

KUOMA RUPANDI
(The parts are dry)

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Deliane Jannette Burck

Ideas and practices concerning disability
and rehabilitation in a Shona ward

Research Report no. 36/1989



African Studies Centre Leiden/The Netherlands

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L- (689.1) 30/18512 Shona		
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LEIDEN 16-7-'90		

door

Deliane Jannette Burck

KUOMA RUPANDI

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CIP-gegevens Koninklijke Bibliotheek, Den Haag

Burck, Deliane Jannette

Kuoma Rupandi (The parts are dry): ideas and practices concerning disability and rehabilitation in a Shona ward / Deliane Jannette Burck - Leiden: African Studies Centre. - Research reports / African Studies Centre; 36) Ook verschenen als proefschrift Leiden. - Met lit. opg.
 ISBN 90-70110-72-5
 SISO 612.1 UDC 615.851.3:3-056.26(689.1)
 Trefw.: gehandicapten; Zimbabwe / gehandicapten ; revalidatie; Zimbabwe.

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Preface

'There is a tree rooted in African soil, nourished with the waters from the rivers of Africa. Come and sit under its shade and become, with us, the leaves of the same branch and the branch of the same tree.'

(R. Mangaliso Sobukwe)

From 1984 to 1987 I worked in Zimbabwe as a psychologist. On account of my work I came in touch with many disabled persons, most of them living in the rural areas. Some contacts developed beyond the sphere of work and led to the research which forms the basis of this study. Since my return from Zimbabwe and while I was writing this thesis, I have been working in The Netherlands in a nursing home for, mainly, elderly persons.

The experiences were so different and at the same time so much related that they almost tore my head apart. It seemed as if there were two conflicting series of slides in my head, one series diffusing the other. I remember Maxwel, who would crawl all the way to the river to fetch water for his tomato plants; I hear people complain about the fact that the elevators are not wide enough to allow for the easy entrance of electric wheelchairs. When in my present work I witness how people await death each in his or her own way, I recall the dignified way in which *amai* Mapfure among her ten children and fifty-seven grandchildren started her career as an ancestor spirit.

Health is a fascinating issue. It forms the beginning of Maslov's staircase and makes for many a pitfall on the way. This study reflects my understanding of a small piece of the puzzle that health continues to be. Although I am solely responsible for everything mentioned in the text, many people contributed to the process of understanding, while others rendered valuable practical assistance.

First of all I would like to thank all the disabled persons, their relatives, community members and the traditional healers, for sharing with me their ideas and experiences on the subject. They allowed me to ask silly questions, to make wrong assumptions and to come back a week later to start all over again.

Equally grateful am I to Mr. B. T. Gudyanga and Mr. Jambaya, who accompanied me on many of my visits to disabled persons and traditional healers. To say

they were interpreters or assistants would be inadequate. They often knew the next 'question' in an interview before I did.

Professor G. Chavunduka was kind enough to supervise the research in Zimbabwe and to comment on the research material. His advice and comments as well as his assistance in solving practical problems were highly appreciated.

Professor Schoffeleers greatly encouraged me to carry the project through without too much delay after my return from Zimbabwe. His elaborate comments on the first, second and final draft helped me to see many inconsistencies in my thinking about the subject.

Professor H. Tieleman provided very valuable comments to the second and third draft and helped me to shape up the conclusions.

Dr. S. van der Geest read all the drafts and gave very elaborate comments and advice both on the content and on the form of the text. In addition he helped me to clarify some of the theoretical issues underlying the research.

Towards the finalization of the study, I had the opportunity to discuss with Mr. T. Shoko, who is preparing a thesis on a related subject. He made very valuable comments and suggestions concerning the final draft and corrected some of the Shona terminology.

The content of this thesis was one thing, getting it into print was something else altogether. I am most grateful to the African Studies Centre in Leiden for their willingness to take care of the reproduction of the book and to include it in their Research Reports series.

And then there are my relatives and friends who apparently had this antenna through which they could feel, even when I was in Zimbabwe, when my spirits were low and when I needed cheering up, encouraging letters, spare parts for the car, a decent meal and assistance with operating the personal computer. The secondary gains of thesis writing are indeed enormous, I wonder how life will be without them.

Finally I would like to thank Mr. R. Fihla, who, despite his initial reservations concerning its subject, has been the most loyal supporter of this research throughout. If I managed to understand anything about health in Africa at all, it is because he made it possible for me to learn about and enjoy the shade of that wonderful tree rooted in African soil.

Chapter 1

Introduction to and description of the problem

1.1. Introduction

It is an acknowledged fact that about 10% of any given population is disabled.¹ This means that in Africa alone there are more than 50 million disabled persons. No less than 80% of the disabled population lives in isolated rural areas in the developing world (United Nations 1982:13).²

The range of medical, socio-psychological, educational and vocational measures designed to 'serve' disabled people is commonly termed 'rehabilitation'. During the 1960s and 1970s institutional rehabilitation services were developed in most countries in the Southern African region, often with financial and professional assistance from western donors. These services cater to only a small percentage of the disabled population, although they use up the larger part of the budgeted rehabilitation funds. Institutional rehabilitation is generally directed towards persons suffering from the more severe physical and mental disabilities. But the majority of the disabled population is left unserved, particularly disabled persons living in rural areas. In reaction a new approach to rehabilitation was developed, generally called community-based rehabilitation. Its intention is to serve disabled persons right in the community where they live, making use as much as possible of the knowledge, services, facilities and experience already available at the community level. The general expectation was that this new approach would be cheaper and easier to implement than the more traditional forms of rehabilitation, while at the same time disabled persons would be provided with better care, adjusted to their specific cultural and socio-economic needs.

For a successful implementation of the community-based or community-oriented rehabilitation approach not only a good understanding of the local medical situation is required, but also a full appreciation of the way disabled persons, their relatives and members of the community experience illness and misfortune in general and disability in particular. In this last respect many community-based rehabilitation programmes seem to fall short.

Recent criticism on community or primary health care to the effect that most community-oriented health services do not sufficiently take the ideas and practices of the community into consideration, but are, instead, based on scientific medical ideas that contradict the ideas held by the rural population, is equally applicable to community-based rehabilitation. It is felt that in this way the quality of the care delivered is seriously affected. This criticism seems to be even more serious now that it is becoming clear that community-rehabilitation is not necessarily cheaper and easier to implement than institutional rehabilitation programmes are. The assumption that better and more appropriate care can be delivered is the only argument left in favour of community-based rehabilitation. But to be convincing this argument needs further elaboration.

In the study presented here an attempt is made to show how, through anthropological knowledge, community-based rehabilitation can contribute to a qualitatively better care for disabled persons in the rural areas. By describing the way disabled persons, their relatives, members of the community and traditional healers perceive illness and misfortune in general and disability in particular, I hope to arrive at a picture of how community-based rehabilitation could contribute to their well-being. In the research the following aspects will be highlighted:

- ideas and terminology to describe illness and misfortune in general and disability in particular as well as the underlying explanatory model used by the rural disabled clients and their relatives (cf. Kleinman 1980, the popular component);
- physical and biological explanations as provided by the traditional healers and the treatment offered by traditional healers (*ibid.*, folk component);
- the role and position of disabled persons in the community.

The purpose of the research will be to provide a description of ideas, practices and differences within the framework of a local medical system. It is not my intention to present scientific and traditional medical ideas and practices as opposites of each other. Neither do I want to prove that traditional medical beliefs are equally valid or that scientific ideas do not always work.

The idea here is not to prove what is 'better', if this could be proven at all, but to try to understand why disabled persons and their relatives consider one type of explanation or treatment more effective than another, and to describe the consequences of these preferences for the implementation of a community-based programme. People's ideas about which medical explanations are valid and what kind of treatment 'will work' are usually not based on scientific investigations but on experience mediated by their culture and worldview. In this way

all of us, consciously or unconsciously, opt for certain explanatory models and treatment possibilities, closing the door on a whole range of others. A simple example might illustrate this statement.

One day, during the fieldwork, I fell from some rocks and sprained my ankle. People in the fieldwork area were quite concerned, but all agreed that they had expected something like this to happen: How could I expect to leave my husband and relatives behind for four years to come and work in Zimbabwe without them taking any action to persuade me to come back? They felt there were three possible solutions to my problem. First of all I could simply go home, secondly I could try to settle things with my relatives but this was considered difficult because of the distance involved, and thirdly I could use stronger medicine than the medicine that had affected me. I appreciated their concern, wore an elastic bandage for a few weeks and considered the matter closed. Only later did I realize how much sense there was in the diagnosis of the people in the fieldwork area and how 'irrelevant' it must sound to them if, in a comparable situation, they were told to wear elastic bandages or to see a physiotherapist.

Traditional ideas about disability are not merely a cultural peculiarity, interesting to be studied while they still exist, but in actual fact slowly giving way to 'better' and more scientific medical practices. It is my view that, although in the tradition of medical science a number of therapies can be offered for isolated physical and psychological conditions, more ultimate questions about the circumstances of illness and disability and perhaps even 'life' remain unanswered. The main aim of the research therefore is not to understand the medical system prevailing in the rural areas in order to facilitate and enhance its assimilation to medical-scientific ideas about rehabilitation, but to study the possibilities for a more holistic, integrated approach.

The medical system is a theoretical construct derived from the explanatory models brought forward by disabled persons, their relatives and other relevant informants and from a literature study of the cultural and medical practices as they exist and existed in the Southern African region in general and in 'Mashonaland' in particular.³

There are many different definitions of what a medical model is. For the purpose of this study the rather general definition of Kleinman (1973:57) is used: 'A medical system is an organized system of ideas and practices concerning illness, a system that is grounded in and derives its structure from a given cultural context.' The choice for this definition has numerous implications that will be discussed in detail in Chapter 5. Here it suffices to say that the localized medical system, as a part of the larger cultural/religious system, will be compared

to the scientific medical model with particular reference to community-based rehabilitation.

This study is descriptive in as far as I seek to provide a detailed account of the way disabled persons, their relatives and traditional healers explain and seek treatment for/treat their disabilities. It is explorative when I try to derive at guidelines concerning a provisional holistic and integrated approach towards community-based rehabilitation.

1.2. Outline of the research activities

The study was carried out in a period of about four years, in three phases. The first phase was orientational and encompassed two activities:

- initial contacts with disabled persons in the fieldwork area;
- preliminary study of relevant literature and checking out other available sources of information.

During almost the entire research period I worked for the International Labour Organization in the Southern African region as an associate expert in the field of vocational rehabilitation. In my daily work I had a lot of contacts with disabled persons and persons who were well informed about the subject. Oddly, during the first twelve months of my stay in Zimbabwe I hardly learned anything about the more traditional ideas concerning illness and disability prevailing in the rural areas. On the basis of a literature study I knew that such ideas existed, but in actual practice I hardly heard them mentioned. In view of my professional status, I was considered to be a representative of the scientific medical establishment and people had to get accustomed to the idea that I might be interested in other beliefs and practices as well. Gradually, after working hours and by directing myself to people I was not particularly involved with through my work, and by asking specific questions that had come up in the literature study, a flood of information became available.

Soon I felt the need to order this information in a more systematic way and at this time the supervision of Professor Dr. J. M. Schoffeleers, Professor in Religious Anthropology at the Institute of Cultural Anthropology and Sociology of Development at the Free University in Amsterdam was requested. Professor Dr. G. L. Chavunduka, Professor of Sociology and Dean of the Sociology Department at the University of Zimbabwe agreed to be in charge of the local supervision of the research activities in Zimbabwe.

In this more formal second phase of the research, three activities took place. First of all, interviews were conducted with thirty disabled informants in a

specific area in Zimbabwe. Their relatives and relevant others were interviewed as well. In addition twelve traditional healers were interviewed. Finally, some specific informants were consulted and relevant observations were recorded.

The major part of the fieldwork was carried out in one ward of Goromonzi district, Mashonaland-East Province. The initial intention was to follow up on a number of disabled persons through their relatives and community members to their traditional or modern healers.

In order to get insight in the social and economic position of disabled persons and to be able to understand the explanatory models they used, it was necessary to restrict the research to a limited geographical area.

Goromonzi district was selected for the first part of the second fieldwork phase for three reasons. First of all, the area is relatively close to Harare, 50-80 kilometres. As all research activities had to be carried out in the evenings and week-ends, easy accessibility of the fieldwork area was an absolute requirement. Also part of my daily work had been in Goromonzi district and therefore the area and the people were familiar. A last advantage was that rather detailed statistical information on the disabled population in the district was available. The preliminary results of a disability survey carried out by the Ministry of Labour, Manpower Planning and Social Welfare, in collaboration with ILO, were made public in a workshop on community-based rehabilitation, held in Harare in May, 1987. The selection of Goromonzi district for the fieldwork activities also had disadvantages because any relationship between the research activities and my daily work had to be avoided. Fortunately, what seemed to be difficult prior to the research hardly posed any problems once the research had started.

Altogether thirty case-studies of disabled persons living in the fieldwork area were prepared. These disabled persons were selected at random.⁴ Next to interviews with the disabled persons, interviews with their relatives and relevant others were conducted. A non-directive interview technique was used, with a check-list to be completed at the end of all sessions.

I approached traditional healers who lived up to some 70 kilometres from the fieldwork area where the disabled informants were interviewed. The healers were not selected at random, but were chosen on the basis of the following criteria:

- relevant specializations to be represented;
- 'equal' representation of healers from both sexes;
- 'equal' representation of healers working with different types of healing power, *shave*, *mudzimu*, acquired knowledge etc.;

- representation of healers with various reputations: 'first-aid-healers', part-time traditional medical practitioners and full-time healers.

During the third and last phase of the research, all research data were compiled and analysed. An additional literature study was carried out.

1.3. Practical problems faced during the fieldwork-period

The initial intention, to follow up on disabled clients through their relatives and community members to the scientific and traditional medical practitioners consulted, had to be changed. Apart from the fact that both the healers and the disabled persons were reluctant to cooperate to make a follow-up possible, it was not always possible to trace all these old contacts with traditional healers. Besides that, a follow-up would mean a violation of the confidentiality that exists between the medical practitioners and his/her clients.⁵ Even if informants would be prepared to confide in me I could not just go ahead and publish the information. When it turned out that equally useful information could be provided by traditional healers that were not clearly associated to any of the case-studies on disabled persons, the original approach was changed. This means that the information gathered did not always refer to specific cases and types of disability and often was of a rather general and sometimes even abstract character. This gave the research a wider scope, because it was no longer restricted to thirty cases. On the other hand the case-studies have lost in depth, because the information provided by the traditional healers could not be linked to individual cases.

There is no doubt that the position and the problems of disabled persons are, to a large extent, determined by the type of impairment or handicap that affects them. This aspect does not receive much emphasis in this research however. If the research were to focus on specific types of disability, it would have been necessary to spread it over a much larger area in order to obtain an acceptable number of case-studies. Also, the case-studies would probably have lost much of their essence, since on this scale detailed insight into the political, social and economic wheelings and dealings is hardly possible. In addition — this point will be elaborated further in subsequent chapters — concentrating on a particular type of disability would have put too much emphasis on the medical and physical aspects of disability. The classification of disabilities and disabled informants along medical terms introduces a certain bias. The purpose of this research should not be to impose a classification, but to find out what type of classification makes sense to disabled persons and their relatives in the fieldwork

area (assuming that classifying disabled persons as a special group makes at least some sense to them).

Particularly during the second phase of the research I had to rely on assistants. A number of interpreters assisted me to carry out the interviews with the disabled persons and a ZINATHA official and Zimbabwean friends assisted in contacts with traditional healers. Although towards the end of my stay in Zimbabwe I was able to follow a simple conversation in Shona, I was not able to conduct the interviews independently. This was a disadvantage; in the process of translation important information was often lost, particularly in the beginning of the research. Later, the assistants became more familiar with the aims of the interviews and were able, often without intervention of the researcher, to ask relevant additional questions or clarification on some points. At this stage working with assistants proved to be more of an advantage than a disadvantage. An additional set of valuable eyes and ears joined in the interviews and observations, complementing all the other useful information and advice that was provided. Also, the presence of an assistant to conduct the interviews made it easier for me to note down all information accurately and to point out gaps, contradictions and obscurities during the interview. In this way information could be gathered quite accurately and efficiently.

In the process of the research I often felt the need to check the information that disabled persons provided concerning their condition: did the scientific medical practitioner really say that nothing was wrong; did the *nganga* only indicate a natural cause, etc. To get confirmation in scientific medical terminology of a diagnosis brought forward by a traditional medical practitioner might seem a scientific and objective way to approach the subject of disability and rehabilitation, but in view of the objectives of the underlying research it was not. Only gradually and with the help of my assistants, I realized how much my thinking about and perceiving of social and medical care for disabled persons is or was linked to modern western models. The assistants commented on my fallacious efforts to translate symptoms and accounts into 'understandable' scientific medical terminology. This tendency of mine influenced the way the initial interviews were conducted, because it often placed more emphasis on the physical experience of the disabled individual than on the cultural and social aspects. The assistants rightfully pointed out that I asked questions on issues (descriptions of physical processes underlying the disability) about which the disabled informants did not have very much information to offer, while other fields (the social and cultural aspects of disability) were hardly touched. I felt that this critique was basically correct. The question remains, however, to what

extent in interviews of this nature the protocol of the researcher or that of the informants should prevail, the question of the etic and emic approach in research (Pike 1971:27). Taking into consideration the fact that my primary aim was to find out what the ideas and practices of disabled persons and healers were concerning disability, rather than to find out if these ideas and practices are right or wrong (if indeed this could be established), an emic approach seemed more appropriate.

In spite of all this a list with basic questions was compiled on the basis of the literature study. Interviews would take their natural, non-directive course, thus giving a good idea of what the informants considered to be the main themes to be discussed. At the end of the interviews the checklist with topics would be consulted and informants would be asked to provide information on the topics not yet covered. If the informants would not have any information available this would simply be recorded. In this way all relevant information could be gathered, without influencing the non-directive course of the interview.

English is not my native language and my command of Shona was very limited. These limitations are bound to be reflected in the text. I apologize for these mistakes and hope that the reader will take them in stride, considering that a more impeccable text in Dutch would not have been of much use to the majority of people involved in community-based rehabilitation in Africa. In chiShona many prefixes are used, among other things for the formation of plurals. Thus the plural for *mudzimu* (ancestor spirit) is *vadzimu*. In order to facilitate the recognizability of Shona words for non-Shona speakers, in the text the grammatical and spelling rules for Shona words were not always strictly adhered to.

In the report literal quotations from informants provided in English are reproduced with quotation marks. If informants spoke Shona, which was generally the case, the translation of the statement is also provided in quotation marks.

A final problem involved the presentation of the case-study material. During the course of my stay in the fieldwork area, I got to know about many of the informants' political and family problems. This knowledge was often very detailed and frequently involved rather serious accusations of one individual or family towards another. As an anthropologist one has to establish a relationship of trust, but sometimes I wished that the informants would not have confided in me so much. When compiling the case histories, the interests of the informants, who collaborated so willingly, had to be protected. The cases are presented in such a way that the persons involved cannot be immediately identified and similarities discovered with disabled persons or families in Zimbabwe are most

likely to be accidental. Names were changed and, despite its value for the research, incriminating information was deleted. Specifics about the exact area in which the fieldwork took place are not provided. This information is available however for anyone who would seriously want to check or follow up on the research data provided here.

1.4. Outline of the research report

This report consists of two parts. The first part gives a summary of the literature study and consists of four chapters. The first chapter (Chapter 2) provides an introduction to the fieldwork area, its administrative structure and organization, its religious structure and cultural setting and its historical background. Chapter 3 introduces relevant scientific medical definitions and theories concerning disability, rehabilitation and community-based rehabilitation. This is followed by a compilation of the statistical information available on the disabled population in Zimbabwe in general and of the fieldwork area in particular. The chapter also provides a summary of the development of rehabilitation in Zimbabwe. The traditional component of the medical system is discussed in Chapter 4, in which a description of the main components of the traditional belief system is given and in which the most relevant references in the anthropological literature to disability and the position of disabled persons in the society are listed.

Chapter 5 consists of a summary of the introductory chapters. The research questions formulated in the previous section are elaborated and specified on the basis of information derived from the literature study. The rather lengthy introduction and the summary are required in view of the aim of this study, namely to understand ideas and practices concerning disability and rehabilitation within their cultural context. Because the contextual information based on the literature study and the research data have a different status, it seemed better not to intertwine the two too much.

The fieldwork data are presented in chapters 6, 7 and 8, the popular, professional and folk view respectively (Kleinman 1980). A summary of the interviews with the disabled informants, their relatives and relevant others concerning the terminology and the explanations used for their disability forms the content of Chapter 6. Chapter 7 provides information on the diagnosis and treatment practices as reported by the traditional healers, while in Chapter 8 the (social) position of disabled informants interviewed for the survey is presented. The rationale for the presentation of the fieldwork data, along the lines presented by Kleinman, will be provided in Chapter 5. Finally, in Chapter 9, all data gathered

influence of the Monomotapa, Torwa and Rozvi 'empires' to a limited extent only and except for the physical damage caused by their raids, the Ndebele did not leave much of a mark behind either (Beach 1984:222ff). Instead of a strong hierarchical structure a delicate balance of power seems to have prevailed among the people, a balance of power between the quick and the dead and a balance of power between the providers of material and practical necessities (the chiefs and headmen) and the guardians of the cultural heritage (the ancestors and their spirit mediums).

It is commonly thought that, unlike French colonial rule, the British characteristically left the traditional hierarchical order and power structure in existence, and that it actually made use of it for the purpose of administering local government. In the area in which the fieldwork took place the opposite seems to have taken place. The delicate balance of power that existed and that made a strong hierarchical structure almost superfluous, was rudely disturbed by giving power to 'the living' and 'the providers of material needs'. Moreover, the power was finally transferred to 'strangers', who in the past had shown contempt for the land and its owners.

During the colonial era, as a result of the Land Apportionment Act (1931) and the Land Tenure Act (1969), the land in Rhodesia was divided into four categories: the European farm areas (naturally the more fertile soils with good rainfall); the African purchase areas (land set aside for purchase by Africans, provided they had enough money and a 'master-farmer certificate'; tribal reserves (land communally owned by Africans) and land set aside for game reserves and the like. Initially (under the Land Apportionment Act) only 30% of the total land area was set aside for the African population, while more than 50%, most of it in the more fertile regions, was set aside for European farmers, who did not constitute more than 3.5% of the population around that time. The Land Tenure Act provided a somewhat more realistic, though still disproportional division of the land (cf. Akers 1973:205; Kay 1970:51, 53). The tribal reserves were renamed 'Tribal Trust Lands' (TTLs) but they continued to serve as labour reserves for the European farms and the industrial sector in the towns.

During the colonial era the administration was delegated to a number of regions and provinces that, in turn, were divided in a number of districts. Each district used to have a native commissioner who administered the reserves c.q. TTLs in a district. The native commissioner was assisted in his task by a local chief (generally one for each 'reserve' or TTL) who was in charge of a number of headmen (generally one for each ward) and kraalheads (one for each kraal or village). The chief and his headmen were appointed by the

colonial government, with or without consultation of the people concerned. They received an allowance and were responsible for collecting taxes, allocating land and trying the majority of civil cases. Chiefs and headmen who were too independent, who kept information to themselves or who did not give in to the colonial powers were simply disposed of.⁵

When the liberation struggle started, it was an accepted fact that many chiefs and headmen had been co-opted into the colonial system.⁶ In such a situation often only the ancestors, through the spirit mediums, gave guidance to the liberation fighters. Aware that the traditional power structure might have been somewhat corrupted during the colonial period, and in order to facilitate the implementation of development programmes at the community level after independence (and during the fieldwork), the government established a new, elected structure at the village and ward level, alongside of the old one. In some areas with no tensions and factions fighting for power, the old and new structures overlap and the people involved cooperate nicely. In other areas, such as the one in which the fieldwork took place, tensions do occur.

At the community level the new structures consist of a village development committee (vidco) and a ward development committee (wadco). The councillor, who may be considered the chairman of the wadco, receives an allowance, allowances for the other members of the committees are under consideration.

The councillor and vidco-chairmen gradually have taken over important responsibilities from the traditional power-bearers, such as the allocation of land and trying simple civil cases. Also, the major development programmes (adult literacy, primary health care and income-generating projects) are channeled through this structure which has close ties with the ruling party. Culture, however, is still considered to be the domain of the chief, his headmen and the ancestor spirits, the latter through the spirit mediums. It seems that gradually a new, but equally delicate, balance of power is emerging in Zimbabwe, with the chiefs, headmen and ancestor spirits on the one side preserving culture and with the government structure looking into development in general and securing everyday needs in particular. The councillor and the headman in the fieldwork area are related, the headman being a classificatory uncle of the councillor. This relationship held the promise of a good cooperation or, as one of the vidco chairmen put it: 'We chose a nephew of the uncle, so that the nephew could learn from the uncle; you can learn from an uncle much more than from a father because there is no fear.'

Initially the headman and the councillor cooperated nicely. The councillor would always introduce visitors to the headman before he started discussions

about development programmes and the headman seemed to be quite happy to leave these discussions to the 'angry young men' of his area as long as the newly established schools and cooperatives would be named after him. However, not all new ideas were equally welcomed by the guardians of cultural heritage in the fieldwork area. At the same time, the angry young men felt it was about time they received due credit for their accomplishments. During the fieldwork period, when this conflict rose to a climax, it could be observed that government personnel visiting the area did not always stop at the headman's place anymore for a talk about the rains and the family, while the headman started to put his foot down on the adherence to certain cultural norms, supported by the local spirit medium, who threatened with a drought. It is within this context that the incident (cf. section 2.5 and Chapter 7), that eventually led to the suspension of the headman, took place. The councillor allegedly reported the incident to the chief of the area, thereby betraying his own relatives.

2.3.2. *The structure of the health care system*

The term 'health care system' will be defined in detail in chapter 5. Here it suffices to say that the health care system consists of two components, a traditional⁷ component based on the healing practices of traditional healers and a component based on scientific and often western medical practices.

The traditional component can be understood fully only within the larger context of the Shona religious system and worldview, to be discussed in Chapter 4. Traditional healing in Zimbabwe takes place within well-defined margins. On the one hand there is the Anti Witchcraft Act, a remnant of the colonial era, primarily designed to prevent witchcraft accusations.⁸ On the other hand there is the Zimbabwe National Traditional Healers Association, ZINATHA. This association, established just prior to independence in 1980, unites traditional healers in Zimbabwe, who previously belonged to numerous different organizations.

ZINATHA functions as a forum for traditional healers and also as a supervisory body. Complaints against a fellow traditional healer are investigated by a special committee which has the right to apply sanctions. It is forbidden to carry out traditional medical practices in Zimbabwe without being a member of ZINATHA, as it is forbidden to carry out scientific medical practices without being a member of a medical professional association.

The scientific component of the health care system has a pyramid structure with a limited number of specialists and specializing departments in general hospitals at a national level in major towns such as Harare and Bulawayo. At

the provincial level at least one well-equipped general hospital does exist, while in each district at least one rural hospital is operational. The latter hospitals are owned either by the government or by missionary organizations and come under the authority of a general practitioner, assisted by a number of medical assistants and nurses. It sometimes proves difficult to find sufficient medical staff for the more remote rural hospitals. The rural clinics, with one or two beds for maternity and other emergency cases, are run by medical assistants, nurses, and lower nursing staff and they serve as a first-aid and referral post. In addition, preventive and other outreach programmes are carried out with the rural clinic as a basis. Assisting a head nurse, medical assistants and nurses, village health care workers belong to the medical staff operating at village level as well. Since 1986 a gradual process has taken place in Zimbabwe, whereby the staff of both the Ministry of Health and the Ministry of Community Development and Women's Affairs, operating at the village level, is being merged into one cadre, carrying out a variety of activities ranging from adult literacy and income generating projects to family planning and immunization campaigns. A merger of the cadres was the only possible way to secure the presence of at least one community development worker in each of the villages, without overstraining the budget. It may be practical to channel the development of the various projects at the community level through one person, but one might ask if not too much responsibility is transferred to one individual in the community.

The actual health care situation in the fieldwork areas is as follows: Urgent medical cases from the ward have to be referred to the district hospital. This is a small clinic established by the Roman Catholic mission in the 1920–1930s. Later also a tuberculosis clinic and an orphanage were established by the same mission. The involvement of the Roman Catholic brothers and sisters in the hospital ceased around 1970 when government drastically changed its policy on financial support to missionary clinics (cf. Chapter 3). The clinic is now government-owned and is run by a medical practitioner and a number of nurses and medical assistants. The hospital also has a medical rehabilitation unit.

The problem of the district hospital, as far as the inhabitants of the fieldwork area are concerned, is that it is farther away from the main medical services in Harare than the ward itself. Urgent cases tend to go straight to town, although this is very expensive. Medical aid is free for people who cannot afford to pay, and for medication and other services only a nominal fee is asked. In cases where referrals have not been made according to the proper channels, the client pays him/herself. The referral system seems to be the weakest link in the scientific health care system in the ward.

2.3.3. *The religious structure and organization*

As far as the religious structure is concerned, a distinction should be made between traditional (cf. note 7) religious influences and modern, mainly Christian religious influences. The outlines of the traditional religious structure will be discussed in detail in Chapter 4. In this chapter I will briefly discuss the Christian influences as they can be observed in the fieldwork area.

It goes beyond the scope of this chapter to describe in detail the historical background and development of the various Christian denominations in Zimbabwe. Excellent studies on this subject have already been prepared by Murphree (1969) and Daneel (1971). Here a short introduction to the denominations represented in the fieldwork area will suffice.

Three Christian denominations seem to be particularly prevalent in the fieldwork area: the Roman Catholic Church, the Apostolic Church of John Masowe (also called the Apostolic Sabbath Church of Johane Masowe) and the Salvation Army.

The Roman Catholic Church belongs to the missionary churches that have their organizational base, at least partly, outside Africa. The Apostolic Church is one of the so-called African independent churches. These churches developed around charismatic African personalities who had been in touch with Christianity as migrant workers or as students or workers at missionary institutions. A rather 'independent', African, interpretation of Christianity was offered by these leaders, less influenced by the traditional theological theories and dogmas that controlled the development of Christianity in the western world. This soon brought them in conflict with the established churches (cf. Daneel 1971:285ff). The Salvation Army seems to take an in-between position. They do not rely on a parent organization or church as much as the traditional missionary churches, but they are not organized around the charismatic leadership of one person either.

None of these churches are physically present in the fieldwork area. There is a Roman Catholic Mission and school at about thirty kilometres distance. In addition there is a small Roman Catholic Church in the ward, but it has not been used for years, due to shortage of priests. The Salvation Army has a school and a church in an adjacent ward, while the basis of the Apostolic Church is again in another nearby ward. Members of the latter church prefer to congregate in the open air.

The Jesuits established the first mission posts in the district towards the end of the last century. The influence of the mission in the area has changed over time, as did government support for missionary societies. Around the 1930s they

received financial support from the government for the development of schools and hospitals (cf. Gelfand 1976:127). In the period before independence the church came under pressure from the government, among other things for their alleged support to the liberation struggle and much of the financial support for medical and educational activities was withdrawn quite suddenly.

In an interview on the problems of disabled persons, one of the priests working in the area mentioned that in times of severe illness or hardship members of his congregation sometimes seek help from the independent churches who, in such cases, 'can give something we cannot give.' The church members often revert to Catholicism again once they are cured, because the rules to which independent church members have to adhere are in some respects much stricter than those of the Roman Catholic Church. According to the priest, it would be incorrect to say that the Roman Catholic Church is not involved in ritual healing (i.e. faith healing) activities. Apart from the medical services offered through mission hospitals, just like the other churches discussed here, the Roman Catholic Church refers to faith in God as the basis of all healing processes. Special prayers may be held for people who are ill or in difficulties. However, according to this informant, the Roman Catholic Church does not go as far as the other two denominations in curing church members from the influence of evil spirits. The existence of these spirits is not recognized and belief in them is considered a fallacy from which people have to be protected through prayer.

What the ritual healing, as practiced by the two other denominations, actually consists of is not clear. Neither informants nor the literature on this subject give clear answers in this respect. Daneel (1971:348) states that 'faith healing' has become one of the major attractions of the independent churches. 'It is at this point, however, that syncretistic tendencies are most apparent, for although *nganga* practices are explicitly rejected and with it all forms of ancestor worship, the prophetic healer's activities include remarkable parallels with those of the *nganga*.'

It is my feeling that belonging to a church is not accidental. Active church membership is a conscious choice people make. Although I do not have any statistical figures available to support this view, it seemed to me that often the more educated persons and those who have been more exposed to aspects of western culture were affiliated with Christian churches. The church may also attract members who have somehow become isolated from their families and communities and so a disabled persons may well be attracted to the church.

Various forms of ritual healing were observed during the research and some of the informants reported to have consulted a 'faith healer' at a particular

moment of time in the treatment process. For most informants faith healing was only one out of many treatment episodes. For some informants the impact of faith healing was more substantial. The number of informants in the survey with a substantial faith healing experience was not sufficient to draw any conclusions and a more in-depth study is required to cover this subject satisfactorily.

2.4. The cultural setting

The people in the fieldwork area speak Zezeru, which is one of the many dialects of the Shona language group.⁹ Some authors have made it a point to prove that the different Shona dialect groups each have a somewhat different cultural heritage. This may be true for other dialect groups and for other Zezeru speakers, but it does not seem very relevant to insist on this for the people in the fieldwork area. They hardly ever speak of themselves as Zezeru speakers, let alone that they see themselves as Zezeru. If they relate to their origins they will give the name of the 'clan' (*mutopo*) and perhaps the house to which they belong. They may give their praise name (*chidawo*) and, if there is a relationship of trust, they may indicate what their totem is.

Basically, the people in the fieldwork area are virilocal and they follow a patrilineal line of descent. There are indications that the Shona speakers in general were exogamous, i.e. marriages with people of the same totem were forbidden, but it seems that nowadays this rule is not always strictly adhered to (Bourdillon 1976:37; Murphree 1969:19, 27).¹⁰

Cultural values and practices are changing rapidly in present-day Zimbabwe, and after independence a thorough revision of traditional norms and policies took place. It will be clear that policy changes do not always imply that the actual behaviour will change to the same degree and at the same pace. One of the main areas in which I observed policy change to have had an undisputable impact, is the position of women both in the family and in the world of work.

In a similar way changes have occurred in the life-cycle of the average Zimbabwean living in the rural areas. In the fieldwork area the majority of children is born in clinics or with the assistance of nurses trained by scientific medicine. The influence of the traditional midwife and traditional birth practices are slowly fading. From all the birth-related ceremonies only the name-giving ceremony and the practice of giving a present to the mother of the wife (formerly a cow had to be given) are still in existence, though not practiced by everyone. The schools have taken over the role of the aunts, uncles and initiation schools as far as social education is concerned. Although the existence of initiation

schools in the more remote parts of the country is occasionally reported in the local press, this practice no longer exists in the fieldwork area. Matrilineal aunts and patrilineal uncles still do play a role in the social education, but primarily when problems arise. Younger generations living in the fieldwork area generally did/do not undergo any initiation or other ritual to mark the transition from childhood to adulthood. This transition nowadays seems to take place in a rather gradual way. Most youngsters in the area seem to become sexually active around the age of sixteen or seventeen, although, strictly speaking, sexual relationships before marriage are forbidden (cf. Garbett 1960:14; Murphree 1969:29). Having a sexual relationship is the first step towards adulthood; having a child and getting married usually leads to full recognition as an adult. It should be noted that only those individuals who have children and who established families can become active and respected ancestors (*vadzimu*) after their death (cf. Murphree 1969:33).

Although relatives often assist in the selection of a suitable marriage partner, I never heard of pre-arranged marriages in the fieldwork area, in the sense that partners were forced to marry. Marriage can take place according to European civil law or according to traditional law. Most marriages in the ward are instituted according to traditional law.

It is not my intention to give a detailed account of the rules governing traditional marriage; these rules are currently being reviewed and adjusted by the government. In general, however, with respect to marriage, the traditional law system seems to differ in three respects from the European law system. Traditional marriages involve the payment of *lobola*, i.e. brideprice, while the wife is obliged to bring some things from her home as a dowry. According to informants in the fieldwork area the average brideprice will be more or less than 1000,- Dfl., depending on how well educated the woman is. A brideprice is usually paid in instalments, i.e. a downpayment and instalments upon the birth of the children. A downpayment will not be accepted by the family of the bride if there is no assurance that the remaining money will also be paid. The greater the doubt in this respect, for instance in the case of disabled men, the larger the requested downpayment will be. A second major difference is that in traditional marriages the widow does not automatically inherit the property or become the children's guardian. These regulations are presently being reconsidered by the government however and some of them have already been changed. In the case of divorce the *lobola* may be returned to the husband and his relatives. In that case the children can remain with the wife. Depending on the circumstances the husband has to pay maintenance to his wife for the children. If the *lobola* is

not repaid, the children will go to the family of the father around the age of six or seven. If the *lobola* is repaid the children may remain with the mother. A third point of difference is that under traditional law it is not forbidden for a man to have more than one wife, provided the first wife agrees with a second marriage, although this often is a matter of interpretation. In the fieldwork area polygamy is a rare practice however. It is mainly members of the Apostolic Church who have more than one wife. As far as I know, the (first) wives in the fieldwork area who were confronted with a second wife opted for a divorce, i.e. return to the homestead of their parents.

Of all stages of the life cycle, the 'last' one, old age, has been least touched by 'modern times'. When they have reached the 'pensionable' age, many people prefer to return to their home village and to their land, even if they have been working in town almost all their lives. Also, many people who die in town are buried in their home village.

A traditional burial ceremony in the fieldwork area consists of at least three phases: the physical burial, accommodation of the dead spirit after six or twelve months and regular appeasement of the spirit thereafter. When someone has died, a delegation of relatives will visit a traditional healer to find out the cause of death. If, according to the traditional healer, a person did not die a natural death, preparations for revenge through a *ngozi* are made (see Chapter 4).

If for one reason or another the relatives or the members of the community at large are not happy to see the deceased person return in the community as an ancestor, ways and means to prevent such a return may be discussed during the meeting with the healer. Such discussions also take place concerning the return of spirits of disabled persons. The most crucial part of a burial procedure is the second ceremony, the *bona/kurova guva* ritual, in which the spirit of the deceased is called home to take its place among the ancestors (until that time the spirit has been wandering around freely.¹¹ Once the spirit has been called home, it is given its rightful place in the realm of local ancestor spirits. Death in a way is not an end-point but more a 'rite de passage' and, if the spirit is not left to wander around in the bush, a promotion.

2.5. The history of the land and its people

The history of the people in the fieldwork area forms part of the larger history of the Shona people in particular and the 'Bantu' groups in general.

The ancestors of the Shona arrived in the area that is now called Zimbabwe in the beginning of the 11th century, probably from the Congo basin. They

merged with the early-iron-age hunters already present in the area (Beach 1984: 19ff). Three major 'empires' or cultures developed in Zimbabwe since then: the Great Zimbabwe culture from around 1075–1440, the Mwene Mutapa empire around 1400–1700 and the Rozvi Changamire/Torwa empire from around 1550 until the arrival of the Nguni warriors as a result of the last *mfecane*.¹² In the beginning of the eighteenth century the fieldwork area with its inhabitants must have been under the influence of the Rozvi-Changamire empire, but it is not clear what exactly this influence was.¹³ The influence of the Rozvi receded in the nineteenth century and it may be assumed that from that time onwards the fieldwork area was under the control of the present inhabitants, although there are indications that, for some time, they paid tribute to other chiefs in the area (cf. Beach 1984:274; Seed 1936/7:12ff), until the tax-collecting authority was finally transferred by the native administration to a group of newcomers.

As mentioned above, the communal lands of which the fieldwork area forms a part come under the traditional leadership of a chief, who is assisted by four headmen, one for each of the four wards. The people in the fieldwork area have their own headman. The people of the family of the chief and the people in the ward in which the fieldwork took place have different origins and they both claim the ownership of the land and the chieftainship. The fieldwork area is inhabited mainly by people related to the headman, while some people who are related to the chief live in the ward as well.

The chief is an old man and he is not very popular, particularly not among the people in the fieldwork area. In the course of the research, a short article appeared in the national newspaper concerning the suspension of the headman of the fieldwork area by the chief. It was stated in the article that the chief suspended two of his headmen on the allegation of violating the traditional law. The headman of the fieldwork area was accused by the chief of trying incest cases,¹⁴ which according to the chief's interpretation of traditional law was not a headman's responsibility. The headman had also authorized a local spirit medium to try such cases and, allegedly, the two had pocketed the fines. According to informants of the chief, a total of twenty-five cattle paid in fines had been taken by the headman, rather than surrendered to the chief. Finally the headman was accused of trying to declare himself chief in his home area. As a result of the article and subsequent developments, frictions and factions came to the surface that I had not been previously aware of but which were highly relevant. It proved necessary to research the area's history further. The history of the chief's people and of the ward population required a study in its own right. Here only those aspects that are of importance for the research are recounted.¹⁵

The people who hold the chieftainship originate from the area in the vicinity of a town called Masvingo, in central Zimbabwe. Due to Matabele raids around the middle of the last century these people left their area of origin and gradually moved north until they reached an area north of present-day Harare, where some of their relatives still live today. The movement of (part of) this group to their present habitat must have occurred around 1840–1850 and was supported or perhaps even initiated by the colonial administration. The people and their chiefs had been heavily involved in the 1896/7 uprisings (cf. Vambe 1972) and the colonial administration saw it as its primary task to calm things down in the vulnerable area so close to Salisbury.¹⁶ To this end two strategies were adopted: First of all they allocated more land to European settlers in the area around Harare. As a result land shortages arose among the 'native' peoples living there and they were consequently moved (urged to move) to different reserves.¹⁷ The succession disputes that arose out of these migrations both within the group of migrants and between the newcomers and the people already living in the areas to which they moved, were considerable. In the second place the succession disputes allowed the colonial administration to appoint and co-opt certain chiefs or potential chiefs into their administration.¹⁸ This tactic of divide-and-rule as well as the tactic to co-opt local leaders was applied with much success against the people who hold the chieftainship in the fieldwork area.

Articles in NADA (the Southern Rhodesian Native Affairs Department Annual) reveal that, in the past, when smaller groups of people belonging to the clan of the chief had found their way to the area, they had shown a certain contempt for the land, its people and their ancestors. They took cattle that had been sacrificed to important spirit mediums in the area. When allocated some land by chiefs then officiating, they did not show much compassion for the original inhabitants of the area (cf. Chidziwa 1964:28).¹⁹

Seed gives the following additional information on the people of the chief:

Today many of these people are living on land that is not their own and so they are *vasokeri* (strangers). The chief himself... is not the master of the soil (*muridzi wevu*); he may not eat the flesh of the pangolin (*haka*) found in that reserve, but he must send it to Musana. (Seed 1936/7:12)²⁰

The people in the fieldwork area who are not related to the chief form part of a less prominent group in the district. They originate from the east and claim to be related to important groups there. As not much information could be found about the particular groups that moved west, I had to rely on oral history mainly. The following account was given verbally by the spirit medium,

or rather, the most important ancestor spirit, respectively the *svikiro* and the *mhondoro* recognized by the people in the fieldwork area:

Our praise name [Mutyawasara] dates from the Matabele raids. The brother of Nyamunga, called Zurgena, mobilized the people to go and fight against the Matabele, but Nyamunga advised against it. Henceforth the cowards who stayed behind and did not join in the fighting were called 'Mutyawasara' people [cowards who stay behind]. They were the followers of Nyamunga. The origin of these people is as follows: they come from an island called Guruuswa.²¹ This is an island in the sea of Mozambique. The first man lived on this island. He was one day vomited by a mermaid. From this one man five persons came, four men and one woman,²² and from this group altogether fifteen children were born. Then fighting took place and two of the adult men were killed. The two adults remaining were Kaguvi and Nehande. They decided to take the children and to depart from the island, leaving the killer behind. Kaguvi flew over the sea while Nehande used her stick to beat the waves away. They passed through the land that is now called Mozambique. When they were there, there was a drought and the people started hacking the alleged witches that had caused this drought to death. Then there was a man amongst them who felt sympathy for the witches and Nehande gave him *muti* [medicine] to cleanse witches. This man was Nyamunga and this is how his family started to clean witches [cf. Chidziwa 1964:32; Paeden 1973:74]. They were given the praise name Chipfuamiti, meaning 'those who feel sympathy for the rejected'. In addition Nehande gave Nyamunga the power to make rain. From Mozambique the group moved to what is now Mutasa communal lands east north-east of Harare. There they left some people behind while others continued to Chihota and Mutoko.²³ In Mutoko the leader left behind was called Chakusika and his son was Muranganwa. Finally they moved to their present habitat. The boundaries of the original land owned by our people by far exceeded the present chieftainship.

As far as the people of the chief are concerned, the medium confuted that they come from the south and are officially Shangaans:

They arrived in the country under the Zulu leader Dingaan and moved north as far as chief Gunduwa's area, around the present Epworth/Mabvuku.²⁴ Gunduwa was involved in a war and asked his guests to help him. When they finally gained victory Gunduwa gave his guests a piece of land as thanks. In that time Tingindi was their chief. Then they moved on to their present area and came under the chieftainship of Nyamunga, and some of them married women from them. Then came a period when, after the death of Nyamunga, three subsequent successors to the chieftainship died. During this period a certain Bernard who was related to them and who was employed as a clerk at the district office in Goromonzi took over the chief's responsibilities. He finally claimed the chieftainship on behalf of his father, a successor in the chief's dynasty, and got it due to his closeness to the native commissioner. The chief's people stole the bow and arrow that symbolize the power of the people [in the fieldwork

area in general and of Nyamunga in particular]. Then the power of the people was broken.²⁵

Until the bow and arrow are found back they will not be chiefs in the area again; however, the present chief is not entitled to the chieftainship either. They are not allowed 'to eat the pangolin' [cf. note 25] and they are not buried in the area either. When asked why the three subsequent successors died and why Nyamunga's power was broken, the medium only answers: 'because they had done something wrong.'²⁶

People in the ward feel strongly that, although they have been on the losing side for the larger part of this century, they may well be successful in claiming the chieftainship after the death of the present chief. It should be noted, however, that victory will not be obtained without sacrifice. They feel that the number of deaths, illnesses and disabilities that affect the direct relatives of the headman is excessively high. 'That is our evil spirit revenging', said one of the community leaders, a relative of the headman. 'We would never have lost the chieftainship if we had treated this spirit properly and we will never get it back if we do not appease it.' This information was confirmed by other community leaders, who added that the headman, in view of his own misbehaviour and that of his relatives, will never be chief: 'He will fight for it but in the end Nyamunga will appoint someone else, some of us already know the name.' The headman in turn feels threatened by all the misfortune. He also agrees that this bad luck is not just accidental, it is brought about by people who strive for his power. He is convinced that with the support of the ancestors he will withstand all these ordeals. The dispute for power between the people of the chief and the people of the headman, as well as disputes for power within the family of the headman, affected a number of the informants and disabled persons interviewed for this research. Insight in the power structure and the different tensions that existed often threw a new light on case histories and sometimes provided the missing part of the puzzle.

Chapter 3

Introduction to the scientific component of the medical system in the fieldwork area with particular reference to disability and rehabilitation

3.1. Definitions and theories concerning disability and rehabilitation

The definitions concerning disability and rehabilitation presented here, are not part of a particular health care or medical system. They were adopted by the UN system and have been generalized to suit conditions in virtually all nations of the world. It should be noted that, although room is left for cultural variation and interpretation, the definitions and theories are derived from the scientific medical model. This model in turn derives its structure to a large extent from the western, scientific social and cultural context.

This study is written in English, which certainly has consequences for its content. In English the terms disability and rehabilitation are most commonly used to describe the phenomena under consideration. In Dutch the terms *handicap* and *revalidatie* are most often used, while in Shona the term *kuremara* denotes disability. The terms mentioned cannot be considered exact meaning equivalents. The preference for and the absence of certain terminology in the field of rehabilitation certainly tells us something about the way the phenomenon is perceived in different cultures.

