

**Sanctified lives:
Christian medical humanitarianism in southern Zambia**

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Abstract

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Throughout Africa today Christian missionaries from the United States and Europe are providing more medical assistance than ever before and yet they remain, in much recent scholarship, more often associated with the colonial past than the humanitarian present. In many rural areas of Africa these missionaries provide much of the day-to-day healthcare that is available, treating commonplace afflictions, such as malaria, broken limbs or complications associated with childbirth. This dissertation considers Christian medical humanitarianism and its historical legacies by examining the lives and relationships of the many people who visited and worked at a small mission hospital in rural southern Zambia. Based on archival research and fieldwork (conducted between August 2014 and November 2015, and a month during August 2016), I consider how rural Zambian patients related to the expatriate missionary doctors and Zambian staff as they sought treatment at the hospital. I look at the motivations of the long- and short-term American missionaries, their relations with patients and staff members, and consider how they imagined the beneficial effects of their work. And I examine the place of the Zambian clinical staff members at the hospital – the nurses, clinical officers, laboratory technicians, and others – as they attempted to balance their multiple obligations to family members, neighbours, and friends with the needs of their patients and the high expectations of their missionary colleagues.

Engaging with central themes in recent anthropological work on humanitarianism, Christianity, morality and ethics, I argue that Christian missionaries, staff members and patients at the hospital enduringly perceived different aspects of their relationships as morally significant: from the missionaries' capacity to see the endurance and suffering of Zambian patients as evidence of God's action in the world, to patients' praise of the American missionaries as 'angels' (*bangelo*) who arrived from elsewhere and treated them 'non-selectively'. At the mission hospital, patients, missionaries and staff members brought to their encounters the capacity to perceive moral meaning in their relations in ways that often exceeded one another's expectations. In response to this, I outline a way of understanding the capacity, among these diverse actors, to perceive moral meaning in their ambivalent and unequal relations. This approach, I suggest, has implications for how we think about suffering, morality and politics, both in contemporary humanitarianism and in forms of anthropological writing.

Declaration

This dissertation is the result of my own work and includes nothing which is the outcome of work done in collaboration except as declared in the Preface and specified in the text.

It is not substantially the same as any that I have submitted, or, is being concurrently submitted for a degree or diploma or other qualification at the University of Cambridge or any other University or similar institution except as declared in the Preface and specified in the text. I further state that no substantial part of my dissertation has already been submitted, or, is being concurrently submitted for any such degree, diploma or other qualification at the University of Cambridge or any other University or similar institution except as declared in the Preface and specified in the text

It does not exceed the prescribed word limit for the relevant Degree Committee.

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Maps



Map 1. Zambia (with the Southern Province highlighted).¹



Map 2. The Southern Province of Zambia.²

Chapter One

Introduction: themes and overview

In 2014, an American missionary doctor, Kent Brantly, appeared on the cover of *Time* magazine as one of the ‘people of the year’ who had worked to prevent the spread of Ebola in West Africa. After being infected with Ebola himself while working in Liberia, Brantly was given an experimental drug and evacuated to the United States where he received specialist treatment and managed to survive. As the anthropologist Peter Redfield has written, at a ‘critical moment of crisis and evacuation some climb on a plane and others do not, their very existence weighed by a passport’ (2016: 223). This point was made visible in February 2017 when Salome Karwah, a Liberian nurse who had also survived Ebola and was featured in the *Time* magazine story, died from complications during childbirth. Unlike the short-term missionaries and humanitarian volunteers with whom she had worked, Karwah continued to live and work in a country with poor healthcare and a high rate of maternal mortality. Her husband claimed that staff members at the hospital had neglected her because they feared that, as a former victim of Ebola, she still posed a threat to them.³

As the Ebola outbreak attracted global attention, many analysts (anthropologists among them) identified the inadequate healthcare systems of Guinea, Liberia and Sierra Leone as one of the central problems in the spread of the disease.⁴ The president of Médecins Sans Frontières (MSF), Joanne Liu, lamented the fact that ‘ill-equipped national health authorities and volunteers from a few private aid organizations bore the brunt of the care in this epidemic’ (2015: 21).⁵ Prominent world events, such as the Ebola epidemic, make the work of these many volunteers momentarily visible and, yet, elsewhere in Africa, similar private aid organisations provide much of the day-to-day basic healthcare in many areas, dealing not with deadly epidemics but with commonplace afflictions: diarrhoea, malaria and broken limbs. Furthermore, while organisations such as MSF or the Bill and Melinda Gates Foundation (BMGF) are featured prominently in media and scholarly accounts – and even described as organisations that have ‘[redrawn] the political map of the world’ (Fassin 2012: 15) – it is American missionaries such as Kent Brantly, who worked for World Medical Mission (WMM), who are increasingly providing this kind of medical care.

American Protestant organisations involved in overseas missions donate over \$2 billion a year (Hudson Institute 2016: 37).⁶ The rise in the number of American missionaries working in Africa should be understood in relation to the domestic politics of the United States – in particular, the growth of a politically powerful evangelical Christianity alongside several pieces of federal government legislation that have strengthened religious organisations, enabling them to receive government funding for providing welfare services (see Clarke 2006; Cooper 2014; Gifford 1998).⁷ Some specialists within the world of aid have suggested that American religious organisations play a far greater role in Africa today than the United States Agency for International Development (USAID).⁸ In the view of one scholar, we are even living through ‘one of the most momentous Christianizing efforts in human history’ (Gerhardt 2010: 165).

This dissertation is an attempt to understand ethnographically this contemporary phenomenon through a study of the lives and relationships of the people who worked at, and visited, a small mission hospital in rural southern Zambia. What motivated these American citizens to go on ‘medical mission’ trips? How did Zambian professionals and patients view this ‘torrent of American do-gooders’ (Donnelly 2012: 4)? Profound inequalities have long shaped the encounters between American missionaries and those whom they have tried to ‘assist’ and ‘help’ in various ways, but what kind of relationships are possible under such circumstances today? And what are the legacies or ‘afterlives’ (McKay 2012) of missionary humanitarianism in a part of the world that has been profoundly shaped by such encounters since the nineteenth century?

Matamba Mission Hospital⁹ was founded in 1957 in the Southern Province of Zambia and since that time it has occupied a prominent position within the regional landscape of healthcare provision. In the chapters that follow, I consider how the Chitonga-speaking rural inhabitants of the area, who were seeking treatment, related to the white missionary doctors and Zambian staff who worked at the hospital. The majority of patients at Matamba Mission Hospital were born and raised in the Southern Province of Zambia. These people spoke Chitonga (although many knew other Zambian languages and some spoke English) and they walked, cycled, travelled by ox-cart or, occasionally, drove by car or motorbike to reach the hospital. They made their

way to the hospital from their homes in the surrounding rural area and suffered from a range of afflictions. These patients arrived to find Zambian nurses and clinical officers with whom they often had little in common – many staff members were raised in towns and cities, trained at medical schools in other parts of the country, and sometimes knew only a few words of Chitonga. Patients also encountered the American missionary doctors and nurses, most of whom spoke of being ‘called’ to go and help people in Africa. While most missionaries arrived with ideas and images of Africa as ‘the world capital of need’ (Malkki 2015: 206), many were also fearful and ‘needy’ themselves, suffering from anxieties about hygiene, malaria and road safety, among other things (Malkki 2015; see also Fabian 2000; Mathers 2010). In this dissertation, I consider the motivations of these long- and short-term American missionaries, their relations with Zambian staff members and patients, and the ways in which they understood the beneficial effects of their work. Finally, I examine the place of the Zambian clinical staff members at the hospital – the nurses, clinical officers, laboratory technicians, and others – as they attempted to balance their many obligations to family members, neighbours, and friends with the claims and needs of their patients, often while under the watchful scrutiny of their white missionary colleagues.

During times of affliction, the limits of certain relationships are revealed and attempts are often made to initiate new ones, even if they are short-lived. Julie Livingston has written that ‘debility’, as a condition, ‘troubles, mobilizes, and intensifies social relations’ (Livingston 2005: 3). At Matamba Mission Hospital, as we shall see, social relations were indeed troubled, mobilized and intensified every day and, in the chapters that follow, these relations are considered from the perspectives of the patients, the American missionaries, and the staff members. It is the relationships between this diverse group of people, all of whom found themselves at Matamba Mission Hospital, that form the central ‘object’ of inquiry in this dissertation and they are situated both historically and ethnographically.

Unsurprisingly, these relationships were complicated and often shaped by multiple forms of misunderstanding (Livingston 2007), yet they also involved moments of mutual support, cooperation and more profound kinds of moral recognition. As a poorly resourced rural institution in an out-of-the-way place, the mission hospital

brought together a diverse group of people from across the world who encountered one another with different moral values, expectations, and needs – all within (and often reinforcing) a context of profound material inequality. In short, the broad question addressed in this dissertation is: what kind of relationships, transient and enduring, were formed and reformed at Matamba Mission Hospital? At a time when ‘global health partnerships’ (e.g., Nicholas et al. 2011) are often framed as a ‘solution’ to problems in poor countries like Zambia, this study reveals the fraught and complicated realities of such ‘partnerships’ in a place where they have been imagined and enacted in many ways over the course of the last century.

Posing the question in this way positions this dissertation at the intersection of various literatures and debates: from the anthropology of Christianity, ethics and morality, medical anthropology, regional scholarship within African studies and humanitarianism. I begin with this last body of scholarship, on humanitarianism, as a way of introducing some of the central themes of this dissertation.

The anthropology of humanitarianism

As Barnett and Stein (2012) have observed, it would be possible to narrate a history of humanitarianism in which the decline of religion was emphasised. Such an account would point out that the aspiration of nineteenth century Christian missionaries to ‘save souls’ gradually subsided as missionaries began to collaborate with secular organisations and governments during the twentieth century. American and European Christian missionaries increasingly promoted ‘secularized international legal principles’ and human rights and, in recent decades, many Christian organisations have ‘downplayed their religious identity’ altogether (2012: 4, 5). Yet, as Barnett and Stein rightly point out, such a narrative would not only obscure the significant growth in religious humanitarian organisations in recent decades (see, e.g., Wuthnow 2009) but would also fail to account for the ‘enduring power and presence of religion’ in contemporary humanitarianism (Barnett and Stein 2012: 5). Many of the most prominent charities established after the Second World War had Christian origins: from Oxfam, Lutheran World Relief, the Church World Service, and Caritas

International to, more recently, Christian Aid, World Vision, CARE, and Catholic Relief Services (see Barnett and Weiss 2008: 23).

The term 'humanitarian' was first used to 'describe a theological position stressing the humanity of Christ' (Bornstein and Redfield 2011: 15; see also Calhoun 2008) and, as Redfield has suggested, 'contemporary humanitarianism retains a language of sacrifice and salvation' (2012: 463).¹⁰ Furthermore, as Didier Fassin has argued, many humanitarian organisations are considered to be 'above suspicion' because, in helping people who are suffering, they are engaged in a self-evidently sacred and morally praiseworthy form of activity (2011: 37). In addition to this, anthropologists have noted that biomedical interventions are often oriented around powerful Christian narratives. In her work on Ethiopian women who suffered from obstetric fistula, Anita Hannig found in media representations and local hospital projects images and narratives of 'biomedicine as a modern form of salvation' (2017: 207) that would radically transform and redeem these women's lives in a way that did not reflect the more complicated realities.¹¹

Despite some of these important similarities between formally secular and Christian organisations, there are also differences that need to be addressed. For example, in this dissertation I demonstrate that the Christian missionaries at Matamba worked with a distinctive set of ideas about 'life itself' (Rose 2007). Rebecca Marsland and Ruth Prince (2012) have shown that anthropologists 'cannot take the concept of "life itself" for granted' because, as they point out, 'It is a cultural and historical product, and one that may well look different in the varied locations in which we work' (2012: 462). Indeed, the Zambian patients, staff members and Christian missionaries who feature in the chapters that follow held different ideas about life, the needs of human beings and the meaning of suffering.

Anthropologists of humanitarianism have often pointed out the historical specificity of the idea – found among humanitarian organisations such as Médecins Sans Frontières (MSF) – that the human is 'a being who is not made to suffer' (see Redfield 2013: 41-42, 65). Contrary to this, Christian humanitarians continue to find important moral meanings in the suffering of human beings, as we shall see. For them, suffering and affliction were 'persistent qualities of a fallen world, unlikely to be completely

resolved through human action' (Schertz 2014: 6). With this in mind, it is worth considering some of the central themes of the anthropology of humanitarianism.

In recent years the anthropological literature on humanitarianism has expanded rapidly, drawing on the work and insights of scholars who have been studying transnational aid and non-governmental organisations (NGOs) since the late 1970s and 1980s.¹² In this dissertation, I engage with some of the central concerns of this work – the mobility of humanitarian workers, the 'suffering body', relations between states and humanitarian organisations, and the legacies or 'afterlives' of humanitarian assistance. At the same time, recognising the suggestion made by Miriam Ticktin that 'there has been little exploration of morality itself in the anthropology of humanitarianism' (2014: 283), I seek to bring some of the themes of this literature into conversations, within the discipline, about morality and ethics.¹³

Expatriate humanitarian workers are globally 'mobile' and typically travel across borders with greater ease than the populations who are on the receiving end of their aid. This has been explored by several anthropologists of humanitarianism. Redfield (2012) uses the metaphor of 'lightness' and 'heaviness' to understand this dynamic. The expatriate Médecins Sans Frontières (MSF) employees with whom he worked had a 'lighter' presence, compared to the Ugandan national staff whose 'heavier' set of attachments to friends and relatives shaped their work. Malkki (2015) has suggested caution here, however, arguing that anthropologists should not simply assume that humanitarian workers are necessarily worldly and cosmopolitan and that we should attend instead to their particular vulnerabilities and needs. These insights, as we will see below, inform the analysis that follows, in which I seek to identify the ways in which the American missionaries understood their own mobility and how, in turn, Zambian patients and staff related to these transient visitors who came to offer assistance.

Drawing on the work of Hannah Arendt (1958), Michel Foucault (e.g., [1963] 2003, [1977] 1991, 2008) and Giorgio Agamben (1995), a significant amount of anthropological work on humanitarianism has considered how suffering bodies are situated and valued within regimes of humanitarian care and assistance. The fact that the 'suffering body' is often 'the best and most legitimate source for claims-making and legal and political

recognition' (Ticktin 2014: 276) has been a prominent theme in the literature. Agamben's notion of 'bare life' and Foucault's conception of 'biopolitics', in particular, have strongly shaped discussions about how recipient populations are subjected to the political calculations and moral values of humanitarian organisations (see, e.g., Fassin 2009; Redfield 2005). In this dissertation, I suggest that, by considering Christian medical missionaries, we can identify how the 'suffering body' has continued to have meaning for western humanitarians (cf. Comaroff and Comaroff 1997: 68) in ways that both complement and depart from Zambian perceptions of suffering and bodily claim-making (cf. Malkki 1996).

A central concern among humanitarian organisations – and the anthropologists who have analysed their activities – has been the relationship between these organisations and the states who legally govern the territory within which they operate. As Barnett and Weiss have noted: 'Boundaries blur as aid agencies perform functions once viewed as the domain of the state and states perform functions once viewed as the domain of relief agencies' (2008: 5). One of the questions this raises is: for whom are these boundaries 'blurred'? In many places, basic services have long been provided by missionaries (or other non-state actors) and people in these areas no longer expect the state to provide for them (if they ever did). The anxiety about relationships with states, however, has long been a concern of humanitarian organisations. Redfield, for instance, notes that MSF have long been 'wary of involvement that would position its work as a substitution for what they see as [the] responsibilities of states' (2005: 338), while Barnett and Weiss observe that, for other organisations such as the Red Cross, 'politics is a moral pollutant' (2008: 4). These are themes that will be explored in what follows and they are concerns for medical missionaries themselves.

Finally, anthropologists have started to consider, more recently, the legacies or 'afterlives' of humanitarian projects. Ramah McKay (2012) has pointed out that, in Mozambique, residents who fled during the conflicts (of the 1980s and 1990s) received humanitarian assistance in refugee camps in Malawi. Today, these residents often recall nostalgically that, in these camps, food and medical assistance was plentiful. Such memories inform their criticisms of contemporary non-governmental and humanitarian organisations, who are often regarded as ungenerous and too selective. Humanitarian assistance was 'recalled as inclusive' in the past and yet 'experienced as

individualised and restrictive’ (2012: 292) in present-day Mozambique. Some organisations themselves have started to recognise the importance of thinking about the possible historical perceptions of outsiders among the ‘beneficiaries’ of their assistance (although perhaps with less historical or regional specificity than anthropological studies). For instance, the Feinstein International Famine Centre notes that,

Humanitarian action is viewed as the latest in a series of impositions of alien values, practices and lifestyles. Northern incursions into the South – from the Crusades to colonialism and beyond – have historically been perceived very differently depending on the vantage point. (Quoted in Barnett and Weiss 2008: 42-43).

The question of how the actions of contemporary missionaries are seen by Zambians today in the context of a long history of outside interventions is taken up in order to contribute to anthropological discussions about the possible meanings of humanitarian encounters for those who have been on the receiving end of them over such a long period of time. In pursuing this approach, I take seriously Jonathan Benthall’s (2012) suggestion that anthropologists need to ‘gain access to the perspective of aid recipients as well as providers’ so that analyses do not ‘remain weighted toward the donors’ side of the equation’ (2012: 372). With this in mind, I suggest, in this dissertation, a way of thinking about these relationships by considering what I call ‘moral aspect-perception’.

Moral aspect-perception

One of the central themes running throughout these chapters (and one that is theoretically elaborated in detail in Chapter Four) is the notion that patients, missionaries and staff members at the hospital were able to ‘see’ different aspects of their relationships and encounters as meaningful, in a moral sense. Much anthropological work in medical settings has drawn on the notion of ‘the gaze’ which, as Noelle Sullivan has pointed out, ‘has become . . . central [to] how scholars think through (and debate) the politics of the encounter’ (2016: 151). Foucault’s influence

here is enduring, particularly his idea of the clinic as an institution in which the biomedical gaze has produced new forms of knowledge about the body, reconfiguring and constituting the individual within biomedical discourses (e.g., Foucault [1963] 2003).

In much anthropological work, the gaze of colonial officials, state actors, or wealthy expatriates is foregrounded. In recent anthropological studies of medical volunteers in Africa, for example, patients are often presumed to be the passive objects of these touristic and clinical gazes of powerful outsiders (see, e.g., Wendland 2012). Such accounts make important points about the unequal nature of these encounters, but they arguably remain committed to what Martin Jay has called ‘the denigration of vision’ (1993). Consequently, such approaches do not always enhance our understanding of what happens in moments of seeing and perceiving.

Alice Street (2014) has demonstrated this strikingly in her study of a hospital in Papua New Guinea. Street makes two important points about the biomedical gaze in this non-western clinical setting. Firstly, the biomedical gaze is not as ‘authoritative’ or penetrative as scholars working in this Foucauldian tradition have tended to suggest. Like other anthropologists (e.g., Livingston 2012; Wendland 2010) who have worked in resource-poor hospitals, Street found that,

biomedical practices in these hospital spaces do not entail the diagnosis of an underlying disease through the exercise of an authoritative gaze so much as the development of pragmatic collaborations with medical devices, professionals, patients, relatives and experimental “tinkering” with technologies, bodies, and everyday lives in order to create solutions that people can live with. (2014: 15)

Furthermore, as Street points out, rather than being subjected to a surveilling or disciplinary gaze, many patients wished to *make themselves* visible to biomedical practitioners because they were so often ignored. Indeed, as Diana Gibson (2004) found in a hospital in South Africa, the problem for many patients is ‘precisely [that] the gaze does not permeate everywhere’ and certain patients ‘remain invisible’ (2004: 2014).

Furthermore, there is a risk of depicting wealthy expatriate clinicians as the only people whose ‘vision’ or ‘gaze’ is worth considering – overlooking the important forms of ‘seeing’ on the part of both patients and staff members (cf. Mathers 2010). While the theme of the gaze and forms of ‘seeing’ has been central to much anthropological work in clinical settings, in this dissertation I expand the scope of these Foucauldian approaches by considering how moral apprehension and evaluation took place in the hospital.

In pursuing this approach, I suggest that Wittgenstein’s notion of ‘aspect perception’ ([1953] 2001) has important implications for thinking anthropologically about humanitarianism, morality and politics. In his *Philosophical Investigations* ([1953] 2001), Wittgenstein made a distinction between what he called ‘seeing’ and ‘seeing as’. There is a difference, Wittgenstein suggested, between these two kinds of ‘seeing’. For example, being able to ‘see’ that there are two people sitting opposite you is quite different from being able to ‘see’ the likeness between those two people. This can be illustrated in a number of ways, but an example from the mission hospital (and one that will be discussed at greater length in subsequent chapters) is worth considering here.

The first kind of ‘seeing’ (or perceiving) can be quite easily described and conveyed to somebody else: ‘I can see that there are lots of patients this morning in the male ward’. The second kind of seeing requires making imaginative connections and is not necessarily easy to convey to others (who might fail to ‘see’ the same aspects of the situation). For example: ‘I can see that the patients in the male ward are strengthened by their love of God’. Wittgenstein often referred to this latter kind of ‘seeing’ as ‘seeing as’. One of Wittgenstein’s interpreters explains this in the following way: ‘Because *seeing as* involves the mastery of a technique, ability to *see as* is an accomplishment requiring imaginative skill, the lack of which is called “aspect-blindness”’ (Hester 1966: 205; emphasis mine). In Chapter Four, where I outline this approach most fully, I refer to my own ‘aspect-blindness’ when it came to ‘seeing’ God’s actions in the lives of Zambian patients in quite the same way that many of the American missionaries were able to.

This approach, furthermore, can offer a way of understanding how Zambian patients and staff members regarded the American missionaries. As I explain in more detail in Chapter Four, the notion of ‘seeing as’ does not need to imply ‘ocularcentrism’ because the verb was used by Wittgenstein as a metaphor intended to accommodate other forms of perception. Indeed, this is consistent with the Chitonga term for perceiving or understanding (*kumwva*) which is more closely associated with hearing and feeling than it is with sight and the capacity to see (*kubona*). Indeed, to be moved to feel compassion (*kumwva luse*) is more closely identified linguistically with hearing and feeling than with seeing – in contrast to the importance of ‘seeing’ and ‘witnessing’ suffering for the American Christian missionaries. This is one of the reasons why Wittgenstein’s concept of ‘aspect-perception’ is useful in this context – it does not involve privileging any single bodily faculty. But, furthermore, as Budd (1987) has pointed out, Wittgenstein’s notion of ‘aspect-perception’ is useful precisely because of ‘its irreducibility either to a purely sensory or to a purely intellectual paradigm’ (1987: 17). In other words, moral aspect-perception cannot be reduced either to moral or ethical reasoning or to a phenomenological or affect-oriented account of moral emotions and feelings. Being able to perceive certain moral aspects of relationships with others, then, is a task that involves imaginative capacities and the ability to make links between different domains of social life. Drawing on the notion of ‘aspect-perception’ and ‘aspect-blindness’ in the work of Wittgenstein and subsequent philosophers,¹⁴ I attempt to show the relevance for this in debates about humanitarianism and morality.

In the anthropology of humanitarianism, questions about how distant ‘suffering strangers’ are ‘seen’ has been a central concern (Butt 2002). However, many accounts of humanitarian workers focus on how they ‘see’ these suffering strangers in largely superficial and reductive ways. The biological condition of individuals is foreground at the expense of their social and ‘biographical’ lives (Fassin 2012: 254) and their relatives and friends are ‘erased’ altogether (see, e.g., Bornstein 2005, 2012; Malkki 2015). One of the problems of these accounts is that the perceptions of humanitarian workers are always described in terms of what ‘lack’ – they are superficial and without ‘context’ (all things which, by implication, the anthropologist him or herself is able to perceive clearly). By contrast, here I suggest a way of understanding the perceptions

of missionaries positively (i.e. not only in terms of what they 'lack' or are unable to see).

In relation to anthropological work on morality and ethics, I suggest that aspect perception can offer a further way of understanding how people come to morally perceive their relationships and encounters with others in such different ways. If, as James Laidlaw (2014) has suggested, 'everyday conduct is constitutively pervaded by reflective evaluation' (2014: 44), then we might wish to consider how people's forms of reflective evaluation are shaped by their acquired perceptual capacities for noticing salient aspects of the social situations and relationships within which they find themselves. Furthermore, I think this has implications for anthropological understandings of 'politics', something which I will outline in the next section in which I briefly introduce the basic argument of the dissertation.

Overview of the argument

The long- and short-term American Christian missionaries who visited Matamba Mission Hospital did not proselytise directly. These missionaries were not 'healing bodies' in order to 'save souls' (see Hardiman 2006). For many missionaries, their vocation in Zambia was not about overt preaching and conversion, but was oriented towards a personal relationship with God, discipline in life, hard work, and attending to the needs of their Zambian patients. This is not unusual in the history of missionary work. Megan Vaughan (1991) noted – in her well-known study of colonial medicine – that missionaries rarely had the time to evangelise as they worked in clinics and hospitals. T. O. Beidelman (1982) suggested that, among the historical aims of missionaries,

Saving souls is only one such aim. Missionary work may also be an act of service and love in helping the poor and suffering. Good acts contribute to God's glory; even though no one is converted, the act of evangelism shows faith . . . [and] serves as penance. (1982: 18)

Rather than only seeking to convert, medical missionaries have also often seen themselves as people who are '[carrying] on the work of Christ Himself' (Ranger 1981: 262). This idea is encapsulated in the account of a medical missionary who, upon being posted to colonial Tanzania in the early twentieth century, asked his Bishop how he could best help to 'spread the Gospel'. To this, the Bishop said: 'A mission carpenter spreads the Gospel by being a good carpenter . . . just be a good doctor' (quoted in Jennings 2008: 42).

The idea that overt proselytizing is not central to the missionary enterprise is much closer to the view taken by present-day American missionaries in Zambia (see also Hefferan and Fogarty 2010: 6). When they did speculate on the influence they might have on Zambians, the missionaries suggested that patients and staff members might come to 'see' the influence of Jesus on their conduct (cf. Bornstein 2005 on 'lifestyle evangelism'). These American missionaries worked long hours at the mission hospital and, outside of their work, they lived lives of seclusion and relative material comfort.

When missionaries imagined that they might, through their actions, be instantiating a model of how to live a Christian life that could inspire Zambians to emulate their conduct, they were mistaken in several ways. Firstly, as I argue in Chapter Two, Zambian patients praised the missionaries precisely because their conduct was so extraordinary. Patients saw the missionary doctors as benevolent outsiders who treated them 'non-selectively' and with careful consideration, something that was uncommon in the clinics and hospitals of rural Zambia. In this sense, patients did not regard the missionaries as exemplary Christians whose conduct they might have wished to emulate, rather they felt that the missionaries were transient and benevolent visitors who remained enduringly outside of local relations. Indeed, the Christian lives of the missionaries would have been 'impossible' for them to emulate (cf. Robbins 2004), not only because missionary lives would have been unachievable in material terms (because they required a considerable amount of wealth, by local standards, to sustain), but also because they would have been unlivable due to the 'existential obligations' (Englund 2008) and relations of 'dependence' (Ferguson 2013, 2015) that shaped ordinary Zambian lives and relationships. Indeed, these aspects of the social lives of Zambians often remained 'unseen' by the missionaries, whose experiences were largely confined to the hospital.

Secondly, as Chapter Five considers, the Zambian staff members at Matamba Mission Hospital did not regard the American missionaries as exemplary Christians. Staff members had multiple obligations and responsibilities to patients who were often also their neighbours, relatives and friends and whose goodwill they needed to cultivate and maintain over time. Staff members therefore tended to privilege such patients over those from more remote rural areas, whom they did not know. As I show, staff members regarded patients they knew as worthy of attention and care and, by contrast, they often failed to see the rural patients from more remote areas (with whom they had no prior relations) as people who were worth their time and concern. Such conduct was severely criticized by the missionaries and, in turn, staff members came to regard the missionaries as outsiders who were unsympathetic to their demanding social lives, who expected too much of them and who dealt with them inconsiderately.

These different moral perceptions are outlined and contextualized in the chapters that follow. Chapters Three and Four outline the ways in which the American Christian missionaries were able to perceive moral meaning in their encounters with Zambian patients – for instance, in regarding Zambian bodies as substitutes for the body of Christ and seeing, in the ability of patients to endure suffering, the work of God as he gave strength to these Zambians. The arrival of missionaries has always been perceived and understood in multiple ways – and their actions have been meaningful to local populations in ways that remained perpetually outside of the control of missionaries, often exceeding or contradicting their original ambitions altogether. This is a classic theme in the anthropological study of missionaries (e.g., Beidelman 1982; Comaroff and Comaroff 1991, 1997; Huber 1988; Hunt 1999; Keane 2007; Pels 1999) and here I suggest a new way of thinking about these encounters in relation to debates about morality, ethics and humanitarianism.

In order to understand the relations at Matamba Mission Hospital, this dissertation locates European and North American medical missionaries within the long history of biomedical treatment in the region. Instead of simply positioning contemporary missionaries within the context of the rise of transnational charities and NGOs – who are often assumed to ‘provide services and welfare that used to be provided by the state’ (Freeman 2012: 24; cf. Comaroff 2009) – I point out, in Chapter Three, that the

activities of missionaries both predate, and intersect with, the more recent history of non-governmental and humanitarian interventions. This is important because many missionaries have, over the years, managed to retain their own distinctive ‘moral ambitions’ (Elisha 2011) and relative autonomy in relation to the Zambian colonial and post-colonial governments. Scholars of ‘public health’ in Africa have correctly observed that missionary medical services rarely stretched ‘beyond a particular locality’ and contributed to the ‘patchy and inadequate’ health services that were available (Prince 2014: 5). Nevertheless, among the array of short-term global health initiatives and NGO projects in the region, Matamba Mission Hospital has had an abiding presence within the domain of health provision and it is important to consider these so-called ‘public-private partnerships’ within a longer historical frame (cf. Geissler 2015).

Based on the approach taken in the dissertation and many of the cases that are considered, in Chapter Six I conclude by outlining a way of thinking about politics which draws on the concept of ‘aspect perception’ that is advanced throughout the chapters. In the anthropological literature on medical humanitarianism and global health, a number of strong arguments are made about politics. Indeed, some works of anthropology in the field are directly intended to be political interventions of a particular kind. In this context, I am thinking of the well-known work of anthropologists such as Paul Farmer (1999, 2004a, 2004b), João Biehl (2005), Nancy Scheper-Hughes (1993, 1995, 2002), and Didier Fassin (2007, 2009, 2012), among others. These anthropologists have what Fassin has called ‘a political view of anthropology’ (2007: xxii) and engage in what Scheper-Hughes’s describes as ‘a politically committed’ anthropology (1995: 410).

I consider many of the criticisms of this style of anthropology: the problem that many of these writers invoke political categories (such as ‘neoliberalism’) in order to explain ethnographic realities (Eriksen et al. 2015; Ferguson 2009; Laidlaw 2014); the charge of ethnographic superficiality and a lack of cultural contextualisation in some of this work (Robbins 2013); and the criticism that many of these anthropologists find ‘politics’ and ‘the political’ everywhere, even when the people with whom they work tend to describe their own lives in altogether different terms or perhaps disavow the category of ‘politics’ altogether (Candea 2011). Taking these criticisms seriously –

although regarding some as more significant than others – I outline a way in which anthropologists might, if they wish to, engage in a more self-aware and intellectually persuasive form of politically oriented anthropology.

In the rest of this introductory chapter, I give an account of the many people who encountered one another at Matamba Mission Hospital and describe where they lived, travelled from, and why many of them wished to visit or work at the hospital. I suggest a way of thinking, methodologically, about the hospital as a ‘social situation’ of a certain kind, attempting to bring together an older tradition of anthropological analysis (e.g., Gluckman 1940; Evens and Handelman 2006) with more recent work on how hospital spaces are ‘made up’ (Street and Coleman 2012). After this, I present a general outline of the chapters. Finally, I describe my entry into the field and discuss how the research was carried out. Before all of this, however, it is important to consider the distinctive regional history of southern Zambia, the location of Matamba Mission Hospital within this history, and the role that missionaries have played in the provision of biomedical treatment.

The ever-present ‘project’ from external agents: a history of the Southern Province of Zambia

The people of the Southern Province of Zambia have been written about extensively by anthropologists over the course of the twentieth and twenty-first centuries. From the two-volume study by the missionary anthropologists Edwin Smith and Andrew Dale (1920), to the longitudinal work of the anthropologist Elizabeth Colson,¹⁵ who was associated with the work of the Rhodes-Livingstone Institute (RLI) and the ‘Manchester School’ (see Werbner 1984; Schumaker 2001), to the more recent scholarship of anthropologists such as Lisa Cliggett (2003, 2005) and Thomas Kirsch (2004, 2008). The long-term research of these anthropologists (and scholars from cognate disciplines) provides valuable and detailed historical insights into life in the region, as will be seen in the use that is made of their work in what follows.

When the first white European explorers, missionaries, and prospectors arrived in pre-colonial southern Zambia, during the second half of the nineteenth-century, the people whom they encountered lived in small dispersed homesteads without any significant degree of centralised political authority. They were living through a period of ‘great political uncertainty’ (Holy 1975: x) at this time because raiders from the neighbouring Ndebele and Lozi states regularly stole their crops and cattle and took many people as slaves. Memories of these attacks were recalled for many years afterwards. In the 1940s, women could still remember that they used to space their pregnancies, waiting until their first child could run on his or her own to avoid having to carry several children as they fled (Colson 1958: 155). As late as the 1970s, an elderly man named Johannes Nyimba recalled that, ‘I was born in the forest while my mother was running away from the Matabele [Ndebele]’ (quoted in Vickery 1986: 16).

Missionaries who encountered such episodes of violence often described them dramatically in their subsequent writing in order to strengthen their arguments about the need for humanitarian intervention in central Africa.¹⁶ Some of the first European accounts of the Chitonga-speaking people of the area described them as peaceful and long-suffering victims of slavery and violence. As the Scottish missionary Charles Livingstone – the younger brother of David – recorded in the 1860s:

The people were driven out of this choicest portion of their noble country . . . Many were killed, and the survivors, robbed of their cattle, fled to the banks of the Zambezi . . . We travelled from Monday morning until late on Saturday afternoon . . . to within 20 miles of Mosi oa Tunya without meeting a single person, though constantly passing the ruined site of Batoka villages.¹⁷

Despite acquiring a reputation for being ‘mild’ and ‘docile’ by the British colonial administration (Dixon-Fyle 1977b; Vickery 2007: 84), it is worth noting that the people of the area never submitted to the political authority of their Ndebele and Lozi neighbours and regarded them enduringly ‘rather as enemies than lords’ (Holy 1975: x).

The first Europeans to settle permanently in the region were agents of the British South Africa Company (BSAC), who governed from the 1890s until 1924, when the

British colonial office began to rule the territory. In many cases these Europeans were initially regarded by the people of the area as a less volatile presence and were favourably compared with the aggressive Ndebele and Lozi raiders of former years (Colson 1962: 22).¹⁸ These newly arrived Europeans, however, were soon to implement profoundly unpopular policies in the decades that followed. When Elizabeth Colson first arrived in the area in 1946, she found that local people were deeply unhappy about the effects of various colonial policies, many of which are still recalled with bitterness to this day.

In their attempt to stimulate labour migration and encourage people to participate in the emerging regional economic system, the BSAC introduced taxation in 1901. When they sent company administrators to collect this new 'hut tax', people in many areas refused to pay. This often occurred in areas where people had managed to avoid giving tribute to the Lozi and they saw the new hut tax in these terms. For these people, the European presence was continuous with the precolonial era and they wished to avoid such demands (Vickery 1986).

Discontent coalesced, more profoundly, around an even more unpopular colonial policy: that of moving local people from their land and resettling them in 'native reserves' so that the most fertile land (and the land closest to the newly built railway line) could be given to white settler farmers as so-called 'Crown Land'. When local people were evicted from their homes by company officials, during the years of 1918-1921, there were reports of 'the wholesale burning of entire villages, destruction of crops and floggings' (Vickery 1986: 124). This period of land expropriation, in the view of some scholars, left a 'deep and lasting impression on the minds of many Tonga' (Vickery 1986: 124). Others have suggested that this was a crucial moment in the formation of anti-colonial sentiments that persisted until independence (Dixon-Fyle 1977a; Macola 2011).

Despite these experiences of land alienation and colonial violence, many farmers nevertheless became highly successful in subsequent years. A number of circumstances were important: the introduction of the plough greatly increased productivity; the demand for food in the new urban mining centres produced a strong market for maize; and the building of a railway line through the province reduced

transportation costs. These circumstances contributed to the emergence, by the mid-1930s, of a successful group of farmers who were able to sell their maize for a profit and began to out-compete the white settler farmers. By the 1930s the Southern Province was far more economically self-sufficient than other regions and the number of men migrating to seek work elsewhere was 'among the very lowest in south central Africa' (Vickery 1986: 177).¹⁹ This was unusual in the context of a regional political economy that was strongly shaped by migrant labour, following the establishment of mines in South Africa, Southern Rhodesia and, in subsequent years, the Katanga region of the Belgian Congo and the Copperbelt of Northern Rhodesia.²⁰

The success of these farmers did not go unpunished. In 1935, under pressure from white settlers, the government introduced the Maize Control Ordinance which allowed them to purchase the maize of white farmers at a higher price than the produce of African farmers. In the words of one (remarkably honest) official from the Colonial Office, the aim was to 'rig' the market 'so as to keep in production a body of white farmers who if exposed to the full blast of native competition would disappear' (quoted in Vickery 1986: 210). Colson recalled some Zambian farmers responded to this overt discrimination with dismay and, at times, humour, asking her: 'Is our grain more bitter than theirs?' (1967: 95).

After these experiences, among many people in the area, 'attitudes toward European settlers, and toward development projects [were] all coloured by . . . suspicion and fear' (Colson 1958: 6-7). Indeed, according to Colson, even after personal relationships were relatively well-established many people remained wary of white settlers.

The suspicion may continue even through long years of association with particular Europeans who deal fairly with them, for it is axiomatic that it is difficult to understand the behaviour of Europeans, who do not obey the ordinary rules that pertain to human beings. In turn, there is a feeling that there is no need to observe the usual standards of morality in dealing with Europeans. (1958: 267-268)

These moral attitudes towards white Europeans (and Americans) remained important in the region throughout the twentieth-century and will be important in subsequent

chapters of this dissertation. The people of the Southern Province have been subjected to a number of colonial and post-colonial projects which continue to influence the discussions and lived experiences of the inhabitants of the province.²¹ Indeed, it has even been said that the ‘identity’ of the people of the Southern Province has been shaped by ‘the ever-present “project” from external agents’ (Cliggett, Bond and Siamwiza 2013: xxvi). Among these, are the projects of the many Christian missionaries who began to arrive in large numbers at the turn of the twentieth century.

The arrival of the missionaries

European missionaries had attempted, without much success, to settle in southern and central Africa from the mid-nineteenth century onwards.²² It was at the turn of the twentieth century, after the BSAC could claim to have secured the territory, that European and American missionaries started to arrive in the region in far greater numbers. The Jesuits and Seventh-Day Adventists (SDAs) were the first denominations to arrive in the area of present-day Southern Province in 1905, in close and confrontational proximity to one another. The Catholic church and the SDA church remain central today within the Christian landscape of the province, alongside the more recent efflorescence of various charismatic and Pentecostal congregations (Colson 2006; Kirsch 2008).

Matamba Mission Hospital was established later on in the century by Protestant missionaries from the Pilgrim Holiness Church. Founded in 1897 in Ohio in the United States during the Methodist ‘holiness revival’ movement, the Pilgrim Holiness Church strongly emphasised evangelising through missionary work, both at home and abroad (Dieter 1996).²³ As the historian Kenneth Cracknell (2010) has suggested, for many Methodist missionaries, salvation was ‘not only [about] the transformation of individuals, but actively changing the conditions in which people live’; this is why ‘Wesleyan-based missiologies have usually focused on social issues . . . [such as] the provision of clinics and hospitals in Africa’ (2010: 260-261). Indeed, soon after its formation, the Pilgrim Holiness church began sending missionaries to Africa.

The first Pilgrim Holiness missionary, Rev. William Hurst, arrived in South Africa in 1904 where he established a church in Cape Town. From this base, the church gained permission in 1930 to set up a mission station in colonial Zambia (Naali 2003: 27) and yet, arriving in the territory, the first Pilgrim Holiness missionaries found themselves in 'the middle of a fierce denominational battle-ground' (Snelson 1974: 183). By this time, several other churches (the Wesleyan Methodist Missionary Society, the Anglicans, the Church of Christ, and the Brethren-in-Christ) had joined the Jesuits and the SDAs and were competing for the most sought after locations in the province (Snelson 1974: 183). Of these missionary societies, the Pilgrim Holiness missionaries had far more in common – both socially and theologically – with the Brethren-in-Christ missionaries who were American Anabaptists whose church was also formed during the holiness revival movement.

By the late 1930s, the Pilgrim Holiness missionaries had established six schools and were receiving 'grants-in-aid' from the colonial government (Snelson 1974: 183). In 1957, Matamba Mission hospital was built as a small clinic, which was then upgraded to the status of a hospital in 1985 (Naali 2003: 79). The hospital has been operating in the Southern Province ever since, under the leadership of different American missionary doctors in cooperation with the Zambian government and the national Pilgrim Holiness church.²⁴

The place of missionaries within the historical development of Zambia's healthcare system is described more fully in Chapter Three, where I discuss how the long-term engagement of missionaries in the country has shaped their moral and political visions considerably. Despite this, it is worth outlining a few aspects of the history of the healthcare system here. When the British Colonial Office started to govern Northern Rhodesia in 1924, there were 11 mission-run hospitals and 37 dispensaries in the whole of the country that provided for the rural population and, at this time, there were 10 government hospitals (Henkel 1989: 147). By 1938, over 65 percent of available biomedical treatment in colonial Zambia was provided by missionaries and yet, as many missionaries often complained, they received from the government around 5 percent of the Health Department's budget.²⁵ After the Second World War, the British government started to invest more in colonial education and health and began a period of introducing 'welfare' programmes in Africa. Megan Vaughan has suggested

that it was during this period of post-war development that ‘the distinction between missionary and secular colonial medicine was being eroded’:

Mission hospitals grew larger and more impersonal, and the medical treatment they offered more technical. Colonial medical departments meanwhile became somewhat better funded and, in their new interventionist mood, colonial administrations began to intrude on areas of African life which had previously been regarded as missionary territory (1991: 74-75; see also Stuart 2011: 193).

It is broadly accurate to suggest that mission hospitals became gradually absorbed within the emerging colonial and post-colonial African healthcare systems of many countries in the region. However, as John Iliffe has written, ‘independent Africa was to inherit a welfare system of baffling fragmentation and complexity’ (1987: 193) and it is worth pointing out that the incorporation of mission-owned hospitals and clinics was very uneven and many mission hospitals managed to retain a great deal of autonomy throughout this period. Matamba Mission Hospital, as Chapter Three shows in more detail, was one such hospital.

The situation today

From the 1980s onwards, as many scholars who have worked in Zambia have recorded, dramatic economic decline has adversely affected the lives of the majority of ordinary Zambians (e.g., Colson 2007; Cliggett 2005; Ferguson 1999; Fraser 2010; Hansen 2000). In the years following the economic downturn and despite the promises of ‘multi-party democracy’ – which saw the election of the evangelical Christian, Frederick Chiluba, in 1991 and put an end to Kenneth Kaunda’s 27 years of leadership – the people of the Southern Province have experienced many hardships. The World Bank and the International Monetary Fund (IMF) attached conditions to the loans taken out by the Zambian government, known as ‘structural-adjustment programmes’ (SAPs) which required the introduction of ‘user fees’ to hospitals (Rakner 2003; cf. Pfeiffer and Chapman 2010).²⁶

Zambia's economic problems were detrimental to rural healthcare. During this period, however, the lack of government spending was often 'less evident in church-run facilities'. As one observer noted during the late 1980s:

Supply difficulties which occur can more easily be overcome by using the close contacts which the churches often still maintain with overseas partner organisations. The personnel situation is also easier in church-run institutions, since doctors from Europe or America are often recruited . . . mission doctors . . . are prepared to work in poor and remote regions . . . [and] Church-run medical facilities are now so much better that patients are prepared to cover great distances to be treated in a mission hospital, often passing government hospitals on their way. (Henkel 1989: 152)

In the post-1980s context, as many have noted, international aid organisations have often viewed NGOs 'as more transparent . . . [and] less weighed down by bureaucracy and corruption' than African governments (Prince 2014: 25).

It was at this point, when medical services were stretched and access to drugs was limited, that the epidemic of HIV/AIDS emerged (Cliggett, Bond and Siamwiza 2013; Colson 2010).²⁷ Since the time of economic decline and HIV/AIDS, many people in the region have become accustomed to the presence of NGOs and charities, who provide a range of services and short-term interventions, particularly in the areas of HIV/AIDS, nutrition, and child and maternal health. Emboldened by the declaration of Zambia as a 'Christian Nation' by the newly elected President Chiluba, increasing numbers of American missionaries began to arrive in Zambia from the late 1980s onwards (Gifford 1998: 231; Phiri 2003: 409).²⁸

This brief historical overview raises certain themes that will be important in the chapters that follow. For example, the historical legacies of the relations between the Chitonga-speaking people of the area and white people (*bakuwa*, singular, *mukuwa*) remain important for understanding the relationships at the hospital in more recent times. As Chapter Two shows, the white missionaries who visited and worked at the mission hospital in 2014 to 2015 were still regarded as people who did not quite 'obey the ordinary rules that pertain to human beings' or 'the usual standards of morality'

(to return to Colson's words, as cited above). Furthermore, as this historical context indicates, it should not be surprising to find that, in the Southern Province, as anthropologists have noted in other contexts, 'people are more concerned with accessing resources made available by NGOs than with agitating for their rights in relation to the state' (Prince 2014: 30; cf. Bornstein 2005: 137-139). This is perhaps all the more understandable in a context in which relations between the people of the Southern Province and the state have never been straightforward and many have often felt hostile towards centralised political authority. Whether or not these sentiments can be traced back to the events of the nineteenth century (or even before), they certainly found expression in the anti-colonial politics of the Southern Province in which political leaders – such as the Harry Mwaanga Nkumbula – advocated, among other things, 'a weak state' (Macola 2011: 117). In the next section, we can turn to the contemporary social life of Matamba Mission Hospital in order to situate more fully the lives of the people who encountered one another and worked together at Matamba Mission Hospital.

Ethnographic overview: the lives of patients, missionaries and staff members at Matamba Mission Hospital

Visiting Matamba Mission Hospital

During the year of 2014 to 2015, thousands of people travelled to Matamba Mission Hospital. They came from many places and arrived with different expectations and needs. Some arrived alone, others with family members, friends, or neighbours. The majority were Zambians from the surrounding rural area, seeking treatment for a number of complaints – broken limbs, tuberculosis, malaria, complications associated with pregnancy, HIV/AIDS-related illnesses, and many others. Of these people, most visited the mission hospital after first seeking other forms of treatment: they might have asked a local pastor to pray for them with the laying on of hands (*kupailila*); they might have spoken to the health volunteer workers in their area; or they might have

visited their local herbalist, healer or diviner (*mung'anga*). These visitors had mostly travelled from poor areas where the majority of the population grew maize on a small scale, alongside other crops such as ground nuts, sweet potatoes and sunflowers, sometimes selling any surplus if the rains had been good and the harvest plentiful.²⁹

Although they constituted the majority, these rural Zambians were not the only visitors to the mission hospital. Some lived in the local town of Matamba (and the surrounding compounds) and were, on the whole, noticeably wealthier than most rural patients. Many of these people had access to electricity, lived in houses with iron corrugated roofs, and sometimes owned vehicles (such as cars or motorbikes). They typically dressed in a more self-consciously fashionable style than their rural counterparts, even if they largely wore second-hand clothing (*salaula*).³⁰ Some of these people worked in local shops or at one of the market stalls. Many of the residents of the town were friends or relatives of Zambian staff members at the hospital and therefore in the advantageous position of being connected to one (or more) wage earners. Aside from these visitors, there were more opportunistic arrivals, such as long-haul truck drivers making their way southwards from the Copperbelt, government officials driving past who wanted medication, or sometimes NGO workers in expensive vehicles who stopped with minor complaints.

These were the people who sought treatment at the hospital for their afflictions. However, a further group of people travelled to the hospital during this year. These were the American Christians who visited Matamba Mission Hospital on short-term mission trips and who travelled from various locations across the United States, including Pennsylvania, Texas, Georgia, California, and New York, among other states. Among these visitors were midwives, surgeons, anaesthesiologists, nurses, and paediatricians and they varied in experience from the newly qualified to the semi-retired. Some of these missionaries stayed for less than two weeks, others for as long as six months. Their prior experience of missionary work and their reasons for going to Matamba Mission Hospital were varied. A few people arrived with a desire to preach and proselytise and were therefore surprised, if not disappointed, to find an abundance of local Christian churches and no discernable shortage of preachers. The majority arrived, however, with a sense that they were *personally* called to Matamba Mission Hospital after reflecting on the decision and praying to God, sometimes over

the course of many years. A lot of these people came to think that if they were to have an effect on people in Zambia, it would be indirectly (by demonstrating how the love of Christ had transformed their lives) rather than through evangelising explicitly (cf. Bornstein 2005). Alongside these visitors to the hospital, were those who had lived and worked there for many years.

Working at Matamba Mission Hospital

The largest group who worked at the mission hospital were the Zambian staff members. There were around 50 members of staff who were graduates of medical training schools. This included the nurses, midwives, laboratory technicians, and the hospital's single pharmacist. In addition to the clinical staff were 35 members of staff known as 'daily employees' and who performed various jobs, including the security guards, the kitchen staff, and several cleaners. In Zambia, healthcare work has been historically highly divided by gender and Matamba Mission reflected this dynamic. Research from 2006 found that 65 percent of health workers in Zambia were women. When this was broken down further, 85 percent of nurses and midwives were women, while just over 80 percent of clinical officers were men (WHO 2010: 31). During 2014 to 2015, there were 5 male nurses, not a single male midwife and none of the clinical officers was a woman. Of the 'daily employees', all were men, with the exception of one woman who worked in the kitchen (alongside a male colleague).

Clinical staff were educated to a high level and many of them came from outside of the Southern Province (a large number, for instance, were from the Copperbelt and Northern Province, making Chibemba a commonly spoken language). The majority of the daily employees, by contrast, were not typically educated beyond primary school level if they had been to school. While many of the daily employees were pleased to have their jobs and regarded themselves as fortunate (in a context of widespread and chronic unemployment), many of the clinical staff, particularly those from outside of the Southern Province, occasionally expressed dissatisfaction with their position. For them, Matamba was a 'village' and they longed to be located in the capital city, Lusaka, or in one of the major Copperbelt cities (cf. Langwick 2011: 30). Most of the nurses and clinical officers lived in subsidised accommodation behind the

hospital which had electricity and running water, while the daily employees lived in the town and surrounding compounds.

In addition to the permanent Zambian staff, were the long-term American missionary couple, Tom and Hannah, who were in their twelfth year of working at Matamba in 2015. They lived within a self-contained compound in Matamba town, a short walk away from the hospital. All of the visiting missionaries also stayed within this compound, in a separate house. Tom and Hannah had worked in the United States for several years after their marriage, in family medicine and internal (also known as general) medicine, respectively, before they decided to become 'career' missionaries and move to Zambia. Dr Tom had worked at Matamba Mission hospital as a medical student in the 1990s and had always wished to return (as Chapter Three discusses in greater length). Finally, the most senior Zambian member of staff was the District Medical Officer (DMO) who occupied a position of authority in relation to the missionaries and who influenced my fieldwork (as I will explain later in this introduction). With this broad outline of the people who visited and worked at Matamba Mission Hospital in place, it is possible to turn now to the question of how, anthropologically, these relationships can be analysed and located within the mission hospital itself as an institution.

