collect, and not the total distribution of authors writing to any particular healer. Authors writing from abroad are listed at the side of each map. Authors writing from within those parts of central and southern Malawi that are not included on the map are not listed.

Those healers who received letters from village headmen and chiefs have separate symbols for these officials, and for lay clients.

MALAWI'S NORTHERN DISTRICTS



0 60 miles

CLIENTS WRITING TO NCHIMI VWAMBA: 1970 - 1979

* = Nchimi Vwamba
 . = Headman/Chief author
 . = Layman author

Rhodesia	4
South Africa	2
Swaziland	1
Tanzania	3
Zambia	15

0 20 miles



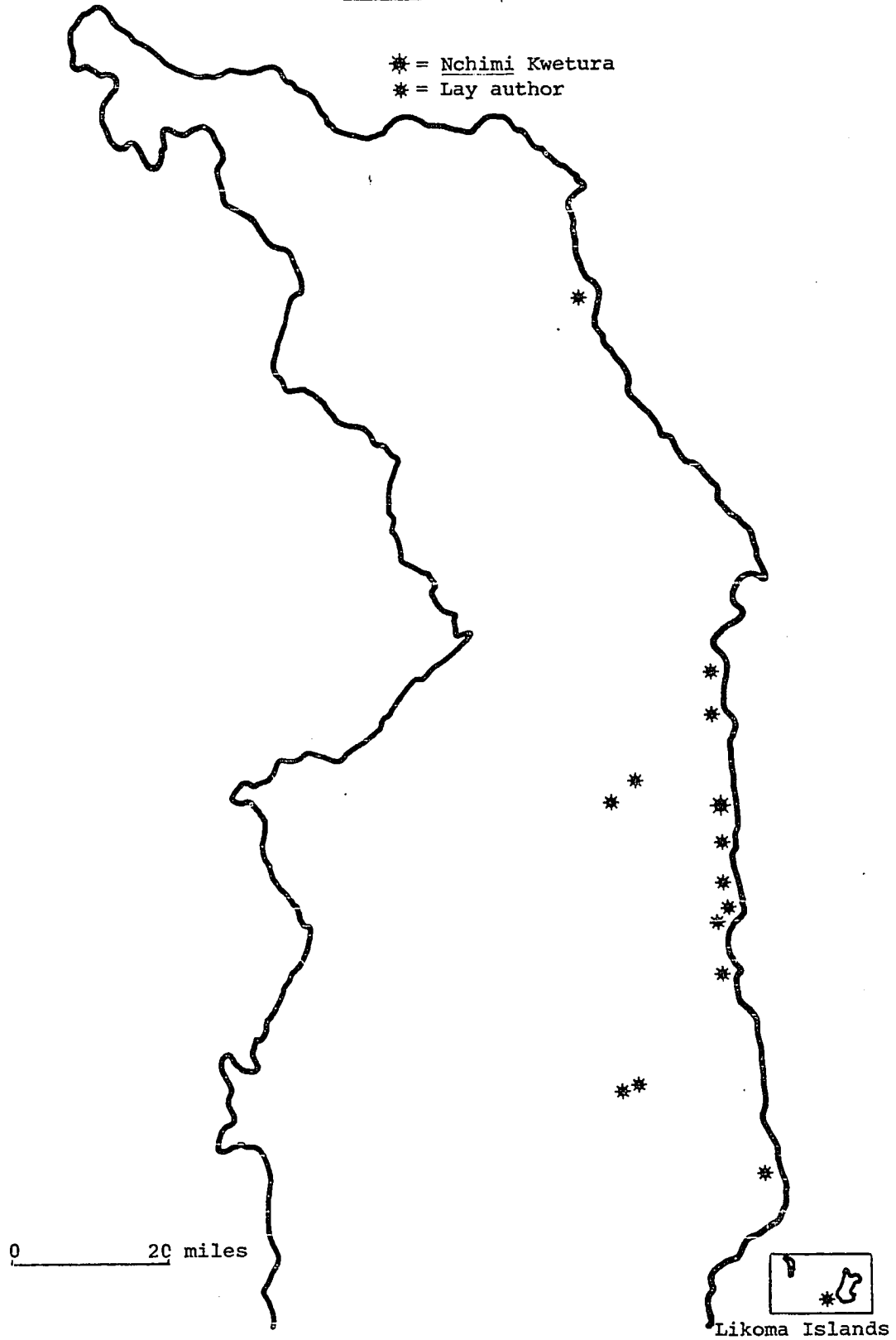
CLIENTS WRITING TO NCHIMI LIPUKA: 1972 - 1979