The concept of disability has developed over time¹ and the definitions presented here are therefore no more than (high level) agreements on interpretation and operationalizations, agreements that do not necessarily have to be reflected in or accepted by the local health care system. Although in daily practice the perception and interpretation of and reaction to disability may differ, a common framework of terminologies has been adopted at an international level. Within this framework, the term 'impairment' is defined as: 'any loss of psychological, physiological or anatomical function or structure' (WHO). A 'disability' is defined as a restriction or lack (resulting from an impairment) of ability to perform an activity within the range considered normal for a human

being (WHO). A 'handicap' finally is a disadvantage for an individual, resulting from an impairment or disability, that limits the role that is normal (depending on age, gender and social and cultural factors) for that individual (WHO).²

The range of services and activities aimed to reintroduce a disabled or otherwise deprived person into his customary environment, restored as near to 'normalcy' as possible, is commonly termed 'rehabilitation'. Rehabilitation of disabled persons (from now on called rehabilitation) encompasses a range of services: medical rehabilitation, social and psychological rehabilitation, special education and vocational rehabilitation. Within the framework of multidisciplinary rehabilitation, two major approaches have been developed: institutional rehabilitation and community rehabilitation. Institutional rehabilitation takes place in a rehabilitation centre, where a disabled person is either a resident or an out-patient. Some centres provide the whole range of rehabilitation services, others concentrate on one or two aspects only. The advantage of the institutional approach is that highly specialistic and intensive services can be offered, which, ideally, makes it possible for an individual to be rehabilitated in a relatively short time. The disadvantage of the approach is clearly that the disabled person is taken away from his community, which may have alienating effects. The institutional approach also implies that only the disabled individual is readjusted to fit into the former environment, as if the family and community members and the physical environment would not need some adjustment as well. This, and the fact that institutional services cater to only a limited number of the disabled population (according to rough estimates, in most countries in the South East African region, not more than 5–10% of the disabled population receives any institutional rehabilitation services,³ though using the larger part of the available rehabilitation budget, have given rise to the development of a new approach in the field of rehabilitation: community-based rehabilitation.⁴ This approach can be characterized as follows: the disabled person is served in the community where he/she lives; as much use as possible is made of knowledge, experience and facilities already available at the community level; in addition, the treatment is directed at the whole community, including the disabled persons and the family members.

The supposed advantage of this approach is that the majority of disabled persons can be served within the constraints of the available rehabilitation budget. Also, it is assumed that the approach gives more guarantees for the successful reintegration of the disabled person in the community, because family and community members are more involved in the implementation of the rehabilitation services. Although community-based rehabilitation is being heralded

as the solution for all contemporary rehabilitation problems, experience all over the world has shown that the approach is not as easy to implement as was originally assumed, while it has many disadvantages as well (cf. Burck 1987: 33ff). In the first place one might ask if it is justified to shift the responsibility for rehabilitation from highly educated specialists to relatively uneducated and untrained community members and workers. This point becomes the more relevant when one realizes why institutional services were developed to begin with: going back into recent medical history one has to conclude that, in developed and developing countries alike, institutional services were established because government and/or charitable persons felt that the family and community members did not properly take care of their ill and disabled persons. Whether this feeling was justified and whether the alternative offered by the colonial administration was really a good one is a debatable point. It is doubtful however if, at a time when almost everywhere in Africa the extended family system is slowly giving way to more nuclear forms of family life, an appeal towards the reinforcement of traditional forms of family and community life and the de-specialization of medical care will have much effect.

The development of community health and community-based rehabilitation programmes should be seen within the framework of a reorientation of the scientific medical system, both in the developed and developing world, towards community-based and first line (if not preventive) services. There are two main motives behind this reorientation. The first one is purely economic in nature; community rehabilitation services are generally considered to be cheaper.⁵ The second motive is of an ideological nature. It is believed that, if the people themselves are more involved in identifying their basic needs and problems, they are more likely to be motivated to work toward a solution.⁶ Although in speeches and papers on community rehabilitation the ideological motive tends to get more emphasis, I feel that, particularly at a policy making level, the economic motives are more decisive. 'To extend institutionally based rehabilitation to meet the needs of all the disabled in developing countries is unlikely to succeed. The number of specialists required is not available now or in the foreseeable future. Furthermore, the costs would be prohibitive.' (WHO 1982:3)⁷ The general practice is that community health and community-based rehabilitation have become the main type of health service for poor, rural patients, whose physical condition is not serious or interesting. The question is whether this should be the target group of community health services (i.e. is the target group always best served with community health and could non-target groups benefit from community health services as well?).

In most developing countries it has become clear that ceaseless development and soaring costs of medical care are bound to reach unacceptable heights in the very near future, i.e. if we would allow this development to continue in the same way. Although it is to our benefit that medical knowledge is developing more and more every day and that scientific health care becomes available to more and more people,⁸ we have reached a stage where even the western economies are no longer capable to foot the bill for all these innovations. It has become clear that expensive operations, like heart transplants, cannot be made available to everyone. At a more mondial level, perhaps another question is more to the point: Should we try to save some 2000 children from death by starvation or should we save the lives of two or three individuals by means of an equally expensive heart transplant?

In 1977 the WHO launched its 'Health for all in the year 2000' campaign.⁹ The policy underlying this campaign, which was further developed during the Alma Ata conference in 1978, implies a preference for primary health care for a majority, instead of highly specialized, institutional care for a few. The community-based rehabilitation approach fits in with this line of thought.¹⁰

From the above it may be concluded that community-based rehabilitation is primarily the result of scientific medical and economic thinking. The participation of the community (the ideological motive) is required to implement the approach. The people have to work as volunteers, to provide funds and material inputs and to keep the costs low. The aims of community-based rehabilitation are set by scientific medicine. The community is supposed to internalize these aims and not to question them. In this way community services are believed to combine the economic advantages of traditional medicine and the scientific advantages of modern medicine. The question remains whether people in the rural areas acknowledge and appreciate these advantages in a similar way and whether community-based rehabilitation is always better than institutional care. Research findings reveal that real participation of the community in primary health care and community rehabilitation is not taking place (cf. Muhondwa 1986; de Kadt 1982). In my research it is demonstrated that community care may be counterindicated for specific categories of patients.

On the basis of the definitions provided above, the distinction between a disease and a disability is not yet clear. A disease is generally considered to be temporary and curable, while a disability is considered to be not completely curable and its effect therefore lasting, possibly lifelong. Through rehabilitation often only restoration of functions is possible. In the rural practice however the rehabilitation worker is confronted with a group of clients suffering from chronic

illnesses such as asthma, rheuma and certain forms of epilepsy that very often could be or could have been cured, if proper medical care had been available or sought. When these conditions remain untreated for a prolonged period, the disease will have a disabling effect and we cannot but consider persons thus affected disabled. In the term disability the objective and subjective components as distinguished in the terms illness and disease¹¹ are united in one word or at least they are not distinguished. It is therefore not unthinkable that in the interviews with persons who were 'objectively' identified as disabled, persons are included who do not feel disabled and vice versa.

Although some sort of international agreement has been reached about the way terms like impairment, disability, handicap are to be defined, this does not mean that uniformity exists in the way disability is operationalized. It depends largely on the professional background of the rehabilitation worker as to who will be considered disabled or not. Identification exercises can be carried out on the basis of impairment, disability or handicap. As far as identification on the basis of handicap is concerned, the following differentiations can be made:

- physical impairment (including visceral, skeletal and disfiguring impairment);
- sensory impairment (including auricular, ocular and speech/language impairment);
- mental and psychological impairment (including mental illness, mental retardation and mental defects);
- other impairments.

Other, often more precise definitions exist (cf. Chamie 1985; UN 1986). The above operationalization format for impairments leaves some issues unresolved. Conditions like epilepsy cannot be easily classified.

Identification on the basis of disability (physical disabilities, social-psychological disabilities and other disabilities), identification on the basis of the causes of impairment (UN 1984:11; WHO 1976) and, in specific cases, identification and classification on the basis of percentage of functional loss (insurance, workmen's compensation), work capacity and level of mental functioning may be considered as well.

For the purposes of this research, disabled persons were most often identified and classified on the basis of their impairment. Instead of speaking about disabled persons, it might have been better therefore to speak of mentally or physically impaired persons, but this term was not commonly used by informants.

3.2. Statistical information concerning the disabled population in Zimbabwe in general and in Chinamora communal lands in particular

3.2.1. *The national disability survey of Zimbabwe, 1981*

In 1981 a national disability survey was carried out in Zimbabwe, under the authority of the Ministry of Labour, Manpower Planning and Social Services, with financial support of Unicef. For the purpose of the survey 'disability' was defined as 'physical or mental condition which makes it difficult or impossible for the person concerned to adequately fulfil his or her normal role in society. . . . It . . . does not include minor or temporary conditions that have ceased to be handicaps' (Report on the National Disability Survey of Zimbabwe 1981:8, 30). The survey was carried out on a sample survey basis in twenty-three preselected areas in Zimbabwe. In addition to gathering general personal data of the disabled population, the following types of disabilities/impairments were distinguished (see Table 1).

Table 1
Types and incidence of disabilities in Zimbabwe

Type of disability	Incidence	Column percentage
Visual disabilities	70 300	24 %
Lower limb disabilities	67 200	23 %
Upper limb disabilities	33 500	12 %
Mental disabilities	26 900	10 %
Hearing disabilities	22 600	9 %
Speech disabilities	20 300	8 %
Neurological disabilities	15 300	6 %
Spinal disorders	10 200	4 %
Respiratory disabilities	3 000	2 %
Heart/circulatory disabilities	2 700	1 %
Skin disorders	2 500	0.5%
Others	1 800	0.5%

Source: Report on the National Disability Survey of Zimbabwe Harare 1981:37.¹²

The figures imply that about 4% of the total population of Zimbabwe is disabled. The major causes of disabilities were identified as: disease (47.6%); accidents (32.0%); war (12.5%); abnormal pregnancies/birth (4.9%); malnutrition (1.6%); hereditary diseases (1.6%).

As regards the causes of disabilities as indicated by people in the rural areas the report states: 'Many people, especially in the rural areas, genuinely do not know what caused their disability. For example, in response to the open ended question "What caused your disability?" 17,000 replied that witchcraft was involved' (*ibid.*:31). A clearer example of the scientific bias towards traditional (i.e. popular) explanations and (folk) diagnoses can probably not be provided.

At the onset of the disability, 65% of the disabled persons interviewed for the national disability survey, chose for scientific medical treatment, 11% opted for traditional medical treatment only, while about 25% opted for a combination of treatments.¹³ The survey also revealed that of the disabled population of school-going age 52% never attended school, about 17% went to school for less than two years, 28% had been to school for up to seven years and only very few had progressed to or beyond secondary school. The survey data further indicate that about 50% of the disabled persons interviewed became unemployed after the onset of their disability, this percentage tends to be even higher for skilled workers and people employed in the formal sector. The figures show a slight tendency for disabilities to occur more among males than among females, especially in the younger age groups.

3.2.2. *Socio-economic data associated with paraplegia, a report on a study of paraplegics in Harare, Sr. V. Brand, Harare, 1984*

In Brand's study social case-history data were gathered on paraplegics staying in rehabilitation institutes in Harare. In addition attitudes towards the disability, as well as its effects on the family relationships (including prospects of care by the extended family) were investigated. Special attention was also paid to 'the impact of cultural and ethnic values and beliefs regarding the cause of illness/injury and the consequent effects of those beliefs on treatment' (Brand 1984:1).

As far as the attitudinal aspects are concerned, the following observations of the researcher seem to be particularly worth mentioning:

— 'Only a minority of the paraplegics . . . really understood the permanence of their disability and its consequences. 28% said they felt their disability was just temporary, 28% was uncertain and 45% thought it was permanent' (Brand 1984:11). Also, 'the responses given by a number of paraplegics indicated an unrealistically high level of expectation of recovery. 40% said they thought they would one day wake up and resume their normal duties' (*ibid.*:11). This view seemed to prevail particularly among persons that had recently become disabled.

- 45% of the paraplegic persons interviewed believed their disability/impairment had a natural cause, 36% attributed it to witchcraft and 11% expressed uncertainty as to the actual cause. The remaining individuals felt their disability was a punishment from the ancestor spirits. About 50% of all the paraplegic persons interviewed had consulted a traditional healer at one time or another, some even at several occasions.
- Variables that affected the attitude of disabled persons towards their disabilities most (as identified by the researcher) were:
 1. nature of the disability (traumatic/medically related);
 2. circumstances surrounding the accident/onset of the disability;
 3. accessibility of information about the diagnosis and prognosis.
- 'Although it would appear from the findings that kinship ties are strong and that most paraplegics place faith in their relatives and their desire to help them, the actual ability of the extended family to provide the necessary support system seems to be extremely limited' (*ibid.*: 14).

3.2.3. *Care of physically handicapped children in Rhodesia, K.G. Dengu, thesis School of Social work, Harare, 1977*

In this study three major ways of traditional treatment of disabled children are indicated: killing the child at birth; treatment by a *nganga* and hiding the child within the family circle; keeping the child in the family but allowing the child to do simple home chores. The researcher states that with the introduction of Christianity and western ideas this pattern has changed. Disabled children are no longer killed but are considered to be a gift from God. According to Dengu, the feeling of shame for a disabled child often persists and the disabled person remains hidden away.

As to the causes of the physical handicaps among children: thirty-three parents and three *nganga* indicated the following (in order of importance): witchcraft; misconduct of the parents; the influence of bad spirits; immaturity of the parents or old age of the parents. 'Misconduct of the parents' refers to the following three types of behaviour: breaking cultural taboos like killing a snake or staring at a disabled person; incest or extra-marital sexual relationships and not having had enough sexual intercourse during the first months of pregnancy. Dengu stresses the important role of the traditional healer in providing not only answers to the question 'how to cure', but also answers to the question 'why did it happen (to us)'. He expects that modern rehabilitation centres will gradually take over the care for disabled persons.

3.2.4. *Statistical data concerning the disabled population in Chinamora communal lands, paper on community rehabilitation in Goromonzi district, presented by D. Mudombi (community rehabilitation coordinator for the Ministry of Labour, Manpower Planning and Social Welfare) at the Jairos Jiri workshop on community-based rehabilitation, Harare, March, 1987*

The figures presented had a preliminary character. The percentages provided in the presentation were rounded off to whole figures. A door-to-door disability survey was carried out in Munyawiri ward by the two community rehabilitation coordinators of the Ministry of Labour, Manpower Planning and Social Services, Mr. B. Gudyanga and Mr. D. Mudombi, in collaboration with the International Labour Organisation. The total population of this ward, according to the 1982 population census, is 7892. The total number of disabled persons identified in the ward is 410, which is about 5.19% of the total population, as compared to a disability percentage of 4% in the National Disability Survey mentioned earlier.¹⁴ For the survey the ILO/WHO definition of disability served as a basis. Although it is generally accepted that disease and disability should be differentiated, the research data show that in actual fact a large number of (chronic) diseases were counted as disabilities. As mentioned, when sufficient medical care is not available or when clients are reluctant to seek proper medical care, such diseases may become chronic and may have a disabling effect.

Table 2
Type and incidence of disability in Munyawiri ward

Type of disability	Absolute number	Percentage of disabled population
Physical disabilities	121	30%
Sensory disabilities	64	16%
Mental disabilities	63	15%
Other disabilities	147	36%
Multiple disabilities	15	4%

In the survey, disabilities were differentiated as indicated in Table 2. In Munyawiri ward disabled persons seem to be somewhat underrepresented in the age groups 0-18 years. This may be due to the improved medical and preventive health care since independence. The figures indicate that the majority of the disabled population is of working age and that vocational rehabilitation should be a major concern. The number of male and female disabled persons in the

authority to carry out minor surgery if required. It took more than two centuries after the arrival of Jan van Riebeeck for western medicine to reach the land that is now called Zimbabwe.

In 1893 a mission post was opened at Mount Selinda in S.E. Zimbabwe by the American Congregational Church. Initially the mission post had a dispensary only, but in 1912 it developed into a full-fledged hospital. More hospitals were established in other parts of the country by missionaries from various denominations: Morgenstern Mission Hospital under the guidance of Dr. Helm in 1899; Chikore Mission Hospital in 1910; Kwenda Mission Hospital in 1913 (but closed again two years later); Mnene and Manama hospitals in Belingwe district by the Swedish missionaries in 1915, Nyadiri Mission Hospital in 1923 and Waddilove Mission Hospital in 1927.

The development of mission hospitals was further encouraged by the fact that the government started to allocate grants to missionary societies for the salaries of doctors and nurses, hospital maintenance, the upkeep of dispensaries, the procurement of drugs and for nurses' training.¹⁶ Around 1930 the government became more and more aware of the importance of good health care provisions for the 'native' population. It had proven to be difficult to safeguard the European population from epidemic diseases without controlling outbreaks of these diseases in the rural areas.¹⁷ Moreover, the government began to see the value of a healthy 'native' population in view of the labour market. In 1940 more than thirty rural clinics were in existence, run either by missionary societies or by the government itself. The 'concern' for the health of the 'native' labourer was also expressed in various labour protection acts and ordinances intended to insure employees against incapacitation during working hours. The 'Master and Servant Act' of 1901 represents the most rudimentary form of such an insurance scheme. The present Workmen's Compensation Act and compensation scheme evolved gradually. In 1912 the 'Natives Employed in Mines Ordinance' (Ordinance no. 6, 1912) was established, catering for 'native' mineworkers. In 1922 the 'Native Labourers Compensation Ordinance' (Ordinance no. 15, 1922) came into effect directed at all 'native labourers in permanent, formal employment' and the 'Workmen's Compensation Ordinance' (Ordinance no. 20, 1922) addressing itself to 'the European workman with a salary of £ 500,- and below'. Compensation would be granted if a more or less permanent disability had arisen. The amount of compensation to be paid by the employer to the 'native labourer' and the 'European workman' varied considerably, as is indicated in Table 5.¹⁸

Table 5
Labour compensation according to Ordinance no. 15, 1922

Compensation granted to the	'native labourer'	'European workman'
Permanent partial incapacity:	1-10 £	375 £
Permanent total incapacity:	10-25 £	750 £ or 3 yrs. wage
Death:	10 £	500 £ or 2 yrs. wage

The compensation ordinances were further amended and in 1940 insurance was made compulsory (Workmen's Compensation Act, no. 12, 1941). In this act 'native' labourers were 'promoted' to the status of workmen, but different compensation schemes for black, coloured and white workers remained. In 1960 the act was revised, under international political pressure, to eliminate any form of racial discrimination, i.e. all incapacitated workers were paid equal benefits in terms of percentages of their salaries (Workmen's Compensation Act, 1960, Chapter 269). In view of the enormous salary differences between white, coloured and black workers, these changes were merely of a cosmetic nature. Although various further amendments of the act took place in subsequent years, the basic principle remained unchanged. Since independence the differences in payments between the various groups are gradually being eliminated. The remaining shortcoming of the present act is that large groups of workers (seasonal workers, domestic workers, outworkers and casual workers) are not covered. Also, the act does not provide for workers in self-employment or informal employment. The government is looking into the possibilities of providing some form of insurance for these groups. However, the financial consequences involved are considerable, and decisions in this respect cannot be taken rashly.

Although compared to other countries in the region the medical health care system in Zimbabwe is very good, it is clear that during the colonial era a dual system developed, with well-equipped institutional health care centres under the authority of the central government and secondary or lower standard health care facilities under the authority of local government or missionary societies in the rural areas.¹⁹ By using the term 'secondary' I mean nothing derogatory about the work done by health care staff in the rural centres. Within the framework of government concern and policy in the past, however, these centres cannot but be called of lower standard, even the referral system points in this direction. As a result patients in the fieldwork area feel that for 'real' treatment they

have to go to town, while many young Zimbabwean medical practitioners feel that a 'real' practice is a practice in town, in an institutional medical health centre.

In attempting to give an account of the rehabilitative services available in Rhodesia, it is convenient to deal with the subject under two headings: 1. the facilities for Europeans; 2. the facilities for Africans. (*The Rhodesia Science News*, 1970, vol. 4, no. 8:1)

The remnants of what was 'convenient' in the colonial era can still be found in present-day Zimbabwe. In the colonial era, short-term rehabilitation for Europeans was carried out in hospitals and by private physiotherapists, while many were referred to rehabilitation services in the Republic of South Africa and the United Kingdom. Rehabilitation expenses for Europeans were generally covered by medical aid schemes, or by the workmen's compensation schemes if the injuries were sustained at work. The long-term rehabilitation of European disabled persons was often not covered by these schemes and this is where the voluntary organizations came in.

If, as was generally was the case, the rehabilitation of Africans was not covered by medical insurance or workmen's compensation it was considered a responsibility of the government. The government provided grants to voluntary institutions involved in rehabilitation of disabled Africans. Until almost the end of the colonial era, rehabilitation services remained segregated, i.e. different rehabilitation services existed for black and white disabled persons. No clear indications can be found in the literature regarding the position of 'coloured' and 'Asian' disabled persons.

The first 'medical rehabilitation centre' for leprosy patients was opened on the premises of the Morgenstern Mission. Chikarudza Leper Settlement was not an entirely successful venture however. Although the number of people in the country suffering from leprosy was quite high at the time, they did not turn up in large numbers at Chikarudzi.²⁰ In 1919 the Leprosy Repression Ordinance was adopted, which gave district surgeons and other qualified medical personnel the right to isolate and hospitalize patients, if necessary by force. If we look at the number of leprosy patients that were actually 'treated' in this way, as indicated in the annual reports of the various ANCs and NCs, it may be concluded that this measure did not yield the expected result. Also, it proved very difficult to resettle ex-patients in their home areas after they had been treated. As a result leprosy clinics turned into settlements. Chikaradzu Clinic was closed and moved to a more favourable location for this purpose and patients from other

clinics were gradually transferred. Around 1962, the Ngomahuru Isolation Hospital, built at this new site, became the major leprosy treatment centre in the country. Around the same time another leprosy centre, Mtemwa Leprosy Clinic, was transformed into a residential settlement for clients without a home to return to after treatment. If only the attitude towards leprosy as it existed among the African population had been understood better, some of the problems concerning the care for leprosy patients could have been prevented.

Since the early 1960s leprosy became more and more controlled medically and new cases seldom occurred. The rehabilitation of leprosy patients nowadays tends to concentrate on old cases mainly, although in the very remote areas of the Zambezi valley occasionally new cases do occur, and small leprosy settlements still exist. It is worth mentioning that, in a sociological analysis of the population of Ngomahuru Hospital carried out by Sr. M. Aquina (1969: 129), it is concluded that there is no significant difference between the stability of marriages involving one partner suffering from leprosy and marriages of the population in general.²¹

Small pox, venereal disease, tuberculosis and related diseases of the bronchial system, received about the same government attention as leprosy.

The care of mentally ill, mentally retarded and otherwise mentally affected persons forms a special chapter in the rehabilitation history of Zimbabwe. The Law Relating to Lunatics (no. 20, 1879) provided the first set of regulations concerning mentally affected persons. The act was amended in 1908 by the Lunacy Ordinance (Ordinance no. 3, 1908) which provided for the establishment and maintenance of asylums for 'lunatics' and it set rules under which people could be admitted to these asylums. Patients could be admitted for three reasons: as a matter of urgency with a special court order valid to a maximum of seven days; they could be admitted on their own free will, or, finally, because they had committed criminal offences. The latter, the so-called 'governor's pleasure'²² and 'criminal' lunatics (those who were held not accountable and accountable for their deeds respectively) formed the largest group. The 'governor's pleasure' lunatics were detained until such time that they were no longer considered lunatics, which often meant until the end of their lives. 'Criminal lunatics' were usually people who had become mentally affected while in prison. The Ingutsheni Asylum in Bulawayo was for long the major asylum in Rhodesia/Zimbabwe. In his B.A. dissertation on this asylum, K. Gumbo raises the question whether this institution should be considered as a prison or a rehabilitation centre. I agree with him that the rehabilitative services at Ingutsheni were minimal and that the differential treatment of black and white patients was

despicable. However, no matter how regrettable this may be, it seems that in Ingutsheni very much the same treatment mistakes were made as everywhere else in the world. By accepting mainly hopeless and long overdue cases and by not differentiating between mentally ill and retarded patients, rehabilitation was made very difficult, if not impossible.

The Mental Disorder Act no. 2 of 1936 brought only limited change in this situation. A classification of mentally disordered persons was provided, ranging from 'infirm' to 'moral imbecile', and some changes in the rules concerning the detention of criminal patients were made, making the administration of the whole system a bit more streamlined. In 1940 a separate hospital for people with nervous disorders was established in Bulawayo. This hospital served European patients and 'curable' patients from Ingutsheni. In the 1960s the Hopeland Trust Fund for the mentally defective (i.e. mentally retarded persons) was established as a private initiative, mainly by parents of such children. Schools, residential centres and workshops were established. Initially the services of the fund were directed towards white clients but later also facilities for black patients were offered, for instance in Harari/Mbare, one of the larger townships in the capital. At the end of the 1970s, the Hopeland Trust Fund and its various centres merged with other agencies and centres for the care of the mentally retarded child and adult into what is now Zimcare Trust. This organization now runs the residential centres and a home-based learning programme for mentally retarded children, on the basis of the community rehabilitation concept. After independence the government opened a number of half-way houses in the major towns, to facilitate the reintegration of ex-mental patients into society. In order to prepare the community and to follow up on released patients, psychiatric nurses have been placed in rural hospitals while cooperation with traditional healers is also sought.

The after-effects of segregation are still discernible in the care of physically disabled persons. The St. Giles Rehabilitation Centre, established in 1964 after the amalgamation of the Poliomyelitis Organization and the Cerebral Palsy Centre, is one of the best-equipped rehabilitation centres in the country. It offers a wide variety of therapies and has both a child and an adult unit. Their treatment of children with cerebral palsy and persons with severe physical disabilities is among the best in the region. In order to maintain this high level of care, financial contributions from the client or from an insurance or compensation scheme are necessary. Although St. Giles's constitution explicitly states that race or financial constraints are not an obstacle for admission in the centre, the fact remains that St. Giles was and actually still is a centre for predominantly

white patients. Most black patients simply cannot afford the services and if they are covered by an insurance or workmen's compensation scheme they tend to be referred to the Workmen's Compensation Rehabilitation Centre in Bulawayo, established in 1970, which currently offers services of a standard comparable to that of St. Giles. In the early 1960s black workmen's compensation cases were supposed to be treated in St. Giles, but according to an interview by one of St. Giles's staff members, no injured Africans were rehabilitated in St. Giles in the 1960-1979 period.²³

Just as St. Giles and the King George Memorial Centre were primarily intended for whites, the Jairos Jiri Centres for the Blind and Physically Handicapped and the Margaretha Hugo School for the Blind and later the Cheshire Home Foundation have been catering for black disabled persons mainly. The Emerald Hill School for the Deaf and the Morgenstern School for the Deaf provide services for deaf children together with the Naren Centre, the latter associated to the Jairos Jiri Centres.

When discussing rehabilitation services in Zimbabwe and former Rhodesia, the name of Jairos Jiri should be mentioned first and foremost. In the rural areas of Zimbabwe 'Jairos Jiri' is almost an euphemism for disability. Jairos Jiri, the son of a chief in the Masvingo area, established, initially without any official assistance, the first rehabilitation centres for physically disabled and blind Africans. Jairos Jiri never received any formal education in the field of rehabilitation but was rewarded a honorary degree at the University of Rhodesia for his work. He started with picking up disabled persons from the street, offering them food and shelter in his own house and transporting them to the hospital on the back of his bicycle. At present the organization has a network of branches and rehabilitation centres throughout the country. The Jairos Jiri Association served and still serves the majority of disabled Africans, answering probably more than any other centre in the country to their particular cultural needs and demands.

In conclusion it may be said that during the colonial era the development of scientific medicine was characterized by two related factors: racial segregation and a division of health care services into well-utilized and centralized services in the towns on the one hand and 'secondary' medical centres and community services in the rural areas on the other. After independence the Zimbabwean government did away with segregation and put a lot of emphasis on the upgrading of rural health care services. Although all formal barriers for the development of community health care services have been removed, a total change in attitude (of the people in the rural areas as well as of the medical

staff) is required before this colonial legacy will be overcome and before it will be realized that, within the context of scientific medicine, community services are not necessarily something 'secondary'. In addition I argued that, given this history of segregation, attempts of scientific medicine to introduce, or rather to impose, community health care, without consultation of the people concerned, are bound to fail.

Chapter 4

The traditional component of the medical system in the fieldwork area

4.1. Introduction

In this chapter an introduction is provided to those aspects of the cultural system that form the basis for the traditional component of the medical system in the fieldwork area (see Chapter 2, note 7). For the people in that area, illness and disability are religious rather than physiological phenomena. This is why the religious aspects of the traditional cultural and medical system require special attention.

This chapter is divided in five sections. After an introductory section, two sections deal with the two realms of the cosmological order: the realm of God and nature and realm of the human beings, i.e. culture. The fourth section is devoted to illness as a cultural or religious phenomenon and the influence of traditional and scientific healing practices. The last section presents a number of statements on illness and disability, gathered from literature on South East Africa.

The general literature available on traditional religious beliefs relevant to etiology and healing practices, is quite extensive but not very much detail is given on disabilities in particular. Also no material was available on this topic for the fieldwork area. For this reason, I sometimes looked over the borders of the fieldwork area, particularly in the last section.¹ Although most material used for this section is dated, it still provides a useful context for this study.

Much of the information provided here reflects not only a broad geographical area, but also a wide range of distinct theoretical and social orientations. There are the frequently very detailed notes of explorers and missionaries, the elaborate studies of anthropologists in government service and the studies that were carried out in the post-independence period (or during the colonial era but with an independent mind). These theoretical orientations imply a certain evaluation of this society and its culture, which in turn reflects on the description

of the healing process and other health-related subjects. Melland (1923:51) warns his readers for condemning the 'natives' for barbaric medical practices 'before we have educated the natives out of these ideas'; Colson (1960, I:205) and others try to use illness and the related witchcraft accusations primarily as an indicator of social tensions in the community. Chavunduka (1978), in turn, describes the traditional medical system of the Shona as a system in its own right.

4.2. The Gods and the natural elements

Almost all South-East African cultures considered in this introduction have a concept of a supreme God.² But it is not always clear to what extent this concept is 'traditional' in origin and to what extent it has been influenced by Christianity. Several authors have discussed the relationship between the Christian and traditional religion and its High God concept (Daneel 1971:244; Eiselen and Schapera 1966:262), while Hunter states: 'There is no proof that the Pondo, before contacts with the Europeans, believed in the existence of any supreme being or beings other than the *amathongo*' (ancestor spirits) (Hunter 1936:269). Regarding the Shona a similar statement could be made. Bucher reports that the recognition of *Mwari*³ as the Shona High God is of a relatively recent origin, i.e. from the time of the Rozvi-Changamire empire, 1650–1850. The cult 'is native to the Matopo Hills and the adjacent areas and it has been embraced by successive generations living there' (Bucher 1980:36).

Little is known about the influence of the *Mwari*-cult in and around the fieldwork area. The *Mwari*-cult developed in a centrally organized structure with headquarters in Matopo Hills, from which the ritual and political operations were monitored, and a number of shrines throughout the country, though notably in the Matopo and Karanga area. Schoffeleers and Mwanza (1978:297) compiled a list of twelve such centres, some active and some dormant. None of these centres are located in the vicinity of the fieldwork area nor in the areas from which the people in the fieldwork area originate. Beach mentions that, in addition to the cult sites, there are local representatives of the cult throughout the country:

These men were drawn from the local people in each area and were not sent out from the shrine, but otherwise they were very much like missionaries in that it was their interest to gain as many worshippers as possible and they were men of dual loyalties in that they were subject to both their local rulers and their shrine priests in the Matopos. (Beach 1984:249)

Neither from the literature nor from informants any clue was obtained as to the involvement of the people in the fieldwork area in these activities.⁴

Various words can be used to denote 'God' (see note 3). Common names are '*Mwari*' and '*Dzivaguru*' (the great pool). According to Daneel, '*Dzivaguru*' is *Mwari*'s most popular praise name, but Bourdillon points at the Korekore/Tarava origin of the name. For them *Dzivaguru* is 'the greatest of all human spirits and through whom are made all requests to the High God' (Bourdillon 1978:249). However the territorial cults, as described by Bourdillon for the Korekore, did not develop in the same way among the Zezeru. Fry (1975:19ff) argues that the Korekore, more than the Zezeru, were affected by a tradition of centralization due to the Mwene Mutapa influence. The idea of hierarchy and imperial organization consequently took a firm root in all spheres of life, including the secular sphere. According to Fry, Zezeru history, on the contrary, stresses the importance of charisma and individual initiative in both worldly and religious leaders (Fry 1975:64).

What Gelfand noted for Mutasa's people (related to the people in the fieldwork area, at least according to oral history) also applies to the people in the fieldwork area:

Usually when a person is in trouble he first calls on his family spirit (*mudzimu*), that of his late paternal grandfather, which is said to give Nyadenga the message. When he is alone ... and had to face a crisis he appeals both to his paternal grandfathers and Nyadenga. ... The people of Nyamaropa believe that Nyadenga makes good things ... and bad ones ... but each one considers the spirit of the grandfather the creator of his family. (Gelfand 1982:72)

From my own observations and informants in the fieldwork area, I conclude that for most people their God is a rather impersonal phenomenon and his actions are beyond the influence of human beings, despite Christian notions of God that might exist.⁵ When asked, most informants would indicate that God is 'too big' to be bothered by requests and prayers from individual human beings and contact with God might best be pursued through the ancestor spirits. Also they often did not have an anthropomorphic picture of God (cf. Bullock 1921:21).

Some disabled people and their relatives indicate that they consider their disability as a gift from God. Particularly the more serious disabilities such as leprosy (cf. Bourdillon 1982:235) are described in this way. Aschwanden (1987:15, 17) states that among the Karanga in south-eastern Zimbabwe 'natural diseases' are ascribed to God, while 'serious diseases or death are, as a rule, ascribed to people or spirits — promoters of evil.' Later, however, Aschwanden (1986:15)

Figure 2a

Causes of illness in relation to cosmic order

Natural cause	Cultural cause	Natural cause
'God'	humans/mediators spirits	'God'

Figure 2b

The human being, classifications

black shadow	human body	white shadow
	human being	
stranger	family member	chief/headman

Figure 2c

Spirits and their influence

spirits of outsiders	spirits of family members	spirits of chiefs/headmen
<i>shave, tkolotshe, chikwambo</i>	<i>mudzimu</i>	<i>mhondoro</i>
their influence is negative	influence positive/negative	what they say/ decide is good

Figure 2d

Spirits and their mediums

<i>shave, chikwambo etc.</i>	<i>mudzimu</i>	<i>mhondoro</i>
witch	<i>nganga</i>	<i>svikiro</i>

mentions that the term 'illness from God ... may, on the surface seem inapt in conjunction with the term natural. However, since these diseases are usually the result of the natural environment, there is no incompatibility.' Aschwanden further states that the term 'illness from God' was also used for three specific, very serious medical conditions (tuberculosis, leprosy and epilepsy): 'the most harmless and the worst diseases can thus have the same names' and are both ascribed to God (Aschwanden 1986:73). The research data show that many disabilities are also classified in this category (see also Figure 2a).

4.3. The realm of culture: human beings and their spirits

Whereas people feel they can hardly influence God and the aspects of life that fall under his authority, there is another component of the cosmological order where humans are in control. As indicated in Figure 2a, in the sphere of human influence and of 'cultural causation' (see section 4), three groups of actors may be distinguished: the spirits of dead human beings, the living human beings and lastly the mediators between the living and the dead.

4.3.1. Human beings

A human being (*munhu*) is believed to consist of three components, a body (*muwiri*), a soul-spirit (*mweya*) or white shadow (*bvuri*) and a black shadow (*mumvuri*). Perhaps it would be better to say that a human consists of two components, a soul or white spirit that enters the spiritual world after death and a black shadow, that disappears after death, and that these two components form the human body, in which the two shadows are difficult to separate (cf. Bourdillon 1976:254ff; Daneel 1971:97; Aschwanden 1987:233ff; Fry 1975: 19ff). The black shadow, according to people in the fieldwork area, is the shadow of a person as it can be seen in the sun. They believe that people possessed by an evil spirit that has taken over their bodies do not have a black shadow. Also stepping on a person's black shadow, at certain occasions, may be offensive or an indication of problems (cf. case 19). Different categories of human beings may be distinguished as well. On the one hand there are the strangers. On the other hand there are the common human 'insiders' and the headmen and chiefs. As far as the cosmological order is concerned, strangers generally do not remain or get a place in the cosmological order, while chiefs and headmen most certainly do. The position of the common human being in this respect is ambivalent, depending on his/her own accomplishments in life and that of the family.

During his/her lifetime a person already has a spirit, but it is considered to be latent as the grandfather's spirit is supposed to be operating in the individual (see also Figure 2b).

4.3.2. The spirits

The world of the spirits is a vast one and many groups and sub-groups can be differentiated. One way of discerning between the different groups is by asking whom they represent. In this way three different groups of spirits can be distinguished:

1. The spirits of family ancestors and important ancestors of the lineage, the *mhondoro* spirits.
2. The spirits of average human beings, attached to a family of their own, the *mudzimu* spirits.
3. Spirits of aliens that have or have not been accommodated in the family or community, the *shave* spirits and other spirits such as the *tikolotshe*, *chikwambo* and *nzuzu* spirits without a proper 'home'.

Spirits representing important ancestors of the lineage or clan (*mhondoro* spirits) are closely associated with the land on which they live(d). Whereas the chief, as the representative of the living, is called the owner of the land, the ancestor spirits are considered to be the 'guardians' of the land and the culture (cf. Schoffeleers 1978). Only the very important ancestor spirits have 'mhondoro quality' and among the important ancestors a strong hierarchy is maintained. The *mhondoro*, through spirit mediums, are mainly concerned with the well-being of the tribe at large and with issues beyond the sphere of the individual or the immediate family.

Concerning the spirits representing the immediate family ancestors (*mudzimu*), Bullock (1921:21) mentions: 'as far north as the BaRundi we have the word *umudzimu*', thereby indicating the universality of this concept in African cosmologies. The word *mudzimu*, in chiShona, belongs to the category of (class 3) nouns that denote living and growing. Whereas the *mhondoro* are important ancestors that have a prominent position in the family hierarchy, a *mudzimu* generally is an ancestor of one or two generations back. Their authority does not go beyond the realm of the immediate family to which they belong and they cooperate with and refer to the *mhondoro* and other senior spirits on more important matters.

The spirits representing strangers/aliens or other deviants⁶ are called *shave* spirits. In the literature this group of spirits is often said to include animals and alien objects (aeroplanes etc., cf. Bucher 1980:89), but in the fieldwork

area the alien spirits I heard about were all spirits of 'real' aliens. Other spirits such as *tikolotshe*, *chikwambo*, *nzuzu* are not mentioned often or discussed in the literature on the Shona, but among the people in the fieldwork area notions about these spirits do exist.

The general idea pertaining all these spirits, with the possible exception of those in the last category, is that they represent the spiritual essence of an individual, the part that remains in existence after the death of the individual and the decay of the bodily form. After death the spirit wanders around for some time. After that, as a result of one of the burial ceremonies described earlier, the spirit is called home to take its rightful place in the world of the ancestors, which forms an integrated part of society as a whole.⁷ There are mainly two categories of spirits that are not called home. First of all there are the spirits of those who die away from home. Their spirits wander around but are never called home because their relatives do not know where they are (cf. Mushoma 1934:31). Basically there are two possibilities in a case like this. It is possible that the spirit will find someone to possess in the area where he/she was killed. If the spirit is accepted, which is more likely to happen if the spirit bestows some positive powers or qualities on the medium (healing power, good huntmanship etc.), we can speak of a *shave* spirit. Not all spirits are easily accepted, however, and those spirits that do not manage to find a host are bound to wander around forever. In their frustration they might be inclined to revenge and evil deeds.

A second category of persons that will not automatically have its spirits called home consists of people whose relatives have decided to withhold this ritual, as some form of punishment or as a part of regular practice. According to literature on peoples in the Southern African region in general, this punishment may be inflicted upon detected witches and sorcerers, on people who committed suicide and on certain categories of disabled persons (cf. Aschwanden 1987:104; Junod H. A. 1927, I:371). People who died too young or who died without offspring, are not believed to leave a *mudzimu* either.⁸ Gelfand reports that a *mudzimu* can only come into existence if a person had children: 'if a man or a woman dies unmarried, no ceremony of *kuchenura* takes place and therefore there is no *mudzimu*' (Gelfand 1982:29; Bourdillon 1978:256; Bullock 1921:9). Holleman reports that when a *pfunda* (someone who is still a bachelor at old age) dies, a hoe handle is placed over his grave and he is told

here is your child, do not come to our children. . . . If in spite of such a precaution, such a spirit nevertheless tries to come to a brother's grandchild or a sister's child, he . . . with the help of a native doctor . . . is driven away by letting a scapegoat free in the forest. (Holleman 1953:28)

The 'scapegoat' may be a fowl or a black goat, while according to informants also a rat may be put in the grave to symbolize a wife or children. This practice was also in existence in the fieldwork area, although people were not keen to talk about it. If not properly handled, particularly this last category of 'spirits', i.e. the spirits that are expelled, may stir up problems. They may fall in the hands of witches and may become their messengers or they may seek revenge independently, like the spirit of 'the little uncle' (*chikwambo*). They may initially present themselves as 'good' spirits, in order to be accepted, but if neglected, they may strike back.⁹

This brings us to the difference in nature of the interference of the spirits (see also Figure 2c). Spirits may be benevolent or malevolent, they may be ambiguous or paradoxical, they provide for good and bad. From the descriptions in the literature (cf. Bucher 1980:31ff) it may be concluded that the spirit of a *mhondoro* is not likely to be rejected, while what a *mhondoro* says, through the medium, is commonly accepted. As far as *mudzimu* is concerned, the overall impact of possession by *mudzimu* is considered to be positive, although they may afflict their descendants when feeling maltreated or neglected. There is a basic unclarity both in the literature and in the accounts from informants about the capacity of a *mudzimu* to inflict evil. Bucher (1980:64) states that they are believed to 'afflict their descendants with a mild illness, but they may also cause other misfortune to befall the family's livestock and property.' However, informants in the fieldwork area state that the *mudzimu* is not expected to inflict evil in an active way. This information is confirmed by Aschwanden (1987:33). According to them, the ancestors are supposed to withdraw their protection as the ultimate indication of their displeasure. This of course opens the way for all sorts of evil to affect the relatives, but it is unlikely that the person will die as a direct consequence of actions of a *mudzimu*. In a similar way a *shave* spirit that has been accepted may become angry because it is neglected, it may withdraw positive qualities from the medium (healing powers) and may bring about mild forms of illness, but will never cause serious harm. The informants stress however that the ancestors do not inflict evil because they have no desire to do so rather than they are not capable.¹⁰ According to Daneel (1971:95) and Aquina (1973:53) there is a difference in the nature of the evil of the paternal and maternal spirits, whereby the evil of the maternal spirits is considered to be more severe.

Serious harm may be caused by ancestors and aliens in a different way, in the form of a *ngozi*. This spirit does not take possession of an individual but acts against him or his relatives (cf. Bourdillon 1976:240). Gelfand distinguishes four types of *ngozi* among the Zezeru:

1. the spirit of a murdered person; 2. the spirit of a person from whom something was borrowed during his life without being returned; 3. the spirit of a deceased spouse who returns to his or her surviving partner because of desertion or bad care during a period of critical illness and 4. the parental spirit that returns to its own children to punish them for maltreatment. (Gelfand 1959:153)

The fact that the evil does not necessarily affect a single individual, but may affect the whole family is important and implies two things. In the first place it means that illness and misfortune is not conceived primarily as an individual burden but as a burden of the family as a whole. In the second place this multiple responsibility allows for many interpretations of the evil, i.e. the illness may be caused by a *ngozi*, by a *mudzimu*, by a *shave*, by witchcraft or by other evil agents and it is likely that the family will try to settle for the least threatening diagnosis. The spirits without a home and other spirits such as *tikolotshe* are somewhat unpredictable. They may provide benefits, but they may also turn against you.

4.3.3. The spirit mediums

So far two major groups of actors in the human influence sphere of Shona cosmology were presented, the living human being/body and the spirits. A third group that mediates between the two consists of the spirit mediums.

Basically three types of mediums may be distinguished, the mediums for evil or unpredictable spirits (witches and other mediums possessed by spirits without a home), the mediums for spirits with a positive intention, mediums who generally use the powers bestowed on them to the benefit of their fellow human beings (although, being human, they do make mistakes at times), the *nganga*, and the mediums for the higher order spirits, the *svikiro* (see also Figure 2d).

In some cultures, as among the Azande (but also among the Shangaan and Cewa), different words exist for a witch and a sorcerer. In other languages only one word exists (Pondo, Venda, Zulu, Shona etc.), although in some, as in Shona and Pedi (Mönnig 1967:71), a differentiation is made within the context of the one word. The Shona differentiate between the night-witch, *muroyi wedzinza*, and the day-witch, *muroyi wamasikati* (cf. Gelfand 1967:3, 27ff and 1984:32).

As far as witchcraft and sorcery among the Shona and in the fieldwork area are concerned two remarks have to be made. In the first place it has to be noted that it is not always easy to obtain reliable information in this respect from informants. In the colonial era making witchcraft accusations was considered to be a criminal offence, this law is still valid today (see Chapter 2, note 8). In the second place, as was mentioned in Chapter 2, the people in the fieldwork area

have a particular reputation as regards to cleansing witches and their attitude towards witches and witchcraft therefore may be different from the general view on this subject (cf. Peaden 1973:71ff).

The differentiation between witchcraft and sorcery, often made in the literature (cf. Marwick 1975), bears only limited relevance to the situation in the fieldwork area. Although witchcraft may be predominantly the domain of women, 'sorcery' is not restricted to men only. Witchcraft seems to be an inherent and inherited quality but at the same time, in Shona culture, a witch is only temporarily affected by evil, just like the day-witch, namely when she is possessed by an evil spirit. In the strict sense of the word, therefore, the witch exists only temporarily. Similarly, sorcerers specializing in evil do not exist. There are bad people, or rather, there are human beings that have been bribed for money or otherwise misled to inflict evil. The difference between these two categories of evil-doers seems to be primarily that the 'witch' has to be cured, while the 'sorcerer' has to be punished.

ZINATHA, the association of traditional healers in Zimbabwe, unites both the *nganga* and the *svikiro* under the title 'traditional medical practitioner'. It might be asked if the *svikiro* can be seen as a healer, as his/her spirit, the *mhondoro*, is involved with issues beyond the level of the individual and immediate family. In order to see that the *svikiro* indeed is a healer, one has to appreciate the way in which the Shona generally conceive of illness. Illness, like disability, forms part of the larger category of misfortunes. There are minor, natural misfortunes that may affect any person without a particular reason. This type of misfortune may come and go all by itself, but there are also misfortunes and illnesses inflicted by outside forces that are directed towards a specific individual. The more important the forces involved, the more serious the condition is considered to be and the more difficult it will be to prevent or treat this kind of evil. The *nganga* can deal with the illnesses and disabilities that fall within his range of competence, i.e. the individual and immediate family.

When the problem is more complex, when important persons or spirits are involved or when taboos or cultural norms have been violated, the *svikiro* comes in. The *svikiro*, of course, through his spirit, sets out the general treatment policy and, in a way, acts as a '*chef de clinique*'.

The *svikiro* is the medium of a *mhondoro* or important ancestor spirit. According to Lan (1985) and Garbett (1963:208ff), among the Korekore the *mhondoro* spirit mediumship is always assigned to strangers, i.e. people who do not belong to the main house. It should be noted that the spirit medium, *svikiro*, for Nyamunga, the major ancestor spirit in the fieldwork area, was a woman from

outside the community. According to informants she was selected precisely for reason of impartiality and credibility.¹¹

Although much useful information is provided by various authors about the Shona spirit cosmology, there seems to be one aspect that has not been given much attention so far. It is beyond dispute that the categories and classifications of human beings, spirits and spirit mediums provided above, are valid. It is important, however, to see them not only as distinct entities but also to look at their coherence. The argument here is that the different groups show considerable overlap, and that spirit possession therefore allows for different interpretations as to the spirit concerned.

Aschwanden (1987:33) writes: 'the transition from living human being to ancestral spirit is gradual. It is not the abrupt change through death which turns a man suddenly into a *mudzimu*. An old man can be called *mudzimu* while he still lives.'

Although generally one *mhondoro* is recognized by a group, various other important spirits of elders of the lineage or clan exist and among them a strong hierarchy is maintained. In addition a certain hierarchy is recognized among the *mhondoro* of different groups living in an area. The people in the fieldwork area recognize Nyamunga as their *mhondoro*. At the same time the *mhondoro* of the chief's people holds a certain influence in the area (although this influence is not generally recognized by the people in the ward in which the fieldwork took place). It is accepted by both the people in the fieldwork area and the clan of the chief that Nehanda and Chaminuka are far more powerful *mhondoro*.

At a certain moment a *mudzimu* is promoted to the category of clan elders, instead of just becoming a simple family elder. This promotion from a living human being to a *mudzimu* and eventually to a *mhondoro* is, again, a gradual process (cf. Aschwanden 1987:33) influenced by the importance of the spirit involved but probably also by the efforts of the medium. In a similar way the demarcation between *mudzimu* and *shave* spirits leaves room for interpretation. The *shave* spirit nowadays seems to be inherited from parent or grandparent and does no longer represent the spirit of a real stranger. In terms of Gelfand (1959:121) they are 'naturalized'. In this context it is difficult to see *shave* spirits primarily as the result of 'enlargement of scale' (Bucher 1980:92; Colson 1969:80) as hardly any new *shave* spirits seem to have appeared on the scene in recent years, despite all the turbulence of the struggle for independence when so many people lost their lives far away from home and when so many alien influences appeared on the scene. It might be suggested that *shave* spirits should be seen more as an enlargement of power instead of merely an enlargement of scale.