The mission hospital as a 'social situation'

Hospitals have historically attracted more interest from sociologists than social anthropologists. Some anthropologists have suggested this is because hospitals have long been regarded as 'too near and familiar' (Long, Hunter and van der Geest 2008: 71).³¹ Early ethnographic work in hospital settings was influenced by scholars concerned with western European and North American contexts (e.g., Foucault [1963] 2003; Goffman 1961; Parsons 1951) and, consequently, the clinic and the hospital have often been imagined as places 'cut off' from the rest of society. In the words of the sociologist Stanley King, the hospital is 'unique as a way of life . . . The round of life, the customs, the relationships between people . . . warrant consideration as a unique subculture' (1962: 399). In recent years, anthropologists have questioned the idea that the hospital is a 'total institution' (Goffman 1961) or a 'tight little island' (Cosser 1962) to

be contrasted with the 'outside' world. Indeed, some anthropologists have reversed this assumption entirely by suggesting that hospitals are places in which 'the core values and beliefs of a culture come into view' (van der Geest and Finkler 2004: 1996; emphasis removed).

A number of anthropologists in recent years have started to think more about hospitals as sites of ethnographic investigation, particularly in Africa.³² In a recent discussion, Street and Coleman (2012) suggest moving beyond the contrast between hospitals as either insulated from the 'outside' world or deeply connected to it. As they point out, hospitals are 'simultaneously bounded and permeable' and a more sophisticated and ethnographically open-ended question to pose is therefore: 'how are hospital spaces made up?' (2012: 5, 6). Rather than deciding whether or not (or to what extent) the hospital is a bounded or permeable space, the real task is to describe how it is assembled (cf. Latour 2005).

Attempts to understand hospital spaces in this way have shown, firstly, that they are made up of multiple 'layers', as Street (2012) points out in her work on a government hospital in Papua New Guinea. Built during the colonial period, many hospitals are then 'repeatedly modified, redesigned, and added to by successive national governments and donor parties' (Street 2012: 45). In addition to this, certain areas within single hospitals, as Sullivan (2012) has shown in her work in Tanzania, are more 'global' (such as donor-funded HIV-AIDS clinics) while others are more 'local' (such as government-built out-patient departments). Even within single hospitals, then, the uneven dispersal of biomedical technologies, equipment and trained practitioners may be highly unequal and reveal the traces of the historical constitution of the hospital space itself over time.

Even if hospital spaces are made up in multiple ways that can be described by the anthropologist, it is a different question to ask how these spaces are experienced and imagined by the different people who inhabit them. In other words, Latour's (2005) methodological injunction to describe how such institutions are assembled (rather than invoking some form of background explanatory concept or framework within which to situate an ethnographic case study) may well be sound advice, however, the people with whom anthropologists work have their own views. People make

judgements about these spaces by inhabiting them (and describing them) in various ways, entirely independently of the anthropologist's description of how such spaces are 'made up' (cf. Laidlaw 2010, 2014).

Matamba Mission Hospital was 'made up' and experienced in different ways by patients, staff members, and expatriate missionaries, as we will see in each of the chapters. Patients and their relatives, for example, were often far away from their homes and had usually travelled long distances. Their experiences of the hospital were shaped by a different set of needs, expectations and encounters. Many patients, for example, had to find somewhere to stay in the local town (if they were not admitted to one of the wards). These people sat within the hospital grounds to cook and to socialise. Some of the women who visited stayed within the 'mother's shelter' (a building for expectant mothers behind the main hospital buildings). People attending to their sick relatives sometimes came to occupy areas of the hospital as domestic spaces of a certain kind (cf. Brown 2012). By contrast, for many of the missionaries, the hospital was far closer to the 'tight little island' image of twentieth century sociology. The missionaries travelled a short distance from the mission compound nearby to get to the hospital and much of the surrounding area was not visible to them. For the staff members, many of whom had houses nearby to the hospital and relatives who worked in the town, the hospital was, as Chapter Five shows in more detail, often both permeable and continuous with their everyday social lives and relationships. It is important to recognise, then, that the hospital space was inhabited, constituted and imagined in remarkably different ways and the aim here is to describe how the hospital was made up in multiple, overlapping ways.

It is worth pointing out, furthermore, the affinity between some of these recent approaches to understanding hospital spaces and an older tradition of anthropological thinking about 'social situations', pioneered by anthropologists who worked in colonial Zambia and neighbouring countries during the mid-twentieth century (see Evens and Handelman 2006). Given that some of these anthropologists were interested in understanding the relations between white settler and African populations, it is worth recalling certain aspects of their work that remain relevant today.

Despite the common suggestion that anthropologists of this period failed to attend to the politics of colonialism in their work (e.g., Asad 1973; Clifford and Marcus 1986), there are several studies of the period in which white settlers (farmers, missionaries, colonial administrators) featured prominently. An early example can be found in Monica Wilson's ([1936] 1961) work, in which she interpreted the arrangement of social life among the Mpondo men and women among whom she worked in South Africa as a 'reaction to conquest', as the title of her book had it (see also Bank and Bank 2013). One of the most well-known examples in anthropology, however, is surely Max Gluckman's famous essay on the opening of a bridge in Zululand (1940).

Unusually for the time, Gluckman narrated his own experiences over the course of a single day in which he attended a ceremony within the territory of Zululand. The many actors involved in the ceremony are described in Gluckman's account, from the Zulu chief and the colonial government officials, to the local men who built the bridge, as well as the Christian missionaries in attendance. Gluckman considered their different motivations for attending and the way in which their relationships and relative status positions could be identified through the unfolding process of the ceremony. Gluckman wanted to show how white Europeans and Africans, in 1930s South Africa, were part of a single 'community'. Rather than treating Africans as isolated, self-contained or 'tribal', Gluckman saw the need to consider Africans and Europeans alongside one another:

That Zulu and Europeans could co-operate in the celebration at the bridge shows that they form together a community with specific modes of behaviour to one another. Only by insisting on this point can one begin to understand the behaviour of the people as I have described it (1940: 10).

Gluckman's essay, as many have noted (e.g., Cocks 2001; Schumaker 2001), was at once a criticism of segregation in South Africa and a denunciation of Malinowski's notion of 'culture contact' in Africa. Here Gluckman may have employed a notion of 'community' that raises further questions about the assumed scale of analysis. As Bruce Kapferer (2006) points out, however, as the method of 'situational analysis' developed, it became one in which '[t]he idea of the situation can be conceived as a kind of net that the analyst casts over complexity, thereby bringing together a diversity

of dynamics and different processes without asserting that in reality they constitute an integrated unity' (2006: 126; cf. Candea 2011).³³

The anthropological critique of the idea that people are naturally 'rooted' to one place (e.g., Gupta and Ferguson 1997; Malkki 1992), alongside the emergence of anthropological studies of 'globalisation' and transnational organisations, gave rise to the use of 'multi-sited' methods (Marcus 1995), particularly in studies of NGOs and humanitarian organisations. Erica Bornstein (2005: 39) writes of how 'the trajectory of research' led her in various directions across space and time as she followed her 'object' of inquiry (namely, Christian NGOs) from America to Zimbabwe. In opposition to this, the suggestion here is that the more methodologically 'ascetic' (Candea 2007) approach of thinking about bounded social situations and demarcating a limited space of inquiry might have much to offer to studies of humanitarianism, which have so often been 'multi-sited'. Indeed, Jonathan Benthall has recently pointed out that anthropologists need to 'gain access to the perspective of aid recipients as well as providers' so that our analyses do not 'remain weighted toward the donors' side of the equation' (2012: 372; see also Barnett and Weiss 2008: 47) and one way of pursuing this method is to engage in situational analysis.

Furthermore, it is important to attempt to understand the interactions between foreign professionals and the populations with whom these expatriates work from multiple perspectives, both historical and ethnographic. Indeed, if the hospital is 'made up' and experienced in several ways, locating these experiences within the idea of 'the situation', as an historically dynamic and open-ended process, offers one way of reaffirming this regional tradition of anthropological work in relation to more recent developments (Englund 2008: 44). The idea of a 'social situation', furthermore, need not be a single 'event' or 'case'. As Gluckman himself suggested, a single case is 'obviously but an incident in a long process of social relations, with its roots deep in the past' ([1961] 2006: 18). Thinking in these terms, I try and offer an account of the perspectives of each of the groups who found themselves at the hospital. With this in mind, it is possible to consider the chapters in turn and identify the central arguments that they advance.

Outline of the chapters

The Zambian patients at the mission hospital: relations of dependence and detachment

The experiences of the patients who arrived at the hospital are foregrounded in Chapter Two. A large amount of anthropological work has explored how people navigate complicated landscapes of healing in urban and rural Africa.³⁴ This literature – and the equally large body of historical work on the effects of colonial biomedicine³⁵ – has shown how, in a number of different circumstances, African populations have made use, over time, of a ‘range of health-related ideas and practices that marry indigenous and imported knowledge in complicated ways’ (Livingston 2003: 138). Some anthropologists have even suggested that although ‘biomedical categories and therapies have reached different parts of the world in very different ways, the condition of medical diversity or medical pluralism is now universal’ (Das and Das 2007: 67). Indeed, medical anthropologists – who have often deployed the notion of ‘medical pluralism’ in their work – have advanced various arguments to explain the enduring importance of non-biomedical forms of healing in parts of the world where biomedical treatment is often easily accessible (see Lock and Nguyen 2011: 61-63).

We know, in addition, from research throughout southern Africa and elsewhere that when people suffer from illnesses and bodily afflictions, they find themselves reliant on their existing networks of support and, at the same time, they often wish to renew older relationships and seek out new ones.³⁶ Furthermore, when looking for treatment in clinical settings, people from rural areas often have to negotiate with trained professionals who are, themselves, subjected to more requests for material assistance than they can satisfy (from people they know) and these staff members, consequently, tend to privilege certain patients over others (see, e.g., Andersen 2004; Whyte et al. 2010). One of the suggestions of Chapter Two is that recent discussions within anthropology about ‘dependence’ have much to contribute to our understanding of these dynamics in African clinics and hospitals. James Ferguson has argued that among the urban and rural poor in southern Africa, a large amount of ‘labour’ is invested in ‘trying to strike up – or assert, or reassert – a social and personal

relationship (even a highly dependent one) with those better off than themselves' (2015: 156).

Chapter Two explores this argument (as it has been presented by Ferguson and others) by contrasting the experiences of two distinct types of patients at the mission hospital: firstly, the well-connected (and usually wealthier) patients who lived locally and had personal ties with hospital staff and, secondly, the less well-connected (and usually poorer) patients who came from more distant rural areas and who did not have any pre-existing relationships with Zambian hospital staff. While the concept of 'dependence' is helpful for understanding many of the relationships at Matamba Mission Hospital, I suggest that much recent anthropological work has assumed that relationships of dependence are inherently 'hierarchical' (e.g., Hannig 2017; Haynes 2015; Haynes and Hickel 2016; Hickel 2015; Schertz 2014). In addition to this, I argue that we also need to think beyond the category of dependence in order to understand the experiences of the many rural patients who were effectively shut out of such relationships. These were people who were largely unable to 'strike up' relationships with wealthy staff members in order to gain access to treatment or medications. In Chapter Two, I show how these patients expressed a strong desire to be treated in a 'non-selective' way (i.e. not on the basis of personal or kinship ties). Indeed, these patients were often strong critics of the 'selective' treatment of certain patients by Zambian staff members.

This is where the position of the American missionaries is important. These missionaries paid little attention to personal or kinship ties (not least because many of them were only in Zambia for a few weeks and did not cultivate strong personal ties with patients) and were therefore able to offer 'non-selective' treatment. Many patients were able to see this as one of the most significant and desirable aspects of their relations with the American missionaries. The chapter explores, in more detail, the way in which rural patients morally evaluated the position of the missionaries as benevolent outsiders. During many interviews and discussions, I found that the missionaries were often called 'angels' (in Chitonga, *bangelo*) by patients. I show that, while this term conveyed the idea that the missionaries were capable of offering transformative treatment and care, it also revealed a sense of distance: many of these

white expatriates arrived in the local town and did not form close relationships with Zambian patients, returning to the United States sometimes after only a few weeks.

In response to this finding, Chapter Two reflects on the moral risks that have been involved in relationships with white people who stand outside of networks of dependence, showing that such positive moral evaluations might be the ‘mirror image’ of more sinister ideas of white Europeans as ‘vampires’, who wish to enrich themselves by taking the blood and organs of Africans (Colson 2006; White 2000). This is where the perspectives of the American missionaries become important. Most of the missionaries identified strongly with the ‘concept of “brotherly love” and the parable of the Good Samaritan . . . in which all in need equally deserve care’ (Redfield and Bornstein 2011: 10). Chapters Three and Four consider how the long- and short-term missionaries tried to realise their moral aspirations in practice.

The American medical missionaries: sanctified lives and parochial cosmopolitanism

The American anthropologist Melville Herskovits once wrote that ‘there is perhaps no aspect of the African experience that has been analyzed with less objectivity than the Christian missionary effort’ (1962: 204). As if to prove Herskovits’s point, several decades later, in one of the first studies of missionaries based on long-term fieldwork, the anthropologist T. O. Beidelman suggested – in the introduction to his book – that ‘Christian missions represent the most naïve and ethnocentric . . . facet of colonial life’ and are ‘callously ethnocentric and mindlessly romantic’ (1982: 5-6, 6).

A number of scholars have examined why there has so often been hostility towards Christian missionaries within the history of social anthropology (see, e.g., Pels 1990; Stipe 1980; Salamone 1986; van der Geest 1990). One of the most obvious sources of discord is the idea that missionaries ‘destroy culture’, while anthropologists ‘like to see themselves as listeners and custodians of culture’ (van der Geest 1990: 588-589).³⁷ In the early twentieth century, however, missionaries had already contributed a significant amount to anthropology and African studies (see van der Geest and Kirby 1992: 60-61) and they had often spent many more years in the field than any anthropologists and possessed superior language skills (van der Geest 1990: 596). A further reason for

hostility, then, as Peter Pels has suggested, was that the professionalization of the discipline required anthropologists to distance themselves from missionaries and express their disdain for their intellectual abilities and methods: 'To become the professional traders of ethnographic knowledge, anthropologists had to deny the value of missionary ethnography' (1990: 107).³⁸

Does the 'ambivalent, uneasy and fraught' (van der Geest 1990: 588) relationship between anthropologists and missionaries continue to exist today? Given how little attention missionaries have received in relation to their size and influence in the world today, it would seem so. There are more than 42,000 full-time American missionaries (Barnett and Stein 2012: 5) – alongside an estimated 1.5 million Americans who go on 'short-term' mission trips annually (Priest and Priest 2008: 54) – and yet they are strikingly absent from the recent anthropological record.

There are several reasons, I think, why the 'missionary factor', to borrow Oliver's (1952) famous phrase, in contemporary Africa has not received as much anthropological attention as it merits. Firstly, in the minds of many anthropologists, missionaries in Africa remain a part of the historical past. The most well-known anthropological texts about missionaries are historical studies or at least include a significant amount of historical material (e.g., Beidelman 1982; Comaroff and Comaroff, 1991, 1997; Fabian 2000; Keane 2007; Pels 1999) and when missionaries in Africa have been dealt with in recent anthropological works it has often been to give historical context to the study of African-initiated churches or the spread of Pentecostalism (e.g., Engelke 2007; Kirsch 2008). Secondly, when anthropologists (and other social scientists) think about the provision of welfare services in the global south, their focus has more often been on secular NGOs and humanitarian organisations. In these accounts medical missionaries are depicted as the 'forbears of such humanitarian medical organizations as the Red Cross and Doctors Without Borders' (Klassen 2011: xv; see also Fassin 2011: 37; Redfield 2005: 331). This can give the impression that missionaries have all but disappeared from the contemporary landscape. Hannes Gerhardt (2010) makes the point that although 'the nineteenth century is often presented as the heyday of global missions, the fact is that worldwide missionary activity, in terms of missionaries deployed, has increased fivefold since the end of that century' (2010: 165).

Other scholars have noted the absence of anthropological work on contemporary missionaries. In her work on American Christian missionaries in Kenya, Julie Hearn (2002) points out that, despite their enormous influence in the provision of healthcare, family planning and food security programmes, they remain ‘invisible’ to many scholars. In considering the forms of ‘transnational’ governance in Africa, Ferguson has also posed the question of why Christian missions have not been studied more often by anthropologists, given that they are ‘arguably more important today in Africa than ever’ (2006: 98). With the emergence in recent years of the anthropology of Christianity as a ‘self-conscious, comparative project’ (Robbins 2003: 191; see also, e.g., Bialecki, Haynes and Robbins 2008; Cannell 2006; Engelke and Tomlinson 2006), it is perhaps all the more surprising that contemporary Christian missionaries have largely escaped recent anthropological attention, something that this dissertation seeks to address.³⁹

In Chapters Three and Four, I consider the experiences of the American missionaries at Matamba. Chapter Three focuses on the long-term missionaries, offering an account of the historical ‘partnerships’ between the colonial and post-colonial governments of Zambia and Christian missionary societies in order to historically contextualise the ‘moral ambitions’ (Elisha 2011) of the long-term American missionaries. I show that while their political and moral arguments were shaped by a temporality of moral urgency (much like many humanitarian organisations) they were, nonetheless, committed to the idea that long-term engagement was necessary – in part due to a pessimistic analysis of the possibility of bringing about change in Zambia.

The chapter deals ethnographically with the day-to-day experiences of Dr Tom and Dr Hannah. Drawing on examples of their work in practice and their relations with patients, I show how these two missionaries conceptualised the nature of their work as a personal endeavour, rather than as an attempt to proselytise explicitly. I try to show, furthermore, how their living arrangements (which were strikingly self-sufficient and self-contained) both enabled them to work untiringly but also left them ‘detached’ from the local community in certain ways that were, I argue, inseparable from their moral vision (cf. Candea et al. 2015).

Their detachment enabled Tom and Hannah to treat their patients as ‘Christ-like’ individuals, rather than as particular situated social persons. As I mentioned above, there has been much use of Agamben’s (1995) work on ‘bare life’ in recent studies of humanitarianism and anthropologists have described how the ‘suffering body’ has become central to making claims and seeking ‘legal and political recognition’ (Ticktin 2014: 276; see also, e.g., Malkki 1996; Redfield 2005). I show here, by contrast, that the missionary doctors did not reduce ‘social life to biological life’ (Fassin 2012: 15). Instead, I suggest the notion of ‘sanctified life’, showing how the most fundamental and enduring identity of the patients, for Tom and Hannah, was to be found in their Christ-like – rather than simply biological – nature.

The notion of sanctified lives, however, is not only a reference to the patients. As the chapters show, the lives of the missionaries themselves were sanctified in a more material sense. They were able to live insulated and protected lives that were ‘set apart’ from those of local people. They slept under mosquito nets, took malaria tablets, drank clean water and enjoyed a level of material comfort that was not achievable locally outside of the mission compound. If their lives had ever been put at risk – through illness or trauma – they would have been fairly swiftly evacuated from the country, much like the missionary Kent Brantly, whom we encountered at the start of this introduction. In other words, we are dealing with what Mark Duffield has called ‘insured’ and ‘not-insured’ lives (2007: 17).

In Chapter Four, the focus shifts to the ‘short-term’ missionaries and their experiences of missionary work, moving at the same time to consider more directly questions about morality, ethics and ‘aspect-perception’. The chapter shows how many short-term missionaries arrived with the capacity to ‘see’ certain aspects of life at Matamba Mission Hospital in ways that were deeply meaningful to them, as Christians. Drawing on recent anthropological discussions about ‘meaning’ (e.g., Engelke and Tomlinson 2006), I show how short-term missionaries were able to identify, in the suffering of patients, the agency of Christ working through them and giving them the strength to cope with profound bodily afflictions. One common context in which this was expressed was when the missionaries noticed that Zambian patients were seemingly able to endure greater levels of physical pain than their patients in the United States – for instance, children who endured having teeth removed without crying, or young

women in childbirth. There have been several interesting discussions about pain and palliation in recent years (e.g., Brown 2010; Livingston 2012) in which suffering and pain are contextualised both historically and ethnographically and Chapter Four shows that Zambian patients' bodies were meaningful for many short-term visitors and offered them the possibility of 'seeing' Christ's work in action.

The chapter also engages with debates about 'cosmopolitanism' and moral obligation. From the work of the philosopher Peter Singer (2009) to Anthony Kwame Appiah (2006), there have been many debates in recent years about the obligations of wealthy westerners to the 'distant' poor, especially in Africa (see also Englund 2012). In these debates a common tension emerges which assumes the following form: do people have the same obligations to people who live in their own neighbourhood, city or country, as to those who live on the other side of the world? In Chapter Four, I show that many short-term missionaries developed a distinctive solution to this problem of obligation and proximity. In many discussions about the beneficial effects of their work, short-term missionaries told me that they were not only in Zambia to attend to the medical needs of the Zambian people, but also to demonstrate to their friends, family, and people from their own churches that they, through their faith, had acquired the strength and fortitude to go to 'Africa' – a dangerous and unsafe place in these accounts (see Dunn 2004). In this way, these missionaries located the recipients of their work, spiritually, back at home in the United States. As short-term missionaries, they were 'exemplary' figures to their friends and family members and engaged in a form of inspirational, Christ-like commitment.

In order to describe these missionaries, I suggest the concept of 'parochial cosmopolitanism'. This term, as I show in the chapter, captures the way in which missionaries were able to reconcile the tension between their (self-proclaimed) moral commitment to their own families and church groups in the United States at the same time as aspiring to help people far away in an African country. Anthropological work on 'volunteers' in African hospital settings (e.g., Sullivan 2016; Wendland 2012) has often focused on how medical students and other 'clinical tourists' (Wendland 2012) seek to gain 'experience' in order to further their careers. Although much important work has been done (by anthropologists and others) to critique short-term medical trips (as I discuss in the chapter), it is also worth taking seriously the aspirations of

these missionaries in order to consider their motivations beyond mere self-interest or personal fulfilment. The missionaries – with their thoughts of Zambian patients and their own families and churches at home – were not the only people at Matamba Mission Hospital who felt the need to reconcile their obligations to different groups of people, as Chapter Five, which considers the Zambian staff members, attempts to show.

The Zambian clinical staff members: professional obligations and personal relations

Chapter Five considers the Zambian staff members at Matamba Mission Hospital. The amount of anthropological work on African hospital workers and biomedical practitioners (i.e. doctors, nurses, laboratory technicians, pharmacists, and other clinical staff) is relatively small compared to the range of literature, as cited above, on medical pluralism and so-called ‘traditional’ healing. In recent years, however, there has been increasing interest in the lives of the many biomedically-trained men and women who work in clinics and hospitals throughout Africa. In her influential study of the experiences of trainee doctors in Malawi, Claire Wendland identified one of the assumptions that had closed off this avenue of anthropological work:

Across the continent, biomedically trained African physicians, nurses, and others examine and diagnose patients, give injections, perform surgeries, and dispense medications – yet they remain functionally invisible in the anthropological literature: African healers are not biomedical; biomedical practitioners are not African. (2010: 23)

Although anthropologists have only recently taken up this theme, many historians have explored the history of African biomedical practitioners (e.g., Hunt 1999; Iliffe 1998; Kalusa 2003, 2007; Marks 1994) and their work has deeply influenced recent anthropological studies.

Scholarship on the lives of African biomedical staff, particularly within the last decade, has generated a range of new directions for anthropological work. A number of studies have shown how African doctors and nurses who work in chronically

underfunded hospitals attempt to provide effective treatment for their patients under stressful conditions and form their own distinctive moral orientation as they help others during moments of illness and suffering (e.g., Livingston 2012; Mulemi 2008, 2010; Wendland 2010). These studies have focused, predominantly, on African staff from relatively privileged backgrounds working within the wards of large urban hospitals.⁴⁰

For example, the Malawian trainee doctors with whom Wendland worked aspired to become District Health Officers (if they stayed within the country) and many had parents who were highly educated (Wendland 2010: 98). At Matamba Mission Hospital, by contrast, few of the staff members aspired to become doctors or District Health Officers – indeed, most would not have been able to afford the necessary training. In contrast to some of this emerging anthropological work on African biomedical practitioners, Chapter Five deals with clinical staff from more modest social and economic backgrounds working with fewer resources. Staff members articulated certain moral visions and hopes about clinical practice, but in Chapter Five these are set against the evidence of how these staff members negotiated their professional and personal responsibilities after years of difficult work.

Like all of the chapters, the ethnographic focus of Chapter Five extends beyond the walls of the hospital. One of the most important facts about the Zambian staff members is that they were paid a regular wage by the government. As Susan Whyte has written of healthcare workers in Uganda, ‘the bottom line is that they have salaried jobs’ (2015: 208). Citizens employed in mission hospitals in Zambia have their salaries paid by the government. While Chapter Two considers the experiences of patients who did not know any of the staff members (and who therefore had to stand by as the relatives, friends, and neighbours of staff members received preferential treatment), Chapter Five considers why these staff members privileged certain people over others. Ferguson (2015) reminds us that ‘those with access to incomes inevitably encounter a wide range of social claims on that income – claims that may be honoured or scorned, to be sure, but in any case cannot be easily ignored’ (2015: 97). In this discussion I return to the concept of ‘dependence’ in order to suggest that, in addition to the need for understanding dependence along a continuum (from hierarchical to horizontal), we also need to consider the difference between people who are situated

within 'loose' and 'dense' networks of dependence on others, a distinction that is explored ethnographically in the chapter.

Building on several case studies, Chapter Five shows how staff members who were embedded within 'dense' networks of dependence were more often under pressure to privilege certain patients over others (i.e. those to whom they had enduring obligations). Some staff members were married with many children. They had high living costs, numerous relatives who depended upon them and many friends and acquaintances in the town. Some also owned animals and planted maize for selling and family consumption. By contrast, staff members situated in more 'loose' networks of dependence (and who did not have the same responsibilities) were better able (and therefore sometimes more willing) to attend to the needs of patients whom they did not know. I see this as one way of attempting to understand the 'depersonalisation' in relations between doctors and patients in African hospitals that has been so widely documented (Feierman 1985: 110; see also Andersen 2004; Langwick 2011: 192).

Based on this account of their relationships and living arrangements, in the rest of the chapter I show how staff members located themselves in relation to ideas about rural life and 'customs'. Staff members were able to both 'romanticize' and 'demonize' rural life (Wendland 2010: 103). I suggest that this ambivalence was related to their position between the missionaries and rural patients as 'middle figures' (Hunt 1999). In relation to the American missionaries, many staff members defended their conduct by appealing to ideas about 'customs' and the need for them to balance their work commitments with attending weddings, funerals, or spending time visiting relatives in other parts of the province or country. By contrast, in their dealings with rural patients, staff members often adopted an attitude of superiority and referred to patients as backwards and uneducated. It is possible now to consider the research itself. In this final section, I offer an overview of the research I conducted in Zambia and discuss some of the methodological and ethical considerations that emerged during the course of the research.

The fieldwork

Ethnographically, this study draws on over a year of fieldwork at Matamba Mission Hospital (carried out between August 2014 and November 2015 with a follow-up trip, of a month, during August 2016). I first visited Matamba Mission Hospital on a visit to Zambia in April 2014 and met several staff members, such as Pastor Mwaanga, who ran the chapel – and also served as the hospital’s dentist when required – and the two long-term missionaries, Dr Tom and Dr Hannah. Through Dr Tom, I met Mr and Mrs Mainza, who agreed to host me during my fieldwork. Both originally from different areas of the Southern Province, Mr and Mrs Mainza were a relatively elderly couple, although in good health. Mr Mainza was in his early 80s and had worked in a number of jobs, including as a court clerk and a vernacular language radio presenter in the capital city, Lusaka. While they lived there, Mrs Mainza, who was around ten years younger than her husband, had worked as a civil servant. In the 1980s, they decided to move back to their home province and bought enough land to farm and keep cattle. Although they were not connected to the town’s electricity grid and did not have running water, the land and cattle they owned made them relatively prosperous compared to their immediate neighbours. They lived with two of their grandchildren, Sarah (who was nineteen-years old) and Given (who was seventeen-years old), and several young men of a similar age who helped to herd the cattle and who worked on the land during the periods of planting and harvesting.

Mr and Mrs Mainza introduced me to many of the people who became my friends and informants and welcomed me into their local church (Seventh-Day Adventist), where I met people who were staff members at the hospital and many others who had been patients and were happy to share their experiences and thoughts with me. Mrs Mainza seemed to know almost everyone who lived in the town and when I spent time with her buying items at the market or visiting friends she would be continuously greeted by younger people as ‘grandmother’ (*banene*). Living with such a well-connected family offered countless opportunities for encounters, discussions and interviews with other people living in and around Matamba township. It also, at times, imposed certain restrictions. There were, for example, certain staff members who were regarded (for various reasons) with suspicion by Mrs Mainza – for instance, because they drank alcohol at one of the bars in town, or attended a rival church that the SDAs

associated with 'Satanism' (usually a new Pentecostal or healing church).⁴¹ I learned to be aware that, in Matamba town, I was often regarded as an extension of the Mainza family and my appearance and behaviour were taken as a measure of how well the family were treating me. Early on in my fieldwork, as I was about to leave the house, I was occasionally called back inside – the first time, to my surprise and embarrassment – and told by Mrs Mainza, in no uncertain terms, that my shirt was too creased or dirty and would have to be changed.

It was through the church that I was fortunate enough to befriend Peter and Clare Mwala, a couple who each helped me, at different times, as research assistants during the year. I travelled with Peter to several villages outside of the town to conduct interviews with people who had experiences of visiting Matamba Mission Hospital. He also knew several *bangelo* diviners with whom we conducted interviews during August 2016. Clare helped me with interviews in and around the hospital on many occasions with some of the women (and their female relatives) who were living in the mother's shelter, a small building in a state of disrepair where expectant women from outside of Matamba town waited to give birth (see Chapter Two).

My schedule involved visiting the mission hospital every week day. During the first three months of fieldwork I spent a considerable amount of time with the hospital's pharmacist, Matthew Mujika (whom we meet in several of the chapters). Matthew dispensed medication to patients who had already been treated by one of the Zambian staff members or American missionaries. He was in a position of authority within the hospital and, in spending time with him, I learnt a lot about the relationships that shaped the work and social life of the hospital. I spent time every week with other staff members, such as Mr. Mwaanga, mentioned above, and several of the laboratory technicians. I conducted detailed interviews with ten staff members (whom I came to know well). One of the difficulties was that some staff members, particularly the midwives and female nursing staff, did not get on well with Tom and Hannah and regarded me initially with suspicion – perhaps, at first, because they assumed I was another missionary visitor. Indeed, it took me a while to realise that I had arrived in a context where there was a great deal of tension between some of the staff members and the missionaries.

When missionary doctors visited I spent time with many of them at the hospital as they encountered patients and began working with Zambian staff members – particularly in the out-patient department, although in several other parts of the hospital as well, such as the male ward and the laboratory. I enjoyed the company of many of the missionaries I met. They were often welcoming and willing to speak honestly about their missionary work. During my time in Matamba, twenty-nine short-term missionaries visited. I conducted detailed interviews (of between one and two hours) with twenty of them during the course of their visits. I was sometimes invited to eat at the mission house when a new group of missionaries arrived. Tom and Hannah appreciated the arrival of new missionaries and enjoyed the company of other Americans. On these occasions I was able to speak to newly arrived short-term missionaries, but also to hear how Tom and Hannah (and sometimes missionaries who had, by then, been around for several weeks or months) described the patients and staff at Matamba Mission Hospital and helped to shape the expectations and attitudes of newcomers.

Particularly during the early stages of fieldwork, when I spent time with the missionaries, I had the sensation of moving between two worlds – as I describe in more detail in subsequent chapters, the missionaries had effectively recreated an American domestic space in the guesthouse, insulated from Matamba township. Before dinner somebody said grace, American food was consumed, there was running water, electricity, and people used their phones and laptop computers. Within the mission compound the level of isolation from the surrounding world could begin to feel unpleasantly surreal and, after spending time there, I was often pleased to return home to Mr and Mrs Mainza's house.

Occasionally I joined visiting missionaries on 'outreach' trips to some of the surrounding rural areas and villages. On these journeys – sometimes a two or three hour journey each way – we would be met by local volunteer staff and large groups of women who had arrived with their children for vaccinations. These trips were often quite eventful and the arrival of several white people (*bakuwa*) was sometimes a source of intrigue. During these trips I was able to speak with some of the health volunteers who had interesting insights into local attitudes towards the Zambian staff and the American missionaries at the hospital. I also made a series of visits, during the year, to

ten different 'rural health centres', which are small clinics that offer basic medications and are staffed by one or two trained clinical staff. These visits offered the opportunity to speak to patients and Zambian staff about the experiences of people who had visited Matamba and the view of the mission hospital from these more distant locations. I was also able to gain more of an understanding, through these encounters, of when and why people decided to visit the mission hospital and the various decisions that had to be made. Over the year, I conducted hundreds of interviews and spent thousands of hours with visiting missionaries, rural patients, and staff members. I also collected material (that features in Chapter Three) over the course of several weeks at the National Archives of Zambia in Lusaka.

When conducting interviews, I took notes by hand rather than recording them. This slowed conversations down, but the absence of a recording device, I think, sometimes made people more open when discussing issues that were sensitive and the slower pace of some interviews (as I wrote down responses) often gave people the opportunity to elaborate on their remarks and qualify their initial responses in interesting ways. This method also helped with the interviews that were conducted in Chitonga. Despite being able to follow conversations and get by easily enough on my own, I was not able to conduct detailed interviews fluently in the language. Instead, with either Peter or Clare as my translators, I was able to follow and write down responses and seek clarification on certain phrases or concepts that were of particular importance. Although Chitonga is the most widely spoken language of Southern Province, there are several distinct dialects that – while more or less mutually intelligible to native speakers – pose difficulties for non-fluent speakers. Furthermore, as mentioned above, hospital staff members from other provinces often spoke Chibemba and Chinyanja as well as English. In addition to this, there were many different registers of language use and code-switching and I regularly found it difficult to orient myself in such a complicated linguistic context.

One of the difficulties of conducting fieldwork at the hospital, as other anthropologists have reported (e.g., Street 2014: 32), was being mistaken for a doctor or a missionary. The staff members came to accept my presence after a while – at times, I think, it was imagined that I was doing something akin to 'auditing' the hospital, at other times as something closer to volunteer or missionary work. White visitors in the area were

often assumed to be missionaries or American Peace Corp volunteers. Many people – including some missionaries, Mr and Mrs Mainza, and members of the SDA church – interpreted my arrival in Christian terms. Whatever *I* thought I was there to do, it was sometimes suggested, there were more important reasons why God wanted me to be in Matamba township.

Finally, here it is worth saying something about the ethics and politics of gaining ‘access’ and conducting research in a rural hospital setting in Zambia. Many anthropologists, especially those working in Europe and the United States, have written about the difficulties of gaining entry to conduct ethnographic work in hospitals (e.g., Matthews 1987). Anthropologists in poor countries, by contrast, often note the disconcerting ease with which they were able to gain access to clinical settings. Some of these issues are avoided by anthropologists who are physicians themselves and whose access is granted on the basis of their direct contribution to the work of the hospital (e.g., Wendland 2010; Zaman 2004, 2005).

I did not find myself in the position of gaining easy and uncomplicated access. Despite complying with the official guidelines (namely, gaining affiliation and ethical clearance with the University of Zambia and being signed off by the Provincial Medical Officer), I had difficulties with the local District Medical Officer (DHO) who was mildly anxious about my research. I later discovered that he probably had two main fears. Firstly, that I might publish rival quantitative material on, for example, maternal deaths or rates of HIV infection from the rural health centres where, as I discovered, a considerable amount of this kind of data is fabricated before being sent to the DHO. Secondly, I think the DHO was concerned that I might write about the mistreatment of patients, particularly in the maternity ward where certain midwives were well-known to treat women from rural areas ‘roughly’ (cf. Brown 2010). Eventually the DHO acquired the idea that my presence was relatively innocuous and he became satisfied that I was not in the business of collecting quantitative data to rival his own.

One of the further issues faced during the research was the fact that many people I met – and this was particularly true in more remote areas where access to clean water was a problem or where the nearest rural health centre lacked basic medication –

asked me for assistance, thinking that perhaps I worked for an NGO or Christian missionary organisation.⁴² In addition to this, I conducted fieldwork during a period when people were more suspicious of the government than usual. The Southern Province's favoured candidate in the presidential elections of 2015 lost narrowly (and reports of vote rigging were widespread) and people felt that the ruling party had no interest in attending to the needs of the people of Southern Province.⁴³ In these situations, I was aware that my arrival as a white person who wished to ask questions about people's medical experiences and their current problems generated the expectation that I might be able to assist them in the future or that my research might contribute to helping people in the area (cf. Bornstein 2005: 117).

Street (2014) has noted that hospital staff hoped that her research 'would help make their clinical work more visible to people in the Papua New Guinean government and other countries, forcing them to recognize and respond to their predicament' (2014: 31), while at the same time, patients hoped that she might 'help them to attract the attention of hospital staff and expedite their treatment' (2014: 32). Such misgivings are common among anthropologists working in similar contexts, but perhaps when doing research related to healthcare they are heightened. These are issues to which I return in the concluding chapter, Chapter Six, when addressing questions about suffering and politics in anthropology. With this overview of the themes of dissertation outlined, it is possible now to turn to Chapter Two, which considers the rural patients who visited the mission hospital.

Chapter Two

Speaking with angels: dependence, detachment and the afterlives of medical humanitarianism

Introduction

At around 5am, on a morning during December 2014, an elderly man in his seventies, Mr Muyuni, left his home to walk to the mission hospital. The previous week he had bought two young oxen (*basune*) from a friend of his and, when trying to train them, had badly injured his right hand. Mr Muyuni was fortunate that the rains had not yet started (they were several months late) because, after the rainy season (*mainza*) was underway, the main route from his home to the hospital usually became flooded and the people living in his area could not access the hospital easily, sometimes for several months. In the small town of Matamba, many people knew Mr Muyuni. He was an energetic man who looked many years younger than his age and he wore a distinctive pair of thick-rimmed spectacles with lenses so badly scratched I wondered how he saw anything through them. After arriving at the hospital and visiting the registry office, Mr Muyuni waited to be seen by one of the American missionary doctors who told him that he needed to take some antibiotics for the wound on his hand which had probably become infected.

When Mr Muyuni arrived at the dispensary – where I first encountered him – he walked past the benches where other patients were waiting for their medication and grabbed the hand of the staff member on duty, Matthew Mujika, addressing him as ‘my friend’ (*mwenzuuma*). They shook hands and laughed at the pleasure of seeing each other and started speaking in Chitonga, exchanging greetings and asking, ‘how is everyone at home?’ (*bali buti kung’anda?*). Mr Muyuni lived near to a relative of Matthew’s and, as I subsequently learned, Matthew had bought several cows (*ng’ombe*) from Mr Muyuni a few years ago. Matthew gestured to Mr Muyuni to come and take a seat in the small room at the back of the dispensary where the conversation proceeded in a mixture of Chitonga and English. Mr Muyuni, who was HIV-positive, explained to Matthew that he needed some antibiotics for his hand and enough

antiretroviral medication (ARVs) to last him through the rainy season. Matthew agreed to give him enough for six months – a larger amount than he was usually prepared to give patients – and proceeded to line up six boxes of pills on the desk. Mr Muyuni pulled out a dusty, crumpled plastic bag from his pocket and filled it up with these boxes of pills. As he did so, he laughed loudly and told us that he was perfectly healthy but the doctors kept telling him to take these pills.

As I later learned, Mr Muyuni took an interest in Matthew's cattle, making sure they were well kept. In return, Matthew made sure that Mr Muyuni had enough medication (ARVs) during visits such as this one. Relationships such as these were important at the mission hospital. Knowing members of staff – as Mr Muyuni did – offered certain patients privileged access to treatment and medication. Nevertheless, not everyone was so fortunate and Mr Muyuni was one of a relatively small number of patients who were able to mobilise their pre-existing relationships with staff members in order to access treatment.

As I show in this chapter, when the process of 'triage' was conducted by the Zambian staff members in the out-patient department (OPD) of the mission hospital – in which patients were assessed and decisions were made about who needed to be prioritised – pre-existing relationships of kinship and friendship strongly shaped the decisions that were made (cf. Redfield 2008).⁴⁴ Patients who knew staff members typically received preferential treatment, while others were made to wait for hours and sometimes even ignored altogether. Patients who were eventually seen often received cursory clinical examinations and were sent away with medication that was basic and in some cases unnecessarily or inappropriately prescribed. Many rural patients, consequently, came to feel that Zambian staff members were 'selfish' and indifferent to their wellbeing.⁴⁵

The American missionary doctors, by contrast, were able to be 'non-selective' (*kutasala*, from the verb 'to choose', *kusala*) in their treatment of patients, the term used by many Zambian patients themselves. Indeed, on the whole, the missionaries took it as their moral obligation to attend to the medical needs of all patients 'equally' (something that will be explored from the perspectives of the missionaries themselves in Chapters Three and Four). This meant that when rural patients dealt with the American missionary doctors, the process of triage was much more concerned with the identification of bodily affliction and medical need. This did not go unnoticed by

rural patients, who were profoundly critical of the ‘selective’ treatment they received at the hands of the Zambian staff. As Haynes (2017) has noted in her work on the Zambian Copperbelt, the term ‘to choose’ (in Chibemba, *ukusala*) is used to convey ‘giving preferential treatment’ (2017: 88) and ‘favouritism’ (2017: 109). This captures the meaning of the term in Chitonga and the accusation that was often levelled against staff members.

This chapter is concerned with the response of Zambian patients to this ‘differential treatment’ (Andersen 2004). I consider several cases of patients who were able to mobilise their pre-existing relationships in order to receive preferential treatment. Reflecting on the position of such patients, I suggest that relationships of ‘dependence’ (Ferguson 2013, 2015) structured these encounters with Zambian hospital staff and made it possible for these well-connected patients to receive privileged treatment. As I suggested in the introduction, however, recent work on the notion of dependence has tended to focus predominantly on its hierarchical forms, even taking the category of dependence itself to be essentially synonymous with hierarchy (e.g., Haynes and Hickel 2016). I suggest, instead, that hierarchical patron-client relationships are one form of dependence that exists alongside more horizontal and mutual forms of dependence.

Patients who did not know any staff members when they arrived at the hospital did not positively value relationships of dependence – whether hierarchical or horizontal. Through several cases I illustrate the limits of the category of ‘dependence’ for understanding how people in the region value their relationships with others. The desire for relations of dependence is not as ubiquitous as anthropologists have recently suggested and, in thinking about this, we need to look more carefully at the moral ambivalence that shapes many relationships in a region of widespread and chronic poverty.

With this aim in mind, the second part of the chapter considers the distinctive vernacular categories that patients used to describe their relationships with the American missionaries. Among these terms, the description of the missionaries as ‘angels’ (*bangelo*) was particularly significant (and is explored in the second half of the chapter). The notion of the missionaries as ‘angels’ disturbs the more common focus of Africanist historians and anthropologists on the many negative images of white

European colonial officials, missionaries and doctors that have been in circulation since the colonial period. In particular, I consider the association of white people with rumours about ‘vampires’ and ‘witch cannibals’ (e.g., Colson 2000; Geissler 2005; Last 2013; Pels 1992; Weiss 1998; White 1993, 1995, 2000). Rather than simply observing that white people can be described in morally praiseworthy terms, I suggest that there are stronger similarities between ‘vampires’ (*banyama*) and ‘angels’ (*bangelo*) than might initially be expected. Both of these figures represent different ‘afterlives’ (McKay 2012) of medical humanitarianism which continue to shape people’s understanding of expatriate humanitarian workers in the region today. With this in mind, we can consider the first two cases of well-connected patients.

Well-connected patients: Gertrude Williams and Mr Sikabondo

On a hot Wednesday afternoon in October 2015, just before the hospital’s scheduled lunch break, a middle-aged woman arrived at the hospital, having been driven by her son from a town called Namwala, around an hour’s drive away. Their arrival at the hospital was conspicuous as they owned a relatively new car, which was unusual among patients and more often a sign that a government medical official had arrived. The woman, Gertrude Williams, had a swollen leg and wanted to be given medication. Gertrude and her son, Nchimunya, told the nursing staff that they would not wait during the lunch break and they requested to be seen immediately. Gertrude and Nchimunya did not go to the registration office where new patients were expected to give their details and they also ignored the large queue of patients waiting to be seen ahead of them.

Gertrude knew some of the Zambian nursing staff and spoke to them in English, calling them ‘*mami*’, while she herself was called ‘*banene*’ (grandmother) affectionately by staff members in return. In English, Gertrude said to one of the young Zambian nurses, in a friendly tone, ‘I am your grandmother, you people have to take care of me’. Gertrude did not have to show the staff members her leg and she was taken swiftly to the dispensary by the Zambian clinical officer on duty who advised her which medications to take. When I spoke to Gertrude and Nchimunya, they told me that they had driven to the mission hospital because they wanted an evaluation and medication

quickly and it was not a long drive for them. Gertrude had married a white farmer many years ago (hence her surname) and they owned a large farm just outside of Namwala. My research assistant, Clare, who had been watching the entire episode with me, commented afterwards (in a tone that was uncharacteristically critical), ‘they used their status to get medication, because they think they are better than the other people here’.

Rural patients who witnessed this kind of preferential treatment (or ‘choosing’) did not forget about it. When I saw Gertrude and Nchimunya, I was immediately reminded of a story, told to me only a few weeks before by an elderly man at a rural health centre around forty miles away from the mission hospital.

There was a time when I was at the mission hospital and I was in a very big queue and a man came and said, “I need this medication now” and he was a businessman from Livingstone and he knew the man giving the medicines and he was allowed to push in front of us all . . . ordinary people will not be allowed to do it! And people, they come back to the village and they say, “I was badly handled at the hospital when I last went” and then they end up going to the traditional healer [*mung’anga*] who is more sensitive to the villager and will not treat him like that.

These experiences were important for rural patients and memories of such events shaped their relationships with the Zambian hospital staff (cf. Crandon-Malamud 1991). Rural patients saw that they were being ‘badly handled’ in comparison with other patients who knew certain staff members.⁴⁶ This can be seen further in the case of a man named Mr Sikabondo.

Mr Sikabondo

As the owner of a successful butchery in Matamba township, Mr Sikabondo was known to many people in the area and to the staff members of the hospital.⁴⁷ On my way to visit a friend who lived on the edge of the town, I often found myself walking past Mr Sikabondo’s shop as the carcasses of cows were being offloaded and carried

into the shop by the young men who worked for him. I first encountered Mr Sikabondo at the hospital early one morning when I arrived to go on an 'outreach' trip to several nearby villages. When I approached the office of the nurse I had arranged to meet, Mrs Magoye, I found her door was ajar and Mr Sikabondo was sitting inside on a flimsy plastic chair while Mrs Magoye took his blood pressure.

This was a section of the hospital that was difficult to access for ordinary patients who would usually have been asked by one of the nurses what they needed. Mr Sikabondo, like several other local people who were well-known by hospital staff, was able to walk straight through to this section in order to have his blood pressure taken. Mr Sikabondo had become concerned about his high blood pressure over the last few years and he regularly came to the hospital at this early hour to have his blood pressure taken. Being concerned about blood pressure or 'having BP' (as most people called elevated blood pressure or hypertension) was a concern of many of the wealthier residents of the town. Aside from Mr Sikabondo, the only other people I regularly heard speaking about 'having BP' were hospital staff members, who sometimes measured their own blood pressure in lunch breaks or before work (see also Whyte 2016).

When Mr Sikabondo greeted me that morning he told me that Mrs Magoye was his friend who helped him with his blood pressure. He then told me of the first time he had had his blood pressure taken and the nurses had to check it again because they had never encountered such a high blood pressure reading. Mrs Magoye said to me afterwards that Mr Sikabondo was well known at the hospital and several of the nurses were happy to take his blood pressure. There were important differences between Mr Muyuni (whom we encountered at the beginning of this chapter), Gertrude Williams and Mr Sikabondo. Nevertheless, we can see in all of their cases the importance of relations of dependence at the hospital. With this in mind, it is worth considering the extent to which the category of 'dependence' can illuminate important aspects of these relationships.

Relations of dependence: hierarchical and horizontal

From at least the 1930s onwards, when the figures associated with the ‘Manchester School’ began conducting long-term comparative research, anthropologists of central and southern Africa have considered how the people of the region have long made use of patron-client relationships and networks of mutual support in order to sustain themselves and their relatives, often under conditions of economic hardship (see Evens and Hendelman 2006; Schumaker 2001; Werbner 1984). Anthropologists such as Godfrey and Monica Wilson, Clyde Mitchell, A. L. Epstein, John Barnes, and Elizabeth Colson were interested in the effects of labour migration on these relationships and they offered rich ethnographic accounts of the transformations in kinship and livelihood strategies in both urban and rural settings during the period of colonial rule and after. It would be difficult to overstate the influence of this body of work on contemporary Africanist anthropology, considering how many researchers have engaged with the arguments and ethnographic material produced by these scholars (for a recent overview see Evens and Handelman 2006).

One enduring aspect of this anthropological work has been the insight that people in the region have typically needed to maintain a series of diverse relationships with various relatives, neighbours and acquaintances upon whom they depend, in different ways, and towards whom they have many ongoing obligations and responsibilities.⁴⁸ It is not entirely surprising, therefore, that recent arguments about ‘dependence’, particularly in the work of James Ferguson (2013, 2015), have drawn upon this older work. Despite the broader ambition, in Ferguson’s work, to contribute to debates about cash transfer schemes in the global south, his particular argument about dependence has brought into sharper focus certain themes from the regional literature and has stimulated several anthropologists to think more fully about how the category of ‘dependence’ might illuminate forms of sociality familiar to them in their own work.

Ferguson advances his argument by drawing on the work of John Barnes (1954) who outlined, in his *Politics in a Changing Society*, the history of the Ngoni state – which was comprised, initially, of a group of Nguni-speaking raiders who, beginning in the 1820s, travelled north from South Africa to reach present-day Zambia and Tanzania. This

state was ‘born suddenly, moved about from one part of Africa to another, and recruited most of its members from outside of itself’ (Barnes 1954: 1). As Ferguson himself puts it, the Ngoni state became a formidable political entity ‘that terrorized and preyed on its unfortunate neighbours’ (2013: 223) and was, over time, able to accumulate an enormous number of dependents. Their violent methods enabled them to enslave the people they encountered and the structure of the Ngoni state enabled newcomers to be integrated with ease. Indeed, this capacity to acquire and absorb new people led John Barnes to call it a ‘snowball state’. The Ngoni snowball state is an interesting historical case, in Ferguson’s view, because it is surprising to discover that such a violent and menacing association was able to positively attract the inhabitants of neighbouring areas who travelled – apparently entirely willingly and knowingly – to subject themselves to this ‘military machine’ (2013: 223).

Ferguson moves historically and regionally from the case of the Ngoni state to the more recent trend for young, urban South African men to offer their services (of various kinds) to wealthy expatriates, for instance, by asking to carry shopping or perform house work or gardening. Ferguson describes the ‘steady parade of out-of-work South Africans offering themselves in one or another form of service’ (2013: 224) who are to be found in South African cities. Despite their distance in time, these cases demonstrate, in Ferguson’s view, the same dynamic: relationships of dependence have, throughout the region, been ‘the principal mechanism for achieving social personhood’ (2013: 226) and have enabled certain forms of claim-making, membership, and the redistribution of wealth.⁴⁹ Ferguson uses this discussion to re-narrate the conventional political-economic history of the region (with a new emphasis on the widespread aspiration for relationships of ‘dependence’) in order to suggest that today we face a contemporary ‘crisis of personhood’ in southern Africa. This is because the population increase across the region has produced people who are ‘surplus’ to economic needs (cf. Li 2009) and it is now unattractive for ‘patrons’ – of various kinds, including, for instance, in Ferguson’s analysis, mining companies – to accumulate ‘dependents’.