- * = Nchimi Lipuka
- = Headman/Chief author
- = Lay author

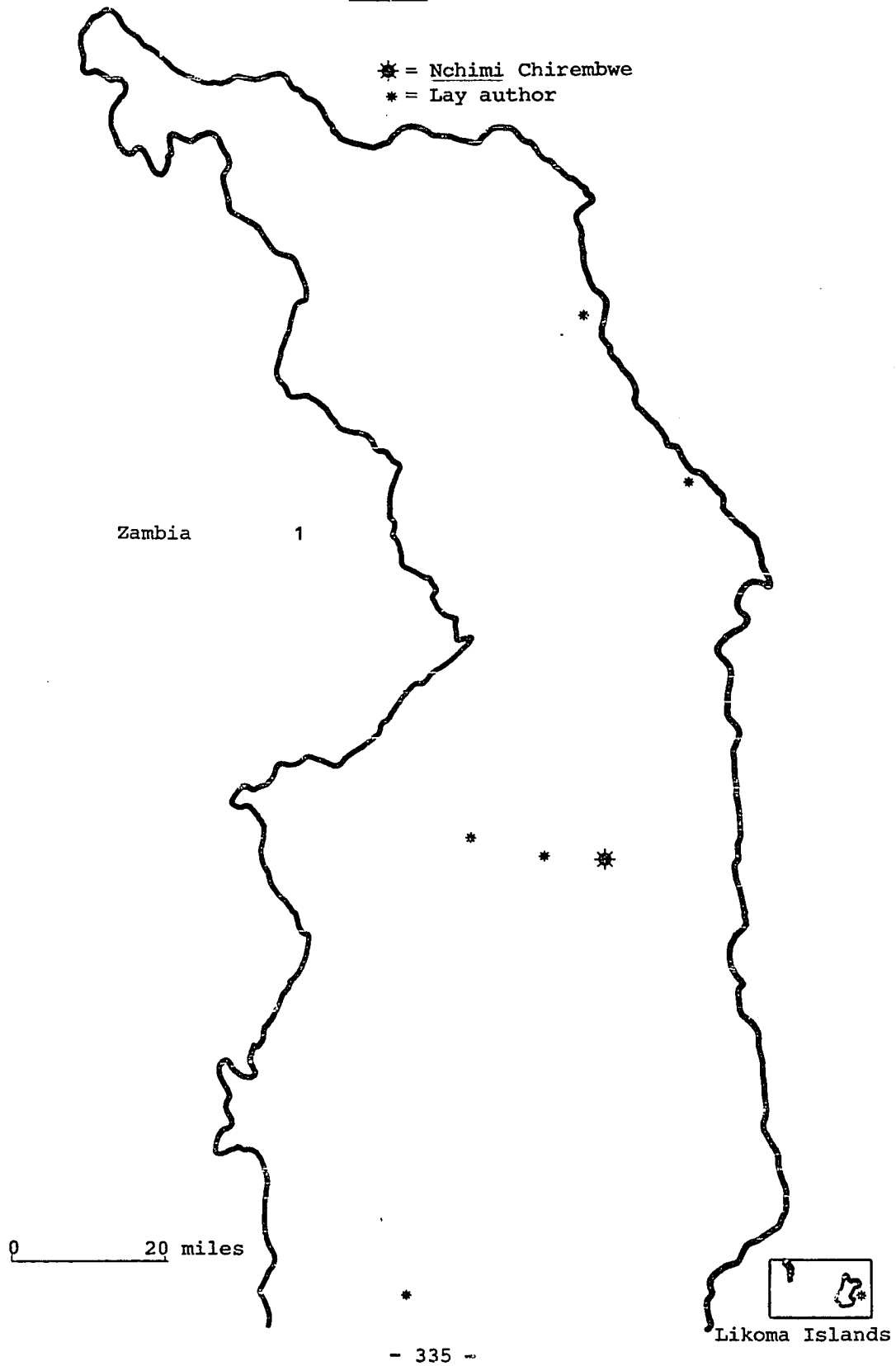
Rhodesia 1
South Africa 3

0 20 miles

CLIENTS WRITING TO NCHIMI KWETURA: 1972 - 1977

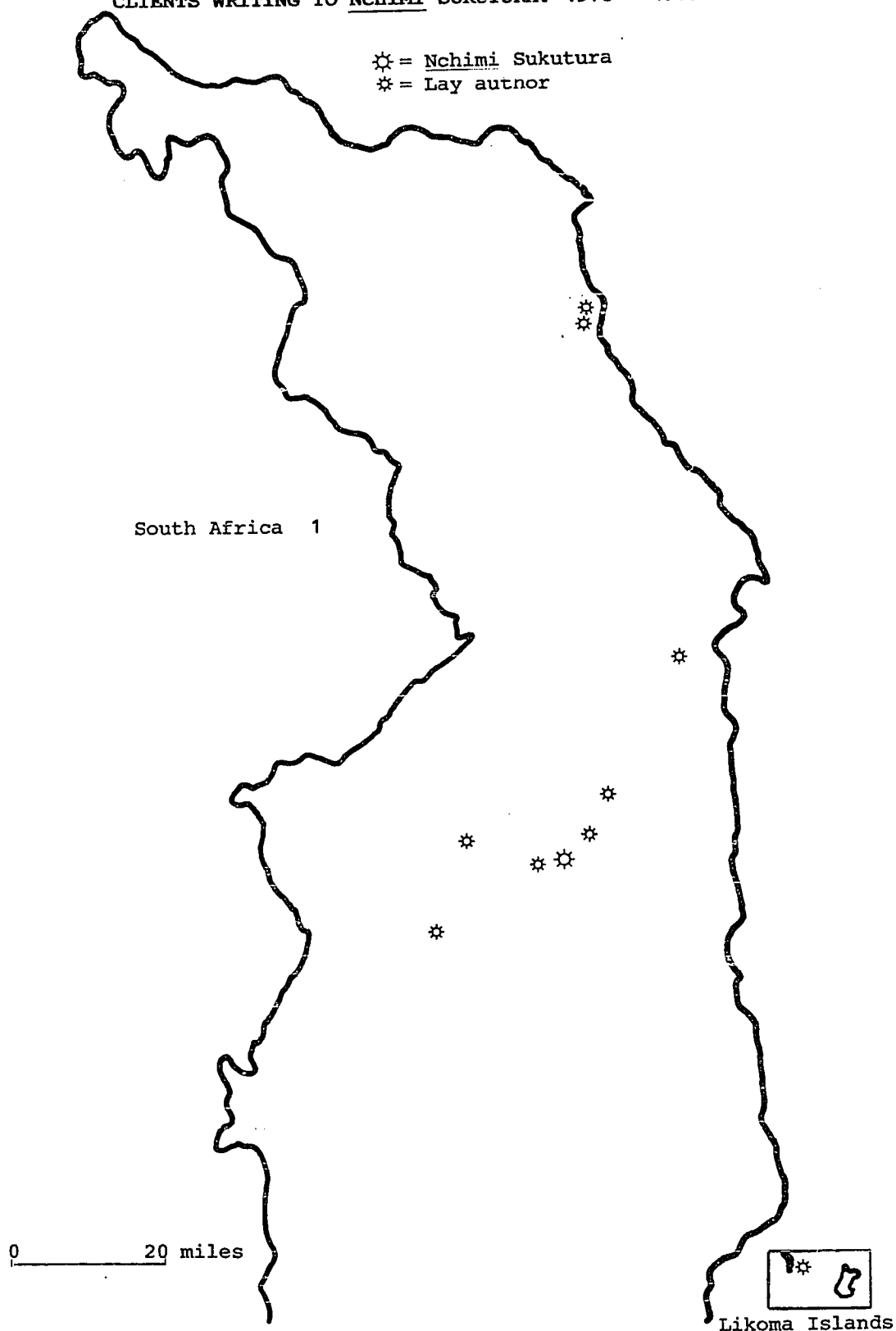