By claiming the alien spirit one claims the new power it brings, thus competing with the already established power structures in the community. Nowadays the new powers have their own structures (see Chapter 2) and as society continues to develop from a '*Gemeinschaft*' into a '*Gesellschaft*', they no longer have to be accommodated within the old structure: hence the phenomenon of alien spirits is on the decline.

It is also important to see the different interpretations of spirit possession that are possible. It cannot objectively be determined whether a spirit is a *mhondoro*, a *mudzimu*, a *ngozi*, a *shave* or another type of spirit — this is a matter of diagnosing and interpreting the behaviour of the medium concerned. The ambiguity in this respect is likely to reflect on the interpretation and explanation of illness and disability as provided by disabled persons, their relatives and relevant others.

In the literature the process of becoming a healer has been described in great detail (cf. Chavunduka 1978:19ff; Gelfand et al. 1985:3ff) and we do not have to repeat that description here. Although the problem is mentioned in the literature (Chavunduka 1978; Bourdillon 1976:279), it seems to me on the basis of my findings in the fieldwork area, that not enough emphasis is given to the problems involved in being acknowledged as a medium. When a medium-to-be acknowledges to be possessed by a spirit, this claim does not necessarily have to be acknowledged by the community at large. In a way spirit mediumship is a career that only starts with the *kubuda* (coming out) ceremony but certainly does not end there.

In Zimbabwe the majority of *nganga* seem to be possessed either by a *mudzimu* or by a *shave* or by a combination of both (cf. Gelfand et al. 1985:14; Chavunduka 1978:20). As far as their healing power is concerned the *shave* and *mudzimu* spirit do not seem to be essentially different and in actual fact the difference between *shave* and *mudzimu* is rather vague because many *shave* spirits have become 'naturalized', as mentioned above. A *nganga* may be possessed by more than one spirit, but according to the sources this does not occur often. In addition it is possible that a *nganga* is not possessed at all, but acquired his/her knowledge through apprenticeship (according to Gelfand and Chavunduka (*ibid.*), this happens in about one-sixth of the cases). The importance of specialization is stressed by these authors. Some specialize in diagnosing the cause of the illness and misfortune (diviners) while others concentrate on healing (healers), or on diagnosing and healing (diviner-healers) some conditions only and referring cases to other healers. From records of ZINATHA it may be concluded that almost all registered healers have such specializations.

4.4. Illness as a cultural and religious phenomenon and the preference for either scientific or traditional healing

The most important thing to be realized about illness and disability as it is experienced in the rural areas of Zimbabwe, is that it is often not considered to be primarily a physical or biological phenomenon, but a condition related to culture and religion (cf. Chapter 6, note 2). Particularly in the case of illnesses with a cultural cause, the physical aspects are believed to be mere symptoms of underlying social and cultural problems. Treatment of such conditions is not considered possible without taking the social and cultural environment of the patient and his family into consideration and is not restricted to the patient's body.

Professor Dr. G. Chavunduka carried out an extensive study into the subject of traditional healing and the Shona patient (cf. Chavunduka 1978:35ff).¹² Evaluating his research among the Shona people in relation to other research in this field, Chavunduka concludes:

While working with the Shona patients it became clear to me that the definition of the illness given by the sick individual and his social group at any given time is the most important determinant of illness behaviour ... two broad categories of illness are recognized by many Shona people: normal and abnormal illnesses. What are considered normal illnesses are treated with herbs or are referred to scientific medical practitioners. Abnormal illnesses are generally referred to traditional healers. But the same illness may be regarded as normal at one stage and abnormal at another stage or vice versa. (Chavunduka 1968:40)

It is the 'vice versa' part of this statement that may be misleading, if we relate it to Aschwanden's statement about normal (natural) illnesses as illnesses coming from God. According to the description provided in the previous sections a certain hierarchical structure in the Shona cosmological order exists. As a consequence the involvement of spirits of a higher order will make the condition more serious. Eventually the situation may become so complex that it is beyond the control of the spirits/human beings and is put back in the hands of God. Although it is true that both the most and the least serious illnesses have a 'natural' (i.e. not human or spiritual) or normal cause, these two types of illnesses are probably of a different order. Whereas Chavunduka speaks of normal and abnormal illnesses in his book, he told me that he does not find these terms very satisfactory. The terms 'normal' and 'abnormal' tend to hold the connotations of a value judgement. In addition, as will be described in the Chapters 6, 7 and 8 in the case of disabilities, 'abnormal' causes are more normal

than 'normal' causes. In order to prevent misunderstandings in this respect, I prefer to speak of natural and cultural causes for disabilities. In Chapter 6 this issue will be dealt with in greater detail.

Chavunduka reports in his study on traditional healers and the Shona patient (1978), that out of a total of hundred observed and reported cases, 78% of the patients initially consulted a modern medical practitioner.¹³

- This treatment preference was not influenced by gender, wage or education of the patient in a significant way.
- There is a certain, though not significant, tendency for chronically ill persons to prefer a traditional healer to a modern medical practitioner. These findings confirm earlier findings of Leeson (1968) in Zambia.
- Of the 156 persons who initially consulted a modern medical practitioner, 53% later consulted a traditional healer for the same condition. Of the forty-four patients who initially consulted a traditional healer, 41% later consulted a modern medical practitioner.
- Out of 109 informants, 79% did not have a specific explanation for their illness and 'informants who do not have specific explanations for their illnesses were more likely than those who did to change therapy subsequently' (Chavunduka 1978:53).
- Not less than 67% of the informants were not informed by the modern medical practitioner they visited about the cause of their illness, 20% were told the cause but could not remember it, while only about 12% of the informants could accurately recall the diagnosis.

It should be mentioned here that the reported causes of health complaints in 250 cases as presented by Gelfand et al. (1985:53) include only one unspecified cause. The range of causes presented (witchcraft, *mudzimu*, *ngozi*, *mashave*, natural causes etc.) indicates that presenting all un-natural causes as witchcraft (see Chapter 3) might be too facile.

4.5. References in the literature about traditional attitudes to illness and misfortune in general and to disability in particular

The literature discussed in previous chapters mentions five main causes for illness and misfortune in general and disability in particular, next to the so-called natural causes:

- witchcraft or sorcery;
- neglect of or an offence against a family member or ancestor;
- being a witch or a sorcerer;

- refusal to accept possession by a certain spirit;
- breaking general or specific taboos, offence against the group as a whole.

Among the various authors there is consensus that the fate of disabled or deformed persons in the Southern African region is/was not favourable. In the old days their position was even worse. Krige (1981:75) states: 'Deformed children were never allowed to live in the olden days and when twins were born one of them was killed by having a lump of earth placed in its throat.' Earchy (1933:79) reports: 'An albino was killed in the olden days. At the present time no one seems to mind them. . . . An abnormality was formerly killed.'

Among the Ila infanticide occurred in the following cases: 1. a child that defecated while being born; 2. a child that was born with the feet first; 3. a child that was born with teeth; 4. a child from a mother who had not yet menstruated; 5. a child that was not able to walk at the age of three; 6. a child that cuts the upper teeth first. Smith and Dale (1920:419), who gathered this information, also state that senicide and the killing of incurables was not a practice among the Ila: 'to give a death stroke to a hopeless invalid is regarded wrong.' Melland (1923:50ff) reports that as far as infanticide is concerned similar practices occur among the Kaonde. He mentions that people found guilty of infanticide of the nature described by Smith and Dale are punished according to British law:

It is open to doubt if even these sentences can be justified before we have educated the natives out of these ideas. . . . On other grounds too it seems extraordinary illogical. We set the law in motion because of the death of one child in one *chisketa* case, I remember the child was not only a cripple but also an idiot and a mute. (*ibid.*: 51)

Melland also points out that child mortality at that time fluctuated around 60–75% and that therefore it did not make much sense to fuss about the occasional infanticide (one out of every thousand births) especially if the child was severely disabled and probably would not have survived anyway. Hunter (1964:146) and Kuper (1947:158) report a different attitude towards disabled people among the Pondo and Swazi respectively. Hunter (1964:270) states: 'All (Pondo) emphatically deny that there was ever any custom of killing infants born deformed. . . . Deformed births are attributed to uThixo' — deformed persons were considered a gift from God. Concerning the Swazi, Kuper (1947:177) reports:

Then there are the real idiots of all places and all times and among the Swazi they are tolerated and fed and sometimes teased by the children. Swazi never treat those unfortunates with cruelty or open contempt, not because of the sensitivity of their feelings but because of fear and anxiety of self-protection. It will come back on you and your children if you mock a cripple or an idiot.

Senicide used to be an accepted concept among the Swazi however. The Swazi, as the Lovedu and Ndebele, would not allow their king or queen to have any mental or physical defect. A disabled heir to the throne would be by-passed. If a disability were contracted during the reign, the king or queen would be expected to commit suicide (cf. Krige 1947:165ff). Beach (1980:97) reports that among the northern Shona the ruler was supposed to be physically perfect. He demonstrates, however, that this was more a theoretical requirement than a practicality (cf. Chapter 2, note 5). In view of this general belief that leaders should be impeccable, it is worthwhile to note that Mönnig (1967:45) reports that, among the Pedi, God is believed to have only one leg (see also Kuper 1952:42 and Roscoe and Schoffeleers 1985:137). As far as the Shona are concerned, Seed (1936/37:11) noted down the following statement from a 'native': 'his younger brother became blind and their father said he must be put out of the way. . . . The father buried the boy alive. That would be around 1903 or 1904.' This information is confirmed by Aschwanden (1987:104) as far as the Karanga are concerned:

Deformed children suffer the same fate as breech births' [i.e. they are killed]. . . . According to the Karanga God never creates such children and there must, therefore, exist some evil influence. As punishment for certain offences God can let a deformed birth happen. . . . Mention is here made of incest.

Disabilities have a certain cultural connotation, and certain conditions, like the appearance of the upper teeth prior to the lower teeth, which would not be considered a disability under the terms of the modern component of the health care system, were considered sufficiently frightful for some people in S. E. Africa to justify the killing of such a child (cf. Krige 1947:211; Bullock 1927:201; Smith and Dale 1920:149, 419; Melland 1923:50; Stefaniszyn 1964:68; Krige 1981:64; Nielsen n.d.:4; Aschwanden 1987:105;). Gelfand (1964:177) reports that the common belief was that a bite of such a child would be fatal, others believed that every time one of the milk teeth of such a child would fall out a relative or community member would die. Nielsen (n.d.:4) explains: 'such a child would be a danger to other children in the kraal . . . as also crocodiles acquire their upper teeth first.' this is confirmed by Edward (1929:21) who adds that 'among the Waziruru [Zezeru] a fine had to be paid to the chief of the tribe', by the relatives of such a child.

This practice of killing children who get upper teeth first should not be confused with the practice of knocking out the upper incisor teeth for esthetic purposes, as was the practice among the Ila and the Tonga. Smith and Dale

(1920:68ff) report this habit of knocking out a maximum of six upper teeth and molars: 'not a single case at that time showed un mutilated teeth' and Smith and Dale related this to the high occurrence of pneumonia scurvia among the Ila. The cutting of upper teeth before cutting the lower teeth is called *kutula* among the Ila (*njechete* or *durama* among the Shona). Such a child would be thrown in a river or in the bush. 'With a *kutula* child it is believed that every time one of the milk teeth comes out, a person has to die, similarly if a nail comes out someone dies' (Melland 1923:50). Among other groups similar beliefs are held. It is also believed that if a *kutula* child will bite someone, that person will die. The only thing a mother can do to save the life of a child that has its upper teeth appearing first, is to pull them out as soon as they appear, together with hair, loose nails etc. and to collect these things in a calabash. When the last upper tooth is collected, the whole lot is carried in the calabash on the mothers back like a baby. The mother will go to the river and will drop the calabash of her back into the water saying: 'Here is the *kutula*.' Next to reporting on pulling out the upper teeth, Bullock (1927:201) reports the existence of preventive medicine to be rubbed on the gums. In a similar way twins and albinos may be considered. Cook (n.d.:97), Stefaniszyn (1964:68), Krige (1981:75ff), Marwick (1966:145), Bullock (1927:258), Aschwanden (1987:86ff), Edward (1929:20) and others report the killing of twins, at least in the old days. Nielsen (n.d.:5) reports that among the Ndebele only one of the two children was starved, while among the Kalangas a custom existed to kill twins by sticking a needle through the fontanelle.¹⁴ Among other groups twins are not killed but special rituals have to be carried out to make the hot situation 'cool' (cf. Melland 1923:49; Turner 1967:13, 180; Evans-Pritchard 1937). The fact is that albinos (see below), twins, *kutula* children and other categories of disabled persons are considered 'hot', dangerous issues. Burying them at the side of the river will cool this hotness down and lessen the danger. Among other groups disabled persons were killed by putting wet earth in their throats or through other cooling practices (cf. Marwick 1966:145; Holleman 1953:38; concerning the burial of leprosy patients: Melland 1923:50ff; Bullock 1927:199; Stayt 1931:163).

Albinos were reportedly killed among the Valenge and the Ndembu (Earthy 1933:69; Turner 1975:273). On the other hand, Melland (1923:292) describes how among the Kaonde an albino is considered a blessing and people are happy to possess only a hair of an albino. Other practices with a disabling effect are reported by the authors. Hunter (1936) mentions the *ingqithi* practice as it exists among the Pondo. This practice requires that the upper joint of the little finger

of the eldest child is cut, with girls on the left hand and with boys on the right hand side. If this were not done, people believed, the child would get ill as a sign of displeasure on the part of the ancestors (cf. Krige 1947:264). Some informants claimed that a similar practice is still in existence among the Tonga of the Lake Kariba area, who, allegedly, cut off (parts of) their toes.

Infertility and being barren should also be considered a disability in S. E. Africa, if not everywhere else in the world as well. Not having offspring has a very negative effect on a person's position in society.

Various authors (Stefaniszyn 1964:127; Holleman 1953:38) report that people with disabilities, notably people who died from leprosy, are buried in a special way that prevents their integration into the realm of ancestor spirits. People without offspring are buried in a similar way. Colson (1958:16) states:

The matrilineal group has the right to decide whether or not a dead man's *mudzimu* shall come into existence, they may refuse to mourn for a man or [refuse to] inherit his *mudzimu* if he died as a leper. . . . This happened to E15. . . . He was a leper and when he died no one inherited his *mudzimu*.

Often also the ritual which is called 'beating the grave' or 'calling the spirit home' in Shona, is not performed for disabled persons and people who die without offspring. Their spirits are left wandering and if they would attempt to descend on someone, a *nganga* will be consulted to send the spirits away for good. In order to prevent their spirits from returning, either a clear sign is made/given on the body so that it will be recognized when it returns (thus it was a practice among certain groups to bury a leprosy patient with a piece of charcoal in his hand) or a substitute for a child or a wife/husband is buried together with the deceased (a rat, an axe handle etc.) in order to prevent that the deceased will return to ask for a wife/husband or child. According to Aschwanden (1986) there is a difference between the expulsion and subsequent killing and burying of a witch, for instance, and a person suffering from leprosy, to the extent that witches are buried together with other people while the leprosy patient is not buried, i.e. through death the witch is supposed to be cured, but the spirit of a leprosy patient will always remain a threat.

Other authors report that disability gave rise to social isolation. Melland (1923:65), as opposed to Aquina (1968), reports that disability is a reason for divorce and this seems to be true for other groups as well. It should be noted, however, that not all disabilities that are considered serious in our western context are considered equally serious in other cultures. A woman suffering from severe post-polio effects but who nevertheless managed to marry and have

children may be considered less disabled than a person who cut his upper teeth first or a woman who never had a child, though otherwise healthy.

A person may become disabled as a result of witchcraft or sorcery practices. LeVine (1963:222) states that 'The witch is a person with a tendency to kill or disable.' Witchcraft and sorcery techniques may be applied in many ways. Beatrice (1963:37) describes wizardry through poisoning, which may cause conditions like dysentery, leprosy, fits, madness, impotence and barrenness. Gray (1963:162) describes the bewitching of butter as it occurs among the WaMbungu in Lake Manyara area in Tanzania, giving rise to leprosy. Huttingford (1963:177) states: 'a result of a spell, direct or indirect, may be: 1) illness or deformity; 2) death; 3) madness; 4) swellings.'

Among the Shona a clear distinction is made between 'witchcraft of the day', in which use is made of bewitched substances and poison, and 'witchcraft of the night', carried out by magical/psychological ways. The later type of witchcraft does not occur as often as the first type, which is fortunate, because night-witchcraft is difficult to prevent or cure.

Disability may also be caused by negligence of or offence against the family or ancestor spirits: 'When I was still a boy, I was lamed on one side and got great pain below the breast. They poisoned me because they disputed my right to the cattle paid for my sister' (Kohler 1941:12). Daneel (1971:138) mentions: 'in the case of one of the well-known Rozvi families in Gutu, the mental derangement of two brothers and their sister, the lameness of another sister and the weak results in school of some of their children are all attributed to the mismanagement of the *ngozi* cattle.'

In Shona culture a procedure called *kutanda botso* exists, which has to be followed by relatives affected by the spirits of an ancestor who was treated badly during his/her life. It usually involves brewing of beer and slaughtering an animal. The procedure bears comparison to that of appeasing a *ngozi* but in the case of *ngozi* the offence committed is usually of a more serious nature while also the penance is heavier. In addition it should be mentioned that a *ngozi* is not necessarily a close relative as in the case of *kutanda botso*.

Witches and sorcerers are often depicted as being disabled. According to Beidelman (1963:74): 'the highly neurotic' are suspected of witchcraft. Buxton (1963:103) states that ugliness and deformity are signs of witchcraft. LeVine (1963:236) writes about a partially blind witch-smeller and a woman, Nyambo, who was believed to take lessons to become a sorcerer and who did not have children except a child with hydrocephalus. He also reports about a blind witch-smeller.

Marwick (1966:239) states, concerning the Swazi, that 'cripples may be suspected of witchcraft, but this is not universal. Men with clubfeet and hunchbacks are not thought to be witches unless they are also ill-tempered.' Stayt (1931:274) reports that 'various creatures, particularly those to whom the average person has a psychological reaction of dread or disgust, are special agents of the *vhaloi* (witches).'

According to the literature, disabled persons may also be individuals who refuse to accept spirits (either ancestor spirits or alien spirits) that want to possess them. Gray (1963:170) states: 'it is believed that a child who refuses his parents' witchcraft will become insane. . . . There is no other accepted cause of insanity at the age of adolescence.' LeVine (1963:228) concerning the Gusi in the Lake Victoria area (Kenya) gives the following report about a witch/mother: 'When her son refused to take instructions [to become a witch] he fell chronically ill with a pulmonary ailment and pains in his joints.' Marwick (1966:276) writes about a sorcerer among the Cewa: 'He had even converted his wife to sorcery. . . . It had not suited her body and she had developed leprosy.' Hunter (1964:321) records that among the Pondo 'refusal to admit *inkathaso* (spirit possession by an ancestor) is said . . . to result in death or deformity, others say it may end in deformity . . . some become hunchbacks.'

Finally, disability may be caused by breaking taboos. Krige (1981:65) reports, like many other authors, that a pregnant mother has to observe certain food taboos. If she eats the meat of certain animals, the child will look like that animal. Stefaniszyn (1964:66) reports that Ambo chiefs are not supposed to eat bush bucks or zebras as it will cause leprosy. A visual resemblance between the animals and the dermatological features of leprosy was given as reason for this taboo by the Ambo. Smith and Dale report that among the Ila a belief is held that a mother who sleeps too much during pregnancy, will give birth to a dull and sleepy child (1920, II:3). According to Krige (1947:273), among the Lovedu a belief is held that a mother who laughs at an albino during pregnancy, will produce an albino herself. Bourdillon (1982:234) reports that the Shona believe that the mere sight of a dead body could turn a child blind, while according to Bullock (1927:196) a pregnant mother

must look at no bad thing, such as a cross-eyed man or a deformed, lest her child be thus afflicted nor must her husband kill a snake for fear that her child be born blind. . . . The wife must be careful too . . . if she should see another mother's child crawling, she must lick its feet; else that child will not walk until after the birth of her own infant. . . . The expectant mother is called *chirema*, the heavy or the disabled one, for we do not know whether she will deliver a child or a monster. (*ibid.*)

Mr. T. Shoko informed me that, according to Shona folklore, sitting on the road may cause wounds and leprosy. Men who cross a broom handled by a sweeping woman, may be rejected by ladies or be barren. Men who look into the cooking pot will develop a protrusion of the forehead (*mahabi*), while someone who stares at a person of the opposite sex may develop protruding eyes (*showera*), as in the case of a kidney deficiency.

In an equal way being looked at by certain animals (either normal animals or witch familiars) may cause the characteristics of such animals to pass to the still unborn child. Among the Shona it is believed that a pregnant mother must not look at a chameleon, because the child may develop round and turning eyes like a chameleon. Among the Pondo it is thus believed that the *iZulu* (lightning bird) can cause blindness (Hunter 1964:282), while leprosy may be caused by being looked at by an *ichanti* (a snake used by a witch (Xhosa)).

Chapter 5

Theoretical Framework

5.1. Summary of the literature study

From the previous two chapters three main conclusions can be drawn, conclusions that form the premises for the research. First of all it was argued that the scientific component of the health care system is strongly influenced by two remnants of the colonial era: racial segregation and a division of the health care system into well-equipped, centrally controlled institutional centres on the one hand and 'second-class' rural health services under local authority on the other hand. After independence the government did away with segregation and put a lot of emphasis on the upgrading of rural health services. Despite the tremendous efforts in this respect, it may still take some time for people to accept that rural and community-oriented services are not of a lower standard and that institutional service is not the (only) 'ideal' of scientific medicine.

Secondly, in the course of our argument, community-based rehabilitation was depicted as an attempt by scientific medicine to combine the economic 'advantages' of traditional medicine (low costs, low level of specialization) with the 'scientific advantages' of modern medicine. Community members are expected to participate actively in this combined approach by rendering volunteer services and by providing financial and material inputs. The aims of primary health care and community-based rehabilitation are laid down by scientific medicine and the community is expected to internalize them:

many of them [disabled people] live a life without dignity in absolute poverty. They are victimized by superstition and beliefs that they are possessed by evil spirits or that their presence is proof of divine punishment of the family. Disabled persons are often socially isolated and are denied education and job opportunities. . . . Thus a new approach is needed. (WHO 1982:3)

The possibility that the direction and content of this new approach does not coincide with the views and priorities of the community is not considered. This might contribute to the difficulties encountered in implementing health care

and rehabilitation programmes in general and community-oriented programmes in particular.

The understanding of traditional healing as part of the Shona religious and cultural system was a third focus of attention of the literature study. Rather than depicting the Shona cosmological order as consisting of dramatic structural oppositions (cf. Douglas 1966; Lan 1985), I emphasized the overlap and gradual differences between the different forces in the cultural and religious system and the delicate balance of power that is maintained between them. The religious system, of which traditional healing forms an integral part, may be hierarchically organized, but there is considerable overlap between the different levels. Summarizing the information about the cosmological classification and the classification of illnesses as provided by Chavunduka (1978) and Aschwanden (1987), one arrives at a scheme as in Figure 3. God, the 'cause' of natural and terminal illnesses stands at the beginning and the end of the hierarchy as the ultimate controlling force. In between there is the realm of culture, controlled by human beings, their spirits or mediators.

Figure 3

Causes of illnesses related to cosmological order

	Simple natural cause	Cultural cause	'Terminal' natural cause
COSMOLOGICAL ORDER	'God'	humans/ spirits	
	-----	-----	'God'
	shave	mudzimu ↑ human	mhondoro
	alien spirit	↓ human body	chief
	black shadow		mwea/soul

Two aspects of Shona cosmological order and its internal structure seem preponderant. In the first place it has to be noted that not the extremities of the (symbolic) structure denote or determine the meaning of life and behaviour, but the grey area in between. The Shona God is impersonal and people do not concern themselves with the area God controls, the extremes of the structure, because no real influence is possible. It is the area in between these extremes

which can be controlled by humans and which contains all the dynamics. This brings us to a related observation. Although all actors in the Shona religious system were listed, it is difficult to determine their values and power relative to each other. It seems to be a matter of gradual differences, of a balance of power among all parties involved. A constant effort is made by each party to confirm and possibly improve one's position. To the family or the individual there are two ways of improvement. First of all a spirit can be promoted from the spirit of a living human being to a *mudzimu* and eventually a *mhondoro*, while downgrading to 'homeless spirit' has to be avoided. Secondly, a person or a family can promote itself by hosting ancestor spirits and/or by becoming a medium to a *shave* spirit. In a way 'spiritual life' and spirit mediumship are 'careers' that may last much more than a lifetime, careers that may develop or come to a standstill in the process of the maintenance of or disturbances in the power structure between the different forces in society and the cultural and religious order at large.

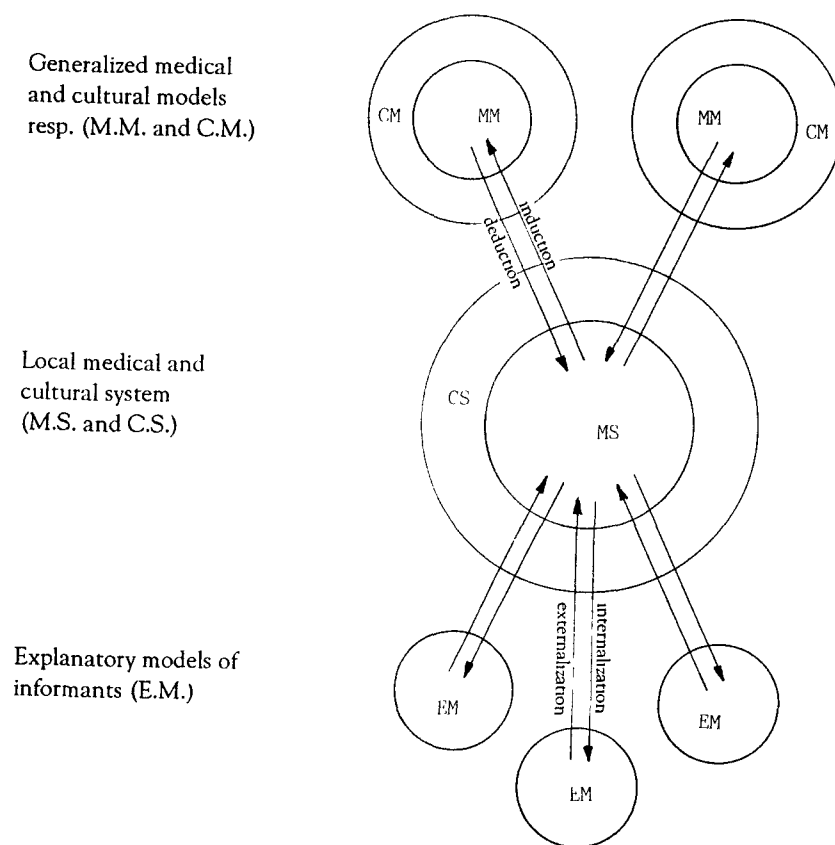
These three points form the context in which this research took place. Before we ask disabled persons, their relatives, relevant others and traditional healers about their ideas and practices concerning disability and rehabilitation (in order to be able to make statements about the applicability of community rehabilitation), we have to realize that, for historical reasons, people in the rural areas do not always appreciate community-based health care programmes. Even if they would understand the concept, they probably would not accept the goals pursued, as these are derived from and imposed by scientific medicine, without a proper understanding of the cultural and religious context in which illness behaviour and rehabilitation takes place. When we make an attempt to understand ideas and practices concerning disability within the context of Shona culture, we have to be aware of the cosmological order that is maintained in this culture and the structures and divisions that it involves. Most essential in this respect seems to be the differentiation between aspects of life (including the causes of disabilities) that can be controlled by human beings and aspects that are considered to be beyond the sphere of their influence.

5.2. The medical system

In this study I try to describe the religiously and culturally contextualized medical system in which illness behaviour and rehabilitation practices take place. The medical system referred to is a theoretical construct, derived from observation, statements and behaviour of relevant individuals in the community (e.g. disabled persons, healers and relevant others). Different definitions exist

Figure 4

*Schematic representation of the relationship
between the cultural/medical model and system and explanatory models*



Explanatory note Figure 4:

The generalized medical and cultural models are abstractions, derived from literature study. A scientific medical model and a traditional medical model as they are assumed to underlie the medical system are differentiated and described in chapters 3 and 4. The models are generally arrived at through induction from human behaviour or a medical system. In this research information is deduced from these models in order to construct a picture of the local medical system.

At a local level a medical system 'exists' as a major part of the cultural system (for a definition of a medical system see text). Medical ideas and practices are part of

culture and in some respects the medical system may show overlap with other sub-systems of the cultural system (for instance with religion). The medical system is a theoretical construct arrived at through deduction from the cultural and medical models and through externalization from the lower order reference models, i.e. the explanatory models used by individual informants. These informants in turn internalize the medical system they have 'created'.

The explanatory models in turn can be seen as constructs consisting of the following components: social, religious and political components, psychological influences, biological and physiological conditions and physical/material circumstances.

(For theoretical references see Adriaansens 1976, Berger and Luckman 1976 and Kleinman 1980.)

of what a medical system is. For the purpose of this study, the fairly neutral definition formulated by Kleinman is used: 'an organized system of ideas and practices concerning illness, a system which is grounded in and derives its structure from a given cultural context' (Kleinman 1973:57). The choice of this particular definition has the following implications:¹

(a) The medical system is perceived as a localized structure in which the influence of the higher and lower order reference models is combined into a synthetic whole (see Figure 4). At the level of the higher and lower order reference models a differentiation is made between different medical models, according to their cultural origin. Instead of simply referring to the name of the culture, the literature introduces a lot of oppositions to label the different medical models. First of all there is the differentiation between bio-medicine and ethno-medicine, as suggested by Hughes (1968:88). To make this distinction would imply 'that non-western medicine is culturally generated, while biomedicine is a natural system of some sort and independent of ideological, cultural genesis' (Press 1980:45). The distinction between medicine (examining and developing treatment) and ethno-medicine (the study of medical care from a social and cultural perspective) as introduced by Fabrega (1977:201) is also not adopted. The term 'ethno-medicine' holds too many ethnocentric connotations to be applied successfully in this study. Therefore, at a theoretical level, I prefer to differentiate between traditional and scientific medicine and between a traditional and a scientific medical model as higher order of reference (see Figure 4) and as components of traditional Shona culture and scientific culture respectively. A differentiation is made between traditional healing and scientific medicine by informants too, providing a lower order explanatory model. For me the adjectives 'traditional' and 'scientific' hold no value judgements. As far as medical practice (i.e. the professional sector of the medical system) is

concerned, there seem to be two approaches in Zimbabwe. One is based primarily on scientific knowledge, the other is based on knowledge of Shona cultural tradition. Both Shona tradition and science contribute to medical knowledge in Zimbabwe. If it makes sense to separate science and tradition (Kuhn 1972), the main differentiating factor in the Zimbabwean situation would be the locus of control (whereas in scientific medicine the focus of treatment for illness and disability is the human body, in traditional medicine it is the social and cultural situation of which the body is merely an exponent).

For the purpose of our research, we will assume that in actual practice, i.e. in the mind of the informant, all information concerning illness and disability is accommodated within the framework of one localized medical system.

(b) A differentiation between the way people think and act concerning their illness is made in the definition. It seems important to make this distinction in a situation where, under the influence of social desirability or other motives, people might be inclined to say something different from what they actually do. In the fieldwork area for instance people repeatedly said they would seek treatment in hospital, but they seldom did.

(c) Furthermore, a distinction between illness and disease is implied in the definition as the two components of sickness. The term 'disease' refers to the definition of a medical complaint by a medical practitioner as a malfunction of the body, while the term 'illness' refers to the way the patient, the relatives and the community view this complaint (cf. Eisenberg 1977). Sometimes this distinction is assumed to be more or less similar to the distinction between scientific medicine (disease) and traditional medicine (illness). But this definition is bound to lead to confusion, because within both traditional and scientific medicine illness and disease are distinguished.

Generally speaking the personal accounts and explanations of the disabled persons, their relatives and community members represent the illness component (popular component, Kleinman 1980:50). The diagnoses and biological explanations of the medical practitioner lead to a description in terms of 'disease' (professional component, Kleinman 1980:59) or, as Eisenberg (1977) put it:

medical practitioners diagnose and treat diseases while patients suffer from illnesses. Depending on social and cultural practices as well as on individual interpretations, there may be illness without disease and disease without illness. (Eisenberg 1977:11)

Within the professional component a traditional and a scientific orientation may be distinguished. In this study the traditional orientation gets most emphasis.

The term 'sickness', finally, 'refers to the social dimension: the [in-]ability to meet obligations of group living' (Twaddle 1981:112). This ability is established in more or less general terms, taking into consideration both the popular and the professional views on the subject (folk component, Kleinman 1980:59).²

(d) The medical system is defined as a cultural system. The cultural system, like all other systems of action, takes human behaviour as its basic unit of observation. The cultural system offers just one way of analysing and interpreting behaviour, and cannot be seen without the context of other systems of action. At the more concrete level of the explanatory model (cf. Fig. 4) these systems also have their influence, though more in the form of 'realities' (Kleinman 1973:28).

5.3. Questions posed for the research, an elaboration

Summarizing the rather scanty literature in this respect, I distinguish three theoretical positions concerning the position of disabled persons towards the medical profession and society, and vice versa. The first view was developed by Parsons. His theory concerning the 'sick role' formed the basis for many models and theories in medical sociology/the sociology of medicine. Parsons developed his theory within the wider context of his social system theory and his point of reference was the American health care system. Parsons (1972:101) and others considered the theory relevant for other cultures and societies too, and we will assume a similar position here. The core of Parsons's theory is that, in the powerplay between individual and society, it is generally assumed that the sick individual cannot help being ill. As a consequence 'society' does not ascribe to a sick individual the status of 'deviant', at least not yet. In turn 'an organized system of participation for the individual in the social system' (Parsons 1972:99), i.e. a role-model, is developed to control the potentially deviant behaviour of the sick individual. The behavioural norms set by society to control illness behaviour are, according to Parsons, governed by four main principles:

1. The individual is not to be blamed for the illness.
2. The individual is relieved from normal duties and responsibilities for the duration of the illness.
3. The fact that normal duties and responsibilities are not fulfilled by an ill or disabled person is not considered as a sign of deviance but legitimate in view of point 2.
4. The three principles are accepted only if the individual sticks to the norms and behavioural patterns set out in the 'sick role', i.e. if the individual makes an effort to get well and obeys to the instructions provided by the

medical profession in this respect (medicine and the medical profession as controlling force in the social system).

Considering the definition of rehabilitation as provided in Chapter 3, it might be stated that this definition fits into the Parsonian theory nicely. Rehabilitation, defined in terms of optimizing the condition and changes of the individual, is but an attempt to extend the 'sick role' to disabled persons.³ In his theory Parsons distinguishes clearly between somatic and mental illness (1972:99). Whereas in the case of somatic illness the individual is not capable of fulfilling one or more tasks (parts of the role), in the case of mental illness the individual is no longer considered capable of fulfilling his/her role in society. Parsons perceives somatic and mental health as the 'adaptive capacity of the human organism' and the 'second line in defense' respectively (Parsons 1972:78).

A complementary rather than contradicting view is presented by Goffman in *Stigma, Notes on the Management of a Spoiled Identity* (1963). In this study Goffman distinguishes three types of stigmata: 1. 'abominations of the body'; 2. 'blemishes of individual character'; 3. tribal and racial stigmata (Goffman 1963:4). Disabled persons, being provided with stigmata of the first kind, may indeed be considered stigmatized individuals, according to this theory. Goffman is not so much concerned with the control that society is trying to exert over the disabled individual, but with the efforts of that individual to get accepted by society. He argues that the disabled or stigmatized individual basically holds the same beliefs about identity as 'normal' individuals do. However, the 'mere desire to abide by the norm — mere good will — is not enough, for in many cases the individual has no immediate control over his level of sustaining the norm' (Goffman 1963:128). Just as society judges the disabled individual to be either sick or deviant, the individual may judge society as being worth the effort or not. In the first case the individual will make an attempt to get accepted. In the second instance, or when efforts to be accepted were not fruitful, the disabled or otherwise stigmatized individual will alienate from society (deviance) and will try to use the stigma for 'secondary illness gains' (compensation).

Murphy et al. (1988), in reaction to the apparent limitations of both Parsons's and Goffman's view, have tried to develop a composite view, encompassing the societal views and the viewpoint of the disabled individual, in the term 'liminality'.

This state of being is clouded and indeterminate, just as that of the man-nor-boy, and the able-bodied commonly deal with this indefiniteness in the same way in which most ambivalent relations are handled by setting up social distance through either hyperbole of conduct or by avoidance. (Murphy et al. 1988:238)

Perceived in this way, our attempt to describe the role and position of disabled persons in society, as well as the reactions of society towards them, would be a description focusing on the 'liminality' of disabled people.

Liminality as an anthropological concept has been explored by authors like Van Gennep (1960), Douglas (1976) and Turner (1967). Van Gennep has described the state of liminality as an important stage in various rites of passage, while Turner has emphasized 'liminality as an interstructural situation', often accompanied by a strong feeling of '*communitas*' (Turner 1967:93).

Whereas for Van Gennep and Turner 'liminality' is primarily a (temporary) state of an individual or a particular group, Douglas is concerned with the boundaries and liminality of society as a whole, the boundaries between the 'purity' of order on the one hand and 'dirt' or danger on the other, as well as with the area in between. These boundaries are reflected in culture and the social system alike and stand in structural relation to each other. In her book *Purity and Danger*, the various pollution beliefs and their social basis were elaborated upon. In *Natural Symbols* she applied these thoughts to a classification scheme of societies in terms of 'grid' and 'group'. In this study Douglas described four different types of societies as they emerge under the influence of the factors 'grid' and 'group'. According to Douglas's scheme (1976:149ff) societies in Central Africa are characterized by strong personal pressure and a rather weak system of classification. Probably the Shona can be classified along with these Central African societies.⁴ Douglas further states that in such societies a system about good and evil prevails which is characterized by fear of witchcraft, i.e. a witchcraft-dominated cosmology. As an important aspect of such a cosmology, Douglas mentions (*ibid.*:153) the idea of the good inside and the bad outside and the idea that the inside is vulnerable to the attacks from the evil outside and has to be protected from them.

Bucher (1980:109) mentions, with reference to Douglas's theory, that both Crawford (1967:292) and Bourdillon (1976:222) 'seem unwilling to call the Shona cosmological order witchcraft-dominated' and he subsequently endorses this view without however giving specific reasons. I agree that it would be a simplification and over-generalization to describe the Shona cosmological order as witchcraft-dominated. Although the description provided by Douglas of this type of society applies in many ways to Shona society, it is more than just witchcraft that concerns its people. First of all it should be recalled that, among the Shona, witches in the strict sense of the word — as defined by Evans-Pritchard (1937) and Marwick (1970) — do not exist; only people temporarily possessed by a witchcraft *shave* and people who conduct evil on their own

account. Secondly it has been made clear in previous chapters, and it will be further illustrated below, that evil forces may affect a person in other ways than witchcraft.⁵ To relate all evil and deviance to witchcraft implies a denial of the wide range of possibilities available to Shona people to control and influence the good, ambiguous and evil forces in society and to maintain the delicate balance of power that exists among them.

Turner (1976:106) defines liminality as 'the realm of primitive hypothesis, where there is a certain freedom to juggle with the factors of existence.' As Figure 3 shows, in the Shona cosmological order the spirits inhabit the realm of liminality, the area where some 'juggling' is possible. Whereas the influence of the *shave* (controllable) and the influence of the *mhondoro* (beyond the control of a single individual) are relatively well defined, the *mudzimu* and, through this spirit, the average human being, is the representative of liminality par excellence. It might seem strange to depict life as conceived by the Shona, as a liminal phase, but at least a lot of characteristics that are ascribed to liminality by Van Gennep, Turner and others seem to apply to the life-concept held by many of informants for this research. The aspects of liminality in general life seem to be more conspicuous than in any of the 'rites of passage', which did not take place in a very pronounced way in the fieldwork area anyway. The concept of liminality generally refers to a situation whereby the individual is on the 'limen', i.e. threshold, passing from one phase to the other. It may refer to one step or to an entire episode. As opposed to the term 'marginality', the term liminality refers to an in-between situation, the two other alternatives are in sight; in fact, they are embedded in the liminal situation. In this way it is possible to search for the nucleus of the threshold which, again, contains a (structural) opposition of its own (see Figure 3).

5.4. Presentation of the research data

In Chapter 1 it was mentioned that I intended to focus on three aspects of disability and rehabilitation in particular:

1. the subjective and personal experience and explanations of disabled persons and their relatives;
2. the diagnosis and treatment offered by the traditional healer;
3. the (social) position of disabled persons in society in more general terms.

We might call these aspects the illness, disease and sickness components of disability. They do not only represent different aspects of disability and rehabilitation, but also refer to different groups of informants. Whereas the disabled

persons and their relatives provided the information on the illness component, traditional healers were approached for information on the disease component. The information on the position of disabled persons was derived from both groups of informants and from my own observations.

In the three subsequent chapters the fieldwork material will be presented in this form. In some respects however there will be overlap. A number of disabled persons provided quite useful information on the treatment they underwent and some healers had been seriously ill or disabled in the process of becoming a healer. The information provided by these informants is presented under the proper heading, irrespective of its source.

At the beginning of each chapter a number of case-studies are presented that bear special relevance to the subject discussed in a particular chapter. Other case-studies will be referred to in the text as well. A summary of the cases not presented in the text is provided in the Appendix. The presentation of case-studies in the text has advantages and disadvantages. The main disadvantage is that the cases have to be presented in a summarized form, for the sake of readability as well as to avoid recognizability. In this way a number of relevant but too revealing details are lost. The advantage is that the reader gets a more composite picture of the life of disabled persons in the rural areas.

In the interviews with disabled persons, their relatives and relevant others the following issues were clarified concerning the way they experience and explain disability and rehabilitation:

1. A list of terms used to describe the various causes of illnesses and disabilities had to be compiled and it had to be checked to what extent these terms have approximate English/Dutch equivalents and what the literal translation of the Shona terms is.
2. Subsequently I had to determine how the difference between illness and disability is defined. Also, it was checked to what extent the differentiation between illness and disease is relevant for the informants and to what extent it bears relevance in terms of 'sick-role' (Parsons), 'deviance' (Goffman) or 'liminality' (Murphy et al.).
3. The various causes of disabilities were indicated at an abstract and a more concrete level. In the literature a differentiation is made between natural and non-natural causes. I checked whether the informants attach importance to such a differentiation. The causes that are mentioned were placed within the context of explanatory models. I compiled information on general explanatory models (i.e. explanatory models that explain general causes of disability), and on specific explanatory models (i.e. models to explain

one particular case). Where possible the influence of physical, economic, psychological and socio-political factors was taken into consideration in the explanatory models, and I have tried to determine the weight of these factors on being considered ill, liminal or deviant.

The traditional healers were asked to provide information on the following topics:

1. The different diagnoses and treatment options had to be identified; their names had to be listed and their meanings described.
2. Next, the reasons for selecting one treatment option and not the other as well and shifts from one treatment to another were to be described. Eventually it had to be established if there is a relationship between selecting a particular treatment option and the disabled individual's position as sick, liminal or deviant.
3. The diagnosis and treatment characteristics of disabilities had to be determined and the actual diagnosis and treatment process had to be described.
4. On the basis of the description mentioned under point 3, the different explanatory models and factors used were mapped out.
5. If possible the disabilities that were considered easy or less easy to treat were indicated, while also untreatable disabilities were identified, i.e. treatable/untreatable in the eyes of healers and disabled persons. This information was connected to the findings under point 2.

Concerning the role and position of disabled persons in society, the following issues had to be clarified:

1. The role and position of disabled persons in the family and the community: first, the basic demographic characteristics (economic status, education, family status etc.) and other indicators of a person's position in society were identified; secondly differences between data found in this research and the data presented in Chapter 3 were brought forward.
2. Differences in the life-cycle of disabled and not disabled persons had to be established as well as problems relative to their status in society. Not only economic and occupational status and level of education had to be considered in this respect: special attention was given to three aspects in particular: marriage prospects, spiritual career and prospects for a career as a spirit medium.
3. Finally, it was assessed whether the position of a disabled person is primarily that of a sick person, a deviant person or a person in a position of liminality. It was determined to what extent social indicators could be generalized for each of these three conditions.

Chapter 6

Illness and disability: the popular perspective

6.1. Four case-studies

Case 5: Maureen Mapfumo

Maureen Mapfumo is about 20 years old. She suffers from severe epileptic fits and the mobility of the left side of her body is impaired. As far as this could be established, the latter problem occurred when she fell and injured her head during one of her attacks.

Maureen is the oldest in a family of five. She has three brothers and one sister. She stays in the house of her parents who are subsistence farmers. The mother also has a small income as a traditional healer and one of the brothers adds to the family income through occasional jobs in town.

Maureen had her first epileptic attack around the time when she began going to school (6-7 years). She left school in grade 2, when the attacks had become too severe. When the illness first occurred, a traditional healer was consulted. His intervention was not successful. Other healers were consulted thereafter, also without success. When asked what the diagnosis of the healers was, the mother said that the consultations were in vain. She implied that the family and the healer could not reach agreement on a diagnosis. The mother thinks a *shave* spirit wants to come out on her daughter (the mother heals through a *shave* spirit herself). However, other *shave* mediums do not recognize her daughter's spirit as a *shave*.

Asked if she ever considered to take her daughter to the hospital or the rural clinic, the mother said that she was contemplating to do so, but that she did not quite know what to expect from such treatment. We explained that a doctor would probably want to examine her daughter in order to be able to prescribe some medicine. We said that the medicine would probably not cure the epilepsy completely, but that it would make the attacks less severe. We also explained that, unless the medicine is taken regularly, it will not have the desired effect. Although the mother assured us that she would take her daughter to the clinic, she never actually did, at least not during the remaining nineteen months of

the fieldwork. When we saw the mother again after some time she explained that Maureen and her younger sister had set out to the clinic, but had found it closed, because the doctor had not come due to lack of transport. They had not ventured to go again, because Maureen had had great difficulties in walking the long distance. The nurses of the clinic, in turn, are not very keen to make a home visit, because the mother is a healer.

Maureen is involved in some household activities on days that her physical and mental condition permits her to do so. On days of or after an attack (two or three times a month) her condition is very poor. Then her speech is stammering and slow and she does not always respond to what other people say. Her muscle coordination, particularly the fine motor coordination, is in disarray. Her sense of balance is disturbed and she can walk only with great difficulty. The third or fourth day after an attack her condition gradually improves and on her 'good' days she is 'only' handicapped by her hemiplegia. Due to the fact that her condition does not allow her to go out independently and the homestead lies rather isolated, Maureen is not included in any community activities and she does not have any social contacts, which she regrets. The mother is concerned about this as well as about the fact that her daughter will probably never have children or get married. She realizes that her daughter will always have to rely on the family for support. We did not manage to get reliable information from Maureen herself in this respect because we always spoke to her in the presence of her relatives.

The vidco chairman of the area has the following to say about Maureen's condition:

You can take her to the hospital three times or more and give her all the tablets you want, but it will not work. Her mother is a *nganga* herself; she knows quite well, but perhaps she will not tell you. These are offences against our culture, no western doctor can cure them. . . . Your medicine [the western medicine of the researcher] can work, it sometimes works quite well, but when culture is involved a *nganga* first has to clear the path for your medicine. . . . The uncle of Maureen killed someone. The spirit of that person now hunts the Mapfumo family. It requires some beer and other traditional things (to be cured), but Maureen's father refuses. He claims there was no murder but only self-defence.

Another informant in the area confirmed the story of the vidco chairman. He identified the evil spirit as a *ngozi*.