One of the central points of Ferguson’s argument is that, while there are many people who are ‘enmeshed in networks of dependence with others in a similar condition’ (2015: 153), it is more attractive, if you are a poor person in the region, to ‘become a

dependent of (and thus to be able to make claims on) an actor with a greater capacity to provide and protect' (2015: 154). Indeed, this is why we find people in southern Africa investing a large amount of time and energy in 'trying to strike up – or assert, or reassert – a social and personal relationship (even a highly dependent one) with those better off than themselves' (2015: 156).

There are two central points about Ferguson's argument that are important here. The first is that the relationships outlined by Ferguson actually refer to two slightly different types of dependence and, while these are not separated in Ferguson's text, it is worth considering them as analytically distinct forms. The second point is that the following questions are not answered by Ferguson and raise certain significant ethnographic questions, such as: how have people morally evaluated these relationships of dependence? And, when do they become undesirable or exploitative?⁵⁰ This second point will be addressed in the final part of the chapter, but first we can consider the different types of dependence that can be separated analytically.

The first type of dependence (described by Ferguson) can be broadly categorised as hierarchical dependence and is based on 'patron-client' relationships. The second, I want to suggest, would be more accurately described as horizontal or mutual dependence and this occurs between people 'in a similar condition' (Ferguson 2015: 153).⁵¹ Most of the anthropologists who have engaged with Ferguson's argument have used the term 'dependence' as if it were synonymous with the first form – namely, hierarchical patron-client relationships. For example, Haynes makes this assumption when she writes that 'dependence is a central quality of the relationships formed between a leader or patron and a group of followers or clients' (2015: 284) and China Schertz (2014), in her work on Christian charitable organisations in Uganda, takes dependence to be the same as 'hierarchical relations of patronage' in which 'dependents seek to attach themselves to patrons' (2014: 3).

Nevertheless, it is worth stressing that the second form of dependence – which we might call horizontal relationships of mutual dependence – are also widely reported in the region, alongside these more often discussed hierarchical patron-client relationships. For instance, Englund (2006) has described relationships in urban

Malawi between street vendors and their clients. In these relationships – in which customers were often in debt to the particular vendor with whom they had a long-term relationship – there was no enduring hierarchy in which one person occupied the position of a ‘patron’. Rather, there was a recognition of mutual need. These relationships, or ‘deliberate dependencies’ as Englund calls them, were positively valued in a context of economic uncertainty and fluctuation. Indeed, the people involved felt that they had a moral obligation to be ‘loyal’ to the relationship (2006: 189; see also the discussion in Laidlaw 2014: 162; cf. Cliggett 2005; Livingston 2007).⁵²

By nuancing the discussion of dependence in this way, we can better understand the dynamics of the relationships discussed above. For example, Mr Muyuni was ‘loyal’ to his relationship with the pharmacist Matthew. Their relations with one another were not defined by hierarchical inequality in which either of them was dependent upon the other as a client. In the hospital setting, Mr Muyuni was momentarily dependent on Matthew to provide his medications for him. However, Matthew was also dependent on Mr Muyuni’s good will towards him and the loyalty to their mutual relationship that was expressed in his monitoring of Matthew’s cattle. By contrast, when we think about Gertrude and Mr Sikabondo, we can see relationships that were more unequal. Mr Sikabondo, with his status and wealth, was somebody who had certain relationships with staff members at the hospital who were, in a sense, his dependents (and who were pleased to be recognised by him). And yet, it was clearly important to Mr Sikabondo for his hypertension to be monitored and he had to therefore maintain relations at the hospital with these staff members over time.

Mr Sikabondo and Gertrude’s encounters with staff members show an additional element of these relationships. Namely, the staff members who knew them treated them well because they were people it was worth cultivating relationships with. Known to be wealthy (in Mr Sikabondo’s case) and married to a white farmer who owned much cattle (in Gertrude’s case), it would have been potentially unwise for staff members to make either of them wait in the queue for too long. Anthropologists have made similar observations in hospitals and clinics in Africa. Sometimes the anthropologist herself becomes the high status, wealthy person who causes staff members to alter their conduct. During her research in rural Uganda, the

anthropologist Hanne Mogensen visited a friend of hers at the nearby government hospital. Mogensen's friend told her afterwards that,

everybody [at the hospital] could see that I was poor . . . But after you had visited me in the hospital it improved a bit, and the nurses became very polite to me. They thought that since a muzungu [white person] visited me I must be somehow rich and educated. (2005: 224).

This gives a sense of the way in which some patients might be treated by many staff members as future possible patrons and, as such, can find themselves treated with deference.

This discussion has attempted to show how useful the category of dependence can be in understanding relationships in the region. I hope to have shown in the discussion above, however, that there are different and co-existing forms of dependence. Indeed, we might want to raise the question – although there is not space to attempt to answer it here – of under what circumstances hierarchical patron-client relationships become more horizontal and turn into (what Ferguson has elsewhere called) 'more egalitarian forms of interdependence' (2015: 138).⁵³

There is also a need to consider the limits of the category of dependence. Given the fact that, as many have noted, successfully seeking out relationships of dependence is likely to become much more difficult for people in the future (see Englund 2011b: 31; Schertz 2014: 2), it is important to think about how people who are *already* effectively unable to access such relationships – something common in institutional settings such as hospitals – have responded to this situation and, from their position, have articulated a desire for more attractive relationships using available vernacular moral expressions. This will be explored in the next section where I look at the experiences of two patients who were shut out of relationships of dependence with Zambian staff members and came to positively value their relationships with the American missionary doctors. The first case deals with a ten-year-old girl named Mutinta, brought by her mother and grandmother from their home in a poor rural area. The second with a young man named Joshua who had travelled a long distance and

wanted to access treatment after failing to be cured by local healers (*bang'anga*) and government health workers at a rural clinic.

Disconnected patients: Mutinta and Joshua.

At Matamba Mission Hospital, visiting times were limited to a few hours per day and those who had travelled long distances to accompany their friends and family members to the hospital would wait outside of the hospital buildings, sitting on the ground together and taking shelter from the sun under nearby trees. Women cooked maize porridge (*nsima*) on charcoal braziers and elderly and unwell relatives could often be seen sitting or lying down alongside them. When the hospital was busy, the atmosphere became lively as people cooked, ate, and joked with each other until late in the day. Unlike patients such as Gertrude or Mr Sikabondo, these patients arrived inconspicuously, knowing that they would have to wait – often for a long time – before being seen.

On a busy Monday morning in January 2015, I spoke to a family who were waiting outside the hospital. A young girl, named Mutinta, lay wrapped in a blanket of *citenge* fabric while her mother, known as BinaMutinta (mother of Mutinta), stroked her hair and whispered to her. Sitting alongside them was a much older woman, the girl's grandmother. As I found out later, this family had travelled a long way to reach the mission hospital from a village around thirty miles away. The family supported themselves by growing maize, ground nuts, sweet potatoes and sunflowers. Like many of their neighbours, in years when they had a good harvest they would sell some of their surplus crops, but the harvests of 2014-2015 had been small due to drought and many people in rural Zambia were struggling with the consequences. In order to get to the hospital, Mutinta's family had taken an ox cart to a neighbouring village where they had relatives who offered them a lift in their car. In many of the more remote rural areas, there were only dusty dirt roads and, besides bicycles, one of the only available forms of transport was the ox cart (otherwise used for transporting crops). People who lived in these areas told me of having to journey to nearby rural health centres and hospitals sitting on the back of these ox carts along the uneven and bumpy

roads – an especially uncomfortable way of travelling for elderly people and pregnant women.

Mutinta had large bruises all over her legs and her family had never seen anything like this before. They took her to a local healer (*mung'anga*) who prepared a remedy for her to drink, made from roots that grow naturally in their area.⁵⁴ When this failed to help Mutinta, they went to their local church where the child was prayed for by a local pastor. There are many Pentecostal-charismatic healing churches in the area where 'praying with the laying on of hands' (*kupailila*) is practised as a method for healing certain afflictions (Kirsch 2008: 63). The strategies adopted by Mutinta's family were fairly common responses to affliction and illness in the area, particularly their decision to pursue different forms of treatment until something visibly worked (see Kirsch 2004).⁵⁵ When people arrived at the hospital it was often after a series of prior unsuccessful treatment attempts.

Based on his research in the neighbouring Gwembe Valley area of the Southern Province, Thomas Kirsch (2008) has pointed out that afflictions were typically identified 'according to phenomenological appearance or the social context of occurrence' which led relatives and friends to decide 'which type of therapy would be appropriate for the particular problem: the hospital, the *masabe* possession cult, the "traditional" herbalist (*mung'anga*) or the African-initiated Pentecostal-charismatic church' (2008: 63).⁵⁶ It is worth adding to Kirsch's description here by pointing out that people's therapy choices were not only influenced by the appearance or context of the onset of the affliction, but also by more basic considerations of the cost and availability of transport. A man at a rural health centre once put this to me in the following memorable terms: 'When you are poor, what else can you do but dig roots and hope for the best?' In other words, some people clearly knew that herbal remedies were unlikely to work and yet, without any other viable option, they visited the herbalist although they would have preferred to go to the clinic or hospital (see Schoepf 2017). Wealthier residents, like Gertude and Mr Sikabondo were able to consider the hospital as a first or second option if they had a serious problem, while families from more remote areas, like Mutinta's, would be more likely to experiment with several forms of treatment before trying to raise the money for the long journey to the hospital and the further cost of staying there for several days.⁵⁷ For many people in rural areas,

the mission hospital was a place to visit in emergencies only because of the high associated costs (cf. Hannig 2017: 16; Langwick 2011: 127).

Mutinta's mother was keen to talk with me and my research assistant, Clare, when we introduced ourselves and sat down with her and her family. We discovered that when they had arrived at the hospital, the previous Friday, Mutinta and her family had not been well received by the Zambian hospital staff (in this case the nurses on duty and the clinical officer). Mutinta's family did not know anybody at the hospital and they were clearly not a priority for staff members. Mutinta and her mother had sat in line at the out-patient department (OPD), but it took many hours before they were seen. Visitors to the hospital from rural areas often felt that they were treated badly because they were seen as 'ordinary people' or were regarded as 'just villagers', a common experience for rural patients in clinics and hospitals in Africa (Andersen 2004; Brown 2012; Dilger 2010; Whyte et al. 2010).⁵⁸

On this particular Monday morning, Mutinta's mother tried to get the Zambian clinical officer to see her daughter again, but was unsuccessful. She showed the staff Mutinta's bruises as a way of making it clear to them that she had a severe problem, telling staff that Mutinta had not been treated properly on Friday. Eventually, Mutinta's mother was told by the clinical officer (after a cursory inspection) that her daughter should take Panadol for the pain, which was the same thing she had been told on Friday. It was common for staff members to tell patients to take antibiotics or painkillers when they could not make a diagnosis or when they did not wish to spend further time investigating their symptoms any further. Sometimes this was because patients were 'generally sick' – a term used by Alice Street (2014) to describe the category of patients, at a public hospital in Papua New Guinea, who could not be diagnosed easily. As Street puts this:

Doctors complain that many patients who arrive at the hospital are already so sick they have generalized symptoms. Some are febrile, some are vomiting, some are comatose . . . Different diagnostic findings do not cohere into a single object. (2014: 97)

While such severe cases did occur at Matamba Mission Hospital, many patients also arrived with a range of milder symptoms that did not 'cohere into a single object' and, in many such cases, they were sent away with antibiotics or painkillers.⁵⁹

On the following day, Tuesday, I met Mutinta's mother again and, by that time, she had decided that the family would not leave without seeing one of the American doctors. The two long-term missionary doctors, Tom and Hannah, as we will see in subsequent chapters, would often work until they had seen every patient, something that could take until 9.00pm or later on busy days. In consultations with patients, Hannah and Tom spoke in Chitonga but there was sometimes confusion and hesitation in these interviews and they might, in cases where communication was becoming too difficult and time-consuming, request a translator (sometimes a local Chitonga-speaking nurse or even another patient) (cf. Fassin 2008: 266).

Mutinta and her mother waited outside of Dr. Hannah's office for several hours and were seen in the early evening on Tuesday. I was not present for the consultation between Dr Hannah, BinaMutinta and Mutinta, but after observing hundreds of hours of interactions between missionary doctors and rural patients, I can comment on several common features of these interactions. Patients from rural areas did not typically speak much to the missionary doctors during these encounters (cf. Brown 2010: 158-159; Mogensen 2005: 220) and they did not address them using informal or kinship terms. Given the prevalence of the use of kinship terms, their absence was striking (and will become important later in this chapter). Patients were often quiet and waited for the missionary doctors to ask questions in Chitonga. In theory, patients were supposed to have their own medical files and these should have contained the patient's medical history, although, even when these files existed, they were often incomplete or inaccurate. Consultations, in consequence, were often taken up with the attempt to reconstruct the patient's medical history, typically drawing on imperfect recollections of various afflictions, many of which were regarded as irrelevant or unrecognisable to the missionary doctors (cf. Street 2014: 91). Occasionally patients would disclose a serious condition towards the end of a consultation (for instance, that they had recently had a stroke) at which point the missionary doctor might then abandon the diagnosis they were working towards and begin asking a new series of questions.

Patients seemed to appreciate this attention and regularly praised the missionaries for examining them carefully and comprehensively. As other anthropologists have found, careful examinations were highly valued. Writing about patients in Uganda, Mogensen notes the following:

Examination – though it is often very limited – is expected and appreciated. It is noticed when the health worker touches the body or puts the “pen” (i.e., the thermometer) under the armpit, looks for anaemia by examining the eyes, or checks for hydration by pinching the skin to see how quickly it smoothes itself out . . . In private drug shops you can buy the medicine, actively participate in the decision about what and how much to buy, and even be treated in a friendly manner, But the problem, people add, is that “they do not do the examination.” (Mogensen 2005: 221)

The biomedical examinations that took place at the hospital were, of course, different to the consultations with herbalists, healers and diviners (*bang'anga*) that many patients would also have experienced. And yet, it is worth pointing out that, at the level of their interactions, there are certain basic similarities – particularly the individualised form of evaluation in which the patient or client is asked questions and a biographical history is reconstructed. Missionary doctors and healers (*bang'anga*) construct very different narratives in order to arrive at their judgements about the nature of the affliction and the appropriate course of treatment, but the similarities are also worthy of attention.⁶⁰

To return to the case of Mutinta, Dr Hannah was concerned by her bruises and thought she might have a blood disorder, perhaps leukaemia. Hannah sent Mutinta for a blood test which came back the following day. On Wednesday, Hannah found that Mutinta had a high white blood cell count, which was consistent with leukaemia, although the hospital lacked the resources to carry out the necessary follow-up examinations. In cases such as this, the missionary doctors and Zambian staff were often unable to identify or fix the ‘authentic disease as biological pathology’ (Kleinman 1995: 32). In similar cases, doctors improvised, often treating the symptoms

and waiting to see if there were desirable results (cf. Livingston 2012; Street 2014; Wendland 2010).

In the case of Mutinta, it was necessary for Dr Hannah to decide what course of action to take in a context where resources did not allow for a clear diagnosis. Tests for leukaemia involve a needle biopsy to draw bone marrow (which could not be performed at the hospital) and, if Mutinta had leukaemia, she would have been too sick to have been treated properly at the hospital anyway. In cases such as these, the doctors had to make a judgement about how much help they could offer patients when they had limited resources and other patients who required attention.

Dr Hannah suggested that Mutinta's family should travel to the capital city, Lusaka, to seek further treatment. This was bad news for Mutinta's mother, as the cost of transport was more than her family could hope to raise. After some deliberation, the family decided to leave the same evening with plans to visit a relative who lived in a town en route to Lusaka. Some families from rural areas had relatives who lived in towns along the central road that ran through the Southern Province. Maintaining links with their town-based kin, upon whom they might be able to depend in desperate circumstances, was crucial for many rural inhabitants of the area. Town residents, themselves, have often struggled with the demands of their rural kin and have developed strategies for avoiding excessive claims on their already limited resources. Some people even move great distances – to other provinces of Zambia altogether – in order to avoid the claims of their rural kin (see Cliggett 2003, 2005: 142-157).

Before her family left, I spoke at length with BinaMutinta about her experiences at the mission hospital and asked her what she thought of the white missionary doctors. The level of animosity she expressed towards the Zambian clinical staff was striking.

No Zambians should be here because the whites [*bakuwa*] have a heart for these people. When you came here you greeted us in our language which we appreciate. If a local doctor was here he wouldn't have greeted us like that ... The missionary doctors have a heart for patients. The other doctors [the Zambian staff] can see the patient, but if we are not satisfied then we can go to doctor Tom

or the wife and when they see what is really wrong they will prescribe us the correct medication that we need. They are angels [*bangelo*] to us here.

Mutinta's mother contributed her view: 'The Zambian staff, they are not for those who come here from the villages and who are not wealthy . . . They think they are better than us.' I asked her what she thought might happen if Tom and Hannah left Matamba, or if missionaries stopped coming to the hospital altogether. She said:

They cannot go anywhere! We will not allow it. If doctor Tom leaves then we will die and children will die here also. So if they are not planning on bringing somebody who is like doctor Tom then this place will no longer be a hospital, this place will turn to ashes.

After Mutinta's family left I did not see them again and, as they were not known to anybody locally, I never discovered whether Mutinta's visit to Lusaka, if it happened, was successful. Dr. Hannah's view was that Mutinta was probably severely ill and it would be difficult for her to receive effective treatment, even in Lusaka. It is possible, even quite likely, that Mutinta's family would not have been able to receive the necessary treatment. We can see a similar series of events in the case of Joshua.

Joshua

When Joshua Mutanda arrived at the hospital, his foot was badly swollen. Joshua had been treated initially by Dr Hannah who was pleased to discover that his foot was not gangrenous (which had been her immediate concern). Although Joshua lived far away from the hospital in a place called Mansa, his sister – whom I knew slightly through the SDA church – had gone to visit him after hearing that he was unwell. Having spent a few days with him, she brought him to the hospital in Matamba.

Joshua, who was in his late twenties, had started to lose weight and had stopped eating much. This is not uncommon and would probably have provoked fears of HIV/AIDS among his relatives and neighbours. When Joshua was tested at a rural health centre, they discovered that he had diabetes or 'sugar' as the disease is generally called. When

I spoke to his sister, Beatrice, about his treatment she told me that when he was taken to the rural health centre they had injected Joshua with insulin, after which he felt considerably better. During the subsequent week, however, the staff members at the rural health centre neglected Joshua (often forgetting his insulin injections) and he started to feel much worse again. At this point, under the advice of his relatives, Joshua spent some time – apparently around a week – with a local healer (*mung'anga*) in whose homestead Joshua stayed. According to Beatrice, this healer had caused the problem in Joshua's foot by placing it into boiling water as part of his treatment regime.

This was the point at which Joshua was brought to Matamba Mission Hospital. One of the problems Joshua continued to face – just as he had at the rural health centre – was that the nurses in the male ward repeatedly failed to give him his insulin injections. Furthermore, they overlooked the fact that Joshua's relatives had been giving him sweet fruit juices and bread which had elevated his blood glucose levels to dangerous levels. Beatrice explained to me, when we spoke at greater length outside of the hospital, that she thought the nurses in the male ward were neglectful of patients in the male ward and were failing to give him insulin as Dr Hannah had instructed them to.

Beatrice said to me that the staff members were 'selfish' while the missionary doctors 'wanted to help the people'. I asked her why she thought some of the patients had used the term 'angels' when referring to the missionary doctors and Beatrice said, 'Yes, they come from that side [the United States] to help the people here . . . [and] the missionaries are called *bangelo* because of their non-selectivity and exceptional care to the patients'. Eventually Joshua's condition improved enough for him to be discharged, but his future, like other patients with type one diabetes, was uncertain. Dr Hannah told me about patients who stored their insulin under pots to keep it cool, but they lacked the equipment to monitor their blood glucose levels consistently and these patients had to reuse their needles many times due to the small supplies available for them (on this, see Hapunda et al. 2015).

Veena Das (2015) has written about the difficult decisions that are made over time and which can culminate in abandoning treatment altogether: 'Abandonment here is not

so much an act of the will resulting from choice but an exhaustion of the will and the capacity to marshal yet more energy, yet more love, to be able to offer care' (2015: 113). This was often the reality for people at the mission hospital for whom nothing could be done. Yet their family members did often find 'more energy, yet more love' and Mutinta's mother and Joshua's sister were such people. Mutinta's mother and Joshua's sister felt that the Zambian staff did not treat them well and they looked to the missionaries as people who would treat them properly. As we have seen, 'arousing interest from health professionals is often an important part of the tactics developed by the patients and their families' (Fassin 2008: 267). In the cases of Mutinta and Joshua, it is worth reflecting on the fact that they were fortunate enough to have family members who were prepared to pursue such tactics. Patients without such people in their lives might have left the hospital much sooner or never arrived in the first place. In the next section of this chapter, I consider the distinctive use of the term 'angels' (*bangelo*) as it was used by patients. But, for reasons that will become clearer, in order to understand the significance of the term 'angels', it is necessary consider the widespread use and importance of kinship terms.

Kinship idioms and the constitution of personhood

While I lived in Matamba township, I found that kinship terms were used in several different ways. They were used, firstly, to address visitors and strangers politely. In such contexts, they were terms that served to enhance the relative prestige of the visitor as a way of welcoming them. Elizabeth Colson observed this in the 1940s and 1950s, writing that because 'kinship is of great importance . . . it is not surprising that terms borrowed from kinship categories are generally used as courtesy terms' (Colson 1958: 59-60). This remains true today and, at the mission hospital, kinship terms were often used by patients in their conversations with Zambian staff members as 'courtesy terms' (as Colson puts it) and this is an important everyday use of kinship language.

They were often much more than this though. As many anthropologists have argued, the use of kinship terms reveals a lot about the constitution of personhood (Comaroff and Comaroff 2001; Fortes 1987; LaFontaine 1985). When I arrived in the small town of Matamba and moved in with Mr and Mrs Mainza, I was quickly referred to as 'son'.

The English word 'son' was often used, but in Chitonga calling somebody a son or daughter is relational – for instance, at social gatherings outside of the home, such as church services or weddings, I would sometimes be called 'child of Mainza' (*mwana waMainza*). This was sometimes said with some degree of amusement – particularly when I first arrived – but, even then, the desire that many people had to locate me as a person connected to the Mainza family was a serious one. It also gave me certain responsibilities, although these were obviously not the same as the other children and grandchildren of the family because I was always a newcomer and an outsider in certain obvious and enduring ways. I was also, importantly, regarded as a person with prior and continuing obligations and responsibilities to my own family in the United Kingdom. For instance, because my mother's name is Julie, I was also sometimes called '*mwana waJulie*' by Mrs Mainza.⁶¹

Despite occupying a distinctive and unusual position, my obligations and responsibilities to the family were, nevertheless, often quite real. The anthropologist Lisa Cliggett (2005), who has conducted fieldwork in the area since the early 1990s, describes her relationships with her host family, in a village in the Gwembe Valley, in the following terms:

I was expected to adhere to the various obligations and responsibilities inherent in kinship relations. Whether I liked it or not, I became part of the family and had to behave appropriately . . . Being a foreigner, white, and perceived to have vast resources clearly influenced the way that . . . [the] family, and the villagers in general interacted with me. In fact, I believe that it is due, at least in part, to my "otherness" and perceived wealth and status that people were so eager to establish a kinship relationship with me. By creating a formal "alliance" with me, they had better access to my resources. The power dynamics of being "white," "foreign," and "rich" cannot be overlooked in the research experience (2005: 41, 170).

The people with whom Cliggett lived were quick to position her within their pre-existing networks of mutual support and they cultivated these relationships with a sense that they might enable access to some of Cliggett's wealth. My experiences were similar, although, as I have mentioned, Mr and Mrs Mainza with were relatively well-off compared to other families in the area and, consequently, the idea that I was

somebody with access to wealth did not seem to shape our relationships as strongly as in Cliggett's case. The point here, however, is that, from early on, kinship terms were central to the people's attempts to locate me within recognisable relationships of obligation, responsibility and dependence. Indeed, I was often struck by the ubiquity of kinship terms in everyday life and the way in which they were used to position people within wider relationships across many contexts. To quote Colson once again: 'If he wished to do so, the Tonga with the faintest knowledge of his local community could probably address everyone within it by some kinship term' (1958: 59-60).

If we return to the cases being considered in this chapter, kinship terms were used as honorific forms of address and as a way of locating people within relationships, but they could become charged with a greater moral significance when they were used to make claims on others. In these cases, kinship terms were used to suggest and evoke the obligations and responsibilities that family members and close friends were expected to have to one another.

When Gertrude and Mr Sikabondo arrived at the hospital they used kinship terms to address staff members. This was a way of evoking notions of obligation and dependence. As we saw, however, this was more often successful when visitors to the hospital were known by the staff members in question – and these staff members were therefore either flattered to be positioned as the dependent of an authoritative and powerful person (in the case of Mr Sikabondo) or they were mindful of cultivating a good relationship with a potential patron (in the case of Gertrude), or they recognised their mutual dependence (in the case of Mr Muyuni). It is clear from the work of anthropologists in other parts of Africa that the obligation to assist family members during times of illness and debility is a powerful and pervasive moral idea. Iliffe (2006) points this out, in his work on the history of HIV/AIDS within sub-Saharan Africa. As he observes, 'it appears [that] families had a unique and morally inescapable obligation to care for their own' (2006: 102). In Zambia, the president Kenneth Kaunda initially opposed the introduction of state-funded care for the elderly because, as he said, it was the responsibility of families to look after their elderly members which is a 'sacred and noble duty' (quoted in Cliggett 2005: 158). Kinship terms, then, were not only courtesy terms, but were also connected to widespread and strongly held moral ideas about relationships and the need to recognise obligations and responsibilities.

It is also important, furthermore, that Gertrude and Mr Sikabondo – once they had established their relations with staff members – were able to explain their afflictions to staff members in such a way that elicited care. Their afflictions were considered to be worthy of attention in the context of their relationships with staff members. Among patients at the hospital who did not know members of staff, all they had was their afflictions – and, outside of any pre-existing relational context, afflictions alone were not always considered to be worthy of attention. Mutinta’s mother and Joshua’s sister showed the staff members the physical afflictions of their relatives (the bruises on Mutinta’s legs and Joshua’s swollen foot) and while this was necessary, it was not always sufficient. These forms of what we might call bodily claim-making are worth considering in slightly more detail here.

Kinship and bodily claims

When Mutinta’s mother was trying to elicit a response from the Zambian staff and get treatment for Mutinta, she showed them the bruises on Mutinta’s legs many times. The fact of Mutinta’s affliction, when regarded by staff members who had no relation to Mutinta or her family was not enough, in itself, to generate a response from the staff members on duty, beyond a cursory and minimal inspection. It is worth reflecting, briefly, on the meaning of bodily afflictions and what this might have to do with moral ‘aspect perception’.

Anthropologists of southern Africa have shown how the body has long been central to moral claim-making and relations of care. In her work on elderly women in Botswana, for example, Livingston points this out clearly, describing how elderly women might use their bodily afflictions to elicit care.

Elderly women might want to let themselves age – to become blind, to walk with a stick, to become bedridden. A slower, shorter range of bodily movements itself marked the moral authority of seniority and self-restraint . . . Such bodily manifestations of aging (which are accelerated in the case of a stroke, amputation, cataracts, etc.) ideally facilitate the flow of care from juniors to seniors, most

critically from daughters to mothers, as bodily needs mark decreased responsibilities and are met with various forms of assistance . . . Nonetheless, and often lacking other options, some women so prefer to succumb to senescence rather than struggle to maintain or regain bodily abilities, in the hopes that doing so will bring care. (2007: 184; cf. Cliggett 2005)

Livingston here points out the close relationship between kinship relations, outward signs of bodily affliction, and relations of care. The body itself can come to signify the need for care when it is situated within a network of relations of dependence and obligation that are recognised – or morally perceived – by others. There are, of course, family members who might not respond to the bodily frailty or afflictions of their relatives, for various reasons (see, e.g., Cliggett 2005: 97-116). Nevertheless, the moral meanings of bodily affliction within kinship relations are different to the moral meanings of bodily affliction in clinical settings between people who do not know each other. Clinical contexts require people who do not necessarily have any prior relationship (or reasons for making compelling claims on one another's time or resources) to enter into new ways of morally 'seeing' one another.

Even when patients have managed to access care in clinics and hospitals throughout Africa, it is their relatives who typically end up providing most of their daily care (see Brown 2012; Livingston 2012; the same is reported in hospitals in other parts of the world, see, e.g., Zaman 2004, 2005). This was also common during the colonial period and was encouraged by missionaries. In colonial Tanzania, a missionary named Dr Taylor wrote (in 1929) that, 'We like the patient to have one relative with him . . . for it is difficult to get anyone to cook and fetch water for him otherwise' (quoted in Ranger 1981: 268).

While I do not want to suggest that staff members simply did not feel compassion or morally perceive the suffering of patients – as Chapter Five will show – it is, nevertheless, important to recognise that moral perceptions of suffering are not uniform or universal. They exist within relationships. The anthropologist João Biehl claims that 'we' have acquired a 'blindness' and a 'learned indifference [to suffering] . . . We manage not to see the abandoned in our homes and neighbourhoods, rich and poor' (2005: 42). Whether the 'we' here is taken to mean people in 'the west',

anthropologists, or some other more or less inclusive category, Biehl's assumption seems to be that it is natural to possess the capacity for perceiving other people's suffering and somehow people have 'learned' to avoid these natural instincts and make themselves 'blind'. Scholars of humanitarianism and historians of political thought have demonstrated the historical specificity and parochialism of this assumption (see, e.g., Calhoun 2008; Ignatieff 1984).

To be able to 'feel' compassion (*kumwva luse*) is a capacity that is acquired and involves learning to 'perceive' and 'notice aspects' of other people's conduct in certain ways. This was once explained to me in the following terms by my friend Peter Mwala (who helped me often as a research assistant): 'Lots of people here, they are shy about asking for things. For you people [i.e. white people] you ask for things very directly. In our case, we show that we have a need and expect other people to react if they have compassion'. This can be seen in the cases under consideration in this chapter.

Gertrude and Mr Sikabondo, for instance, were able to evoke the conditions within which their bodily afflictions were recognised by staff members. After all, the kind of 'succumbing to senescence' that Livingston describes – in which the impaired body comes to constitute a visible moral claim in itself – is only successful in contexts where others already have a reason to morally perceive the body in question as one that requires, elicits or even demands care and attention (a theme that will be further considered in subsequent chapters).

Some bodies, then, were perceived as being worthy of care in the context of relations of obligation and dependence. When rural patients encountered the missionary doctors their afflictions elicited care without the need for prior relations of kinship or friendship. In the next section of this chapter, I consider the distinctive form of praise used by patients – the term 'angels' (*bangelo*) – in order to argue that the concept reveals a lot about the moral aspect-perceptions of the patients in their encounters with the American missionaries.

Making claims on the American Missionary doctors

During my time at the mission hospital I only heard a few patients refer to either of the long-term American doctors (or any of the visiting missionaries) using kinship terms. Not only is this surprising because of the importance of kinship language, as we have seen above, in constituting persons and forming relationships, but it is also unusual because there are ethnographic examples of missionaries and foreign healthcare workers in Africa being incorporated within vernacular languages of kinship (e.g., Pels 1999; Molyneux and Geissler 2008).

In the next part of this chapter, I show that patients positively valued the American missionaries' location outside of local relationships of kinship and friendship. It was not necessary for patients to evoke relationships of care and obligation using kinship idioms because it was sufficient for them to show the American doctors that they had a bodily affliction. When Mutinta's mother dealt with Dr Hannah all she needed to do was to show her Mutinta's bruises and this was enough, in itself, to persuade Dr Hannah to treat her daughter. Indeed, in Chapter Four I show how the bodies of patients were positioned in the moral imaginations of the missionary doctors – often patients were regarded as exemplary Christ-like figures who suffered in faithful and silent endurance. Patients, on the other hand, positively valued their relationships with the American missionary doctors precisely because the labour of trying to 'strike up' relations of dependence with staff members (in order for their bodily afflictions to have been taken seriously) was not required.

The American missionary doctors as bangelo

When I conducted interviews with patients and spoke with visitors to the hospital I became aware of the use of a Chitonga term to refer to the American missionary doctors, in particular Tom and Hannah, and this was the term *bangelo* (singular, *mungelo*), which literally translates as 'angels'. We have already encountered the use of this term in the cases of Mutinta and Joshua. A characteristic use of the term occurred when I spoke to a woman who was with her pregnant daughter, who was

scheduled to give birth in the next week. She said: ‘Where we come from most women die when they give birth. In our village we know about doctor Tom and he is like an angel [*munghelo*] to us.’

Bangelo is a concept with an interesting genealogy in the region that is worth considering here. The term *bangelo* was introduced into the Southern Province of Zambia with the arrival of Christian missionaries in the early twentieth century. Unlike certain other Christian concepts – for instance God (*Leza*), Lord (*mwami*), or heaven (*kujulu*) – there was no sufficiently similar pre-existing Chitonga term that missionary translators of the Bible could expand to accommodate the new Christian concept of ‘angels’.⁶² The word takes its root from the English ‘angel’ (*-ngelo*), with the *ba-* and *mu-* prefixes (which denote the plural and singular forms, respectively) being used for the class of nouns which includes people and large animals. The term, as we shall see, like many others in the context of missionary encounters, came to be used in ways that exceeded the expectations and understanding of missionaries themselves (cf. Comaroff and Comaroff 1991, 1997; Keane 2007; Pels 1999). Indeed, the concept of *bangelo* is an example of the way in which, in Zambia, ‘Christianity [has] populated the invisible world with new spirits’ (Gordon 2012: 12). One area in which this had significant consequences was in the domain of healing and divination.

Among diviners (*bang’anga*), there have been some, historically, who have practised a form of divination to cure people whose afflictions are caused by alien spirits (*masabe*). These spirits can cause various problems and the role of the diviner is to tell the person what they must do to appease the alien spirit. A new form of divination emerged in the region during the 1960s and 1970s in which diviners started to channel a new type of spirit: the spirits of angels (see Colson 1969, 2007; Keller 2007). Unlike *masabe* spirits, which caused illness, *bangelo* spirits gave the diviner the ability to identify the cause of illness or misfortune whether this was a *masabe* spirit, for instance, or witchcraft (*bulozi*), or the displeasure of ancestral spirits (*mizimu*). *Bangelo* diviners were visited in person (and often in dreams) by these angel spirits. The angel spirits themselves have often been described by *bangelo* diviners as white people (*bakuwa*) dressed in white clothing.⁶³

These diviners, as Colson has noted, were distinctive in making use of imagery associated with hospitals and Christian worship (2007: 362). Bonnie Keller (2007) conducted one of the few anthropological studies of *bangelo* diviners during the 1980s in a large town in the Southern Province. Keller worked with urban *bangelo* diviners who took their clients into small 'divining houses' that were built specifically for the ritual. These divining houses had no windows and were made of bricks constructed from dried mud. As Keller notes, these small buildings were 'white-washed to represent angels' and above their doors often 'a Christian cross was painted in red, to symbolize the ultimate power of God and Jesus' blood' (2007: 158). The *bangelo* diviners with whom I spent time also described the strong association of whiteness (in clothing and objects) with angel spirits. A diviner known as Dr Simamba directed me to the shrine in her homestead in which she had placed a white feather which, she told me, would be attractive to the angel spirit that occasionally visited her in person and in dreams. Like many other accounts of diviners and healers in the region (for a recent account see Langwick 2011) the *bangelo* diviners I spoke with all became aware of their healing abilities during their own experiences of serious illness.⁶⁴ They sought treatment from diviners and healers who, in turn, recognised and encouraged the healing abilities of their patients.

What is particularly relevant here is that diviners had no ongoing obligations to *bangelo*, who were alien spirits but essentially benevolent. They arrived to assist diviners with the diagnosis of afflictions. This made *bangelo* spirits different to other spirits, to whom people had a number of clear and enduring obligations. People in the area have historically taken their relationships with ancestral spirits (*mizimu*) seriously, although this is less common today (particularly among Christians from certain churches, such as SDAs and many Pentecostals). These were relationships that might be usefully characterised as hierarchical patron-client relationships of dependence. When people felt that certain ancestral spirits were failing to meet their needs, they would switch their allegiance to other ancestral spirits at alternative local shrines in much the same way as dependent clients might have switched their allegiance to alternative patrons in certain circumstances (e.g., Miers and Kopytoff 1977; Ferguson 2013, 2015). 'Spirits, like people, were expected to observe the rules of reciprocity', as Colson wrote, and therefore, 'if they failed to make return when approached in due form, they were told in no uncertain terms that they would be

forgotten and people would seek more responsive patrons' (2006: 29; cf. Langwick 2011: III). As James Pritchett (2011) has written: 'The binding nature of promises and obligations does not cease with death' (2011: 46).

Clearly, then, *bangelo* spirits have exemplified a form of power that was closely connected, symbolically, to both Christianity and biomedicine and was also located outside of local relationships of obligation and dependence. The suggestion I wish to make here is that the term 'angels' has retained traces of its historical moral meanings and people's relations with angel spirits (*bangelo*) have been remarkably similar to their relations with the American missionaries.⁶⁵

In some conversations with diviners, the distinction between *bangelo* spirits and American missionaries blurred, particularly in the reporting of dreams. An elderly diviner called Mrs Chipepo, who used to be visited often by an angel spirit, told me about a dream she had which reflects the transient nature of both missionary and *bangelo* visitations and the impossibility of returning with *bangelo* spirits or missionaries when they leave Zambia and return to their homes elsewhere. Mrs Chipepo referred to her *mungelo* spirit as a white person (*mukuwa*) in this context.

There was a time when I flew with the *mukuwa* in a dream I had. I was putting on white clothing and then we flew and eventually we reached the roof of the sky. And then the white man went through the roof but I couldn't go through it so I started to fall down again on my own.

The white person who flies through the roof of the sky resembles (almost too literally) Redfield's metaphor – which was mentioned in the introduction – of the 'lightness' of expatriates compared to the 'heaviness' of local populations who are the recipients of aid (2012, 2013). And yet this metaphor is another way of expressing the notion that the missionaries were not dependent on anybody and were able to leave at any time. Mrs Chipepo's dream seemed to reflect this relationship of transience and the mysterious disappearance of the white person/angel spirit to an unknown place elsewhere, from which she was disconnected at the last possible moment (cf. Ferguson 2006). Unlike Redfield's suggestion that expatriates leave behind them 'a thin residue of artifacts

and memories' (2012: 370), however, such images are hardly 'thin' and convey morally significant memories and sentiments.

The idea that missionaries – like *bangelo* spirits – stood outside of local relationships of obligation and dependence was sometimes expressed in the language people used when they explained to me why patients might have called the missionaries 'angels'. For example, when I first asked Peter Mwala about the term, he found it necessary to explain it with reference to the history of other spirits.

Mizimu [ancestral spirits] have been believed to have episodes of anger when certain rituals or norms have been violated. *Bangelo*, on the other hand, have never been known to manifest any anger. A person surviving a fatal accident would be said to have been protected by his *mungelo*. To this day, *mungelo* is still used to refer to someone who has helped somebody else he does not know. For instance, if you consistently reach out to the needy, people will begin to refer you as *mungelo*. That is why some people say that about [the missionaries].

It is important, then, that this term of moral praise was used to describe the missionary doctors given that *bangelo* have historically occupied a place that is quite unlike other spirits and they have been situated perpetually outside of locally enduring relationships of dependence and the language of kinship. This is important because, as I will outline in the next section of this chapter, it is illuminating to locate this notion of missionaries as 'angels' alongside the more commonly discussed images of missionaries and biomedical practitioners as 'vampires' or 'witch cannibals'.⁶⁶ How have such positive moral evaluations of self-sufficient outsiders co-existed with these more sinister visions? And what might such moral evaluations tell us about relations of detachment and dependence? These questions will be considered in the final section of this chapter, where some of the further implications of this particular ethnographic case will be considered.

Europeans as vampires and angels

The concept of *bangelo*, as it was used by rural patients at the mission hospital, can show us something of the ambivalent place that white Europeans and Americans have occupied in the imaginations of the Chitonga-speaking inhabitants of the region from the colonial period to the present. For understandable reasons, anthropologists and historians have emphasised the multiple ways in which foreign visitors have been associated with ideas and images of unwanted exploitation and the extraction of vital life forces, such as blood and body organs. Much of this work has argued that the colonial system of labour migration and the introduction of biomedical technologies have, in different and complicated ways, provided people in the region with powerful images and metaphors to describe and morally evaluate the actions of white settlers during the period of British rule and after. Nevertheless, it is also important to stress some of the ways in which the outsider position of white visitors has also been positively valued by people over time – although, to be sure, not without ambivalence or uncertainty. It is worth thinking about these images and ideas of white Europeans as a part of the ongoing ‘afterlives’ (McKay 2012) of colonial and post-colonial humanitarianism.

There are many examples from within Zambia – and elsewhere in central and southern Africa – of Christian and biomedical ideas and practices informing and shaping pre-existing religious and healing rituals in ways that emphasised negative feelings, among African populations, about certain elements of colonial rule. One of the most widely documented cases is that of white and Indian settlers being known as *banyama*. This word is translated as ‘witch cannibals’ by some (e.g., Colson 2000: 340) and as ‘vampires’ by others (e.g., White 1993).⁶⁷ *Banyama* were people who extracted the organs and blood of other people in order to enrich themselves – something that some scholars have been keen to identify as a symbolic representation of the extractive political economy of mining in southern Africa or, in more recent years, ‘neoliberalism’ or ‘occult economies’ (e.g., Comaroff and Comaroff 1999).⁶⁸ Ideas of ‘*banyama* gangs who worked for European and Indian bosses [seeking] to obtain blood or turn victims into zombie labourers’ (Colson 2000: 340) have been around since the 1920s according to historians of the phenomenon (e.g., White 2000; see also Wilson

1959: 150). In the Southern Province, reports of *banyama* first became prevalent in the 1970s and 1980s and, by the mid-1990s, these stories had come to reflect a knowledge that people had of 'the market for transplant organs' in other parts of the world (Colson 2000: 340).⁶⁹

I heard several stories of people being killed in the area for their organs. The explanation for this, when I heard these stories, was that wealthy businessmen from South Africa enlisted local Zambians to kill their relatives and harvest their organs in exchange for large amounts of money. This was why some people were able, mysteriously, to buy cars and other luxury items. A sign that somebody might have been involved in this kind of activity was, often, that they had acquired a large amount of wealth and were visibly failing to share this wealth with their family – indeed, the failure to attend to one's family obligations was usually a morally suspicious sign. Witchcraft, vampire and zombie rumours have long been associated with ideas about proper moral relationships of obligation and dependence.

In the Lowveld area of South Africa where Isak Niehaus (2005) worked, there was a 'perception that witches used zombies to compensate for their lack of helpful dependents' (2005: 202). In other words, the 'asocial' or non-dependent status of certain people provoked a considerable amount of anxiety. This is an illuminating way of understanding the attributes of witches: they fail to fully participate in ordinary human relationships. They are, for example, infertile (Comaroff and Comaroff 1999: 289) and cannot eat with other people (Green 2005: 255). Ultimately, in various ways (and in different contexts) they demonstrate 'the inversion of normal human attributes of sociality . . . Witches walk upside down, fly when others walk and prefer night to day' (Green 2005: 251).

Luise White (1993, 1995, 2000) has traced anxieties about white settlers (such as mine workers, missionaries, and shop owners) in central Africa using archival research and oral histories in her well-known book, *Speaking with Vampires* (2000). White gives many examples of European settlers being called *banyama* – for instance, shop owners who treated locals poorly; Catholic missionaries (the White Fathers) in the north of colonial Zambia who made their students perform agricultural work to pay for their lessons; and white settlers who were accused of abusing African children (see White

1993). According to White, these images and ideas are not reducible to any other level of explanation.

These images and characters had the power to terrify and explain because they touched on so many Zambian . . . experiences and concerns. They had intense meaning because they were told and retold in the vocabularies of peoples' daily lives and conflicts. For this reason no one interpretation fits all banyama rumours, no single analysis can explain how banyama accusations develop and then fade. Banyama rumours, like the blood extracted and abstracted in them, had the fluidity to describe many situations. (1993: 772)

White avoids the temptation to explain away the rich imagery found in *banyama* rumours and persuasively suggests that their 'fluidity' is a part of what made them such compelling stories for Zambians in many different contexts. What I want to suggest here, however, is that what connects angels and vampires – *bangelo* and *banyama* – is that neither have, historically, been 'inhibited by human obligations' (Colson 2000: 335; cf. Niehaus 2005).

The idea that European, American, or Indian settlers in Zambia are somehow outside of local relationships, and therefore not bound by obligations to Zambians, is one that has produced considerable anxiety and fear in the case of *banyama* rumours and yet also positive regard towards outside benevolence in the case of *bangelo* narratives. Seeing *bangelo* and *banyama* within the same frame helps us to understand how people who were not subject to local moral obligations and responsibilities have offered Zambians both the terrifying image of the *banyama* or the reassuring image of the *bangelo*. Put simply, vampires take and do not give, while angels give and do not take.⁷⁰ Both exist and somehow sustain themselves in the absence of obligations to local people and this has created fears, but also attractive possibilities, depending on the context.

For instance, during moments of colonial rule when Zambians in rural areas began to experience some of the uncertain effects of labour migration, white settlers could easily become figures of moral uncertainty who could not be influenced and who were often assumed (with good reason) to have sinister motives. However, in the context of

postcolonial healthcare, where patients have often needed to have relatives or friends among the staff members to ensure adequate treatment, white missionary doctors (as outsiders) have offered attractive possibilities for poor rural patients precisely because they have no specific local obligations and therefore have not tended to privilege anyone in particular.

Some anthropologists have noted that vampire rumours often diminish as the people under concern (for example, healthcare workers or missionaries, among others) enter into more recognisable relationships with local people and become incorporated within relations of obligation and dependence. Indeed, ‘outsiders’ can lose their outsider status and, furthermore, ‘insiders’ (friends, relatives or neighbours) can become subject to new suspicions. The missionaries at Matamba, however, tried to avoid becoming incorporated within locally recognisable relationships of obligation or dependence. It has been observed that humanitarians ‘engage in altruism that offers little scope for reciprocity’ (Keane 2016: 257) and, as we will see in the next chapter, the missionaries needed to remain perpetually outside of local relationships in order to pursue their moral vision. Indeed, the asymmetry of wealth and power that structures the relation of the benefactor to the beneficiary (see Simmel 1965; Elisha 2008) was central to their form of Christian medical humanitarianism

Conclusion

In this chapter I have tried to show how rural patients who visited the mission hospital positively valued their relationships with the American missionary doctors and I have offered a way of understanding their use of the term *bangelo*. Because the American missionaries were located outside of local relationships of obligation they offered an attractive alternative to the Zambian staff who tended to privilege certain patients over others. Indeed, anthropologists who have worked in the region have noted many times that for patients at clinics and hospitals: ‘Knowing somebody – anybody . . . may help one move in the right direction’ (Mogensen 2005: 224).⁷¹

This has also been noted in other parts of the world. In her work on humanitarianism in Delhi, Erica Bornstein (2012) has noted that

one helps those one has relationships with, not abstract others. Webs of kinship obligations present constant demands and responsibilities; even friendship works in the same manner . . . That humanitarians help others with whom they have no connection is what makes them distinctive in the Indian context. (2012: 146-147).

Missionaries, as I have shown in this chapter, were distinctive in the Zambian context. One of the purposes of this chapter has been to show that this distinctiveness was positively valued by rural patients. In the first part of this chapter I mentioned that Ferguson's discussion of dependence failed to address the question of how people in southern Africa have morally evaluated relationships of dependence and it is this question to which I return here.

As we have seen, in the last few years many anthropologists have written about relationships of dependence and hierarchy. One of the claims made by these anthropologists is that these relationships pose a challenge to 'liberal common sense' and the political sensibilities of anthropologists (Ferguson 2013: 226; see also Schertz 2014; Haynes and Hickel 2016; Haynes 2017). Therefore, it is suggested, anthropologists need to question certain of their own political and moral assumptions in order to begin to understand and properly contextualise such aspirations for 'subordination' – an argument that has been made, influentially, in other contexts (e.g. Mahmood 2005).⁷² Many of these arguments are premised on a rhetorical contrast between 'liberal' and 'nonliberal' values. It would certainly be misguided to assume that the rural patients who visited Matamba Mission Hospital were, in any sense, 'liberal individualists' who valued autonomy and independence. As I have indicated, relations of dependence and mutual support were central to most people's lives inside and outside the hospital.

Nevertheless, as I hope to have shown, it would be equally problematic (and, indeed, premature) to suggest that the patients at Matamba Mission Hospital in Zambia, or people in southern Africa more widely, are committed to a radically different, and somehow thoroughly 'nonliberal', set of values (cf. Englund 2013; Laidlaw 2014). The rural patients who visited the mission hospital – and who valued their treatment at the hands of the American doctors – were expressing (albeit in an initially unfamiliar

vernacular idiom) the recognisable desire to be treated on the basis of their immediate needs rather than on the basis of pre-existing personal relationships with hospital staff members (which they were unable to mobilise). In southern Zambia, the need to sustain relationships of dependence, although a common aspect of people's lives, is regularly a source of difficulty and frustration – especially for those who find themselves unable to make claims on others in contexts such as hospitals and clinics where such relationships determine, to a large extent, who receives treatment.

The American missionaries represented an opportunity for local people who were shut out of such hierarchical relationships of dependence to be able to avoid some of the burdens of such relations. Being treated by 'outsiders' who were not subject to the same forms of obligation and mutual dependence – and who were therefore 'detached' in a certain sense – was highly desirable (cf. Candea et al. 2015). I think this indicates the danger of writing as if 'the kind of self that is characteristic of persons in "the modern West" were entirely different from, indeed something like an inversion of, those found everywhere else' (Laidlaw 2014: 33). When Ferguson (2013) writes about the importance of relationships of dependence in southern Africa, he suggests that outside of 'networks of dependence' people have often been regarded suspiciously as 'asocial': a person outside of relations of dependence would be 'nobody – except perhaps a witch' (2013: 226-227). Another possibility, however, is that they might be regarded as an angel. If we fail to remain open to such possibilities – by closing them off analytically in our expectation of discovering 'nonliberal' aspirations – then we may miss certain important dimensions of the social and political lives and values of those whom we are trying to understand.

Chapter Three

Dealing with Jesus himself: moral obligations, material inequalities and the missionary vocation

Introduction

On Christmas Eve in 2014 there was a service for the patients at Matamba Mission Hospital. This was organised by local churches and the ceremony involved pastors from different denominations leading songs and prayers in different sections of the hospital: in the out-patient department (OPD), the maternity ward, the male and female wards, and in the children's ward. I found myself with Dr Hannah, crowding into the maternity ward, where we were all given candles to hold as we greeted the mothers. Some of these women were tired or sleeping and did not wish to be disturbed, while others sat up in their beds and greeted us all. Each of the mothers had recently given birth (most of them earlier that day) and they were all offered gifts of *citenge* fabric, biscuits, and bottled drinks.