CLIENTS WRITING TO NCHIMI CHIREMBWE: 1977 - 1979



CLIENTS WRITING TO NCHIMI SUKUTURA: 1976 - 1979

☼ = Nchimi Sukutura
* = Lay author



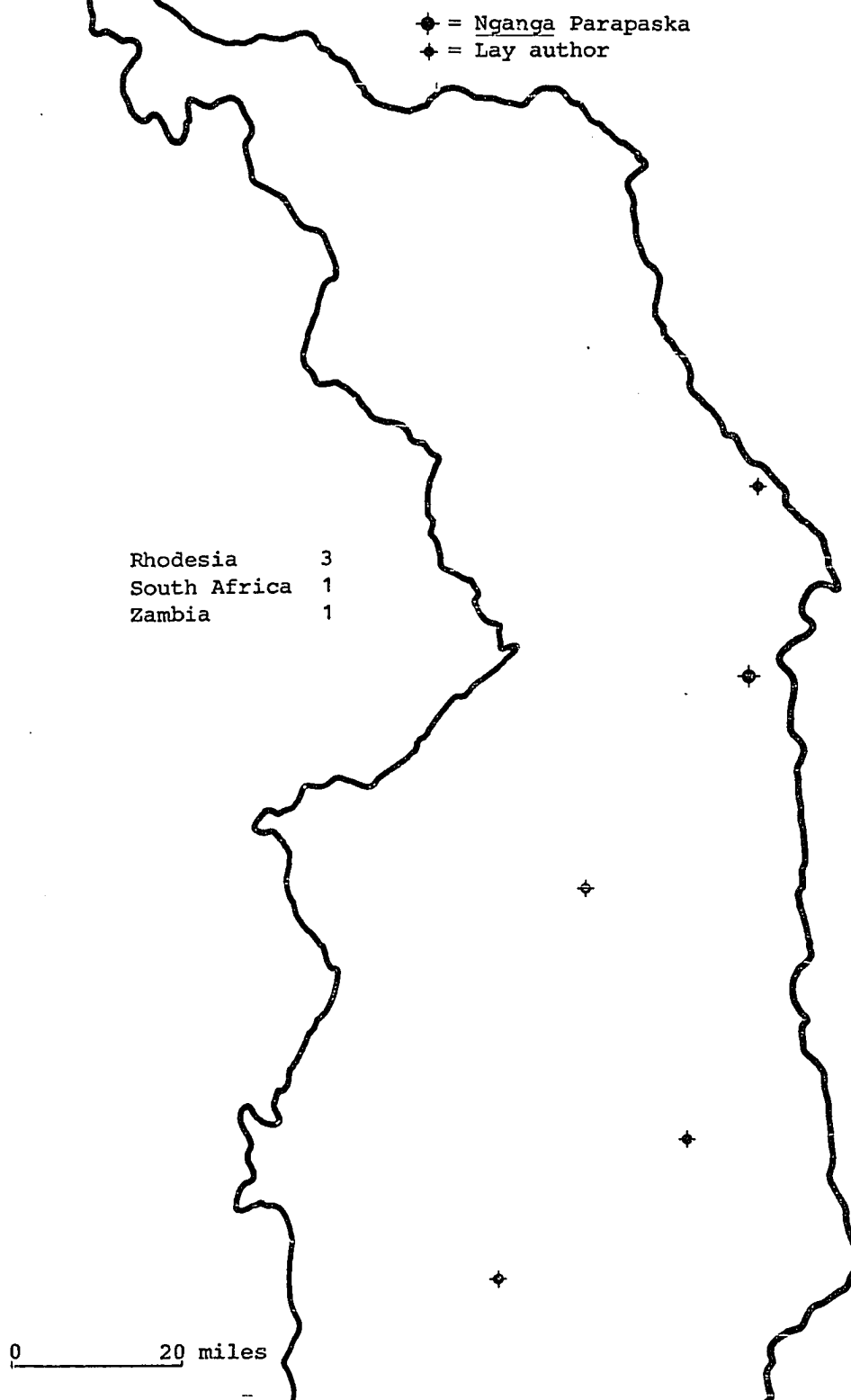
CLIENTS WRITING TO NGANGA TYAPULA: 1970 - 1979

- * = Nganga Tyapula
- = Headman/Chief author
- = Lay author

Rhodesia 1
Zambia 5

0 20 miles

CLIENTS WRITING TO NGANGA PARAPASKA: 1977 - 1979



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