I repeatedly expressed my amazement over the fact that Maureen could be made a scapegoat-for-life so easily, due to an alleged offence committed by an uncle. I asked informants why in cases like this the individual was not

protected by the ancestors. Most informants were not concerned about this at all. When asked, one of the healers interviewed for the research offered the following explanation about the way a *ngozi* works, with reference to this particular disabled person:

The family of the deceased will put medicine on the grave of a relative, whom they feel might have been murdered and they will say: 'If you died at the rightful time [i.e. were not murdered], may your soul rest in peace. If you died too early, then take revenge,' and then they will spell out exactly how revenge has to be taken. Then the *ngozi* will try to go to the culprit and will try to take revenge. But the culprit, knowing what he has done wrong, will have taken protective medicine already. Then the *ngozi* will consult the spirits of the family or lineage of the culprit and then the *ngozi* will explain to them why revenge is required. The family spirits will agree and they will say [to the *ngozi*]: 'Okay, if you insist, you can go to so and so.' Usually this is a young person or someone who is not well protected by his/her guardian spirit. So the *ngozi* will go to the spirit of this person and they will talk it over and the spirit of the victim will say: 'But I am here to protect, nothing wrong was done by this person,' and the spirit will negotiate with the *ngozi* to make the disability as light as possible, to make it a disability instead of death, but finally the guardian spirit will have to give in, because it cannot go against the wish of the family spirits that revenge is required.

(The healer actually showed how the guardian spirit in the end will put his hands on his eyes and look away, so that the *ngozi* can do what he wants to do).

Case 19: Edward Samukange

Mr. Samukange is about 45 years old. He is married and has five children and suffers from attacks of mental illness. These attacks are not frequent, in the past year he has had three such attacks. In addition, Mr. Samukange is disturbed by dreams. It all started when he was walking home from town one day. A man came towards him. At the moment when he wanted to pass the man and had to step on his shadow, the man pushed him on the ground. Mr. Samukange tried to get up three subsequent times, but he was pushed back. After this incident, he started dreaming of watery places, of pools and wells and rivers. He dreams in particular about the caves in Chinhoyi.¹ He can describe these caves in detail, although he has never been there (the descriptions are accurate, but could have been derived from verbal accounts or a touristic folder equally well). He also dreams of a pool on a sacred mountain (the mountain can be seen from his house and is on chief Masembura's land) and he can also describe this pool.

When the dreams continued, Mr. Samukange consulted a traditional healer who lives nearby. This healer, who specialized in 'water spirits', died while Mr. Samukange's treatment was still going on. The diagnosis of this healer was

that a *nzuzu* spirit wants to come out on Mr. Samukange. This spirit requires a ceremony in which both the medium-to-be and the relatives participate. Although the *nzuzu* was diagnosed almost three years ago, the required rituals have not yet taken place. Mr. Samukange gives two reasons for this. In the first place he himself and especially his wife are Christians. It is not acceptable for Christians to believe in spirits, far less to act as a medium for them. Only recently his wife is beginning to accept that something has to be done about the *nzuzu* that is bothering her husband. She is prepared now to assist and join him in the 'coming-out' ceremony.

A second problem is posed by Mr. Samukange's family. His father had two wives. With the first wife he had six sons, with the second wife he had two daughters and one son (Mr. Samukange). When Mr. Samukange's sisters married, the father had already died, and Mr. Samukange was still young. The six brothers shared the *lobola* among themselves. Now they are afraid to engage in any ritual concerning their youngest brother, as they fear that Mr. Samukange will ask his share of the *lobola*.

At the time the incident with the man who pushed him down on the ground took place, Mr. Samukange was working in town. However, when the dreams and the mental illness continued and became more serious, he had to leave his employment to come home. He said: 'You cannot work in town when these things are not properly solved.' At present he is involved in subsistence farming. His social contacts are limited, because he tends to get the attacks of mental illness when he is in large crowds of people and at places where beer is brewed for the *mudzimu*. The only thing he can do then is to jump in a pool or river to cool off, but this in turn is dangerous, because the *nzuzu* spirit lives in the water and might want to keep him there for an apprenticeship.² Asked what the *nzuzu* spirit that wants to possess him is like, Mr. Samukange tells us that his father died by drowning in a river, thereby indicating that the spirit is in a way related to his father. This makes the cooperation of his brothers even more indispensable.

Other informants in the area agree that a *nzuzu* must be involved in Mr. Samukange's place. They are not certain however whether it is a *nzuzu*, *shave* or *mudzimu* or a real *nzuzu*. Generally more importance is attached to possession by the latter type of *nzuzu*.

Another *nganga* told him that the conscious consent of his brothers was not required. The healer said that Mr. Samukange should just prepare beer and invite his brothers to come and drink, without telling them the purpose. Then the spirit will come out and they will not be in a position to refuse it.

Mr. Samukange was reluctant to follow this approach however. He wears a bracelet to protect himself from the *nzuzu* spirit as much as possible for the time being, until everything is properly solved. Mr. Samukange expects that, when his spirit is recognized, he will be able to make a decent living as a traditional healer.

From a traditional point of view this is a clear case. A *nzuzu* wants to come out on Mr. Samukange and is not given the honour and respect it deserves. Unless this is done, the mental problems will continue. In addition it is almost certain that Mr. Samukange did not leave his job voluntarily. His employer probably left the country and did not recommend him to others.

His mental problems might have been caused by or might have contributed to this situation. Returning to his village, he might have been wondering how to maintain his family. He turned to his relatives for support and requires either a share of the *lobola* paid for his sister or the (healing) spirit of his father.

Case 1: Kenneth Madzima

Kenneth is from a large family and a number of disabled persons were identified in his family. According to some family members these cases are all related, and caused by the same witchcraft.

In Kenneth's family four disabled persons were identified. His grandfather suffers from swellings in both legs. He has difficulties with walking and suffers from a spinal injury since 1967. He does not see a doctor for his complaints and he does not take medication. The grandfather is married and is said to have had no less than eight wives (from six of them he divorced). He was employed in town as a driver, but some years ago he returned to his village to spend the last years of his life resting among his family.

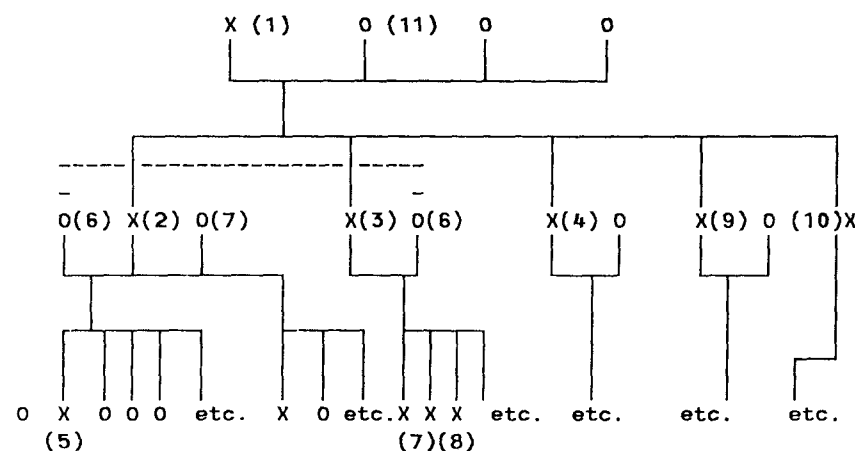
Then there are two brothers, William and Peter. William (22 years) is partially deaf. The problem occurred when he was one year and six months old and his condition is still getting worse. Peter suffers from epileptic fits and later it became clear that he had severe learning difficulties as well. He is 25 years and his problems began when he was three years old.

Kenneth is 28. He suffers from mental problems since 1967, although he adamantly denies them himself. It was difficult to establish what his problems consist of. They seem to be a combination of socially deviant behaviour, at least partly due to *mbanje*-smoking and delusions.

All family members tell their own story as to the causes of the disabilities and the happenings around 1964-1967. These stories are reflected in Figure 5.

Figure 5

Schematic representation of witchcraft and other accusations regarding the disabilities in the Madzima family



- (1) The grandfather divorced his first wife, the mother of the five sons involved here. The grandfather is physically disabled and accuses a former girlfriend of Kenneth of witchcraft.
- (2) The father of Kenneth allegedly neglected Kenneth's mother (6) and re-married (7), accuses his father of immoral behaviour and has disputes with his brothers about land and money.
- (3) The father of William and Peter accuses Kenneth's father (2) of being the cause of the witchcraft in the family because he does not appease the spirit of his deceased wife.
- (4) A younger brother of the fathers of Kenneth and William and Peter accuses the wives of his brothers (2 and 3) of witchcraft. Note that they are sisters, he indirectly accuses his brothers (2 and 3) for not controlling their families properly.
- (5) Kenneth is considered to be mentally ill by the family but does not consider himself to be ill or disabled. He claims that the immoral behaviour of his grandfather and his father is the source of all evil in the family.
- (6) The wives of Kenneth's father and William and Peter's father, respectively, they are sisters and the mothers of the disabled children in the family. Kenneth's mother was seriously neglected by her husband. Her sister remarked 'How can one sister sit and enjoy when the other sister suffered like that'. Informants outside the family believe that the mother of William and Peter is punished (with ill children) for not revenging her sister.
- (7) and (8) William and Peter. They believe that their disabilities as well as the disability of Kenneth have natural causes.

- (9) and (10) Younger brothers of 2 and 3. They partly confirm the accusations and add that their own mother (11) was not treated properly by their father so that it is perhaps also her spirit, possibly strengthened by the spirit of the daughter in law, that is causing the problems.

Informants in the area are not certain about the cause of the problems in the family. Most of them believe it is either witchcraft or a *ngozi* or a combination of both. What actually happened in the years 1964–1967 cannot be established clearly. Both Kenneth's grandfather and his father mistreated their wives. Both wives have died. Now misfortune has struck the family. Guilt feelings about things that happened in the past re-appear. In addition there are problems with the younger generation. The relationship between Kenneth, his grandfather and father is very bad. The oldest son (Kenneth/Kenneth's father) does not show respect for his father but accuses him of immoral behaviour. Kenneth does not show respect for his grandfather either.

Kenneth does not go to school anymore. He did not pass his A-levels. Presently he looks after his father's house during the week. His father works in town. When he comes home in the week-end, with his second wife, Kenneth leaves the house and stays with his uncle (the father of William and Peter). He does not earn any money so he cannot think of getting married. He does not know whether his father will eventually help him with a *lobola*. He claims to have had several girlfriends already.

The grandfather has consulted a *nganga* concerning Kenneth's condition, but the other family members do not accept the outcome of that consultation. However, all family members, except the youngest generation, agree that the cultural problems have to be solved before any other form of medical treatment (scientific medicine) can be considered. It should be mentioned that informants in the fieldwork area feel that a *ngozi* is causing all the misfortune in the family.

Case 25 Apollonia Rusere

Ms. Rusere is 45 years. She is unmarried and has three children and suffers from a series of physical disabilities brought about by polio. In particular her right and left leg are affected (she cannot bend them at the knee, but she is still capable of walking) as well as her right arm and hand (muscle contractions). She mentions two names for her condition: *chutsinga* (as the cause) and *mheta-makumbo* (as the description of her physical condition).

Ms. Rusere is from a family of ten children. Of these ten, only six children have survived, five girls and one boy. The brother and one of her sisters are also

suffering from post-polio effects. They stay at one of the rehabilitation centres in town.

The mother of Ms. Rusere was in love with someone from Manyikaland. The man had already visited the homestead of her parents and had made some pre-*lobola* payments. Then she decided to marry someone from Zambia. Her first lover became angry and then used witchcraft (*chitsinga*) to harm her children. In this particular case the lover is believed to have used a love-token given to him by Ms. Rusere's mother and he paid a black *nganga* to infect this token with witchcraft. The token, thus affected, was thrown on Ms. Rusere's mother.

There are various types of witchcraft that may be used in this way. The term *chitsinga* is used, according to the informant, when the witchcraft affects the legs, as in her case. Also the term indicates that someone has taken back what belonged to him.

The father of Ms. Rusere worked as a civil servant. He had come to Zimbabwe during the period of the Federation. After some time he was transferred back to Zambia. According to the informant, he did not want to take his disabled children along. He wanted to throw them in the river, saying that that was customarily done in Zambia. The grandmother of Ms. Rusere opposed him and offered to take care of the children instead. The mother and father and the four brothers left for Zambia and Ms. Rusere never saw them again. Her brother and sister, who were younger and who had been even more affected by polio, were admitted to a rehabilitation centre in town. Ms. Rusere stayed with her grandmother and after her death, Ms. Rusere moved to the homestead of a younger sister of her grandmother. That is where she still stays today.

Ms. Rusere, who has not attended school, never visited a hospital or a traditional healer about her condition. Once the cause of the polio in the family had been established, the issue was closed, mainly because there was no money to pursue treatment or countermeasures.

Ms. Rusere gave birth to seven children. She had two 'marriages' but it is almost certain these were not official marriages for which *lobola* was paid. She lived with her first husband in Harare. He worked for a church organization. One day he appeared at his work while he was drunk and he was fired. He then had to return to his home village. His family did not want to see a disabled woman coming along. They suspected Ms. Rusere of being a witch. Then the man deserted Ms. Rusere. After that she found another husband with whom she had four children. This husband also deserted her, for about the same reason as the first man. Of the seven children, three children are still alive. They stay with Ms. Rusere, which is an indication that probably no *lobola* was paid.

Ms. Rusere has her own house and her own fields, although she stays close to her family. She is an accepted member of the community and people respect her. When she compared her own situation to that of her brother and sister in the rehabilitation centre, Ms. Rusere felt she was better off. Her brother and sister know how to read and write and they earn small but regular incomes at the rehabilitation centre, but Ms. Rusere attaches more value to her freedom and her children.

Only recently Ms. Rusere managed to find out where her brother and sister stay and she has re-established contact with them.

One reliable informant in the fieldwork area said he does not see any problems concerning the return of Ms. Rusere's spirit after her death. He expects her spirit will be accepted easily as Ms. Rusere is an industrious women with many skills, besides 'she has children'. This statement provides another 'proof' of the fact that Ms. Rusere is a respected member of the community in general and her family in particular.

6.2. The informants

Out of the 410 disabled persons identified in the fieldwork area, fifty were selected at random. As mentioned earlier, the main reason for randomization was to increase the qualitative representation of the sample. In view of the small size of the sample, quantitative representation was not considered. The researcher feels that the statistical data presented in Chapter 3 provide more reliable information in this respect. The idea was to compile information on at least twenty-five to thirty cases of the fifty that were selected. Altogether forty-two disabled persons were approached. In the process of the research, twelve cases had to be discarded. Four cases had to be left out because we had difficulties in reaching or locating the homestead, two cases were dropped because the persons had moved since the initial identification, while on two occasions there was a great reluctance on the side of the disabled person and/or the relatives to provide us with the information required (In actual fact more informants showed some initial reluctance, but I felt that by skipping all those cases a bias might be introduced). Finally, four cases had to be disregarded because neither the disabled person nor any of the relatives was found home during three subsequent visits.

The case-studies vary widely in length, comprehensiveness and quality of the information provided. Some disabled persons proved to be born narrators, others preferred to answer questions with a simple yes or no. It is obvious that

not all cases are equally 'spectacular'. However even the 'meagre' cases usually provided some new information.

Apart from disabled persons in the fieldwork area a number of relevant others were interviewed, generally one or two in each case. These relevant others could be family members, neighbours or community leaders (headmen, vidco-chairmen). It seemed important to find out the opinion of other, well-informed people in the area about a case in order to get a more complete picture of the underlying problems. It appeared, however, that only a limited number of people in the surroundings of a disabled person were prepared to provide such information. Most people do not mind to talk in general, but they are reluctant to answer specific questions. They are all the time busy gossiping about each other, but if one explicitly asks them to confirm negative information, they will refuse to do so. This made the interviews with relevant others difficult to conduct, and the actual information gathering had to be done during countless beer drinks and at funerals. Some of the most productive information gathering took place when an informant needed a ride to town. During the one-hour drive often extremely useful information would be revealed in the seclusion of the car. More often than not the information provided by some relevant others contradicted the information given by other informants or by the disabled persons. In this way tensions in the community and the family were brought to light and the relativity and the subjectivity of the information was clearly shown.

After a few trials, a checklist with topics for the interviews was prepared on the basis of the literature study. Usually two to three interviews were required to obtain the information on all topics listed. The first interview with the disabled person and/or the relatives was of a general informative nature. We explained the purpose of the visit and gathered data for the personal history. During the first visit the question whether a scientific medical practitioner or a traditional healer was consulted would also be raised as well as questions concerning the cause of the disability. Many disabled persons, especially those who were young at the onset of their disability and those who still had their parents or elders alive, would refer to them for answers to these questions. The second interview would then be devoted to a discussion with the parent or older relative, in the presence of the disabled person. If no parents or older relatives were available, the disabled person would usually provide this kind of information him/herself. The main reason for referring some questions to older relatives is that the disabled persons sometimes were too young at the time of the onset of the disability and therefore could not give an eye-witness

account of the outcome of consultations of medical practitioners. However, the referrals also clearly indicate respect for the elders and acknowledgement of the fact that illness is not an individual experience but a family affair. It should be mentioned in this respect that, with the exception of a few clients suffering from mental conditions, all disabled persons who referred us to parents or relatives for answers on questions concerning the cause and nature of the disability, could have provided this information themselves equally well. As far as could be checked, there were never any details in the information provided by parents and elders that were new to the disabled persons concerned.

The third interview was used to fill the gaps on the checklist and to verify some of the information gathered earlier. The third and sometimes fourth interview were also used to get more detailed information from the disabled person about his/her attitude towards disability in general and one's own disability in particular. In these rather informal conversations that were often arranged away from the homestead and over a beer, issues like the position in the family, hopes for the future, marriage prospects and marriage life could be discussed. It was not possible to have these discussions with young children, while, in view of the age of the researcher and her assistant, it was not possible either to reach the required level of confidentiality with people of forty years and above. Therefore the information gathered in this respect is biased for a certain age group. Male and female disabled informants could be approached equally well however.

The cases compiled include fifteen male disabled persons and fourteen females. All major types of disability were represented in the sample. Persons with sensory disabilities and chronic illnesses seem to have been somewhat under-represented in the sample while persons suffering from mental conditions were somewhat over-represented. In general the case-studies reflect the history of only one person, but, in at least five instances, other disabled persons in the family had to be considered as well in order to get a composite picture of the situation. In at least three families a clear relationship between the case histories of the different disabled family members could be established. A good example of this sort is provided in case 1. In this family altogether four family members are disabled. An uncle of Kenneth drew attention to the complexity of the case by asking us to listen to his story 'because the whole family is being killed by witchcraft'. Different family members ascribe the disabilities to different causes. Some, especially those from the younger generation, only acknowledge natural causes. The fathers accuse each other's wives of witchcraft and the grandfather, in his turn, does not want to hear about witchcraft in his family and blames outside forces.

6.3. General nature and causes of disability as indicated by the disabled informants and relevant others

In general two main causes of disability were mentioned by the informants: 'natural' causes and 'cultural' causes. Natural causes for disability or 'natural disabilities' are those disabilities that, according to the informants, have a purely physical cause and that require only simple medical treatment by a scientific medical practitioner or a traditional healer as well as those disabilities that are considered to be beyond treatment. Although during the identification exercise the majority of the disabled persons and their relatives indicated that their disability had a natural cause, subsequent interviews revealed that the majority of disabled person in actual fact believed that their disability had a cultural cause. Usually this was brought forward by the disabled person or the relatives later on in the first interview or in one of the subsequent interviews.

The term 'cultural' is used here to denote the non-natural illnesses because this is the English term the informants used themselves to describe this condition and/or the alleged causes. They would say: 'It is (our) culture.'³ By saying that they meant that, apart from a physical defect, the condition reflects/reflected cultural or social problems in the family and/or the community and the interference of humans or spirits in the causation of the disability. Chavunduka (1978) has used the term 'abnormal' to describe the types of illnesses and the causes that are referred to here. In this report the term 'cultural' will be used, not only because this term was brought forward by the informants themselves, but also because terms like 'abnormal' or 'unnatural' have a connotation of 'unusual', while in actual fact cultural causes of disability are mentioned more often than natural causes. In addition to that the term 'cultural' seems to describe most accurately the type of conditions and causes that the informants refer to. This point will be elaborated later.

The natural and cultural conditions and causes should not be seen as mutually exclusive. In general it can be said that most disabled informants, as well as their relatives, initially thought that their illness or disability had a natural cause. Only when the condition continued or got worse, cultural causes were considered. They still believed their condition was polio, rheumatism or epilepsy, but they wanted to find out why this particular person at this particular time had to get this disease or disability. Sometimes when misfortune is expected by a family in relation to certain happenings in the past, the traditional healer is only required to confirm what the family was already thinking. In such cases

the medical diagnosis and the medical treatment are completely subordinated to the cultural explanation and treatment, but generally the two can go side by side. Cultural causes include:

- a *mudzimu* who wants to come out but who is not recognized or well received;
- a *ngozi* who is not properly appeased;
- a *shave* spirit who wants to come out but who is not recognized or not well received;
- (breaking) taboos;
- witchcraft, either 'witchcraft of the night' or 'witchcraft of the day'.

In the case of night-witchcraft usually a specific person is mentioned as witch; in the case of day-witchcraft not the name of the sorcerer or the evil-wisher is mentioned but the name of the poison used or the evil carried out.

The terminology used and the descriptions offered concerning day-witchcraft are quite complicated and varied in nature. As this terminology was used continuously by the informants when describing the causes and circumstances of their disabilities, it seems important to give a full description of the terminology used. Here the information as provided by the disabled informants, the traditional healers and other informants is compiled. It is possible that some pieces of the information and some translations are incomplete or even incorrect. I interviewed many informants on the subject without, however, arriving at a consistent description for all terms.

- *Mamhepo*, literally 'evil spirits', is translated by Hannan (1974) as 'sickness caused by black magic'. It is a rather general type of day-witchcraft which brings bad luck and eventually fever (cf. Chavunduka 1978:99) and, if not treated properly, it may lead to disabilities of various nature. '*Mamhepo* is like a spell, like calling a name. It works with the spirit of a dead person.'
- *Chikwambo* is an evil spirit that is believed to originate in the Chipinge area (it is noteworthy that Karanga-speaking informants tend to ascribe this spirit to Ndaue speakers, while Ndaue speakers tend to ascribe it to Karanga speakers. Other informants again claim the spirit comes from South Africa). *Chikwambo* can take a human form and has human characteristics. A person whom one owes a debt might send a *chikwambo* to retrieve it (cf. Aschwanden 1987:43). Some informants believe *chikwambo* will come as a snake. Others believe it will come in the form of a *tikolotshe*. Others again believe that *chikwambo* will remain invisible, bringing misfortune and illness. The illness will get worse if the debt is not repaid. The general belief is that a person affected by *chikwambo* will eventually turn mad, because the illness and misfortune will grow too much. A person can also call upon a *chikwambo* himself. Such

- a *chikwambo* has to be bought from a sorcerer for a considerable amount of money and will then be sent around in the area to steal money and other material wealth. The more wealth the owner of the *chikwambo* will accumulate, the more demanding the *chikwambo* will become, until its demands can no longer be met. Then *chikwambo* will turn against the owner, bringing illness and misfortune to his house and eventually driving him mad. It seems that *chikwambo* is often associated with mine workers⁴ or other migrant workers, who accumulated considerable wealth outside their communities of origin. They are torn between the western, individualized consumer society in which everyone looks after himself, and their families and communities in the rural areas. The latter will expect the wealth to be shared. The choice is between rich and lonely on the one hand and poor and loyal on the other. Either way will leave the individual with frustrations (see also Chapter 8, case 14 and note 2).
- *Chipotswa* and *chitsinga*: Hannan (1974) describes these terms as follows: a physical disorder caused by witchcraft, harmful medicine or magic; and a physical disorder believed to be caused by witchcraft (*tsinga* literally means vein or muscle). Informants describe it as a bewitched object or medicine, placed on or in the ground. As soon as a person passes he will be affected by it. Informants differ of opinion as to whether it is possible to direct the medicine against someone in particular. Some describe the evil force in the medicine as *mamhepo*. According to the informants, the main difference between *chipotswa* and *chitsinga* is that *chipotswa*, although it may initially only affect the legs, can eventually circulate to other parts of the body, while *chitsinga* is restricted to the legs (cf. cases 4, 16, 27). *Chipotswa* operates via throwing evil or bewitched objects in the direction of the victim or by 'calling a name' (cursing). *Chitsinga* is applied in the form of a poisonous trap put on a path or a crossroad. In general *chipotswa* is considered a more serious condition, as it is more difficult to cure, affecting the blood and the bones and the whole body, while *chitsinga* only affects the flesh (although the literal translation of the term *chitsinga* points in another direction). The *chipotswa* and *chitsinga* cases seen during the research would probably be diagnosed as rheumatism and polio in scientific medical terms.
 - *Kushina* is the incapacity to find a marriage partner. Some attribute this to witchcraft or an angry ancestor spirit, others to jealousy on the side of the individual (inborn jealousy). Some informants claim that *kushina* is associated with people who are involved with *shave* spirits, i.e. they are married to the *shave* spirit and cannot marry someone else.

- *Kushangira* is a kind of witchcraft which is similar to *chikwambo* as far as its intention is concerned; it is used to get back something of which one feels one is the legal owner, usually the object in question is not material but immaterial, i.e. a lover, a child etc., this as opposed to *chikwambo*. Basically *kushangira* may result in any type of disability or illness, but physical and mental conditions were reported most often.
- *Chidyiswo* is a poison that is put in food or drink and enters the body through the mouth. It is a form of witchcraft, a slow form of poisoning, that is usually treated with emetics. The poison will first affect the alimentary channel, but if not treated properly, may also affect other parts of the body and eventually the blood. One case (case 26, Violet Mazire) of *chidyiswo* was observed during the research. The patient was treated for epilepsy in a local clinic without much success. She recovered only after receiving treatment with emetics by a local traditional healer.
- *Runyoka* is a term used to describe particular sexual conditions as well as the medicine/poison that is used to inflict such conditions, i.e. a medicine used to check the fidelity of one's wife. The medicine is put in the bed or on the body of the wife and should she commit adultery, swellings and pains will occur in the genital parts, the abdomen and stomach of the man as a punishment. If left untreated, informants feel it may lead to conditions very similar to a 'venereal disease' and it may also cause difficult labour on the part of the wife. The *runyoka* punishment that speaks most to the imagination of the people however, is that *runyoka* may cause people to be sealed together after sexual intercourse. Apart from any medicine that might be applied, a straight forward confession is required before the disease can be cured, or, in the latter case, before people can be separated again. Some informants claim that this condition is restricted to people who come from the Mt. Darwin area, north of the field work area, or to people who learned the practice there.
- *Mayorwa/kuchekova* is the name for the practice of breaking cultural norms; this is a fairly general indication for a cause of a disability. The term was used and examples were provided by various informants but could not be linked to concrete cases. One of the informants provided the following explanation: 'If a girl elopes and if a baby is born from that marriage, which is not a real marriage, and if the mother of the wife sees the baby without any prior arrangements (i.e. without the issue of the elopement being settled between the parties involved and the *lobola* payment settled), that baby may fall ill or become disabled because the custom was broken' (cf. Gelfand et al. 1985: 37).

- *Kutanda botso* is an offence of a similar nature which may also cause disability in the end. If one offends one's parents and does not make up for that offence during one's lifetime, the parent might retaliate after death, almost like a *ngozi*. Hannan gives the following descriptive definition (Hannan 1974): 'going around begging for millet, covered in rags, to brew beer for aggrieved parents who died before forgiveness for an offense could be asked.' The term may refer to the aggrieved spirit or to the harm done by it. In addition ancestor spirits that are not properly received and alien and angry spirits, *ngozi*, may be the cause of disabilities (cf. Aschwanden 1987:25).

6.4. Terminology for and causes of disabilities as mentioned by disabled informants, their relatives and relevant others

Apart from indicating whether their disabilities had a natural or a cultural cause, the disabled informants and their relatives were very unclear in their terminology as regards illness and misfortune in general and disability in particular. The terms they used to describe their condition sometimes referred to the condition *per se*, sometimes more to the alleged cause. It should be noted that this seems to be a common problem in scientific and traditional medicine alike. In this section we concentrate on the terminology for and explanation of a limited number (31) of disabilities, as provided by the disabled informants, their relatives and relevant others. In the next chapter the medical terminology as provided by the traditional healers will be discussed.

The list presented in Table 6 (see pp. 98–99) provides causes of or names for conditions as brought forward by the disabled persons, relatives and relevant others. Where more than one cause/name is mentioned the person(s) in question could not quite agree on one cause or gave different causes during subsequent interviews. It should be noted that during the initial identification the majority of disabled persons, relatives and relevant others indicated that their disability had a natural cause. The fact that a traditional healer was consulted was generally not mentioned either. These initial responses, though relevant to illustrate to what great extent the people in the fieldwork area know and are prepared to 'dance the dance' of scientific medicine, were interpreted in terms of social desirability and are not reflected in the list below. In Table 6 only the causes are mentioned that remained after we penetrated a considerable amount of social desirability and resistance.

There was a certain order in the way most informants provided information about the causes and circumstances of their disability, as well as a hierarchy in

the amount of threat involved in the causes mentioned. Initially most disabled persons and relatives would refer to the disability as a more or less natural thing. The next step would be to get the information on the visit to the traditional healer. The two statements do not necessarily contradict because a natural cause can also be treated by a traditional healer. The disabled persons would often refer to their parents or elders for a full account of the visits to and diagnosis and treatment of the traditional healer.

When asked about the diagnosis elders often would mention one of the types of day-witchcraft (see section 6.3), without mentioning the name of the evil-doer. This diagnosis tends to be rather general and almost comparable to the evil-eye type of diagnosis in Islamic cultures. The active substances in *mamhepo* or *chipotswa* may affect anyone, provided the substance is not mixed with components of the body of a prospective victim (nails, hair, sweat etc.). Also, people do not usually connect the name of a day-witch or sorcerer with these activities, although they may have their suspicions.⁵

In some case histories, the older relatives did not go beyond the *mamhepo*/*chipotswa* stage, although I strongly felt, and other informants confirmed, that there was more to the story. But some people were just not prepared to open their heart on the issue. In other cases after the *mamhepo*/*chipotswa* explanation either a *mudzimu* or *ngozi* was introduced. Sometimes a direct witchcraft accusation was made (day-witchcraft). Here again the different levels of explanation are not contradictory. If a person is affected by *mamhepo*, *chipotswa* or any other type of day-witchcraft, the question remains why the person was not protected against these influences by his or her own protective spirit or the ancestor spirits, as would normally be the case. This lack of protection from the side of the personal and family spirits would then be explained by admitting that some offence in the past might have annoyed the ancestors or that the case was beyond their control.

When the relatives do not recognize the cause as brought forward by the disabled individual (case 19) or when the relatives and the disabled persons bring forward different causes that exclude each other (case 10, case 24) this points in a similar direction, although relatives will not admit that they do not recognize the claim of the disabled family member.

Regarding the hierarchy in causes according to the amount of threat involved, the data indicate the following. Relatives and particularly relevant others speak in terms of cultural causes of the disability, while the disabled informants more often indicate that their disabilities have either natural causes or causes that cannot be determined clearly. These data seem to imply that,

Table 6

Causes/names of disabilities mentioned in research

case number	treat-ment	disabled persons	relatives	relevant others
no. 1	T	natural	witchcraft	ngozi
no. 2	S	natural	natural	natural
no. 3	–	natural	natural	witchcraft
no. 4	S/T	natural	natural/ chipotswa	witchcraft chipotswa
no. 5	T	–	–/shave	ngozi
no. 6	T	chipotswa	culture	witchcraft
no. 7	S	natural	natural	natural
no. 8	S/T	(this client is not always considered disabled)		
		natural	natural	natural
no. 9	S/T	natural	natural/taboo	natural
no. 10	S/T	mudzimu/ngozi/ shave	mudzimu/ngozi shave	mudzimu/ ngozi/shave
no. 11	S/T	chitsinga	chitsinga	–
no. 11a	S/T	natural	kushangira	–
no. 12	T	natural	natural	kushina
no. 13	S/T	natural	natural	cultural
no. 14	S/T	not disabled	chikwambo	rutsinga/ chikwambo
no. 15	S	natural	natural	natural
no. 16	T	chipotswa	chipotswa	chipotswa
no. 17	S/T	not disabled	mudzimu/ natural	mudzimu/ natural
no. 18	–	too young	natural	natural
no. 19	T	nzuzu	nzuzu not recognised	nzuzu shave
no. 20	S	not disabled	natural	natural

(Table 6 continued)

case number	treat-ment	disabled persons	relatives	relevant others
no. 21	S/T	–	natural	witchcraft/ ngozi
no. 22	S/T	natural	natural	ngozi/ witchcraft
no. 23	S/T	cannot speak	natural	witchcraft
no. 24	S/T	mudzimu	natural/ mudzimu	mudzimu
no. 25	–	chitsinga	chitsinga	chitsinga
no. 26	T	chidyiswo	chidyiswo	chidyiswo/?
no. 27	S/T	chitsinga	chitsinga	chitsinga
no. 28	T	cannot speak	natural	kutanda botso/ngozi
no. 29	–	–	do not want to talk	natural
no. 30	S/T	natural	ngozi	natural/ ngozi
TOTAL		13 natural 9 cultural 9 undetermined	13 natural 14 cultural 4 undetermined	8 natural 20 cultural 3 undetermined

Treatment pursued:

- traditional treatment only: 8
 - scientific treatment only: 4
 - both scientific and traditional treatment: 15
- for one person no reliable information could be obtained; three others never received any training according to their information or that of relatives

- 'Treatment' reflects all treatment pursued concerning the disability;
- 'Relatives' contains information provided by the nearest relatives; differences of opinion within the family about the cause are not always reflected, but are mentioned in the case histories;
- When both natural and cultural causes were mentioned the answer is listed as 'undetermined'.

the greater the distance between informant and disabled individual, the clearer and more threatening the causes mentioned are. Cases 3, 4, 12, 13, 22, 23, 28 and 30 illustrate this point. Although it was not possible to arrive at a complete hierarchy of natural and cultural causes in this research, such a hierarchy seems to exist in the minds of the informants. The various types of day-witchcraft and the *mudzimu/shave* are considered to be less threatening than a *ngozi*, and witchcraft is considered to be the most serious cause, as very little can be done about it. One would expect the disabled informant and the relatives to opt for the less threatening diagnoses/causes, while members of the community are more likely to indicate or gossip about possibly more serious causes. A difference in diagnosis between the disabled individual and his immediate relatives on the one hand and relevant others on the other may reflect a problem between the relatives and the rest of the family or the community (cf. Maureen Mapfumo, case 5). When this pattern is not adhered to, i.e. when the relatives bring forward different and perhaps even more threatening causes than the disabled informant and the relevant others, or causes that exclude each other (cf. case 1, 10, 11a, 14, 21 and 24) this may point to serious problems within the family.

Sometimes the relatives do not recognize the cause as brought forward by the disabled individual (cf. Edward Samukange, case 19); this points in a similar direction. Relatives do not always openly admit that they do not recognize the claim of the disabled family member. However, disabled persons, relatives and relevant others do not necessarily disagree about the cause of their disability, as in the case of Apollonia Rusere (case 25).

The findings in Table 6 should also be related to what was mentioned in Chapter 4 about the two types of natural causes that are differentiated. The informants who spoke about natural causes of their disabilities usually referred to the second type of natural cause, i.e. not the simple natural cause considered at the onset of an illness and that generally is solved easily, but the natural cause that is beyond the control of human beings and beyond treatment, except through interference from God, i.e. a miracle.

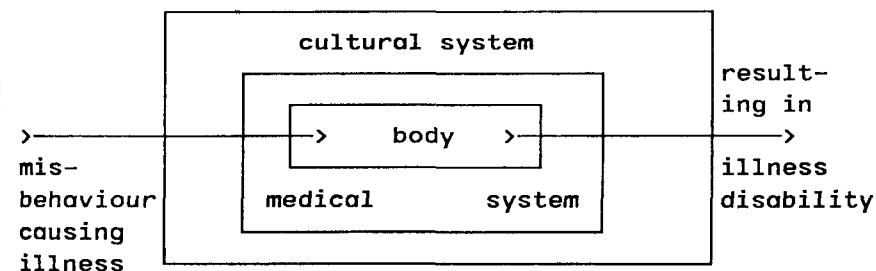
Most informants were not entirely certain whether their condition should be considered an illness or a disability. When asked to describe the difference between illness and disability (*kurwara* and *kuremara*) most of them only mentioned examples. In a more abstract form only one informant mentioned that disability is something 'that comes with birth', while another informant defined disability as 'an illness that cannot be cured, but still you do not die'. In a similar way when asked to define their condition in a more general way, most informants failed to do so.

As mentioned, most informants do acknowledge that there is a difference between the natural and cultural causes of an illness. Many disabled persons indicate that their condition has a natural cause, but they are generally unable to describe their disability in physical or medical terms. It is remarkable how many informants cannot give a consistent account of the medical diagnosis of their condition, even when they visited a scientific or traditional medical practitioner on several occasions.

Behaviour, in particular misbehaviour, witchcraft and sorcery-related activities as part of the cultural system have an influence on the body and manifest themselves as misfortune, illness and disability. The internal processes that take place in the body are not known and most informants are also not very interested in them. To most informants therefore the body is a black box. They can describe the misbehaviour that affects it and they can describe the misfortune that results from it. An ill or disabled person is considered to be affected primarily in social-cultural terms (i.e. if the condition is not simply natural). What happens inside the body and with the individual is a result or symptom of social or cultural problems (see Figure 6 below).

Figure 6

Schematic representation of the body as a black box, and as perceived by the majority of disabled informants



In all cases where explicit witchcraft accusations were made, i.e. accusations of night-witchcraft, they were made by brothers or fathers-in-law against sisters or daughters-in-law. In case 1, the grandfather believed that it was a girlfriend of Kenneth who had bewitched the family. The brothers of Kenneth's father pointed the finger in the direction of their mother, who was being mistreated by their father, and to the first wife of Kenneth's father as being the evil-doers. Sometimes they speak of them as witches, other times they speak of them as

ngozi, i.e. 'spirits' who have some justification for their revenge and evil. It also shows clearly that a cultural diagnosis is open to various interpretations. The influence of witchcraft can, under certain circumstances, also be interpreted as the influence of a *ngozi*. What is sheer evil in the first case is justified evil in the second case. The influence of a *ngozi* in turn can be interpreted as the influence of a *mudzimu* or *shave*. In the first instance we talk about punishment for a major sin, in the second case we talk about a minor sin or forgetfulness. Although the traditional healer is the one who formally makes the diagnosis, a lot of diagnosing goes on in the family and community as well and, as was the case with Maureen Mapfumo, a diagnosis does not have to be accepted by the family. In the final diagnosis, therefore, not only the condition of the individual but also the socio-political situation of the family and the community are reflected.

As mentioned earlier, a typical *mudzimu/shave* case involves an ancestor spirit who wants to come out. Although in the literature a clear distinction between family and alien spirits is always made, in the field it proved rather difficult to distinguish between these two categories of spirits. Hardly any new *shave* spirits have come out in the fieldwork area. The *shave* spirits who do come out are usually inherited from parents or grandparents. Although the rituals surrounding the coming out of an ancestor spirit or a *shave* spirit differ, the *shave* spirit is no longer as alien as it used to be. It has become part of the family. Many disabled persons suffer from the fact that a *shave/mudzimu* apparently wants to come out in them but that some relatives do not want to acknowledge this. The case history of Edward Samukange (case 19) provides a clear example in this respect (cf. cases 10, 17 and 24). As a punishment for not having their wishes honoured, the spirits are believed to retaliate by inflicting more physical harm. The reasons for not accepting a spirit may differ. Sometimes the individual or his/her family do not want to accept a spirit for religious reasons. Especially for members of a Christian church, like Edward Samukange and his wife, it is difficult to accept spirits. Often (cases 10, 14, 19) acceptance of a spirit goes together with leaving urban life and formal employment in town. In such cases it may be claimed that these people have been called home by their spirits, although this often coincides with problems in the employment situation. Also, there may be disagreement or jealousy within the family about the nature of a spirit coming out. As mentioned earlier, spirit mediumship does bring along additional status, although strictly speaking this is not supposed to be the case, as the medium is considered to be no more than a tool of the spirit. Case 19 illustrates clearly that it is very important in which house of a family an ancestor

spirit comes out, not only because of the status and power involved but also for the protection an important spirit can offer. In addition there may be financial motives involved when the spirit in question has healing powers.

6.5. Preliminary conclusion concerning the way disabilities are experienced and perceived by disabled persons, their relatives and relevant others

In this chapter the ideas and feeling of disabled persons, their relatives and relevant others concerning disability were presented. We might term them the 'illness component' of disability. In their explanations the informants do not concentrate so much on the medical aspect of disability, but on the subjective experience and on the explanations given for it within the framework of culture and religion.

The information provided allows a number of preliminary conclusions. First of all it may be concluded that there is a certain order or hierarchy in the causes indicated. Some causes and explanations are less threatening than others and basically the family will want to protect itself against threatening diagnoses. In general people are more concerned about cultural than about natural causes. A *shave* or *mudzimu* is considered less fearsome than witchcraft, while day-witchcraft is feared less than night-witchcraft. This kind of information is reflected in the way people reveal the cause of their disability (they tend to begin with the least-threatening cause possible) as well as in the differences between the explanations offered by disabled individuals, their relatives and relevant others (the disabled individual will generally provide the least-threatening explanation).

When we look more in detail at the causes presented by the different informants, three groups or forms of causation seem to exist:

- Unanimity about the causation and explanation between all parties concerned;
- Main difference in causation and explanation between relevant others on the one hand and immediate relatives/disabled person on the other;
- Main difference in causation/explanation between relatives and disabled person.

The case-studies presented in the first section of this chapter provide clear examples of the different types of causation/explanation distinguished here. The material should be interpreted with caution, however, as it does not necessarily reflect all factions and interpretations that exist in the community. It provides merely an illustration of the statement that different interpretations exist.

The first form, unanimity, is reflected in the case of Apollonia Rusere (case 25). Everyone agrees that her condition is caused by *chitsinga*. It is remarkable to note at the same time that medical treatment was/is not pursued in her case and that her social status in society is quite acceptable.

The case of Maureen Mapfumo (case 5) illustrates clearly how differences can exist between the immediate family and the lineage or community about the explanation, whereas the cases of Kenneth Madzima and Edward Samukange (case 1 and 19) provide examples of a situation where problems exist within the immediate family. The problems in the Samukange family have not yet polarized to a same extent as the problems in the Madzima family, but basically they are of the same nature.

The case histories presented are characterized by stagnation, stagnation as far as medical treatment is concerned, and stagnation in cultural/religious respect because no solution for the underlying cultural problems is found, and/or social and political stagnation with respect to gaining a position of status or at least respect in the society. The case history of Apollonia Rusere seems to be an exception, but when we realize what her situation must have looked like at the onset of her disability, even her case is no different. Nevertheless it does make clear that stagnation may be gradually resolved or coped with in the course of time.

Chapter 7

The diagnosis and treatment of disability: The professional perspective

7.1. Four case-studies

Case 23: Monica Murape

Monica Murape was born in 1970. The delivery was normal. She was the oldest child. Her father and mother worked in town. After the delivery the mother returned to the fieldwork area. Monica has two brothers and a sister.

The mother of Monica Murape described to us in detail the different types of medical treatment she sought for her daughter when, at six weeks, she noticed that something was wrong with her child. She took her baby to the clinic, but the nurse in charge said the baby looked nice, healthy and had a sound complexion. After three months the condition had worsened, the baby would sleep all day long and could not open her eyes, not even to drink. The fontanelle would not close either. At that time the mother consulted a traditional healer who concentrated on treatment of the fontanelle and this treatment had some positive results, although the general condition of the baby remained poor. At about six months the baby stopped to grow, while until that time it had been healthy and of normal posture.

Then the skin of the baby started to crack and the mother really knew something was wrong. She collected all her money and consulted a private practitioner in town: 'They help you immediately, but you have to pay.' The doctor referred the mother to Harare hospital where the baby was admitted for six weeks. A lady doctor carried out the examinations. Concerning the diagnosis brought forward by the physician, Monica's mother stated: 'She said: "It is a cretin," I do not know what she meant.' For two months the mother visited the hospital on a monthly basis to collect brown tablets for her baby, but she saw no improvement. Then in 1970 the mother gave birth to a healthy son and thereafter she did not go to the hospital anymore. The condition of the first child did not improve however. It had been established by the doctor that she

could not hear, but later it became clear that she could not speak either. For this purpose traditional practitioners were consulted.

The first traditional healer concentrated on the excessive growth of the child's head and, according to the mother, he was successful in reducing the growth. The healer told the mother that, because of the treatment, the baby would not grow anymore, but that at the same time the excessive growth of the head was stopped. Thereafter another traditional specialist was consulted for the speech problems. This healer cut a muscle under the tongue. The idea behind this operation is that the muscle under the tongue is too tight (to allow a normal blood circulation) and needs to be loosened to allow the tongue to move freely and hence produce a normal speech. The operation remained without the desired effect however. The mother came to accept the disability as 'a gift from God'. She does not think that much can be done about it anymore, nor does she think that the disability could have been prevented.

People in the area, but particularly the relatives of the husband, claim there is witchcraft involved. According to them either the mother is a witch herself or she is punished for sins she committed in the past. At all costs they make it clear that their family does not have anything to do with the disabilities (when the mother of Monica gave birth to a second disabled child, they persuaded Monica's father to divorce his wife).

Case 27: Maxwell Mafure

Maxwel is a young man suffering from the severe after-effects of polio. He is about 27 years old, unmarried and has no children. As a result of polio he has severe contractions in both legs. He cannot stand up and 'walks' on his hands and knees. According to his father, Maxwel was attacked by some form of day-witchcraft, *chitsinga*, when he was young. He had been herding cattle and when he came home his legs were very weak. They consulted several traditional healers, but all in vain. The condition was diagnosed to be *chitsinga* (see Chapter 6) which causes this kind of disability. The father claims he knows who put the poison to trap his son, but he cannot make an accusation openly, as that is not customarily done in the area. The father also says that in cases like this there is no need for treatment. If a healer did manage to take the witchcraft away from his son, it would attack another person in the family.

Maxwel is trying hard to earn some money. He is engaged in a gardening project of his own and in an experimental income-generating project in the area. There have been some problems in the past about the fact that Maxwel had his own garden, but did not contribute to the farming activities of the family. His

brothers sold his crop without informing him and kept the money. The example shows that economic prosperity, little as it may be, is not always appreciated by relatives and community members and it holds important implications for the development of income-generating projects for disabled persons at the community level. Nevertheless Maxwel continued his efforts to earn money. The main reason is that he is trying to save money for *lobola*, because he wants to get married.

His father agrees that it is important that he should try to get married. They do not see his disability as a real obstacle to reach this goal. If there is an obstacle at all, it would probably be the amount required for the *lobola*, as the prospective in-laws apparently are not prepared to settle for a small down-payment. Maxwel already has a particular girl in mind, but he did not want to reveal her name in front of his mother, who was present when we discussed the issue.

During the course of the fieldwork Maxwel developed an enormous wound on his hand. The wound did not heal, but got larger and more infected every day, because he continued to walk on his hands and knees. Maxwel attached a piece of rubber to his hands but the piece of string with which the piece of rubber was tied, cut into the open wound at every step he made. Time and time again I tried to convince him to have his hand treated. He always gave excuses for not having to go. His main fear was that the nurses of the rural clinic would send him to the rural hospital in Makumbe and this is indeed what the nurses would have done. Finally, his condition deteriorated to the extent that he developed a serious fever and a paralysis in the affected arm. Then his father forced him to go to the hospital with me. He stayed in the hospital for about ten days, but as soon as the fever ceased, he hiked home again, his arm being in almost the same condition as when he arrived. Asked why he left the hospital in that state, Maxwel answered that he did not like hospitals and that they did not do anything for him anyway. He also indicated that he wanted to see his relatives again.

Case 26: Violet Mazire

Violet Mazire is 20 years old and attended school until grade 7. She married when she was 19 years old, but she was sent home by her in-laws when she started suffering from epileptic attacks. Her relatives arranged for her to be treated by a traditional healer. They selected a healer with a good reputation and a specialization in the treatment of epilepsy. The arrangement with the in-laws was that Violet would return to their homestead when she was cured. However, recently she received a letter from her husband saying that, irrespective

of the outcome of the treatment, he would not take her back (later the in-laws apologized for this letter and claimed it was written by a brother of the husband and that, indeed, they would be very happy to receive Violet back, provided she was cured).

According to Violet and her relatives the epilepsy is caused by *chidyiswo*. This is a kind of poison that is put in food or drinks and that enters the body through the mouth. It is the kind of poison that may be used by jealous neighbours. Violet nor her relatives want to be more specific about the accusation. Other people in the area have nothing more than gossip to present about the reason why people were planting poison in Violet's food and their stories in this respect are not consistent. One informant suggested, and I am inclined to follow this suggestion, that probably not epilepsy, but the fact that Violet had not conceived in the period she was married, was the main reason for her dismissal. Nevertheless, even this informant agreed that it is *chidyiswo* that affects Violet.