The pastor from the local Catholic church, Daniel Mubita, led us all in singing a hymn in Chitonga and then he asked Dr Hannah if she would say a prayer. Daniel translated Hannah's words into Chitonga as she prayed and, towards the end of her prayer, Hannah's voice stuttered as she held back her tears. In her prayer, Hannah pointed out that Jesus was once a vulnerable child, just like the newly-born babies in the maternity ward. Hannah said,

Seeing these babies, Lord, it reminds all of us here that when you sent your only son to us, to save us, he was born of a woman and he looked just like these babies here. He was vulnerable and he was tiny and he needed to be looked after and cared for. He was just like these babies, but he was your son. If Jesus was born again today, he would be just like one of these tiny babies here.

Hannah's emotional prayer was met with gratitude from Daniel Mubita, who offered his thanks and said several words of his own to conclude the service. The visitors

exchanged words with the mothers in Chitonga and English and eventually we all filed out of the maternity ward into the warm evening air. We could hear the sounds of loud prayers and enthusiastic singing in some of the neighbouring wards, in which Pentecostal pastors were taking longer to dispense gifts and engaging in altogether more energetic forms of worship than we had seen in the maternity ward.

I had regarded Dr Hannah, until that moment, as a relatively unsentimental person and was surprised by how moved she had been by the vision of each of the newly born children, in the maternity ward, as figures of the baby Jesus. At this time, however, I did not yet realise how compelling this image was for both Hannah and Tom when they thought about their work in Zambia and their obligations to the patients at the hospital. As I heard them speak about their missionary vocation over time, it became clear that, for both Dr Hannah and Dr Tom, the obligation to treat and care for patients at the hospital was profoundly shaped by their sense that, as Christians, they should regard patients with the same kind of ‘love’ that they felt for Jesus himself. Indeed, for the missionaries, the patients at the hospital were Christ-like in several ways. Firstly, their lives were Christ-like and ‘sanctified’ in their preciousness, something that is considered in this chapter and, secondly, patients were regarded, at times, as Christ-like in their capacity to endure suffering and distress, something I look at in the next chapter.

In this chapter and the next I consider how the Christian missionaries at Matamba Mission Hospital imagined and experienced their obligations towards the Zambian recipients of their medical care and how, by contrast, they viewed the Zambian clinical staff at the hospital, whom they often suspected of lacking a sufficient Christian work ethic and commitment to their patients. In this chapter, I look at the long-term or ‘career’ missionaries (Dr Hannah and Dr Tom) and, in the next chapter, the short-term visiting missionaries are considered. In these chapters I take seriously Liisa Malkki’s recent suggestion that, in order to understand contemporary humanitarianism, we need to consider

the frequent weakness, neediness and non-universality of the humanitarian “benefactor” – the giver who, no less than the receiver, always sets out from a

social and existential position both specific and precarious. (2015: 8; cf. Fabian 2000; Mathers 2010).

In order to do so, I examine the circumstances in which the American missionaries lived in order to show how their day-to-day habits shaped their relationships with local Zambians, both patients and clinical staff members. In this chapter, I show how Tom and Hannah worked to maintain a position of independence and detachment in their lives in Zambia and I suggest that it was ultimately from such a position that they were able to continue to fulfil their demanding Christian moral obligations over time. It was their ability to be able to refuse the widespread condition of mutual dependence upon others that enabled them to treat patients, to a large extent, as equal Christ-like individuals – certainly something that nobody else living locally was able to do in quite the same way (which, as we saw in the last chapter, is one reason why they were so positively valued by rural patients).

Furthermore, I suggest that, at Matamba Mission Hospital, patients were not reduced to their individual ‘biological’ or ‘bare life’. Rather than a shift from ‘social life to biological life’ (Fassin 2012: 15), in the hospital there was a shift from ‘social life’ to ‘sanctified life’. I consider relations at the mission hospital from Tom and Hannah’s perspective by looking at two central ethnographic cases. The first was a particularly unusual and demanding week when a large number of women needed emergency caesarean sections which were performed by Dr Tom. The second was a controversy about whether the mission hospital should acquire a generator or not – a dispute that took place many years before I arrived at Matamba, but one that still featured in the thoughts of Tom and Hannah and to which they often returned as way of explaining their own moral convictions.

Before turning to these questions, however, it is necessary to historically contextualise the way in which Christian medical missionaries have pursued their distinctive moral and political ambitions over time in the region, something explored in the first half of this chapter. Today, Matamba Mission Hospital is administered through a ‘partnership’ between expatriate missionaries and the Zambian government. Mission hospitals (in southern Africa and further afield) are historically distinctive institutions and it is worth thinking about them in contrast to government hospitals. For instance,

Street (2014) has suggested that rural government hospitals in Papua New Guinea have ‘not historically emerged as a technology of governance so much as the site[s] of multiple ongoing, incomplete, and contested projects of state building’ (2014: 22; emphasis removed). In Zambia, by contrast, rather than projects of ‘state building’, mission hospitals have been part of a diverse array of ongoing Christian moral projects that have taken place within negotiated (and often strained) ‘partnerships’ with the colonial and post-colonial governments. It is worth situating American missionary projects within this history in order to demonstrate how missionaries have strived to maintain their independence and autonomy in relation to the state and how these struggles have shaped their moral and political aspirations.

Collaboration and compromise: missionary partnerships in historical context

Referring to the place of mission stations in rural central Africa, the anthropologist James Pritchett (2011) has written that the ‘degree of continuity between the colonial and postcolonial roles of these mission stations is astonishing’ (2011: 29).⁷³ Indeed, these historical continuities are often overlooked in anthropological attempts to understand the relationships between African governments and non-governmental organisations (e.g., Ferguson and Gupta 2002). From the colonial period to the present day, Christian missionaries have been providing healthcare services in rural central and southern Africa. In some parts of Zambia, mission hospitals and infrastructure have been incorporated within the government healthcare system, although in other areas missionary organisations have maintained a greater amount of autonomy and distance from the government. It is worth pointing this out because historians of colonial medicine have often downplayed the role of missionaries and, consequently, exaggerated the extent to which colonial states were in control of medical practitioners (e.g., Arnold 1993; MacLeod and Lewis 1988).

As outlined in Chapter One, during the early colonial period (c. 1890s-1924), the territory of present-day Zambia was administered by Cecil Rhodes’s mining company, the British South Africa Company (BSAC). The relationship between the BSAC and the earliest missionaries was, in the words of the historian John Ragsdale, one of ‘mutual toleration’ (1986: 93). While often suspicious of the potentially disruptive

effects of their proselytising, BSAC officials regarded missionaries as useful political actors who could help them to reduce the costs of governing the territory. As Cecil Rhodes once put this, 'missionaries are better than policemen, and cheaper' (quoted in Snelson 1974: 19). Early missionaries, for their part, often tended to keep their distance and resisted incorporation into the Company's formal governance of the territory.⁷⁴

The earliest missionaries did not have extensive medical training and the first medical missionaries were sent primarily to care for other missionaries. It was only later – towards the end of the nineteenth century – that medical missionary work emerged 'with its own rationale' and identity (Hastings 1994: 277). As greater numbers of medical missionaries arrived, they wanted clarity about their role in the territory. When the British Colonial Office started to govern the territory in 1924, the position of missionaries did not become any more sharply defined, although they continued to provide more medical services than the colonial government. As Vaughan has shown in her work on medicine in British colonial Africa, during 'most of the colonial period and throughout most of Africa, Christian missions of one sort or another provided vastly more medical care for African communities than did colonial states' (1991: 56). By 1938, for instance, over 65 percent of biomedical treatment in colonial Zambia was provided by missionaries and yet they received from the government only around 5 percent of the Health Department's budget (Henkel 1989: 147).

Missionaries therefore found themselves in a difficult position. They wanted to receive money from the colonial government but, at the same time, they also wished to retain their autonomy and right to proselytise – an aspiration that many colonial officials viewed unsympathetically.⁷⁵ Many missionary societies, therefore, wanted the government to explain the nature of their relationship while, at the same time, colonial officials remained 'reluctant to set precedents in providing funds for missions' (Jennings 2008: 45).⁷⁶ Furthermore, despite their desire for 'grants in aid' from the government, many medical missionaries were regularly critical of the British administration, suggesting that the government was failing to provide basic services and privileging urban areas, while ignoring the medical needs of Africans in rural areas.⁷⁷ In a letter that is representative of the exchanges between medical missionaries and the colonial government during this period, we find an American

missionary from the Southern Province writing to the Director of Medical Services to say that:

The grant received now is very small indeed when we think of the work done. With the ever increasing flow of patients and the threatened cut in our funds the future does not look too bright. We trust that your office will be able to help us in our task . . . During the past year we have been put to a great deal of extra expense in taking care of these [new] people . . . I am still of the opinion that we should be allowed more in the help of these people who are too far away from your [government] hospital in Choma for daily treatment.⁷⁸

This particular mission hospital was located at some distance away from the nearest government hospital in Choma⁷⁹ and this American missionary was directly criticising the colonial government's unwillingness to build more hospitals – a strategy, of course, that did not always endear missionaries to their potential benefactors.⁸⁰ The Director of Medical Services, perhaps frustrated at being criticised, expressed his surprise that the missionaries needed money from the government, reminding them that they had, after all, taken this task upon themselves: 'I have always understood that your mission, like others, undertook medical work at its own desire and for its own purposes'.⁸¹

This idea – namely, that missionaries were engaged in projects of their own making – was common among colonial officials. Many were suspicious of missionaries and feared that, if they became formally recognised providers of healthcare in the country, their evangelising might adversely affect their medical practice (Henkel 1989: 148; Vaughan 1991: 70). One Director of Medical Services wrote that medical missionaries were simply performing these services as 'an adjunct to evangelising' and were, therefore, an inconsistent and unreliable source of labour in the longer term.⁸² The same official went on to suggest that, given that missionaries were pursuing their own independent work, they would have a 'diminishing part to play' in the provision of healthcare in colonial Zambia.⁸³ In making this judgement, the Director of Medical Services could not have been more mistaken.

In the years immediately after independence the new government invested more money into both government and mission hospitals.⁸⁴ During this period, the newly independent government's bureaucracy included former British colonial administrators who remained in place during the period of transition to independent rule. In some cases, these former colonial officials were still working by the late 1960s and early 1970s (see Cowen 1995: 161; Sardanis 2014). The attempt to 'Zambianise' government and public services was slow, not least because of the limited preparations put in place by the British government before the 'hand over'. This was a period of considerable 'tension between black politicians and white civil servants' (Leenstra 2012: 169). Similar difficulties were experienced in many former mission churches.

An elderly Zambian member of the Wesleyan church, Rev. Thomas Maduba, told me about the independence period in the following terms:

For us, in my opinion, the transition was very abrupt. The missionaries were doing the work well, but politically there was independence and then there was a realization that nationals needed to take over, but there was no road map in place for nationals to be trained . . . Nationals were not prepared. So they had to step in without preparation, so there was frustration on both sides – from the nationals and the church in the United States (cf. Maxwell 2006: 406; Stuart 2011: 16).

The task faced by the new Zambian government, namely to staff health facilities with Zambian nationals, was particularly difficult given the limited number of trained Zambian doctors and nurses. Five years after independence, there were over 500 doctors in the country and fewer than 20 of them were Zambians (Leenstra 2012: 172).

Within Zambia, the move from the era of colonial medicine to a post-colonial healthcare system was also geographically uneven. Missionary medicine in Southern Province, for example, did not change as significantly as missionary medicine in other areas of the country, where mission hospitals were more fully and smoothly incorporated within the emerging Zambian healthcare system. According to the historian Walima Kalusa (2014), in the postcolonial period in the Eastern Province of

Zambia, missionaries accepted their new circumstances without significant opposition. Kalusa points out that these Catholic medical missionaries no longer charged patients for treatment, nor did they ‘undercut “traditional” medical knowledge and practices’ (2014: 238).⁸⁵ By contrast, in the Southern Province, we find the Provincial Medical Officer responding to complaints from local people that American missionaries (ten years after independence) were continuing to charge patients for transport costs to and from the hospital. The missionaries, themselves, responded by saying that they were not receiving enough money from the government to cover their petrol costs and therefore had to charge patients.⁸⁶ There are many examples of such conflicts over running costs. However, it was not just that missionaries were dissatisfied with levels of government funding, many also believed that paying for treatment was in some sense ‘morally improving’ or, at least, led to a higher level of compliance with therapy, an idea that remains important to some missionaries and humanitarian workers today (cf. Bornstein 2012: 76-77).⁸⁷

Despite these conflicts, some administrators looked to missionaries as a solution to the problem of the lack of clinical staff in the Zambian healthcare system. In 1968, a former British colonial official (who had stayed with the independent Zambian government as a permanent secretary) made the suggestion – directly contradicting the view of his colonial-era predecessors – that the government should actively recruit missionaries from overseas to work in hospitals in rural areas of the country, which were the most badly understaffed.

It is my belief that during this transitional period when Zambians are still training to take their rightful place in the health services of the country that such a scheme would be of immense value to the rural areas of Zambia . . . It is worth noting that at the present time Missions in Zambia are responsible for 45% of the medical services of the country . . . It has already been proved that the cost of running a Mission hospital is far less than if the same institution was run by Government. The reason for this is because Missions receive, apart from grants in aid from Government, assistance from charitable organisations outside of Zambia. All such assistance helps to subsidize the normal overheads and running expenses connected with a hospital which would normally have to be born *in toto* by Government.⁸⁸

Indeed, one of the enduring features of the political economy of healthcare in present-day Zambia is arguably the accepted idea – particularly among politicians – that missionary organisations (and now NGOs) can provide a considerable amount of the funding and provision of healthcare in rural areas. This has been particularly true since the period of economic decline in the 1980s, as discussed in the Chapter One, when mission hospitals were able to withstand these economic pressures to a larger extent in comparison with government hospitals, due to their sources of outside funding and the work of expatriate doctors (Henkel 1989: 152). Marsland (2007) has found the same situation in Tanzania, where ‘the government . . . has depended heavily on missions to provide biomedical services at a time when its own resources have been underfunded and stretched way beyond their limits’ (2007: 758).

Matamba Mission Hospital has remained relatively autonomous in its ‘partnership’ with the Zambian government compared to other mission hospitals in Zambia and this has shaped the moral vision of many missionaries. There are interesting comparisons to be made here with the NGOs and international charities who engage in short-term work and who wish to avoid having any long-term influence. Recent anthropological work (e.g., Bornstein 2005; Fassin 2012; Malkki 2015; Redfield 2005, 2012, 2013) has tended to focus on organisations who have short-term encounters with the recipients of their aid. Redfield notes that MSF attempt ‘to remain a minimal and temporary response, not the basis for a new regime’ (2013: 21) and MSF remains perpetually vigilant about ‘involvements that would position its work as a substitution for what they see as the responsibilities of states’ (2005: 338). Redfield shows how this recognition has long been crucial to the moral and political stance of MSF as a humanitarian organisation.

Missionaries, in comparison, have not had the same misgivings about their own work in relation to ‘the responsibilities of states’ because, as we can see in Zambia, they emerged alongside the state and in the context of rural healthcare missionaries often helped to form ‘the basis for a new regime’. This is important to note because when the World Health Organisation (WHO) writes that it is currently Zambian government policy ‘to support private-public-partnerships (PPP) in health services delivery’ (WHO 2010: 21) we can see, in a longer historical frame, that this has, in a

sense, been the enduring policy from the earliest period of BSAC rule to the present day.

It is important, then, to situate contemporary Christian medical humanitarianism in Zambia within this context. Today new questions have emerged among missionaries about the nature of their work, but these often bear the traces of older debates. Important questions for some missionaries today include: does missionary work make recipient populations 'dependent' on outside help? Should missionaries remain independent of governments and politics? In this chapter and the next, we will see that while Dr Tom and Dr Hannah had their own answers to these questions, other missionaries disagreed with them and there were lively debates among missionaries about the nature of missions in the twenty-first century. It is worth noting, however, that the kind of 'internal critique' that Redfield has written about within MSF (e.g., 2012, 2013) was strikingly different from the debates that the American missionaries engaged in. I cannot recall, for example, a single occasion when missionaries expressed misgivings about the colonial legacies of missionary work or the power relations involved in medical and humanitarian work.⁸⁹ In the next part of this chapter, I will describe Tom and Hannah's decision to become missionaries as well as their day-to-day lives in Zambia, before turning to their understanding of the missionary vocation today.

The American missionary doctors

The first time I met Dr Tom he had been awake for around thirty hours. He had performed several consecutive emergency caesarean sections during the night and had spent a long time the following morning making sure that these women were recovering well. He had also conducted a lengthy round of daily check-ups on the new and expectant mothers in the maternity ward. Dr Tom looked physically exhausted and spoke in a weary and slow tone of voice, welcoming me to the town and offering various suggestions and forms of help before telling me that he hoped to get a few hours of sleep in case he was needed again later in the day.⁹⁰

Eventually, I became used to seeing Dr Tom in this condition and his wife, Dr Hannah, would say that there was no chance of encouraging him to rest until he had finished his daily duties completely (cf. Malkki 2015: 57). I was shocked, at first, by the number of hours Tom and Hannah worked. The arrival of visiting missionaries, for several weeks, meant that Tom had a lighter schedule – although this did not mean that he stopped working, but rather that he did not have to be ‘on call’ for twenty-four hours every day. Visiting missionaries would often remark on Tom and Hannah’s regime of work. An anaesthesiologist from the United States, who was visiting for two weeks, captured the prevailing feeling among visitors when he said, ‘I would be so burned out if I had to work like Tom and Hannah do. It takes a special person be able to do that kind of work . . . I don’t know how they manage to do it’. Several visitors – particularly those who stayed for longer periods of time – even expressed concern, saying that Tom and Hannah were ignoring their own health and wellbeing by working such long hours over so many years.

Dr Tom had visited Matamba Mission Hospital for a month during the 1990s when he was still a medical student and the story of his first visit was still important to him. He had taken a ten-hour train journey from the capital city, Lusaka, and when his train arrived in the middle of the night he found himself several miles outside of Matamba township and unable to find his way to the mission compound. As Tom recounts the story, he had to wait through the dark night in an unknown place, wondering why he had decided to go to Africa and whether he had made the right decision. When the sun rose in the morning, Tom explored his surroundings until he found some local women who greeted him enthusiastically and directed him onwards to the hospital. In Tom’s description of his arrival, he stressed the beauty of the place and the friendliness of the first people he met – something familiar in other missionary narratives (see, e.g., Cowen 1995; Donnelly 2012; Gerrard 2001).

Tom and Hannah met each other as newly graduated doctors working at a rural hospital in the Midwest. Tom made it clear to Hannah that he wished to return to Zambia when there was a vacancy for a long-term missionary doctor at Matamba Mission Hospital. According to Hannah, she was initially unsure about Tom’s ambition to go to Zambia – a country she knew nothing about and had never visited –

but, after praying about it for several years and eventually appreciating how important it was to her husband, she agreed to join him.

Career missionaries who worked for the Wesleyan Church raised the money to pay for their four-year long 'terms' by attracting funding from different churches in the United States. Tom and Hannah were funded by over forty different churches across the country and, when I spent time with them in Zambia, they were in the middle of their third consecutive term (i.e. their tenth year). By contrast, the 'visiting' missionaries usually had to raise their own money and they pursued missionary work when they could, such as during holidays or while on leave from work. The anthropologist Brian M. Howell has pointed out that distinguishing between 'career' and 'visiting' missionaries is perhaps more useful than the terms 'long-term' and 'short-term', which raise such questions as, how long exactly is 'long-term'?⁹¹ As he suggests, the more significant difference is whether missionaries are paid for doing mission work as their salaried job or not (see Howell 2012: 45).⁹² In addition to this, visiting missionaries often had a different sense of the moral dimensions of the mission trip, as we will see in the next chapter. Before looking at the way in which Tom and Hannah experienced their obligations to Zambians and their ideas about missionary work itself, it is worth considering the circumstances in which the missionaries (both career and visiting) lived in Zambia and which made it possible for them to carry out their work.

Making home in Zambia

Missionaries in Africa have always paid careful attention to their living arrangements. For the missionaries of the nineteenth century, this was largely because of the high rates of mortality. As Adrian Hastings (1994) observed in his history of Christianity in Africa: 'In theory they had come to serve others. In practice it had to be that life revolved largely around their own needs' (1994: 269). Although rates of mortality among missionaries declined dramatically from the late nineteenth century onwards, the living arrangements and needs of contemporary missionaries have remained highly important to their work.

Writing about Catholic missionaries who taught at a secondary school in Zambia, Anthony Simpson has observed that, while their 'domestic space was by no means a palace, it was still strikingly more splendid and more comfortable than the nearby homesteads, and built on a much grander scale than the accommodation for teachers and workers' (2003: 61). In colonial Tanzania, as Peter Pels has written, 'Big [mission] stations . . . were often economically self-sufficient communities led by an all-male European staff that set itself off from its surroundings by an architecturally enclosed space, like a monastery' (1999: 87). The same can be said of the accommodation for the missionaries at Matamba and, indeed, the 'enclaved' space of the mission compound was striking (cf. Ferguson 2006: 194-210; see also Duffield 2010).⁹³

During a conversation with Dr Tom at the hospital, shortly after I had arrived, he expressed his surprise at my decision to live with a local family 'in the bush' and told me that there were always rooms available in the guest house within the mission compound if I changed my mind.⁹⁴ The mission compound itself was regarded by most of the missionary doctors and visitors as a safe, ordered and comfortable place in the midst of the disorder of the local town. Dr Hannah reflected honestly on her living circumstances in the following way:

People back at home say, "You're so brave going to Africa and putting up with the conditions over there." And I don't know what they mean. I say to them, "Sure, it's not the United States, but we have everything we need: food, electricity, running water, and a TV". I mean, I think people imagine that we're over here living in a mud hut, or something like that.

Certain colonial-era ideas of the embattled 'white doctor in a dark Africa' (Vaughan 1991: 1) would find expression occasionally, although the missionaries were more often prepared to acknowledge that they lived materially comfortable lives compared to the people of Matamba township and its surrounding areas.

Missionaries of the nineteenth century regarded the mission house 'as a model of Christian domesticity' (Comaroff and Comaroff 1997: 293) which they hoped would be emulated by newly converted African Christians. By contrast, the mission compound

at Matamba was not supposed to be seen by local people and it certainly could not have been emulated. The houses were miniaturised American suburban homes, built using expensive materials such as tile roofing, a rare sight in rural Zambia and a sign of extraordinary wealth. The large guesthouse house was built by a missionary couple in the early 1990s and was, Hannah told me, designed to be as much like an American home as possible.

Indeed, visitors to the missionary guesthouse often noticed that it was made to feel like an American home. There was a long dining table where visitors ate their meals together and a shared living space which contained an old out-of-tune piano, a computer, and a large bookcase. Many of the books dealt with the difficulties of missionary work or 'cross-cultural ministry', while others were old paperback novels or autobiographies. A small number of the books were about Zambia, mostly aimed at a tourist readership and detailing activities such as safari tours or trips to the nearby Victoria Falls. Some visiting missionaries would occasionally venture into the town and many of them visited the Methodist church on Sundays during their stay. Nevertheless, outside of their hospital work, most missionaries stayed within the compound, watched films, read, and ate familiar food during the entirety of their stay. Indeed, the question of food is worth reflecting on here in slightly more detail. Not only did the missionaries eat predominantly American or 'western' food, they were almost entirely self-sufficient when it came to the preparation and consumption of food (cf. Pels 1999: 88, 99).

Tom and Hannah did not buy food or other amenities from the market or small shops in town. Indeed, they bought all of their food from the nearest city in bulk every few months and thus avoided relying on local sources of food. This was a significant difference between the American missionaries and local people. Going to the market to buy relish to eat with *nsima*, walking to a nearby borehole to collect water, or picking up milk or eggs from nearby houses, were all basic activities that were central to the daily lives of everyone in the surrounding area.

From the work of Audrey Richards (1939) onwards, anthropologists of southern Africa have appreciated the centrality of food to the formation of relationships, particularly in rural areas where social life is oriented around cycles of agricultural production.

Talking about food was a common way of speaking to people and disclosing the nature of certain relationships. A common informal greeting in Chitonga, used among friends, was ‘have you eaten?’ (*mwalya?*). People who were close wished to be kept aware of one another’s wellbeing and knowing about food consumption was fundamental to this. But the interest was not purely altruistic. Indeed, if a friend or relative had plenty of food at home, this was information worth knowing. Finding out if people had eaten was simultaneously a way of expressing concern about their wellbeing and discovering how well they were doing. Asking somebody if they had eaten, as a greeting, often contained this recognition and could become a source of humour. For example, if somebody replied to the greeting in the affirmative, their friend might respond by asking, ‘what have you eaten?’ (*mwalya nzi?*) to which they might say something deliberately underwhelming, as I heard many times, such as, ‘nothing, we’ve only eaten cabbage’ (*takwe, twalya macabbage*) at which they would laugh at the meagre description and the unsuccessful attempt to elicit information about some good food (such as meat or fish).⁹⁵

These forms of greeting made visible – albeit in a fleeting and joking idiom – the forms of obligation and dependence that structured many relationships. For the missionary doctors to be entirely self-sufficient and private in their consumption of food situated them outside of important local relationships that were structured around buying, selling, preparing and eating food. As anthropologists have long observed in many parts of the world, the ‘sharing [of] food does not just represent social togetherness, but produces it’ (Boylston 2013: 262). On a few occasions – such as when new short-term missionaries arrived – I was invited to eat dinner with the missionaries at their house. When I returned home, I would always be asked what the missionaries had eaten. Alongside simple curiosity, the consumption of food was a source of interest, I think, because the missionaries seemed to live mysteriously and self-sufficiently outside of local relationships, within which food is so central. Indeed, concern about the consumption of food can be serious. As Maia Green (2005) found in rural Tanzania, witches are sometimes characterised as people who are unable to share food with others (2005: 255).

Missionary refusal to eat local food is not uncommon (e.g., Pels 1999: 88) and has perhaps contributed to suspicions about how white people manage to sustain and

enrich themselves (as we saw in Chapter Two). It became an enduring source of fascination to visitors to the house and to people at church that I was able to eat the staple maize porridge, *nsima* – and even appeared to be enjoying it. It was widely assumed that white people either dislike *nsima* or are somehow physically incapable of consuming it (see also Simpson 2003: 42). Given the private and unseen nature of the consumption of food among white visitors to the area, it is unsurprising that many people imagine that white people cannot (for various reasons) consume local food.



Photo 1. The barbed wire gate of the mission compound (seen from the inside).

The sense that the missionaries were self-sufficient was reinforced by the space of the mission compound, which was situated next to the main road of the small town. The compound was contained within high barbed wire walls (see photo 1) and was guarded throughout the night by a local security man employed by the Wesleyan church. Tom and Hannah lived in their own house within the compound and visiting missionaries stayed in a larger guest house nearby. Some people in the town were wary of the mission compound because there was a guard dog who was known to be unfriendly to strangers. It is common for white residents in the region to have dogs for security reasons and the way these animals are often treated by white people – namely, as

domesticated pets who are regarded in fond and sentimental terms and whose wellbeing is prioritised – is often considered strange by Zambians and can be a source both of amusement and moral criticism (Englund 2011b: 46; Simpson 2003: 68).

The enclaved and securitised space of the compound was all the more striking in the context of the open and interconnected nature of so many local spaces – such as homes, shops, market stalls and bars. The family I lived with were perpetually receiving a steady stream of uninvited guests and visitors. Some would be asking for water (*meenda*), fresh and sour milk (*mukupa* and *mabisi*), while others would be returning borrowed items, or inquiring about buying a chicken (*inkuku*) or even sometimes a larger animal, such as a cow (*ng'ombe*) or oxen (*musune*). Some would be relatives passing through, others would be old friends paying a visit. On one occasion several men on motorbikes rode past the house noisily, appearing to everyone's surprise, from the nearby trees. It was decided, after several theories were put forward, that these men were probably trying to avoid the traffic police who occasionally established a temporary barricade along the main road (and who invariably expected to receive a bribe from drivers lacking the requisite paperwork).

The spatial openness of the living arrangements in, and around, Matamba town emphasised the feeling of connection to others and the sense of being constantly involved in other people's lives. In this context, it is worth commenting on the mobility of missionaries in relation to the local population. At a certain scale, it seems to be true, as Redfield notes (2012), that expatriates have a 'lightness' compared to the 'heaviness' of local populations. Indeed, as the last chapter showed, the idiom of the missionaries as '*bangelo*' – who arrived and left of their own volition, free of attachments – was an expression of this important difference. Nevertheless, if we consider the town of Matamba itself, the missionaries, while they lived in Zambia, were remarkably immobile compared to most local people. When we think about global and national borders, the missionaries were able to move great distances. However, once they had arrived in Matamba and moved into the mission compound, they hardly moved around at all – the journey from the mission compound to the hospital (a short walk of a few hundred metres) was the full distance travelled by some of the visiting missionaries.

The mission compound was, like the accommodation of the Catholic missionaries studied by Simpson, 'not so easy to inspect' for local people and the private lives of the American missionaries consequently 'held a certain mystery and mystique for outsiders' (2003: 62). Missionary lives, to a large extent, were insulated and 'set apart' from the lives of local people. One way of putting this – to return to the terminology explored in the last chapter – is to say that the missionaries were not, in their everyday lives, 'dependent' on local Zambians and they did not have the kind of 'existential obligations' (Englund 2008) that shaped relationships among most of the residents of the area.

In addition to this, the long-term missionaries (Tom and Hannah) did not have children. This was both conspicuous and discomfiting to some Zambians. Beidelman has noted that in some areas of colonial Africa, celibate Catholic priests were considered to be 'abnormal and antisocial' (1982: 12). Whether such a strong description is appropriate in the case of the American missionaries at Matamba, their lack of children and wider family members no doubt added to local perceptions of difference. Colson (1958, 1962, 2006) has written extensively about the importance of fertility and childbirth among the people of the Southern Province and the Chitonga terms for mother and father are regularly used in everyday greetings and honorific forms of address.⁹⁶

While their lives were set apart from those of most people living locally, Tom and Hannah enjoyed their encounters with many of the visiting missionaries.⁹⁷ It was often enjoyable for Tom and Hannah and visiting missionaries to spend time together, not least because in such contexts negotiations around status and expertise were often more relaxed. Pels (1999: 90-91) has observed, similarly, that for the Dutch Catholic missionaries in colonial Tanzania in the mid-twentieth century, the 'careful distinctions' of status between Fathers and Brothers that were important in the Netherlands were loosened considerably in the mission context. This was similar at Matamba, in a further sense, because junior American clinical visitors were given a greater level of responsibility and a higher status than they were accustomed to in the United States – something many of them clearly enjoyed (see Chapter Four).

In characterising the living arrangements of the missionaries, Simpson's assessment of the position of the Catholic missionaries with whom he lived in Zambia rings true for the American missionaries in Matamba: 'Their established material presence spoke of the inequalities of the mission encounter' (2003: 61). This inequality, however, was not unrelated to the missionary vocation itself. Indeed, as we will now consider, it was this very condition of material inequality that made it possible for the missionaries to conduct their work and pursue their distinctive Christian moral vision (cf. Laidlaw 2014: 158).

Dealing with Jesus himself

The anthropologist Erica Bornstein, in her book *The Spirit of Development* (2005), considers Christian NGO workers in Zimbabwe who worked for the charity World Vision. Many of them explained to Bornstein that they had no intention of directly 'proselytizing' when they went into villages and met with Zimbabweans. Instead, they told her that they tried to conduct themselves in an exemplary manner, so as to incite the interest of local people and encourage them to reflect on and question their own lives and conduct. For instance, an NGO worker described her attitude in the following way:

you are not going in with a sort of harsh edge to say "you should do this, you should do that," but through the way you do things, people will transform and see things in a different light . . . We want the people to see Christ in us . . . we don't mount platforms and try to evangelize in that way. We want to do so through our lives. (2005: 51, 53)

Bornstein calls this 'indirect' form of proselytising 'lifestyle evangelism' and she writes that it was after hearing a sermon on the life of Christ (during her fieldwork) that she first understood this way of proselytising:

Missionaries and NGO workers suddenly made sense to me as walking examples of Christ's life. If it was impossible to emulate the life of a supra-human God, it was possible to emulate the life of Christ. In contrast to a God larger than the

human ability to comprehend it, Christ represented and embodied model humanness. (2005: 31)

This has arguably been a feature of missionary work from the colonial period onwards. As Michael Jennings has observed, missionary medicine was imagined to have ‘both an evangelistic purpose, and an indirect social impact through its example’ (Jennings 2008: 42).

Tom and Hannah did not self-consciously describe what they were doing in quite the same terms. Nevertheless, they explained the possible beneficial consequences of their work in Zambia in a similar way, with reference to their own conduct. They suggested, for example, that some people might come to see ‘a light’ in them or recognise Jesus’s work in their actions. This was not, however, elevated to an explicit method of proselytising in the same way as the ‘lifestyle evangelism’ that Bornstein describes among the World Vision workers with whom she spent time. Tom and Hannah were engaged in a more personal project of living their lives in relation to God and a large part of this project involved discharging (as they saw it) their obligations to others.

Furthermore, on many occasions, both Tom and Hannah remarked that they found the label ‘missionary’ an unhelpful one because it carried unwanted connotations, leading Zambians to assume that they were there to preach to people or had some sort of ‘agenda’ beyond their medical work (cf. Howell 2012: 214-216). Dr Tom once said to me,

I would have been happier in a government hospital here just doing the work. Then I would know that I am serving the Lord and being a light for others to see and people would not look at me and think, “he is here to convert us”. Then I could feel that I was serving the Lord without having to be called a “missionary”. But here [in Zambia] it is actually easier to come and work if you say you are a missionary and you come with a church, rather than just coming here and trying to get an ordinary job in a government hospital.

Tom seemed to be giving voice here to a desire – and it is one expressed by missionaries in other contexts – to escape the feeling of difference that shapes

missionary lives.⁹⁸ Dr Tom's remark reveals an aspiration to erase an enduring feeling of difference, but he was also articulating a criticism of the label of 'missionary' itself.

Similar criticisms of the term 'missionary' have been voiced by African Christians. The Kenyan pastor Oscar Muriu has said: 'The problem with calling it a mission is that it implies an agenda. There's something I need to come and do for you, or to you, to better your life' (quoted in Howell 2012: 212-213). Muriu wishes to see more collaborative and 'equal' relations between missionaries and African churches and populations. As we will see, however, despite Tom's criticism of the term 'missionary' and his sense that his vocation was a deeply personal one, the unequal relationships – of the kind that critics such as Muriu wish to abolish – were central to (indeed, constitutive of) the missionary vocation at Matamba. This was because Tom and Hannah's personal form of religious life was not one that could be lived under circumstances of vulnerability to, or dependence on, others. This will be seen by considering further the content of their moral vision.

To return to the opening story of this chapter, Dr Hannah spoke of the fact that the babies in the maternity ward each exemplified Jesus's condition of vulnerability and need. There is a sense in which Dr Hannah was able to morally perceive the newly born babies in the maternity ward as Christ-like in their vulnerability and need (something that is explored further in the next chapter). The idea of regarding others as Christ-like has a long history in Christian ethics. A well-known passage from the gospel of Matthew (25: 44-45) was particularly important to Tom and Hannah. In the famous parable, Jesus indicts those who call themselves Christians for failing to treat him when he was in desperate need: he was hungry, thirsty, a stranger, lacking clothes, sick, and in prison. These people, who think that they love Jesus, are surprised and respond by asking, 'Lord, when did we see you hungry or thirsty, a stranger or lacking clothes, sick or in prison, and did not come to your help?' Jesus responds, 'In truth I tell you, in so far as you neglected to do this to one of the least of these my people, you neglected to do it to me'. This passage is central to the idea that 'the individual's relation to God is determined *wholly* at the point of his relation to the neighbour' (Critchley 2007: 51; see also Løgstrup 1997). It was this notion – of relating to God through one's relation to others – that was crucial to Tom and Hannah's sense of their missionary vocation.

Tom and Hannah thought and spoke often about their decision to become medical missionaries and why they felt they had obligations to assist people in Africa. They reflected on their work and read books written by theologians and missionaries. After asking Hannah one day about what first motivated her to do missionary work she gave me a book called *What Jesus Meant* by a theologian and historian called Gary Wills. Around halfway through the book, as I read it, I found a passage, underlined heavily in pencil by Hannah, which read:

Did you treat everyone, high or low, as if dealing with Jesus himself, with his own inclusive and gratuitous love, the revelation of the Father's love, whose sunshine is shed on all? Love is the test. In the gospel of Jesus, love is everything. But this is not a dreamy, sentimental, gushy thin love. It is radical love, exigent, searing, terrifying. (Wills 2006: 56)

When I later discussed this passage with Hannah (and suggested that it seemed to encapsulate some of the remarks that she and Tom regularly made) she told me that it was a central idea she had carried with her for a long time. Tom and Hannah felt that patients at the hospital needed to be treated as if any one of them might have been Jesus – they needed to be treated as equal, morally valuable, and in some sense 'sanctified' individuals. Indeed, in the view of the Danish theologian Knud Ejler Løgstrup (1997), a central aspect of Jesus's injunction to love others is that it 'never concerns itself with our relationship to the other person as determined by kinship or nationality' (Løgstrup 1997: 109).

In a certain sense, this is remarkably similar to the 'very definition of medical competence' which, as Claire Wendland has pointed out, is often defined as 'the ability to see past the individual patient's subjectivity, specificity, cultural and social embeddedness' (Wendland 2010: 7). In the case of the Christian injunction, the need to transcend kinship and nationality is part of coming to recognise the Christ-like nature of each person in the world, all of whom are equally worthy of love. In the case of medical competence, it is 'to get at the underlying pure organic pathology that will define diagnosis and dictate therapy' (Wendland 2010: 7). Nevertheless, there is an affinity here between these ideas and both require being able to move beyond

personal feelings or social ties of relatedness in order to recognise something more 'foundational' or 'essential'.

For example, when a visiting missionary nurse from Tennessee, Rose Taylor, described her approach to treating patients in the following way, she was proclaiming both her 'medical competence' (in recognisable terms) and her Christian commitment to regarding others as equally worthy of consideration:

For me, it doesn't matter if somebody is dressed in a nice suit and they are very wealthy or whether they come in and they are in rags, I treat them just the same, that's what you have to do. And it doesn't matter what your background is, I won't give you anything other than the medication that I think you need, based on the examination.

There has been much research on how medical students and doctors learn to view patients' bodies over time and cultivate an orientation of 'detachment'. Talcott Parsons introduced the notion of 'affective neutrality', suggesting that 'in the physician's role as an applied scientist . . . whether he likes or dislikes the particular patient as a person is supposed to be irrelevant' (1951: 435). The way in which bodies are transformed from social persons into objects with pathologies that need to be identified and located has since been explored in many contexts (see, e.g., Hafferty 1991; Newton et al. 2008). Arthur Frank (1995) has called this a form of 'modernist universalism' in which 'the greatest responsibility is to all patients . . . before the particular demands of any individual patient' (1995: 15). It is perhaps worth considering how 'modernist' this idea is, especially when set against the Christian injunction to see, in particular bodies, the universality of Christ's body.

A similar insight has been translated into studies of humanitarianism in which the idea that previously socially embedded persons with complex relationships and social lives are stripped to their 'biological' or 'bare life' (Agamben 1995), particularly in contexts such as refugee camps (see Malkki 1996; Redfield 2005; Ticktin 2014). However, it is important to note that the missionaries were able to 'see' the bodies of their patients as bodies that contained 'pure organic' pathologies which needed to be identified and *at the same time* as frail human bodies – indeed, substitutes for Christ's

body – that presented them with an image of their Christian obligations. For Tom and Hannah, the patients at Matamba were not simply ‘reduced’ to their ‘bare lives’ but were also seen as possessing ‘sanctified lives’. The Oxford English Dictionary defines ‘to sanctify’ as to ‘set apart or declare as holy’ and this encapsulates the way in which Tom and Hannah set patients apart from others.

The injunction (that we find in the gospel of Matthew) to think about needy and suffering people everywhere as if they were worthy of the same affection as Christ (‘In truth I tell you, in so far as you neglected to do this to one of the least of these my people, you neglected to do it to me’) was taken seriously by Dr Tom and Dr Hannah. As we will see in the next chapter, this was one instance of the wider idea that people in Zambia, in their lives and suffering, were somehow closer to God than wealthy Americans – who were, in the language of many missionaries, too often led astray by the sinful consumerism and excess of life in the United States (cf. Elisha 2011).

Not only is this a way of adding a greater amount of complexity to our understanding of how medical humanitarians regard the bodies of those they seek to help, but it also suggests a different way, as anthropologists, that we might wish to engage with theological texts. Writing about the relationship between theology and anthropology, Joel Robbins (2006) has suggested several ways in which anthropologists might relate to the work of Christian theologians.⁹⁹ Among the approaches mentioned by Robbins is the idea that ‘anthropologists might read any given piece of theology . . . as data that can inform us about the particular Christian culture that produced it’ (2006: 286). In using theological texts as ‘data’, however, there are several important further considerations that need to be made. Timothy Jenkins (2013) has pointed out, for instance, that texts in Christian theology ‘are not primarily descriptions of native categories, but rather active interventions into specific kinds of situations’ and, as such, it is misguided ‘to imagine that theology books contain direct transcriptions of the practices and beliefs of believers’ (2013: 371). Indeed, this is important when we consider how Tom and Hannah read theological texts. By reading these texts through their eyes (and following the importance of certain passages underlined in pencil) we can begin to see such texts not merely as data about the ‘Christian culture that produced it’, but rather as interventions that can come to constitute important moral demands for particular readers at certain moments. In this sense, we can identify the

profound meanings that certain notions have for practising Christians. In the case of Dr Hannah, her reading of a popular work of theology came to be worked into her recurring moral aspect-perceptions and relations with others. We can now consider how, in several cases, Tom and Hannah enacted their moral vision of the missionary vocation at the mission hospital.

Dr Tom 'on call'

During February 2015, there was a period of time (just over a week) when many women who arrived at Matamba Mission Hospital needed emergency caesarian sections. These procedures could take a long time and were difficult for everyone involved. They were performed by Dr Tom in the hospital's small operating theatre and required a number of Zambian staff members to be present. There were many complicating factors. The women could lose a lot of blood and, as a precaution, their blood type had to be identified by the laboratory technicians who then had to check if the hospital had a supply of the correct blood type in stock. Furthermore, the men who worked in the theatre (the Clinical Officer, the theatre nurse, and the theatre attendant) all had to be available and ready to perform the procedure, sometimes at relatively short notice. Much of the medical equipment used in the theatre was made in the 1970s and 1980s – indeed, one visiting missionary told me that the equipment was already obsolete by the time he began his training as an anesthesiologist in the US.

Within the operating theatre – a small building on the edge of the hospital grounds – the floors were dirty and the walls discoloured. Despite this, the missionary doctors and staff worked hard to make sure that everybody who entered wore the necessary protective clothing and observed the protocols meticulously. I experienced this routine when I entered the operating theatre to witness a Caesarian-section surgery in September 2015. When Dr Tom performed this surgery in the theatre, the mood was tense and it required a considerable amount of concentration and coordination from everyone involved. After the patient was prepared for the surgery, before making the first incision, Dr Tom said, in Chitonga, 'Let us pray' (*'atupaile'*) and then said a few

words for the mother and her child in English after which everyone present said, 'Amen'.¹⁰⁰

During the busy week in February, there was a single night when four women needed caesarian sections. When Dr Tom had finished doing his rounds he went back to the mission house and ate and rested for three or four hours before returning to the hospital to see how the women were recovering after their operations.¹⁰¹ Unlike the Zambian staff, Dr Tom was able to perform these procedures and then return to the compound where he remained isolated for a number of hours without disturbance from family members or friends – in fact, every effort was made, by those in the mission compound, to ensure that he was not disturbed during these moments of rest. During this week many people at the hospital had commented on the number of caesarian sections that had been performed. Some men and women, who were patients at the hospital, commented approvingly, remarking on Tom's commitment and energy while others, such as the men who worked in the laboratory and the theatre, were less impressed. Some even suggested that Tom was 'too eager' to perform surgeries and had no consideration for the needs of staff members to sleep, to spend time with their families, and to attend church activities, weddings and funerals.

I saw Dr Tom at the hospital during this week and noticed how exhausted and withdrawn he looked after he had been awake, at one point, for over thirty hours. One morning I encountered Tom leaving the maternity ward having just checked on a young woman called Precious whom he had operated on in the early hours of the morning. He said to me, afterwards, that Precious's caesarian section had been a difficult one: she had lost a lot of blood and Tom was worried about the possibility of infection. According to Tom, some staff members had not cooperated with him when he phoned them at around two in the morning to come into work and several staff members had been absent for the procedure. He said to me, gesturing towards the maternity ward: 'Each of these people are precious in God's eyes and we've been sent here to look after them. Sometimes these staff members don't realize that!'

There was, I think, a strong affective dimension to Dr Tom's 'need to help' (Malkki 2015). When I was discussing with him why he first decided to do missionary work,

Tom told me that he had read somewhere about a Christian athlete who had described the feeling of running as an experience of ‘closeness to God’. Tom said that, for him, when he was rushing around at the hospital, in the middle of performing surgery or treating people, this produced the same feeling for him – he was closer to God in these moments of action than during moments of contemplation or rest. Christian writers and theologians have often described the feeling of closeness to God in the context of reflection, prayer, and contemplation. Indeed, it was with inner reflection in mind that the Catholic theologian Thomas Merton spoke of the ‘transforming sense of moral self-transcendence’ (1972: 7) that such forms of contemplation make possible. And yet, for Dr Tom, it was in the midst of the immediacy and urgency of the hospital that he experienced this feeling. It was an energetic and practical ‘moral self-transcendence’ achieved through effort and engagement and, in this sense, was much closer to Don Cupitt’s suggestion that, ‘we can and do regain eternity when we are so immersed in life, in moral action . . . that we completely forget about time and anxiety’ (2010: 5). Indeed, Malkki (2015) describes a similar feeling among Red Cross workers for whom ‘selflessness became most powerfully articulated as a desire to lose themselves in the intensity of sustained demanding work . . . they experienced, I think, a pleasurable kind of *self-loss*’ (2015: 11; emphasis in original). Tom’s closeness to God was achieved through practical engagement and effort and he was able to ‘lose’ himself in his work (Beidelman 1982: 24).¹⁰²

In the midst of this busy activity and the demands of patients, the lives of the staff members with whom Tom and Hannah worked were often obscured from view. Dr Tom was unable to see – to use Steven Feierman’s (1985) term – the ‘social costs’ of working in the hospital for the staff members: namely, their wider relationships, forms of material support, and the costs to their personal wellbeing and health that were a part of sustaining a professional vocation over many years. In Tom and Hannah’s view, the staff members who did not wish to return to the operating theatre at 2am were ‘lazy’ or lacking in motivation and they did not treat patients equally or attend to their immediate needs with sufficient energy. Dr Tom might have been able to engage in a distinctive and difficult ‘aspirational practice of self-discipline’ (Malkki 2015: 185) in which his obligations were to each individual patient – one at a time, day after day – but this was, quite simply, not an option for the overwhelming majority of Zambian staff members.

Dr Tom and Dr Hannah's Christian form of moral life, by contrast, did not depend on immediate others: the 'social costs' of their conduct were minimal in comparison to their Zambian colleagues. They did not need to feed and look after children, cultivate the goodwill of local patrons and mutual dependents, meet their daily obligations to family members, or attend church gatherings at the same time as they worked their long hours. They could devote all of their energy to attending to patients and resting. They came to judge the staff members at the hospital in relation to a standard that was unachievable for most of them.

There is an important further parallel here with the work of Bornstein (2005) who discusses an idea that was common among Christian NGO workers: namely, that there was no such thing as 'humanitarian giving' in Zimbabwe. Christian NGO workers told Bornstein that, in Africa, people had to attend to the needs of their extended families and had so many obligations (and so few resources) that they could not give gifts to anonymous strangers (2005: 90-95). In short, supporting anonymous strangers is a humanitarian and Christian act, while supporting relatives is not. Hannah once expressed this sentiment by saying,

I'm not sure how half of these staff members can call themselves Christians when they treat patients so badly. They let me work here until nine in the evening and they go home straight away when there's a big queue at the OPD or the pharmacy! And I say to them: "You're supposed to be Christians aren't you? Well look at your Christian brothers and sisters in the queue here!" and they don't care, they just leave anyway, as soon as they can.

There were many cases when the missionaries (short- and long-term) expressed their disapproval of the actions of Zambian staff members precisely because their definition of what constituted being a 'good staff member' excluded from view the many ways in which staff members had to discharge a series of ongoing and multiple obligations to family members, neighbours and friends alongside their professional responsibilities at the hospital. Indeed, staff members often left the hospital early precisely in order to attend to these obligations.

Based on a partial view of their lives, Tom and Hannah judged that certain staff members were not engaged in properly humanitarian or Christian conduct at the hospital. Unlike Dr Tom and Dr Hannah, however, such staff members were unable to refuse their condition of dependence on others. They could not insulate themselves from their social lives in order to work as self-sufficiently as possible.¹⁰³ Redfield makes a similar point when he discusses the perceptions of Ugandan national staff by expatriate MSF workers: 'A proper humanitarian . . . deferred obligations to kin to care for strangers. Such transcendent dedication was difficult for national staff to demonstrate, weighed down as they were by their local connections' (2012: 367-368). In the final section of this chapter, I open up the larger question of the relationship between the experience of moral obligation, for the missionaries, and their understanding of (and aversion to) 'politics'.

The politics of Christian missionary work

The Wesleyan church in the United States today promotes the idea that missionaries should strive to make sure that the people with whom they work do not become 'dependent' on the outside assistance of missionaries. Indeed, to this end (and alongside workshops and training sessions) they advised all of their missionaries to read a book called *When Helping Hurts* (2009) by Steve Corbett and Brian Fikkert. The central argument of this book is that when American Christians give directly to people in poor countries (money, medical care, other services) this can often be 'harmful' (and is a form of 'paternalism') unless it is accompanied by measures to bring about 'self-reliance' among those people and promote the development of 'sustainable' political and economic institutions and organizations. Such ideas have been popular, more generally, among aid and development organisations for a long time (see Duffield 2007) and it seems that they have, in recent decades, become central to much Christian missionary work.¹⁰⁴

Despite being missionaries for the Wesleyan church, Tom and Hannah did not accept this way of thinking about the nature and purpose of missionary activity. In this, they join a long line of missionaries who have had disagreements with their 'directors' back in the metropole (see, e.g., Comaroff and Comaroff 1991, 1997). For Tom and Hannah,

being a good Christian was about responding to the suffering of other individuals in the present. Tom once said to me, when we were discussing *When Helping Hurts*, that he would find it strange to look at somebody who needed his help and deny them assistance because he was trying to ‘calculate’ whether it would be in that person’s ‘best interests in the longer term’. There was a strong temporal dimension to Tom and Hannah’s arguments about needing to orient themselves firmly in the immediate concerns of the present, rather than looking forward to the longer term consequences of their actions – and I would suggest that this was related, to some extent, to their experience of closeness to God through their immediate practical engagement in the world of the hospital, as we saw above. An interesting example of these arguments being put into practice took place around four or five years before I arrived in Matamba and revolved around the question of whether the hospital should have a generator so that operations could proceed during interruptions to the electricity supply.