The treatment by the traditional healer to cure *chidyiswo* consisted of two parts. First *muti* (medicine) was ground until a fine powder remained. The powder was mixed with water and porridge and Violet had to drink it. Thereafter, within two minutes to an hour, she was expected to vomit, which she did. With the vomit the poisonous substance is supposed to come out and thereafter the patient is cured. According to Violet this is also how the medicine worked in her case.

Although she did not consider this to be part of the treatment, Violet stayed at the place of the healer for a considerable length of time. She also discussed with the healer the problems she encountered while staying with her in-laws. Ever since the treatment, until the end of the fieldwork period, Violet claimed she did not have any more epileptic attacks. At two occasions she reported to experience the kind of dizziness that leads to an epileptic attack in her case.

It is difficult to say whether Violet's account concerning her attacks is true. There is quite a lot at stake for her. First of all there is the issue of the *lobola*. If a divorce takes place because Violet cannot conceive children or because she has epilepsy, it is likely that her in-laws will want the *lobola* back. If the epilepsy is cured, or does not reoccur and if the attention is diverted from the fact that Violet did not get pregnant the return of the *lobola* becomes an issue for negotiation. The *lobola* is an important source of money for a family. It may be used by the sister's brother to pay his *lobola* but, more likely in the fieldwork area, it may also be kept by the parents as a provision for old age, thus relieving the financial burden on the son/brother. When the epilepsy continues or when Violet will not be able to have children, she will become dependent on her father

and brothers, so the *lobola* is a very delicate issue that has to be dealt with with great care.

Violet was identified as a disabled person and she was offered the opportunity to participate in an income-generating project for disabled persons in the area. Her father did not allow her to participate. He said Violet could not be earning money without the consent of her in-laws. Later he admitted that it was not opportune to have Violet identified as a disabled person, while the negotiations about her marriage were still going on.

Case 16: Milly Kaseke

Ms. Kaseke is a lady in her seventies. No one knows her exact age. She suffers from pain in the left upper arm and knee. She also complains of swellings, although they were not visible at any of the instances I visited her.

Amai Kaseke is suffering from a variety of conditions that are related to her age. She has mobility problems and because of that she becomes somewhat isolated, as she remains in her house all day. She cannot get up from the floor independently and she can only walk a few steps at a time. The range of motion (ROM) of her arms is limited and she misses the grip in one of her hands. She is supported by her children, both financially as well as for activities of daily living (ADL).

Ms. Kaseke was married but she is a widow now. She is the mother of ten children, seven boys and three girls. One of the boys and a girl died prematurely and she now stays in a homestead with her two daughters and a son. They are all married and/or have children. Her other sons work in town, but still have their houses in the homestead and return for the week-end.

When she first fell ill *amai* Kaseke had swollen knees. She visited a traditional healer who made incisions in her leg and rubbed in medicine to stimulate the blood flow. This treatment helped, as the pain got less. Two months ago she felt a similar pain under her arm. She visited a *nganga* again. This time a different type of treatment was performed and the condition was diagnosed as *chipotswa*. This is a type of day-witchcraft which, according to Ms. Kaseke, was used because she is strong and because her children are successful, i.e. people envy her. The diagnosis is not disputed by informants in the community. She was still undergoing treatment at the time of the last interview and she was considering to visit the hospital as well. Although the treatment of the *nganga* was successful, because the pain had decreased, Ms. Kaseke felt that perhaps the healer would not be able to remove all the pain, and she had hopes that the hospital would be able to deal with the part that remained.

At the same time she was reluctant to go to the hospital because two of her brothers had died there. She could not tell for what reason her brothers were admitted in hospital in the first place, but she does know that they died there during/after operations. She asked if she could get treatment at the hospital (formerly a mission hospital) if she is not a christian and she wanted to know if she could leave freely any time she wished, even when the doctors wanted to perform an operation on her. In the months that followed, Ms. Kaseke never actually visited the hospital, although I had offered her transport at several occasions.

Despite the fact that her physical condition was uncomfortable and often very painful, Ms. Kaseke's social position and status were not in any way affected by her condition.

7.2. Traditional healers approached

When the disabled informants were asked which healers they had consulted, they often mentioned relatives or community members living nearby as the first healers they went to. Only when the condition persisted healers with a good reputation in a specific field were consulted. They often lived far away from the fieldwork area.

The local healers that were initially consulted, may be regarded as 'first-aid healers'. They have a rather limited clientele and usually do not charge much for their services. In most cases they are not registered with ZINATHA, the Zimbabwe National Traditional Healers Association.¹ Carrying out the practice of a traditional healer or spirit medium in Zimbabwe without a ZINATHA registration is illegal.

During the first phase of the research, when disabled informants were interviewed, it became clear that it would not be possible and practical to interview the healers involved in these cases. Apart from the fact that the majority of healers could not be traced, healers are not prepared to talk to strangers about particular clients, even if the client approves. This is a very understandable part of their medical ethic that has to be respected. The initial set-up of the research among the traditional healers clearly reflects some bias on my part as regards the level of professionalism of the healers in this respect.

For the purpose of this research twelve traditional healers were interviewed. This figure includes two *svikiro* or spirit-mediums for a *mhondoro*, who also acted as healers in individual cases. The majority of these healers were associated with ZINATHA and were approached with the assistance of Mr. N. Jambaya,

the treasurer of the association and himself a healer of outstanding reputation. In order to get a more complete picture however, also some of the so-called 'first-aid healers' were interviewed. As far as the value of their information on the medical aspects of the disability is concerned this group takes a somewhat intermediate position between the specialists among the traditional healers and the disabled informants. Healers with various specializations were interviewed, while also healers with different sources of healing power (*mudzimu*, *nzuzu*, *shave* etc.) were included. Both male and female healers were interviewed, but unless this is explicitly mentioned, their answers were the same concerning the topic under consideration. In addition I visited a few healers from Malawi and South Africa. These healers lived in Zimbabwe for the larger part of their lives and both had practices with many clients. They were quite familiar with the healing practices existing in Zimbabwe, and better than anyone else, they were in a position to evaluate them and point at weaknesses and peculiarities.

While the registered traditional healers offer a somewhat elaborate explanation for the physical aspects of disease and disability, the disabled informants, their relatives and relevant others adhere to the medical black box model for illness and disability discussed earlier (see Chapter 6). The explanations of the first-aid healers fall somewhere in between.

A first-aid healer may be the type of part-time healer without much specialization, as described above. He may also be in the process of developing a specialization. Traditional healers often work with the assistance of a *shave* or *mudzimu* spirit with healing powers. An individual cannot simply make a claim of being possessed by such a spirit and start a practice as a healer. This involves an often time-consuming process whereby the claim of the potential healer is checked and gradually acknowledged by other traditional healers and by the community in general (see also the case history of the disabled healer and spirit medium, Mr. C. Musana, Chapter 8).

In four of the thirty-one case-studies recorded for this research (see Table 6) it was clearly stated that at no stage a traditional healer was consulted concerning the disability and that only the assistance of scientific medical practitioners was sought. In three cases no treatment was sought at all and in one case no clear information could be obtained in this respect. In the twenty-three remaining cases a traditional healer was consulted at one or several occasions, while in fifteen of these twenty-three cases a scientific medical practitioner was consulted as well. In those cases where both a scientific medical practitioner and a traditional healer had been consulted, it could not be established clearly in what order the consultations took place. Although all informants provided

answers to these questions, these answers are less than reliable. The order of the consultations was often determined by outsiders, as when an individual was taken to hospital 'by force' after an accident or in an otherwise serious condition. In other cases the disabled individual was too young to have any influence on the consultation of either a scientific medical practitioner or a traditional healer. Of the fifteen cases in which both a scientific medical practitioner and a traditional healer were consulted, only two informants indicated that they did not expect any relief from traditional healing anymore and that they had completely discarded this approach, while three informants mentioned an explicit refusal to consult a scientific practitioner. The informants could not give clear reasons for shifting from one type of healer to the other type. My impression is that both circumstantial factors and the belief in the effectiveness of a certain type of treatment play a role. In addition shifts in therapeutic preference occur at particular moments in the life history of a disabled person: the mother of Monica Murape changed the treatment for her daughter after the birth of a second, able-bodied child. Later she looked for treatment again when another disabled child was born. The stepfather of Tendai Hungwe (case 4, Chapter 8) considered to have Tendai fitted with a new calliper when it became more probable that a divorce would take place.

The information provided in Table 6 clearly indicates that in a considerable number of the cases (75%) traditional healing is or was considered an essential part of the rehabilitation process. If the case-study data are compared with the statistical data provided in Chapter 3, the difference is apparent. It should be mentioned in this respect that in the initial phases of the interview most informants indicated that their disabilities had a natural cause and they did not make reference to traditional healing. Most informants mentioned lack of confidentiality as the main reason for not having revealed what they really felt the cause was. Often informants first asked my opinion of traditional healing before they expressed their own feelings in this respect. Fairly reliable information could be obtained in this way concerning the explanatory models that disabled persons use, but it was a time-consuming exercise.

It also seemed that in some cases the informants did not feel it necessary to inform us about 'the obvious'. A clear example of this nature was provided by the mother of Tendai Hungwe (case 4) mentioned above. She gave us a very detailed account of her trips to hospitals, doctors and church organizations in order to get treatment for her disabled daughter. I had already recorded this as a case in which no traditional healing was considered, when, in a very casual way, the mother remarked that not much was to be expected from the consultations

of these doctors because the condition of her daughter was caused by witchcraft. When asked to elaborate, she revealed that she had visited various traditional healers with her daughter, albeit without much success. She explained the fact that she had not mentioned these visits to a *nganga* earlier on, by saying that she had thought that the researcher would not be interested in this side of the story.

As mentioned earlier, some informants have visited scientific medical practitioners but do not know the diagnosis arrived at in their case. Some were treated and spent several months in hospital without being able to explain what they were treated for. The mother of Monica Murape remembered the diagnosis, but did not have the faintest idea what it implied. She had visited scientific medical practitioners for over a year and traditional practitioners for an even longer period. Besides that she is a literate woman and she received some training as a health worker. Nevertheless, when describing the physical condition of her daughter, she said that the body and particularly the head appeared to her to be 'full of water and loose and flexible as if it had no bones but only plastic'. In another, rather extreme case (case 9) a young man was operated on his eyes when he was three or four years old, but he himself and his family are of the opinion that 'nothing happened' during the boy's stay in the hospital at that time. This total lack of insight in the processes and practices of scientific health care also explains the reluctance of some disabled persons to undergo scientific medical treatment (cf. Maxwell Mafure, case 27 and Milly Kaseke, case 16).

Disabled informants were not always present when traditional healers were consulted and only a few can give an account of a consultation the way Violet Mazire (case 26) did.

7.3. Terminology concerning disease and disability

Not all conditions termed disability in scientific medicine are considered *kuremara* (disability) by the disabled informants and the traditional healers. On the other hand some conditions that are considered *kuremara* by the healers and disabled persons are not called disabilities in scientific medical terms.

Most disabled informants did not draw a clear distinction between disease and disability or *kurwara* and *kuremara*. The traditional healers often found it equally difficult to talk about this difference in abstract terms. Only a few statements could be recorded from traditional healers in this respect. In one of these statements, an interviewed healer (healer B) indicated:

An illness is a temporary thing. The blood may be affected, but it is still supplying the whole body. In case of a disability, the blood will no longer go to that part of the body. It is the spirit (of the individual) which enables the blood to function. For certain categories you cannot say it is an illness or a disability. It depends on how much the disease has developed. You have to name it as an illness. It also depends on the possibilities of treatment, like in the case of Mr. X, he cannot be treated anymore and is therefore disabled.²

Because not many clear explanations were offered and because the statements of informants often showed internal and external contradictions, a list of Shona terms for a number of illnesses/diseases and disabilities was compiled and the healers were requested to indicate if these conditions were diseases or disabilities, *kurwara* (k) or *kuremara* (c).³ This list is provided in Table 7 (see pp. 116–117).

Most traditional healers specialize. It is generally considered as a lack of professionalism amongst healers not to specialize in a particular type of disease. Most healers interviewed are capable of diagnosing different diseases, but they will refer a client to another healer if the disease is not in their field of specialization. Traditional healers may also refer to scientific healers if they feel a patient may receive better or more suitable treatment there.⁴

It should be mentioned that healers sometimes found it difficult to speak about conditions that did not belong to their field of specialization. Bearing this in mind, we shall now discuss the explanations offered by the traditional healers for the diseases and disabilities mentioned in Table 7:

- *Kuoma rupandi*, 'the parts are dry', refers to a condition comparable to what scientific medicine terms paralysis, hemiplegia and perhaps also paraplegia. The condition is generally considered to be a disability, caused by the fact that blood circulation in that part of the body has ceased. This in turn causes the paralysis and the decay of the flesh. The status of the actual blood circulation in the various parts of the body can be checked by making incisions, as described above. If referred to the right traditional healer in time, the condition can be treated by removing the 'black blood' and blood clots through 'cupping', or, as some healers report, by placing the client in a hole in the ground up to the level where the blood is no longer flowing. Then the hole and the affected parts of the body are covered with soil mixed with *muti* in an effort to solve the stagnant blood and to re-start the blood circulation. The reasons for the initial breakdown of the blood circulation may be either natural/hereditary or day-witchcraft, notably *mamhepo*, *chipotswa* and *kushina*.

- *Mheta-makumbo*, 'folded legs,' is a condition that is associated to what is called paraplegia or polio in scientific medical terms. *Mheta-makumbo* specifically refers to the muscle contractions of the legs as may be the case in paralysis and polio. It is also considered to be a disability and may be treated like *kuoma rupandi*. Some informants say that *mheta-makumbo* is less serious than *kuoma rupandi*, mainly because in the latter condition the blood has 'dried up' completely. Also it was mentioned that *mheta-makumbo* is more likely to be caused by *chitsinga* than by *chipotswa* (see Chapter 8).

There are no specific terms in Shona for amputations and deformities. The term *chirema* is used to describe these conditions: 'the person is disabled, he is not the way he used to be.'

- *Upofu* (blindness), and *tsanga*, 'a single grain' (cataract) are two conditions affecting the eye. Another eye condition, *chirwere che maziso*, 'eye illness,' is always considered a disease, as the name indicates. This condition is comparable to what is called conjunctivitis or eye infection in scientific medical terms. *Ruchonyoroka* is a term used to describe a condition comparable to squinting. None of the healers interviewed specialized in this condition. Some healers believe treatment is possible and therefore rate the condition as a disease. Others, who do not believe that the condition can be treated, consider it a disability. *Upofu* is generally seen as a disability. It may be caused by dust and dirt and by witchcraft, notably day-witchcraft carried out while the victim is still in its mother's womb. If the blindness is caused by one of these, it may be curable, if treated in time. *Upofu* may also have natural or hereditary causes, in which case most healers feel it is not curable. A person may also be blind because he is possessed by a *mudzimu* or *shave* that was blind during his lifetime. In such cases the blindness is only temporary for the duration of the possession. The physical explanation for *upofu* is twofold. Sometimes it is believed that the blood circulation to and in the eye is affected and the eye has become or is getting 'dry'. Another, less serious, possibility is that the muscles of the eye are affected. As the muscles are considered to be the carriers and transporters of blood, this indirectly affects the blood circulation and may eventually lead to blindness, when the eye becomes dry. *Upofu* refers to a condition of total blindness. Poor eyesight is called '*haaoni zvakanaka*'. *Tsanga* is considered curable, provided treatment is sought in time. If treatment is delayed, it is no longer possible to cure the eye problem and the condition may be termed '*kuremara*'. The condition is believed to be induced by blood clots and black blood, but the blood never becomes stagnant. Therefore the prospects of treating *tsanga* are considered

Table 7

Disease (k) or disability (c) as indicated by traditional healers

Name of the condition	1	2	3	4	Healers interviewed									13
<i>kuoma rupandi/</i>														
hemiplegia	c	c	c	k	c	k	c	c	c	k	c	c	c/k	
<i>mheta makumbo/</i>														
paraplegia/polio	c	c	c	k	k	c/k	c	c	c	c	c	c	c	
<i>chirema anakumina/</i>														
clubfoot	c	c	c	c	c	c/k	c	c	c	c	c	c	c	
<i>tsanga/</i>														
cataract	c	c/k	c	k	k	k	c	k	c/k	k	k	k	c	
<i>upofu/</i>														
blindness	c	c	c	c/k	k	c/k	c	c	c	c	c	k	c	
<i>chirwere che maziso/</i>														
conjunctivitis	k	k	k	k	k	k	k	k	k	k	k	k	k	
<i>nuchonyoroka/</i>														
squinting	k	c	k	n	c	k	k	k	k	c	c	c	c	
<i>mburunzewe/</i>														
deafness	c	c	c	c/k	c/k	c	c	c	c	k	c	c	c	
<i>chimumumu/</i>														
muteness	c	c/k	c	k	c/k	c	c	k	c/k	c	c	c	c	
<i>tsviyo/pfayi/</i>														
epilepsy	k	k	k	k	k	k	k	k	k	k	k	k	k	
<i>kupenga/</i>														
mental illness	c	k	k	k	k	k	k	c/k	k	k	k	k	k	
<i>kuzungaira/</i>														
mental retardation	c	c	c	c	k	k	c	c	k	c	c	c	k	
<i>dofo/</i>														
slow learning	c	k	c	c	k	k	c	c	n	k	c	c	c	
<i>gwiri kwiti/</i>														
measles	k	k	k	k	k	k	k	k	k	k	k	k	k	
<i>maperembudzi/</i>														
leprosy	c	c	c	k	c/k	k	c/k	c/k	k	k	k	k	k	
<i>chirwere che moyo/</i>														
disease of the heart	c/k	k	c/k	k	k	k	k	k	k	k	k	k	k	
<i>msoro kubanda/</i>														
headache	k	k	k	k	k	k	c/k	k	k	k	k	k	k	
<i>gurokuro/</i>														
goiter	k	c	k	k	k	k	c/k	k	k	k	c	k	k	
<i>dhiropu/siki/</i>														
venereal disease	k	k	k	k	k	k	k	k	k	k	k	k	k	
<i>chirwere chesunga/</i>														
diabetes	k	k	k	k	k	k	k	k	k	k	k	k	k	
<i>chikosoro chorutakura/</i>														
whooping cough	k	k	k	k	k	k	k	k	k	k	k	k	k	

(Table 7 continued)

Name of the condition	1	2	3	4	Healers interviewed									13
<i>chikosoro chorurindi/</i>														
tuberculosis	c/k	k	k	k	k	k	k	k	k	k	k	k	k	
<i>sope/</i>														
albinism	c	n	c	c	k	c	n	c	n	c	n	c	c	
<i>njechete/durama/</i>														
upper teeth appearing first	c	c	n	c	k	k	c	k	n	c	c/k	c	c	
<i>manyaviri/</i>														
twins	n	c	n	c	c	n	c	n	n	c	n	k	n	
<i>lungoma/</i>														
barrenness	k	c/k	c/k	c/k	c	k	c	k	k	c	c	k	c	
<i>chipotswa/</i>														
day-witchcraft	c/k	k	c/k	k	k	k	k	k	k	k	k	k	k	
<i>mamhepo/</i>														
day-witchcraft	c/k	k	c/k	k	k	k	k	k	k	k	k	k	k	
<i>chikuwambo/</i>														
day-witchcraft	c/k	c/k	c/k	c	c/k	k	c	k	k	n	n	k	c	
<i>kushina/</i>														
day-witchcraft	c/k	k	c/k	k	k	k	k	k	n	n	n	k	n	
<i>chidyiso/</i>														
day-witchcraft	c/k	k	c/k	k	k	k	c/k	k	k	k	k	k	k	
<i>kushangira/</i>														
day-witchcraft	c/k	k	n	k	k	k	k	k	k	n	n	k	k	
<i>runyoka/</i>														
day-witchcraft	c/k	k	c/k	k	k	k	k	k	k	k	k	k	k	
<i>chipande/</i>														
depressed fontanelle	k	k	k	k	k	k	k	k	k	k	k	k	k	
<i>kabhokisi/</i>														
small pox	k	k	k	k	k	k	k	k	k	k	k	k	k	
<i>kuminyuka/</i>														
sprains	k	k	k	k	k	k	k	k	k	k	k	k	c/k	
<i>kutanda botso/</i>														
ill treatment parent	c/k	k	c/k	c	k	k	k	k	k	k	c	k	k	
<i>kuzimba muviri/</i>														
oedema	k	k	k	c	k	k	k	k	k	k	k	k	k	
<i>matyorwa/</i>														
social misbehaviour	c/k	k	k	k	k	k	k	k	k	k	k	k	k	
<i>musana unorwadza/</i>														
backpain	k	k	k	k	k	k	k	k	k	k	k	k	k	
<i>nyaviri/</i>														
rash	k	k	k	k	k	k	k	k	k	k	k	k	k	

k = *kurwara*, disease;

n = informant does not know if the condition is a disease or a disability or feels it is neither one;

c = *kuremara*, disability (*chirema*);

c/k = informant feels the condition can be either a disability or a disease depending on the circumstances.

to be much better than those of treating *upofu*. The treatment of *tsanga* by a traditional healer concentrates on the removal of the opaque film on the eye, just as in scientific medical practice. With a special *muti* on the tip of his finger, intended to make the film stick, a specialist *nganga* can remove a cataract. This was confirmed by all but one healer. I once met a person who claimed to be cured in this way, but I was never able to be present during one of these operations. There was one healer who felt that *tsanga* had another cause. This healer believed that blindness in general, including *tsanga*, was caused by worms, worms that he described almost like bacteria. He believed that too many worms caused disease and that, when so many worms are present in the eye also a lot of worm-faeces is likely to occur. According to this healer, the thin film on the eye, in the case of *tsanga*, is nothing else but worm or bacteria faeces.

- *Mburunzewe*, 'the ears are holes', i.e. the ears only have a symbolic function and the hearing organs are missing. *Mburunzewe* refers to either deafness or being 'hard of hearing' in scientific medical terminology. *Mburunzewe* is often related to *chimumumu*, an idiophonic word that refers to muteness. Not being able to talk is generally believed to be caused by tightness of a muscle under the tongue. This muscle has to be cut so that the tongue can move more freely. Virtually all disabled persons suffering from speech defects had undergone this operation (cf. Monica Murape, case 23, and case 28). Some healers associate *chimumumu* with deafness. They noticed that very often people who do not speak also do not hear. One healer indicated that the same muscle that runs under the tongue, to make speech possible, continues to the ears, to make hearing possible. Once the muscles under the tongue are freed, the muscles to the ears will also be free to operate. The effect of a tight muscle is that the blood flow will be reduced. Cutting the muscle will allow the blood to flow more freely. Other healers clearly distinguish between *mburunzewe*, without loss of the capacity to speak, and a combination of *mburunzewe* and *chimumumu*. These healers feel that *chimumumu* may be the result of *mburunzewe*: 'There is nothing wrong with the speech, but because she cannot hear, she cannot speak.' In other cases it is believed that the tongue has been immobile too long, so that even after cutting the muscle, 'it does not know how to speak anymore'. According to the healers *mburunzewe* on its own usually develops later in life and can have three main causes: infection of the eardrum; severe beating or accident (cf. case 3) and witchcraft or anti-witchcraft activities (cf. case 3).⁵ Only two healers were capable of describing the eardrum: 'A thin piece of skin in the ear like the skin

on a drum. When this piece of skin is pierced, this results in deafness.' One of the healers reported that there are also other organs involved in hearing, he referred to small bones, for which there are no Shona names. He said he had forgotten the European names for these organs. Temporary deafness may be caused by being possessed by a spirit of a person who was deaf during his life-time.

- *Kupenga*, *benzi*, *tsviyo* and *kuzungaira* are all names for mental conditions, mental illness of a violent and non-violent character, epilepsy and mental retardation respectively. For mental retardation or slowness in learning the term *dofu* is used also. In the *Shona Standard Dictionary* (Hannan 1974) the term is translated as mental retardation. According to the informants the term has strong connotations in the direction of 'slow learner' and can even be used teasingly or as an insult, 'imbecile'. From the information of the healers it became clear that the Shona terms for mental illness and mental retardation cannot be considered synonyms of the English terms. Reports of the healers and other informants revealed that *kuzungaira* only includes mild forms of mental retardation. Down's syndrome and comparable conditions are unknown to most informants but when the symptoms of these conditions are described, virtually all informants agree that such conditions are not meant when they speak of *kuzungaira*. Comparing the conditions of *kupenga* and *kuzungaira*, the informants agreed that *kuzungaira* is a less serious condition than *kupenga*. As far as I can judge, an evaluation of the English 'equivalents' of the Shona terms would probably not lead to the same result, i.e. in scientific medicine mental retardation is not unequivocally regarded as less serious than mental illness. The fact that conditions like Down's Syndrome are not included in the general terminology may be related to the fact that only recently, and due to improved health care services, children suffering from this condition manage to survive in the rural areas.
- Terms like *zwifa-zwifa*, *pfau-pfau*, are idiophonic terms to describe various forms of epilepsy. *Tsviyo*, another term used in this context, refers to the suddenness of the attack. For the various mental conditions two main causes are mentioned by the informants: natural causes (illness, accidents or hereditary factors) and cultural causes, notably witchcraft and spirits. If a mental condition has a natural cause, it cannot be cured by traditional healers; it is irreversible. It has to be determined however if the cause was really natural and if there was a particular reason for the person to become mentally affected at that particular time and place. Hereditary conditions form a borderline case between natural and cultural causes. They are often ascribed to a *ngozi* or

to *kutanda botso*. A particular family member may be cured from a hereditary form of epilepsy, but the illness will reappear in another family member. Often in hereditary cases a *ngozi* is involved. *Kupenga ne ngozi* is characterized by quiet behaviour during the day and shouting, singing and the use of abusive language during the night (cf. symptoms case 11b). Epilepsy can also be caused by a *ngozi*. Here two forms can be distinguished. One form is characterized by convulsions and fits (the behaviour of the patient will actually resemble the behaviour of the person on behalf of which the *ngozi* is revenging, at the moment that person died in a horrible way). *Kupenga ne ngozi* can be easily diagnosed according to the healers. When stepping on the shadow of a person thus affected, that person will fall. The other form of epilepsy caused by *ngozi* occurs usually when the person mixes with large groups of people (cf. symptoms Edward Samukange, case 19). Witchcraft, notably day-witchcraft, may also cause mental illness. Witchcraft brings about rather violent behaviour. It can also cause epilepsy, particularly the type of epilepsy that occurs at regular intervals, for instance once a month. According to the informant the physical process behind the mental condition is that the brain somehow got turned upside down. 'It is like a whirlwind.' As a result the patient will also see everything upside down, i.e. the wrong way. Apart from being turned upside down the brain is in no way physically affected according to the informants, other than by the obvious wounds in case of accidents. The only other physical indication mentioned by some of the informants is that 'the eyes are wrong'. Two other mental conditions were mentioned by the informants: '*gombas*', which seems to be a type of epilepsy that is inherited, and '*mhengera gunazi*', 'confusion in the shade of the hut'.⁶ The latter condition is relatively mild: 'We do not yet know how it is going to develop.' According to the informants a family is not likely to come forward with a patient suffering from this condition. Such a potential mental patient is kept in the shade of the hut, i.e. behind the door in the corner where the women usually sit, until it is clear that professional help has to be sought and the patient has to be brought out into the open or that the condition will pass spontaneously.

- *Maperembudzi*, 'a hybrid between a hyena and a goat', is the name given to a person suffering from leprosy. The hyena with its spots and the goat 'who only has two fingers', show some physical resemblance to the caricature of a person suffering from leprosy. Almost all traditional healers considered leprosy a hereditary disease. It affects the family and remains with their spirits when they die. The only way of curing it is by transferring it to another family by means of witchcraft.

- Albinism, '*sope*', is considered a disability by some healers only. One informant classified it as a disease, others feel it is neither a disability nor a disease but just a natural condition. The informants who feel it is a disability believe it is caused by the fact that the blood of the father was not strong enough at the time of conception, thereby allowing the blood of the mother to dominate. Her blood has no colour because it is not strong. Other healers indicate that albinism is caused by the fact that the mother has been breaking certain taboos during pregnancy. These healers could not say which taboos existed in this respect. The taboos may differ from area to area and from totem group to totem group.
- *Njechete/durama* is a condition whereby the upper teeth appear first when a child starts teething. Only two healers were of the opinion that there is nothing wrong (anymore) with the upper teeth appearing first. The other healers classified this condition either as a disease or a disability. The main reason for classifying it as a disease was that those healers felt the condition can be prevented by rubbing a certain medicine on the gums when the upper teeth want to come out first. Healers who consider it to be a disability, say that even when the teeth are prevented to grow the condition will affect the individual and his family for the rest of his life. Some healers recall that such children were killed in the past, but that does not happen anymore.
- *Hungoma* and *chibereko* are terms for infertility. This condition can have a natural or hereditary cause, in which cases treatment is difficult. Infertility can also be caused by various types of day-witchcraft (in those cases treatment is possible), or it may occur as the side effect of another (witchcraft-related) disease. It is believed that if the disease itself can be cured, the infertility will be solved as well.
- *Chipande/nhova*, which literally means a closed fontanelle and fontanelle respectively, refers to a condition where the fontanelle does not close properly or is depressed. *Chipande* is considered a disease and all healers feel it can be cured if treated in time. However the condition always causes great concern and a baby suffering from it is usually considered a bit special all its life. This is why some consider this condition a disability. Folk beliefs have it that crossing a river while breast-feeding may make the condition worse. Also, the company of other children with a strong protective charm against *chipande* should be avoided. *Chipande* is generally considered to be a danger sign. Many mothers of disabled children (for example Monica Murape, case 23) reported problems as regards the closing of the fontanelle. 'The body and the head were very soft and flexible, they did not contain any bones, only

water and plastic.' The lack of bones, the main causal factor in *chipande*, is often blamed on the father. The belief is that after conception frequent intercourse is required to shape the bones, the semen of the father thus makes the bones strong. *Chipande* may also be caused by witchcraft that affects the foetus in the womb. If the situation is very serious, a baby may die from *chipande* within 3–4 days after being born. In those cases, according to some informants, a pimple arises on the palate (a similar pimple or blister is believed to be a sign of a beginning influenza in adults). Various curative and preventive medicines exist for *chipande*. The preventive medicine often has a symbolic value: medicine prepared from the head of a sheep, as the head of a sheep is considered to be very hard; medicine prepared from the tail of a chameleon, with the idea that a child thus protected will adapt to changes in the surroundings like a chameleon adapts to its environment.

- *Kuzvimba muviri*, oedema, is considered to be a disability by only one of the healers. This healer differentiated between two types of oedema. One type will cause water to come out of the leg when an incision is made, while the other type shows black blood coming out from an incision. According to this healer oedema is caused by malfunctioning of the kidneys and it can be treated if referred to a healer in time.
- *Chirwere che moyo*/heart disease, *msoro kubanda*/headache, *gurokuro*/goiter are conditions that are usually considered to be diseases that can be treated. Those healers who were not familiar with the possibilities for treatment or who knew a patient that could not be treated would classify the condition as a disability.

In conclusion it can be said that for most healers disabilities are conditions that are inborn or hereditary and therefore difficult or impossible to treat, or conditions that started later in life but that are also difficult to treat or untreatable. These latter conditions usually 'affect the blood or the bones' of the patient and more often than not have a cultural cause.

The other conditions mentioned in Table 7 were considered diseases by the great majority of the informants and are therefore not discussed here.

7.4. Diagnosis and treatment

The traditional healers, just like the disabled informants, differentiate between natural and cultural causes of misfortune, disease and disability. As a matter of principle all illnesses can have a natural and cultural cause. A healer therefore

always has to diagnose a case to find out what the cause is. Then they decide whether they can offer treatment themselves or whether they should refer the client to another healer.

There are natural and cultural diseases and disabilities. A natural disease is a type of disease where you feel weak and where you take some cafenol [the Zimbabwean 'aspirins'] or vitamins and then it is over. Natural diseases are usually caused by poor hygiene such as throwing food away and defecating and urinating in the garden. If a disease lasts longer people will go to a diviner to see what the cause is.

As far as diseases and disabilities with a natural cause are concerned, the healers are quite unanimous about the following explanatory model: according to all healers a human being can be conceived as consisting of two parts, a body and a spirit. After death the body decays but the spirit remains. The body in turn consists of three major components: the flesh (*nyama*), the blood (*ropa*) and the bones (*pfupa*). Some healers also mention nerves, veins and muscles as 'organs through which the blood flows'. Like other organs such as the heart and the brain, these organs are usually classified as 'blood'. It is believed by most healers that in a foetus, the flesh is supplied by the mother, while the bones are supplied by the father. As far as the blood is concerned, most male healers and some female healers feel that the blood is supplied by the father. The major reason given for this belief is that, in the case of settlement of maintenance cases (when a father does not want to recognize a child as his own and refuses to maintain it), the blood of both the baby and the father is examined. 'If it is the same, the baby is a child of the father.' Therefore, it is argued, it must be the father who supplies the baby with his blood. Some female healers hold the view that the baby's blood is the mixture of that of the mother and the father. Going one step further some healers associated witchcraft with the flesh, spirits (good and bad spirits) with the blood and God with the bones.

A natural disease or disability is believed to enter the body directly through the flesh (malaria, wounds) or indirectly, through the air and via the mouth and nose. Initially a disease will affect a limited part of the flesh only. At that stage the disease can still be relatively easily cured. When the condition persists it may affect larger parts of the flesh and may reach the blood. Once the disease has reached the blood it will spread through the body and eventually may reach the heart. A person with the disease spreading through the body and usually with pains all over is seriously ill and it is much more difficult to cure a person in such a condition than a person whose disease/illness only affects the flesh on a localized spot.

The next phase starts when the blood is no longer only the transporter of disease, but is itself affected. The blood will get dark and blood clots will form and in the end the blood will lose its viscosity, become stagnant and dry up. When there is no more blood supply, the flesh will decay and in the end only the bones will remain, though severely affected.

At the stage that the blood gets affected, we have to do with a borderline case between disease and disability. If the blood has gone, or, rather, if the healers believe it has gone, these parts of the body are called 'dry'. *Kuoma rupandi*, the Shona term for a condition comparable to the term hemiplegia in scientific medicine, literally means: the parts are dry. The stage of being 'dry' may be considered the last stage before dying. If the body has dry parts, these are clear cases of disability and once the condition has reached this stage it is felt that it can no longer be cured.

The breaking point between disease and disability (in the case of physical disability) seems to be where the blood has stopped flowing for good. Even if the blood circulation is seriously affected treatment is still possible. Incisions into various parts of the body are made and medicine is rubbed into these incisions. Depending on the reaction of the blood to the medicine it can be determined if the blood is still flowing in that part of the body. In this way the boundaries of the circulation problem can be determined. There are various methods to remove blood clots and black blood and to restore the blood circulation. In the literature frequent reference is made to methods like cupping, whereby large quantities of black blood or blood clots are taken from the body. Although healers mention this method as a sign of high professionalism, I never met someone who had actually been treated in this way. It seems more common to apply medication externally or internally. The actual surgery that takes place in Zimbabwe by traditional healers seems to concentrate on cutting the muscle under the tongue (although accounts of this type of operation always dated back at least five years) and on making superficial incisions for diagnostic and preventive purposes.

With one exception none of the healers could indicate what 'it' is that affects the body in case of disease and disability. Most of them said that 'it cannot be seen'. Others felt it was more like air or a spirit. Only one healer referred to small worms and his description came very close to what would be called bacteria in scientific medicine. According to his account, the worms feed on and travel through the blood. If they get too many, they will cause disease and infection. This healer, but some of the other healers as well, made several references to scientific medicine in his discussion. He liked to discuss medicine with us and was very much interested in the more 'scientific' explanations we offered.

Cultural diseases/illnesses and disabilities follow a similar route as the natural diseases. They first go to the flesh, then affect the blood and finally reach the bones. Cultural diseases come in the form of spirits. 'Even if they used poison it is not the evil substance that attacks the body but the spirit that is attached to it'. Spirits affect the flesh through the air and via the nose and mouth. It should be noted that each individual has his own protective spirit and is also protected by the ancestor spirits of his family. A spirit that wants to possess or harm an individual will have to deal with his spirit first, sometimes with the support of the more powerful ancestor spirits. This seems to be particularly the case if the attacking spirit is a *ngozi*. Some *mudzimu* spirits already enter when the child is still in its mother's womb. Others come later. Some healers state that a *mudzimu* generally comes from the father's family while a *shave* spirit is in most cases inherited through the family of the mother. According to other informants a *mudzimu* may equally well come from the mother's family. Only when both the family of the father and mother intend to have a *mudzimu* on the individual, a conflict of interest may occur that will generally be solved in the favour of the father's family.

The influence of possessing spirits comes and goes. When the spirit is 'on' a person, the spirit is more powerful than the spirit of the individual.

Your own spirit, like all other spirits, you cannot see it, but it can be best described like this: you sit in the grass under a tree and you feel so comfortable and happy, then suddenly you get this feeling, usually in the back of your head, indicating that something is wrong, you do not feel comfortable anymore. When you get up you see a mamba behind you. Now that what causes you to get up and what made you see the mamba is your protective spirit. But you have to listen to your spirit and meet its demands, otherwise it will not protect you. . . . Your own spirit is not so powerful. It needs the support of the ancestor spirits. If your *mudzimu* does not have their support for its activities, it will lose.

Here we touch upon an issue that gave rise to heated debate between the different informants, the crucial question being if *mudzimu* spirits and other ancestor spirits will ever physically harm a person to the extent that the individual becomes disabled. Some healers believe that a *mudzimu* only warns, it will never cause irreparable physical harm. Other healers believe that in the end a *mudzimu* can cause physical harm. They agree however that a *mudzimu* will not consider such measures easily. Others again describe the *mudzimu* as some sort of immunity system. If the *mudzimu* are not respected and treated properly, the immunity system will develop breaches, i.e. the ancestors do not punish actively, but passively by no longer offering the same tight protection to their relatives.

When a *shave* or *mudzimu* is about to take over, the medium feels it in the head and in the shoulders, '*mudzimu* is now near, it is coming'. The spirit will travel through the blood to the heart, when one is possessed the heart pounds excessively. From the heart the spirit will travel to the brain, there it will come out. If a spirit is in the body in an inactive state, it is usually in the blood, but one cannot see it there, not even with a microscope. If the spirit takes over, the *mudzimu* of the individual who acts as a medium steps back and hands over power to the *mudzimu*.

7.5. Provisional conclusion concerning the diagnosis and treatment of disability by traditional healers

The information provided in this chapter leads us to conclude that there is a relationship between the medical diagnosis made and the treatment pursued. There is a relationship but the relationship is not causal. In general it can be said that as long as the blood is still there, there is a certain hope of recovery. When the blood has dried, recovery is unlikely. There is a critical stage: when the blood has become stagnant. If treatment is initiated in time, it is considered possible to restore the viscosity of the blood. However, it is equally possible that the diagnosis is arrived at the other way around; because treatment did not prove successful, probably the blood must have been more stagnant than could be foreseen.

If applied to the accounts of disabled persons, their relatives and relevant others, the explanatory model concerning the physiological indicators of disability leads to a classification of their conditions as presented in Table 8, below.

From this information it can be concluded that all disabilities, except one, involve conditions in which at least the blood and often also the 'bones' were affected. In the case of deafness and blindness 'bones' should be interpreted in a figurative way: membranes, veins and nerves are affected in such a way that blood flow is no longer possible: the parts run dry.

Sometimes a similar condition may be classified differently. The epilepsy of Maureen Mapfumo (Chapter 6) is classified as beyond treatment, because the relatives do not seriously consider treatment anymore, whereas Violet Mazire's condition is considered 'stagnant' but with prospects for recovery as she is still undergoing treatment for her condition. This means that, although the physical condition may be a very important indicator for rehabilitation, it certainly is not the only one. The condition of Violet Mazire bears in it the possibility to develop into a completely stagnated situation, comparable to that of Maureen

Table 8

*Classification of conditions of disabled informants
according to the explanatory model of traditional healers*

Case number	Flesh affected	Blood affected	Bones affected parts dry
1	scars	mental	
2			albinism
3			deafness/ mental illness
4			post-polio
5			epilepsy/ hemiplegia
6			speech problems/ physical disability
7			
8			post-polio
9			poor eyesight
10		mental problems	
11		physical disability	
12		stuttering	
13			deaf/mute
14			mental
15			physical disability
16			physical disability
17		mental	
18			albinism
19		mental	
20		ear infection	mental problems
21			mental problems
22		epilepsy	
23			cretinism deaf/mute
24		epilepsy	
25			post-polio
26		epilepsy	
27			post-polio
28		infertility	deaf/mute
29			mental retardation
30		alcoholism/ mental problems	

Mapfumo. If no agreement is reached on Violet's return to her in-laws or a refund of the *lobola*, it is not unlikely that in future witchcraft accusations will be made between the two families. This may re-activate accusations of incest, that already existed between the two families and eventually either Violet or her husband will take revenge for the unjust treatment they received by returning as a *ngozi* to their in-laws. However, the problem has not yet escalated to this extent and therefore is still considered to be 'in the blood', i.e. treatable. Next to physical indications, social and cultural factors are also considered when assessing the possibilities for treatment and rehabilitation.

As mentioned earlier in this chapter, the mother of Monica Murape pursued scientific medical treatment when her first child was found to be disabled. When she gave birth to a second, healthy child, she stopped with this treatment. Later she gave birth to a second disabled child and then she considered traditional treatment once more. Not so much changes in the physical condition of Monica, but changes in the family situation and the explanatory models considered made Monica's mother opt for other treatment possibilities.

The case history of Mr. Musana, a traditional healer and spirit-medium-to-be, to be presented in the next chapter, shows that at a particular moment in the development of his career it was opportune to visit the rural hospital in order to show how serious his condition was. The cases of Tendai Hungwe, case 4, and Violet Mazire, case 26, prove a similar point.

In general, in the professional sector, as was the case in the popular sector, the views concerning illness/disease and disability leave ample room for interpretation and manoeuvring. Diagnoses and treatment options are considered in accordance with the position of the disabled person and/or his family in the community.

Chapter 8

The (social) position of disabled persons

8.1. Four case-studies

Healer E: Mr. Clever Musana

Mr. C. Musana is the vidco chairman of his ward. He is the father of seven sons and one daughter. He was born in the main house of the family which rules the area, but he is a younger son, so it is not likely that he will ever get a position of high status in the family. Within the community the vidco-chairmanship is probably the highest position he can get. Like most people in the area, Mr. Musana is involved in subsistence farming. Because of his social and political obligations, the actual farming is done mainly by his wife and children. Although he is respected in the community, Mr. Musana is poor. He owns one of the smallest houses in the vidco, has difficulties paying the schoolfees for his children and does not have proper clothes to wear at political meetings.

When he was young, Mr. Musana left his home area, together with his older brothers, to find a job in town. According to his own accounts, he was a respected worker and a good Christian in those days. Then he had a serious accident. He was electrocuted and fell into a deep coma. Since he was a member of the Roman Catholic Church, people were praying for him 'as if he was going to die'. When he regained consciousness he was paralyzed. He remained in the hospital for a long time and was finally sent to the United States for treatment (this part of the story is rather vague and could not be confirmed; other informants say he went to the Republic of South Africa). While ill, he had dreams of his great-grandfather, called Abraham. The dreams about his grandfather merged with dreams about Abraham in the bible and it is from these two persons that his healing power originates. He returned to his home village and a ceremony was organized to allow the spirit of the great-grandfather to come out. From then on relatives would come to consult the great-grandfather concerning family problems and illnesses. Mr. Musana thus became a respected man in the community; he was entrusted with the vidco-chairmanship and he became treasurer of the primary school.

When I first met Mr. Musana, he was in a difficult position. He held a lot of responsibilities, but his socio-economic status was not quite in accordance with his responsibilities. His ambitions had outgrown the level proper to the spirit mediumship for a great-grandfather. At the same time Mr. Musana was aware that people envied him for the responsibilities he held and he felt it was inevitable that people would try to bewitch him. At that time he began to isolate himself from the community and he claimed he heard all sorts of voices in his head. He dreamt about the history of his people and in his dreams he saw things that the people had already forgotten, but that were confirmed to have happened by the local *mhondoro*. It was then suggested by Mr. Musana that probably a more important spirit was trying to come out on him.

During the course of the fieldwork period, this idea was gradually being accepted by his relatives, although they differed of opinion with Mr. Musana about the identity of the spirit (Mr. Musana had a spirit in mind that would come next to the *mhondoro*, while the relatives did not want to go quite that far, the more so because this same spirit had been claimed already by another house of the family). Mr. Musana fell seriously ill at two subsequent occasions.

The first time he suffered from a severe attack of mental illness. His speech was confused, he did not hear people speak to him and he became afraid that people tried to harm or even kill him. He lost a lot of weight and his general physical condition deteriorated. The second time he suffered from chronic chest problems. There was blood in his sputum and when at last convinced to go to the clinic, he was found to suffer open t.b.

Initially he did not want to go to the hospital and he was convinced that his illness was cultural and could not be treated in the hospital. Finally we managed to convince him that his body and the spirit that protected it needed some rest. We argued that the spirits that attacked him were only minor spirits that could not reach him in the hospital, while his spirit would still be able to oversee the 'battle field' even from the hospital bed.

Mr. Musana recovered miraculously, but he was convinced that both illnesses were caused by enemies of his and his family. He also saw his recovery as proof of the fact that he was really protected by a great and important spirit. He needed the diagnosis from the clinic to substantiate his claim and he was certain that without the protection of these important ancestor spirits either condition would have been fatal.

After his return from the hospital, Mr. Musana openly claimed the spirit mediumship for the spirit next to the *mhondoro* and started to make preparations for a 'coming out' ritual.

Case 4, Tendai Hungwe

Tendai Hungwe is 20 years. She is married and has one child. Tendai's father died when she was young and her mother remarried. The attitude of the stepfather towards his stepdaughter was not very positive. Irrespective of the problems involved, the father's main interest was to marry Tendai off as soon as possible.

Tendai suffers from post-polio effects. Her legs are affected most. She wears a calliper on the left leg and walks only with great difficulty. The calliper was fitted when she was a child and is too small now, while the shoe attached to it is worn, the calliper does more harm than good.

When Tendai fell ill she was about 5 years old. Her mother, who is a Christian (a Wesleyan Methodist) took her to a mission hospital. There she stayed for a long time. The mother did not know what kind of treatment took place in the hospital. After some time Tendai was taken to a hospital in Harare where she was operated upon. The mother and Tendai did not know what was involved in the operation and Tendai only could point at the scars that remained, when we asked which part of the body was operated upon. During the first three meetings Tendai and her mother referred to nothing but the scientific medical treatment she underwent. Only during a fourth discussion, while expressing her disappointment about scientific medicine, the mother said: 'but of course these things (scientific medicine) do not help, because the disability was caused by witchcraft.' When asked to elaborate, she reveals that after the operation, she visited various traditional healers with her daughter, although without much success.

Tendai's condition was generally diagnosed as *chipotswa*. *Chipotswa* is a kind of witchcraft that is left at a cross road. The relatives were not very specific on this. They claim that it is characteristic for this type of witchcraft that it comes as a surprise. If one expects it, one can take counter-measures and, if the counter-medicine is strong enough, no harm can be done. The appropriate ritual to perform in case of *chipotswa* was performed by a first-aid healer living nearby. She tried to transfer the *chipotswa* to a black goat. This animal was subsequently set free in the bush. If such a goat encounters someone to transfer the witchcraft to, the patient who initially suffered from it will be cured. If this does not happen and if the goat dies without transferring the *chipotswa*, the witchcraft will return to the person who was initially affected by it.¹

In Tendai's case the transfer of the witchcraft never took place. The mother claims she did not have enough money to pursue further traditional treatment. Also she fears that the witchcraft may be transferred to someone else in the

family. Asked what she would advise mothers with children affected with a similar disability, the mother said that she would advise these mothers to go to hospital first. She herself went to hospital because she was a Christian and because she knew someone who had been treated successfully in hospital. However, according to the mother, in hospital they can treat the signs only. Thereafter one still has to visit a traditional healer to take away the cause of it all.

When she became pregnant, Tendai's husband, or rather boyfriend, disappeared and went to town for some time. The husband was in a similar position as Tendai: he lived in the house of his stepfather and could not expect much support from his family as regards the *lobola*. Eventually his oldest stepbrother helped out. According to others, i.e. not relatives, there was quite a hassle over the *lobola*. In the first place the husband is poor, in the second place Tendai will never be able to run her household independently. As soon as the *lobola*, little as it might have been, was paid, she moved to the house of her in-laws. There she had a difficult time while her husband worked in town. She had no one to assist her and because she could not join in many of the tasks women usually do in the household her mother and sisters in-law did not accept her. When her baby was born, it was even more difficult for her to cope. She would not have enough food for herself and the baby and sometimes she had to return to the homestead of her stepfather to ask just for food. There she was not received with open arms either. Her mother was quite prepared to help out, but the stepfather insisted that the in-laws should take proper care of her. He threatened to come and take her home officially if the situation would not improve. In that case he would not feel obliged to repay any *lobola* as the in-laws were clearly at fault.

Tendai took a rather passive but determined position in the whole affair. She would not complain about her in-laws or her own relatives. When she was really in need of something she would try to get it from her mother. She did not expect much support from her in-laws. When the support had been provided and conditions allowed, she would return to the house of her in-laws again. When, as a result of inter-family negotiations, a younger sister of the husband was assigned to assist Tendai in looking after the baby, Tendai would allow her to do so only in as far as she really could not perform these tasks herself. She did not want the baby to be taken away from her.

Tendai was not interested in getting her callipers fixed and although she got involved in an income-generating project for disabled persons in the area, on the insistence of the relatives and in-laws, she was not an active contributor to the project. It did not become clear why she was not enthusiastic about the project. Perhaps she felt it was not opportune for her at that time to

show signs of economic independence, perhaps also she was disappointed by the outcome of an earlier project in which she had been incorporated. Around 1980 a rehabilitation project started at a nearby mission hospital and, as a part of this project, Tendai was given some training as a dressmaker. It was envisaged that she would be able to earn a modest living making and repairing clothes on a sewing machine owned by her mother. However this plan was never realized. There is little demand for new clothes in the fieldwork area. Only after the harvesting season and at the beginning of the new school year clothes are bought. Tendai did not have enough capital to have a choice of material in stock and if people had to go to town anyway to buy the cloth, they preferred to buy clothes there. The towns offer good quality for a reasonable price and it is very difficult to come up with a competitive product with a hand sewing machine anyway. Later, when she was married, the usage of the sewing machine became an additional problem. The stepfather would not allow Tendai to use her mother's sewing machine any longer to make clothes for the baby. He said the in-laws should provide her with a sewing machine.

Asked whether she felt she was better off with her in-laws or with her own relatives, Tendai said that she preferred to remain married, despite all difficulties. She was afraid that, in case of a divorce and the *lobola* not being repaid, she would have to leave her child with the in-laws.

Towards the end of the fieldwork period, when it became more and more likely that Tendai's marriage would end in a divorce, the stepfather all of a sudden became interested in medical treatment and a new calliper for Tendai.

Case 24: Mission Machipisa

Mission, who is about 23 years old, suffers from epilepsy. He is the eldest son and has three brothers and two sisters. Mission's father works in town and has married a second wife there with whom he also has a number of children. Mission's epilepsy is said to have started when the second wife appeared on the scene and got worse when, during the course of the fieldwork period, the problem between his mother and the second wife came to a climax.

The general opinion in the fieldwork area was that Mission's father was not giving his first wife and Mission's mother the respect due to her. He clearly favoured the second wife and her children and this caused much bitterness in his first wife and her children. Finally, Mission's mother packed her things and moved to the homestead of her parents. She left her children behind under the care of Mission and his younger brother. Mission was so much emotionally affected by the affair that he had severe attacks once or twice a day. He

roamed around through the area and did not sleep or eat at home anymore. His body was covered with infected wounds incurred while falling during the attacks. While previously he had been able to suppress his attacks reasonably well through medication, as soon as he stopped taking the tablets regularly he lost control completely. His speech deteriorated and his movements were badly coordinated.

Once when drunk, the father revealed that he feels Mission is not his real son, because there is no epilepsy in his family. By saying this he implied that the epilepsy of his son must be the result of a mistake of his wife or her relatives. Mission's mother claims, and this is confirmed by other relatives, that a *nganga* has diagnosed that a *mudzimu* wants to come out on her son. The father denied this claim of his wife and eldest son, saying that as a Christian he does not believe in ancestor spirits. In those days he suggested his son should go to the Apostolic Faith Church for treatment.

Mission is a pawn in and a victim of the struggle going on between his father and mother. The mother is prepared to forget that she does not receive the proper respect from her husband and said: 'If only he would treat my children right, there would be no problem.' Mission is not the beloved eldest son he perhaps had hoped to be. He carefully registers all the favours bestowed on the second wife and the children from that marriage. When Mission's attacks became more serious, the father was accused even more of not treating his family properly. He lost the respect of his family and of the community.

Later he gave in and joined in a 'coming out' ritual. The spirit indicated however that it wanted more than beer alone. It asked Mission's father and his brothers for very specific things which, particularly the father, was not prepared to deliver. The mother and the healer feel that the epilepsy will get worse if the spirit is not appeased. The father refused to do what is required to satisfy the *mudzimu*. The importance of the first wife and her eldest son is symbolized by the fact that an important family spirit wants to come out on the eldest son. By not acknowledging the claim of his son, the father does not acknowledge the position of his wife and eldest son. The spirit is angry because it is not welcomed in the proper manner and it retaliated by making Mission even more ill. Mission and his mother claim to be afraid that the father or his second wife will try to use witchcraft against them. They do not want to eat from the family cooking pots anymore as they are afraid of being poisoned. It is said by other informants that, even if the father would want to settle things now with his first wife, this would not be easy. The father, according to these informants, has brought down two potential *ngozi* on his family: his eldest son and his first wife.

The family problems have made it difficult for Mission to make plans for the future. He went to school and knows how to read and write. He was involved in some gardening activities and in an income-generating cooperative but all these activities failed when the problems between his parents reached a climax. He hopes he will be able to get married in the future; he already has a particular girl in mind. He anticipates problems with the *lobola* because of the problems with his father. It is not likely that the father will assist him in this.

A few weeks after his mother left, Mission disappeared from the scene entirely. He was nowhere to be seen for weeks. Later he revealed that he stayed in a nearby community with adherents of the Apostolic Faith Church. He prayed with them and he felt quite good the first week. He left when their claims that he should become a member and ought to change his attitude and behaviour became more persistent. He continued to wander around and we lost track of him again for a couple of weeks. When he showed up again, he said he had been in a large hospital in town. He claimed that he was taken there after he had collapsed in a nearby clinic. According to people his condition worsened because his father had ventured to slaughter two of his mother's cows, another act of extreme disrespect.

Case 14: Milton Chitunga

Milton Chitunga is in his fifties. He is the younger brother of kraalhead Chitunga. He suffers from mental illness and stays in the homestead of his brother. It is not easy to get in touch with Mr. Chitunga. He thinks we are doctors from the hospital who want to give him sedatives or injections and he fears to be taken to a hospital in town (this happened to him in the past). When finally we talked to him he only answered certain questions. He referred to the past and showed us all sorts of papers related to his financial affairs when he was still working in the mines in South Africa. From his stories it does not become clear what actually happened and the relatives do not know what went wrong either. It is certain that his present problems started somewhere in the sixties.

At that time Mr. Chitunga was married, had three children and worked in the mines. Then something must have happened which probably had to do with money, as this is what Mr. Chitunga refers to all the time. He returned home in a rather aggressive and confused state of mind and found work in a nearby mine. There he was fired because of misbehaviour. Mr. Chitunga was very quarrelsome and aggressive and finally his wife divorced him. She took the children home with her, which is an indication that Mr. Chitunga was probably at fault.

Mr. Chitunga was given medication by the local clinic. He does not want to take the tablets so now his relatives crush it in his evening *sadza*. However when Mr. Chitunga discovers this, he refuses to eat. According to the relatives, the tablets are intended to make him less aggressive.

Relevant informants in the area feel this is a clear case of 'culture'. Although the kraalhead does not want to go into much detail and does not want to reveal the diagnosis of the traditional healers consulted on behalf of his brother, the vidco-chairman states it is a *chikwambo* case. When a person owes money and does not repay it, the owner of the money might send someone to collect it (this can be a hare, a *Tikolotshe* or a snake (*chikwambo*)). If the debtor refuses to pay he will become gradually mad. This seems to have happened to Mr. Chitunga. The informants do not want to reveal who sent the *chikwambo* and to whom Mr. Chitunga owed money.²

Mr. Chitunga is totally dependent on his relatives and he is a burden to them. They tolerate his presence and no more than that. When I asked (when there were no relatives present) if there was any possibility of Mr. Chitunga's *mudzimu* to come out on one of his relatives after his death, the question gave rise to laughter. The (other) informants were unanimous that Mr. Chitunga's spirit would never return as a *mudzimu* but that, instead, it would be chased away if it dared to approach one of the relatives.

8.2. Factors influencing the position of disabled persons in the community and the prospects for rehabilitation

8.2.1. General conditions of life and problems faced by disabled persons

Although it is difficult to generalize on this point because no comparable data on the general population in the fieldwork area are available, the personal histories of the majority of disabled persons selected for this survey show hardship and suffering. The harsh measures applied towards disabled persons in the old days are no longer in existence however. Only Ms. Rusere (case 25) reported that her life was, at one stage, in danger. Her father came from Zambia and worked in Zimbabwe during the Federation. When his work urged him to return home, he wanted to take along only his wife and the children that were not disabled. He suggested to throw the three disabled children in the river. They were saved from this fate by their grandmother.³

Twins are no longer considered disabled, as in the old days, but they still have a special position. Albinos are still considered ill or disabled but their fate, too, has improved considerably. Two albino informants were included in the survey.

One of them (case 18) was too young to inform us herself, but her relatives gave us the impression that the girl was not treated differently from her brothers and sisters. The family was concerned about her marriage chances later in life however. The other albino person was about 19 years old (case 2). Initially he was somewhat reserved, but later he talked quite freely about the problems he faced as an albino. Apart from physical problems, sun-burn and eye problems, he did face a lot of social problems as well, especially when he started to go to school. His classmates used to tease him and they did not want to sit next to him in the classroom. The most traumatic experience was however when, at the height of the struggle for independence, some people in the community said that he should be sent to a school for whites and that people should be careful with him because he might be a spy. Now he realizes that these remarks were perhaps made within the context of a political debate or as a joke, but at that time he was really scared that he would have to leave his family. The remarks made him feel very lonely, almost as if he was not part of the community.

As far as the social status and position of disabled persons is concerned, the same criteria apply as for those who are not disabled. It is sometimes more difficult for disabled persons to meet them. This is true not only for a good education and permanent employment as the indicators of status, but also for acceptance in the social and cultural realms of society, either as a married person with a family or as a spirit medium. In the following sections we will discuss the most important criteria or indicators of status and position, pointing out the problems disabled persons may face to comply with them.

8.2.2. Economic position

Although the economic position of the disabled person and/or his relatives does influence the general position they held in society, this influence is rather limited in comparison to other factors such as family life and cultural/religious position. Like education, one's economic status tends to become more important when one wants to shift from rural to urban life.

Of the thirty disabled informants interviewed, about twenty-three were of working age ($\pm 17-50$ years). Of the remaining seven cases, four were of school-going age (cases 1, 2, 20 and 18), while three informants were considered to be above working age by themselves and/or the community (cases 6, 15, and 16).

Of the twenty-three disabled informants of working age, only one was formally and permanently employed (case 13). She worked in town as a dressmaker and only returned to the village in the week-ends. Thirteen were self-employed. This figure seems to be somewhat high as compared to the employment situation

of disabled persons elsewhere in Zimbabwe. It should be mentioned, however, that a number of clients had benefited directly or indirectly from two experimental rehabilitation projects that had recently started in the area.

The economic activities disabled persons in the fieldwork area are involved in vary. Case 8 is a cobbler, while case 11 is involved in gardening and crocheting. She sells her products in town, going from door to door and in this way she pays for the school fee of her children. Case 7 provides for her cash income in a comparable way. Case 14 is involved in carpentry. Another five informants are involved in subsistence farming and usually grow tomatoes on the side for the market in Harare. The other informants (21) are economically dependent, i.e. they rely completely or largely on their relatives. It is very difficult to get a good comparative picture of the economic position of the disabled persons and of the community. There are no regular work patterns because economic life is very much dependent on the rains. If there are no rains, the disabled cobbler will appear to be fully engaged in this activity. He will not have many customers however, because, if there has been no harvest, no one will have money to have any shoes repaired. If the rains are good the cobbler will spend most of his time in the fields, assisting his family. Likewise cases 11 and 8 will send their children to town to sell their products, while they remain on the land themselves if the rains are good. Generally family members will be provided with board and lodging in exchange for their labour on the communal fields. This revenue from communal labour is administered by the head of the household, i.e. the father or husband. In addition, all family members of about 18 years and above may engage in their own gardening activities. In principle the money earned in this way is the property of the individual owner and it is up to him to decide for what purpose it will be used. Especially younger disabled persons, around the beginning of their twenties, face problems in this respect. Maxwel Mafure (case 27) reported that an older brother stole and sold the tomatoes he had grown. This incidence seemed to be particularly painful because the client cannot walk, but crawled on hands and feet from his field to a nearby river to fetch water for his tomatoes almost daily. When asked about this incident, the father is reluctant to discuss it. He indicates that it is difficult to control his sons. The other sons are of the opinion that their brother should first contribute to the communal farming before he engages in projects of his own. Other disabled persons, involved in cooperatives for disabled persons, sometimes faced problems when relatives wanted to control their money or started to make rather excessive demands as regards contributions to the family income (cf. case 22, Cecilia Nyamitunga). Disabled persons seem to face a problem similar to that of all cash-income earners in rural

communities in Zimbabwe. If they spend their money on family or communal purposes they gain status, if they spend the money to meet their individual needs, this does give individual satisfaction but does not always lead to approval of the family and community (see also case 14, Mr. Chitunga and note 2).

A differentiation has to be made between the disabled persons who are heads of households and those who (still) stay with their relatives. All disabled informants who are self-employed and belong to the first category (cases 9, 10, 11, 19) earn incomes below the national minimum wage of 70 z\$ per month. There may be months when they earn this amount, if the rains are good, but on average, over the period of a year they do not earn that much. Usually most subsistence farmers earn enough to pay the school fees for their children and the occasional set of clothes. The heads of households also reserve a certain amount to buy beer. In this respect the disabled heads of households generally do not seem to differ much from other heads of households in the area. Although we have no quantitative data to prove this statement, it seems that the economic position of disabled persons with a family is very much comparable to that of other people in the area. The possibly lower level of production owing to the disability of the head of the household is negligible compared to the effect of rainfall or sudden misfortune in the family (costs of funerals, traditional healers etc.) on the family income. The disabled head of the household carries out those tasks that he/she can perform in view of the disability. The other family members fill up the gaps. This may lead to a change in the formal division of labour. The cobbler, case 8, who is not capable of clearing his own grounds at the beginning of the agricultural season (traditionally, clearing the land is a task for the head of the household and his older sons), once paid neighbours to do the job, while on another occasion his wife assisted the sons.

The position of disabled persons who still live as 'children' in their father's household is more problematic. They have to find a balance between pleasing their relatives and meeting their own individual needs. Disabled persons in this category generally want to buy clothes with the money they have earned. Some dream of buying a radio. The younger men/boys among them talk about saving money for *lobola*. Mr. Chitunga (case 14) is self-employed. He does not stay in his father's household, but in the homestead of a brother. He used to work in the mines in South Africa and earned a good income. It is not clear whether he lost his job and got mental problems afterwards or whether the mental problems were the reason for losing the job. He was taken to psychiatric clinics but ran away and finally settled down with his younger brother who, after the death of their father, assumed the role of family elder. Mr. Chitunga has his own

house in the homestead and his brother provides him with clothes and food. He earns only very little as a carpenter and the brother has never asked him to contribute to the family income from his earnings. This may be because the mental condition of the client is somehow related to money or property.

Next to the people who are self-employed there are also a number of people (about ten) of working age who are not employed in the true sense of the word. Although some of them fulfil minor household tasks they depend fully on their relatives economically. This group includes disabled persons who cannot be engaged in gainful employment of any sort, due to the nature of their disabilities (cases 5 and 23) and persons who could do something but do not really want to (case 17) or are not allowed to by the relatives (cf. case 26, Violet Mazire).

Maureen Mapfumo (case 5) is a young woman who suffers severe epilepsy and paralysis. She is involved in knitting and small animal husbandry. Both these activities are intended more to keep her busy than to gain money. The family, which is relatively well-to-do, supports her and assists her to carry out these activities solely for recreational purposes. Maureen's is one of the *ngozi* cases that apparently cannot be solved because the family does not want to admit guilt. Perhaps the permissive attitude of the family towards Maureen's low level of productiveness should be seen in this light. Monica Murape (case 23) is a woman of about the same age. She suffers from what is called 'cretinism' in scientific medicine. Her body is not fully developed and she is mentally retarded. Although her mother engages her in as many home chores as possible, she carries them out in such a slow way that her assistance is often more of a burden than a help. She is quite keen to work and she is definitely not lazy. The only problem is that she is very slow and it is hard to imagine that her productivity will ever reach a gainful level.

The financial situation of the family of the disabled person also plays an important role in the position and rehabilitation prospects of the disabled person. In general it was observed that the better the financial situation of the family and the more links exist with urban life, the more the family will be inclined to (also) consult a scientific medical practitioner. Out of the eighteen cases in which both a scientific and a traditional medical practitioner were consulted, twelve come from relatively prosperous families. These are families with a number of members working in town who bring in cash income, with relatively good housing (brick/corrugated iron/asbestos houses and in some cases brick under tile), with enough money to pay the school fees for all children and with the opportunity to consult a scientific medical practitioner in town. Although the fieldwork area is only 50–70 kilometres away from Harare, it should be noted

that generally it is not possible to go to town by public transport, consult a doctor and return home the same day. Public transport is slow and waiting times in the general hospitals are long. There is no telephone within a range of 30 kilometres, so it is not possible to arrange an appointment beforehand either. Consultation of a doctor in town is facilitated if one has relatives in town where one can stay. Some disabled persons had never been to town. They do not know how to board a bus, how to enter through a rotating door and how to use an elevator. Conversely they have skills that the average urban dweller does not possess (the young man described in case 20 could catch a hare by chasing it), but when it comes to consulting a doctor in town these skills are not useful. In addition in most cases one consultation with a scientific medical practitioner is not enough. When accompanying disabled persons on their visits to scientific medical practitioners, I noticed how easily these practitioners ask a client to come back for a follow-up visit. Often more than two or three consultations are required before any treatment is initiated and before the client is given an idea of what is wrong (and, as we have noted before, even then most disabled persons do not appreciate the diagnosis fully). There is no possibility of remaining in the area, as in the case of a prolonged consultation with a traditional healer, nor is there anything to discuss with the family members when they come home. Therefore very often they lose hope already after the first or second consultation. Only X-rays and injections seem to be able to arouse their interest a bit longer.

The contacts in town can open a wider range of treatment possibilities for the disabled persons, but they can also have a more negative effect. There is a tendency that in families with a relatively strong urban basis, the young and healthy family members stay in town, while the older, not so successful, ill and disabled family members stay in the village. The home village is sometimes used by relatives as a 'dumping place' for their old and disabled relatives. This is confirmed by repeated observations that parents migrate to town with their able-bodied children, leaving their disabled children behind with the grandparents (cf. Apollonia Rusere, case 25).

All people, including disabled persons, are keen to earn their own cash income to satisfy their individual material needs, but the rural economy turns on the community and communal labour and gain. Individual economic successes, although envied, are at the same time the target of gossip and criticism, or worse. Decisive for the economic position of virtually everyone in the fieldwork area is whether the rains will fall and if they will be sufficient. This material uncertainty as well as the (im)possibility to exert control over these natural

resources influence the outlook people have on life and this, in turn, has an influence on the way the community perceives illness and misfortune in general and disability in particular.

8.2.3. Education

Once a disabled child reaches school-going age, particular problems have to be faced. A schoolteacher told the informant how difficult it is to keep a disabled child, particularly a slow-learning child or a child with other mental problems, in a class room with forty-five other children. Once the rumour is spread that the child suffers from witchcraft, no one will want to sit close to such a child and some do not even want to sit in the vicinity. These thoughts of the children are often stimulated by the parents and there is not very much a schoolteacher can do about it. Sometimes it blows over after some time and some understanding between the disabled child and the classmates can be established, as eventually happened in the case of the albino boy (case 2). When this is not possible, the child usually leaves school.

Although the majority of disabled persons in the fieldwork area were literate to some extent and about 75% of the disabled children of school going age received education, there are still a number of disabled persons who do/did not receive formal education. Disabled children were sometimes stigmatized as mentally retarded and dismissed from school. In a way the disabled persons who were dismissed from school may be considered doubly disabled. A striking example is case 20, a boy of 18 years old who was generally considered to be mentally retarded. He was dismissed for this reason the first year he went to school. Later it became clear that the boy is only mildly retarded. He is left-handed, which may explain some of the initial problems at school, and for the rest he shows socially unadjusted behaviour. Also, his intellectual performance is below average for a boy of his age. One may rightfully ask, however, if this was because he lacked intellectual skills or because they were not developed.

The importance of a good education for successful rehabilitation should not be underestimated. The case history of Conny Chidyaisiku (case 13), the only disabled person in the fieldwork area with a job in town, illustrates this point clearly. Nevertheless, even Conny was prepared to jeopardize her education in order to have a child.

The involvement of disabled persons in any income-generating activity requires that they know at least how to read and write and make simple calculations. When an experimental project for disabled persons was started in the area, disabled persons who know how to read and write could hardly be

found. This makes it necessary to involve relatives or others in these activities for the administration, thus making disabled persons more dependent. Second to marriage and raising a family, education was mentioned as a major goal in life by virtually all disabled persons.

I noticed that the disabled children who face most problems in receiving the proper education are those suffering from mental retardation or defects.⁴

8.2.4. Family life

In at least fourteen of the thirty cases serious family or relation problems could be recorded, ranging from being the 'black sheep' of the family to being divorced or deserted. Another group of disabled persons faced family problems when they were still young. Of the thirty disabled informants interviewed, at least fourteen are from families in which the parents divorced, the father died or took a second wife. Six disabled informants faced marriage problems themselves. It is hard to establish a causal relationship between the condition of the disabled person and the problems in the family situation. However, it seems that the occurrence of family problems is higher in families with disabled persons as compared to other families (extrapolation of the figures from the interviews with disabled persons to the population in general would indicate a divorce rate of almost 50%, which seems rather high). If we assume that disabilities are randomly distributed, it may be concluded that disabled family members may cause 'handicapped' families. Family problems seem to affect in particular those disabled persons suffering from epilepsy and other mental conditions (cf. cases 29, 24, 22, 17, 26, and case 1).

From a social point of view, it seems very important for the integration of disabled persons in the community that they marry and raise a family. For all disabled persons interviewed, finding (or having) a partner and raising a family were the most important goals in life. Relatives and relevant others also mentioned this issue often. Family members and relevant others do not see any objections against disabled persons getting married and raising a family. The only condition they pose is that the disabled person and the partner engage in the marriage of their own free will and know what they are doing. The main stumbling block here seems to be the payment of the *lobola*. The question whether *lobola* should be paid in the first place is never raised, the general idea being that if *lobola* is paid in the case of marriages with women who are not disabled, *lobola* should also be paid for disabled women. From the interviews it becomes apparent that although sometimes less *lobola* is paid in case of the marriage with a disabled woman, this is not a standard practice. Much depends

on the type of disability, i.e. whether it affects the capacity of the women to bear children, manage a family or work in the fields.

A woman who cannot hear and speak (case 28), got married and the full *lobola* was paid for her. The husband knew of the disability of his future wife but did not make any objection. Only when it became clear that the client probably would not be able to get any children, she was divorced and the *lobola* was paid back.

While through a somewhat adjusted division of labour it is relatively easy to get around the negative influences of the disability on the level of production, it might prove more difficult to marry and raise a family. It was observed that the position of married disabled persons in the community was comparable to that of married persons without disability. In a way being unmarried (and being without prospects of getting married) seemed to be more of a disabling factor than many physical, sensory or mental conditions. The importance of having a family is about the same for disabled men and women. For disabled women, however, there is an additional virtue attached to motherhood, even outside a marital context.

In the case of Tendai Hungwe (case 4) only a symbolic amount of *lobola* was paid. It is unclear whether this had to do with the fact that the family of the husband, like the family of the wife, was extremely poor or with the fact that the wife is disabled. The husband did not look after his wife and he did not provide her with enough money to survive. Neither did his relatives offer any assistance, as would normally be expected in Shona culture. She often had to return to the homestead of her mother and stepfather, where she was not very welcome either. The fact that she continued to return there shows the difficult position she was in. Returning to the homestead of one's parents almost amounts to asking for a divorce and Tendai's mother repeatedly mentioned this possibility. Tendai prefers to keep her status as a married woman however, even if no *lobola* is paid for her.

Apollonia Rusere (case 25) is a mother of three children. She probably never married officially (according to traditional practice). The relatives of the fathers of her children were opposed to a marriage, as they suspected Ms. Rusere might be a witch. At present she lives alone with her three children in the homestead of the family of her grandmother. She is a respected community member and although people agree that her life perhaps has been more difficult, she has a position and status in the community similar to that of other women in a comparable situation, mainly because she has children and manages to take good care of them.

Among the unmarried disabled men interviewed, the issue of getting married and having to pay a *lobola* was a major topic of discussion (cf. Maxwell Mafure, case 27). There are indications from the interviews that disabled men face more difficulties in this respect than men who are not disabled. Apparently there is a tendency among the relatives of the wife-to-be to demand a larger down-payment prior to the marriage or even to demand the entire *lobola*. Also, because the contribution to the family labour pool is often not comparable to that of the other brothers, a disabled young man may not receive the same support from his relatives in paying the *lobola* or making the down-payment. In general the young men indicate it would not be so difficult for them to find a wife if only they could raise the *lobola*.

It is the general opinion of informants that disabled persons who have mental disabilities or who cannot procreate will not be able to find marriage partners. This information was confirmed by my observation. It seems to me, though, that the ability to earn/save enough money for a *lobola* is an important criterium as well, at least where disabled men are concerned. I could not establish to what extent young men in general and disabled young men in particular can count on the assistance of their relatives in making these *lobola* payments. When it is not possible for a disabled person to find a marriage partner, spirit mediumship (for men mainly⁵) and motherhood (for women) are the only ways to acquire at least a little social status.

If a person becomes disabled later in life he or she may be deserted by the partner. This often happens to women who become disabled (cf. Violet Mazire, case 26) but it can also happen to disabled men. On the basis of the research it cannot be concluded that the divorce rate among disabled persons is higher, but the data of Aquina (1969) (i.e. no difference in divorce rates between leprosy patients and the population in general) should probably be interpreted with caution. Not only has it become easier to get a divorce (and alimony for the children) since Aquina wrote her report, but Aquina's figures do not say anything about one's chances to get married when one is disabled (Aquina's figures mainly relate to leprosy patients who became disabled later in life, i.e. after they were married and had children).

8.2.5. Political status

Political factors are of importance in explaining the cause of the disability. The political and social status of the persons involved in the case-studies determine the level at which an eventual treatment has to be sought. Problems can arise and can be solved at three levels. First of all there is the rather informal level of

the first-aid healer. This is a local healer, without much of a reputation and without well-developed specializations. This healer is consulted in the first instance, he/she is nearby and not expensive. After consulting a first-aid healer, but often also without previous other consultations, a *nganga* of reputation may be consulted. A *nganga* can diagnose and treat cases of various nature, either with a natural or a cultural cause. The cultural causes should be fairly clear-cut however and should not go beyond the boundaries of the immediate family or neighbourhood. When matters are more complex, a local spirit medium has to be consulted through whom the ancestors will speak. This is how being untreatable, or at least difficult to treat, can have two sides. On the one hand it is terrible if the illness does not subside after treatment by a *nganga*, but on the other hand this may be a sign of the importance of the problem and of the people/spirits involved in it and, for the ill or disabled individuals, it may hold a promise as to their potential powers as spirit mediums (cf. Mr. Musana, Healer E).

In two cases interviewed for the research, the disability was directly or indirectly associated with supporting the 'wrong' party in the time of the liberation struggle (cf. cases 7 and 30). An informant who had been pointed out to me as being mentally disturbed and in need of rehabilitation, made the following statement in this respect:

Before the war I was a farm worker and I also worked as a clerk in the mines. During the war I found a job as a policeman. People said I was a 'sell-out' (defector) because my homestead was well organized, with brick houses, a scotch cart and fertilizer for farming. They tried to chase me but they could not find me because I was working. Then they found my son. They took him to a nearby river and shot him. They tied a stone around his neck and dropped him in a pool. That pool is where my in-laws lived. We missed the son and a *nganga* in the area dreamt what had happened and informed my in-laws. They did not dare to tell me what had happened, but it affected me nevertheless. I knew that something terrible had happened. Then, four years later, the *sekuru* across the road told me: 'If you want to find out what happened to your son, ask your in-laws, they know.'

The informant asked his in-laws and they brought him to the place the *nganga* had indicated. There on the bottom of the pool they found a decomposed body. Remains of clothes and shoes showed it was his son. The informant then turned to the local spirit medium, asking her what to do to appease the spirit of his son. She told him to come again and to bring a goat. This response of the spirit medium made the informant angry. Why should he bring a goat if his son was killed. He claims that his anger was justified and whatever he did as a result should be seen in that context. The informant thinks that his son may come

back as a *ngozi* if the community does not want to cooperate in bringing his spirit to peace. Some informants in the community claim that first the *ngozi* or *chikwambo* that caused the death of the son has to be appeased.

8.2.6. Cultural and religious position

Neither the older nor the younger disabled persons talk very much about death in general or about their own death, not even if death comes or has been close due to their disability. If the issue was discussed at all, it led to questions to me instead of answers. Informants repeatedly expressed their difficulty in choosing between or combining the different religious influences they have been exposed to. The father of the albino boy (case 2) is a Christian and only wants to accept a natural cause of the disability of his son, although people in the area sometimes suggested other causes. He considers the disability of his son a natural thing and at the same time a gift from God that has to be accepted as it comes. 'God divides happiness and unhappiness in that way.' When asked if he feels that God was actively involved in the disability of his son and the illness of one of his daughters, the father hesitates to answer. He does not feel that praying to God will help much in the case of his son. 'God is concerned with the big things such as the rains. He can also affect individuals of course, but he only does so when he feels it is necessary, not to meet the requests of individual human beings.' The idea that disability is a gift from God and has to be accepted as it comes was shared, with two exceptions, by all disabled persons and informants who indicated that the disability had a natural cause.

Concerning the fate of the *mudzimu* of a disabled person, the informants provided me with a number of statements. With the exception of one healer, all informants were of the opinion that the *mudzimu* of a disabled person will carry the disability with it. This seems to be one of the major problems for disabled persons. One informant stated explicitly:

Whether a person is disabled since birth or becomes disabled during his lifetime, the disability will not only affect the body, but also the spirit; that is our belief. If such a spirit wants to possess someone, that spirit will show those signs. People will not want the spirit of a disabled person to come back. They will chase that spirit away and they will consult a healer to prevent that the spirit comes to a child or other relative.

This informant also mentioned the example of a disabled healer of very good repute. The healer is blind and normally his relatives would not be keen to see his *mudzimu* back, but in the case of this healer with such a good reputation the informant does not see a problem:

Even if they would have to accept the disability that the mudzimu carries, they would not mind to welcome this spirit, because it brings many good things as well. Besides the blindness will only affect the medium for the duration of the possession.

Another informant was more positive with regard to the prospects of the spirits of disabled persons. He remarked:

The spirit of a disabled person will go where the spirits of all dead persons go. There is no need to fear the spirit of a disabled person; you will not suffer from such a spirit when it is on you and it will bring advantages as well. It will depend on the particular relative how the spirit will be received: however, some spirits will come back and some will not, here it is the spirit who decides. . . . It is not the spirit itself that is disabled, but if that spirit comes on someone that person will be disabled. . . . The spirits of both the disabled and able-bodied persons will join the other spirits of deceased persons. If a disabled person was a healer, his spirit will be welcomed. If some irreputable disabled person wants to possess someone, the relatives will consult a *nganga* and chase it away. Disabled persons will be buried in the same way as not disabled persons, however.

One of the healers interviewed for the research (the healer who felt the spirit of a disabled person was not disabled) said:

The spirit of a *chirema* is not disabled, but if it possess a person, that person will be disabled. Nobody likes a *chirema* spirit and nobody will accept it. They will come to us healers for protection. . . . A disabled person is buried in the same way as anyone else. If a disabled person wants to come back, the relatives do not love it but they have to accept it. Where will they chase such a person? We can only chase it if it causes harm.

If a disabled person dies, he/she can come back just like anyone else. If the person comes without anything good, we will chase it. A disabled person is often without children and will die as a person without children. We put a maize cob in the coffin to represent the child and hope the spirit will not come back.

From these statements it can be concluded that the position of the spirits of disabled persons is as difficult as the position of the disabled person themselves. The position of married disabled persons with children is better. If the disabled person has been a responsible parent, the children are not likely to chase the spirit away, also for fear of the spirit of the disabled person turning into a *ngozi*. Another possibility to evade the fate of having one's spirit chased away after death is to develop particular skills or to accept a *shave* possession that might compensate for the disability. It should be mentioned that this way out is not as easy as it seems to be. As indicated earlier, a claim of spirit possession is not always easily acknowledged. Of all disabled informants, at least four made such a claim. But not one of these claims had been fully acknowledged during the fieldwork period.

On the other hand it should be realized that the position of the family is not very easy either. Not all healers are keen to assist in chasing away such a spirit and there is the additional risk that the spirit will return as a *ngozi*.

Informants did confirm that the spirit of an unmarried person is prevented from coming back. By putting a certain object in the grave to represent the husband/wife and eventually the child (this particular informant said that, in his home area, a dead rat was used for this purpose), the spirit of the unmarried person might be put to rest. As disabled persons often are not married, this treatment might also be applied to them, but only when they are unmarried. The spirits of disabled persons who were married and had children cannot be chased away without good reason.

8.3. Disability and liminality

In Chapter 5 three alternative theories for describing the position of disabled persons in the society were presented. None of the theories was developed with disabled persons in Third World countries in mind. In this section we will check to what extent the terms 'sick', 'liminal' and 'deviant', used in these theories, bear relevance to the description of the social position of the disabled persons I interviewed.

The classification of disabled persons according to their position in society was, more than the other data presented here, subject to interpretation of the researcher. The information presented in this section is therefore different from the data presented earlier in this chapter and in the previous two chapters.

It seems to me that of the indicators for position and status, described in the previous section, family life and cultural/religious position, possibly in combination with political position, are the most important factors. This seems to be particularly true for people in the rural areas with an inward orientation, i.e. people who are oriented towards rural life and who do not have urban ambitions. To people with urban aspirations economic position and level of education are important criteria. Anyway, all criteria mentioned are related to each other and the order (of importance) indicated says perhaps more about the causal relationship that people suggest exists between the factors than about their actual importance.

There is a difference between the value that disabled men and women attach to these factors. For disabled men family life and cultural/religious position are as important as for women. But disabled men have another possibility to acquire status: spirit mediumship. The alternatives for disabled women are

confined to the realm of family life, they may opt to have children without a formal marriage arrangement. Theoretically speaking disabled women might opt for spirit mediumship, just like disabled men, as indeed the number of female healers in Zimbabwe almost equals that of male healers. For disabled women in the fieldwork area spirit mediumship apparently was not an attractive option.

It was mentioned earlier that in the Shona worldview all living human beings take a somewhat liminal position. They may improve themselves in life or they may end up being degraded to the level of an alien or outsider. This basic form of liminality seems to apply to disabled persons as well as to persons who are not disabled.

In terms of social position in the community one can distinguish three main groups of disabled persons.

- In the first place there are disabled persons who are impaired, disabled and often also handicapped, but who are completely integrated socially. In terms of scientific medicine these persons would be considered 'rehabilitated', although often no active rehabilitation took place in their cases. If rehabilitative forces can be said to play a role, they would be marriage, motherhood and/or spirit mediumship.
- A second group to be distinguished is that of disabled persons who do not have much to look forward to in terms of social or economic improvement. Here a distinction is made between those disabled persons whose condition is considered to be beyond the control of human beings or spirits, and individuals who have become outsiders due to their own misbehaviour. Whereas a member of the first sub-group may best be described as 'a gift from God', the term 'deviant' might be applied to the second sub-group. While it is unlikely that members of the first sub-group will improve their social or physical condition or their relationship *vis à vis* the spirit world, the second sub-group still has some possibilities for improvement.
- A third group consists of people whose position is not yet fully determined, they are still 'juggling with the factors of existence', to speak in Turner's terms (Turner 1977:106). It may be that they are still pursuing medical treatment, it may be that they are trying to get married (or to stay married) and have a family, it may be that they are claiming that an ancestor spirit is trying to possess them (or any combination of these).

In Table 9 the disabled informants described in Chapter 6 and Table 6 in particular are grouped according to the description provided above (marital status, motherhood, spirit mediumship and to a lesser extent educational status and economic position). Table 9 reflects my assessment of the position of the

Table 9

Classification of disabled persons according to social position

Case no.	Rehabilitated	Liminal	No prospects
1			x
2			x
3			x
4		x	
5			x
6		x	
7			x
8	x		
9		x	
10			x
11		x	x
12		x	
13	x		
14			x
15	x		
16	x		
17			x
18			x
19		x	
20			x
21			x
22			x
23			x
24		x	
25	x		
26		x	
27		x	
28			x
29			x
30		x	

disabled informants in the society, using a scale ranging from full rehabilitation to 'no prospects at all'. The disabled persons, their relatives and community members often valued these positions differently. This is inherent in the problems that sometimes existed within a family or between the family and the community concerning a disabled person.

The case-studies presented in this and previous chapters illustrate the classification provided above. Apollonia Rusere (case 25) may be considered 'rehabilitated' socially. There is agreement over the cause of her disability and no treatment (has been) is pursued. She has children and is a respected member of society. She is not laughed at for the way she walks and if children dare to do so they are reprimanded by their parents or by Ms. Rusere herself. There is no reason to doubt that her spirit will be welcomed back by her children when she dies.

Mr. Musana represents one of the more successful liminal cases. Edward Samukange (case 19) and Mission Machipisa (case 24) belong to the same category but have not yet been successful. Mr. Musana and Mission have pursued scientific medical treatment, while all three gentlemen consulted traditional healers. There is disagreement between them and (some of) their relatives about the cause of the disability and about the fact that the claims of spirit possession that they make are not recognized. Socially speaking their position is unstable or 'liminal' and open to negotiation.

Monica Murape, Maureen Mapfumo and Milton Chitunga represent the category of disabled persons that is generally considered to be beyond rehabilitation. Medical treatment is no longer pursued, stagnation occurred concerning the diagnosis of the disability; marriage, spirit mediumship and motherhood are out of the question. They are considered deviants or 'a gift from God'; it is generally accepted that their spirits will not be welcomed back after death.

In conclusion it may be said that, as far as the social position of the disabled informants are concerned, there are a number of useful indicators. However, as was the case with the popular and professional views on disability, the values of the indicators are, to a certain extent, subject to interpretation and manipulation. If rehabilitation is aimed at the integration of the disabled individual in the society, perhaps instead of offering vocational training and psychological counseling, we should teach community rehabilitation workers to effectively manipulate the factors of existence, or we should involve traditional healers, who are experts in this respect.

Chapter 9

Summary of data, points for analysis and recommendations

9.1. Summary of data obtained

Community health care and community-based rehabilitation have been heralded as answers to the financial and personnel problems facing health care and rehabilitation services all over the world.

The position adopted in the first chapters of this study concerning this issue is that, in Zimbabwe, due to a history of racial segregation and institutional health care, community health services are regarded as 'secondary' by the people who are supposed to use them. Even if this were not the case, the indispensable participation of the people in the community could not be secured. Community health and rehabilitation are being imposed on people by scientific medicine, in an effort to combine the low costs of traditional medicine and the 'scientific' advantages of western medicine. I believe that in this form community health hardly constitutes any improvement over the more institutionally-oriented health care services.

Now that it is becoming clear that the community approach is not as cheap and easy to implement as originally expected, its defence has to focus on the only argument that should have had weight in the first place: community health provides better care for ill and disabled persons, because it involves and takes into consideration the culture and the home situation of the patients concerned. This argument has not received much attention so far. Community rehabilitation was considered 'better' for economic reasons, but not for professional reasons. The general practice is that physiologically complicated cases and patients who receive rehabilitation services under some insurance scheme are referred to an institutional rehabilitation centre, run by doctors, physiotherapists and other specialists. Community-based rehabilitation has thus become the 'predicament' of poor, rural, physiologically not seriously disabled persons, instead of being directed at those cases in which an understanding of and

influence on the local and cultural circumstances could have a rehabilitational effect.

The aim of this study was to demonstrate how community-based rehabilitation programmes could be set up to contribute to a better care for disabled persons. In order to find out about this, it was necessary to get an understanding of the way disability is perceived and experienced in the culture and the community in which the disabled person lives.

It was argued that illness and disability as they occur in the rural areas of Zimbabwe should be understood as cultural and religious phenomena. I outlined the Shona cosmological order in which the human spirit takes a central, though not very clearly defined place. I ventured to describe the position of the human being in traditional society as 'liminal' and as 'deeply involved in juggling the factors of existence'. Thereafter we outlined what the position and chances are for disabled individuals in this and to what extent community-based rehabilitation can possibly come to their assistance.

The ideas and practices of disabled persons, their relatives, the community members and a number of traditional healers concerning disability were investigated, focusing on three areas in particular:

- the terminology used to describe illness and disability and the explanatory models used by disabled persons, their relatives and relevant others;
- the explanatory model and treatment practices mentioned and used by the traditional healers;
- the position of the disabled person in the community.

In total thirty-one disabled persons and twice that number of relatives and relevant others were interviewed for this research. Also, twelve traditional healers provided information.

A list of Shona terms for illnesses and disabilities was compiled. From this list and the discussions that followed its compilation, it became apparent that, although comparable terms for illness (*kurema*) and disability (*kuremara*) exist, informants tend to define these terms somewhat differently than is done in scientific medicine. In general the term *kuremara* is defined as a condition of being physically or mentally unfit, a condition that is prolonged or that exists since birth and that cannot be treated or cured, other than with great difficulty. In many discussions about the term *kuremara* it became clear that, although the condition only affects one individual, it reflects on the family as a whole.

Traditional healers indicated whether they considered a particular condition an illness or a disability for all the conditions on the list. This information showed that some conditions are included (upper teeth appearing first) under

the heading *kuremara*, while others (diabetes) are not. Also, some Shona terms have different connotations than their English equivalents (mental illness/*kupenga* and mental retardation/*kuzungaira*). In addition, a large number of Shona names for the causes of illnesses and disabilities were brought forward. These terms relate mainly to types of day-witchcraft that are often considered to be the cause of disabilities. A list of these terms was compiled together with the different descriptions as provided by the informants and/or information from the literature on this subject.

Two main causes were distinguished for *kuremara*: 'natural' and 'cultural' causes. In case of the natural causes, illness and accidents are considered. But as soon as it becomes apparent that the condition is not temporary, people will want to know why that illness or accident occurred, at a particular time, involving that particular person etc. By raising these issues, they look for cultural causes, i.e. the interference of human beings/spirits. Sometimes cultural conditions may develop such that they are considered 'beyond' the control of human beings or spirits. These conditions are called natural again. Thus the very simple and very serious conditions are believed to be of natural origin, whereas the majority of disabilities are assumed to have a 'cultural' cause and to be susceptible to influences of human beings or their spirits.

The cultural causes of disability can be divided in five sub-groups:

1. A *mudzimu* or *shave* spirit who wants to possess the disabled person but is not acknowledged or well received;
2. A *ngozi* or *chikwambo* or otherwise angry spirit who wants to punish the disabled persons and/or his relatives;
3. Witchcraft, either day-witchcraft or night-witchcraft;
4. Breaking a taboo or social norm (an offence against a living human being);
5. Being a witch or a sorcerer and/or the punishment given for that.

An explanatory model is built around the natural and/or cultural causes. In these models explanations for the physical and the socio-cultural processes leading to the disability are provided. The disabled informants and their relatives are very vague in describing the physical processes underlying the disability. To them the human body is like a black box. Misbehaviour against the cultural norms forms the 'input' and this results in illness and/or disability. They do not have a clear picture of what happens inside their bodies and as a consequence the standard scientific medical explanation is wasted on them. Fortunately, the traditional healers were able to provide a more detailed account of the physical processes they believe to be underlying disability. According to them, most illnesses start in the flesh. First they are rather localized infections or injuries,

but after some time the illness spreads and eventually it may reach the blood. The blood will carry the illness or disability further through the body until the stage where the blood itself gets affected. The blood will lose viscosity and blood clots will form. Finally the blood will turn black and will stop flowing altogether. The affected parts become 'dry'. When the blood flow has stopped the flesh will gradually decay until only the bones remain, as in a dead body. In such cases the healers tend to speak of a disability. When this condition is not treated immediately it becomes incurable, beyond the control of humans and 'a gift from God'. Although disabled persons or their relatives never produced a complete account like this concerning the physical processes underlying their disabilities, their fragmented statements on the issue generally concur with the model presented by the traditional healers.

As far as diagnosis and treatment are concerned, some specific data were gathered on the way diagnoses are made and treatment is implemented. This information is interesting because it places the treatment of disabled persons by traditional healers in a certain context, but the information as such is not specific for the treatment of disabled persons. In the majority of the cases compiled, a cultural cause of the disability was indicated, if not by the disabled person him/herself, then at least by relatives or relevant others. The number of cases in which a traditional healer was consulted (75%) was much higher than that reported by the other researchers in this field. The difference with the figures provided by Brand (1984) and Chavunduka (1978) can be explained by the fact that these researchers interviewed in an institutional/urban setting respectively, while Chavunduka was concerned with ill people only. The discrepancy with the figures from the national disability survey might have arisen because a high level of confidentiality was established with the informants. Initially the informants in this research were also reluctant to discuss the cultural causes of their disabilities. Also the fact that a disability is a lasting condition makes it more likely for the person and family to consider different causes and different treatment approaches. Probably Chavunduka's (1978) and Leeson's (1968) findings relating to chronically ill patients should also be understood in this way.

A certain hierarchy was observed in the way people revealed the different causes of their disabilities. At the same time it became clear that some causes pose more of a threat than others. Informants did not like to talk to outsiders about the cultural causes of their disabilities, particularly not to white outsiders. Once this barrier was taken, it proved difficult to reveal what the real cultural cause underlying the disability was. Different and often conflicting cultural causes may be mentioned for a certain condition, depending on the time and

place as well as the person who provides the explanation. Generally there is more than one treatment option available and treatment involves more than just aiming for the best medical solution. Often social and political reputations are at stake.

One characteristic of the diagnosis and treatment of disabled persons by traditional means, is that, in the majority of the cases compiled, somewhere along the line stagnation occurred. A diagnosis was not accepted or a prescribed ritual was not performed. From the viewpoint of an outsider it might be possible to relate the stagnation directly to the incurability of the disability, but within the cultural context this kind of stagnation can only be understood in relation to the fact that different, conflicting causes for a disability were brought forward. When underlying social or political problems cannot be solved, the disability cannot be treated and this is how the disability can be understood and accepted by the people involved. A difference can be made in this respect between conditions that are still being treated, those where treatment has stagnated and conditions that are considered beyond treatment.

Treatment preference for either scientific medicine or traditional medicine could not be established reliably in this research. Somewhere along the line, both a scientific and a traditional medical practitioner were consulted. Although conditions that are assumed to have a natural cause are often referred to a scientific healer, this is not necessarily the case. Traditional healers do treat conditions with a natural cause as well, usually with herbal medicines, provided the particular condition is in their field of specialization.

One final, rather obvious but important observation was made regarding the shifts in treatment preference between traditional and scientific medicine. When clients change from scientific to traditional treatment or vice versa, this does not imply that their perception of the medical system changes. This is why it is important to perceive the local medical system as it exists in the fieldwork area and as the people see it as an integrated whole. The traditional healer and the scientific medical practitioner both have their place in this system. Shifting from one healer to the other takes place within the same medical system, in terms of the same explanatory model. A change of treatment preference therefore does not necessarily imply a change in explanatory model.

Concerning the position of disabled persons in the community, the information revealed that social status (marital state, having children, the possibility to claim spirit mediumship and the prospects of one's spirit becoming a *mudzimu* after death) is of more importance than economic and educational status. The latter two tend to become more important when an urban 'career' is envisaged.

The possibilities for disabled persons to find formal employment may be less than those for other persons but the difference is not great, as the chances to find any form of employment (including informal or self-employment) are small indeed for disabled and non-disabled persons alike. Economic dependency, at least partial economic dependency, is generally not something people are ashamed of and it does not necessarily have a negative effect on one's social status, provided some form of compensation in other fields can be arranged. Nevertheless, when given the chance, most people, including disabled persons, are keen to earn their own cash income to satisfy their individual material needs. At the same time the rural economy still turns on communal labour and gain. Individual economic successes, nice as they may be, are the subject of gossip, criticism, and envy. Decisive for the economic position of virtually everyone in the fieldwork area is whether there will be enough rainfall. This material uncertainty as well as the impossibility to exert control over these natural resources influence the outlook people have on life, and this in turn has an influence on the way the community perceives illness and misfortune in general and disability in particular.