The generator at the mission hospital

Tom and Hannah used to be assisted by some other American missionaries, a married couple named Paul and Louise Walker, who worked in the guesthouse. They were non-medical career missionaries and they worked with Tom and Hannah for around three years before they were asked by the Wesleyan church to move to a mission station in South Africa. Both Paul and Louise were strongly committed to the ideas presented in the book *When Helping Hurts* (among other missionary books that advocated a similar position). They began to disagree with Tom and Hannah’s approach to missionary work when a decision had to be made about whether or not to purchase a generator for the mission hospital.¹⁰⁵

When I conducted fieldwork the hospital had relied on the generator, by that time, for many years. I was in Zambia during a period in which the country was suffering from intermittent power shortages that were called ‘load shedding’.¹⁰⁶ The generator was indispensable at this time, especially during operations that required electricity for machinery and lighting – for instance, during the week (described above) in which there were so many caesarian section operations performed, it would only have been

possible to carry out a fraction of them without the generator. Paul and Louise suggested, however, many years previously, that it was not a good idea to get a generator because the hospital staff would not know how to use it themselves and it would be too expensive to sustain when (not if) the missionaries eventually left Zambia. The idea of calculating the long-term impact of the generator and deciding that it would not be sustainable was, for Tom and Hannah, an incredible suggestion that amounted, essentially, to an un-Christian rejection of the immediate needs of the people they came to serve. As Hannah said to me:

I couldn't understand the idea that we shouldn't get a generator. I said to them [Paul and Louise], "People in the hospital are dying! They need a generator. If you don't want to help the people here, then I don't really understand why you came here. We need to help them otherwise they'll die when there are power cuts and we're in the middle of an operation". That's what I said, but they were reading this book of theirs [*When Helping Hurts*] and they just couldn't understand what I was saying to them.

There was, then, a temporal dimension to Tom and Hannah's orientation. There was also an explicit rejection of thinking in 'political' terms. Indeed, Hannah once remarked to me that the Wesleyan church and the book *When Helping Hurts* promoted a 'political view' whilst she and Tom were doing missionary work and implementing their 'love for Christ'. It is fair to say, that for Tom and Hannah, 'politics [was] a moral pollutant' (Barnett and Weiss 2008: 4). The idea of calculating the long-term impact of different courses of action and thinking in terms of the political implications of certain decisions did not come naturally to Tom and Hannah, who felt their obligations to be both immediate and morally obvious. Indeed, the story of the generator – which I heard several times – was exemplary, for Tom and Hannah, because it seemed so obvious (in the contexts of its telling) that the self-evidently right course of action was to acquire the generator and save people's lives immediately.

In a sense, Tom and Hannah's aversion to thinking about the political dimensions of their actions is understandable as an historically situated judgement about who will meet the needs of local people if missionaries do not. Missionaries have been providing basic healthcare to people in rural areas for so many years because colonial

and postcolonial governments have so often lacked the political will or capacity to do so, as we have seen above. In a recent essay, Robbins (2010) has suggested that present-oriented ethical arguments and movements (and he is thinking of the spread of Pentecostal Christianity in particular) occur in contexts where people are uncertain about their future. In such circumstances, living a present-oriented moral life gives people an ethical ‘crutch’ to lean on, retuning them to their obligations in the present and diverting them from considerations of longer-term consequences.

This was true to some extent in Tom and Hannah’s case, although there was a further aspect of their position that is worth considering. Their rejection of the arguments of *When Helping Hurts* and their aversion to thinking ‘politically’ about the possible long-term sustainability and consequences of their activities was not only because they were unwilling to think about the future consequences and because they were oriented towards the present. They were also shaped by an awareness that in the long historical life of Matamba Mission Hospital, the needs of local people have been met by missionaries like them. For them, this was not a political judgement but a Christian judgement that took the form: ‘but who will help people if we do not?’¹⁰⁷ How to respond, anthropologically, to people who say that they are not doing politics or that their actions are outside of the realm of ‘politics’ has been the subject of considerable debate within the discipline. In the conclusion to this dissertation, I suggest a way of approaching this difficulty and return to the position of Dr Tom and Dr Hannah that has been outlined here.

Conclusion

In this chapter, I have shown how the long-term American missionaries follow in a long line of Christian missionaries who have pursued their own distinctive projects in the historical context of ambivalent relations with the colonial and post-colonial governments. The career missionaries, Tom and Hannah, as I have shown, pursued their vocation from a position of independence and self-sufficiency: they ‘live[d] their faith practically’ and were ‘sustained by acts rather than states of mind’ (Englund 2011a: 9). They were able to work hard and attend to their patients at the same time as the lives of their Zambian colleagues and staff members often remained outside of

their comprehension – something that led them to question the moral commitment and Christian dispositions of these Zambian healthcare workers.

Tom and Hannah attempted to treat patients ‘impartially’ in the sense that the term is often used by those working for humanitarian organisations: ‘Impartiality presumes that all those at risk, regardless of their identity, deserve equal attention and consideration’ (Barnett and Weiss (2008: 12). In a sense, ‘impartiality’ is easier for humanitarians working for short periods of time to achieve because they are less likely to be drawn into long-term relationships – although, even in short-term engagements the aspiration to remain independent is fraught with difficulties (see, e.g., Redfield 2013). Missionaries like Tom and Hannah, however, managed to retain their independence and continue to treat people as sanctified individuals over a long period of time. As I hope to have shown in this chapter, their detachment was central to their work (rather than contingently related) and it made possible the forms of moral apprehension that animated their vocation.

In closing here, I reflect on the possible difficulties that Tom and Hannah’s moral orientation produced for them. We have seen in Chapter Two that patients praised Tom and Hannah for treating them ‘non-selectively’ and for ‘not choosing’ or privileging certain patients over others. The Zambian staff, by contrast, were situated within networks of obligation and dependence and this strongly shaped how they treated patients. The mission doctors avoided being situated in networks of obligation and dependence precisely because when somebody is entangled in relationships of obligation and dependence this is when they, necessarily, to begin to privilege some people over others.

There is perhaps an irreconcilable contradiction in certain forms of Christian love. To respond to Jesus’s injunction to love others as if they were Jesus himself – his ‘impossible demand’ (Critchley 2007) – requires a certain detachment, self-sufficiency, and ruthless energy to remain ‘above’ or ‘outside’ of relationships of mutual support or perhaps even ‘mutuality of being’ (Sahlins 2013). Dr Tom and Dr Hannah recognised others as fellow brothers and sisters in Christ – and indeed, regarded their obligation to others as stemming from this moral status. However, this helps to explain why they could not (and did not want to) become entangled within the lives of local

people and enter into relationships of mutual dependence. The demand of treating ‘everyone, high or low, as if dealing with Jesus himself’ could not be reconciled easily with the idea of an ‘inclusive’ love based on submitting oneself to another person and coming to rely on them (cf. Wolf 1982). The energy and labour of trying to care for patients at the hospital gave them no real opportunity for morally perceiving people as *social* persons – both staff and patients.

Another way of describing this is to say that the attempt to treat people as if they are Christ-like is to refuse to engage in ordinary relationships with them, even to refuse them a certain form of personhood. It is possible that this is an irreconcilable contradiction at the heart of the injunction to treat others as Christ-like. Simone Weil (1951) hints at this possibility when she writes that ‘the Gospel is concerned only with Christ’s presence in the sufferer’ and, for the suffering person, ‘he no longer lives in himself but Christ lives in him’ (1951: 84). The personhood of the suffering individual has given way to the presence of Christ in this account. Indeed, it could be said of Tom and Hannah that – like the Nobel Prize-winning medical missionary Albert Schweitzer – they often ‘treated healthy Africans with arrogance, while medically treating sick Africans with compassion’ (Mazrui 1991: 101; see also Redfield 2013: 49). Indeed, as I will see in Chapter Five, some Zambian staff members certainly thought this was the case. In the next chapter, we will see how the short-term American missionaries, who were in Zambia for sometimes as little as a week, occupied a different position and came to ‘see’, in their encounters with Zambians, certain deeply morally meaningful Christian aspects of life.

Chapter Four

Seeing suffering in Africa: faithful Zambians and parochial cosmopolitans

Introduction

On a busy Wednesday morning during September 2015 I was with one of the visiting missionaries, Jacob Lewis, when he received a phone call from Dr Tom while we were in the male ward. Jacob was a medical student from Texas in his final year of medicine and was visiting Matamba Mission Hospital with his wife Sarah, who was also a medical student. This was one of their last days at Matamba Mission Hospital, a place where – as they both told me – they had learned a lot. Jacob enjoyed being given a greater level of responsibility at the mission hospital than he was accustomed to in clinical settings in the United States and he had a good relationship with Dr Tom; he joked with him, discussed difficult cases and was deeply impressed by his commitment to work. On this occasion, however, Jacob adopted a serious tone on the phone with Dr Tom and, once the conversation was over, he explained that there had been an ‘RTA’, the shorthand for a road traffic accident. This meant that the ward round had to be abandoned and the clinical staff needed to assemble at the hospital entrance to wait for the injured people to arrive.

There is no ambulance service in rural Zambia and, after serious road accidents, injured people were usually brought to the hospital by people at the scene, or nearby, who had a vehicle large enough to transport them. We waited for around half an hour before the first patients arrived. There was a tense atmosphere as we waited. Patients and staff members gathered and spoke to each other in hushed tones – information about the crash had reached certain members of staff and certain details of the event were already in circulation. Eventually, a minibus arrived and a woman emerged who needed to be held up by two men. Although limping slightly, she was able to walk and, as she walked with them towards the X-ray building, she wept and shouted, ‘my child, my child!’ (*mwanaangu, mwanaangu!*). Jacob’s wife Sarah, who arrived at this scene

was unfolding, was visibly shaken by this. Indeed, Sarah told us that she had met this woman only hours earlier and had asked her how her baby was. One of the hospital drivers, a young man called John who was usually cheerful, shook his head and said quietly, 'the baby is dead' (*mwana wafwa*), adding to us in English, 'this world is a world of pain'. Everyone present seemed to gather around more tightly as we waited for the other injured passengers to arrive, wondering how badly injured they were.

The clinical officers waited with stretchers laid out and, after around five minutes, one of them noticed a vehicle heading towards us towing a cattle trailer which, we realised as it got closer, contained the injured passengers, all of whom appeared to be lying down. There were groundnut shells and pieces of straw all over the floor of the trailer and I could see around five people inside. Nearest to us was a little girl who – unlike the others – began to sit upright and look around at the assembled crowd. The left side of her face was bruised and her eye was swollen shut. At this point the staff started to carry these people onto the stretcher beds and the crowd looked on, watching everything. The driver of the car began explaining to several men in the crowd what the scene had looked like when they arrived. They had found the car lying on top of the girl's chest and had struggled to lift it up and roll it over in order to free her. At this point a member of staff stepped into the trailer and picked up the last person remaining – the baby of the woman who had arrived first. The baby was dead and there was a large pool of blood on the trailer's floor. Some people in the crowd gasped at this. The baby was taken into the casualty room with the other injured passengers, wrapped in *citenge* fabric and left in a small store room.

Jacob gave his immediate attention to the small girl, whose name we discovered was Mercy. Sarah joined some of the Zambian clinical officers who were taking the adults, several of whom were conscious, to be X-rayed. Jacob was initially concerned that Mercy might have fractured her skull, so we joined the queue outside of the X-ray building. In the queue I heard one of the adults from the accident saying to a Zambian nurse, 'I hope I don't die. I am the only one who supports my family – I am the breadwinner'. At this, the nurse laughed and said to him, 'You will be okay, you are at least awake, unlike some of your friends'. The X-rays took a long time and, a few hours later, there were many men and women waiting outside of the hospital. These were mostly the friends and relatives of the injured passengers and, among them, were

Mercy's parents. When Mercy's X-rays had been completed (and revealed, fortunately, that she had only broken her collar bone), Jacob and I walked with her parents and helped to wheel her to the children's ward, where we were met by Mr. Sipatunyana, the hospital administrator.

Mr. Sipatunyana typically spoke to Jacob in the tone of an older man speaking to a younger, inexperienced person, something Jacob disliked. On the other hand, given that Jacob did not respect the abilities of Mr. Sipatunyana – and, indeed, regarded him as a 'lazy' practitioner who was not interested in the wellbeing of his patients – he did not treat Mr. Sipatunyana with the respect and deference that would have been appropriate in Zambia given their age difference (as will be discussed further in Chapter Five). On this occasion Mr. Sipatunyana was short both with Jacob and with Mercy's parents. He said to them, 'Looking at her won't heal her, so there is no reason for you to be in here taking up all of this room. You should leave her alone and come back during visiting hours'. Later in the day when Jacob checked on Mercy in the children's ward he reported that she seemed to be doing well, although she wanted to see her parents.

Among the other injured passengers, several were critically injured and had to be taken to the capital, Lusaka, while others survived with broken limbs. The event was important for Jacob and Sarah. Neither of them had seen a road traffic accident during their time at Matamba, despite their frequency, and it became the subject of a sermon that Jacob gave in the hospital chapel a few days later, on Friday (his and Sarah's last day). Jacob had asked the Pastor of the chapel (and part-time dentist), Daniel Mwaanga, if he could deliver a sermon in order to tell the congregation about his visit and how it had shaped his faith.

On Friday morning, when I arrived at the hospital chapel, I found a small group of people waiting outside, alongside Jacob and Sarah. The majority of the women were expectant mothers who resided in the 'mothers' shelter'. The men were predominantly patients at the hospital. I had met a few of these women before and greeted them. Pastor Mwaanga arrived a few minutes later and, after the greetings had been completed, we all filed into the building and sat down on the wooden pews. Much like his favourite preacher, the Nigerian Pentecostal healer T. B. Joshua, Pastor

Mwaanga delivered his sermons in a bold and theatrical Pentecostal style. On this occasion, however, the performance was reined in and the stage was given over to the American visitor.

Jacob began by telling a story about a person he knew whose faith was put to the test. 'She was a person who was able to endure such hardships because she believed in God and she trusted him and had faith that her suffering wasn't in vain', Jacob said. This person had recently suffered deeply in the form of a painful accident, Jacob told us, before describing the car accident. The person Jacob was telling us all about was Mercy and, for Jacob, she exemplified what it meant to suffer and to endure suffering with determination through a faith in God. Jacob told us that, in Mercy, he had seen somebody whose love for God provided her with the strength to endure anything and, even though she was a young girl, we could all learn something valuable from her example. Once he had finished his sermon Daniel Mwaanga thanked the missionaries for their work at the hospital: 'We are so grateful that you have come here. Jacob, and all of you, who have come here to help us, we are thankful and we thank God. You will not be forgotten!'

When I later thought about Jacob's sermon, I realised that he had not spoken to Mercy (or her parents) about her background, her hardships, or her Christian faith. Rather, on the day of the car crash – as on many other days – Jacob had been able to 'see' somebody exhibiting a profound faith in their suffering. Indeed, many of the visiting missionaries arrived with the capacity to see in this way and they perceived a great deal of moral meaning in the suffering they encountered.

This chapter is about the short-term missionaries and their experiences at Matamba Mission Hospital. In some recent work on short-term missionaries, anthropologists (e.g., Howell 2012) have used the notion of 'narrative' to understand how missionaries construct meaning in their encounters with adults and children during overseas mission trips in poor countries. In this chapter I make use of Wittgenstein's notion of 'aspect-perception' ([1953] 2001) in order to suggest that the visiting missionaries did not only arrive with pre-existing 'narratives' which structured their experiences, they also arrived in Zambia with a heightened capacity to *see* certain Christian meanings in the suffering that they found. The capacity to perceive Christian meaning in events

was something that enabled short-term missionaries to make sense of their surroundings, particularly when they encountered shocking and difficult episodes, such as the road traffic accident described above. As I suggest below, the interest in ‘meaning’ in the anthropology of religion has a long history and yet, in considering ‘the meaning-saturated world of Christianity’ (Tomlinson and Engelke 2006: 23), there are still new ways of understanding how Christians apprehend and perceive such meaning in the midst of their lives, particularly in contexts such as missionary work. In this chapter I reconsider some of these classic anthropological themes in order to contribute to recent discussions within anthropology about morality and humanitarianism.

In the second part of this chapter I consider how short-term missionaries understood the beneficial effects of their work. In certain debates about the morality of humanitarianism – especially among philosophers (e.g., Appiah 2006; Singer 2009) – the question is sometimes posed in the following terms: how should people balance their moral obligations to the ‘distant’ poor with their moral obligations to their own fellow-citizens, neighbours and family members? In these discussions, the debate is often framed in terms of distance and proximity. In this chapter I show how short-term missionaries framed the question in similar terms but developed a distinctive response to the problem by invoking the importance of their own example. By this, I mean that many short-term visitors to Matamba Mission Hospital understood their mission work as something that might give hope and inspiration to their families, friends, and the members of their local churches. Their example would demonstrate Jesus’s love in action.

This undermines the contrast sometimes made in scholarly accounts between worldly globe-trotting humanitarians who are deeply aware of the suffering of others and those, on the other hand, who are ‘only bound to those who are close to [them] . . . [and whose] ethics are invariably parochial, communitarian, and exclusionary’ (Butler 2012: 138). I show how many short-term missionaries arrived in Zambia to volunteer at the hospital and yet felt that the most important work they were doing (as missionaries) might be to show their fellow congregants, back in the United States, the effects of faith on their lives – which had, after all, given them the strength to travel to a remote and ‘dangerous’ place to carry out God’s work. In characterising this combination of

moral aspirations, I call these missionaries ‘parochial cosmopolitans’. Before taking up these themes in the rest of the chapter, I consider several of the people who visited Matamba Mission Hospital and describe how they became missionaries.

Becoming a short-term missionary

Dr Michael Harbeson was an anaesthesiologist from California who came to Matamba Mission Hospital with his wife, Susan Harbeson, and their two children in the summer of 2015. They all stayed in the guesthouse within the mission compound for the two weeks of their stay. Dr Harbeson originally wanted to go to Tenwek Mission Hospital, a large institution in the former Rift Valley Province of Kenya.¹⁰⁸ Some of Dr Harbeson’s colleagues from California had volunteered at Tenwek and encouraged him to do the same. After the Westgate shopping mall attacks of September 2013 in Nairobi, however, Dr Harbeson decided he was unwilling to take his family to Kenya and decided to look into other mission hospitals that might benefit from the work of an anaesthesiologist for two weeks. Like many of the missionary volunteers I met at Matamba, Dr Harbeson applied to serve as a missionary through the Christian charity Samaritan’s Purse.

Samaritan’s Purse was founded in 1970 and its President, Franklin Graham, is the son of the prominent evangelical Billy Graham.¹⁰⁹ Samaritan’s Purse describes itself as ‘a nondenominational evangelical Christian organization providing spiritual and physical aid to hurting people around the world’.¹¹⁰ Founded in 1977, the medical arm of Samaritan’s Purse is called World Medical Mission (WMM) and is affiliated with many mission hospitals throughout the world, including Matamba Mission Hospital.¹¹¹ American doctors and nurses who wish to work at one of the mission hospital’s affiliated with WMM in Africa, Asia, Latin America or Papua New Guinea, have to apply through the organisation with two professional references and a letter of recommendation from their church pastor. In addition to this, volunteers have to sign statements of their Christian faith, conduct and practice (see Appendix 1). These statements explicitly asked volunteers to confirm that they would ‘consistently demonstrate Christian conduct’ and agree ‘to provide excellence in medical care and to present Jesus Christ as Lord and Saviour’.¹¹² One notable advantage for volunteers

who applied through WMM was that the organisation assisted with many of the procedural and administrative aspects of missionary work, such as applying for visas and work permits – often a difficult and time-consuming task in Zambia.

Like other volunteers, Dr Harbeson admitted in an early conversation that, ‘I had no idea where Zambia was when I got a response from World Medical Mission. I told them when I was available and said that I wanted to go to Africa . . . and then I found out about this place’. The fact that volunteers chose to apply through WMM meant that they were from a range of backgrounds in the United States and attended churches that, while all Protestant, were often quite theologically diverse. Dr Harbeson, for instance, attended a small local church with his family and described his own Christianity as ‘*very* evangelical’. As we will see, later in the chapter, his missionary work strongly connected him (and his family) to his local church. Other volunteers, however, did not apply through WMM and some of them had a more direct relation to Matamba Mission through their own local churches.

Katherine Wright, for instance, volunteered at Matamba for one month during April 2015. She was a nurse in training at a Christian college in Georgia and her local Methodist church had a long-standing relationship with Matamba Mission Hospital as her church had helped to fund Tom and Hannah for many years. Katherine had met Tom and Hannah many years earlier when they visited her church in Georgia to give a presentation about their work in Zambia in order to request financial support from the congregation. Given that Katherine’s parents had been missionaries (in Eastern Europe in the 1980s), she was attracted to the idea of becoming a long-term missionary herself when she graduated as a nurse. The trip was, in part, a way for Katherine to decide whether she enjoyed missionary work enough to pursue it as a career. As Katherine had met Tom and Hannah before, rather than applying through Samaritan’s Purse, she had simply contacted them directly and they helped her to arrange some of the necessary paperwork before her arrival.

Other visitors to Matamba applied directly through the missionary ‘wing’ of the American Wesleyan Church, which was called Global Partners. Indeed, Jacob and Sarah were members of the Wesleyan church and decided to apply through Global Partners. The majority of missionaries who worked for Global Partners were non-

medical and this meant that missionaries seeking to practice at a clinic or hospital were limited in their choices. This was one of the reasons why Jacob and Sarah chose Matamba. The missionaries who applied through Global Partners tended to share a certain scepticism about Pentecostal forms of Christian worship and, in this sense, they differed from many of the missionaries associated with WMM (who were often delighted by the Pentecostal styles of worship they encountered in Matamba, including the style of Pastor Mwaanga).

These differences – in Christian background and institutional affiliation – meant that the short-term visitors were far from a unified group. The missionaries described by Howell (2012), who went on mission trips organised by their church, were brought together by their shared church affiliation and their months of collective preparation. The missionaries at Matamba, on the other hand, found themselves encountering new people from different backgrounds in Zambia and they did not arrive with a shared collective ‘narrative’ about the missionary trip. What they did share, as we will now consider in more detail, was the capacity to perceive certain aspects of the lives of Zambian patients at the hospital as morally meaningful. This was something that can be seen in a further episode involving Jacob and Sarah.

Mrs Chibbula’s faithfulness

In the OPD one morning, where I was spending time with Sarah, a woman came to be seen who was HIV-positive, blind and heavily pregnant. The woman, whose name was Mrs Chibbula, had become blind due to trachoma (a contagious bacterial infection that occurs in places where people do not have access to clean water). According to the missionary doctors, this was not common at Matamba Mission Hospital and if she had been treated in time, a simple course of treatment with antibiotics would have prevented Mrs Chibbula from becoming blind.

Mrs Chibbula was visiting the OPD because she had been told by Dr Tom to attend the hospital to make sure that her pregnancy was progressing without complications. Mrs Chibbula was visiting the hospital from her home area, around fifteen miles away

and, during the consultation, she spoke a small amount of English. Sarah, like many other visitors, spoke in a fast American-accented English and in many of her interactions with Zambian patients and staff members there were misunderstandings and moments of confusion. At some point in the interaction, Sarah acquired the idea that Mrs Chibbula had walked the fifteen-mile journey on her own – an idea that was instantly captivating to Sarah, although it was only later that I discovered why.

When I spoke to Mrs Chibbula later on, with my research assistant Clare, she explained to us that, while she did indeed live at least fifteen miles away from the mission hospital, she had been driven to the hospital by her husband's brother, who also wanted treatment, alongside several other relatives and people from their area. Later on in the day, I was present when Sarah spoke about her encounter with Mrs Chibbula to her husband Jacob. After explaining Mrs Chibbula's medical history and her condition, Sarah said,

That woman was blind and yet she had managed to walk all that distance on her own. She walked from her home village – in the middle of the bush – to the hospital, despite being blind. People at home will be amazed to hear about people like her. How does somebody who is blind get the courage and strength to walk on their own to the hospital? That takes real faith. Seeing that woman and seeing her faith makes me really think about the effect that God's love can have in our lives. It gives people the faith to achieve impossible things. Can you imagine walking that far in her situation?

I pointed out, during this conversation, that Mrs Chibbula had been driven by her husband's brother. Jacob, who had already grasped the importance of Sarah's story, was not surprised by, or even particularly interested in, my correction of the basic facts of Mrs Chibbula's journey to the hospital. In response, Jacob said to me that it did not really matter whether Mrs Chibbula had walked on her own or been driven, because the story itself was such a powerful one and, besides, 'there are loads of patients who walk miles and miles to get here anyway, everyday'.

For Sarah and Jacob, then, there were certain aspects of Mrs Chibbula's life that were highly visible and meaningful to them. The image of the blind woman who had to

trust others and have faith in her everyday life was a powerful one. Sarah and Jacob did not need to ask Mrs Chibbula about her life or her faith (or even whether she really walked alone to the hospital or not) because they could see something that was more fundamentally important than these more trivial aspects of Mrs Chibbula's life – just as Jacob had not needed to know much about the girl in the accident, Mercy, before giving his sermon. Jacob and Sarah could see that the lives of Mercy and Mrs Chibbula – among other patients at the hospital – were full of acts of faithful devotion and, furthermore, these were meaningful stories that they could take home with them and which they could tell their friends and family about. Stories that might even change the lives of their friends and families. The capacity to perceive Christian meanings in the lives of patients can be found in other contexts. Anita Hannig, for instance, has written about Protestant missionary doctors in Ethiopia who referred to their patients as 'pilgrims', 'thus rendering patients' voyages in search of treatment as experiences of a religious kind' (2017: 104).

Anthropologists of humanitarianism have been interested in how humanitarian workers perceive the lives of those whom they seek to help, however, they have tended to characterise humanitarian depictions of the recipients of aid as decontextualised and simplistic. These anthropologists have pointed out that humanitarian organisations have a tendency to imagine the recipients of their aid in ways that divorce from their wider networks of neighbours, friends, and relatives in order to depict them as needy and worthy of care or admiration. This is especially noticeable in the case of children. Malkki points out that there is often a 'suspension (if not erasure) of the child's parents, siblings, grandparents, and other relatives, and also friends, teachers, and neighbours' when humanitarian workers imagine 'the needy child' (Malkki 2015: 9; cf. Bornstein 2005, 2012).¹³ I think it is worth looking in more detail at what happens when humanitarian perceptions involve the 'suspension (if not erasure)' of the wider relationships within which recipients are situated. In doing so, it is worth turning to Wittgenstein's ([1953] 2001) notion of aspect-perception.

Aspect-perception and Christian suffering

There have been extensive debates within anthropology about meaning in religious life (e.g., Asad 1993; Geertz 1973; Gellner 1998; Keyes 2002; Engelke and Tomlinson 2006). In studies of missionaries, the theme has been explored in several ways. Anthropologists have described how missionary behaviour was always already being perceived and interpreted as meaningful in ways that were perpetually outside of the control of missionaries themselves. At the same time, missionaries themselves found a great deal of meaning in many aspects of the lives of the people they encountered (e.g., Comaroff and Comaroff 1991, 1997; Keane 2007; Pels 1999). Among anthropologists of Christianity there has recently been an engagement with some of these classic themes and they have returned to questions about meaning and the 'limits of meaning' in anthropological analysis (Engelke and Tomlinson 2006).

In this section of the chapter, I want to suggest that some of these concerns can be usefully brought into dialogue with anthropological studies of humanitarianism and morality/ethics. The lives and experiences of Zambian patients were meaningful for many of the short-term visitors and gave them the chance to 'see' the work of Christ at close quarters. Here I suggest a way of understanding, to use Asad's words, 'the processes by which meanings are constructed' (1993: 43) in the context of missionary encounters.

Anthropological discussions about 'meaning' often make reference to Wittgenstein's argument that the meaning of words is their use within certain 'forms of life' or 'language games' (see, e.g., Tomlinson and Engelke 2006: 9-11). Wittgenstein wrote that, 'For a large class of cases – though not for all – in which we employ the word "meaning" it can be defined thus: the meaning of a word is its use in the language' ([1953] 2001: 43).¹¹⁴ Yet, as I briefly outlined in Chapter One, I want to suggest here that Wittgenstein's work offers a further way of thinking about questions of meaning and particularly moral (or ethical) meaning.

In part II of his posthumously published *Philosophical Investigations*, Wittgenstein discusses what he called 'aspect-perception'. The most well-known and discussed image that Wittgenstein used in this context is the often-reproduced line drawing of

the 'duck-rabbit', which can be seen as either a duck or a rabbit ([1953] 2001: 166). However, I will concentrate here on certain other sections of Wittgenstein's discussion that are more illuminating in this context. Before his discussion of the 'duck-rabbit' image, Wittgenstein introduces a distinction between two kinds of seeing.

Two uses of the word "see".

The one: "What do you see there?" – "I see this" (and then a description, a drawing, a copy). The other: "I see a likeness between these two faces" – let the man I tell this to be seeing the faces as clearly as I do myself.

The importance of this is the difference of category between the two objects of sight. ([1953] 2001: 165)

Wittgenstein is suggesting here that there is a difference between being able to 'see' such things as people and objects in the world and being able to 'see' the likeness between two people. To return to the example mentioned in Chapter One, to say 'I can see there are lots of patients here this morning in the male ward', is different to a claim such as, 'I can see that God is giving these patients strength'. The latter is something that requires a certain degree of 'imagination' and involves making certain connections. Furthermore, if I cannot 'see' the likeness between two faces or I am unable to 'see' that the patients in the male ward are being given strength by God, it is not necessarily possible to simply 'show' these things to me in any straightforward sense of the term.

In Wittgenstein's discussion, his terminology changes slightly. In some places he writes about 'seeing as', sometimes about 'seeing an aspect' and also 'noticing an aspect' (on this see Seligman 1976: 205). This is important because these terminological differences help to demonstrate that Wittgenstein was not concerned only with the activity of 'seeing' in its most literal sense, but used the notion of sight as a metaphor for many different kinds of perception. Perceiving or noticing an aspect, for Wittgenstein, included such diverse things as being able to hear music, find humour in a remark, or recognise somebody's actions as courageous. This is important to stress because anthropologists are, by now, familiar with the many criticisms of 'ocularcentrism'. Fabian's anxiety that, in anthropology, vision has too often been privileged as 'the noblest sense' (1983: 101) has encouraged anthropologists in the last

twenty years to rectify this prejudicial treatment of sight, offering accounts of ‘the senses’ and ‘the sensuous’ dimensions of human life and experience (e.g., Fabian 2000; Okely 1994; Stoller 1989; Taussig 1993, and others).¹⁵ The suggestion here, however, is that Wittgenstein’s notion of aspect-perception can illuminate the way in which people come to find moral meaning in various ways and Wittgenstein’s framing of these issues is not intended to open up discussions about phenomenological perception. As Budd (1987) has pointed out, Wittgenstein’s notion of seeing is useful precisely because of ‘its irreducibility either to a purely sensory or to a purely intellectual paradigm’ (1987: 17).

We can see how this might be useful, for instance, when anthropologists write about how humanitarian workers depict ‘suffering others’ in ways that are ‘superficial’ and ‘decontextualized’ (Feldman and Ticktin 2010: 15). It would surely be worth paying more attention to *how* such depictions of ‘suffering others’ emerge in the first place. If we dismiss humanitarian narratives and visions as simply ‘superficial’, then we are only describing them by reference to what they lack and thus failing to pose the question of how, positively, they are constituted. In other words, the depictions by the American missionaries at Matamba Mission Hospital of Zambian patients were not simply ‘bad descriptions’ or ‘decontextualised’ – as if ‘context’ is simply ‘out there’ to be discovered. There is something worth describing anthropologically about their practices of moral apprehension and this is where moral aspect seeing is a useful concept.

One way of thinking about aspect-perception is to consider some of the remarks Wittgenstein made about what he called ‘aspect-blindness’. In a sense, when I questioned Jacob and Sarah about the details of their accounts, I was exhibiting a form of ‘aspect-blindness’. I was surprised, for instance, that Jacob had seen in Mercy a form of faithful suffering without knowing, for instance, whether or not she was a Christian and without asking her about how she was managing to cope. I was also surprised to find that Sarah took Mrs Chibbula to be a faithful person who was given strength by God to endure her hardships. Wittgenstein uses the metaphor of being able to hear and appreciate music when he remarks that: ‘Aspect-blindness will be akin to the lack of a ‘musical ear’’ ([1953] 2001: 182). Elsewhere he poses the question, ‘What would a person who is blind towards these aspects be lacking?’ and he suggests that, ‘It is not

absurd to answer: the power of the imagination’ (quoted in Monk 1990: 531). One of the questions then becomes: how do people acquire such an ‘imagination’?

Wittgenstein’s celebrated biographer, Ray Monk (1990), has suggested that while ‘imagination’ was one of the terms that Wittgenstein used, he meant this in a broader sense and often went further than this: ‘What is further required for people to be alive to “aspects” (and, therefore, for humour, music, poetry and painting to mean something) is a culture’ (Monk 1990: 531). Indeed, this is where the direction of Wittgenstein’s work begins to intersect with the history of anthropological thinking. Wittgenstein’s work on language and the notion that language is connected to certain ‘forms of life’ has profoundly influenced anthropologists, particularly those who have pursued the notion that ‘cultures’ can be considered as texts of a kind to be read and interpreted – the most famous practitioner of this approach being Clifford Geertz.¹¹⁶ Geertzian interpretive anthropology no longer has the appeal that it once had within the discipline (for many reasons, the discussion of which exceeds the scope of this chapter, but see Kuper 1999) and the idea of ‘cultures’, in the plural, which Wittgenstein’s work seems to rely upon, is something many anthropologists remain highly sceptical about today. However, what requires more attention is not the question of how to understand or interpret a ‘form of life’ or ‘culture’, but rather the question of what enables some people to ‘see’ certain moral aspects of their social world so clearly, while others cannot? This is a question posed by Wittgenstein that is worth returning to – even if there are good reasons for rejecting some of the wider assumptions (about language, ‘forms of life’, or ‘cultures’) that have shaped the reception of Wittgenstein’s work within anthropology up to now (although see also Das 1998).

With this question in mind, I wish to suggest that being able to ‘aspect see’ may well be a capacity that is acquired and has to be trained over time. This is because ‘*seeing as* involves the mastery of a technique’, which is why the ‘ability to *see as* is an accomplishment requiring imaginative skill’ (Hester 1966: 205; emphasis mine).¹¹⁷ In her recent work, Tanya Luhrmann (2012) has argued that reflection, attention and training produce a heightened capacity, among Christians, to hear the voice of God. It might be useful to think about moral aspect seeing, similarly, as a capacity that is

trained and involves attending to certain aspects of social life with a heightened level of awareness over time.

Indeed, this is where moral aspect-perception might be added to some of the concepts debated among anthropologists of ethics and morality. In his *Ethics and the Limits of Philosophy* (1985), Bernard Williams points out that philosophers influenced by Wittgenstein have often been reluctant to talk about the acquisition of moral attitudes or ethical perspectives independently of language. Williams points out that ‘a group of people similarly brought up would share of seeing certain cases as like certain others’ and this is – in broad terms – what ‘followers of Wittgenstein are disposed to believe’. However, Williams suggests that the explanation for this goes beyond the fact that these people would have been participating in shared ‘language games’.

It is not merely that the ability to use language requires a shared capacity to see similarities, but that the capacity to see ethical similarities goes beyond anything that can adequately be expressed in language . . . [This] does not mean, however . . . that there is no explanation, at any level, of these human dispositions (1985: 97-98).

Two people who are able to ‘see ethical similarities’ (between different contexts or domains) might not be able to express this in language to a third person. Just as being able to see the likeness between two faces is not something that can be conveyed to another person. And arguments cannot be given. Wittgenstein sometimes expressed a similar idea in the following terms: ‘If I have exhausted the justifications I have reached bedrock, and my spade is turned. Then I am inclined to say: “This is simply what I do.”’ ([1953] 2001: 72).

This might be an accurate way of describing what happens during conversations and exchanges with other people that cannot go further. Yet, in Williams’s view, the fact that people often have to abandon language and say to one another, ‘This is simply what I do’ does not mean that ‘there is no explanation, at any level, of these human dispositions’, as he puts it in the passage quoted above. Indeed, an altogether more anthropological approach – or ‘ethnographic stance’ – would be to offer an account of the formation of these ‘human dispositions’ in order to consider how it is possible for

some people to morally perceive certain aspects of social life in ways that others cannot.

Indeed, this is where it is possible to return to the anthropology of ethics and morality. If moral aspect perception is both acquired and trained, then, as suggested in Chapter One, we might wish to consider how people's forms of 'reflective evaluation' (Laidlaw 2014: 44) are shaped and influenced by their perceptual capacities. Heightened over time, these perceptual capacities enable people to notice certain meaningful aspects of social situations, relationships and encounters of various kinds. Some debates in the anthropology of ethics might be helped by this notion – for example, the extension of 'ethical subjectivity' to animals (or other entities), such as spirits, might entail precisely this kind of acquired capacity for aspect seeing (Keane 2016).

The idea of moral (or ethical) aspect-perception would not need to entail any commitment to a 'theory' of ethical subjectivity. Indeed, if the anthropology of ethics and morality is to advance in a similar way to our understanding of 'gender' in the discipline – a model suggested by Laidlaw (2014: 2) – then it might be more useful to begin to think, not in terms of 'theories' of ethical and moral life, but in terms of concepts that enhance our ability to describe ethical and moral life. For example, there have been debates about the suitability of different philosophers in guiding anthropologists' understanding of ethical life. Cheryl Mattingly (2012) has suggested that there are dangers in seeing Foucault's work as a model for anthropologists – given some of his theoretical commitments and apparently anti-humanist stance – whereas virtue ethicists, in a broadly conceived Aristotelian tradition, are more likely to offer approaches that are compatible with anthropology in Mattingly's view. However, if we think of philosophers (whether Aristotle, Foucault or Wittgenstein, among others) in terms of the tools that they provide in helping with the anthropological description of different aspects of ethical life, then there is no need to be concerned about the other theoretical commitments of these thinkers.¹¹⁸

By this, I wish to suggest that some concepts – the idea of ethical substance, the notion of reflective evaluation, ethical affordance, existential obligations, and so on – are going to be more or less useful in different ethnographic contexts. When anthropologists study lives as diverse as those of crack cocaine dealers in East Harlem

(Bourgois 1996), Palestinian women living in Israel (Kanaaneh 2002), and prisoners in Papua New Guinea (Reed 2003), it is unsurprising that an overarching theory about moral and ethical life might produce disagreement among anthropologists. Nevertheless, we might still be able to describe some of the ethical and moral aspects of the lives of people in contexts as diverse as these by using some of the tools of description that are being suggested in the anthropology of ethics and morality. It is with this conception of the anthropology of morality and ethics in mind that I suggest that the notion of aspect-perception might be an additional conceptual tool. Furthermore, to this might be added the notion not only of aspect seeing but also aspect showing.

Missionaries often attempted to 'show' certain aspects of their surroundings to other missionaries. As we saw in the conversation between Jacob and Sarah about Mrs Chibbula, missionaries would often encourage each other to 'see' the meaning of a certain event by describing the event and discussing its significance, often at great length. Drawing on Wittgenstein's discussion of aspect-perception, the philosopher Ze'ev Emmerich (2011) has suggested that we might also devote more attention to how people are encouraged by others to 'see' aspects of social life that they have failed, so far, to attend to. Emmerich suggests that the attempt to get others to 'see' these aspects of social life are 'speech acts' of a quite distinctive kind, 'the function of which is to shape/alter other people's modes of "aspect seeing"' (2011: 62).

In acquiring the capacity to see the meaning of Christian suffering, then, these are all important elements to consider: the backgrounds of the missionaries and the multiple ways in which they have been encouraged to see the world; the heightened capacities to see their new surroundings (which were associated with the excitement and uncertainty of travel and arriving in a new place); and, finally, the conversations they had with each other in which they engaged in 'aspect showing'. It is worth at this point considering, ethnographically, how thinking about moral aspect showing can illuminate our understanding of the perceptions of short-term missionaries.

The importance of aspect seeing

There are many consequences of moral 'aspect seeing' in missionary encounters. It seems clear that the capacity to see in certain ways enabled expatriate Americans to feel that they had transcended the barrier of language. Brian Howell makes a similar point when he discusses an American woman who went on a short-term trip to the Dominican Republic. She described lots of children greeting her and the other American missionaries when they arrived in a poor neighbourhood: 'They just would come running from everywhere for a hug. I think these kids are never hugged. It's just heartbreaking' (quoted in Howell 2012: 164). Howell points out that 'it seems unlikely that the dozens, if not hundreds, of children running to greet the North American visitors to a poor, urban neighbourhood were coming primarily for hugs and to receive needed affection'. Nevertheless, he continues to suggest how important it was, for this American missionary,

to see her interaction as the creation of deep affective bonds in a brief encounter in which barriers of culture and language were irrelevant in light of the common human, and theologically loaded expressions of love and of concern she felt she was able to unambiguously convey to the nameless children. (2012: 164)

Similar forms of seeing were common at Matamba Mission Hospital. Dr Harbeson's wife, Susan, occasionally visited the operating theatre when her husband was administering anaesthetic to women about to have caesarian sections (which can be a painful and uncomfortable process). Susan told me that she would hold the hands of these women, almost all of whom she could not communicate with in a shared language, in order to comfort them and, through her gestures, convey that everything was going to be fine. Susan described to me, on several occasions, the 'deep affective bonds' (to use Howell's term) that emerged between her and these women. She once said, 'You can see in these women's eyes that you are getting through to them and that by taking the time to be with them . . . it is making a difference'. Missionaries have often attended carefully to gestures and forms of bodily communication in contexts where there are linguistic barriers (see, e.g., Comaroff and Comaroff 1991: 198).

A consequence, then, of being able to perceive such bonds in these transient encounters was that short-term missionaries were able to feel that they had made important emotional connections with these formerly distant 'needy' people. This relates to a further consequence of aspect seeing. As we saw above, Jacob and Sarah were struck by the 'faithful' suffering of patients. They were not alone, among short-term visiting missionaries, in seeing the suffering of patients as morally meaningful. Almost all of the short-term missionaries with whom I spoke were struck, at one time or another, by the fact that Zambian patients seemed to be able to endure greater levels of pain than the American patients they were used to treating. I was often told by missionaries who spent time in the labour ward, for example, that women were able to give birth remarkably quickly without complaining or screaming in pain. These women would sometimes get up and walk out of the ward shortly after giving birth – something that would never have happened (indeed that was entirely unthinkable) in the United States, these missionaries reported. I often heard similar remarks about children who came to the hospital with broken limbs or serious illnesses and who did not complain, instead stoically enduring the treatment they needed. Indeed, during consultations between missionaries and patients, I often observed that many patients seemed to be able to withstand greater amounts of physical discomfort without much complaint.

As Julie Livingston (2012) has shown in her work in Botswana, there is a long history of Europeans and missionaries puzzling over the fact that their African patients seemed not to feel pain severely (2012: 134-141). As Livingston argues, these patients did not experience pain in radically different ways, but rather 'pain may be spoken of, but rarely screamed or cried over' (2012: 124). Livingston continues:

Bodily reserve and continence in the face of pain was a technique of autopalliation in and of itself. Women learned during labour and children learned during the scrapes and accidents of childhood, that becoming overwrought would only intensify the pain . . . This is a cultivated disposition, one that is respected as much for its rationality as for its mark of self-discipline and control. (2012: 144)

Livingston's interesting suggestion is that missionaries (and others) were often oblivious to the many ways in which people were taught to endure pain. Methods of 'autopalliation', as Livingston calls them, were widespread but European observers tended to find alternative explanations for the ability of their African patients to endure bodily suffering (including racist suggestions that Africans did not feel pain in the same way because of their biological inferiority).

Forbearance in the midst of painful experiences has been noted by many anthropologists. Hannah Brown found, at a hospital in western Kenya, that women were expected to remain silent during childbirth, one woman saying: 'If you cry out people will say, "why are you screaming, you are not the first to feel this pain!"' (2010: 169; cf. Fassin 2008: 265). At Matamba Mission Hospital, many short-term missionaries saw, in the ability of patients to endure pain, a more profound meaning. One of the consequences of this ability to see Jesus's work in Zambia (as he gave patient's the strength to endure suffering) was that many missionaries came to feel closer to God.

Historians of medical missionaries have suggested that missionaries often preferred to deal with African patients who were unable to walk, who were blind, or who suffered from leprosy. In other words, who were enduring 'biblical manifestations of disease and misery' (Jennings 2008: 35; see also Hardiman 2006: 26, 33; Shankar 2006: 281). Medical innovations could incite the same Christian moral perceptions. After the introduction of antibiotics in colonial Tanzania, one medical missionary noted: 'People say the age of miracles is past . . . it is certainly *not* with regard to the work of healing . . . It is to us and to them miraculous the way in which things are done and people are healed' (quoted in Ranger 1981: 265). As J. D. Y. Peel points out, missionaries regularly 'called up Biblical precedents for themselves' (2000: 9).

While missionaries today continue to perceive Christian dimensions in their medical work, one of the clear differences is that they imagined Zambia as a place where life was more 'basic' and stripped back – and therefore God's work was more visible. Earlier missionaries felt that they were entering a place of 'darkness' where God's work needed to be done. By contrast, many missionaries at Matamba expressed the idea that their patients were morally pure, while the United States was a place of depravity and vice. Perhaps this reversal of the colonial-era construction of Europe as

civilized and Africa as sinful confirms that notion that – as Nicholas Thomas (1994) has argued – images of others as ‘authentic’ or ‘morally pure’ are closely related to images of them as ‘depraved’ or ‘uncivilised’.

This final point is worth thinking about further because the conversations that short-term missionaries had with each other were not only conversations in which they encouraged each other to see the faithful suffering of Zambian patients. They were also conversations in which missionaries thought about how they would describe their experiences to their friends, family, and fellow church members when they returned to the United States. It is to these relationships – with people at home – that we turn to consider now because, as I will show, these relationships were central to the short-term missionary vocation.

Missionary relationships with people at home in the United States

Tom and Hannah, as we saw in the previous chapter, lived relatively ‘self-sufficient’ lives in Zambia. In relation to the patients and staff members at the hospital they lived extraordinarily self-sustaining lives. They had no children – something which did not go unnoticed by Zambian staff members (as I mentioned in the previous chapter) – and they were able to entirely provide for themselves. Tom and Hannah were also, it is worth stressing, emotionally self-sufficient in comparison with most of the visiting missionaries, for whom family, friends, and fellow church members remained important during their stay in Zambia. Short-term visiting missionaries received many kinds of support from their family members and friends – in the form, firstly and most obviously, of telephone and email communication but also, and perhaps more importantly, in the form of prayer.

As we saw earlier, when considering how people became short-term missionaries, Katherine Wright was somebody who had close relationships with people at home in the United States and she was a member of a church that had a pre-existing connection to Matamba Mission Hospital. Many people helped Katherine to raise the necessary funding for her trip and she was expected to keep church members updated

by taking photos and giving a thorough account of her mission ‘experience’ when she returned to Georgia. Indeed, Katherine sent newsletters home while she was in Zambia – the contemporary equivalent of the mission journals of the nineteenth and twentieth centuries where ‘readers were encouraged to keep track of their favourite patients, to pray for their souls, and to follow their medical and spiritual progress’ (Vaughan 1991: 61; see also Pels 1999: 55-66).¹¹⁹ Katherine took these responsibilities seriously and sometimes spoke of them as a burden. Indeed, this is something noted by Beidelman in his discussion of nineteenth century missionaries who were able to ‘feel pleasantly altruistic abroad’ but whose ‘position *vis-à-vis* . . . home [was] uncomfortably, one of receiving charitable support’ (1982: 15). Aware that people at home thought she was doing ‘good work’ in Zambia and even considered her to be a brave and inspirational member of the church, Katherine sometimes felt that she was not doing enough in Matamba.

During an interview, I asked Katherine how her friends and relatives at home imagined her missionary work.

I think people [at home] think that missionary work is all about Bible study. But a huge part of missions is actually just living out your faith. I mean, I don’t pray with anyone here, but that doesn’t mean that I’m not a light to others. The problem is that people at home don’t realise that – so they want me to be sending reports back saying that I’ve shown ten people to Jesus or something like that, when actually I was just working everyday and that’s what medical missions is about. So, the expectations [of the people at home] scare me sometimes.

This sense of distance from friends and relatives at home (whose misconceptions about missionary work could be frustrating) reinforced the feeling of shared bonds with other missionaries. Indeed, to remind herself of her fellow Methodist missionaries across the world, Katherine had created a wall of images of other missionaries affiliated with Global Partners. Katherine had met many of these missionaries the previous year at a Global Partners missionary conference in the United States and, when she was having a difficult time, she would look at these images as a source of spiritual support. Anthropologists of humanitarianism have sometimes observed that when aid workers return home they feel that their family

members, friends and colleagues do not understand what they have been through (e.g., Malkki 2015).

However, as well as this attitude of distance from family members and friends, they were also held up as a source of emotional and spiritual support. Before they left the United States, visiting missionaries were encouraged – by World Medical Mission, Global Partners, and by Tom and Hannah – to prepare for the trip by asking their friends and loved ones to pray for them during the length of their mission. For example, when missionaries agreed to come to Matamba they were sent some information from Tom and Hannah, including a booklet with the following advice:

You will be leaving family and friends behind to come to a very different world. You may have times of loneliness. Communication by letters with loved ones and communication in prayer with the Lord is very important in these times. This leads to the important area of spiritual preparation for your trip. There are spiritual battles within and without during overseas service. You will find it essential to prepare yourself as well as recruit a group of loved ones and friends who will pray for you daily while you are there.

Visiting missionaries were often deeply aware, during their time in Zambia, of the importance of their churches in sustaining them spiritually throughout the duration of their stay. Dr Harbeson, who was introduced earlier, said to me on several occasions that, without the support of his church members, his trip would not have been possible. He described this in terms of forces of good and evil in the world.

Physicians everyday see the miracle of healing. And we are aware that things can also go very badly and there are forces in the world – the love of Jesus is there, but there are also evil forces. And when you are in a place like this, knowing that there are people at home who are praying for you is important and I know there are times when it makes all the difference . . . keeping you safe on a car journey, or helping a patient to survive an operation.

The idea of church members in the United States offering spiritual support as short-term missionaries went to Africa to do battle with the forces of evil was not expressed often – although, when it was, it was usually by missionaries from more evangelical

backgrounds, such as Dr Harbeson. For these missionaries, ideas of patients visiting local healers – whom they invariably called ‘witchdoctors’ (see also Marsland 2007: 757) – or being ‘possessed by demons’ became a part of such Manichean narratives.¹²⁰ Congregations in the United States were important in a further sense. When short-term missionaries had reasons to doubt the value of their trips, they were able to describe their friends and relatives as, in some sense, the ‘real’ beneficiaries.

When I interviewed visiting missionaries, I usually asked them how, if at all, they evaluated the ‘success’ of their mission trips and what criteria of ‘success’ they used. This was a relatively unpopular question and, in some interviews, it provoked quite defensive reactions. What was interesting, beyond this, was how often, when missionaries felt that they were not achieving as much in Zambia as they had hoped and expected, they would identify their family, friends, and church members as the people who would be the most profoundly transformed by their missionary work. This may become more understandable by introducing part of a conversation between Jacob and Sarah about the effects of short-term missionary work.

Jacob: The crazy thought is that, even if we have no impact here, then at least we may have some impact back at home. Our stories to people back at home are powerful . . . And, our story is God’s. So who are we to say? What if God has us all here right now so that we can touch the life of one person in Texas? Then it doesn’t matter what impact we have here because he loves *them* as well.

Sarah: Well, I do wonder if I am a light and whether people recognize Christ in me [here in Zambia]. Or maybe sometimes – and this might sound strange – but, yes, sometimes I think I am being more of a light for people back home in Texas. Because, really, people here don’t know me. And, it’s crazy, but maybe the whole point of all of this is for people back at home to see my faith in action.

Other anthropologists have noticed that by ‘emphasizing the spiritual dimension’ of the mission, short-term missionaries are able to feel that they have worked ‘directly for the spiritual (or at least emotional) betterment of those to whom the group has ministered’ (Howell 2012: 165). However, when even this aspect of the mission is questioned, the recipients or beneficiaries of the mission can be located back at home,

as people who might be inspired and spiritually nourished – or even able to ‘see’, in a new way, God acting through these short-term missionaries.

Furthermore, it was central to some of these arguments that the short-term missionaries themselves were from humble or parochial backgrounds. For some missionaries, it was important that their friends and family members knew that they were going on a short-term mission trip despite being nervous about travelling. By stressing their own weaknesses, these missionaries could suggest that their decision to go to Zambia would have a bigger impact in the lives of those who had remained in the United States. In other words, the idea was often expressed in the following form: ‘They will see that if *I* can do this, then God must be acting through me’.¹²¹

Parochial Cosmopolitanism

American evangelical Christians are frequently depicted as ‘parochial’ and inward-looking. Indeed, the stereotypes of American evangelicals as, for instance, ‘backward, rural, southern, uneducated’ (Harding 1991: 373) are connected to this notion of being community-oriented and, it is assumed, uninterested in the wider world. By contrast, well-educated and mobile ‘cosmopolitans’ are often imagined as deeply connected to the wider world. Cosmopolitans are ‘open-minded’ and ‘tolerant’ of difference, even seeking to understand and embrace such difference. Anthropologists have considered this definition of ‘cosmopolitanism’ at great length (see, e.g., Amit and Rapport 2012; Hannerz 2007; P. Werbner 2008) and often consider what it might mean to be ‘a citizen of the world’.

Yet as Kwame Anthony Appiah (2006) has pointed out, there is another aspect of cosmopolitanism and one that has often been in tension with this notion of being ‘a citizen of the world’ – and that is responding to the suffering of others. I try to show here that missionaries have been able to overcome one of the common tensions that we find, repeatedly, in anthropological and philosophical discussions of cosmopolitanism – namely, the missionaries were able to situate themselves between the parochial and the cosmopolitan, or in other words, they have identified a way of

trying to orient themselves 'between community and humanity' (Amit and Rapport 2012: 85).

Philosophical arguments about responding to the needs of distant suffering others are often addressed to self-consciously 'cosmopolitan' audiences, who imagine themselves to be worldly citizens – precisely the opposite of the imagined parochial evangelical Christian. Such people are perhaps the imagined audience, for example, of Peter Singer's (2009) recent work, in which he enjoins his readers to treat the distant poor as moral equals. The readers of Singer's recent book, *The Life You Can Save*, are encouraged to sacrifice seeing a play or buying an expensive pair of shoes and, instead, offer their money to a charitable organisation instead (such as Oxfam, Against Malaria Foundation, Fistula Foundation, and other charities that are considered by Singer to be doing worthwhile work).

Like other moral philosophers who have made similar arguments, Singer has to deal with the issue of the motivational or affective dimensions of encouraging people to care about the suffering of the distant poor. This is something that Simon Critchley, in a similar context, has called a 'motivational deficit' (2007: 7). In other words, Singer might persuade a reader of his book that there is no moral difference between saving the life of a child who is drowning (and who could be saved without risk to one's own life) and saving the life of 'a starving child in Africa'. Philosophical arguments that demonstrate the moral equivalence of these two situations are one thing, but successful moral 'aspect showing' (to use this term) is a different matter.

Indeed, this is something acknowledged directly in the work of Kwame Anthony Appiah, who suggests that we do not need to embrace either a community-oriented localism or an austere cosmopolitanism in which we come to regard all lives without partisan sensibilities. As Appiah puts this, it is not necessary to make a choice between

the nationalist who abandons all foreigners nor with the hard-core cosmopolitan who regards her friends and fellow citizens with icy impartiality. The position worth defending might be called (in both senses) a partial cosmopolitanism. (2006: xiv-xv)

The idea here of a ‘partial cosmopolitan’ is suggested as a more realistic modification of a position such as Singer’s. Appiah acknowledges here that there is often a tension between the moral obligations people feel to their family members, loved ones and friends and, on the other hand, to people whom they have never met who live in other parts of the world. Their moral aspect-perceptions are unlikely to change in such a way that they genuinely perceive all life as equally valuable and act accordingly. Appiah, then, is acknowledging that arguments about the equal moral worth of individuals alone will never transform people’s forms of moral aspect-perception because arguments alone cannot transform the relationships and acquired capacities to perceive and respond to other people’s needs and suffering in ways that are necessarily ‘partial’. This is a theme to which we will return in Chapter Six.

Interestingly, then, the point here is that the short-term missionaries with whom I spent time were able to avoid this sort of tension by perceiving – in spiritual terms – the significance of their mission trip as something beneficial *both* to people in Zambia and to those at home, at the same time. In this sense, framing the discussion in terms of ‘cosmopolitans’ or ‘communitarians’ is misguided. The short-term missionaries were parochial cosmopolitans. This formulation enables us to move beyond the assumption that concerns that are ‘parochial’ are necessarily limited in scope or ambition.

Some anthropologists have suggested that cosmopolitanism can be defined, in the broadest sense, as ‘an impulse towards the opening up of new ethical, existential or social horizons that extend beyond narrowly parochial allegiances’ (Amit and Rapport 2012: 45). In this formulation we might wonder why ‘parochial allegiances’ are necessarily ‘narrow’ in scope. The American missionaries travelled to Zambia not despite their parochial allegiances but, in many cases, because of them. This analysis supports the broader argument – that we find most notably in the work of John and Jean Comaroff (1991, 1997) – that the Protestant missionary enterprise has always been simultaneously a project both abroad and ‘at home’. The work of missionaries is never simply going on in the ‘mission field’ alone.¹²²

Conclusion

In this chapter I have considered how the short-term missionaries saw Zambian forms of suffering as meaningful and imagined the beneficiaries of their missionary work in rural Zambia and in the United States. In this conclusion, I want to suggest, briefly, that the way in which the missionaries depicted the suffering of Zambians is worth thinking about in relation to recent anthropological arguments about ‘suffering’.

In a recent essay, Joel Robbins (2013) has suggested that, within the last twenty-five to thirty years, the notion that anthropologists should study radically different ‘others’ has become anachronistic, giving way to a different approach within anthropology in which the task has been to describe the lives of ‘suffering subjects’. As the successor to the notion of studying radical difference – or the ‘savage slot’ as Robbins calls it, following Trouillot ([1991] 2003) – the ‘suffering subject’ paradigm attempts to evoke the way in which people throughout the world suffer in contexts of violence and poverty. According to Robbins,

This is a way of writing ethnography in which we do not primarily provide cultural context so as to offer lessons in how lives are lived differently elsewhere, but in which we offer accounts of trauma that make us and our readers feel in our bones the vulnerability we as human beings all share. (2013: 455)

The notion of a shared human condition of suffering seems to have an obvious Christian genealogy. Indeed, the way in which the missionaries were able to find meaning in suffering has parallels with the kind of writing that Robbins discusses. In one sense this should not be too surprising. The moral sensibilities, for instance, of writers such as João Biehl (2005) and Paul Farmer (2004b) – both of whom have been influenced considerably by liberation theology – are distinctly Christian in many respects. And, if we follow the argument I have been making here about ‘aspect-perception’, it is possible to understand how these anthropologists themselves are able to see the significance of human suffering in ways that others might not wish to – or, indeed, be able to.

This is something to which I return in the conclusion to this dissertation, where I consider the question of whether attempting to evoke the condition of suffering – in anthropological writing – in order to create a ‘communion in trauma’ is necessarily incompatible with offering sufficiently ‘culturally contextualized’ anthropological accounts of suffering. Or, whether, on closer inspection it turns out to be a contingent fact that some of the accounts of suffering (i.e. those described by Robbins) happen to be lacking the kinds of cultural contextualization that make for persuasive anthropological description and argumentation (in Robbins’s view).

Either way, when anthropologists attempt to make their readers feel vulnerability by evoking circumstances of suffering, it may be worth thinking about this as moral aspect showing of a certain kind. The difference here between the missionaries – who encouraged each other to perceive the suffering of patients as meaningful in a Christian sense – and the work of certain anthropologists is perhaps not as considerable as anthropologists like to imagine. In this sense, it is perhaps still worth discussing the similarities between missionaries and anthropologists – even if anthropologists, from Malinowski onwards, have wished to disavow any such affinities. The next chapter is concerned with different kinds of relationships of ambivalence and considers the Zambian members of staff at the hospital.

Chapter Five

Between the village and the hospital: the obligations and anxieties of Zambian staff members

Matthew Mujika was one of the first people at the hospital I came to know well. He worked in the pharmacy of the mission hospital (we encountered him in Chapter Two) and it was through spending time with him that I became aware of how staff members viewed, and related to, many of the rural patients who arrived at Matamba Mission Hospital. Matthew was in his early thirties and lived in a house close to the hospital with his son from a previous marriage. When I first met Matthew he was preparing to get married again, this time to a local woman. Matthew once told me that, as a younger man, he had lived a 'very sinful' life before training to become a pharmacist. Working in a hospital, Matthew said, 'I saw so many people coming to get ARVs [anti-retroviral drugs] and I knew I had to change my own life because I could have been one of those people myself'. Matthew worked long hours on his own and he seemed to be pleased when I arrived because I could help him to count pills, look over his stock checks, and keep an eye on things when he made one of his visits back to his house to check on his son, or to pick up extra medicines from the main hospital store room. Every few weeks Matthew would make visits to his rural home area where he would see some of his family and check on his cattle. He would take his mother large bags of maize flour (*busu*) and other goods and was always proud to explain that he looked after his mother very well. In many ways, Matthew's early life experiences were similar to those of many rural patients.

Matthew grew up in the Southern Province and spoke Chitonga with patients. He enjoyed joking with people and making them laugh, especially when they were people from the town, from his church, or other friends and relatives. Indeed, as we saw in Chapter Two, Matthew's friends would often walk straight into the pharmacy through the side door or otherwise push to the front of the queue and request their medication ahead of everyone else. Matthew was usually happy to oblige as his friends would tell him about their situation, addressing him using such terms (in English) as 'cousin' or

'uncle' and (in Chitonga) '*mudaala*' (elder) or '*mwenzuuma*' (my friend) and Matthew would try his best to deal with their problems.

The pharmacy itself was a small room in which the most common medicines were stored (e.g., antibiotics, painkillers, and anti-retroviral drugs). It had a large window that opened into the central space of the hospital. There were wooden benches that faced this window where patients waited to receive their medicines once they had been seen by a clinician and had been given a prescription. Over the course of the first few months, as I worked with Matthew in the pharmacy, it became obvious that he visibly prioritised particular patients. Other patients, who were less fortunate, would sometimes complain to Matthew and suggest that he was somehow benefitting from his job. Some of this took the form of joking, particularly when people would comment on Matthew's access to the hospital's medicine and suggest that he was keeping them to himself or saving them for his family.

One morning, a confident middle-aged woman had a long and animated conversation with Matthew about how he never seemed to suffer from illness. Afterwards, I asked Matthew about why the woman had said this to him:

She was saying to me that I never get sick. She said to me that I must be keeping all the good medicines in here for myself and for my family and friends and that is why I am always here and I am never ill. She said to me that she wanted an injection because she felt sick and an injection would make her better and she was saying that she knows that I have injections back here but she says I am hiding them from everyone else!

Matthew then laughed and told me that people who are 'from the village' always thought they needed an injection and imagined that Matthew had special access to 'secret medicines' (cf. White 1995).

Matthew was friendly with many patients and I never saw him shout or speak rudely to anyone. Nevertheless, for Matthew, it was clear that patients 'from the village' were in a different category to the well-dressed and wealthier residents of the small town – whether these were his friends, fellow staff members, shop owners, or government

employees. As Matthew sometimes explained to me, being ‘from the village’ meant that people were ‘uneducated’ and they did not understand how the hospital worked (cf. Fassin 2008: 266). This was the explanation that Matthew sometimes gave when patients, like the woman above, complained to him that they were being overlooked or suggested that he gave preferential treatment to his family and friends.

During the early stages of my fieldwork, when I was spending my time with Matthew in the pharmacy and beginning to observe such interactions, I recorded in my field notes an observation about staff members’ attitudes to patients who were in mourning. I had been struck, one afternoon, by the way in which certain staff members seemed to have an indifferent, sometimes even amused, attitude towards patients who were in mourning. In my field notes, I recorded my initial unease about this.

In the afternoon today a family came to mourn the death of a young man (aged 33) who died in the male ward. He was admitted to the hospital last night having attempted to commit suicide by drinking poison (probably fertilizer). He died during the night and his family arrived this afternoon. The family arrived with a coffin for burial and the men from the family stood around, while the women screamed and cried. His mother walked to the morgue behind the hospital to see the body and then returned, weeping and shouting in Chitonga. She was helped to walk by a few other women and she fell on the ground several times.

While all of this was happening, another woman was lying on the floor outside of the entrance to the hospital with many women sitting around her, one of whom was lifting her head off the ground – she was also screaming. I was very shocked by this and also by the general attitude of indifference of almost everyone else around. I asked one of the nurses, Claire, what was happening and she laughed and said, “Ah! These people from the villages, they mourn too much. Look at them!” and then she laughed again and walked slowly away. At the same time, and very close to the woman lying on the floor and the grieving mother, I met Henry [who worked in the OPD] who was casually throwing rocks at the mango tree just inside the hospital gate. “I like these fruits, but they are hard to get at” he said to me and laughed and then started looking for more rocks. Lots of staff members must be de-sensitised or completely used to these displays of sorrow, which are very difficult to witness.

At this stage of fieldwork, these notes reveal my own expectations and the shock of seeing the disturbing scene of these women in mourning for a young person. Nevertheless, these first impressions are still worth thinking about. When a member of staff was ill or died, the staff members adopted attitudes of deference towards the mourning family and the concern of staff members was more visible. Staff members often regarded the mourning displays of rural patients, by contrast, with a mixture of indifference and mild amusement and some staff members even seemed to think that there was something undignified about these displays of grief.

Historians of biomedicine in Africa have noted that Europeans have often claimed that African nurses and other clinical staff members display ‘negligence and callous indifference’ (Iliffe 1998: 155) in treating patients. Steven Feierman (1985) suggested many years ago that this was related, among other things, to the pressure on resources in African contexts.

In most cases a great cultural gap separates practitioners and patients. In earlier generations most practitioners were Europeans. Today, most practitioners are Africans drawn from a stratum of society whose members are in a small minority in terms of income and education. The majority of African patients receive treatment under conditions of extreme medical scarcity. This means that doctors must examine, assess, and prescribe in a very short time, to get on to other pressing cases. We can assume that the doctors do their best, but under these conditions patients are often treated like faceless cases. (1985: 110)

A large amount of literature since then has reported on the poor treatment of patients by staff members in African clinical settings (Andersen 2004; Brown 2010; Jewkes et al. 1998; Marks 1997; Marsland 2012; Wendland 2010).

Some scholars, however, have called into doubt the idea that the poor treatment of patients is reducible purely to the workload in under-resourced hospitals (e.g., Fassin 2008; Hadley and Roques 2007). During his fieldwork in a South African hospital, Didier Fassin wondered, for instance, why ‘nurses might chat in their break room while stretchers accumulated in the queue’ (2008: 267). Indeed, it is relatively common

for anthropologists to note their surprise at the way in which clinicians seem accustomed to the suffering of others. Hannah Brown (2010) reports her own surprise in the following terms:

After the death of a baby the doctor on duty calmly continued the conversation we had been having before the worried mother had rushed into the room carrying her sick daughter wrapped in a blanket, as though the world were no different for its loss. (2010: 182)

As I suggest in this chapter, the apparent ‘indifference’ of staff members towards rural patients and their characterisation of rural patients as ‘backwards’ and ‘uneducated’ needs to be understood in the wider context of the multiple obligations of staff members and their relations with their own neighbours, relatives and friends.

By exploring staff relationships with missionaries and patients, I hope to demonstrate the point, expressed in the introduction, that for staff members the hospital was both a social and professional domain. There was a material dimension to this, because, as I show in this chapter, some of the hospital’s resources were funded by staff members themselves. To contact patients and other clinics, nurses and clinical officers often had to use their own mobile phones and they regularly had to purchase certain objects (e.g., disposable latex medical gloves) because the hospital was chronically under-resourced.¹²³ When the staff had to make decisions about who should receive the use of their own personal resources, unsurprisingly it was often their family, friends, and neighbours whom they privileged.

In this chapter I show, furthermore, that staff depictions of rural patients as ‘uneducated’ or ‘unclean’ were common at times when staff members had to justify their own conduct in situations where they had to privilege certain patients over others. Anthropologists have considered how ideas of ‘the village’ and rural life have emerged within the context of rural-urban migration (Ferguson 1997, 1999), are shaped by elite education (Simpson 2003) and are produced within institutional contexts in which professionals have to differentiate themselves from the recipients of their assistance (Englund 2006, 2011). They are also used when medical professionals have

difficulties in reforming patients' conduct (for instance, around hygiene and self-care) in hospital settings (Hannig 2017: 157-160).

Here I show that the ambivalent attitude that staff members held towards rural life and rural patients was often a product of their own difficult position within the hospital. Idioms of 'the village' as a place of backwardness and superstition provided staff members with a language for justifying their selective treatment of certain patients over others and, at the same time, the idea of 'the village' as an authentic place where 'customs' (*cilengwa*) were preserved and where powerful healers (*bang'anga*) resided, provided staff members with ways of justifying their conduct in relation to the missionaries.

In other words, staff members were located between several different groups: the rural patients who visited the hospital; their own relatives, neighbours and friends; and the American missionaries. In relation to rural patients, staff members had to maintain their superiority and, in doing so, they often used idioms of the 'backwardness' of rural life when they were challenged or criticised by patients. In relation to the missionaries, on the other hand, staff members cast themselves as people who had many obligations outside of the hospital, many of which were to do with rural life and 'customs' – such as, for example, attending funerals, weddings, and other ceremonies.¹²⁴ An available language for staff members to describe these obligations was that of 'custom'. Staff members could depict rural patients in unflattering terms and then, moments later, find themselves defending the lives and values of people from 'the village', with no sense of contradiction.

The way in which staff members experienced and negotiated their multiple obligations and the language they used in the course of doing so, forms the central subject matter of this chapter. In the first part of the chapter I briefly consider the backgrounds of staff members and look at the cases of several staff members in particular – Mr Sinazongwe, James Lungu, and Precious Mbala – in order to show the influences upon staff members when they had to make decisions in the hospital about which patients to privilege and why. I suggest that staff members who had a larger number of dependents and a higher cost of living were more inclined to privilege friends, neighbours and relatives, while (often younger) staff members who were more

independent were in a position to attend more consistently to the needs of patients. I suggest that, for staff members, their daily lives at the hospital required them to select or choose (*kusala*) some patients over others. To choose or 'not to choose' (*kutasala*) was something I discussed in Chapter Two in which I pointed out that, in the hospital, 'to choose' was a concept identified with closeness and favouritism (between relatives, friends, and neighbours) and 'to *not* choose' was associated, for rural patients, with the idea of non-selective treatment. Here I return to the concept in order to show the dilemmas of choosing and not choosing as they were experienced by the staff members themselves.

In the second part of the chapter I consider staff members' relationships with the American missionary doctors. I show how staff members felt that the missionaries did not attend to important rules about interacting with, and respecting, other people. This was particularly important in contexts where staff members were accustomed to being treated with a greater amount of respect than rural patients and where their sense of their own superior status was important to them. In the final part of the chapter, I consider the ways in which this institutional and relational context produced an ambivalent series of depictions of rural patients and 'the village' and I explore some of these in relation to age and seniority, healing abilities, and fears of witchcraft. In the conclusion to this chapter, I raise the question: was it possible for staff members, as socially embedded and dependent persons, to be 'good' staff members (in the eyes of the missionaries and rural patients)? Before considering the educational and clinical backgrounds of the Zambian staff, in the next section I provide some information about the heterogeneous group of staff members, in order to give a sense of the range of different people this chapter deals with.

The Zambian staff at Matamba Mission Hospital

Recent anthropological work has begun to consider, in greater detail, the lives of African biomedical practitioners as well as the large number of 'volunteer' staff who work in medical settings (see, e.g., Prince 2015; Prince and Brown 2016). A lot of the work on African biomedicine has focused on relatively well-resourced hospitals, by

regional standards. Two such notable studies include Claire Wendland's (2010) work in a large urban teaching hospital in Malawi and Julie Livingston's (2012) study of an oncology ward in Botswana. These works have shown how African medical staff develop ways of coping with the pressure of high numbers of patients and limited resources, having to make difficult decisions at the same time as they position themselves morally. These works deal with African medical staff who are well-trained and have high hopes for their future careers. Wendland's work, in particular, considers the training of medical students who are largely from wealthy backgrounds, many of whom had never visited rural areas of Malawi and had ambitions to leave the country and gain employment elsewhere in the world after their training.

The experiences of the clinical staff members at Matamba Mission Hospital were no doubt similar, in many important respects, to those of the medical staff with whom Livingston and Wendland worked, however, it is worth pointing here that the lives of many of the staff members considered in this chapter were also significantly different. Furthermore, we need to go beyond the reported intentions of African biomedical professionals and their descriptions of their own moral values and aspirations in order to look at the decisions they made in practice in response to the real pressures and multiple obligations that were central to their livelihoods.

The Zambian staff who worked at Matamba Mission hospital were a diverse group. There were around 50 members of staff who were graduates of medical training schools – this included the staff who were nurses, midwives, lab technicians, and the hospital's single pharmacist. In addition to the clinical staff there were 35 members of staff known as 'daily employees' and who performed various jobs, including the security guards, the kitchen staff, and several cleaners. In Zambia, healthcare work, historically, has been highly gendered since the colonial period and Matamba Mission reflected this.¹²⁵ For instance, in 2006, it was found that 65 percent of health workers in Zambia were female. When this was broken down further, 85 percent of nurses and midwives were women, while just over 80 percent of clinical officers were men (WHO 2010: 31). When I was at the hospital, there were 5 male nurses and no male midwives and none of the clinical officers was a woman. Of the 'daily employees', all were men, with the exception of one woman who worked in the kitchen.

There were further important differences between the clinical staff and daily employees. The clinical staff were educated to a high level and many of them came from outside of the Southern Province (a large number were from the Copperbelt and Northern Province, making Chibemba a commonly spoken language among the staff). This meant that some staff members had difficulties communicating with rural patients (cf. Fassin 2008: 266). By contrast, the majority of the daily employees, if they had been to school at all, were not typically educated beyond primary school level. A further difference is that, while many of the daily employees were pleased to have their jobs and regarded themselves as lucky to have them in a context of chronic unemployment, many of the clinical staff (particularly those from outside of Southern Province) were dissatisfied with their position and felt that they were in the unfortunate position of being at a 'rural hospital' and referred to the small town of Matamba as a 'village' – a term with various negative connotations for many staff members as will be seen later in this chapter. Many of these staff members wanted to return to practice in a major city where they felt they belonged (cf. Street 2014: 149).

The available research shows that there has been a high rate of attrition among healthcare workers in recent years.¹²⁶ At Matamba Mission Hospital, clinical staff members would sometimes say that they wanted to leave as soon as they could find a job in Livingstone, Lusaka, or the Copperbelt. The majority of the staff members I interviewed told me that they were posted to Matamba by the Ministry of Health after they finished their training because rural hospitals and clinics are always in need of more clinical staff. Despite the dissatisfaction of being posted to a rural area, many staff members were pleased to be working at a rural mission hospital, which were more highly regarded than rural government hospitals or rural health centres.

In what follows I refer mostly to the clinical staff, although it is worth pointing out that, despite these significant differences, most of the 'daily employees' (with a few exceptions) were probably closer, in their social lives and daily experiences, to the clinical staff than they were to the rural patients – after all, they all lived within the town and were paid government salaries, they were much better off than rural patients and, indeed, regarded themselves as such. With this in mind, it is possible to consider some of the staff members and their lives at Matamba Mission Hospital.

Choosing and not choosing patients

A few years before I arrived, a staff member at Matamba Mission Hospital died. A young nurse who had recently married a man from the town was scheduled to give birth at the hospital. She was well liked by her colleagues and I heard several stories about her during my fieldwork. She died after giving birth due to blood loss (known as postpartum hemorrhage). When I first heard the story – told to me in hushed tones by Daniel Mwaanga and then again by several others, I was struck by the fact that this was a story about an event that happened with some regularity at Matamba Mission Hospital. Every month, at least, a mother would die in childbirth at the hospital. What was different, however, in this case, was that the woman was a nurse at the hospital. As such, she was the kind of patient whom the nurses and midwives tended to look after especially well.

In her work in Botswana, Livingston observed that some of the oncology nurses did not wish to make it known that particular patients were their relatives. These nurses were worried that that ‘this might complicate matters,’ and could have led other patients to think that the nurses were ‘playing favourites’ (2012: 99). At Matamba Mission Hospital, staff members were not often concerned about being seen to be ‘playing favourites’, unless they were perhaps working alongside one of the American missionary doctors. In this section of the chapter I will consider why choosing certain patients over others was necessary for the staff members. I try to emphasise that for staff members, friends, neighbours and relatives always entered into their daily considerations – and while these might have been ‘hidden others’ at certain times in the hospital, for staff members they were others ‘around whom living revolve[d]’ (Marsland and Prince 2012: 463). In order to understand the position that staff members found themselves in I will briefly give an account of three members of staff: their backgrounds, the size of their families, their earnings, and their extended networks of relatives and acquaintances. In each case I will describe how they worked at the hospital and dealt with the claims of patients and people they knew.¹²⁷

Mrs Sinazongwe in the maternity ward

Mrs Sinazongwe was a midwife at Matamba Mission Hospital who worked in the maternity ward of the hospital. She was born in the Southern Province and trained at a mission hospital called Chikankata Mission Hospital, run by the Salvation Army. She moved to Matamba around ten years ago when her husband, a laboratory technician, was offered a job at Matamba. Mrs Sinazongwe had four children and when I first met her she had just given birth to a boy. She was active in the Seventh Day Adventist Church and had an extended network of friends and relatives who stayed in, or near, the town of Matamba. She also had two brothers who lived in Lusaka, whom she travelled to see every few months. Mr Sinazongwe, her husband, was an elder in the SDA church and could often be seen riding his motorbike around the town. Because Mr and Mrs Sinazongwe worked at the hospital they were paid good salaries and were not poor. They had recently moved into a house that Mr Sinazongwe had built with some men from the town and they were close enough to the town to be connected to the main electricity grid. They had a number of outgoing costs, including school fees for their children, petrol, food and other daily necessities, and in their garden they planted a small amount of maize and some vegetables, although these were for their own consumption and not grown in order to sell any surplus. Mr Sinazongwe had ambitions to acquire some oxen and begin planting more maize in the future.

I knew and liked Mr and Mrs Sinazongwe and was surprised when two visiting missionaries expressed their criticism of Mrs Sinazongwe's conduct in the maternity ward. They told me that they had been working in the maternity ward with Mrs Sinazongwe when there were two women in labour. One of these women was a friend of Mrs Sinazongwe, another nurse and who worked in the women's ward at Matamba. The other woman was much younger and had travelled from a rural area. According to these two missionaries, Mrs Sinazongwe refused to help them in attending to the young girl, even during moments when the other woman did not require immediate attention. Missionaries often reported such stories and they reveal as much about missionary expectations as they do about the conduct of the Zambian staff members in question. Indeed, Dr Hannah once described the situation to me by saying, when a

fellow nurse at the hospital was having a baby then the other midwives ‘roll out the red carpet and do the job properly.’

James Lungu in the laboratory

James Lungu grew up in Kitwe in the Copperbelt and worked in the laboratory at Matamba Mission Hospital. He was trained in Monze (a large town in the province), where he worked to save up for the cost of medical school where he learned to do laboratory work. He was a young man (in his late twenties) and unmarried with no children. James was always seen wearing immaculately clean shirts and shoes and he lived in a small house that was part of the subsidised accommodation for staff members. He could be found – many evenings – drinking beer at one of the bars and playing pool with other men who worked in the hospital. Although he had many friends among the staff at the hospital, James had only recently arrived in Matamba. He was hard working at the hospital and quite critical of some of his colleagues who, in his view, neglected their jobs. Most of his family lived in Kitwe, although he had a few relatives who lived in Monze whom he would visit every so often.

I often arrived at the laboratory to speak to James and, on many occasions, found him working on his own, hunched over his desk examining a blood sample through one of the microscopes. Other staff members would arrive at the laboratory only to announce that they were going somewhere else for the day, leaving James to take up the work of several members of staff. Indeed, he was one of the few members of staff who was routinely praised by the long-term and visiting missionaries for being able to analyse blood samples quickly and for arriving at the hospital on time and for working for the full working day. Nevertheless, some of the other men who worked in the laboratory suggested that Dr Tom and Dr Hannah took advantage of James’s willingness to work so hard and set too many tasks for him.

I had many casual conversations with James about patients who visited the hospital from rural areas. James was sometimes critical of the treatment that certain staff members offered to patients and yet, at the same time, he expressed the sense that, as he once said, many of the patients were ‘uncivilized’ (he used the English word). In

this, like the Zimbabwean NGO workers with whom Erica Bornstein worked, he ‘echoed the civilizing mission of earlier eras’ (2005: 145). On one occasion, James told me that patients from ‘the village’ caused the hospital staff many problems because they could not read the signs in the hospital and did not know how to use the flush toilets properly (cf. Zaman 2004: 2030).

Precious Mbala in the out-patient department

Precious Mbala grew up in Lusaka and moved to the Southern Province with her mother in the 1990s. She worked in the hospital in the out-patient department and trained to be a nurse in Lusaka around five years before I first met her. When she first arrived in Matamba, she lived with her mother and had a number of friends among the staff members at the hospital, although she did not have many relatives who lived locally. Her father died in Lusaka in a car accident before her and her mother moved to the Southern Province. In 2015, she got married to a man – Thomas Mbala – who worked in a shop in the town that was owned by his father. I was surprised to discover that Precious – by her own admission – did not speak Chitonga well and told me that she often found it difficult to understand patients from rural areas who spoke in unfamiliar dialects. Chitonga speakers from the Gwembe Valley, for instance, spoke a much ‘deeper’ dialect in which certain words were entirely different. When patients arrived in the out-patient department from outside of the province, Precious would often speak to them in Chinyanja (in the dialect that was common in Lusaka). After marrying her husband, Precious told me, she made a number of friends through her husband, several of whom were also from outside of the province.

On a day in August 2015, one of Precious’s friends arrived at the hospital, in the out-patient department with a badly cut hand. He explained that he had taken his car to one of the mechanics who worked near to the market and had been helping the mechanic with his car repairs, during which time he injured his hand. When I spoke to him he said that he was a friend of Precious’s husband and he knew that he would find her at the hospital and he wanted to be seen quickly. He spoke with Precious in Chinyanja and English and she left with him to one of the small adjacent rooms to wash and treat the wound.

I introduce these staff members and describe some of these encounters because it is useful to recognise that the staff were not homogeneous in their outlook and their social lives. Their daily lives were often strikingly different and they had their multiple obligations to friends and relatives. They also often had different future ambitions and considered their time in Matamba, therefore, in different ways. For example, Mrs Sinazongwe was well-established in Matamba and had made herself a home. By contrast, James Lungu might have wished to leave at some point and suggested to me, during discussions, that he did not know how long he wanted to stay in Matamba. Again, in the case of Precious Mbala, she said that she would, eventually, like to leave Matamba because it was 'like a village'. In her view, places like Lusaka or Livingstone were more desirable destinations where she would be living 'more comfortably'.

Dense and loose relations of dependence

What these cases help to demonstrate, I think, is that staff members were situated within networks of dependence that we might characterise in terms of their density or looseness. The people who were situated within the most 'dense' networks of dependence can be described in the following way: firstly, they had often lived in Matamba for a long time; they were married with several children; had relatively high living costs; had numerous relatives to whom they had ongoing obligations and many friends and acquaintances in the town; and, finally, they owned cattle (or other animals) and planted maize for selling and family consumption. By contrast, those who found themselves within looser networks of dependence were younger men and women who were unmarried with no children; they typically had not lived in Matamba for long and, indeed, were often posted to Matamba immediately after their training; they had relatively low living costs, especially if they lived in the hospital's subsidised staff housing; they had fewer relatives to consider and these relatives might have lived far away; they had fewer friends and acquaintances in the town; and they did not own animals or plant maize for selling or family consumption.¹²⁸

From the account of staff members outlined above, we can see that Mrs Sinazongwe was situated within relatively dense networks of dependence, James Lungu was

relatively loosely dependent, while Precious Mbala might be located somewhere in the middle. This categorisation helps because I wish to suggest – in broad terms (and with certain important qualifications) – that the staff members who were located within dense networks of dependence were also the staff members for whom it was the most difficult to be ‘good’ clinicians (in the eyes of missionaries and patients), while the more loosely connected staff members found themselves in a position to achieve this more easily (although, of course, not all of them wished to achieve this). It should not be surprising that, if we were to situate the American missionaries in these terms, they would occupy a position at the extreme ‘loose’ end of the continuum of dependence.

For the more densely connected staff members, it was always more problematic for them to fail to privilege their family members, friends and acquaintances when they were doing their job. And this does not just refer to the clinical settings either, but also to the multiple obligations that caused them to take significant amounts of time off work. These staff members had a greater number of obligations to attend to in their daily lives and this meant that they were much less likely to conform to the model of the ‘good’ clinician who treated patients non-selectively, without ‘choosing’.

One aspect of the position of staff members that is worth stressing is that the hospital as an institution did not define how actions were morally evaluated. When staff members chose to help somebody, this was not merely choosing to help them, it was also choosing *not* to help somebody else at the same time (cf. Colson 2006), something that could be unwise for staff members who needed to carefully ‘manage’ the image that people had of them (cf. Englund 1999). This was much more important for most staff members than being considered – in the eyes of the missionaries or patients – to be a ‘good’ nurse, laboratory technician or clinical officer. Indeed, in certain contexts, for a staff member to treat patients equally would have been an insult to the relatives and friends of these staff members who had an expectation of receiving assistance. Indeed, it is for this reason that Peter Redfield found a nurse in Uganda telling him: ‘It’s much easier if you’re from somewhere else and they [the patients] don’t know you’ (2012: 365).

A similar point was made many years ago by Elizabeth Colson (1958) when she discussed the dilemmas, for shopkeepers, of trying to make sure that they were not subjected to the many demands of their neighbours and family members. It is worth quoting at length because it reveals something of the material circumstances of trying to treat people non-selectively in a context where relationships are defined so strongly by pre-existing forms of obligation and dependence.

The wise hawker attempts to trade outside his own neighbourhood, for otherwise the begging of his kinsmen and neighbours is likely to reduce his profits to a minimum or he may find himself operating at a loss. Moreover, it is in dealing with strangers that the Tonga feel free to follow what they consider to be 'business' ethics . . . But this does not protect them from the demands of their own kin, for the location of the store is known and its assets are clearly visible. On one occasion, in conversation with two store owners of Mujika, I argued that one had shown greater wisdom than the other in placing his store at a distant village away from his kinsmen. The men roared with laughter at my innocence, and then one commented: "No man with wealth is able to move far enough to hide himself from his kinsmen. If I moved to Lusaka, they would still follow me." (1958: 82-83)

Like these shopkeepers in the 1940s, staff members at the hospital were visibly wealthy and, as Ferguson has written more recently, 'we find that those with access to incomes inevitably encounter a wide range of social claims on that income – claims that may be honoured or scorned, to be sure, but in any case cannot be easily ignored' (2015: 97).¹²⁹ Susan Whyte puts the point clearly when she writes, of healthcare workers in Uganda, that 'the bottom line is that they have salaried jobs' (2015: 208). Indeed, this was important in a further sense given that, as I mentioned in the introduction, staff members often had to use their own private wealth to pay for some of the hospital's resources – the line between their own personal resources and hospital resources was blurred.

When staff members had to use their own mobile phones to phone patients or other hospitals (for various reasons) they were more inclined to spend this money on people they knew. Long phone calls could be expensive. Indeed, after arriving in Zambia I quickly became used to the fleeting phone conversations of people who were trying to save their mobile phone credit. When staff members had to phone, for instance,

Lusaka University Teaching Hospital or check with pharmacists in other towns if they had certain medications, this could take a long time. For the missionary doctors this was not a problem – and, when missionary doctors were available, staff members would ask to borrow their phones to make such lengthy, and costly, phone calls (sometimes taking the opportunity to phone a friend or relative afterwards).

Furthermore, the cost of other items was significant. In one of the small staff rooms in the hospital, a note on the wall – written by Dr Hannah – addressed the nurses working in the maternity ward, reminding them that the hospital would no longer be providing sterilized latex gloves anymore and that staff members needed to purchase these for their own use. Visiting missionary doctors were often shocked by the fact that gloves were so often used and re-used and that this must have contributed to the relatively high rates of infection. Staff members, like Mrs Sinazongwe, were more inclined to use fresh gloves (which they had paid for themselves) when they were dealing with their friends, neighbours and colleagues in the maternity ward. In this sense the pressure to ‘redistribute’ wealth continued at work. In the first part of this chapter I have tried to describe some of the pressures that staff members faced and offered a way of understanding their different situations – in terms of their networks of dense and loose dependence. In the next section of the chapter I consider staff members’ relationships with the missionaries (both short-term and long-term).

Staff members’ relations with American missionaries

Mr Namianga was a middle-aged man who worked in the operating theatre with Dr Tom. Like other staff members, he had a difficult time in his dealings with Dr. Tom and did not feel that he was being treated appropriately, given his age and wider social commitments and responsibilities. Mr Namianga expressed his frustrations with Dr. Tom (and some of the visiting American missionaries) in the following terms:

You know, when you get into another person’s society, you should learn . . . about what makes them happy or unhappy because I can’t just walk up to you and command you to do what I want you to do. You can’t just say to me, “bring the patient now!” or something like that . . . You see, even if you want me to do

something for you, you have still walked into people's space and ideally you are supposed to greet and find out what is happening at that time and if you could fit into the programme, rather than just imposing your programme without taking them into consideration . . . Some of the visitors who are advanced in age, they know that and they understand how to request nicely.

This was a common sentiment among certain members of staff. Mr. Namianga expressed himself here in terms of the etiquette of making requests. This relates to the larger question of how to treat others in such a way that their situation and wider obligations and responsibilities are being recognised. Dr. Tom and Dr. Hannah had high expectations of staff members, as I have suggested in previous chapters, and they thought that staff members should treat all patients equally and devote every day of the week to working the full hours of 8am to 4pm. Indeed, Tom and Hannah's criticisms often echoed colonial-era medical missionaries who complained that African orderlies did not 'accept hospital discipline' (quoted in Kumwenda 2006: 205).

As we have seen, however, the extent to which staff members were able to conform to the expectations of the missionaries depended (among other things) on how densely or loosely they were connected to wider networks of obligation and dependence. One of the outcomes of this situation was that the American missionaries were frustrated with many staff members and, furthermore, many of the patients from rural areas chose to find the American missionaries or other visiting missionaries if they could, rather than see a Zambian staff member (see Chapter Two). This, in turn, sometimes affected the staff members badly as they felt that they were not being fully appreciated or, indeed, treated well by either the patients or the American missionaries. Many staff members complained, during interviews, that they were treated like 'strangers, not as fellow Zambians' by rural patients and not given the recognition they deserved. There was a great deal of resentment about what was, in the eyes of many staff members, 'preferential' and 'selective' treatment on the part of patients *themselves*. Patients who chose to see the white missionary doctors over Zambian staff were a source of frustration for many Zambian members of staff. The case of Mr. Namianga is worth considering further.

Mr. Namianga in the operating theatre

When a woman at the hospital was in labour and the situation had become dangerous and a caesarean section was needed, Dr. Tom would often phone up the men who worked with him in the operating theatre and tell them to get to the hospital as soon as possible – whatever the time of day. Dr. Tom addressed staff members without much deference or courtesy – indeed, he sometimes shouted at staff members in the heat of the moment. One day when I arrived at the hospital, I greeted Mr. Namianga and when we started talking he told me that he had not slept at all during the night because Dr Tom and the staff had performed three consecutive emergency caesarean sections. Dr. Tom had phoned him during the night and called him in (indeed, this was during the busy week that is mentioned in Chapter Three).

Towards the end of my fieldwork, I arranged to meet with Mr Namianga to have a discussion, among other things, about his experiences of working at Matamba Mission Hospital and his relationships, over the years, with the various missionaries with whom he had worked. Tellingly, Mr Namianga insisted that we did not meet anywhere nearby to the mission compound or the hospital (where we might be seen or overheard by any missionaries or hospital staff). Our conversation took place sitting under a tree, next to his house, in the heat of October. Early in our conversation Mr. Namianga said,

When people make mistakes you should find time to spend with them to find out why they have made those mistakes. But with Dr. Tom there is no discussion about why those mistakes have been made. At my age, I am 53 turning 54. Even if we disagree, I won't be at peace until I talk to you when your temper has cooled down and my temper has cooled down and then we can find out what has happened. With some people here, they argue with Dr. Tom and the hatred continues because people don't forget.

The arguments that Dr. Tom had with staff members were not particularly important to him because, like other American-trained clinicians, the space of the hospital was considered to be not only hermetically sealed from the outside world but also from social and personal relationships. This meant that shouting or ordering people around

was a necessary and routine aspect of clinical work. Indeed, I was present once when some older visiting missionary doctors shared their stories with Dr Tom and Dr Hannah of periods when they were in training and were shouted at by temperamental surgeons and other senior doctors. These stories were a source of pride. This was not the case for Zambian staff members, for whom the space of the hospital was not sealed off from the rest of their social lives. The hospital was a place where staff members expected to be treated with politeness or deference – to be recognised by their juniors, to be asked considerately to do things, and to be treated with respect.

Regarding people with deference (commensurate with their status) has long been considered a prerequisite for asking them for assistance. Colson (1958) found that some people would often refuse to acknowledge their responsibilities if they felt injured by their previous treatment. If somebody felt that their position or status was not sufficiently recognised by another person, they often subsequently felt no necessary or obvious obligation to that person in the future. In the following passage, Colson comments on the fact that ‘headmen’ needed to feel that they had been treated properly in the past in order to mediate in a dispute.

If he has been previously disregarded, he may refuse to intervene, saying, “In the past you forgot that I was your headman. Now I cannot assist you in this matter.” In this he is following the customary Tonga method of dealing with the problem of reciprocal rights and obligations. A person must be given the due measure of respect to which he is entitled by virtue of his position, whether this be based on kinship or some form of headmanship. Only then does he feel called upon to exercise reciprocal obligations. The formulation is: “If you do not treat me as a father, then I shall not behave as a father; if you do not treat me as a headman, then I shall not behave to you as a headman. If you do not consult me when I have a right to be consulted, then I know nothing about the matter and can not be called upon to deal with any problems arising from what you did on that occasion”. (Colson 1958: 37-38)

Something similar was at work in the relationships between the American missionaries and some of the staff members. The lack of recognition of their status was not forgotten and it led staff members to feel that they were not being treated appropriately. Indeed, many staff members spoke of the fact that, after they had been

treated badly or disrespected by Dr. Tom, they (and others) often felt a ‘grudge’ towards him that would be remembered in the future.

In other contexts, missionaries have tried to establish themselves in terms of local ‘conceptions of authority, to be a big man’ rather than just a ‘young man’ (Pels 1999: 101). Indeed, this was something the American missionaries never worked hard to do because their authority (in their view) was established within the institution by their professional role. This meant that staff often felt injured in their dealings with young American men and women (as we saw in Jacob’s relationship with Mr Sipatunyana, in Chapter Four) who acted as if they were more senior than their years allowed.

A further aspect of these relationships was that Dr Tom and Dr Hannah would occasionally reprimand staff members using a language of Christian morality. When Erica Bornstein worked with World Vision she found that the ‘Christian context of employment could simultaneously provide a supportive “Christian family” atmosphere and offer tensions of faith when others were not behaving “as Christians”’ (2005: 61). This was also the case at Matamba Mission Hospital – although the supportive Christian family idea was less common than the tension. On several occasions, as we saw in Chapter Three, Dr Tom and Dr Hannah told staff members that their conduct was not sufficiently Christian. There is a long history of Zambian staff members being chastised for their perceived moral failings by missionaries. As Linda Beer Kumwenda writes, in her study of British missionaries in colonial Zambia, because ‘the mission hospitals [were] closely bound to the life of the church, [Zambian staff members] found that they were judged on their morals as well as on their professional skills’ (2006: 218). I once heard Dr Hannah say to a young nurse: ‘This is a mission hospital and you’re supposed to be Christians!’ For staff members whose Christian lives were important to them, this was an especially unwelcome form of moral criticism. Many responded (in private) by suggesting that it was *really* Dr Tom and Dr Hannah themselves who were not sufficiently Christian because they did not attend local church services and spent all of their time in the hospital.

Other staff members – particularly the men in the laboratory – responded to the difficulties in their relations with Dr Tom and Dr Hannah by finding humour in their conduct. When I spent more time with the men who worked in the laboratory – James

Lungu and his colleagues – I found that they had developed an elaborate series of gestures and impressions of both Dr Tom and Dr Hannah (and occasionally some of the short-term missionaries) which they deployed in contexts where they felt they had been treated badly. Much like the forms of laughter that Julie Livingston (2012) has written about in contexts where there is high tension or suffering, these staff members had developed a way of coping with tense situations in their relations with the missionaries.¹³⁰ Anthropologists have found, in other hospital contexts, that senior doctors are often mocked in their absence, something that, as Zaman plausibly suggests, is a way in which to ‘neutralize’ a situation of perceived inferiority (2004: 2032).

For staff members – in their position between the missionaries and the patients – some found themselves drawing on ideas about their own ‘customs’ (*cilengwa*) which, they said, were incompatible with the demands of the missionaries. And yet, as I have suggested, staff members also blamed patients from rural areas who, of course, at other times were regarded as the custodians of ‘customs’, for being backwards, unintelligent, or unclean. It is to the ambivalent place of ‘the village’ and ‘customs’ that we can now turn.

Customs, ‘the village’ and ambivalence among staff members

Mr. Mwaanga, who worked in the dentistry, once complained to me, during a conversation, that the missionaries did not appreciate the importance of ‘customs’ for staff members. He told me that Dr. Tom and Dr. Hannah said to staff that ‘work is more important’, however, ‘we have our own customs here and they can’t impose on our customs’. Attending to ill relatives or going to funerals and weddings were explicitly conceptualised by Mr Mwaanga as Zambian ‘customs’ (as they were by many other staff members).

The idea that Zambian ‘traditions’ or ‘customs’ need to be protected from missionary ‘interference’ has a long history in the country. As Kalusa has written, ‘the post-colonial regime made it abundantly clear that hospitals staffed by Christian clergymen unwilling to respect African culture would be ineligible for state subsidies’

(2014: 232). In the Southern Province, however, as I showed in Chapter Two, missionaries have worked with a greater degree of autonomy from the government than in many other areas. The point here, however, is that for Mr. Mwaanga (and others) this was an available narrative for framing their disagreements with the American missionaries. In this section of the chapter, I look at the way in which discourses about ‘the village’ and ‘customs’ provided staff members with a language for doing two different things: firstly, for framing their own actions in relation to the missionaries and, secondly, in justifying their conduct towards ‘uneducated’ rural patients from ‘the village’.¹³¹ This apparent contradiction is captured well by Claire Wendland who writes of Malawian trainee doctors (whose relation to rural Malawi was similarly ambivalent), that, for these elite Malawians, ‘the village’ was

a community defined, positively or negatively, by its opposition to modernity. This opposition was typically depicted in one of two ways: the village was either a recalcitrant site of ignorance and superstition, waiting for redemption by the teachings and techniques of the modern/urban world, or – less commonly – a romantic site of resistance in which the “true” values of Malawi stayed pure despite encroachment by the outside world. (2010: 103).

In this section, I will consider staff members’ ambivalent attitudes to ‘the village’ and ‘villagers’ in relation, firstly, to the age and seniority of rural patients; secondly, in relation to staff members’ admiration and respect for the healing abilities of rural healers, diviners, and herbalists (*bang’anga*); and finally, in relation to their fears of witchcraft (*bulози*) and the capacities of rural people to use sorcery.

Age and seniority in the mission hospital

There were many occasions when I saw staff members expressing deference and respect towards elderly patients at the hospital. The levels of deference varied, but many staff members were respectful towards elderly people and treated them in a gentler way than they treated younger people or children. On several occasions I saw elderly men and women treated with a great deal of respect and deference by the hospital staff and, in addition to this, I saw elderly patients making their superior

status known to others by expressing that, as ‘grandmothers’ or ‘grandfathers’, they needed to be treated well by their ‘grandchildren’ (cf. Brown 2012; and Chapter Two on kinship idioms).

This deference could be seen in the grammatical forms of address adopted. For example, when patients came to pick up their ARVs, Matthew would speak to them in a small room at the back of the pharmacy. When he was addressing a young woman, for example, he would typically instruct her to sit down abruptly by saying, ‘you sit!’ (*kukkala*). When he was addressing an elderly man, by contrast, Matthew would more often use the polite form and say, ‘please sit down elder’ (*amukkale mudaala*). There were still elderly patients who complained about how they were treated at the hospital and a greater level of respect for elderly patients was not found uniformly throughout the hospital among all the staff members. Nevertheless, this was one area in which staff members often differentiated between rural patients.

Indeed, this fits with the more general claim (discussed in Chapter One) that the hospital was not an isolated social space but deeply connected to staff member’s sense of their social obligations and appropriate forms of behaviour. In this sense, as Brown (2011) has also found, staff members were torn between their educational and institutional sense of superiority in relation to rural patients and yet, also, their need to observe their obligations to their elders – just as they had to do in their lives outside of the hospital.

Admiration for the healing abilities of rural Zambians

A further reason why staff members often adopted a different attitude towards patients was in the context of recognising (and even praising) the healing abilities of certain healers, diviners, and herbalists (*bang’anga*).¹³² The way in which staff members related to these forms of healing varied and, importantly, it should be noted that it was often difficult for me to gain an understanding of what certain staff members really thought about these forms of healing because many did not want to draw attention to the fact that they occasionally advised patients to visit one of the local healers – and

this was, in part, because the American missionary doctors were usually critical of the work of local healers.

There were, however, several members of staff who spoke to me about healers. One forthcoming staff member was Daniel Mwaanga. One morning, in the dentistry when there were no patients, Mr Mwaanga explained to me what he thought about local forms of healing, divination, and herbalism.

My late mother was a *mung'anga* and she knew how to treat people. What would happen is that she would know when somebody was going to come and see her and she would know what illness they had. Around half an hour before they came she would get ill with whatever the patient had wrong with them – if they were critically ill, then she would become critically ill. She would lie in bed and then be shown, by the spirits, exactly what kind of medicine the patient required. She would then wake up and dig in the bush for the roots and then when the patient arrived she would say, “I knew you were coming, and I have the treatment you need, here it is.” Then, they would take the medicine and they would be alright.

I have taken herbal remedies myself when I had stomach problems and they do work. The problem is that the measurements have to be measured correctly. Some of these people over that side in the villages know a lot of medicine and have cures.¹³³

On one occasion, when I met with a local diviner, he explained to me that staff members from the hospital would often tell patients that they had an illness that was not amenable to ‘hospital medicine’ and they needed to see the diviner to find out the real cause of the problem.

A *mung'anga* (whom we encountered in Chapter Two) known as Dr. Simamba told me that people often came to see her having been advised by staff members at the mission hospital (and other hospitals) that, if they hoped to get better, they needed to visit a *mung'anga*. Dr. Simamba told me:

Yes, there are many cases where patients come here from the mission hospital and there are many cases where I send people from this side to the hospital. There was a child who came here from UTH [University Teaching Hospital in Lusaka] and he was given lots of medications and injections and all of this failed, but now he has been healed because he came here.