From a social point of view, it seems very important for the integration of disabled persons in the community that they marry and raise a family. Through a somewhat adjusted division of labour, negative influences of the disability on the level of production can easily be prevented, while having a family and children is an important determinant for social status. It was observed that the position of married disabled persons in the community was very much comparable to that of others. In a way being unmarried (and being without prospect of getting married) seemed to be more of a disabling factor than many physical, sensory or mental conditions. The importance of having a family is about the same for disabled men and women. For disabled women, however, there is an additional virtue attached to motherhood, even outside a marital context.

Social and political factors are of importance in explaining the cause of the disability. The political and social status of the persons involved in the case-studies determined the level at which a treatment has to be sought. Problems can arise and be solved at three levels. First of all there is the rather informal level of the first-aid healer. This is a local healer, without much of a reputation and without well-developed specializations. This healer is consulted in the first instance, he/she is nearby and not expensive. After consulting a first-aid healer but often also without previous other consultations, a *nganga* of reputation may be consulted. A *nganga* can diagnose and treat a variety of cases, with either a natural or a cultural cause. The cultural causes should be fairly clear-cut and

should not go beyond the boundaries of the immediate family or neighbourhood. When more is involved, a local spirit medium has to be consulted, through whom the ancestors will speak. This is how being untreatable, or at least difficult to treat, can have two sides. On the one hand it is terrible if the illness does not subside after treatment by a *nganga*, but on the other hand this may be a sign of the importance of the problem and of the people/spirits involved in it and, for the ill or disabled individual, it may hold a promise as to his/her potential powers as spirit medium.

The chances of being accepted as a spirit medium or getting married and raising a family are important indicators of status. In addition, having one's *mudzimu* accepted in the realm of the ancestors after death seems to be an important accomplishment. The latter two aspects are connected. Although some informants feel that the *mudzimu* of a disabled person will always be chased away, or at least that a *mudzimu* will not be accepted unless the disabled person possessed qualities (for instance healing power) to make up for the disability, others say the *mudzimu* of a disabled person cannot be chased away so easily, particularly not when that person is married and has children.

9.2. Points for analysis

Looking at the medical system in the fieldwork area we see that it is characterized by communalism instead of individualism and by external instead of internal control. Disability, especially when cultural factors are involved, is a family affair and the family consults a traditional healer to find out about the cause. The role of the disabled person in the community is not comparable to the 'sick role' as described by Parsons. In sociological terms illness behaviour and the role of medicine cannot be understood in terms of the control of society over an individual. It is not so much a matter of the individual sticking to norms, but a powerplay between different groups in society. The disabled person is a pawn in this play going on inside society, rather than a deviant or drop-out.

The disabled persons in the fieldwork area are often scapegoats. Society purposely placed them outside the social order and often does not try to get them integrated in society again. Rehabilitation, if it occurs at all, is but a side-effect of a solution of problems that affect the family at large. Nevertheless, some people are 'rehabilitated' after a period of illness, disability or liminality in general. Such an individual is given back a place in the social order, while also the contact with the ancestor spirits is re-established. Belonging to the social order and adhering to the norms are important aspects of rehabilitation and

in this respect Parson's theory does apply. However, rehabilitation or recovery cannot be understood in terms of social coercion or control by the community, through the medical practitioner, over the individual. In the Shona medical system the medical practitioner is only a mediator between different forces in society, neither he nor the disabled individual control these forces. From the explanatory models it can be derived that disability is perceived, at least by the disabled persons and their relatives, as something that comes from outside, something that is very often beyond the control of the individual and sometimes even beyond the control of the family or community.

It seems that the more serious a condition is considered to be (whereby seriousness does not only refer to the medical, but also to the social and cultural aspects of the disease) the further the causal explanation is placed away from the control of the individual. While a simple and curable condition is believed to have only a natural/physical cause, in more complex and less curable cases cultural causes are primarily considered. Finally, at a macro level, when disabled persons do not consult a *nganga* any longer, but ask the advice of more important spirit media, people will look for more general reasons behind the illness or disability; reasons that go beyond the level of the single individual. It does not seem important to put much emphasis on internal and individual aspects of the condition when it appears to be of a more serious nature. In scientific medicine the situation seems to be almost the opposite. The emphasis is placed more and more on the control of internal body processes, especially if the condition becomes more serious. While most people who adhere to a scientific medical system may be prepared to ascribe a condition like a cold or a fever to external factors or 'chance' (i.e. an open door, a sudden draft), they will require a more detailed physiological explanation if the condition becomes more serious. Both medical systems try to offer explanations and treatment for illness and disabilities. In the scientific medical system emphasis is put on internal control, i.e. mastering the problems within the framework of the body, while in the fieldwork area much more emphasis is put on controlling the external causes as far as these external causes are not beyond the control of human beings. This might have to do with the fact that life of the people in the fieldwork area is very much controlled by external forces (the rain, the ancestors, the family), while at the same time at least part of these external forces seem to be controllable. In the fieldwork area, society is still felt to be a *Gemeinschaft* (Tönnies, 1935) in which members can influence and (socially) control each other. In the individualistic modern society, these things are usually considered to be 'beyond control'.

Zimbabwean society is gradually developing into a more individualistic and internally controlled society. These changes of course influence the medical system and one might ask what the future of traditional healing will be. Will traditional healing develop into a system of herbal remedies for conditions with natural causes and will the cultural aspects slowly fade away, or will it be possible to preserve some of these values and maintain a holistic approach to medicine? The main strength of community-based rehabilitation seems that it is able to contribute to the maintenance of the latter. This is exactly why community rehabilitation is important and needs further attention, i.e. not for economic and organizational reasons, but for the social and psychological well-being of the individuals concerned.

It is particularly in the context of a world changing from *Gemeinschaft* to *Gesellschaft*, that deviance is beginning to occur. In a *Gemeinschaft* situation the fate of the individual was subordinated to that of the group. In such a situation misformed children were killed without any moral consequences or guilt. Everything that could possibly weaken the position of the family *vis à vis* the outside world had to subside. Disabled persons were not deviants, but scapegoats or, if they were lucky enough to stay alive, 'a gift from God'. Accusations from the outside world concerning a family member were always denied and a 'witch' or 'murderer' would always find shelter with his own family. Turning away from one's own family was about the last thing to do and comparable to signing one's own death warrant. Such deviant individuals were likely to be killed or expelled from society and their spirits unlikely to be included within the realm of ancestor spirits. Deviance in this form did not occur at a considerable scale in traditional society.

However, modern times brought wars and migrant labour, activities for which 'turning away from your own family' is almost a prerequisite. An adjustment in the social and cosmological order was made to accommodate this category of people and their spirits. Strangers and the spirits of strangers could be accepted in the adjusted system, provided they brought some positive qualities along. An alien warrior had to transfer hunting or healing skills to the society that adopted him, the migrant labourer had to share his knowledge and experience as well as his financial assets. As we argued in Chapter 4 the 'shave system' is on the decline. It is no longer absolutely necessary for a the individual to link up with the traditional system to survive: currently deviance can have its merits. Equally, it is no longer absolutely necessary for a disabled individual to adhere to the interest of the family to survive. People may move away from their traditional context to towns, disabled persons may go to rehabilitation

institutions and they may become happier than they ever could have been 'at home'.

Apart from the 'rehabilitated' disabled persons and those who may be considered 'deviant' or 'a gift from God', there are disabled persons in a 'liminal' position. Actually, the larger number of disabled persons interviewed for this research might be classified as such. It seems that not the extreme oppositions count most when we want to understand the Shona culture and medical system, but the small differences that may turn the *nganga* into a witchdoctor or witch, the differences that will determine whether a human being will remain a human being or become an outcast. These small differences maintain a delicate balance in society, leaving enough room to 'juggle with the factors of existence'. This juggle as it takes place, for instance, between the chief and headmen on the one side and the ancestor spirits, through the spirit mediums on the other, is also reflected in the relationship between the patient and the outside world, with the body as medium. In the case of illness or disability, it is not a matter of irrefutable evil but an issue of careful negotiations between all 'parties' involved, concerning the direction in which the power will swing and the place at which the evil will strike, at least for the time being.

9.3. Conclusions

The main aim of this study was to find out how community-based rehabilitation might contribute to a better care of/for disabled persons. In order to find out about this, we had to understand how disabled persons, their relatives, relevant others and traditional healers perceive disability and rehabilitation. In the course of the research we focused on three aspects: popular terminology and explanations, professional diagnoses and treatment practices, and social position. These three aspects may serve as indicators to the kind of rehabilitation services that are required. In order to demonstrate this, we have to look back at the figures and tables discussed in the previous three chapters. From these data we may conclude that there are basically three types of indicators, related to the three aspects of disability mentioned before: the cultural explanation, the physical diagnosis and the social position. When we apply these indicators to the three categories of disabled persons mentioned in the previous chapter (e.g. 'rehabilitated' persons, liminal persons and deviant persons) this leads to the following picture.

Let us start with the individuals that were considered fully 'rehabilitated', the cases 8, 9, 13, 15 as well as *amai* Mafure (case 16) and Apollonia Rusere

(case 25) (the cases 6, 11 and 30 that tend towards liminality are not being considered here). If we look at the causes and names given for the disabilities of these individuals, as indicated in Table 6, Chapter 6, it is the relative unanimity concerning the cause (among the disabled person, relatives and relevant others) that draws attention. In addition, in most cases the cause is considered natural. If a cultural cause is indicated, this is done in an undifferentiated way, mainly because treatment is no longer considered. This is reflected also in the physical classification of the disabilities, as indicated in Table 8, Chapter 7. Without exception the conditions of the 'rehabilitated' disabled individuals are classified as 'beyond treatment'. The blood stream in the affected part has been stagnant for a long time and it is not expected that it will ever flow again; the affected part is 'dry'. The only exception is case 30, a family-man who lost status in the community due to collaboration with Smith's forces during the war. His originally stable social position and physical condition are becoming more and more liminal.

There is a second group of disabled individuals interviewed for this research that is over-represented in the category 'beyond treatment'. It is the group of disabled persons that inclines to the negative side of liminality, as indicated in Figure 6, and does not have much prospect left for improving their social position. As we mentioned earlier this group consists of two sub-groups. One sub-group consists of disabled persons, often children or youngsters, that have been 'given up' by their relatives, as scapegoats for a higher cause involving the family as a whole (cf. Maureen Mapfumo, case 5; Monica Murape, case 23; as well as the cases 20 and 29), or cases that were considered to be natural right from the start (notably the cases 2 and 18, both involving albino persons). They are generally classified as 'a gift from God'. The second sub-group consists of disabled persons who have turned against their families and sometimes against the traditional system as a whole (cf. the case of Kenneth (case 1), the case of Milton Chitunga (case 14), the case of Edward Samukange (case 19) as well as the cases 3, 6, 7 and 21). While the first sub-group consists entirely of individuals who have been given up for treatment, in the second sub-group three individuals are not classified in this way. One of them (case 7), is a woman who was mutilated because of collaboration with Smith's soldiers during the war. According to physical indicators only her flesh is affected, she is a social outcast and her condition is considered natural. She is not in any way classified as liminal, but the combination of extreme qualifications ascribed to her give her a marginal position. From a medical point of view the individual in question is not disabled, but a lot of people in the fieldwork area felt we should include

her in our project, because: 'If you talk about disability, she is really disabled, we do not know what to do with her.' As far as the causes and names for their disabilities, the first sub-group of the second category of disabled persons falls mainly in the sphere of natural causations, with the exception of case 29, where we did not collect a very elaborate and consistent case-study anyway. The causes and names indicated for the disabilities in the second sub-group are more diverse. Actually the causes given by the disabled person, the relatives and relevant others show great contradictions (with the exception of case 7 mentioned above).

In this respect this group shows similarity to the group classified as liminal according to their social position. This group (Tendai Hungwe (case 4), Mission Machipisa (case 24), Violet Mazire (case 26) as well as the cases 12 and 28) is actually classified as liminal on all three indicators. From a social point of view it concerns individuals who have not yet managed to secure a stable family life. Some married, but their marriages failed and the women did not get children (cases 26, 28). Two others have not yet married but their chances are reasonable (cases 12, 24). As far as the physical classification of their condition is concerned they are not considered 'beyond treatment', with the exception of case 4, while also the cultural explanation offered leaves ample room for different interpretations. Only Tendai's case forms an exception. Her condition is considered beyond treatment. She got married and has a child. This would have placed her in the category of 'rehabilitated' or integrated disabled persons (which shows clearly that marriage/motherhood is much more important than any physical condition whatsoever), but her marriage is on the verge of failing and it is doubtful if she will be able to maintain her child. This makes her social position liminal. It is worthwhile to note that during the research, when the intentions of the husband and his family became more and more questionable, the family of the wife made an effort to pursue medical treatment and to get her new callipers. These efforts might be interpreted as a way to restore the balance within the family as well as the position of the wife in society, a position disturbed by the behaviour and attitude of the husband and his family.

The data presented here reveal a relationship between the explanations for disability in terms of cultural/religious explanation (withdrawal from/of the family in general and the family spirits in particular), physical explanation (stagnation of blood) and the actual social position disabled persons take in the family or society (extent of liminality). A schematic representation of the relationship is presented in Figure 7 below. The relationship is neither causal nor unequivocal. Reality does not tend to be that tidy, whereas it may be considered a

characteristic of the etiological system in the fieldwork area that it leaves ample room for interpretation and manipulation. Nevertheless, a careful evaluation of the various indicators does give us a picture of the problems involved and may eventually lead to a conclusion as to the manoeuvring space available and the rehabilitation approach to be followed. This issue will be elaborated further in the next section.

Figure 7

Causes of disability and the relation between indicators

Indicator	Simple natural cause	Cultural cause	Terminal natural cause
1	'God'	humans/ spirits	'God'
	shave	mudzimu	mhondoro
	stranger	human	chief
2	black shadow	human body	mwea/soul
	flesh	blood	bones
	flowing blood	stagnant blood	dried blood
3	'rehabilitated'	liminal	deviant/ gift from God

9.3. Recommendations

'Kuoma rupandi': the parts are dry, the blood, the family, the protection of the ancestors, all hope is gone. The essence of disability in the rural areas in Zimbabwe can hardly be described better than with this term. In this study we have seen, however, that not all disabled people are in a position where the blood has stagnated completely and even in cases where there is no hope that the blood will ever flow again, there are still possibilities for rehabilitation.

From the analysis presented here it may be concluded that, in order to understand the way disabled persons in the rural areas of Zimbabwe, their relatives and relevant others perceive disability, three types of indicators may be

used: cultural explanation and terminology; physical explanation and medical treatment; social position. These indicators do not necessarily point in the same direction, but when we consider them together, they do give us a fairly good insight into the situation of the disabled person. They may also provide an indication of the prospects for rehabilitation in general and community rehabilitation in particular.

In the first section of this chapter we have outlined the fallacy of community rehabilitation. It is considered a cheap solution to rehabilitation problems, particularly in less serious cases for which a high level of professionalism is not required or available. But study of the three aspects mentioned reveals that an indication for community-based rehabilitation does not always coincide with a less serious physical condition, while seriously disabled people in the rural areas are not necessarily served better with institutional and specialist care. When we consider this issue more concretely, on the basis of the research material gathered, the following recommendations could be made in this respect.

First of all there is a group of disabled individuals who live fairly integrated lives. They are impaired, disabled and sometimes even handicapped, but the differences between their lives and those of non-disabled individuals are only marginal. They may be assisted with simple prosthetic or orthotic devices, but including them as clients in community rehabilitation projects will probably do them more harm than good. They are in a socially well-balanced position. If we bring them in a position where they have access to economic gain, while the other villagers have not, this is likely to raise all sorts of envy and gossip (cf. the *chikwambo* stories). In addition it will make disabled people depend on aid while they managed perfectly well without. Nevertheless it should be realized that it is particularly this group of disabled persons, which may not be so much in need of rehabilitation services, that is most likely to be included in community-oriented rehabilitation projects. Disabled persons of this group can easily be reached and because many of them are heads of households, it seems economically relevant to be concerned with their position.

Secondly, there is a group unlikely to improve their condition, either medically, socially or culturally. They may be in this position either because of their own mistakes or because their families used them as scapegoats in the process of solving important family problems. The position of some individuals in the first sub-group could be improved by careful negotiation, preferably between a *nganga* or *svikiro*, on behalf of the disabled person, and the family and ancestors. A similar improvement is not likely in the case of disabled individuals who have been used as scapegoat by their families. Community-based rehabilitation

directed towards this group should be aimed at consolidating their position and creating secondary gains in economic and educational terms, as part of the 'shave mechanism'. Also, it might be possible to improve their social and cultural status through marriage, motherhood or spirit mediumship. Here again the role of traditional healers is indispensable.

It should be considered, however, in consultation with the individual and perhaps also the relatives and the healer, whether these 'gains' should be provided in a community setting or in an institutional setting. The case of Conny Chidyausiku (case 13) shows that institutional rehabilitation may work out quite successfully. At the same time it should be realized that Conny was quite prepared to jeopardize her urban career in order to have a child, while Apollonia Rusere who has a brother and a sister in an institutional rehabilitation centre stated clearly that she would not want to change places with them. Other disabled persons interviewed (e.g. Kenneth Madzima, case 1) indicated clearly that they wanted to leave their community in order to get rid of the stigma attached to them.

The third group, consisting of disabled persons with a liminal position, should be the primary target group of community-based rehabilitation programmes. These programmes could assist them in three possible ways.

1. Through medical rehabilitation we might try to optimize their physical condition. These are probably the disabled persons that will regard scientific medical intervention more positively than the other two groups discussed above. Medical rehabilitation should be presented in terms that appeal to the disabled person and their relatives.
2. A traditional healer could intervene on behalf of the disabled person to sort out the underlying cultural problems and all possible family and community forces should be set at work to find a suitable marriage partner.
3. Vocational rehabilitation and income-generating projects can be of assistance in this respect to help the disabled man to pay *lobola*, so that he can become a respectable husband, or to help the disabled woman to buy baby food and clothes so that she can be a respectable mother.

It should be realized that, basically, medical rehabilitation and vocational rehabilitation are only goals to an end and never goals in their own right. When it has been established, however, that the disabled individual will not be able to acquire an acceptable position in the community, placement in an institutional setting should be considered. It is then that medical, vocational and educational rehabilitation may become goals in their own right, while, as a consequence, the physical, vocational and educational condition of the disabled person may

become important indicators of status, as is the case elsewhere in present-day Zimbabwe.

At the community level, a very important role in the rehabilitation process is assigned to the traditional healer. I look upon traditional healers as community rehabilitation workers *par excellence*. These healers, better than anyone else, are able to judge the prospects for integration and to work towards this goal. They possess most of the inside information that is required to make this judgement and to induce certain developments, and if they do not have this information yet, they are the ones in the best position to obtain it. In addition, the organizational level of traditional medicine in Zimbabwe has reached a level of professionalism that justifies the involvement of these healers in formal social and health care programmes to a much greater extent than is the case at present.

Notes

Notes to Chapter 1

1. As estimated by World Health Organization (WHO) 1976.
2. Economic Commission for Africa (ECA/SDEHSD/DDP.1), n.d.:1: 'The number of disabled persons in the world today is estimated to be 500 million and it is said to be increasing rapidly. It is further estimated that at least 350 million or 70% of these disabled persons are to be found in areas of the world where services to them are least available' (cf. UN 1982:1). Given the fact that about 10% of the world population lives in Africa (*Times Atlas* 1978: pop.fig. 1975), estimations are that Africa has at least 50 million disabled persons.
3. Bourdillon (1982:1) states: 'The derivation of the word "Shona" is uncertain. It appears to have been used first by the Ndebele as a derogatory name for the people they had defeated.' In the literature the term has been used to refer to different geographical areas. Here the term refers to the areas that are presently named Mashonaland, i.e. the Mashonaland provinces in north, west and central Zimbabwe, in which the fieldwork area is situated.
4. The randomization took place primarily to prevent that only those informants who were easily accessible or those who were eager to talk were included. In view of the relatively small number of cases studied, the randomization has contributed to making the sample more representative of the disabled population in a qualitative way, but does not provide a reflection of the disabled population in the fieldwork area in a quantitative way. For more information as to the actual randomization procedure, see Chapter 6.
5. Unless explicitly mentioned otherwise the text refers to both male and female disabled persons and/or other informants.

Notes to Chapter 2

1. In the colonial period the area was first included in the Salisbury district (this was gazetted by the BSAC in 1897). The headquarters of the district initially were in Salisbury and were later (1899) moved to Fort Enterprise. Thereafter the headquarters were moved to Goromonzi in the Chinyika reserve. In 1909 the district, which included the fieldwork area, was renamed: Native District Goromonzi. By government notice 1639, no. 6 of 20 January 1910, the boundaries of this district were laid down.

By government notice 266 of 1912 the Goromonzi district was renamed Salisbury district until in 1949, government notice 33, a new Goromonzi district was formed, including the fieldwork area. The boundaries of this district were further adjusted in subsequent years, without consequences for the fieldwork area however.

To avoid misunderstanding, in this report we will speak of 'Goromonzi district', even if at a certain time the area officially belonged to Salisbury district. For more information on this issue see note 4 and paragraph 2.3.

2. Source: Central Statistics Office Harare, Zimbabwe 1984.
3. The figure of the average size of homesteads is based on a sample survey of 100 homesteads, carried out by the researcher. It is difficult to establish where one homestead ends and where the other starts. I looked at huts that stood close together and asked informants: 'which other houses belong to this house?' Larger homesteads tend to belong to families who have a lot of relatives working in town. Instead of establishing their own homestead, like older sons living in the area sometimes do, these relatives prefer to have a house close to their family, so that someone can look after it in their absence.
4. A district in Zimbabwe may contain individually/privately owned land (the former European and African purchase areas), government land (nature reserves and game parks) and communally owned land (the former reserves/tribal trust lands). The communally owned land is under the authority of a chief. His area can be subdivided in a number of wards, each of which is under the traditional leadership of a headman, and a number of villages and kraals. For more information on the administrative structure and organisation see paragraph 2.3.
5. Cf. National Archives of Zimbabwe, files on chiefs and headmen and successors (A 3/18, A/3/18/18, vols. 1-3, S 1563). It may be interesting in this context to note the case of chief Siatshilaba of Sebungwe who suffered from leprosy. 'Arrangements for his isolation were made by the native department and Simariapongo was appointed as care-taker until a new heir would be appointed. At a meeting to discuss the succession, Sianbubi (the son of Siatshilaba's sister) was chosen as successor. . . . Sianabu however is a confirmed invalid, having injured his spine as a child, and therefore could not perform the duties entrusted to him' (according to the report of the native administration). The native commissioner therefore appointed Simariapongo as chief. During the trial of a murder case it became clear however that Simariapongo's authority was not generally recognized by his people and that the old chief had much more influence. Finally Siatshilaba is reappointed chief and Sianbubi is accepted as his successor. Posselt, involved in this case on behalf of the 'native' administration, advised to proceed with the envisaged isolation of the chief as soon as possible, 'because otherwise no other care-taker will ever have a chance.' It is remarkable that particularly in this case, with two disabled persons involved, the colonial administrators gave in. It should be noted however that in other cases, where more political issues were at stake, they did not agree to the wishes of the African population so easily.

6. Bucher speaks in this context of chiefs who have spoilt the land: 'chiefs are nowadays salaried by and responsible to the central government in Salisbury' (Bucher 1986:42ff).
7. The term 'traditional' is here interpreted in a way comparable to the interpretation used by Bourdillon (1973:11). With 'traditional' we do not necessarily refer to the things that existed before the colonial era, but more to the aspects of culture that have been passed on from one generation to the other, though deriving their basis from the culture in the pre-colonial era. Traditional aspects of culture are therefore not seen as static entities but as dynamic components of culture.
The term 'scientific' is used in the same way as Chavunduka (1978) uses it. Although the scientific medical model is also 'traditional', because it relies on scientific tradition, the term 'scientific' is preferred to terms like 'modern' and 'western'. The first term implies that traditional medicine is static, which it is not, while the second term leaves the impression that scientific medicine is solely a 'western' achievement, while in actual fact a lot of non-western people have contributed to its development. In Chapter 5 this issue will be elaborated further.
8. The Witchcraft Suppression Act, Ordinance 14, 1899, replaced the witchcraft regulations imposed by the BSAC in 1895. The purpose of the Act is 'to suppress the practice of pretended witchcraft'. In the Act witchcraft is defined as 'the throwing of bones, the use of charms and any other means or devices adopted in the practice of sorcery'. In the Act people who accuse others of witchcraft and witchdoctors, i.e. healers who cure other people from witchcraft, are considered to be the culprits. Witchcraft is not punished because the existence of witchcraft is denied and no penalty can be given for something that does not exist.
9. The derivation of the word 'Shona' is uncertain (see Chapter 1, note 3). The word seems to refer more to the language of the people than to a specific culture. The following Shona dialects are generally distinguished: Korekore, Zezeru, Manyika, Ndau and Karanga (cf. Kay 1970:27). Posselt, who does not base his account on language groups but on family descent, differentiates a much larger number of tribal groups (Posselt:1927). From a linguistic point of view it has been pointed out that in actual fact not less than sixty-five Shona dialects (sub-groups) exist. The area in which the fieldwork was carried out is commonly seen as a 'Zezeru' (speaking) area. Bourdillon indicates: 'The Zezeru do not have a common history. . . . Industrialization has affected the Zezeru peoples more than peoples in remoter parts of the country' (Bourdillon 1982:32).
10. That nevertheless some importance is still attached to totem and *chidawo* only became clear later on in the fieldwork. People do make jokes about the fact that they are not supposed to eat the meat of a certain animal and the fact that they are not supposed to marry a girl from the same totem, as if they do not adhere to these restrictions anymore. In actual fact it often calls for a lot of courage to break these rules. This is illustrated in the letters to 'aunt Rhoda'—a question-and-answer column in one of Zimbabwe's popular magazines—: 'dear Aunt. . . . My problem is that I fell in love with a girl. . . . I have loved this girl since 1982, but now I have found

out that she is my relative. It is my father and her mother who have the same totem. Please auntie help me. Shall I stop seeing her only for this reason? Please help me because I love this girl so much that I have become dull in class.' Auntie Rhoda answers: 'There is no real problem here, you do not say how you are related so I cannot advise you other than to say, see your *Vakereka* who will be able to tell you about your *mutopo* and *chidawo*' (*vakereka*=family elders) (*Parade*, September 1987).

11. There are various opinions about where the spirits are before they are called home (cf. Murphree 1969:37) and where they are after they have been called home. Gelfand (1982:26) reports that these spirits live in the air and that they do not eat and drink. Other authors however depict these spirits as living in sacred valleys and on sacred hills. Before they are 'called home' the spirits roam around freely and do not form part of any community of spirits. When they are 'called home' they are absorbed in the community of spirits. Sometimes it is felt that to each living spirit a family spirit is attached as a protector.
 12. 'The original Early-Iron-Age Bantu speakers who crossed the Limpopo in the first few centuries of this era ... came to occupy an area of extremely high potential for agriculture and cattle-keeping. ... In this favourable environment the numbers of people and their herds of cattle increased to the point where it became desirable to start moving back towards and beyond the Limpopo' (Beach 1984:20). The 'gigantic reflex movements' described by Beach are generally called *mfecane* movements.
 13. I was unable to establish clearly to what extent the people in the fieldwork area were influenced by or related to the Rozvi. In a discussion with the local *svikiro*, when she was not in trance, any association was denied — but then the purpose of the whole seance with the local *mhondoro* had been to stress the independence and seniority of the people in the fieldwork area to other people in the area. The name 'Nyamunga' and the name of 'Rozani', one of the leading houses of the Mutyawasara clan, appear among Rozvi groups as well (cf. Beach 1984:286; Holleman 1961:367).
 14. Without wanting to elaborate too much on this issue, I should think it interesting to look more in detail at the history of the people in the fieldwork area, the recent incest cases, which according to informants seem to have taken place within main houses of the people in the fieldwork area, and Bucher's remark (1980:33) about incest as a way of acquiring extraordinary powers.
 15. I am greatly indebted to Mr. S. Mutswairo of the Department of African Languages and Literature at the University of Zimbabwe for sharing with me his detailed research material on the Chishawasha people and for correcting my views on 'the people of the chieftainship' on some essential points.
 16. In his (annual?) report of 4 November 1897 (N 1.1.9) Assistant Native Commissioner Campbell of Goromonzi district reported that the chiefs in his area were among the prime movers in the 1896/7 rebellion and he felt that none of them should be paid any allowances. He even goes as far as suggesting that it might be better if these chiefs would appoint their next of kin as chiefs, provided these relatives would manage to collect the annual taxes.
- The anger of Campbell and his dissatisfaction with the people of the chieftainship in

the fieldwork area in particular, can be understood better if we realize that during the rebellion his brother, G. Campbell, was killed in the kraal of the brother of Kuvimadzima, who was then their chief (cf. AOH/33/8).

17. In a letter of 20 May 1897 (N 1.1.9) ANC Campbell had indicated that, due to land allocations to European settlers, land and food in the reserve where the people of the chief had originally settled had become scarce. He suggested that the people could be moved to the 'reserve' of which the fieldwork area forms part, 'where there is sufficient land.' Initially only part of the chief's people moved to the new areas allocated to them. The larger part of the group that initially stayed behind on the old land, was later moved to Chikawaka 'reserve'.
18. Before the migration, succession problems occurred between different houses of the chief's family. At that time it had been decided that the chieftainship would rotate between the three major houses (cf. Chidziwa 1964:26).

After the migration, the succession problems were further aggravated by the fact that some houses were divided over different geographical areas. It seems that the colonial administration took advantage of this lack of unity by supporting the claims on the chieftainship of people who were positive towards or had been co-opted into the colonial system.

After the death of a chief called Kuvimadzima, succession problems arose (cf. Chidziwa 1964:31). The title was claimed, among others, by a representative of one of the houses who according to informants was employed in the ANC's office himself or, as other informants claim, whose son was thus employed. The claim on the chieftainship was acknowledged by captain Nesbit, the native commissioner at that time. The appointment was made without proper consultation of the people involved and ran counter to the succession rules (i.e. with the appointment the chieftainship remained in the same house, while it should have gone to the house that was staying in the reserve of which the fieldwork area forms part.

After the death of this wrongly appointed chief, similar succession problems occurred. One branch based in the old land favoured the appointment of a chief from among their midst, but the majority of the family, by now moved to the reserve, was in favour of the appointment of another chief. Probably because of the first candidate's role in the 1897 rebellion and the dissent of the people concerning the appointment of the previous chief, Nesbit decided to follow the will of the majority of the people this time and appointed their candidate (cf. S 1561, vol. 2, 1917/18; SN 27/8 and A 3/18/18 3-4).

Another indication of the bias of the native administration towards 'Europeanized' chiefs can be found in the annual report of the native commissioner of Goromonzi district over 1938 (S 1563/1938:19): 'The ANC Goromonzi reports an improvement in the works of the chiefs of his district. ... It is possible that the influence of the newly appointed chief Chinamora (lately messenger Kahari of the Salisbury office), from which much help and influence may be expected, is responsible for this change for the better.' More information about the civil service career of chief Kahari is provided in NADA 1950, vols. 27-31:55.

19. The idea that the people of the chief were not owners of the land in the fieldwork area is also supported by findings which indicate that they did not have a *svikiro* to assist with the appointments of chiefs. The general idea is that a group that does not control the *svikiro/mhondoro* of an area cannot be the owner of the land. A certain Chigodoro was the first chief of the family to be appointed over the area, which was then called a 'native reserve'. Chidziwa (1964:32) reports that the native commissioner Nesbit asked at the appointment of Chigodoro: 'Should not the chieftainship be given by a *mhondoro*?' They said: 'no we give the chieftainship by our own agreement and custom. We have no *mhondoro*.' Later the people pleaded with the native commissioner to give them back their original land north of Harare: 'Chigodoro is living in the country of Domboshawa and Domboshawa is not ChiShawasha it is in the country of Buru... The other area... [were they lived, Domboshawa]... was of Mutyawasara... the owner of that place.' (Chidziwa 1964: 32).
- In the delineation report of Latham it is stated that the appointment of a particular chief in the area was facilitated by a *svikiro* called Mazimbi. This information is contradicted in the annual report of the chief native commissioner of that time (S 1563/1937).
- The fact that the people of the chief do not have an important spirit medium to refer to, to make rain and to control the soil, is a clear indication for the people in the fieldwork area that they cannot be chiefs of the area: 'how can we have a chief who cannot give us rain?'
20. Msana is the chief of another communal area in Goromonzi district. The pangolin is a rather rare animal. When caught it should be presented to the owner of the area. It was practice to present the animal to the local chief, who would eat it. The rumour goes that the people in the fieldwork area once presented a pangolin to the headman instead of the chief, thereby supporting the claim of the headman to the chieftainship. Nowadays however people prefer to present the pangolin they find to the new owner of the land, the president, Dr. R. Mugabe.
- The statement from Seed also points to another fact. Seed mentions that the pangolin had to be given to chief Msana, thus indicating that the people in the fieldwork area probably paid tribute to this chief and were never independent chiefs, as they claim to have been.
21. Guruuswa is mentioned as their place of origin by a lot of Shona people. The word literally means: 'place of long grass.' Beach points out that 'the dynasties that claim to have come from such a place locate very different areas as their point of origin' and he suggests that the term refers to an environmental condition (grass and not wood) more than anything else' (Beach 1984:62ff). Lan (1985:77) goes one step further saying that the Dande, a group in the Zambezi valley, refer to Guruuswa as the place where everything comes from, not only ancestors, but all men, all animals and even all plants. This suggestion of Lan is certainly confirmed by the Guruuswa interpretation of Nyamunga, although he/she depicts Guruuswa as an island, east of Mozambique. As far as could be traced, it seems that the people in the fieldwork

- area did come from the east and are related to groups which originate in the east of Zimbabwe and Mozambique. One of the informants present during the consultation with Nyamunga said afterwards: 'Guruuswa is the place where we all come from, even you. At that time there was no difference between black and white people. That only happened afterwards at the time of Kain and Abel.'
- Bucher states: 'Some think Guruuswa roughly corresponds to the present-day Matabeleland' (1980:22). This statement in a way confirms the assumption of Lan, because the Rozvi/Changamire whose origin Bucher refers to in the above quotation indeed have much of their 'roots' in Matabeleland.
- In a similar way it might be noted that the people of the chief, who call themselves after a hill in their area of origin, depict Guruuswa as a hill (cf. Chidziwa 1964:18).
22. The medium was not entirely clear about the names of these five people. Informants who commented on the account later did not seem to know this exactly either. One informant mentioned the following names: Kaguvi, Chaminuka, Nyadati, Nyamadvambire, and Nehande as the first woman. In a later discussion he admitted not to be quite certain about these names. He felt that the names could not all be Shona names because at that time the first men were born. 'At that time there was not yet a difference between black and white... they were the ancestors of all people, even of you.' He then suggested that the first five people referred to by the medium must be located a bit further in time, i.e. the first five people of the tribe: Mutasa, Rusikwa, Femara, Nyamunga and Njemba, the sister.
23. The idea of the tribe trekking and leaving groups of people behind on their way is also found among other groups among the Shona. A fairly similar story as told by the spirit medium in the fieldwork area, was told by the related Chihota people (AOH/39/Chinoyi, 15-16). According to their myth of origin they come from Malawi; references are made to Lake Malawi. This reference to a lake in the myth of origin apparently appears in other myths of Shona peoples as well (cf. De Heusch 1982:313; Frobenius 1973:192ff).
- According to one of the informants in the fieldwork area, the following happened upon arrival in the land that now belongs to Mutasa: 'Nyamunga had been given the power to cure witches by Nehande and when they reached Mutasa area, they found a lot of witches and Nyamunga cured them. Then the oldest brother, Mutasa, was allowed to settle down there with Njemba, the only daughter. When they reached Chihota, something similar happened and Rusika stayed behind. Then Femara and Nyamunga continued. Femara liked fighting very much, so he wanted to continue fighting the Matabele but Nyamunga felt that there had been enough fighting and he wanted to settle down. This he did in the present Chinamora communal lands. Femara continued to Mazoe where he finally died fighting in Mapote. His spirit is the spirit of Pasipamire. It came to Nyamunga's family because Nyamunga had helped him so often.' (The last sentence was added after a question of mine why such an important spirit had sought to come to the family). According to this informant Njemba, the only daughter, was a fierce and unmarried woman, 'she was almost a man' (cf. AOH/34/40 in which Njemba is depicted as 'a woman who is not

supposed to be married since she was the custodian of all the hunting *muvi* used in the hunting of elephants').

24. This is most likely Gunguwo, a Rozvi ruler conquered by the Chihota (cf. Beach 1984:78ff).
25. Since this incident took place the people in the fieldwork area and their spirit medium do not use the sacred mountain any more for rain ceremonies. The story goes that when Nyamunga felt his time had come, he went up to this mountain alone. He did not want people to accompany him or sit by his side. When he died immediately an anthill was formed over his dead body. That is the place where the grave still is today. After some time a *muhacha* tree (*parinari curatetellifolia*) started growing on top of the grave. The tree was treated with medicine by the people of the chief around the time the bow and arrow were stolen and the tree eventually died (an important indication that the graveside should no longer be used for rain ceremonies). As a sign of their rising power, various members of the people in the fieldwork area indicated that the tree was showing some fresh sprouts. At present the *svikiro* holds the rain ceremony on a mountain called Chidagwe/Madabwe. This mountain has many caves and ravines. On the bottom grows fresh green grass, the symbol of rain.
26. It should be mentioned that according to some informants, who also could not specify the exact nature of the wrongdoings, all this must have happened around the time of the great eclipse in February 1896. Other informants relate the wrongdoings then to similar wrongdoings now, whereby they refer to the incest cases (see note 14).

Notes to Chapter 3

1. See for example the categories considered in a disability survey carried out in Egypt in 1907, probably the first disability survey ever carried out on the African continent, and those of a survey carried out in 1960 and subsequent surveys in 1976 and the 1979–1983 period, also in Cairo. (See Table 11.)
2. An example from a WHO publication on community rehabilitation illustrates the difference between these terms clearly:
'A 16-year-old boy is involved in a traffic accident and one leg has to be amputated above the knee.
Impairment: loss of leg.
Disability: decreased ability to walk.
Handicap: decreased ability to work, to enjoy normal social activities (sports, dancing) and to have social relationships'
(WHO 1984:12.)
Although the term 'handicap' refers most to the individual and subjective experience of the 'disability', it can not be compared to the term illness in the disease-illness dichotomy. Using the term 'handicap' does not imply that one refers to individual/subjective experiences only.

Table 10
Disability categories

Categories	1907	Censuses 1960	1976	HIS 1979–1983
Sensory:				
Visual:				
Blind	x	x	x	x
Partial loss				x
Loss of sight in an eye	x	x	x	
Speech and hearing:				
Deaf (totally)			x	x
Partial loss			x	
Mute (no speech)			x	x
Partial loss of speech				x
Physical:				
Amputee:				
One or both arms		x	x	
One or both legs		x	x	
Other general:				
Upper limb disabled				x
Lower limb disabled				x
Leprosy	x			
Mental:				
Mental disability				x
Mentally ill (psychological)	x			
Mentally retarded (intellectual)			x	
Other general:				
Debility				x
Multiple impairments:				
Deaf-mute		x	x	

Source: United Nations, Development of Statistics of Disabled Persons, N.Y., 1986 (ST/ESA/STAT/SERY/2).

3. If we take Zimbabwe as an example, the following estimation may be made. Zimbabwe has a population of over 7 million people. If we assume that at least 5% of the population (this is only half of the 10% estimation of WHO) is disabled and needs rehabilitation services, this leads to a disabled population of 350,000 persons. On the basis of a rough estimate, it may be assumed that Zimbabwe has no more than 1000 institutional places for disabled persons, and probably far less. The average stay

in a rehabilitation centre (this includes residential centres) is estimated to be about 3 years and is probably much longer.

According to these estimations, in a period of 45 years, which is about the average life-span of a Zimbabwean, 15,000 disabled people can be served.

4. The term community-based rehabilitation was introduced by WHO and therefore has a medical connotation. As an alternative the terms community-oriented rehabilitation and community rehabilitation were introduced, however there is no *communis opinio* about the exact meaning of these terms.
In the ILO glossary (ILO 1981:30), the phrase 'community participation in rehabilitation' is used. According to this publication the term refers to 'the range of organized, public and private, social and economic and/or cultural sectors (e.g. church, employers, half-way houses, schools) which may assist disabled persons in making adequate social and vocational adjustments. It can therefore succeed in mobilising economically important resources of skill, manpower and care which would be beyond the financial capacity of any community to undertake on a paid or contract basis. Community rehabilitation, as opposed to institutional services, is considered less costly and more effective as well as more humane, as it reduces or eliminates the need for institutions which tend to deprive people of their basic rights and of contacts with their family and the community.'
5. According to WHO calculations/estimates the costs for one place in a rehabilitation centre amount to US\$ 0.43 per capita, while the per capita costs for community rehabilitation are about US\$ 0.13 (source: WHO 1984:12). Without wanting to go too much into details about the validity of the WHO estimation, I feel that US\$ 0.13 is a gross under-estimation of the actual costs of community rehabilitation. This figure can only be valid if no personnel costs are considered, if the overhead costs are accounted for on the general health care budget and if the majority of financial and material inputs for medical rehabilitation, special education and vocational rehabilitation are being brought in by the community. This would indeed be an ideal situation. My experience is that it is not very realistic.
6. The idea is that the community will be more motivated to work towards a goal that they themselves have indicated as a priority. However, when is a community still setting its own priority and when are these priorities imposed upon them by the donors and the project management, the community development workers etc.?: 'Dat is in feite wat je als onderzoeker in Afrika doet: de mensen zo ver krijgen dat ze toch doen wat jij wilt' (W. van Binsbergen, interview in *De Tijd*, 19 July 1985:6).
7. See also Bichman (1979) who presents a rather materialistic view on the development of health care services in Africa. I cannot subscribe to this view fully; more than just the materialistic viewpoint should be taken into consideration to understand the development of health care services in Africa. Nevertheless, Bichman's point is well worth noting.
8. The admission of Africans in hospitals has increased steadily over the years as has the treatment of Africans as out-patients in mission and government hospitals (cf. Chavunduka 1978:10ff), but until the beginning of the 1960s the health care provisions

for 'Europeans' and 'Africans' have been disproportionally in favour of 'Europeans', particularly as far as in-patient admissions were concerned (cf. Gelfand 1976:52ff).

9. Resolution WHA. 30. 43 of the General Assembly of the World Health Organization.
10. Cf. WHO 1981:13.
11. See also Chapter 5 for a more elaborate description of the difference between illness and disease and cf. Kleinman 1980:72.
12. It is mentioned in the report that: 'The present treatment preference pattern shows a significantly altered picture. There has been a detectable swing in favour of either formal or informal treatment, while there has been a marked reduction in the number of disabled persons seeking a combination of both formal and traditional treatment' (Report on the National Disability Survey in Zimbabwe 1981:32). From the data it cannot be derived how significant the swing really is. It might be suggested however that, at a particular moment of time, people are in favour of either modern or traditional medical care, but when looking back over a certain period of time, their preference went to a combination of them.
13. The differentiations made seem to reflect impairments more than disabilities. In the survey the following sub-differentiations were made:

Visual	(70.300)	Speech	(20.300)
Blind both eyes	22.700	Dumbness	9.800
Blind one eye	14.700	Harelip	700
Albinism	1.600	Cleft-palate	800
Partial blindness	31.300	Disordered speech	8.700
		Other	800
Lower limb	(67.200)		
Loss of leg/s	8.800	Neurological	(15.300)
Loss of use of leg/s	58.400	Epilepsy	9.800
		Stroke	2.100
Upper limb	(33.500)	Spasticity	1.300
Loss of arm/s	18.600	Other	2.100
Loss of use of arm/s	14.900		
Mental	(26.900)	Spinal	10.100
Retardation	15.300		
Behavioural	7.300	Respiratory	3.200
Both	4.300		
		Cardio vascular	2.700
Hearing	(22.600)		
Total deafness	8.500	Skin disorders	2.500
Deaf one ear	1.900		
Part deaf one ear	900	Other	1.800
Part deaf both ears	11.300		
		TOTAL	276.300

Source: Report on the National Disability Survey of Zimbabwe, Harare 1981:36.

14. Although not too much importance should be attached to these findings, a statistical comparison of the grand total of the national survey (4%) and the local survey (5.19%) shows us that the difference between these two figures is fairly significant (χ^2 : $p < 0.01$: 22.35). As there is no reason to assume that there should be a different incidence of disabilities in the fieldwork area as compared to the sample areas covered in the national survey, this significant difference might equally well point to more general problems concerning the compilation of disability statistics in general and the compilation of disability statistics in rural areas in Africa in particular: (1) there is a general unclarity about the definition and classification of disabilities; (2) there is a problem with enumerators for these surveys, they should neither be unfamiliar nor be too familiar with the area in which the survey takes place. In addition it should be mentioned that both percentages (4% and 5.19%) fall below the WHO estimate of 10% mentioned in Chapter 1. It should be realized, however, that the latter is an estimate while the first two figures represent actual countings. Not all disabilities can be perceived with the bare eye and of the total of 10% one would expect only 5% to be identifiable by means of a disability survey carried out by enumerators without medical training.
15. Not only the effect of the mass literacy campaign and the great emphasis the government has placed on education after independence are reasons for this low rate of illiteracy among disabled persons in the area. Already in 1970 A. A. Le Roux reported in the *Rhodesian Science News* (vol. 4, no. 4, April 1970:135ff) that a survey, carried out in 1966, had shown that only 195 people of the local population had never received any education, as compared to 325 people of the national population. Le Roux relates these higher literacy rates in Domboshawa to the more extensive schooling facilities in the area as well as to the general prevalence of modernism, of which, according to him, the Domboshawa Training Centre and the larger number of rectangular houses are an indication. However, even at an earlier stage the relatively high level of education of people in the area had been noted by the native commissioners: 'There is doubtless point and truth in the oft leveled criticism that too much time and money is spent on academic and religious aspects of native education. It is said that this leads to an increasing disinclination on the part of our natives to earn their living by the sweat of their brows, as the much needed farm and mine hands of European employers; and that it merely induces in them an exaggerated idea of their importance as clerks and office boys. "If you must teach them," say these critics, "then teach them to be useful as farm hands, artisans and so forth, teach them the dignity of labour" ... (the critics say) "You are now teaching them to compete with us in our farming operations and industries".' (Report of the native commissioner Salisbury for the year 1938 (S1563/1938, vols. 1 and 2). In his annual report for 1937 the same native commissioner had already expressed his dissatisfaction about the large number of natives that applied for clerical jobs (S 1563/1937).
16. Government Notice 543, 10 August 1928, replacing Government Notice 335 of 17 June 1927.

17. Cf. F. Chisokela (1985) and a document in the National Archives of Zimbabwe (S 246/528), in which C. E. Duff (N.A.Z.) reports that in 1928 only the Europeans living in the area could be vaccinated against smallpox, for financial and organizational reasons. Only when it became clear that it would not be possible to suppress epidemics in this way, immunization campaigns at a much larger scale were organized. It is worth mentioning that among the Shona a traditional method of self-immunization had already been in existence before the immunization campaigns started, whereby the puss of a smallpox patient was rubbed in an artificially made incision in the skin of a person who had not yet contracted the disease (cf. Chisokela 1985).
18. One illustrative and well-documented case in this respect is that of 'native Kapusi' (National Archives S138/22 1923-1926). He was accidentally shot by a visitor at his master's farm and severely injured his legs, which led to amputation and permanent incapacity. The employer was obliged to pay compensation to Kapusi in accordance with ordinance no. 15, 1922, as the accident took place during working hours. The employer however tried to solve the case by firing Kapusi with immediate effect, without paying him any salary. An administrative hassle followed for a number of years. The employer claimed insolvency and was not in the least interested in the fate of Kapusi and his family. Despite his insolvency, he went as far as to hire a solicitor to defend his case. However the N.C. stood firm in this case and finally a compensation of £ 5,- was paid. This amount was just enough to pay for the wooden leg with which Kapusi was fitted.
19. The developments in Rhodesia are to a large extent comparable to those described by Van Etten in Tanzania (cf. Van Etten 1972:337).
20. It was argued that this was because of the obligation of treatment established by law in 1919 (State Law of Rhodesia, no. 3, 1919). Another leprosy centre, based on the principle of voluntary treatment, was opened in Mtoko in 1930 and proved to be more successful.
21. In the article Sr. Aquina compares the marital status of the population in the leprosy settlement to the marital status of the population in a particular Shona ward as provided by Garbett (1960). It should be noted, however, that these figures only give an indication of the people who got divorced after they became disabled. It does not say anything about the marriage prospects of disabled persons in general and leprosy patients in particular.
22. National Archives of Zimbabwe, document S1542 L15 1933-1939 provide some illustrative case histories of clients of this category: 'Hloma' (1926) and 'the native woman Utopis' (1932-1936).
23. See Chinake (1985), in an interview with B. Chigasara.