Many staff members clearly had a large degree of admiration for the accumulated knowledge of rural healers and diviners (cf. Langwick 2011; Marsland 2007, 2015; see also Appendix 2).¹³⁴ This is connected to the next area in which staff displayed their ambivalence towards rural patients, namely, witchcraft.

Fears of witchcraft and sorcery

Many anthropologists working in southern Africa have observed that witchcraft accusations are not only directed at wealthy people who seem to have acquired wealth by dubious means, but they are also directed at poor people whose 'visible failure to thrive' (Green 2005: 252) arouses suspicion. Indeed, some have suggested that witchcraft accusations are used against people who might make claims on the resources of wealthier people. As Isak Niehaus has suggested, in his work on the South African Lowveld region, witchcraft accusations often work 'against the levelling processes of needy kin and neighbours' (2005: 207).

As conspicuously wealthy residents of the area, many staff members feared that certain rural patients might have access to powerful sorcery or witchcraft. This meant that, despite the tendency for staff members to speak about rural patients as 'backwards' and as 'villagers' (with the negative connotations of this term), many staff members were also highly sensitive to the fact that 'out there' in 'the villages' there were people who could practice powerful forms of sorcery and witchcraft. On several occasions I was told about certain notable individuals who arrived in the town who were thought to be 'witches' or 'wizards'. While it was difficult for me to learn about staff members' relationships with patients who were associated with rumours about witchcraft (*bulози*) and sorcery, it is worth reflecting on how suspicions of witchcraft can affect people's relationships.

Colson (1975) has shown how fears about sorcery and witchcraft have often motivated people in the area to act in seemingly altruistic ways. Colson describes an event in 1972 when the homestead where she was staying was visited by an elderly woman who was a stranger. Colson describes the arrival of the visitor and says that she was given – by the mother of the host family – a gift of grain, ‘enough grain to fill the visitor’s basket to overflowing’ (1975: 47). Colson’s initial interpretation of the scene was that this was simply ‘in the best traditions of Tonga hospitality and the gift of grain was made with every indication of gracious generosity.’ However, a few days later, Colson heard the mother who offered the grain explaining why she had done so. The mother said, nobody knows ‘what kinds of medicine a person might have or who might be a sorcerer’ and, therefore, when a visitor arrives asking for grain or food: ‘It is not safe to deny them. You saw me give grain to that woman who came the other day. How could I refuse when she asked me for grain? Perhaps she would do nothing, but I could not tell. The only thing to do is give.’ (1975: 48).

More recently, Lisa Cliggett (2005: 132-135) has shown how certain elderly women in the Gwembe Valley have been able to exploit the fears of some of their neighbours in order to receive food and assistance. She points out that some elderly women were quite happy for there to be vague suspicions hanging around them – for instance, that they had bad spirits (*zyelo*) attached to them – so that their relatives and neighbours felt compelled to assist them. One elderly woman, for example, told Cliggett: ‘zyelo are good for an old woman so that she can get things she asks for’ (2005: 133). Whether or not staff members altered their conduct with patients whom they suspected of being powerful, it was clear that the ideas held by staff members about ‘villagers’ involved this kind of awe and suspicion alongside more straightforwardly negative images of backwardness or lack of sophistication.

Moses Mwale, a staff member who worked in the laboratory alongside James Lungu, told me one afternoon about the powers of certain people ‘in the villages’. Moses’s father worked in a school in a rural area in the Southern Province and once sold some bricks to a local man. Instead of taking the money immediately, his father told the man to pay him later on, when the man could afford the bricks. Moses described what happened after this:

My father said to the man that he did not need to pay straight away, because he could pay the money in a few months. The man took advantage of the situation though and he was not paying at all. Even in three months he was not paying. Then my father saw the man and he had started to build with the bricks and he said to the man, “Look, this is enough. Give me the money or give me something else for these bricks you are already using.”

Then this man, he got upset and he said to my father, “You will regret this. This time next week you won’t be alive, I will put a curse on you”. In a week my father was very sick. He was in the garden and we all found him and he was vomiting up a black substance that looked like oil and it was thick and this black substance was everywhere in the garden.

At this point, we all started to pray for my father. He started to get a bit better and he stopped vomiting. In a normal world my father would be dead. But we prayed and the Lord answered our prayers directly. And the next time we saw the man, he couldn’t understand how my father was still alive – he thought it was not possible, it didn’t make any sense to him! Some of these people out there, that’s what they can do.

This was one of the more dramatic descriptions of what people in rural areas were able to do to their enemies. More everyday evocations of the power of sorcerers, witches, and wizards were also common. In the pharmacy, Matthew and I were once talking about air travel and how long it takes the American visitors to fly to Zambia. Matthew said to me, matter-of-factly, ‘White people have invented aeroplanes so you can fly like that. But, here, there are wizards in the villages who can be moving about on a spoon. I want to understand the mechanics of that! How are they able able to do that? Somebody needs to look into it. It is possible.’ Matthew told me further stories (a few of which I subsequently heard other people repeat) about men who were able to travel in space from one end of the country to the other or to shrink cattle and carry them in their pockets – all by using certain forms of sorcery (cf. Ashforth 2005; Niehaus 2005). These kinds of stories revealed a deep sense of ambivalence and uncertainty about the powers of people from rural areas.

Conclusion

In this chapter I have tried to show how staff members were ‘embedded in social relationships that [were] crucial to their sense of self-worth’ (Keane 2016: 262). For the staff members, their ‘educated’ and ‘professional’ status was often important to their sense of who they were in relation to ‘uneducated villagers’. This, however, was not a static or unchanging opposition. At certain moments, staff members would treat rural patients well or express admiration or fear towards them, revealing an ambivalence and uncertainty in their ideas of themselves. Furthermore, staff members located their sense of personhood in relation to wider networks of dependence and these shaped the extent to which staff members could be ‘good’ clinicians.¹³⁵

I have tried to show in this chapter how staff members were working in a context in which there were serious conflicts that came into play when they had to decide whether to be good clinicians or good social persons. Writing of missionary medicine during the colonial period, Vaughan has written that,

It was continually stated that nursing and caring for the sick did not come ‘naturally’ to the African. The process of training was described as ‘tedious and often disappointing’, for ‘the native does not take naturally to work, and has a cordial dislike for anything nasty’. (1991: 65)

It is interesting that missionaries continue to think that caring for the sick is something that Africans are incapable of – although often missionaries would attribute this to ‘culture’. While missionaries were capable of perceiving Zambia as a place where God’s actions could be perceived clearly, they also relied on ‘well worn tropes of a diseased Africa, steeped – as it continues to be perceived by many – in tradition and dysfunction’ (Hannig 2017: 205).

I hope in this chapter (and previous chapters) to have shown that these ideas about the clinical staff emerged, in part, because a large part of the lives of African clinicians remained invisible to missionaries (and other short-term visitors). The missionaries valued a certain form of ‘care’ in the hospital context and they did not recognise that, for staff members, being caring and trying to treat people well was not always

compatible with being a 'good' member of staff. To link the discussion in this chapter to the analysis of the position of the missionaries in previous chapters, it might be useful to point out that the staff had to maintain their standing as social persons and therefore had to support people in their networks of mutual support. They had to cultivate relationships with potential patrons. And they had to do all of this at the same time as maintaining a vigilance about the possibility of powerful patients who were capable of witchcraft and sorcery.

Furthermore, we have also seen that the appeal to 'customs' was not due to a 'concern with social control, as though they deployed rules as tools to regulate an imagined social whole' (Englund 2008: 41). These were not, in older anthropological terms, 'customs' that were 'binding' (Fortes 1949). Rather, the appeal to customs was strategic (and therefore often contradictory), revealing much about the ambivalent place that staff members found themselves in. They were 'educated professionals' in relation to rural patients but felt the need to stress that they had to recognize 'customs' when they dealt with the American missionaries. Such forms of ambivalent or contradictory self-understanding has been the subject of much post-colonial writing (from Fanon onwards) and anthropological work on elite education (e.g., Simpson 2003), although I hope to have shown here that there are material and institutional dynamics that are related to, and indeed sustain, these forms of self-understanding on the part of Zambian staff members.

It is worth reflecting, in this conclusion, on an important issue within the study of African medical professionals. Anita Hannig (2017) has written carefully about the need to reject the 'widely circulated myth that African men and women are quick to banish their sick'. She writes that,

Such blanket assumptions are dangerous not only because they deny to others the kind of nuanced engagement with bodily affliction we like to claim for ourselves but also because they nurture age-old notions of cultural primitivism that have long dominated popular Western perceptions of Africa. (2017: 55)

Hannig is correct to point this out and I do not wish to reinforce this tendency in writing about the way in which Zambian staff members failed to attend to many of their patients.

It is also important, however, to recognize that the bodily afflictions of suffering strangers pose profound challenges for healthcare workers that they cannot always meet. In contexts where healthcare is well-funded and professionals are supported in their work, the stress and emotional labour of dealing with suffering patients remains – and it is important to note that in contexts of chronically underfunded healthcare, the ability to feel compassion and pity and meet the needs of others is not straightforward, nor is it a limitless capacity that can be expected of people who have extensive obligations to meet in their social lives. In the next and final chapter, many of the themes of the preceding chapters are brought together as I consider how we might think about the politics of Christian humanitarianism.

Chapter Six

Conclusion: anthropology, aspect showing and politics

Throughout the chapters in this dissertation, I have attempted to demonstrate that rural patients, missionaries and clinical staff members found one another's conduct morally significant in different ways. The people who found themselves at Matamba Mission Hospital were able to morally 'aspect see' in different ways and, as I have suggested, their capacity to perceive certain aspects of their relations with others is historically situated and acquired through instruction and learning.

The capacity to aspect see is, in a sense, something that anthropologists who engage in fieldwork and anthropological writing attempt to acquire. In discussing the idea of adopting an 'ethnographic stance' (Williams 1985), Laidlaw (2014) offers an account of what this might mean, suggesting that it involves,

gaining an imaginative understanding from the inside of a set of ethical concepts and of a form of life, and . . . learn[ing] to use and think with those concepts and participate in the form of life, without, as a prerequisite for doing so, having to adopt its concepts and values as his or her own (2014: 45).

A part of this effort to participate in a form of life and 'think with those concepts', I would suggest, involves acquiring the capacity to perceive certain dimensions of life as morally significant in new ways. Webb Keane refers to Kluane hunters in Yukon, Canada, who say that certain animals offer themselves to the hunter and, as such, it is important not to reflect for too long on the suffering of the animal because it has offered itself willingly as a gift. As Keane suggests, these Kluane hunters 'take their prey to be persons with whom they enter into social relationships guided by the ethics of reciprocity' (2016: 15). And, furthermore, as Keane observes, the basic 'ethics of reciprocity in itself might not look so unfamiliar to, say, urban Euro-Americans', except that the inclusion of animals within this ethics extends 'the scope of appropriate ethical concern' (2016: 15).

This example indicates the difference that moral aspect seeing might make, as a concept, to our anthropological descriptions. For anthropologists to adopt an 'ethnographic stance' in relation to Kluane hunters would involve not only thinking with their concepts and participating in their form of life, but acquiring the capacity, over time, to perceive hunted animals as moral persons of a certain kind. To reiterate a point that I have already made, there is no reason why this form of moral aspect perception needs to be conceived of in terms of sight and seeing. It might be that such moral perception occurs through feeling the warmth of the animal's body after it has been killed, or by hearing the sound of it running through the trees.

In Chapter Four, I tried to illustrate this point by suggesting that I was unable to perceive the same moral aspects as the American missionaries when I witnessed suffering and the endurance of pain among Zambian patients at the hospital. While the missionaries perceived moral meaning in the suffering and endurance of patients – they found Christ-like suffering and God's agency at work as he gave people the strength to endure their bodily pain – I did not immediately perceive such things. I could conceptually understand what they were talking about, but I lacked the capacity to perceive these moral dimensions. In other words, when it came to perceiving the moral meaning of suffering and finding God's agency in the lives of Zambian patients, I suffered from what Wittgenstein called 'aspect-blindness'. I was not 'alive' to these dimensions or aspects of the lives of Zambian patients in the same way that the American missionaries were. I was alive to other aspects, of course, some of which the missionaries were not, as discussed in several chapters.

In Chapter Two, I suggested that relations of obligation and dependence shaped the way in which Zambian patients and staff members perceived suffering. For example, if a young man found that his mother was unwell, her bodily afflictions had a different meaning to this young man than they would have had to the unknown clinical staff member at the mission hospital – as we saw in the examples of Mutinta and Joshua. When it came to responding to the bodily afflictions of patients, many staff members were 'aspect-blind' to the extent that the afflictions of patients did not have the same moral meaning (and incite the same relations of care) as the afflictions of their own relatives, friends or neighbours. To feel compassion (*kumwva luse*) is, in certain respect, to morally aspect perceive – and such perceptions are profoundly shaped (just

as they were in the case of American Christian missionaries) by material circumstances, historical experiences and the imagination. In other words, they are not ahistorical or natural and did not emerge from nowhere.

Furthermore, in Chapter Four, I suggested that the American missionaries were not only able to morally perceive certain aspects of their experiences as meaningful but also engaged in what, following Ze'ev Emmerich (2011), we can call 'aspect showing'. As Emmerich suggests, aspect showing is intended 'to shape/alter other people's modes of "aspect seeing" (2011: 62). As well as being central to the social lives and relationships of the many people who found themselves at Matamba Mission Hospital, aspect seeing and showing is also central, as I will now suggest, to anthropological writing. In what follows, I make the suggestion that by attending to the forms of aspect-perception of which anthropologists are capable, alongside the forms of aspect showing that feature in their anthropological texts, it might be possible to clarify recent discussions within the discipline about politics and the nature of politically oriented anthropology.

Anthropology, global health and politics

Anthropologists working within medical anthropology and 'global health' have often been closely engaged with humanitarian organisations (both collaboratively and critically) and their work has often had a self-consciously political orientation. In this context, we might think of the work of scholars such as Paul Farmer (1999, 2004a, 2004b), João Biehl (2005), Nancy Scheper-Hughes (1993, 1995, 2002), Didier Fassin (2007, 2009, 2012), and several others. These scholars have called for (and indeed practise in different ways) what Scheper-Hughes's refers to as 'a politically committed' anthropology (1995: 410) and Fassin calls a 'political view of anthropology' (2007: xxii).¹³⁶

These anthropologists are driven by the desire to highlight the appalling circumstances of so many people's lives in places such as Haiti, Brazil and South Africa. These anthropologists perceive moral and political meaning in the world around them and this finds its way into their anthropological texts. Not entirely unlike

the American missionaries, many of these writers have found an urgent moral meaning in the suffering they have encountered and written about. These energetic – even adversarial and accusatory – forms of political anthropology have come under criticism for a number of reasons and it is to these criticisms that I will now turn.¹³⁷ Many of these criticisms are helpful while others, I think, are misconceived. In the discussion that follows, I suggest that we might find a way through these debates by considering both aspect seeing and aspect showing in politically engaged anthropology.

In what follows, I deal with what I take to be certain major criticisms of this anthropological work under the following headings: political anthropology and inadequate explanation; political anthropology and superficiality; and political anthropology and the ubiquity of ‘the political’. I then suggest a way of alternatively conceiving of a politically oriented anthropology that avoids some of these deficiencies.

Political anthropology and inadequate explanation

Within the work of the anthropologists cited above, it is common for certain political concepts to be used as forms of explanation. For instance, ‘neoliberalism’ or ‘structural violence’ are commonly used as a way of explaining why people pursue certain courses of action and why they lack access to effective medical care and suffer from preventable deaths and illnesses. Although there are many examples that could be chosen from in this literature, a particularly striking example can be found in the work of Salmaan Keshavjee who is, like Paul Farmer and Didier Fassin, a trained physician and anthropologist. In Keshavjee’s book (2014) on healthcare and development organisations in Tajikistan – which comes with a foreword by Farmer – we find references to ‘neoliberal ideology as a global force’ (2014: 121) that has shaped access to healthcare throughout the world. We also find local worlds being subjected to ‘external ideological forces like neoliberalism’ (2014: 9). This is relatively common in works of anthropology that seek to denounce ‘neoliberalism’ (on this, see Ferguson 2009).

One of the problems with this kind of writing, however, is that it makes use of a politically provocative and arguably analytically indeterminate term – in this case ‘neoliberalism’ – in order to produce explanations. For instance, if neoliberalism is an ‘abstract causal force that comes in from outside (much as “the world system” was reckoned to do at an earlier theoretical moment) to decimate local livelihoods’ (Ferguson 2009: 171), then it can be used to *explain* why, for instance, pre-existing healthcare systems have weakened or child mortality has increased (cf. Biehl 2005; Farmer 2004a, 2004b). The interesting thing about such explanations is that they very often enable anthropologists to avoid *describing* how this has happened (cf. Cook et al. 2009; Eriksen et al. 2015; Latour 2005; Laidlaw 2014). While I am not suggesting that all of the anthropologists under consideration here are necessarily guilty of this, it is an important criticism that this form of politically engaged anthropology has to take seriously.

This is where the notion of aspect showing can further illuminate certain dimensions of these texts. For instance, the term ‘neoliberalism’ is a ‘thick concept’ in Bernard Williams’s (1985) sense of the term. Thick concepts, for Williams, are those that can be used to refer to things empirically but which also have a substantial normative inflection. To refer to somebody’s actions as a ‘betrayal’, for example, might cover a range of actions that could be empirically described (revealing a secret told in confidence, for example) and yet the term also conveys an evaluative dimension at the same time (namely, a morally negative perception of the action). The term ‘neoliberalism’ is, quite clearly, just such a term. And this means that when anthropologists use the term they are not simply offering a description (or explanation) of a set of events or processes, but simultaneously signifying their own political orientation to the reader, demonstrating their disapproval of the ‘force’, ‘system’ or ‘ideology’ (depending on the author) that is ‘neoliberalism’.

In much of this work, there is an undeniable Christian quality to this aspect showing, in which a coherent evil is being identified. This one of the reasons why Ferguson has suggested that anthropologists need to ‘go beyond seeing in “neoliberalism” an evil essence’ (2009: 183). Many other things are going on in these texts, but it is worth differentiating this kind of ‘aspect showing’ (namely, aspect showing one’s political sensibilities) from some of the other features of this kind of anthropological writing –

for example, description, analysis, stylistic strategies, and so on. This can be seen more clearly in the next line of criticism.

Political anthropology and superficiality

At the end of Chapter Four I referred to Joel Robbins's (2013) recent criticism of the way in which anthropologists have dealt with suffering. It is necessary to return to this here in order to address the criticism levelled at certain kinds of politically oriented anthropological writing – namely, that these anthropologists sometimes fail to offer a sufficient amount of cultural contextualization when they describe and evoke various kinds of suffering. It is worth briefly returning to the argument. Robbins has suggested that some of these writers – and he is thinking of Fassin, Biehl, and others mentioned above – ‘do not primarily provide cultural context so as to offer lessons in how lives are lived differently elsewhere’, but rather they ‘offer accounts of trauma that make us ... feel in our bones the vulnerability we as human beings all share’ (2013: 455). Robbins calls this the anthropology of the ‘suffering subject’ and suggests that the ‘suffering subject’ has become the successor to the ‘savage slot’ anthropology of an earlier period. Robbins (2013) points out, correctly, that in works like Biehl's *Vita* (2005) – which focuses on the life of a single woman, Catarina, who was left by her family in a decrepit private institution – we do not learn much about the ‘specificity of Brazilian cultural life’ nor in any ‘ethnographic depth’ about how Brazilians ‘who cannot productively regulate themselves’ are abandoned (Robbins 2013: 455). There are echoes here of Sherry Ortner's (1995) notion of ‘ethnographic refusal’ (see also Cooper 1994), in which she showed how the category of ‘resistance’ was used by anthropologists in ways that were ethnographically thin and insufficiently contextualized (in fact, the idea of the ‘suffering subject’ might be more accurately situated not as the new ‘savage slot’, but rather as the politically impotent successor to the ‘resisting’ subaltern).

As I suggested in the conclusion to Chapter Four, however, it is perfectly possible to imagine an anthropology that simultaneously offers ‘accounts of trauma that make us ... feel in our bones the vulnerability we as human beings all share’ (Robbins 2013: 455) and yet, at the same time, provides ethnographic depth and description. It is possible

to imagine, among other reasons, because such anthropological texts exist. I would suggest that in scholarship such as Veena Das's (2015) work on illness in a poor neighbourhood of Delhi, Anita Hannig's (2017) account of women suffering from obstetric fistula in an Ethiopian hospital, and Julie Livingston's (2012) ethnography of a cancer ward in Botswana – to mention only recent works – it is precisely *through* their attention to ethnographic particularity and description that these anthropologists are able to evoke a sense of the universality of human suffering and demonstrate the creative ways in which forms of suffering are negotiated, managed and sometimes overcome. Robbins suggests that by evoking ideas of universal human suffering anthropologists have depicted suffering as a reality 'with universal and in some ways obvious import that [does] not require cultural interpretation' (2013: 454). But it is precisely through what Robbins calls 'cultural interpretation' that suffering acquires its 'universal' and 'obvious import'.

This is a debate with a long history in the discipline and the idea that anthropologists might look for, as Max Gluckman put it, the 'similarities within differences' (1965: 254) is not a new suggestion. In a 1975 essay in which he reflected on the work of Isaac Schapera, Gluckman suggested that it was through the rich detail of Schapera's work that it was possible to see how people 'think, and feel, either individually or in collective debate and intercourse' in recognizably similar ways throughout the world (Gluckman 1975: 36; cf. Englund and Yarrow 2013). This is where we might wish to return again to the concept of aspect showing and seeing. Whether or not the reader has the desire or imaginative capacity to perceive these aspects is a question that remains and one to which I will return in closing.

Before moving on, it is important to point out that one of the difficulties in criticizing Robbins's position, is that many of the anthropologists under consideration here explicitly express their impatience with what Robbins's calls 'cultural contextualization'. Indeed, Robbins's characterization of their work is not far from some of their own suggestions. At the end of his work on 'humanitarian reason', for example, Didier Fassin suggests that 'the boundary is often drawn between those who challenge the structural violence of the world and those who seek to give an account of the unique ordering of each society: critical anthropology versus culturalist

anthropology' (2012: 245). The idea of a critical anthropology versus a culturalist anthropology comes in at least two slightly different forms.¹³⁸

The first is a sort of impatience with what is regarded as politically disengaged anthropology. As Farmer has written, in much anthropological work, 'a focus on atomistic cultural specificities is usually the order of the day. This is what anthropologists are expected to do' (2004b: 13).¹³⁹ The implied criticism here – and elsewhere in the work of Farmer and others – is that, by focusing myopically on 'atomistic cultural specificities', the great global forces of 'neoliberalism' and 'structural violence' (which, on this view, are discernible at a different scale of analysis) are eliminated from view. Indeed, we find much criticism, among these writers, of anthropologists (who are imagined to be insufficiently politically oriented) whose 'diverted gazes' (Farmer 2004b: 12) and 'failures to see' (Scheper-Hughes 1995: 419) are highlighted and held up for criticism.

The second criticism of 'culturalist anthropology' is sometimes expressed in a form that suggests a commitment to a theory of knowledge that can be found in some of Marx's work and which, in the twentieth century, found its fullest expression in the writings of the Frankfurt School thinkers (see Held 1980; Horkheimer 1995; Jay 1973; Rush 2005; Wiggershaus 1995). On this view, descriptive social science is categorized as inherently conservative and complicit in the maintenance of the status quo. What is required, on this view, is a 'critical' social science in which 'ideology' is 'unmasked' and 'exposed' (see Fassin 2012).

Both of these positions – the position of impatience and the commitment to 'critique' – reinforce a distinction (culturalist versus critical) that does not help us much. We are not really dealing with a difference between culturalist and critical anthropology (even if this is how Fassin and Robbins wish to describe the situation). If politically oriented anthropologists (who also wish to evoke suffering in their work) fail, at the same time, to offer deep or detailed ethnographic descriptions, this is because their work fails to offer deep or detailed ethnographic descriptions – in other words, it is not because they are engaging in political or moral aspect showing. Indeed, if my point above is taken, it might even be that their lack of ethnographic depth is actually what undermines their attempts to show the universality of suffering.

With this point in mind, it is possible to elaborate more fully how the notion of aspect showing might help us to understand what is at stake in politically oriented anthropology. This can be illuminated by thinking about a more substantive criticism that has been levelled at politically oriented anthropology – namely, where does ‘politics’ begin and end? What do anthropologists mean by ‘politics’? And are we working with a definition of ‘politics’ that is so broad as to include everything (and therefore nothing)?

Political anthropology and the ubiquity of ‘the political’

In a stimulating essay, Matei Candea (2011) makes the suggestion that anthropologists have ‘expanded’ the concept of politics so much that ‘everything is political’ (2011: 314). Under these circumstances, Candea suggests, it becomes difficult to take seriously the people with whom we work who might wish to make a clear demarcation between ‘the non-political’ and ‘the political’ – indeed, anthropologists tend to identify this very demarcation itself as ‘political’. Furthermore, Candea associates the tendency to find politics everywhere – which he identifies in particular with the work of Foucault – with an increasing reluctance, on the part of anthropologists, to define what they might mean by ‘politics’. To this effect, he cites Joan Vincent’s suggestion in her introduction to a reader on the anthropology of politics: ‘Anthropology’s definition of politics and its political content has almost invariably been so broad that politics may be found everywhere, underlying almost all the discipline’s concerns’ (Vincent 2002: 1, cited in Candea 2011: 309).

As a paradigmatic and influential instance of this form of anthropological work, Candea cites Ferguson’s (1994) notion of ‘anti-politics’ in which Ferguson famously showed how a World Bank project was able to define its intervention in a seemingly neutral and technocratic language that both erased the historical and political context of rural Lesotho (where the project was based) and obscured and naturalized the political consequences. It is worth attending briefly to the way in which Candea describes Ferguson’s text. In Candea’s analysis, *The Anti-Politics Machine* is a book in

which ‘the non-political is [shown to be] the result of an eminently political operation on a pre-existing “political reality”’ (2011: 313). Candea continues,

The pitfall in this denaturalization of the non-political, however, lies in a concomitant naturalization of the political. Often, the price to pay for insight into the non-political is an assumption about the ontological status of politics as the really real ground of reality. If “politics” simply becomes the new real against which the (always ultimately illusory) production of the non-political is to be studied, then we have just exchanged one set of blinkers for another. To leave unquestioned the ontological status of “political realities” when we happily dissect that of figures of the non-political such as ethics, objectivity, economics, or taste seems rather strange. Why does “politics” deserve this privileged treatment? Why can it not actually be an ethnographic object in its own right? Or in other words, why could we not, as anthropologists, refrain from establishing the political as either figure or ground but rather attend to it as the people we work with make it appear? (2011: 320)

Interestingly, then, the problem – when framed in these terms – is that by expanding the scope of politics and uncovering the political dimensions of such things as NGO projects in Lesotho, anthropologists risk assuming ‘the ontological status of politics as the really real ground of reality’. In Candea’s language here, particularly the idea that anthropologists should ‘attend to [politics] as the people we work with make it appear’, he is applying the same set of concerns that have animated science and technology (STS) scholars who have been interested, for a long time, in how the objects of scientific investigation are made to appear in practice (see, e.g., Latour 1987).

The suggestion I wish to make here is that this is not a useful way of thinking about politics and, furthermore, when we try to understand what Ferguson and other anthropologists have been doing in using terms like ‘anti-politics’ we will see that, rather than making assumptions about the ‘ontological status of politics’, they have been doing something that is both less complicated and more interesting, namely aspect showing.

Going further than this, I wish to suggest that not only is this a better description of what anthropologists, such as Ferguson, have been doing, it is a more plausible (and

more defensible) way of understanding politics than Candea's analysis would allow. In other words, politics is not the name of a 'domain'. It is the name for a way of 'seeing' certain aspects of social life. When anthropologists speak about politics, much of the time they are inviting their readers to see things politically. By understanding politics in this way, the concern about finding 'politics' everywhere (and the term therefore losing its meaning) begins to look like a misconceived way of framing the problem.

Anthropology and political aspect seeing

If we take anthropologists who regard their work as politically engaged – from Farmer to Scheper-Hughes to Biehl – to be 'showing' their readership some of the political dimensions of the lives of those with whom they have worked, we might find more productive ways of understanding their work. We might think of this in the same way – following Wittgenstein – as somebody attempting to 'show' somebody else that the actions of a person were 'courageous' or that a song or work of art is 'beautiful'. To engage in these activities would not necessarily be to imply the ontological existence of a domain of 'courage' or 'beauty'. Indeed, when people say things such as, 'beauty can be found everywhere', this is not typically taken to be an over-extension of the word 'beauty' that implies an ontological claim about the nature of reality. It might refer, instead, to a way of attempting to perceive beauty in the world.

When Candea writes of 'the classic move of political anthropology . . . of showing the political to operate in seemingly un-political places' (2014), it would, perhaps, be more accurate to write of the way in which anthropologists have developed the capacity to perceive the political dimensions of many aspects of human social life that were previously regarded as being 'un-political'. Just as I spoke of 'aspect seeing' earlier as an historically acquired capacity, this is one way in which we might think about this change in anthropology. Anthropologists were aspect-blind to these dimensions in ways that they are no longer. Feminist anthropology – which is not mentioned in Candea's essay – might be an instance of precisely this expansion of aspect-perception. New ways of seeing emerged in which relations between men and were examined in novel ways, assumptions to do with 'nature' and 'culture' were questioned and, as Strathern has written, women . . . could no longer be 'relegated to

a chapter dealing with marriage and the family' (1987: 278). Webb Keane (2016) makes this point clearly by quoting Gloria Steinem: 'Now, we have terms like *sexual harassment* and *battered women*. A few years ago they were just called *life*' (1995: 161, quoted in Keane 2016: 179). As Keane puts it: 'When the scope of ethical concern expands to include a wider sociological range – more people – it commonly involves a redescription of the world' (2016: 179).

To return to the cases we have considered so far, we can see that the use of terms such as 'neoliberalism', as we saw above, might be thought of as attempts to aspect-show (that take the form of signifying the author's own political orientation) but which simultaneously fail as explanations. In the case of the attempts to evoke the universality of suffering, by contrast, we can see that these attempts to 'aspect-show' are independent of forms of contextualization and description. And although I agree with Robbins's suggestion that a lot of the works he cites (e.g., Biehl 2005) may be lacking in ethnographic detail and cultural particularity, this is a feature or property of these texts that is independent of their attempts at political and moral aspect showing. Finally, to take the case of anthropologists who write about politics and identify 'anti-politics' at work, these anthropologists are 'aspect showing' in ways that we might find plausible or not and this relates to a further question about how we conceive of 'seeing politically'.

When we consider politically oriented anthropology as a form of aspect seeing, we do not encounter quite the same difficulties (of the kind suggested by Candea) in defining 'politics'. Indeed, several loose definitions of 'politics' – in its adjectival sense of seeing things politically – might be plausible candidates. Raymond Geuss (2008) takes Lenin's definition of politics seriously. For Lenin, it was important to ask: 'Who, whom?' Geuss interprets this question as, '*who* does what to *whom* and for whose benefit?' (see Geuss 2008: 23-30). Indeed, this is certainly one way of looking at human life 'politically'. We might consider that politics is about seeing human social life in terms of the friend/enemy distinction (Schmitt [1932] 2007) or it might be about dispersed relations of power (e.g., Foucault [1977] 1991, [1978] 1998). But, the important point here is that this is the level at which anthropologists might want to be clear about what, for them, it means to perceive things politically.

Contrary to Candea's suggestion that anthropologists have failed to define 'politics', I think it is possible to identify the central ways in which anthropologists have perceived the political dimensions of the lives of those with whom they have worked. The meanings can be found in their use. These anthropologists may not have defined politics as a 'domain', but there is no reason why they should have done so. This kind of analysis, however, raises a further final question about motivations and interests.

Anthropology, politics, and motivation

The anthropological claim to be able to see the political dimensions of a certain case is an instance of 'aspect showing'. It follows from this, that anthropologists are not offering a rival claim to describe reality that should be contrasted with those of their informants. This is important because although rival claims about reality or ontology often have political dimensions – for existence, whether witchcraft exists or not (see, e.g., Langwick 2011) – political claims are not necessarily claims about the nature of reality or ontology. Furthermore, seeing politically is deeply connected to interests.

Englund has pointed out that there may be particular reasons why people do not have an interest in accepting the anthropologist's description of a certain event or social situation (2011: 87). For example, the World Bank officials studied by James Ferguson (1994) did not have an interest in seeing the political dimensions of the economic lives of the inhabitants of rural Lesotho who were the 'target population' of their development project. Anthropologists regularly encounter people who deny that what they are doing has anything to do with politics. Candea says, 'why could we not, as anthropologists, refrain from establishing the political as either figure or ground but rather attend to it as the people we work with make it appear?' (2011: 320). Surely, it is possible to do this at the same time as recognizing that people are able to perceive the political dimensions of a given situation because they have acquired the capacity to do so and have a continued *interest* in doing so. Anthropologists are not dealing with rival claims about the nature of reality. We are not confronted by an array of disinterested rival ontological claims made by disembodied individuals. Anthropologists deal with people who have interests and have certain (perhaps very good) reasons for rejecting the arguments and descriptions of anthropologists.¹⁴⁰

This means that anthropologists should be able to ‘attend’ to politics as a concept or idea that emerges in the lives of our informants while, at the same time, being able to make our own judgements about the political dimensions of their lives – and these may well be judgements that our informants do not agree with or accept. And when thinking about seeing politically, it would be strange to admonish anthropologists for doing something (i.e. seeing politically) that the people we work with do all the time – namely, disagreeing with one another about the political aspects of social life and inciting others to ‘see’ the political (or religious or moral) dimensions of their lives in new ways.

With this in mind, it is important to mention one of the central mistaken assumptions of some politically oriented anthropological writing. This is to think that scholarship will incite or motivate certain forms of political action. Leslie Butt criticizes the work of scholars such as Paul Farmer by saying that, ‘these brief accounts of the suffering stranger generate a muted, detached concern in the reader and are meant more to legitimize the accompanying arguments than to compel her/him to real commitment and action’ (2002: 6). The assumption here – namely, that an anthropological audience will share the political sensibilities of the writer and share their prescriptions for political action – is probably a misguided one. Furthermore, it assumes a relationship between aspect seeing, interests and motivation that is not necessarily present. As Keane’s (2016) citation of Gloria Steinem suggests, when ‘aspect showing’ is successful enough to generate new ways of seeing certain aspects of social life, this can have important political consequences. For people who have a pre-existing interest in seeing aspects of the present in ways that might direct their political action, particular works of anthropology might be significant. But there is no reason to assume that being encouraged to expand or alter one’s political perceptions will have any necessary connection to political action. In the final section of this chapter, I will conclude by suggesting how these arguments about politics and anthropology can be applied to this study of medical humanitarianism.

The politics of Christian medical humanitarianism

As we saw in Chapter Three, the long-term missionaries thought of their work as outside of 'politics'. As I have suggested, this does not mean that we have to accept their claim that they were operating outside of politics. For Tom and Hannah, their work was driven by their love of Christ and they were not particularly concerned about the long-term consequences of missionary work or 'calculating' whether or not people were becoming 'dependent' on their assistance – these kinds of issues were too political, in their view. Dr Hannah once suggested to me that the book that they disliked, *When Helping Hurts*, was an attempt to force Christian values into a pre-existing political message. As I suggested in Chapter Three, for Tom and Hannah, 'politics [was] a moral pollutant' (Barnett and Weiss 2008: 4).

When they considered their own work, Tom and Hannah simply did not perceive certain political aspects of their work – not because they 'erased' these political aspects or had a 'decontextualised' understanding of their work (see Chapter Four); rather, they did not perceive certain political dimensions of their work because they perceived what they were doing in all-encompassing and expansive Christian terms. For instance, they did not perceive the power relations that are involved in delivering medical care or the historical legacies of colonial rule. In their relationships with staff members, whose living arrangements, extended networks of support and responsibilities outside of their work shaped their conduct within the hospital, they viewed the conduct of staff members predominantly in Christian moral terms. Larger questions about the relationship of non-governmental organisations to the state and the long-term responsibility for providing welfare were not often thought about. These were all 'political' dimensions of the work of medical missionaries at Matamba Mission Hospital that anthropologists, in other contexts, have perceived and written about. The missionaries were capable of thinking about many of these questions, but because they perceived their own conduct predominantly in terms of their Christian commitments and love for Christ they did not 'see' these political aspects and were therefore able to claim that they operated outside of politics.

What is interesting to note here, I think, is that Tom and Hannah were not necessarily operating with a radically different understanding of 'politics' to many

anthropologists, for whom politics also seems to be a ‘moral pollutant’. Indeed, one of the consequences of my argument here is that, if it is possible to perceive the political dimensions of almost all aspects of human social life, then it becomes important to consider which political aspects are worthiest of attention.

In Ferguson’s (2009, 2013, 2015) recent work, he has suggested that anthropologists need to go beyond ‘critique’ and simple denunciation. Ferguson’s own contribution to a positive political programme has been to highlight many of the ways in which ‘cash transfer schemes’ could have beneficial consequences in southern Africa. Ferguson considers the history of welfare and social assistance in Europe and asks whether anything resembling ‘the social’ (in Nikolas Rose’s 1999 terms) has existed in colonial and post-colonial southern African countries. While Ferguson’s discussion focuses on social assistance payments (pensions, unemployment and disability benefits, and so on), little attention is paid to the question of infrastructure (see 2015: 64-76; see Rossi 2016: 575). Indeed, while Ferguson’s recent work demonstrates the many ways in which people’s lives could be dramatically improved through cash transfer schemes, the issues of basic welfare service provision remains a serious one.

Many anthropologists write as if the state should be the provider of such services. Indeed, much of this writing is shaped by an admiration for the European social democratic welfare state model. However, this is an inappropriate political model for thinking about the African context. For the foreseeable future, the Zambian government – and others in the region – lack the capacity and political will to provide infrastructure and welfare services on a wide scale. Therefore, anthropologists and others will have to make political judgements about some of the organisations that currently provide healthcare in contexts where it is clearly needed. Writing of missionary medicine in early twentieth century colonial Tanzania, Michael Jennings notes that when it came to infectious outbreaks and other problems that required ‘curative’ medicine, ‘There was no other agency in many of these rural areas willing to share the burden. If the missions had neglected this aspect of health care, it would simply not have been done’ (2008: 45).

While the situation is different today, there are aspects of rural healthcare that would be neglected in the present day if they were not carried out by humanitarian

organisations, NGOs and American missionaries. If anthropologists begin to follow the example of Ferguson and move beyond a politics of denunciation, then perhaps we might also think about politics as Max Weber did. For Weber, maintaining the moral purity of one's convictions – as the American missionaries wished to – is not a realistic or responsible position to adopt. As Weber pointed out, 'the eventual outcome of political action frequently, indeed, regularly, stands in quite inadequate, even paradoxical relation to its original, intended meaning and purpose' ([1919] 2002: 355). While this is a legitimate criticism of the missionaries, it is also not enough – as many anthropologists have imagined – to simply criticize such people for their 'anti-politics' in order to 'expose' and 'denounce' (Fassin 2012). Weber thought it equally futile to despair 'when the world, seen from [one's own] point of view, is too stupid or too base for what [one] wants to offer it' ([1919] 2002: 369).

The suggestion I have offered here is that a realistic politically-oriented anthropology would need to take account of the importance of anthropological description and both aspect seeing and showing. Furthermore, for those who wish to engage in such a form of politically-oriented anthropology, seeing things politically is not the end of the anthropologist's task but the beginning of an altogether more difficult and complicated one.

Notes

¹ Map data © 2017 Google.

² Map data © 2017 Google.

³ <http://www.bbc.co.uk/news/world-africa-39133459> (accessed March 2nd 2017).

⁴ See Abramowitz, Sharon Alane. 'How the Liberian Health Sector Became a Vector for Ebola', Hot Spots, Cultural Anthropology website, October 7, 2014. <https://culanth.org/fieldsights/598-how-the-liberian-health-sector-became-a-vector-for-ebola>

⁵ See the full report by Médecins Sans Frontières, 2015. *Pushed to the Limit and Beyond: a year into the largest ever Ebola outbreak*. http://www.msf.org/sites/msf.org/files/msfiyearebolareport_en_230315.pdf (accessed February 3rd 2017).

⁶ *The Index of Global Philanthropy and Remittances 2016*. Available at <https://s3.amazonaws.com/media.hudson.org/files/publications/201703IndexofGlobalPhilanthropyandRemittances2016.pdf> (accessed February 20th 2017).

⁷ The 1996 Personal Responsibility and Work Opportunity Act, signed by President Bill Clinton, contained provisions for 'Charitable Choice', which enabled religious organisations to receive government funding. President George W. Bush created the White House Office of Faith-Based and Neighborhood Partnerships under an executive order in 2001. This was created to increase the remit of faith-based organisations in the provision of social services at home and abroad (see Clarke 2006: 837; Hefferan and Fogarty 2010). On the rise of the number of North American Protestant missionaries working in Africa, in the context of post-colonial African Christianity more generally, see Maxwell (2006: 407-408). For an argument that US domestic policy has been shaped by a conservative Christian agenda that is extending into Africa, see Cooper (2014).

⁸ On the idea that American religious organisations play a larger role in Africa today than USAID see Donnelly (2012: 31). Scholars of humanitarianism have noted the many difficulties in collecting accurate historical data on, for instance, the changing numbers of organisations, their amounts of funding, the numbers of people whom they have treated, and so on. For discussions of these difficulties see Barnett and Weiss (2008: 30); Fearon (2008).

⁹ Matamba Mission Hospital, the town of Matamba and all personal names in this dissertation, unless otherwise stated, are pseudonyms to protect the anonymity of informants. Some of the personal details of several of the people described in the chapters that follow have also been altered so as to further obscure their identities. It is also worth noting here that I prefer to use the term ‘Chitonga-speaking people’, rather than saying, as older anthropological texts tend to, ‘the Tonga’. There are several reasons for avoiding the term when writing about historical events – not least the fact that the historical creation of the category of ‘the Tonga’ (conceived of as a ‘tribe’) did not occur until the first half of the twentieth century.

¹⁰ I do not attempt to offer a general definition of contemporary ‘humanitarianism’ here, although I find Andrew Lakoff’s recent work helpful (2010). Lakoff makes a distinction between two contemporary ‘regimes of global health’. One he calls ‘global health security’, which refers to the efforts of wealthy countries to secure themselves against infectious diseases – such as smallpox, SARS, Ebola, etc. – many of which are hypothetical future risks. The second ‘regime’ of global health Lakoff calls ‘humanitarian biomedicine’, which,

targets diseases that currently afflict the poorer nations of the world, such as malaria, tuberculosis, and HIV/AIDS. Its problematic is one of alleviating the suffering of individuals, regardless of national boundaries or social groupings. Such intervention is seen as necessary where public health infrastructure at the nation-state level is in poor condition or non-existent. (2010: 60).

Contemporary medical missionary organisations today operate directly within this second regime of ‘humanitarian biomedicine’ (see also Calhoun 2008).

¹¹ Further examples of the religious or Christian dimensions of apparently ‘secular’ humanitarian work can be found. Scholars of so-called ‘faith-based organisations’ point out that many people who work for formally secular humanitarian and non-governmental organisations are motivated to do so by their religious faith (Jones and Peterson 2011: 1298; cf. Twaddle 2002: 14). It has also been suggested that ideas about Christian missionaries continue to influence contemporary aid and development work. According to Roderick Stirrat, stereotypical depictions of missionaries can trouble development professionals who wish to differentiate themselves from such images, even using them to criticise development professionals who are thought to be ‘fuelled by some romantic dream’ (2008: 412).

¹² The literature here is large, but any overview of the field would need to include the following: Boltanski (1999); Bornstein (2005, 2012); Calhoun (2008); Duffield (2001, 2007, 2010); Englund (2011, 2012); Fassin (2005, 2011, 2012); Feldman (2007, 2012); the essays contained in Feldman and Ticktin (2010); Ferguson (1994, 2006); Ferguson and Gupta (2002); Lakoff (2010);

Malkki (1995, 1996, 2015); McKay (2012); Redfield (2005, 2006, 2012, 2013); the essays contained in Redfield and Bornstein (2011); Robins (2009); Schertz (2013, 2014); Ticktin (2011, 2014).

¹³ The rapidly growing literature on morality and ethics in anthropology includes Englund (2008); the essays in Fassin (2008, 2012); Faubion (2001, 2011); Keane (2016); Laidlaw (2002, 2010, 2014); the essays in Lambek (2010); Lambek, Das, Fassin and Keane (2015); Robbins (2004, 2007a); Zigon (2009), among others.

¹⁴ The scholars of Wittgenstein whose work I am referring to here include Aldrich (1958); Baz (2000); Bar-Elli (2006); Churchill (1998); Emmerich (2011); Hester (1966); McGinn (2013); Mulhall (1990); Seligman (1976).

¹⁵ For example, Colson (1958, 1962, 1969, 1971a, 1971b, 1980, 2000, 2006, 2007, 2010, among others).

¹⁶ Vickery has suggested that Livingstone's perception of himself as a 'liberator' probably led him (and other Europeans) to exaggerate the desperate circumstances of the people of the area (2007: 84). It has recently been shown that David Livingstone's account of the 1871 massacre of four hundred Africans by 'Arab' slave-traders in the town of Nyangwe (in present-day Democratic Republic of Congo) was probably altered to exclude the involvement of his own men, see <http://www.telegraph.co.uk/news/science/science-news/8863964/Dr-Livingstone-lied-in-famous-account-of-slave-market-massacre.html> (accessed January 20th 2017).

¹⁷ Charles Livingstone 'Description of the country of the Batoka', LMA 2/4/4/1/3/5 (undated, but early 1860s). *Mosi oa Tunya* is the SiLozi name for the waterfall that is more widely known throughout the world today as the Victoria Falls (named for the Queen by David Livingstone in the 1850s). As can be seen in the passage by Charles Livingstone, the earliest European visitors to this area tended to call the people 'Batoka' instead of 'Batonga'. The anthropologist Ladislav Holy has attributed this to the way in which SiLozi-speaking people (who were often guides and porters for European travellers) tended to pronounce 'Tonga', which was heard by Europeans as something closer to 'Toka'. European colonial officials also made a distinction between the Tonga and the Toka (or Toka-Leya) people based on slight differences in dialect and their historical incorporation within, and proximity to, SiLozi-speaking areas. This distinction does not seem to be especially significant to people in the area today.

¹⁸ After the political violence had ended, former slaves attempted to return to their homes 'in many cases with only vague memories to guide them in their search for the villages from which they had been stolen many years before' (Colson 1958: 9-10).

¹⁹ The precise circumstances that led to the creation of successful peasant farmers is more complicated than the brief overview given here and can be found in the work of the historians Vickery (1986; 2007) and Mac Dixon-Fyle (1977a, 1977b, 2007). The anthropologist Marvin Miracle (1959) attributed this success in farming to a pre-existing spirit of entrepreneurialism that was able to find full expression (see Vickery's criticism, 1986: 28).

²⁰ During the first decade of the twentieth century, many Chitonga-speaking men travelled to Southern Rhodesia (particularly Bulawayo) in search of work. However, unlike other parts of the territory – for instance, among the Bemba of Northern Province (Richards 1939) – young men from the Southern Province did not migrate to urban centres in large numbers or stay for a long time (Colson 1958: 9). When men did migrate, it was usually a 'personal choice rather than a formalized feature of the economic system' (Siakavuba 2013: 112). Furthermore, men from the Southern Province were sensitive to the experience of working for exploitative employers and were usually happier working on white farms, rather than being employed by the mining companies. One historian has written about the 'extensive intelligence system' in operation 'by word of mouth, by marks on trees, and even by messages nailed to trees, telling of opportunities or good and bad employers' (MacKenzie 1969: 339).

²¹ Of these, the creation of the Kariba dam in the Gwembe Valley, which neighbours the plateau area, is one of the most noteworthy. The project to build a hydro-electric dam was conceived during the period of federation (when Southern Rhodesia, Northern Rhodesia and Nyasaland were ruled together from the period of 1953-1963) and it required 57,000 local inhabitants of the area to be resettled so that their land could be flooded to make way for the new dam. Many rain shrines and other places of local significance were destroyed (see Colson 1971b). As Julia Tischler (2014) has recently shown, the rural population of the Gwembe Valley were systematically marginalised in the aftermath of the building of the dam, while mining, commercial fishing and tourist companies all benefitted significantly from this source of electricity. Indeed, today, the dam remains contentious. It is thought that its foundations may have eroded considerably and, if the dam were to collapse, this would threaten the lives of millions of people, see <http://www.zambiawatchdog.com/in-not-repaired-immediately-kariba-dam-might-collapse-within-3-years-report> (accessed 20th October 2016).

²² The earliest missionary expeditions were disastrous, resulting in the deaths of large numbers of European missionaries. Between 1885 and 1900, missionaries began to have more success. During this period seven different missionary societies started to operate in the territory. The first organisations to establish mission stations were the Paris Missionary Society among the Lozi in the south west and the London Missionary Society in the far north (Henkel 1989: 145). John Ragsdale (1986: 18-19) has pointed out that the first enduring mission

stations were often located in areas where there was a great deal of pre-existing political turbulence. In the north, the Ngoni state's movements and the slave trade had left a fraught political context and, in the south, the Lozi chief Lewanika was under threat both from internal opposition and Ndebele raiders. Ragsdale makes the interesting suggestion that the inhabitants of such areas were 'comparatively receptive to missionaries, especially if they could promise some protection' (1986: 19). Similar arguments have been made by historians such as Lamin Sanneh (1983), who has argued that West African responses to the arrival of missionaries were shaped by the pre-existing interests and power struggles of powerful local actors.

²³ This movement, which began among Methodists in the 1840s and 1850s, drew from John Wesley's teachings about the 'perfectibility' of Christians through conversion. Advocates of the 'holiness revival' movement emphasised the importance of the doctrine of Christian perfection, thinking this aspect of Wesley's theology needed to be renewed among Methodists. The holiness revival movement shaped profoundly the subsequent history of Pentecostal Christianity within the US (see Cracknell and White 2005).

²⁴ The history of the Pilgrim Holiness Church in Zambia is slightly more complicated than this. In 1968, at a conference in the United States, in Indiana, the Pilgrim Holiness Church merged with the Wesleyan Methodist Church (another church formed during the holiness revival movement in 1840s New York) and became, more simply, the Wesleyan Church. In Zambia, however, the national church wished to emphasise the historical importance of the Pilgrim Holiness Church and decided to retain more of the original name. This is why it is today the Pilgrim Wesleyan Church of Zambia, see Kalembo (2009: 18).

²⁵ The Health Department's budget in 1938 was £75,000 and missionaries were given £3765 (Henkel 1989: 147).

²⁶ The introduction of 'user fees' was not mentioned very often by patients, staff members or the American missionaries. There is a debate about the effects of the introduction of user fees in other African countries during the period of structural adjustment, with certain anthropologists arguing that some patients benefitted from the formalization of payments which otherwise had to be paid informally as bribes (see, e.g., Mogensen 2005; van der Geest 1992). This should be set against the large literature on the detrimental consequences for healthcare of the introduction of structural adjustment programmes (for an overview, see Pfeiffer and Chapman 2010).

²⁷ In 1985, 23,960 people were recorded as HIV-positive (out of 36,707 recorded cases in the country as a whole) and, in that year, 635 people died of AIDS-related complications (out of

845 total recorded deaths in the country). By the year 2005, there were 12,578 deaths in the Southern Province (out of 95,373 in the country as a whole). The number of recorded cases of HIV diagnoses and AIDS-related deaths in Southern Province dropped as a proportion of the country's total amount because the number of cases of HIV/AIDS in the Copperbelt rose dramatically (cases of HIV infection, for example, rose from 6,719 in 1985 to 270,525 in 2004). Having seen how statistics are acquired in rural healthcare settings, I do not think these are reliable. But, if they are even vaguely close, they raise interesting questions about provincial differences in rates of HIV infections, see the 'HIV/AIDS epidemiological projections, 1985-2010'. Available at: <https://knoema.com/ZMHIVEP2012/hiv-aids-epidemiological-projections-1985-2010-zambia> (accessed May 11th 2017).

²⁸ Gifford goes as far as to suggest that 'after the declaration of Zambia as a Christian country missionaries have been granted open access' (Gifford 1998: 245). On this period of Zambian history, see also Cheyeka (2008) and Phiri (2003).

²⁹ In 2014-2015, however, the rainfall was poor and many families were left hungry.

³⁰ For an analysis of the broader importance of clothing styles in signifying urban and rural allegiances, see Ferguson (1999). For an ethnography of the second-hand clothing industry in Zambia, see Hansen (2000).

³¹ Indeed, the same thing has been said of Christianity (e.g., Robbins 2003, 2007b) and, if we take both of these suggestions seriously, this might be one reason why mission hospitals have not been studied very often by anthropologists.

³² There have recently been a number of ethnographic studies in hospitals, for example, Andersen (2004); Brown (2012); Garcia (2010); Hannig (2015, 2017); Langwick (2008); Livingston (2012); Mulemi (2014, 2017); Renne (2017); Sargent and Kennell (2017); Street (2014); Wendland (2010, 2017).

³³ Gluckman himself suggested that situating Europeans and Africans within a 'single social system' was not his own idea but the 'breakthrough' of Isaac Schapera (Gluckman 1975: 24). It is worth pointing out that, despite the attempt to situate Europeans and Africans within the same analytical frame, in a more profound sense the place of white settlers was never fully explored by these anthropologists as deeply as it might have been. There is a difference between including white settlers, missionaries, and administrators in the frame of analysis and examining in detail, the ideas, aspirations, and daily lives of the white population. In this sense, it is difficult to disagree with the judgement of Ferguson that the Manchester School anthropologists, on the whole, 'were not much interested in anthropologically understanding

the point of view of the [white] settlers' (1999: 31). Hooker put this memorably in his suggestion that 'extravagant generalizations about the manners, morals and motivations of white settlers were tossed off by anthropologists who would have raged had such things been said of Africans' (1963: 457, quoted in Ferguson 1999: 32; see also Powdermaker 1966). Jan Bart Gewalt (2011) and Ian Phimister (2011) have recently reconsidered the work of one of the few anthropologists of the time who did study white settlers in detail, J. F. Holleman, who carried out studies of white mine workers on the Copperbelt. For a far less sympathetic account of Holleman and his work, see Schumaker (2001).

³⁴ See, for example, Comaroff (1985); Dilger, Kane and Langwick (2012); Feierman (1985); Feierman and Janzen (1992); Janzen (1978, 1992); Langwick (2011); Last and Chavunduka (1986); Livingston (2005); Luedke and West (2006); Prince and Marsland (2014); Whyte (1997).

³⁵ The literature here is extensive and includes some of the works cited above (see footnote 34). See Arnold (1988); Comaroff and Comaroff (1997); Hunt (1999); Lyons (1988, 1992); Marks (1994); McLeod and Lewis (1988); Packard (1989); Vaughan (1991); White (1993, 1995, 2000).

³⁶ This has been explored in works such as, for example, Janzen (1978); Dilger and Luig (2010); Langwick (2011); Livingston (2005).

³⁷ To the idea that missionaries 'destroy culture' should be added the notion that missionaries exercised a more insidious form of power than colonial governments ever did. For example, Walter Rodney wrote that missionaries were 'agents of colonialism in the practical sense, whether or not they saw themselves in that light' ([1972] 2012: 252). The scholar V. Y. Mudimbe (1988) has argued (along Foucauldian lines) that missionaries – by seeking to transform consciousness and reform the soul – exercised a more penetrating form of power than their secular counterparts. As Norman Etherington has pointed out, one of the difficulties of this kind of argument is that European Christian missionaries 'accomplished very little in the way of conversion' (2005: 7) which largely 'occurred far away from missionary eyes' (1996: 217).

³⁸ One of the obvious culprits here is Malinowski. It is unsurprising that missionaries (among others) might have resented Malinowski's pompous self-description:

the manner in which my white informants spoke about the natives and put their views was, naturally, that of untrained minds, unaccustomed to formulate their thoughts with any degree of consistency and precision. And they were for the most part, naturally enough, full of the biased and pre-judged opinions inevitable in the average practical man, whether administrator, missionary, or trader, yet so strongly repulsive to a mind striving after the objective, scientific view of things. (1922: 5-6).

³⁹ A notable exception is Brian Howell's (2012) work on short-term missionaries, which I draw from in the chapters that follow. Howell writes as a practising Christian (see also Howell 2007) and his work is in conversation as much with missiology as with social and cultural anthropology.

⁴⁰ Indeed, Mulemi (2010) and Livingston (2012) both worked in the oncology wards of large urban hospitals.

⁴¹ Naomi Haynes, when she points out the diversity of Pentecostal worship on the Zambian Copperbelt, mentions that, early on in her fieldwork, she was able to 'go to a different Pentecostal meeting every day of the week' (2017: 30). If I had wanted to visit different churches in this way, I would have been strongly discouraged by the family.

⁴² Anita Hannig, in her description of her research at a hospital in Ethiopia, suggests that her 'status as someone perceived to be tied to the foreign power structures of the hospital could have led patients to dramatize certain aspects of their accounts' (2017: 25). Many people I met and interviewed seemed to view me as somebody who would listen to their grievances and might be able to help. In itself, it is interesting that people felt that a white foreigner was a potentially responsive person who offered some form of hope. I always explained my research project and made it clear that I was in no position to bring about changes and that, furthermore, people's answers were not connected to their treatment (Hannig 2017: 26).

⁴³ The idea that infrastructure is denied to rural populations in areas where opposition parties are strong can be found in other African countries. Hannah Brown notes that in the area of Western Kenya where she worked, the 'condition of the hospital was frequently used a symbol to comment on the district's comparative underdevelopment', which was associated with 'the neglect of the region by politicians in power, perceived as punishment for its identification as an opposition stronghold' (2010: 72).

⁴⁴ 'Triage' is often used to refer to emergency medicine, where quick decisions have to be made (on 'triage', see Nguyen 2010). In this chapter I extend its use to the (usually) nonemergency context of the OPD.

⁴⁵ This chapter is mostly concerned with patients who were visiting the out-patient department (OPD) of the mission hospital. It is worth pointing out, however, that these patients were not usually suffering from immediately life-threatening conditions. When there were car accidents or antenatal emergencies, for instance, the situation was different and Zambian staff were more responsive (see Chapter Four).

⁴⁶ There were other forms of being ‘handled badly’, which included being spoken to badly or ‘scolded’ by staff members (cf. Zaman 2004: 2028).

⁴⁷ I have changed several of the details here about Mr Sikabondo to disguise his identity further.

⁴⁸ Indeed, this is why some anthropologists of the region (e.g., Englund 2008) have expressed their unease in relation to some of the opening arguments for a turn to ‘ethics’ in anthropology (e.g., Faubion 2001; Laidlaw 2002), in which the ‘cultivation of the self’ was a central analytical concern at the expense, perhaps, of questions about relationships and forms of dependence within contexts of material scarcity and poverty. I discuss this issue in Chapter Four.

⁴⁹ Ferguson’s argument, it should be stressed, forms part of a larger project of understanding cash transfer schemes (see, e.g., Ferguson 2009, 2013, 2015). In this context he wishes to highlight the limitations of social policy that ‘takes maximizing independence and autonomy (and minimizing dependence and patronage) as its ultimate goal’ (2013: 238). However, anthropologists who have engaged with Ferguson’s argument have taken the central idea of ‘declarations of dependence’ seriously.

⁵⁰ Ferguson makes his argument with reference to Saba Mahmood’s (2005). This seems unhelpful. Firstly, it is not clear that relationships of dependence are similar to the forms of religious devotion and submission described by Mahmood (beyond the fact that ‘liberals’ apparently have a problem with both of them). Secondly, even if they were sufficiently similar to warrant the comparison, the question remains – just as it does in the case of Mahmood’s work – of the place of evaluative reflection in these projects and relationships (see Laidlaw 2014).

⁵¹ Ferguson seems to be aware of the difference between these two forms of dependence. Cash transfers, Ferguson writes, would ‘enable less malevolent sorts of dependence to take root and a circuit of reciprocities to unfold within which one-sided relations of dependence [i.e. hierarchical patron-client relations] can become more egalitarian forms of interdependence [i.e. horizontal mutual dependence]’ (2015: 138).

⁵² In her most recent work on Pentecostal Christianity in the Copperbelt, Haynes refers to ‘egalitarian’ relationships as well as ‘hierarchical’ ones, although this is mostly in relation to the distinctive relationships that exist within *chilimba* groups, the Chibemba term for ‘rotating credit associations’ (2017: 49).

⁵³ I think the beginning of an answer to this question might recognise that there are certain parts of the southern African region (and the Southern Province of Zambia might be one such area) in which horizontal mutual dependencies have been more enduringly significant and positively valued than hierarchical patron-client relationships. This discussion I have been developing in this chapter also suggests, I think, an alternative approach to the Dumont-influenced perspectives in which ‘hierarchy’ is identified as a ‘paramount’ value throughout southern Africa (see Haynes and Hickel 2016). Indeed, such approaches not only fail to account for the presence of more horizontal relationships of mutuality and loyalty, but they also fail to take into account the historical constitution of values. The values of the people of the southern Province (e.g., their enduring aversion to centralised hierarchy) become much more comprehensible, for example, when situated against the history of the region (see Chapter One).

⁵⁴ The case of Mutinta and her mother, as described here, combines elements of the cases of two patients I met at the hospital. It is also worth noting here that the word *mung’anga* (plural, *bang’anga*) in Chitonga can refer to a ‘herbalist’, ‘healer’ or even ‘diviner’. People often play on the ambiguity of the term in certain contexts, making jokes that those who visited herbalists and healers might be involved in witchcraft. Englund has noted the same among Chichewa speakers in Malawi: ‘The word for “healer,” *sing’anga* (plural, *asing’anga*), is ambiguous in Chichewa, its scope encompassing morally neutral herbalists and immoral sorcerers, with some healers thought to combine both qualities in their practice’ (2011: 84; see also Marsland 2007: 757). Given this ambiguity, it is interesting that the number of witchcraft accusations increased after 1967 when the newly independent Zambian government permitted ‘traditional healers’ and ‘herbalists’ to work as recognised ‘health practitioners’ (Colson 2000: 336; see also Sugishita 2009). Both Marsland (2007: 754) and Langwick (2011: 89) have noted that, in Tanzania, people more often distinguished between types of medicine rather than different types of healer and both biomedical and ‘traditional’ healers can be called *waganga* in Kiswahili.

⁵⁵ Langwick makes the important point that, in seeking to rid themselves of afflictions, ‘the process of moving from one healer to the next is a process of diagnosis by addition’ (Langwick 2011: 201; cf. Feierman 2000). By this, Langwick means that the healers with whom she worked in Tanzania were not seeking ‘to identify single disease mechanisms through processes of elimination’ (2011: 201), rather it was through different healing *practices* that afflictions emerged as identifiable. A similar insight has been applied to biomedical healing by Alice Street (2014), in which afflictions are identified through treatments. Anthropologists have also pointed out that people might seek further forms of treatment if they simply do not like what they are being advised to do. For instance, Colson observed a diviner tell a man that he needed

to marry another wife (because having only one wife to give beer offerings to both of his ancestral clans was angering the ancestral spirits and bringing illness to his house) and the man replied: 'I cannot marry another wife. You will have to divine again and find another cause for my illness' (1958: 121).

⁵⁶ For similar descriptions of treatment options in the regional anthropological literature, see Brown (2010: 76); Geissler and Prince (2009: 620-623); Hannig (2017: 134-136); and Mogensen (2005: 214).

⁵⁷ Medical anthropologists who have studied the processes of deliberation that take place around illness and affliction have been profoundly influenced by John Janzen's idea of the 'therapy management group' which emerges

whenever an individual or set of individuals becomes ill or is confronted with overwhelming problems. Various maternal and paternal kinsmen, and occasionally their friends and associates, rally for the purpose of sifting information, lending moral support, making decisions, and arranging details of therapeutic consultation. The therapy managing group thus exercises a brokerage function between the sufferer and the specialist. (1978: 4)

For a recent interesting discussion of the enduring relevance of Janzen's concept on studies of African healing, see Olsen and Sargent (2017).

⁵⁸ There is a history of patients feeling inferior to Zambian hospital staff members. In her research on medical missionaries in colonial Zambia, Linda Beer Kumwenda found a patient complaining, in a letter, of the conduct of the African staff: 'such people . . . dispiese [sic] us . . . we are good for nothing we are uneducated men' and they 'call us only rough names' (Kumwenda 2006: 202).

⁵⁹ Street also discusses the use of antibiotics in cases where diagnosis was difficult (2014: 101).

⁶⁰ Street has noted that, in Papua New Guinea, 'white people's medicine' was identified with the ability to see into people's bodies, particularly because of the use of X-rays. This was also something that certain diviners were associated with. They were described by patients as having 'X-ray eyes' that are 'able to penetrate the patient's body to see what social relationships lie behind their illness' (2014: 129). As we will see later in this chapter, diviners in Zambia have also made use of biomedical and Christian imagery in their healing practices.

⁶¹ I was called this particularly when Mrs Mainza wanted to stress her responsibility to my mother to ensure my wellbeing – a common injunction of hers, for instance, was 'you must

return home before dark *mwana waJulie*, reminding me of my multiple relationships and responsibilities. La Fontaine (1985) suggests that the tendency to refer to people as ‘extensions of their parents’ (1985: 130) is more common in contexts where ‘social dependency is being stressed’ (1985: 131). In this context I was being referred to as a dependent of my mother to whom Mrs Mainza felt she had certain obligations.

⁶² Missionaries used the Chitonga word ‘*Leza*’ – a term which was already in use in the pre-colonial period as a word for the creator of the world – as a way of translating ‘God’. They used the pre-existing word for ‘sky’ (*kujulu*) as a way of translating ‘heaven’. The word ‘*mwami*’ referred to local men with authority and prestige and it was taken by missionaries and colonial officials to mean ‘chief’. For missionaries, this was close enough to ‘Lord’ to be used in translations, hence the common usage today of such terms as ‘*mwami Leza*’ for ‘Lord God’. Interestingly, the term can also be used as an honorific form of address between friends or strangers. In some places missionaries used pre-existing vernacular terms to translate the concept of ‘angels’ (see Hunt 1999: 65). Derek Peterson offers a fascinating account of the complexities involved in missionary translations of the Bible in colonial Kenya. Peterson suggests that such translations often ‘emerged out of a long and tense dialogue between . . . converts and missionary translators’ (1999: 50).

⁶³ *Bangelo* spirits, then, seem to be quite unlike the concept of *majini* in Tanzania, which can also be translated as ‘angels’ (Langwick 2011: 106). The use of biomedical imagery in healing practices has been found in other contexts and the association of biomedical practitioners with white clothing is common in the region (see, e.g., Marsland 2007: 753). Indeed, the historian Terence Ranger made the suggestion, many years ago, that medical missionaries in colonial Tanzania were regarded, primarily, as a new healing cult. In discussing the treatment of yaws patients, Ranger suggested that ‘the movement of yaws victims to the mission hospital resembled nothing so much as an indigenous healing cult, of which there had been a succession in the region’ (1981: 265).

⁶⁴ As Langwick found in Tanzania, ‘falling ill can thrust an individual into therapeutic practice. Seeking treatment and being healed establish a trajectory through which a person can be called into relationship with a variety of actors’ (2011: 94), including spirits and other entities. This way of becoming a healer was also noted by missionary observers in the nineteenth and early twentieth centuries (Hokkanen 2004: 326-327).

⁶⁵ It is worth pointing out here that people certainly did not think the missionaries were literally ‘angels’. Indeed, when I suggested this in discussions and interviews, people invariably explained that the term was a form of praise rather a literal description.

⁶⁶ In her ethnography of a hospital in Ethiopia, Hannig notes that many patients ‘had the sense that hospital doctors possessed an extraordinary amount of power’ (2017: 132). The term *bangelo* seems to indicate, similarly, the powerful capacities of the missionary doctors and many patients did stress their admiration for the doctors’ abilities to save lives and perform transformative procedures. And yet, as I have indicated, I found more often that the term was associated with ideas of ‘non-selectivity’ and attention to the needs of patients rather than ideas of extraordinary power. It is worth making the further point here, however, that healers (*bang’anga*) are often thought of as people who can both heal and cause harm (see, e.g., Ashforth 2005; Geschiere 1997; Langwick 2011; West 2005) and this ambivalence, unsurprisingly, has also been applied to biomedical healers (Wendland 2010: 206). White has noted that medicines used by missionaries have been associated with healing as well as harmful powers (1995: 1394).

⁶⁷ The word *banyama* comes from *nyama* for ‘meat’ or ‘flesh’ with the *ba-* prefix denoting the noun class for people (and large animals). So it is literally ‘the people of meat’. The word *nyama* is found in Chitonga and several other Bantu languages, although White claims that the word *banyama* came originally from Swahili (1993: 751). Monica Wilson (1959) reported that her Nyakyusa informants spoke of Europeans who ‘go around killing people and taking their blood for the Government to use for medicines’ (1959: 150). Because human blood was used in their own powerful medicines, people assumed that European medicines also required human blood (1959: 151). The term they used was *abanyambutu*.

⁶⁸ If scholars such as Jean and John Comaroff (1999) are correct in identifying rumours about witches and zombies with changing political-economic realities, then perhaps the scarcity of these rumours in the Southern Province has to do with the relatively small number of male labour migrants during the colonial period. This explanation, however, does not help us to identify why *banyama* rumours subsequently emerged in the 1970s and 1980s in the area.

⁶⁹ In 1996, residents in a small town in the Southern Province attacked some Indian shop owners, claiming that they had heard rumours that these shop owners were in control of *banyama* gangs (Colson 2000: 340).

⁷⁰ This formulation was suggested to me by Finbarr Curtis.

⁷¹ Wendland reports the following at the hospital in Malawi where she worked: ‘A 2006 letter to the editor in a national newspaper, pinned to a bulletin board . . . expressed the writer’s shock and gratitude at obtaining timely medical care for his gravely ill child without having to track down a staff member he knew’ (2010: 278n).

⁷² Ferguson cites Mahmood's (2005) work as an example of how to understand such 'non-liberal' aspirations and one that anthropologists of southern Africa could learn from in seeking to understand 'dependence' (see footnote 50).

⁷³ Pritchett is writing predominantly about two mission stations in Zambia's North-Western Province.

⁷⁴ A company official, for instance, wrote in a letter of 1902 that, although the administrators in the territory might have 'very little sympathy with the faith and purposes of the missionaries,' they nevertheless 'know quite well their value, and they know that the more work the missions can do the less it costs the government to keep the country in order' (quoted in Rotberg 1965: 100). The missionaries were often less enthusiastic about the BSAC. In 1899, for instance, the BSAC asked missionaries from the London Missionary Society if they could provide medical services for company employees. The LMS refused this offer saying that it 'did not wish to bind itself to supply medical men to attend to Europeans to the neglect of their missionary duties' (quoted in Henkel 1989: 147).

⁷⁵ Not all missionaries wanted to receive funding from colonial governments. Some missionaries argued that government funding would draw missionaries away from the proper task of evangelising or, more profoundly, that collaboration with governments corrupted the purity of the church (see Beidelman 1982: 21).

⁷⁶ The history of government collaboration with missionaries in the context of education was more satisfactory from the perspective of many missionaries, as they received more funding (Jennings 2008: 44). In missionary correspondence with British colonial officials, missionaries often compared the relatively desirable situation in education with that of the unsatisfactory arrangements in the provision of healthcare, see NAZ, '1939-1942 Missionary Conferences', MHI/8/2/loc. 3261.

⁷⁷ By 1938, for example, the Health Department's budget was £75,000 and missionaries were given £3,765. Given the fact that rural healthcare was almost exclusively the domain of missionaries, this indicates the way in which urban areas were privileged by the colonial government (see Henkel 1989).

⁷⁸ NAZ, MHI/2/18, loc. 3153.

⁷⁹ It is around fifty miles away and it took over two hours to travel from Choma to Macha Mission Hospital by car when I made the journey in August 2015.

⁸⁰ The Director of Medical Services replied on January 19th, saying that ‘there are many mission stations in the Territory further removed from a Government station [...] which are doing equally good and plentiful work but receiving no grant whatever’ (NAZ, MH1/2/18, loc. 3153).

⁸¹ NAZ, MH1/2/18, loc. 3153. Scholars such as Fields (1985) and Comaroff (1989) have shown that missionaries were often regarded warily by colonial officials who were committed to the idea of ‘indirect rule’ precisely because proselytising missionaries were thought to undermine the ‘traditional’ authorities and ‘native customs’ upon which indirect rule depended (cf. Jennings 2008: 36).

⁸² NAZ, MH1/2/18, loc. 3153. As well as being opposed to missionary evangelising, colonial officials were perpetually concerned about funding, which remained sporadic throughout the early twentieth century becoming gradually more ‘formalised’ during the 1930s (Jennings 2008: 45; cf. Hardiman 2006: 5).

⁸³ NAZ, MH1/2/18, loc. 3153. Kumwenda reports that many government officials, in the 1940s and 1950s, were strongly opposed to cooperation with medical missionary organisations (2006: 214).

⁸⁴ Between 1964 and 1981, the number of beds in hospitals and health centres doubled, something which benefited people from areas that were not well provided for during the colonial period (Henkel 1989: 150). The government also gave more money to mission hospitals – from 5 percent under the British it rose, in 1967 to 13 percent and by 1968 to 15 percent (Henkel 1989: 151). It is worth noting here that some independence leaders in Africa (and here Kenneth Kaunda is a prime example) were themselves mission educated and therefore had a great deal of ‘intellectual sympathy’, to use David Maxwell’s words, with the mission churches (2006: 414).

⁸⁵ According to Kalusa, the Catholic missionaries of Eastern Province allowed themselves to be incorporated within the newly emerging healthcare system. As Kalusa writes, missionaries became ‘agencies via which the post-colonial regime in Zambia championed public health and trained local medical personnel to staff both mission and public health institutions’. In this context, Kalusa claims, as ‘agents of the Zambian state, medical missions not only shed their earlier hegemonic trappings but also lost their religious flavour’ (2014: 238). Jennings’s description of Tanzania, however, would more accurately reflect the situation in the Southern Province of Zambia. Jennings suggests that, while the colonial state ‘gradually brought control and direction over national health care into its own administrative sphere, contracting the missions . . . as co-providers in the rural sector’, it is important to note that the ‘process was

not . . . an annexation of mission independence' (2008: 50-51).

⁸⁶ NAZ, Letter dated 26th February 1975, 'Medical Policy', SP3/4/16/ loc. 463.

⁸⁷ In addition to the need to cover costs and ideas of payment being 'morally improving', missionaries gave other, more pragmatic, reasons for charging patients. Dr Daniel Weston, an American who was a District Medical Officer in the 1950s, explained to me that patients were charged so that they would return to the hospital:

On the Mission Station Hospital, we had the new drug: penicillin. And it was proving very useful for the nurses when cases came in and infections were already out of control . . . We had to give the patient a shot, then another shot was due, I think it might have been the next day and finally the last shot was due the next day. Now, I might not have the timing of the shots correctly, but the outcome was that they felt so much better after the first shot that they often would not come back for the second and third shots. And you know, they then got very sick and often died. So we started charging for our Penicillin shots. I think it was 15 shillings, or about \$2 in those days. And we charged in advance. And you know what happened? they would come back for the second and third shots. Why? because they had paid for them and they wanted full value for their payment and there were no more problems with people not taking the full three shots.

This argument (and variations of it) can be found in many different contexts (see, e.g., Ranger 1981: 266). In her recent work on humanitarianism in India, Bornstein found an American doctor making the same argument. This doctor suggested that patients who had to pay for their treatment were more 'motivated to comply with the therapy' (quoted in Bornstein 2012: 77). Hokkanen gives the further (and related) example of Scottish missionaries in colonial Malawi who were concerned that, because local healers charged their clients, by comparison 'free treatment would undermine the status and authority of the missionary doctor' (2004: 328).

⁸⁸ NAZ, 17th December 1968, MH1/7/43, loc. 3258.

⁸⁹ Many seemed to think that because it was the British who were the former colonial rulers, Americans were therefore innocent outsiders. A significant number of missionaries did not seem to know very much about colonial rule at all.

⁹⁰ Dr. Tom's daily routine and workload was similar to that of 'Dr. P' in Botswana, as described by Livingston (2012: 68).

⁹¹ Like Howell in his book – which is entitled *Short-Term Mission* (2012) – in this dissertation I continue to use the terms ‘short-term’ and ‘long-term’ for variation, with the understanding that these terms are not entirely satisfactory and that, when I do so, I am usually referring to those who are more appropriately termed ‘visiting’ and ‘career’ missionaries, respectively.

⁹² Short-term volunteers are different to professional humanitarian workers, as Bornstein notes, because their ‘activity [is] outside the productive realm of wage work’ (2012: 113).

⁹³ Like the accommodation for the MSF staff described by Redfield, the missionary accommodation in Matamba was ‘hardly opulent’ and yet ‘these compounds occupied the higher end of any local comfort scale’ (2012: 368). It is worth pointing out that some historians and anthropologists of missionaries have suggested that male missionaries started to have considerably less contact with local populations once it became routine for them to live with their wives and children (see, e.g., Biedelman 1982: 13; cf. Stoler 2002).

⁹⁴ Different visiting missionaries also voiced their surprise, concern, or admiration when they found that I was staying with a local family. American visitors asked me why I was living ‘in the village’ given that it must be ‘unhygienic’ and ‘dangerous’. I was often encouraged to stay safe and to be careful ‘out there’, especially in relation to preparing and consuming food.

⁹⁵ Colson suggested that one of ‘the arts’ of life for people in the region has been to make ‘claims on others that they can be shamed into acknowledging’ (2010: 128). Knowing how much food one’s neighbours, friends and relatives have, at any given time, might be crucial information if one’s aim is to ‘shame’ them into offering assistance.

⁹⁶ The importance of fertility and having children was made clear to me when my host mother, Mrs Mainza, asked me how many children I intended to have in the future. When I replied that – if I ever did have children – perhaps one or two would be a sensible number, Mrs Mainza said to me, ‘Oh no! You must have at least five or six’.

⁹⁷ Howell laments the fact that, when visiting missionaries meet with career missionaries, one of the common results is that ‘networks between North Americans are reinforced, while new networks involving national leaders and other members of the communities visited are left undeveloped or underdeveloped’ (2012: 219).

⁹⁸ For example, Simpson writes of Brother Francisco, a Catholic missionary who expressed a certain uneasiness about the distance between him and ordinary Zambians. Brother Francisco spoke of ‘a dream that he knew would never be realised in Zambia: to live “an ordinary life”

in “an ordinary house”, to go out to work and come home again, sharing the everyday life of those around him in the village or the urban compound’ (2003: 75).

⁹⁹ Robbins discusses three ways in which theology might inform anthropology. I deal with the second approach (discussed by Robbins) above. The other two approaches include, firstly, that anthropologists can consider the Christian influences upon the discipline of anthropology itself – its theoretical assumptions and concepts, whether ideas of religious meaning, human nature or agency and sincerity (see, e.g., Asad 1993; Sahlin 1996; Keane 2002). Secondly, a further approach is for anthropologists to think about how the work of theologians – such as John Milbank (1990) whose work is the focus of Robbins’s essay – might enable anthropologists to scrutinize some of the foundational assumptions that we bring to bear in our forms of analysis from a radically different vantage point. This engagement with theology, in Robbins’s view, might leave the projects of anthropologists transformed in certain productive ways.

¹⁰⁰ I was told, by others present, that Dr Tom prayed like this on every occasion.

¹⁰¹ Dr Tom being called in the night calls to mind the account offered by Peter Pels of Dutch Catholic missionaries who were bound by canon law to attend to ‘sick calls’ at any time, even in the middle of the night (1999: 98)

¹⁰² Bornstein has written about expatriate Americans in India who discussed being ‘in the moment’ as a way of avoiding thinking about the future of the lives of children living in desperate circumstances in an orphanage in Delhi (Bornstein 2012: 135-136). Their idea of being in the moment was an attempt to be emotionally resilient by inhabiting the present and imaginatively closing off the future.

¹⁰³ There are, once again, similarities here with the Catholic missionaries described by Simpson, whose

place was very much a place of work, of almost constant activity. It was noticeable how their days were taken up with industry, either intellectual work in the school or manual work within or around their house, *and this left little time or opportunity for social visiting*. (2003: 69; emphasis mine)

¹⁰⁴ There is, of course, a case to be made that notions of ‘self-reliance’ and aversions to ‘dependency’ have a Christian genealogy in the first place. Indeed, there is a much longer history of missionaries promoting the importance of ‘self-sufficiency’ (see, e.g., Comaroff and Comaroff 1991: 242). Nevertheless, the point here is that these more recent arguments advocate

minimal involvement by missionaries and turning over jobs to national staff in a way that is new and arguably borrows much from development discourses about ‘sustainability’.

¹⁰⁵ They also had significant theological differences that cannot be fully explored here. Tom and Hannah had a different view of healing compared to Paul and Louise (and to many of the short-term missionaries). When local church leaders would cast out demons on the hospital wards, Tom and Hannah raised their eyebrows and maintained a sense of detachment from such practices. Some of the short-term visitors, however, were quite taken with the idea that in Zambia there were demons who might well be responsible for illness. Tom and Hannah shared Wesley’s suspicion of ‘visions and voices . . . fits and convulsions’ (Comaroff and Comaroff 1997: 66) and they tended to avoid ‘the ecstatic, spirit-filled church service[s]’ (Freeman 2012: 12) of the local Wesleyan church.

¹⁰⁶ ‘Load-shedding’ was a controversial policy at this time in Zambia (beginning in around August 2015). The government’s official explanation was that low rainfall had left the Kariba dam short of water, thus reducing the hydroelectricity available. Other media reports pointed out that the rainfall shortage was not significantly worse than previous years and they alleged that the government had sold electricity to neighbouring countries. In the Southern Province, where the government was incredibly unpopular after the election of the Patriotic Front (PF) leader, Edgar Lungu, many people were highly cynical about ‘load-shedding’ and inclined to believe that the government was somehow enriching itself and disregarding the well-being of citizens.

¹⁰⁷ A point that I have not been able to explore here is that the missionaries felt that they had acquired a particular set of skills over the years and their improvised ‘expertise [was] entirely confined to place’ (Street 2014: 90; cf. Livingston 2012). Their abilities were now highly context-specific and they would no longer be qualified – without considerable re-training – to work in medicine in the United States.

¹⁰⁸ For an interesting discussion of Tenwek Mission Hospital in Kenya (and USAID’s decision to fund mission hospitals in the country) see Hearn (2002: 48-49; see also Hearn 1998).

¹⁰⁹ For an interesting account of the life of Billy Graham and, among other things, his relationship to anthropology, see Howell (2015).

¹¹⁰ <https://www.samaritanspurse.org/our-ministry/about-us/> (accessed December 5th 2016).

¹¹¹ In late 2016, this was 25 hospitals in Africa, 3 in Asia, 7 in Latin America, and 1 mission hospital in Papua New Guinea, <https://www.samaritanspurse.org/medical/mission-hospitals/> (accessed December 5th 2016).

¹¹² Dress was an important part of ‘conduct’ in such contexts. Missionaries were told to wear conservative clothing. This is common in other settings. For example, Redfield reports the MSF guide suggesting clothing for women: wear ‘something your grandmother likes!’ (Redfield 2012: 369).

¹¹³ The term ‘erasure’ is often used in these contexts (e.g., Wendland 2012: 116).

¹¹⁴ Wittgenstein also wrote in *On Certainty* that, ‘A meaning of a word is a kind of employment of it. For it is what we learn when the word is incorporated into our language’ (1969: 61). Tomlinson and Engelke suggest that this definition ‘provides a useful way to understand how many anthropologists, from Malinowski on, have deployed the concept of meaning in their work’ (2006: 10). Ernest Gellner claimed that Wittgenstein’s central argument about meaning was already present in Malinowski’s early work in which it can be seen that ‘Malinowski already possessed the culture bound theory of language, later to be acclaimed as the terminal revolution in philosophy’ (1998: 148).

¹¹⁵ Some have criticised the assumptions behind the condemnation of vision in much of this work, calling for more consideration of situated practices of seeing (e.g., Ingold 2000).

¹¹⁶ For example, Wittgenstein wrote,

What is it like for people not to have the same sense of humour? They do not react properly to each other. It’s as though there were a custom amongst certain people for one person to throw another a ball which he is supposed to catch and throw back; but some people, instead of throwing it back, put it in their pocket. (Quoted in Monk 1990: 532)

Geertz enjoyed depicting the anthropologist as a person who is perpetually catching the ball and then putting it in his pocket – not realizing that it needs to be thrown back. The influence of Wittgenstein is so pervasive and long-standing in anthropology that it is difficult to locate with any precision. Geertz himself insisted that, when he started out,

anthropologists read people who were anthropologists. The notion that you should read philosophers, that Wittgenstein had anything to say that anthropologists might be interested in, would be way off base . . . Now it’s wide open (Quoted in Handler 1991: 611).

This is a claim that might be more relevant in the North American context given the influence of Wittgenstein on British social anthropologists who did not explicitly cite him. For an account of anthropology's relationship with Wittgenstein's thought, that is influenced by Stanley Cavell's reading of Wittgenstein, see Das (1998).

¹¹⁷ Wittgenstein scholars have debated whether Wittgenstein was interested in aspect perception primarily in terms of perceptual change (i.e. the 'dawning of an aspect' when the drawing of the rabbit is suddenly perceived as a duck) or in 'continuous' aspect perception as something that is pervasive in human life. Stephen Mulhall argues that Wittgenstein was overwhelmingly interested in the latter (1990: 255). For the discussion here, Mulhall's interpretation is the most useful, however, it might be interesting to think about moments of perceptual change in which there is a sudden perceptual change. Indeed, this might be one way of reframing what Jarett Zigon has conceptualized as 'moral breakdown' (2007).

¹¹⁸ In Foucault's case, we might think of his influential categorisation of ethics in terms of ethical substance, rules, ascetic practices, and teleology ([1984] 1998: 26-28). This categorisation has influenced many discussions within the discipline among anthropologists who do not necessarily share any of Foucault's other commitments or theoretical interests (see, e.g., Faubion 2001; Laidlaw 1995; Robbins 2004; Mahmood 2005). It has been, in other words, a highly useful conceptual tool that has enabled anthropologists to describe certain aspects of ethical life in a diverse range of contexts.

¹¹⁹ For a discussion of the promotional material and imagery accompanying short-term missionary literature see Hancock (2014).

¹²⁰ There has been considerable debate among historians about missionary perceptions of African healers (e.g., Comaroff and Comaroff 1997; Etherington 1987; Gordon 2001; Hokkanen 2004; Kalusa 2007). While some missionaries – particularly David Livingstone – have been depicted in this literature as both curious and sympathetic in their attitudes towards African medicine, it is more common to find missionaries described as hostile and dismissive. Regardless of the actual relationships between missionaries and healers during the colonial period, it is unsurprising that missionary writing – particularly texts composed for a British Christian public – were unfavourable to African healers. As Hokkanen notes, 'the image of "witch-doctor" was useful and powerful in creating the adversary to heroic missionaries, a representative of superstition and abuser of the ignorant' (2004: 342).

¹²¹ Similar sentiments have been noted in other contexts. Bornstein mentions an American volunteer in India who was ‘surprised’ to discover that her work in India was ‘inspiring’ to her friends at home (2012: 142).

¹²² See Pels (1999: 53) on the consequences for families of their sons deciding to become missionaries.

¹²³ This situation could be described, in Max Weber’s ([1948] 1991: 196-244) terms, as one in which the staff themselves owned some of the ‘means of administration’. It was not just the staff who had to provide such materials. Women arriving to give birth were expected to bring large black disposable plastic bags that were placed over the delivery bed, so as to minimise the task of cleaning up bodily fluids after the delivery. Similar practices are reported in other resource-poor hospitals (see, e.g., Brown 2010: 171).

¹²⁴ Staff members often had to leave work to attend funerals which, like elsewhere in Africa, as ‘a key marker of sociality in reverence to the dead as well as the living’ (Hannig 2017: 49) could not be avoided easily.

¹²⁵ Although the majority of nurses are now women (and have been for some time), this was not always the case. During the colonial period, African women were thought by colonial officials to be incapable of working in clinics and hospitals. The Principal Medical Officer in colonial Zambia wrote, in 1926, that the ‘native female is at present inherently unsuited to [medical] work . . . and I hold the opinion that she should be at present altogether disregarded in this connection’ (quoted in Kumwenda 2006: 210-211). Until this point, trained African medical staff were predominantly male orderlies. In part this was ‘to save the female nurse from the indignity of and impropriety of caring for male patients’ (Kumwenda 2006: 210). After the Second World War, attitudes changed and in 1947 the first training school for African nurses was established by Salvation Army missionaries.

¹²⁶ For an account of the situation of healthcare workers in Zambia, see Schatz (2008). He points out that as well as leaving the country altogether, many trained Zambian healthcare workers leave government employment to work for NGOs and humanitarian organisations – a form of what Schatz calls ‘internal brain drain’ (2008: 639).

¹²⁷ At Matamba Mission Hospital there were certain staff members who wanted to make money in addition to their government salaries. One way of doing this was to accept money from wealthier patients in order to then offer them preferential treatment or access to certain medicines. One of the difficulties in understanding the practice is that it was unclear whether wealthy and privileged patients were given preferential treatment because staff members

expected some sort of compensatory payment, or whether staff members looked up to wealthy patients and gave them preferential treatment because they valued them more highly than other patients. In other words, there was probably a slight difference between: a) wealthy patients who explicitly promised to give staff members something (including people who discreetly offered them money); and b) patients who *appeared* to be wealthy or of elite status and who, therefore, might be worth treating favourably. It was a very common to hear criticisms of staff members framed in terms of their desire for money. Patients sometimes suggested that staff members who treated them badly must have gone into the profession, not for love of the job, but for the money. This referred to the staff salary but when some people said this they were clearly hinting at other dubious ways of accumulating extra money. This practice was not something I was able to observe very often and therefore I am not able to say much about it here.

¹²⁸ In their work in the Southern Province, Cliggett and Wyssman (2009) have shown that primary school teachers did not regard farming, gardening or owning livestock as unusual: ‘These strategies are so prevalent that informants did not consider them a side job’ (2009: 33). The same could be said of many of the staff members whom I characterise here as ‘densely connected, who pursued such activities alongside their work at the hospital.

¹²⁹ Street reports that for doctors in Papua New Guinea, ‘the demands on their salaries from extended kin mean there is little money left over for consumption of the kinds of household goods that white people have’ (2014: 155, 162-164).

¹³⁰ The forms of mimicry and joking that I witnessed were similar to those described by James Pritchett in a discussion of the way in which white people were mocked in North-Western Province.

Youth, in particular, excel at improvising skits about the *muzungu* (white person). A standard theme has long been the humorous contrast between the European and African modes of doing very basic things. “Africans walk like this,” a narrator might say as his confederate glides by with a smooth, elegant, and well-balanced gait. “Muzungu walks like this,” he then intones as the village clown rambles into view with jerky motions, head bobbing out of control and ultimately tripping over a barely visible twig, in Charlie Chaplin fashion . . . Such skits are generally accompanied by such carefully crafted vocal inflections and bodily movements that the audience might well be aware of a particular *musungu* being parodied at the moment. (2011: 39)

The impressions of Dr Tom and Dr Hannah that I witnessed were perhaps not quite as theatrical and extravagant but it was obvious to everybody present how well certain staff members were able to capture the eccentricities of the missionary doctors as well as certain turns of phrase that were distinctive or amusing.

¹³¹ Langwick found the term ‘custom’ being used by rural Tanzanians to cover ‘the practices that lie outside the clinical setting, and are often deemed subversive . . . threaten[ing] the continuity of biomedical treatments and perhaps that of biomedicine’ (2011: 219). As will be seen in what follows, the term was not used in exactly this way by the staff members.

¹³² Colson distinguishes between the terms for ‘diviner’ (*mung’anga* or *musonde*), ‘diviner witchfinder’ (*munchape*), and ‘herbalist’ (*musilisi*) (2006: 40). In my experience, the term *mung’anga* was often applied to diviners and herbalists, with there being a degree of choice, on the part of the practitioner, whether he or she preferred to be called a *mung’anga* or a *musilisi*, the latter of which was sometimes used for doctors at the hospital and would be translated by English speakers as ‘doctor’. The term ‘traditional healer’ was sometimes used by English speakers to refer to both diviners and herbalists.

¹³³ Healers being aware of the affliction of a person who had not yet arrived (through a vision or dream) is common in other contexts (see, e.g., Langwick 2011: 96). Furthermore, Daniel Mwaanga comes close here to expressing the idea (one that I heard on other occasions) that the medicines of herbalists and healers are the same as those of biomedical practitioners – in that they all derive from naturally occurring substances (cf. Marsland 2007: 758).

¹³⁴ Marsland found that ‘Tanzanian biomedical practitioners generally share the moral supposition that “traditional” medical practices are inherently dangerous, and put patients at moral risk’ (2007: 755). I did not find this view among members of staff, but I did find, as Marsland also points out, that afflictions associated with witchcraft were considered to be the domain of healers (*bang’anga*). In these cases, particularly if hospital treatment had not been successful, then some staff members thought it was necessary for the person to visit a *mung’anga*.

¹³⁵ The way in which staff members regarded themselves and their professional expertise is similar to other examples of ‘professionals’ or ‘experts’ dealing within rural populations. For example, Englund has described how Malawian NGO workers regarded themselves in relation to rural Malawians (e.g., 2006, 2011). These officials were often, themselves, from rural backgrounds (much like the staff members at Matamba mission) and there was a ‘fundamental similarity between the lifeworlds of these development professionals and those they objectified as their illiterate beneficiaries in villages’ (2011: 72). Despite the NGO workers’

shared experiences, they were unable to identify with the villagers precisely because the language they used – a language which positioned them as technically skilled professionals – meant that they could not ‘draw on their own situated and embodied experiences as relatives and neighbours of the poor, because such identification could have obliterated the very boundary that made them professionals in the first place’ (Englund 2011b: 72). This was equally true of the Zambian staff members. As we have seen, however, they also had to position themselves in relation to the missionaries – an additional task that required them to draw on their ‘experiences as relatives and neighbours of the poor’ at the same time as they disavowed such experiences in other contexts.

¹³⁶ Pfeiffer and Chapman situate this work in what they call the ‘critical medical anthropology’ tradition (2010: 153).

¹³⁷ Among the criticisms that I do not address here are those who have raised concerns about some of the concepts used by these anthropologists – such as the notion of ‘structural violence’, which has been debated at length (see, e.g., Biehl and Locke 2010; Farmer 2004a) – while other anthropologists (who might, on the whole, be sympathetic to this work) have raised questions about the rhetorical use of narratives of ‘suffering’ (see, e.g., Butt 2002).

¹³⁸ When he uses the term ‘culturalist anthropology’, I take it that Fassin is here referring to descriptive forms of anthropological writing, rather than, more narrowly, ‘interpretive’ or ‘symbolic’ anthropology. There are, of course, a number of reasons why the term ‘culture’ has been politically suspect for many anthropologists (see, e.g., Kuper 1999).

¹³⁹ Orin Starn’s (1991) essay, entitled ‘Missing the revolution’, is often cited to suggest the weaknesses of politically disengaged anthropology (see, e.g., Farmer 2004b: 12; Scheper-Hughes 1995: 419).

¹⁴⁰ This is one reason, I think, why some of the arguments involved in the so-called ‘ontological turn’ are troubling (e.g., Holbraad 2012). Taking people ‘seriously’ turns out to be more about taking their claims seriously in so far as they might be contributions to anthropological concerns about knowledge, truth, anthropological theory, and so on, rather than as statements to be fully contextualised in terms given by the people themselves.

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Appendices

Appendix I: Statements of Faith, Christian Conduct, and Practice

STATEMENT OF FAITH

What a person believes is the foundation for both life and ministry. Please read carefully and prayerfully this statement of faith of World Medical Mission.

1. We believe the Bible to be the inspired, the only infallible, authoritative Word of God. I Thessalonians 2:13; 2 Timothy 3:15-17.
2. We believe that there is one God, eternally existent in three persons: Father, Son, and Holy Spirit. Matthew 28:19; John 10:30; Ephesians 4:4-6.
3. We believe in the deity of our Lord Jesus Christ, in His virgin birth, in His sinless life, in His miracles, in His vicarious and atoning death through His shed blood, in His bodily resurrection, in His ascension to the right hand of the Father, and in His personal return in power and glory. Matthew 1:23; John 1:1-4 and 1:29; Acts 1:11 and 2:22-24; Romans 8:34; I Corinthians 15:3-4; 2 Corinthians 5:21; Philippians 2:5-11; Hebrews 1:1-4 and 4:15.
4. We believe that all men everywhere are lost and face the judgment of God, that Jesus Christ is the only way of salvation, and that for the salvation of lost and sinful man, repentance of sin and faith in Jesus Christ results in regeneration by the Holy Spirit. Luke 24:46-47; John 14:6; Acts 4:12; Romans 3:23; 2 Corinthians 5:10-11; Ephesians 1:7 and 2:8-9; Titus 3:4-7.
5. We believe in the present ministry of the Holy Spirit, whose indwelling enables the Christian to live a godly life. John 3:5-8; Acts 1:8 and 4:31; Romans 8:9; I Corinthians 2:14; Galatians 5:16-18; Ephesians 6:12; Colossians 2:6-10.
6. We believe in the resurrection of both the saved and the lost; the saved unto the resurrection of eternal life and the lost unto the resurrection of damnation and eternal punishment. I Corinthians 15:51-57; Revelation 20:11-15.

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7. We believe in the spiritual unity of believers in our Lord Jesus Christ and that all true believers are members of His body, the Church. I Corinthians 12:12, 27; Ephesians 1:22-23.
 8. We believe that the ministry of evangelism and discipleship is a responsibility of all followers of Jesus Christ. Matthew 28:18-20; Acts 1:8; Romans 10:9-15; I Peter 3:15.
 9. We believe God's plan for human sexuality is to be expressed only within the context of marriage, that God created man and woman as unique biological persons made to complete each other. God instituted monogamous marriage between male and female as the foundation of the family and the basic structure of human society. For this reason, we believe that marriage is exclusively the union of one genetic male and one genetic female. Genesis 2:24; Matthew 19:5-6; Mark 10:6-9; Romans 1:26-27; I Corinthians 6:9.
 10. We believe that we must dedicate ourselves to prayer, to the service of our Lord, to His authority over our lives, and to the ministry of evangelism. Matthew 9:35-38; 22:37-39, and 28:18-20; Acts 1:8; Romans 10:9-15 and 12:20-21; Galatians 6:10; Colossians 2:6-10; I Peter 3:15.
 11. We believe that human life is sacred from conception to its natural end; and that we must have concern for the physical and spiritual needs of our fellowmen. Psalm 139:13; Isaiah 49:1; Jeremiah 1:5; Matthew 22:37-39; Romans 12:20-21; Galatians 6:10.

STATEMENT OF CHRISTIAN CONDUCT

Samaritan's Purse / World Medical Mission are Christian organizations wholly devoted to spreading the message of the Gospel of the Lord Jesus Christ throughout the world. It is important that all our volunteers consistently demonstrate Christian conduct, whether while working at the mission hospital or during travel time which was arranged by your Logistics Coordinator at World Medical Mission.

Some examples of Christian Conduct:

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1. Exhibit conduct consistent with the highest degree of moral, ethical, legal and biblical integrity
 2. Maintain high standards of individual behavior at all times and avoid the appearance of improper or questionable conduct. Male and female volunteers should honor each other by incorporating respect and purity which is stated and established by God in His Word. It is our policy that we not allow unmarried members of the opposite sex to travel alone as a couple or be perceived as an unmarried couple at Mission Hospitals. This is unacceptable by the Mission Hospitals and by Samaritan's Purse/ World Medical Mission.
 3. The use of illegal drugs and alcohol is prohibited. Samaritan's Purse / World Medical Mission are responsible for the reputation of the organization and must be conscious of public perception. We ask that you refrain from any use of illegal drugs and/or alcohol from the time you leave the U.S. until returning to the U.S.
 4. Be aware of cultural differences and abide by cultural standards when in their country.
 5. Go to the assigned area with a humble heart. Always ask "what can I do to help you" rather than "what do you have planned for me".

STATEMENT OF PRACTICE

The commitment of World Medical Mission is *to serve and not to be served*. Serving on assignment means your agreement to the following:

1. I am willing to set aside personal preferences, habits and schedule in the interest of others to fulfill the ministry of the mission hospital to which I am assigned and to seek to win patients to Jesus Christ.
2. I understand there are variations in practice and understanding of Scripture in some areas of doctrine, Christian living and witness. In serving with World Medical Mission, I will abide by the standards of the hospital to which assigned in all areas including dress, entertainment, activities, etc. This includes a willing agreement to abstain from the use of alcohol, drugs, and tobacco and

-
- being sensitive to cultural, regional, church and hospitals expectations and standards.
3. I understand that hospitals served by World Medical Mission are Protestant evangelical mission hospitals in basic harmony with the World Medical Mission Statement of Faith. However, due to varied viewpoints on some Christian doctrine (examples: eschatology, spiritual gifts, security of the believer, etc.) in serving, I agree to refrain from promoting, discussing or practicing in public any doctrine, teaching or gift that is contrary to the beliefs, standards and practices of the mission hospital in which I may serve.
 4. In cooperation with the hospital, I will seek to provide excellence in medical care and to present Jesus Christ as Lord and Saviour.

(Available at: <https://www.samaritanspurse.org/medical/volunteer-application/>
accessed December 10th 2016)

Appendix 2, Letter from a government medical worker, 1969

The Health Assistant
Chitongor, Choma
15. 4. 1969

ILLNESS STILL GROWING WORSE

Dear Sir,

I am hereby informing you that even after several medical check up and treatment, instead of getting better my health is being threatened due to the same trouble, i.e. a severe pain in my left side of the chest. I have had several attention and treatment by Doctors, but still nothing could be diagnosed and so no improvement to my health.

And so at present my weight is worsening and at times my limbs especially at the left side of my body can hardly be lifted due to the severe pain centred on the heart side and because of this dredd control which I am facing daily, I could hardly hesitate to be brought at Pemba township to contact the African doctor who is at present attending me.

It may seem very peculiar for me as a health Assistant to abandon medical attention, but however if I am to survive definitely this is the only way. Those who live with me closely and see how much I am being troubled by this condition can speak in support of me.

It is a pity that how much I explain it is not heard probably because some of the problems of African nature with to illness are not known, but herewith no fear I am pointing out that, it is not a strange thing to say that some of the illness which Doctors at the hospital might fail can simply be cured by a simple African Doctor, if I may call them.

Despite the consideration in taking disciplinary action on me which as been already taken, I have no fear in telling you that I am at present at Pemba township being attended to by African Doctor who I hope with the wishes of almighty will be able to cure me.

And should these be improvements, I shall immediately go back to my station but at present because of this my life is still being threatened and so I can not tell out when I shall be going and if you wish to contact me you just contact the Medical Assistant at Pemba clinic, he knows where I am in Pemba township.

Yours obediently,

(Source: NAZ, 'Witchcraft and Native Doctors', SP3/25/9.)