Notes to Chapter 4

1. Cf. Kuper (1977:7) and De Heusch (1982:15) for the usefulness of regional comparative research in Africa.

2. See Soga (1932:150) concerning the Xhosa; Berglund (1976:32ff) and Krige (1981:286) concerning the Zulu; Hunter (1936:269ff) concerning the Pondo; Hughes (1956) and other authors concerning the Ndebele; Mönnig (1967:45) concerning the Pedi; Junod, H.A. (1927, II:428ff) concerning the Shangaan; Stayt (1932:230) concerning the Venda; Colson (1962:4), Dale and Smith (1920) and Reynolds (1963) concerning the peoples in S.E. Zambia; Stefaniszyn (1964:134) concerning the Ambo and Melland (1923:154) concerning the Kaonde.
3. *Mwari* is just one of the many names used for the Shona High God. Other names are *Musikavanhu* and *Wedenga* (Fry 1975:19), *Dziva* and *Dzivaguru* (Van der Merwe 1959:34, 14) and *Nyadenga* and *Karuwa* (Gelfand 1982:72, 135 and Mushoma, 1932). Many other names are in existence in other areas of Zimbabwe, but the above names are reported to exist in the Zezeru and N.E. Shona language area. According to Ranger (1974) the concept of *Mwari* is indigenous to Zimbabwe. He bases his argument on archeology. In addition it is felt that the Shona term '*Mwari*' is related to the term '*Mwali*' as it exists in the Kilimanjaro area (Tanzania). *Mwali*, the term means 'sower', was involved in the Shona/Bantu diaspora South of the Zambezi to Great Zimbabwe. The Shona also think of *Mwari* as the God of fertility and even nowadays he is petitioned at Matonjeni in the Matopo hills for the fertility of crops and barren women.
4. It may be suggested that the Mutyawasara people, who were not of Rozvi-Changamire stock, probably felt little attracted to the *Mwari* cult of their 'conquerors'.
5. This as opposed to Daneel (1971:83) who argues that *Mwari* 'did become the Personal Being beyond and above the ancestral hierarchies and therefore only could be approached indirectly'. The question remains however if and to what extent this development took place in the fieldwork area as well.
6. Something comparable to the *shave* spirit exists in other cultures as well: the *indiki* among the Zulu (Sibisi 1975:50); the *zwidhadyane* among the Venda (Stayt 1931:240); the *mashabe* among the Tonga (Colson 1951:148); the *tuyobela* among the Ila (Smith and Dale 1920, II:15) and *masyabe* among the Ambo (Stefaniszyn 1964:152). The *shave* mechanism as it is used in Zimbabwe to incorporate alien influences deserves further study. It is particularly noteworthy in this respect that alien/marginal spirits seem generally accommodated by women. This occurs when it has not yet clearly been established whether the *shave* will bring predominantly positive influences. Once this has been established, a *shave* may become 'naturalized' (Gelfand 1959:121) and will then be inherited mainly by male relatives, almost like a *mudzimu* (i.e. women run the risk of being possessed by ambivalent aliens, once the risk has been calculated for a few generations, men take over).
7. Informants nor the literature are of much help in the question as to where the spirit stays before it is called home. According to Gelfand (1982:29) they live in the air and do not need to eat and drink. Other accounts depict these spirits as living around sacred hills and valleys, while some informants felt the spirits dwelt closely around or inside the body, in the latter case they were believed to stay in the heart.

8. It was reported by informants from outside the fieldwork area that children may come back as *chipunha* spirits, exhibiting childish qualities. In the fieldwork area I never heard of *chipunha* spirits however.
9. It is not entirely clear if spirit inheritance exists among the Shona. As far as the people in the fieldwork area are concerned, it could not be established if each *mudzimu* is inherited by a child or grandchild, while also the rules governing the direction of a possible inheritance were not clear. Daneel (1971:107) reports on the name-giving ceremony which usually takes place on the day or the day after the spirit has been brought home (6–12 months after the person actually died). During this ceremony, according to Daneel, the name of the deceased is transferred to the eldest son, who then becomes the head of the family. It is not clear from Daneel's report whether the transfer of the name holds implications for the transfer of the spirit.
In the south of Zimbabwe I witnessed a case where the name of a grandfather had not been given to the oldest son but to the oldest grandson, though apparently the name (and the spirit of the grandfather) was also claimed on behalf of other grandchildren. This observation is in accordance with the account of Aschwanden concerning the Karanga. According to Aschwanden (1987:326ff), the title and the name are inherited separately, although it is possible that they are inherited by the same person. From observations in the fieldwork area I got the impression that not always the oldest son but the son who remains at home receives the name of the father or grandfather. It seems to happen more and more often, also in the fieldwork area and not only in the case of deceased women, that the *kugadzira* (bringing home) ceremony and subsequently the name-giving ceremony is postponed until somebody falls ill or other misfortune confronts the family (cf. Daneel 1971:106).
10. During my stay in Zimbabwe there were three years of severe drought. This drought was generally ascribed to anger of the *mudzimu* and *mhondoro* spirits. These spirits were considered to be aggrieved because the people no longer adhered to Shona norms. Various healers of reputation as well as some *svikiro* explained the absence of rain in these terms and the longer the drought had persisted, the more people believed what they said. Also if the drought lasted longer people would adhere to the *chisi* days (day on which, on instigation of the *svikiro/mhondoro* people are not allowed to work on their land). Initially, after a period of rain, people would argue that on *chisi* days one was not supposed to work on land that was dependent on rainfall, i.e. they felt they could work on land watered from a dam or a river, but when the rain stayed away, they became more strict. One of the elders said in this respect: 'The *chisi* day is supposed to be to us what a Sunday is for Christians, a day on which you rest and praise your forefathers.'
11. The *svikiro* should be able to provide details of the family history in an accurate way in an initiation test. For an insider, i.e. family member, these details may be easy to reproduce, but when an outsider mentions them, it is considered to be proof of the fact that it is not the person himself who speaks, but the spirit.

12. Chavunduka conducted his study in one of the suburbs of Harare (then Salisbury) and his findings cannot be applied directly to the situation in the rural areas.
13. These findings confirm earlier findings of Leeson in a town in Zambia (Leeson 1968:4) and contradict findings of Gelfand's (1964) study involving a rather small number of mainly chronic patients (all indicated that they had previously consulted a traditional healer). Chavunduka indicates, on the basis of his own study as well as on findings of Gould (1960) and Leeson (1968) that there is some evidence 'that chronic illnesses are more likely to be referred to traditional healers than other illnesses' (Chavunduka 1978:41).
14. Through the Native Affairs circular minute 1087, 3 December 1894 (National Archives CT 24/8-12), which was circulated extensively among the hut tax collectors and the police, the acting administrator of the BSAC (Rhodes) tried to 'put down the barbarous custom of destroying twins at birth.' In an earlier memorandum (d.d. 29 November 1894) concerning the same matter, the acting administrator remarked: 'The mode of killing them appears to be always the same, they are placed in a large urn, covered up with hot ashes and then put into a running stream.'

Notes to Chapter 5

1. In the literature there is a lot of discussion about the various terms and theories to describe the phenomena under consideration. I took a rather eclectic approach in this respect, selecting the terminology that fitted the terms used by the informants. For that purpose I drew mainly on what is termed by Hahn (1984) the 'Eisenberg, Good and Kleinman school' of thought concerning illness and disease. Hahn points out that these authors reflect inconsistent thoughts concerning the nature of illness and disease and the relationship between them. Concerning the issue of the nature of illness and disease, Hahn's criticism is basically correct and I am inclined to accept his 'way out' of this dilemma by taking 'human suffering' as the basis of observations instead of (reifications of) illness and disease. Hahn's approach leaves open the possibility of including other types of human agony apart from physical and mental suffering. Although both from a theoretical and a practical point of view there is much to say in favour of such an elaboration, I restrict myself to physical (i.e. biological and mental) suffering in this study. Also, I do not adopt the disease-disorder distinction suggested by Hahn. Generally speaking, there is a difference between scientific medicine and traditional medicine. It would be an oversimplification, however, to say that in scientific medicine only or mainly biomedical aspects are considered while traditional medicine concentrates on social and circumstantial aspects. In both types of medicine the biomedical and circumstantial aspects are being considered. The difference lies in the way the emphasis is placed and in the way causal relationships are drawn. Finally, Hahn points at a fact that will be reiterated later in the text, namely that there can be illness without disease and disease without illness. Hahn feels that with the development of our knowledge of illness and disease 'manifestations of any of these

- in absence of the others . . . is less likely to occur.' In view of earlier statements of Hahn, this conclusion seems somewhat odd, because there is only one manifestation to be accounted for: human suffering. Inconsistencies of this nature, as displayed by Kleinman, Hahn and most probably myself, are almost inevitable. Without wanting to deny the value of a consistent set of terminology, I consider it important in this study to select terminology that approaches as much as possible the terminology and intentions of the people in the fieldwork area. Despite its inconsistencies, the terminological framework suggested by Eisenberg and Kleinman proved to be most useful in this respect.
2. Kleinman (1980:59) states: 'The folk sector shades into the other two sectors of the local health care system. Folk medicine is a mixture of many different components, some are closely related to the professional sector, but most are related to the popular sector.' In this study traditional healing in Zimbabwe is considered to be part of the professional sector (and not a part of the folk sector). The level of organization, the increasing professionalism as well as the internal control and supervision of the ZINATHA associated healers justify this conclusion.
 3. The criticism on Parsons in this respect (cf. Frankel and Nuttall 1984; Gallagher 1976; Twaddle 1973) is not entirely justified. Parsons never intended to apply his theory to chronically ill or disabled persons and his theory is not primarily about ill or disabled persons but about the way their behaviour is controlled by society. As mentioned before, the definition of rehabilitation provided in Chapter 3 is an extension of the 'sick role' to disabled persons: as long as they get themselves optimally rehabilitated, society will excuse them for their disabilities.
 4. It is interesting to note in this respect that in his study *Primitive Concepts of Disease*, in which the main disease concepts are compared world-wide, Clements does characterize a number of South African tribes as being dominated by 'spirit intrusion' (i.e. spirit possession) and to a lesser degree by 'soul-loss'. 'Sorcery' is not considered to be an important cause for illness in the area, according to Clements (1931:201).
 5. This as opposed to the vision of Murphree (1969:59) who depicts witchcraft beliefs as the main expression of anti-social behaviour and magic as its main controlling force.

Notes to Chapter 6

1. The Chinhoyi caves, N.N.E. from Harare, along the road to Lake Kariba and Zambia, are now a tourist site. There are a number of stalactitic caves with pools of water on the bottom. As some sunlight can shine into the cave, this gives special light effects. The caves were used by the people who inhabited the area for various cultural purposes. When, during the end of the colonial era, the caves were turned into a tourist attraction, this gave rise to a lot of opposition from the indigenous people. According to informants, attempts to fence the place were jeopardized by the ancestor spirits, who managed to tear down the fences at night every time they had been erected. The ancestors opposed the idea that one would have to pay an

- entrance fee or could be restricted from entering the caves by the colonial authorities, particularly because the government did not 'own' the land in the first place.
2. The *nzuzu* or *njuzu* is depicted as a *shave* spirit by Daneel: 'The *njuzu* spirit is by far the most popular agent among them when it comes to the procurement of medicines for epilepsy, scabies and especially barrenness among women. *Njuzu* is regarded as a water spirit living in or underneath a pool or river. At one stage or another the *njuzu* possesses a host (hardly ever a male) and leads her to the 'city' of the *njuzu* spirits under the nearest dam or river, where she stays for several days', as an apprentice between possession by a *nzuzu shave* and possession by a *nzuzu* directly. The first type of possession is just regular *shave* possession and is not considered very spectacular. The second type of possession is very meaningful as the *nzuzu* is an ambiguous but nevertheless very powerful spirit. As opposed to the findings of Daneel, all persons possessed with a *nzuzu shave* encountered in this research were men. I never managed to get a clear description of what a *nzuzu* spirit actually looks like. Mr. T. Shoko provided me with the following description: it is a half-human, half-fishlike creature, like a mermaid, light in complexion, with breasts like a woman and long, fair hair; from the hip downwards the creature has a tail, to ease movement in the water.
 3. One informant in the fieldwork area made the following statement in this respect: 'You do not take out the roots of the problem if you look at the natural causes only, because some of these diseases are caused by (our) culture.' By saying 'our culture' the informant implied that the researcher would not be able to understand the circumstances of the disability from the perspective of her own culture. Generally the statement 'this is caused by (our) culture' was the beginning of a detailed explanation of traditional beliefs concerning illness, disability and their possible treatment.
 4. Many Shona people have worked in Johannesburg under the WENELA mine recruiting programme, for instance.
 5. According to the research assistant and other informants from outside the fieldwork area, this seems to be rather unusual as compared to the situation in their home area. They feel the absence of personal witchcraft accusations may be related to the Chipfumi myth, the alleged control of the Mutawasara people over witches and a fear of people to make witchcraft accusations in view of the Witchcraft Suppression Act.

Notes to Chapter 7

1. ZINATHA, the Zimbabwe National Traditional Healers Association, is the organization in which most Zimbabwean traditional healers with a reputation are associated. It was established in 1980, shortly after independence, under the auspices of the Ministry of Health. ZINATHA was a merger of at least seven associations of traditional healers existing at that time in Zimbabwe or having branches in Zimbabwe. ZINATHA has adopted the commonly accepted WHO definition of a traditional healer: 'a person who is recognized by the community in which he/she lives, as

- competent to provide health care using vegetable, animal and mineral substances and other methods based on the social, cultural and religious background as well as on the knowledge, attitudes and beliefs that are prevalent in the community regarding physical, mental and social well being and the causation of disease and disability' (Chavunduka 1984:4; WHO 1976:3-4). Recognition by the community makes a healer eligible for ZINATHA membership. This does not mean however that all recognized healers are members of ZINATHA. Particularly a large number of 'first-aid healers' are not members of the association. They have objections against the membership fee. Some of these first-aid healers simply do not gain enough income from their practices to be able to pay. Other healers object to the control of their medical practices by a medical council attached to ZINATHA. The first-aid healers often have not enough confidence in their own medical practices to allow this kind of supervision, while other healers have a firm belief that their particular spirit does not require control or supervision from human beings. It should be mentioned that some of the healers, who were leading figures in one of the associations that existed before ZINATHA, lost considerable influence and power and therefore now oppose ZINATHA rules.
2. Informants generally used the terms illness and disease as synonyms, without reference to any theoretical framework.
 3. I am greatly indebted to the elaborations of Mr. E. Chidombwe on the Shona terminology presented. Concerning the difference between the terms *kurwara* and *kuremara* he remarked: 'The difference between *kurwara* and *kuremara* is almost equal to the difference between illness and disability. *Kurwara* (from the stem *kurwa*, 'to fight') means that an otherwise healthy person is physically unwell. The term has connotations of being temporary in nature and therefore it is generally considered treatable. The term may be used as an euphemism for mental illness but does not include conditions caused by general misfortune' (Interview with E. Chidombwe, Department of African Literature, University of Zimbabwe, 12-10-1987).
 4. Most interviewed traditional healers considered traditional and scientific medicine as complementary medical methods and they did not generally oppose the treatment by a scientific healer. Traditional healing in Zimbabwe does not seem to have much to do with the doubtful, obscure and mystic practices that one often reads about in (western) studies on this subject. The majority of healers proved to be very caring persons, who know how to 'treat' individual tension and tension of a group or family in a very professional way. Their medicine does not consist of a heap of tiger teeth and crocodile tails, but is contained in rows of neatly labeled glass jars. Most medicine has a herbal basis, but sometimes minerals are used as well. Other components might be included mainly for the psychological effect. Anyway, no matter what it consists of, I experienced that the medicine, if well prescribed, can be very effective.
 5. It is remarkable to note how often the explanations used by the disabled persons and their relatives for their disabilities are worded in exactly the same terms as the explanations offered by the traditional healer. In case 3, the family of the disabled person holds a view about the cause of the disability of the woman in question (deafness and

mental illness) that contradicts the explanation of the husband. Nevertheless, both explanations fit into the theoretical framework offered by the traditional healers, without reference to any case in particular.

6. The terms *gombas* and *mengera gunazi* were noted down phonetically from the mouths of two informants. Later on, when analyzing the terminology, no other informants had mentioned these terms and neither Mr. Shoko nor Mr. Chidombwe knew the terms. According to Mr. Shoko the term *mhengera mumba* might be a synonym for the latter term.

Notes to Chapter 8

1. At the turn-off to one of the larger townships of Harare, a number of these black goats can probably still be seen. People do not like to come close to them, far less dare to catch and kill them for their meat. One day I saw that a goat was fatally hit by a car. This incident took place around month's end when a lot of people in the townships have not seen meat for a long time. It was a healthy goat but nobody dared to take it. At several occasions during my stay in Zimbabwe, I was warned not to come too close to a black goat. These warnings often gave rise to discussions, partly serious and partly jocular, whether I could be affected at all by witchcraft if I did not believe in it.
2. Later the same informant told many more, rather fantastic *chikwambo* stories, though unrelated to the case of Mr. Chitunga. 'A *chikwambo* may be bought from a bad *nganga*. Some say one buys the medicine, others say one buys the animal or *tikolotshe* when it is already doctored. The *chikwambo* will go to the homestead of the person who borrowed the money. If the person is not inclined to pay the money, he himself or one of his relatives may fall ill. A person may also buy *chikwambo* for selfish purposes, i.e. to steal money from people. A person who owns such a *chikwambo* soon becomes excessively rich. Such a *chikwambo* may easily turn against the owner. If the *chikwambo* is not treated properly and not given the same privileges as the owner (if the owner builds a new house he also has to buy a house for the *chikwambo*) it will affect the owner and his family instead of attacking outsiders for money.' In the case of Mr. Chitunga, the informants could not say if he was a victim of the first or the second type of *chikwambo* and they could not say either if other people were involved. Perhaps they knew more but were not prepared to talk about it. I heard of a couple of other *chikwambo* cases in the fieldwork area, although those cases were not included in the sample. In the two other cases the victim was also suffering from mental illness as a result of *chikwambo* and both cases involved men who had worked in town and in the mines and had accumulated considerable wealth over the years until they were fired or fell ill. The *chikwambo* myth resembles certain fairy tales in the west, that warn people not to be too greedy for material wealth and to value immaterial wealth and happiness. In the fieldwork area the myth is used in particular to explain and justify the fate of community members who valued material wealth too much and forgot about their family and community.

3. This brings us to the position of the mothers and grandmothers of disabled children. The mother of Maureen Murape reported that her husband, who divorced her after she had given birth to two disabled children, only wanted to pay maintenance for the able-bodied children. Equally, the father of Mission Machipisa tried to accuse his wife of Mission's epilepsy. These and many more examples make it clear that the mothers of disabled children are very often blamed for the disabilities of their children. Often husbands expect their wives to choose between their 'sins' and the healthy part of the family. In such cases mothers leave their children behind, often in the care of their mother or grandmother, as did the mother of Apollonia Rusere.
4. Virtually all informants felt *upofu* (blindness) was the most serious disability. It is interesting to note that in many, if not most countries in Africa (and in Europe for that matter), rehabilitation activities were initially directed towards blind persons. Equally, in the area of self-organization, blind persons have been forerunners. It may be interesting to investigate the causes and consequences of this cross-cultural similarity further.
5. I did not interview enough female traditional healers to establish this with certainty. Taking into consideration that Zimbabwe has a lot of female traditional healers who are not generally considered to be of lower professional standard than their male counterparts, it may be interesting to investigate what the surplus value of spirit mediumship is/could be for disabled women.

Appendix

A summary of the case-studies

Case 1: Kenneth Madzima: see Chapter 6.

Case 2: Rabion Chikore

Rabion is 18. He is from a family of seven and suffers from the effects of albinism. He has poor eyesight and skin problems. Rabion and his relatives believe the condition has natural causes. They are Christians and they never consulted a traditional healer about the cause of the albinism. The father considers the condition 'a gift from God'. According to the father this is the way God divides happiness and unhappiness.

Other informants in the area remember that in the past albinism was related to breaking taboos. Albino children used to be strangled as soon as they were born and they were buried in a clay pot on the banks of a river. The belief was that failure to kill albinos would result in poor rains or the absence of rains for at least a year. The informants also believe that Rabion's condition is 'a gift from God'. They feel nothing much can be done about his condition; it is considered to be 'beyond the control of human beings'.

Rabion recalls that the first time he felt discriminated against was when he went to primary school. The other children did not want to sit next to him. They teased him and said he was bewitched. He realized however that it would be very important for him to get a good education. So he continued schooling despite all the problems. In the period the fieldwork took place Rabion had to leave school because of his eyesight problems. He could not read the notes on the schoolboard anymore and his schoolwork became poor as a consequence. It was felt that his eyesight could not be improved. He tried on the spectacles of an old man in the area but that did not bring an improvement. Fortunately, new spectacles could be arranged towards the end of the fieldwork period and thereafter Rabion returned to school. Rabion dreams about going to university one day. Currently he lives a rather isolated life in the community. He does participate in some community activities but he remains an outsider. His

academic ideals do not particularly contribute to his integration. He feels his marriage chances will depend very much on his success in the field of education, but he is very uncertain about actual success in this respect.

In addition he realizes that many people still hold prejudices against albinos, not so much in theory but in practice. Rabion feels that this might affect his chances of finding a marriage partner. The question of his spirit returning after death does not occur in his case, because he and his relatives are Christians who do not attach much importance to ancestors.

Case 3: Emelda Mandara

Emelda Mandara is 35 years old. She is divorced and has four children, who remain with her husband. After her divorce, Ms. Mandara returned to the homestead of her father. Ms. Mandara suffers from hearing difficulties and she also has mental problems (depression and withdrawal symptoms). She does not want to see a scientific or traditional healer and she refuses any other sort of help or assistance. She only wants to get her children back.

When Ms. Mandara returned home, her parents had already died and only her younger brother, who had just married, and some distant relatives remained. In order for Ms. Mandara to get her children back, the *lobola* once paid for her would have to be returned. However, the younger brother used the money as payment for his own *lobola*. During the fieldwork period it became apparent that his wife could not conceive.

Ms. Mandara and her relatives believe her deafness has a natural cause. They claim that she was mistreated by her husband. He had taken a second wife and did not show his first wife the respect due to her. He beat her repeatedly. One day the beating was so severe that she lost her sense of hearing. Then she felt the time had come to return home. The family believes her mental problems are related to the fact that she misses her children. They believe these problems will disappear as soon as she is united with them. At the same time the family does not take any initiative to establish contact with the former husband.

According to informants in the area, Ms. Mandara is deaf because she is a witch. This was discovered by her in-laws and they attached a protective device called *muchape* or *chapewa* over their door. When at night Ms. Mandara wanted to enter to do evil things, she could not pass through the door but 'froze' instead. Then the in-laws hit a wooden nail through her ears. According to the informants, this was done to destroy her witchcraft but probably it also caused the deafness. The witchcraft that affects/affected Ms. Mandara is believed to

come from her mother. When Ms. Mandara's father died, her mother refused to marry his younger brother. She married someone else instead and departed, leaving all her cooking pots behind. Later she claimed three heads of cattle as damages for these pots. Her in-laws refused to pay this amount. They claim she left voluntarily. It is believed that the mother, as either a witch or a *ngozi*, is causing the infertility of her daughter-in-law as well as the witchcraft that affects her daughter.

Ms. Mandara is involved in some light household cores. She does not work in the fields nor does she have a garden. Also, she refuses to be involved in any activities planned in the community and the community members are not keen to involve her either, because of the witchcraft suspicion they hold against her.

Case 4: Tendai Hungwe: see Chapter 7.

Case 5: Maureen Mapfumo: see Chapter 6.

Case 6: Immaculate Mazheru

Ms. Immaculate Mazheru is over 70. Her exact age is not known. She suffers from speech problems and various physical complaints induced by old age, including rheumatism. Ms. Mazheru stays in the homestead of her oldest son. She is related to Emelda Mandara (case 3).

Ms. Mazheru's complaints started suddenly around 1970. Her arms started shaking in a terrible way. She could not control them. She went to a healer in Marondera who specializes in treating such conditions. She underwent treatment for about six months and finally her condition improved. Immediately afterwards, however, her legs started shaking and she had to seek treatment for a second time. Again her condition improved, but then her speech problem started. Ms. Mazheru and her relatives believe the cause of her condition is cultural, i.e. some form of day-witchcraft. The witchcraft is rather powerful, as it returns in a different form every time treatment is sought. Therefore Ms. Mazheru has decided to accept the condition and to learn to live with it.

According to relevant others in the area, Ms. Mazheru's condition is caused by the fact that she is or has been involved in witchcraft activities herself: 'They do those things themselves, and now it comes back to them.'

The Mazheru family does not originate from the area. They are relatively poor as compared to other families in the area and they do not play a prominent role in the social or political life in the community. They have small houses and

cannot afford to send all their children to school. Ms. Mazheru is supported entirely by her sons, but the support is limited. She does not even have a good blanket and sleeping mat, which worsens her rheumatic condition.

Case 7: Tambudzai Maburutsa

Ms. Maburutsa is 39 years old. She was mutilated during the war by people from the community, because she collaborated with Smith's soldiers. She underwent plastic surgery, but still suffers from the scars, both physically and emotionally. She stays at the homestead of her father and has two children. She supports her family by raising chickens and by selling them in town. It was difficult to discuss with Ms. Maburutsa. The father was more open. He considers the condition of his daughter to be 'a gift from God'.

Relevant others do not want to comment on Ms. Maburutsa's case. Most people claim they do not know her because her family is new in the area, although in actual fact the family has been around for at least a generation. Nevertheless most informants agree that Ms. Maburutsa is really disabled: 'We do not know what to do with her.'

The story of Ms. Maburutsa was included here, because it resembles that of many other people who were involved in the war of independence, but backed the wrong side. Due to its vicinity to Harare/Salisbury, a lot of fighting and underground movement took place in the area during the war. There was even a stronghold of Smith's troops in the fieldwork area.

Collaborators were punished severely. Men were shot, in or nearby a river. Killing a person in or near water has the effect of cooling off the evil. Women who collaborated were often mutilated. The collaboration of certain individuals could be established with great certainty. However some cases were doubtful. Sons were punished for wrongdoings of their fathers and sometimes alleged war crimes were used as an excuse to settle scores from the past.

Case 8: Danger Jojo

Mr. Jojo is about 45 years old. He is married and has six children. He originated from Malawi, where, at the age of 3, he was involved in an accident that damaged his left foot. He believes the accident was completely natural and does not recall what kind of treatment was imposed. As far as he can remember he was treated by both scientific and traditional healers.

During the time of the Federation, Mr. Jojo came to Rhodesia and he went to evening school where he learned how to read and write. He had a friend who

was a shoemaker. The friend made an orthopaedic shoe for his damaged foot. Out of interest and in order to be able to make his own shoes in future, Mr. Jojo learned the skill from his friend. At present he is involved in part-time farming and he also repairs shoes. His shoe-business is not flourishing. He cannot meet the competition from the shoes and shoe-repair shops in town.

Mr. Jojo stresses the importance for disabled persons to get married and have a family. Despite his rather serious handicap, Mr. Jojo did not have difficulty in finding a wife. He managed to pay the *lobola* and he is able to support his family. His wife and oldest son take over some of the farming work that is generally done by the head of the family. Mr. Jojo is a respected man in the community and people do not generally consider him disabled.

Informants in the area agree that Mr. Jojo's condition is natural. They admit that they probably would have consulted a *nganga* after the accident. Whatever the cause of the accident might have been, Mr. Jojo left it behind in Malawi. It was not strong or serious enough to chase him to Zimbabwe and therefore the informants consider the matter sufficiently settled.

Case 9: Alois Matope

Mr. Matope is about 35. He is married and has one son. Mr. Matope suffers from poor eye-sight; the pupils of both eyes are blurred. This stops him from reading or doing anything else for which accurate vision is required. The medical history remains vague even after several interviews. According to the mother the eye problem is the result of measles contracted when Mr. Matope was about 5 years. At the time when the illness started the mother was pregnant. It is a taboo for a pregnant mother to look at a child with measles, but still she had to nurse her child. The general belief is that the measles will try to attack the unborn child but that the mother will protect her child and return the measles, with more power, to the person it came from. It is said by nurses from the clinic that Mr. Matope was operated on when he was a child. The family admits that he was in hospital for quite some time, but according to them, no operation took place. As soon as she discovered the eye problem of her son the mother started to apply herbal medication. She had learned from a traditional healer how to prepare the medicine. But when Alois grew older he refused to apply the medicine. The mother said that perhaps some evil spirit prevented her son from using the medicine. Spectacles were prescribed at one stage, but Mr. Matope tried the spectacles of someone in the neighbourhood and did not find much improvement, so the issue of spectacles was forgotten.

Informants in the area describe the condition of Mr. Matope as *tsanga*. They do believe the cause of the condition is natural and they feel Mr. Matope might have benefited from scientific medical treatment. He should have been treated in the mission hospital and he could have visited a mission school for blind children. The father, who was not a Christian, refused to send his son to the missionaries, as he was afraid he would be made a priest.

Judging by his homestead and his fields, Mr. Matope is rather poor. He is involved in subsistence farming but his fields are small. He only has one hut to live in and his wife, who suffers from asthma, cannot always perform all household chores. His son has epileptic fits. Nevertheless, Mr. Matope is a man like other men in the area. He drinks with them and participates in the community disputes and ceremonies.

Case 10: Motsi Makore

Mr. Makore is 35, married and has five children. He suffers from attacks of mental illness. The attacks start with severe headaches. Thereafter Mr. Makore withdraws and becomes absent-minded. He starts to wander around and sometimes he does not return home at night. This is generally followed by a complete blackout, during which he displays various forms of maladjusted behaviour. Afterwards, Mr. Makore cannot recall what happened. The whole 'attack' lasts about 5–6 days. Sometimes the attacks follow each other quickly, at other times more time elapses between them.

Mr. Makore is the oldest son of a family of eight. The youngest brother is a stepbrother, the son of his father's second wife. His mother divorced his father on account of this second marriage.

Mr. Makore worked in town with his brothers when he first fell ill. He was admitted in hospital several times, but each time he was dismissed by the doctors, who, according to Mr. Makore, claimed they could not find anything wrong. They gave him medicine which looked like *cafenol* ('*asperine*'). He never bothered to take this medicine because he felt simple medicine could not possibly cure his condition. Finally Mr. Makore returned home where he consulted a traditional healer. It was established that a spirit wants to come out on him. When asked which spirit wants to possess him, Mr. Makore is evasive. Later he says that his father suffered from similar attacks, thereby indicating that the spirit that wants to possess him is either the *shave* or the *mudzimu* of his father. Mr. Makore's problem is that his brothers and other relatives do not recognize the claim and do not want to join him in a coming-out ritual.

The brothers, who are members of the Apostolic Faith Church, are not keen to join in a ceremony, but they say they would be prepared to come if only their brother would be more cooperative. In addition they point at another problem. The Makores originate from the Korekore valley. Their father became an orphan at a young age. He stayed with his relatives. One day when he was out, herding cattle, the family was killed with poison in their relish (*chidyiswo*). As their father was out, he was the only one to survive. There were witchcraft implications and the father was sent to live with an aunt in the fieldwork area, where he married and stayed. The relationship with the remaining relatives is poor. They do not come to attend rituals or ceremonies and if they attend, they come as onlookers; they do not participate the way relatives should. This apparent lack of family support is another reason why the brothers of Mr. Makore feel it is not opportune for their father's spirit to come out on their brother at this moment of time.

In the meantime, Mr. Makore feels his condition will get worse and worse as long as the ceremony is not organized.

Mr. Makore is rather poor. His brothers do not support him. Due to his illness he cannot work on his fields the way he should. His wife assists him as much as possible, but it is very difficult for them to make ends meet.

The family is avoided by other people in the village and no-one wants to comment on the situation. One informant said it is a *ngozi* case, but he did not want to elaborate. It was said that Mr. Makore's father was killed during the war, together with his second wife, at the side of a river (implying collaboration with Smith's troops).

Case 11: Emeria and Sipiwe Mangoma

Ms. Emeria and Ms. Sipiwe are sisters. They are both in their thirties.

Ms. Emeria has one child. She is unmarried. She became disabled when she was about 10. According to Ms. Emeria and her relatives, it was a typical case of *chitsinga*. She was returning home from boarding school. She had just got off the bus and she was carrying her trunk across the cross-road, when she fell. Immediately she felt that her lower leg moved into her upper leg. She was taken to hospital and the leg was put in plaster. She cannot recall if she was operated upon. The treatment was repeated, but her leg remained shorter. Also a traditional healer was consulted to find out the cause of Ms. Emeria's condition. The traditional healer diagnosed the cause to be day-witchcraft: *chitsinga*. Neither Ms. Emeria nor her relatives want to elaborate on the origin

of the poison. Ms. Emeria stated that she is not interested to know why someone wanted to harm an innocent schoolgirl.

Ms. Sipuwe fell ill about a year ago. She suffers from severe headaches and her relatives complain about her socially maladjusted behaviour during these attacks. She sits in her hut and shouts insults for nights in continuation. Nothing seems to be able to stop her when she is in this mood. A brother of Ms. Sipuwe claims his sister is mentally ill. The mental attacks were the reason for her former husband to ask for a divorce. The family returned the *lobola* and Ms. Sipuwe remained with her children. The *lobola* was repaid with the money from the *lobola* of Ms. Sipuwe's oldest daughter. There is still some dispute in the family about the way this issue was arranged. In addition the brother feels that the prolonged duration of the condition of his sister might have something to do with the fact that she intended to marry another man after the divorce from her first husband. The latter was very jealous and tried to prevent the marriage. The brother thinks the former husband might have been using day-witchcraft, *kushangira*, in the process. A traditional healer was consulted to find out more about the cause. The family was not very talkative, however, and we did not manage to reach the heart of the matter.

Both Ms. Emeria and Ms. Sipuwe are involved in subsistence farming and they appear to be doing quite well. Ms. Emeria is also involved in crocheting and she sells her products in town, going from door to door.

No informants in the area were able or prepared to offer additional information on the cases.

Case 12: Bernard Shamu

Bernard is 27 years old. He is unmarried and he was reported to us as a person suffering from mental illness. Nothing much proved to be wrong with Bernard. His only problem is that he stutters and because of that he shuns social contact.

Bernard's parents divorced in 1975 and that is when his stuttering started. A traditional healer was consulted, but without the expected results. The mother did not want to disclose the diagnosis of the healer. She just stated in general that speech problems are often caused by a muscle under the tongue that is too tight, but that, in her son's case, this was not the cause of the problem.

People in the area suggested that Bernard suffers from *kushina*. This is a condition where a boy does not approach females, due to spirits from the mother or her family. Others associate *kushina* with homosexuality. Gelfand (1985:36) relates it to an angry spirit.

Bernard sometimes stays with his father and sometimes with his mother. His father, who works in town, secured jobs for him several times, but Bernard did not manage to keep the jobs, due to his shyness and his communication problems. He did work in the fields of his mother and he was interested in joining the cooperative for disabled persons. Bernard did not want to discuss the issue of marriage. His mother was very concerned about this. She was afraid that her son will remain unmarried for the rest of his life.

Case 13: Conny Chidyausiku

Conny Chidyausiku is 22. She cannot hear and she cannot speak. She is unmarried and has one child.

According to her relatives, a traditional healer was consulted when it became apparent that Conny could not hear or speak. The traditional healer cut a muscle under the tongue, but this did not help. The relatives do not want to reveal what the diagnosis of the traditional healer was, and Conny was too young at the time to remember anything.

At age six Conny was taken to a hospital in Harare. She was examined and her parents were advised to send her to Loreto School for the Deaf (presently Emerald Hill School for the Deaf). There she learned how to read and write. Just towards her final exams, she fell in love with a boy who also stayed at the school and she became pregnant. The boy in question denied all responsibility however and Conny was left on her own with her baby. She managed to find work in town as a dressmaker. She still holds this job and earns about 180,- z\$ a month. Compared to other people in the community she is quite well off. It was not possible to establish exactly what her status is/was in the community, because she works in town during the week and only returns occasionally during the weekends. Although she is somewhat of an outsider, she has a child, which is considered very important by Conny herself and by the community. She has a good education and earns a fairly good income and might be considered 'well off', according to the standards of the community.

Informants in the area claim there is much more to the story than the relatives tell us. Conny's father is from the ruling house of the ward. A lot of accidents and misfortunes have happened in his family. The informants point them out to me one by one and, indeed, it is an impressive list. The informants fielded the question to me and asked me if I sincerely believe that all these accidents and misfortunes could happen in a family just because of bad luck, without any additional reasons.

Case 14: Milton Chitunga: see Chapter 8.

Case 15: Enesia Chidakwa

Enesia Chidakwa is over 70. She suffers from physical weakness and poor eyesight, due to old age. The combination of these two problems reduces her mobility and this in turn has additional negative effects on her physical condition. *Amai* Chidakwa married twice. When her first husband died, she married a man from Malawi, who is much younger.

The family belongs to the Salvation Army congregation. They never consulted a traditional healer in relation to Mrs. Chidakwa's condition. They would never consider to do this, even when her condition got worse. They do not believe that illnesses have 'cultural' causes, and if they have, traditional healing is not the way to solve the problem. They did consult a scientific healer in the past, but nowadays she no longer seeks treatment for the poor eyesight or the physical problems, she accepts these conditions as side effects of old age.

Amai Chidakwa lives in the homestead of her oldest son, who also takes care of her daily needs. The position of the husband in the homestead is not quite clear. It is likely that he holds a certain position in the congregation and is accepted because of that position.

People do not generally consider Mrs. Chidakwa disabled, although her handicaps are quite considerable. She has a status comparable to any other older mother in the community and she is respected.

Case 16: Milly Kaseke: see Chapter 8.

Case 17: Happy Chideru

Happy is 28. He is unmarried and he suffers from epileptic attacks. He is reported to be mentally ill or retarded (*kuzungaira/dofu*), but I only observed socially maladjusted behaviour. Happy tends to withdraw from social contact. He does not talk easily, although he is very well able to communicate. Sometimes he is hostile and aggressive. His appearance is untidy to say the least. He wears layers of clothes on top of each other and he seldom washes his body or his clothes.

Happy's problems started when he was still school-going. All of a sudden, around the time his father died, he lost interest and attention. He did not complete his schoolwork anymore and he did not respond to questions asked by

the teacher. Finally the teachers, who did not know what to do with him, sent him home, saying that he was mentally retarded.

A *nganga* was consulted and he concluded that in important family spirit wanted to come out on Happy. Happy's father, who had died, had been in line for the headmanship of the area, but was considered 'unfit' for the post by the community and he was bypassed. It could not clearly be established whether the father had been physically or otherwise unsuitable for the post. A younger brother, Happy's uncle, claimed the post and was appointed instead. After the death of Happy's father the uncle took over the responsibilities for the family. He was responsible for the organization of the ceremony to appease the ancestor spirit that wants to possess Happy. The uncle however denied the claim of his nephew. He said that such an important ancestor spirit cannot come out on a person like Happy. He felt it might be a *shave* or a simple *mudzimu*, but certainly not the important *mudzimu* that his nephew claimed. Happy's case is hopeless.

In one of his more talkative moods Happy admits that he is aware that people consider him 'dofu'. He knows that that is not true. If something is wrong with him at all, he feels it is his stomach; he has stomach cramps quite frequently. He went to the clinic, but he did not take any of the tablets prescribed because he felt they do not work.

His mother reports that some time ago, during one of the attacks, he started wandering. He disappeared for more than a year. He was recovered more than a hundred miles north, when he visited a hospital to get treatment for a boil on his foot. Happy himself does not recall this episode.

Happy claims to have one friend, a neighbour, who suffers from polio. The friend confirms Happy's statement that nothing is wrong with Happy mentally: 'It is just the way people treat him.' Happy sometimes talks about having girlfriends. This is confirmed by other informants in the area, but it was not possible to establish who his girlfriends were. Happy is not involved in any income-generating activity. At one time, people would ask him to herd cattle, but apparently he was not very reliable as a herdsman. Nowadays people only ask him for this job during harvesting time when there is no one else available.

Happy is aware of the hopelessness of his case. Without his father and without the support of his uncle, his place in the community can only be marginal. The uncle's reluctance to support Happy's claim is equally understandable. He tries to secure certain important positions for his own branch of the family. At the same time this is dangerous. Some informants already warned that Happy is likely to return as a *ngozi* after his death.

Case 18: Wendy Chidembu

Wendy is only 3 years old. She suffers from the effects of albinism. She does not go to school yet so it has not been established whether she will need glasses, but already she is troubled by sunburn and skin rash. Because she is still a child, she does not understand that scratching only makes things worse. As a consequence she often has small wounds on her face and arms and they get infected easily. Wendy plays joyfully with her brothers and sisters within the borders of the homestead. Nothing points to the fact that she is an exception or that she is treated differently.

Her parents work in town and she stays with her grandparents. All the children of the family that are under school-going age stay with the grandparents and Wendy is no exception in this respect. Her grandparents talk about her with great affection and without shame or restriction. The grandfather recalls that in the past albino children and twins were left to die. Such children were considered a curse for the family. This is no longer the case. The grandfather considers Wendy's condition a 'God-given' thing. The family never bothered to consult a healer about it. They are concerned about the future however. As Wendy is a girl, it is more important for her than for a boy to have a smooth skin. Otherwise she might remain single. Fortunately, the time of dating is still far ahead.

Wendy's grandfather is a Christian, but at the same time he does believe in the protective power of ancestral spirits. He does not think this to be contradictory. He told us about an accident that happened in the war to one of his sons. We asked him why the ancestral spirits did not protect his son and Wendy. According to the grandfather the family is quite large, while the ancestor spirits are few. When the war started they asked the ancestors for special protection, but none of the family members wore any special protective charms. One cannot expect to have an ancestral spirit at one's side all the time. According to the grandfather, when the accident occurred, the ancestor spirits came rushing to protect his son. In this way death was prevented. At the end of the war a ceremony was organized to thank the ancestors for their rescue operation. The grandfather mentioned that, according to the priest, an illness will get cured if the belief is strong enough. The grandfather believes that this will only work with minor ailments and will not be of any effect with more serious conditions. (The way he interprets it, curing through a strong belief, is curing by human beings/spirits and not curing through the will of God.)

The grandfather further stated that, in case of illness he and the members of his family would prefer to consult a scientific doctor. Traditional healers,

according to him, are only useful in a limited number of conditions. When consulting a scientific doctor he prefers to go to a hospital. There many doctors work together, which, in his view, is always better than having to rely on just one doctor.

Case 19: Edward Samukange: see Chapter 6.**Case 20: Power Nyakudya**

Power is 18 years old. He is a tall boy who looks somewhat young for his age. He is reported to be mentally retarded and suffers from chronically infected ears and has some hearing difficulties on account of this.

The diagnosis 'mental retardation', was first made by a schoolteacher, who had difficulties dealing with Power. When the teacher asked Power to sit, Power would ask the teacher why he was not sitting himself. When the teacher asked Power to be quiet, Power would ask why the teacher was still speaking himself.

His remarks caused hilarity among his fellow students and despair among his teachers. The remarks may reflect a strong sense for non-conformity on Power's part, but can hardly be interpreted as an indication of mental retardation. His remarks and the fact that he proved to be left-handed and not prepared to write with the other hand, finally made the teachers decide to send him home. It should be realized that classes sometimes had/have over forty pupils. In such a situation it is very difficult to finish the curriculum, even with children that are bright and cooperative. Schoolteachers are under terrible pressure and are not in a position to devote much time to pupils who require special attention.

The mother believes, and she claims that this was confirmed by a doctor in hospital, that Power's hearing problem is related to his mental retardation. This is strange, because, according to her own account, the ear troubles started when he had left school already.

Apparently Power was very close to his father. They were together all the time and Power assisted his father, who was a mechanic. When the father died, Power was depressed for a long time. He would remain in bed without bothering to get up for days. Slowly he recovered. Now he is mainly involved in catching birds, fish and hare. He usually gives the fish to his mother to eat. He gives the birds to eat to younger children in the neighbourhood. He feels it is important for them to get this food because they still have to grow. Power likes to do things on his own, but sometimes he plays with the younger kids in the area. He is friendly to other people in the area as well, though in a rather reserved

way, i.e. when it suits him. People in the area laugh about him sometimes, but they do treat him with respect at the same time. They all know his sharp tongue.

During the first interview, Power told us that he had seen us several times earlier in the area. He could recall the time and place very accurately. He wanted to know exactly what our intentions were before he was prepared to answer any question. He wanted to know why we were making notes and why we were laughing. When we left he escorted us to the car, he arranged for one of the neighbours to get a lift to town and he gave me indications on how to turn the car on the narrow road.

One day, when we wanted to collect him to go to the clinic to get some treatment for his ear, he refused to come along. He could only be convinced with great difficulty. In the car he was timid and it is clear that he feared to go to the clinic. He wanted us to assure him time and time again that we would wait for him and that we would bring him back when he is ready. The family never consulted a traditional healer for Power. In the first place they believed that the cause of his condition is completely natural and 'God-given'. Secondly the mother is a Christian and does not believe in the power of ancestor spirits.

When asked, Power said he knows about girls and marriage but that he cannot possibly discuss these matters in front of a woman.

Case 21: Rhoda Chiberu

Rhoda Chiberu was identified as being mentally ill in 1986. At that time she was 50. Her mental problems started in 1976 and more members of the same family suffer from mental problems. Rhoda wanders around and it was not possible to establish contact with her or to ask her any questions. Sometimes she sleeps in her hut, which is very dilapidated, sometimes she sleeps in the open air. At the end of 1986 she disappeared from the scene completely and we did not see her again. Relatives visited a healer of the Apostolic Faith Church, who saw Ms. Chiberu at the bottom of a deep pool. According to the healer, Ms. Chiberu drowned in the pool when she wanted to drink, tired as she was from all her wanderings. In addition a mobile psychiatric team got involved with Ms. Chiberu's case. As far as could be traced, their intervention did not yield much success.

According to informants, the problems in the Chiberu family are caused by a *ngozi*. The family did not bother to appease the spirit and now more and more members of the family become affected. Now that she has drowned in a pool, her body will not be recovered. It is likely that Ms. Chiberu's spirit will become angry as well and will return to the family for revenge.

The family of Ms. Chiberu is split up. One part of the family lives in town, they do not visit the village any longer. The other part lives in the family home-stand. Their housing is bad and there was a year when they did not plant any maize.

Case 22: Cecilia Nyamitunga

Cecilia is 28. She is unmarried and she suffers from epileptic fits. Her parents divorced when she was young and she stays with her grandmother and a paternal aunt. She has a younger brother who also stays with the grandmother. There is another child, probably a stepbrother or sister, who stays with the mother in town.

Cecilia's problems started when the divorce of her parents was underway. Her arms were swollen and, according to informants, she had a swelling in/near the right frontal lobe. She was operated on this swelling in a hospital in town. It was a serious operation and people believed she would not recover from it. When she did, the epilepsy started. She visited school but had to stop due to the severity of the attacks. She was taken to various traditional healers, without success. The medication prescribed by the clinic was not very useful either. It had some effect initially, but the attacks always returned and they gradually became more severe. In addition the medication made Cecilia very dull.

While the relatives do not want to discuss the cause of the disability and the diagnosis brought forward by the traditional healer, informants in the area claim the cause to be related to the divorce of her parents. Some say it is witchcraft from the side of Cecilia's mother, others say it is a *ngozi* that takes revenge for wrongdoings of her father.

It is very difficult to convince persons with epilepsy in the rural areas of the necessity to take their tablets regularly and to keep a supply of tablets. Basically, they should be responsible themselves for taking the tablets, but when people suffer from longer attacks, it may be difficult for them to remember taking the tablets on those days. In most cases a relative should keep an eye on this. Cecilia does not have many people who are prepared to look after her medication and this makes her case difficult.

Cecilia is quite open about the fact that she longs to be married and would like to have a baby. There are men in the area who try to take advantage of this desire. Once a man of an adjacent ward was discovered in a promiscuous situation with Cecilia. In a miraculous way, Cecilia's father, who had not bothered

about his daughter for years, was informed about the matter. He returned to claim a head of cattle from the man in question as damage.

The relatives do not think that Cecilia will ever get married and, because she is not very capable to work in the fields, she is a burden to them. They were pleased when Cecilia joined an income-generating project for disabled persons in the area. Cecilia enjoyed her work in the cooperative. Although she was not a very productive member and hence earned only a little income, she liked the social contacts with her colleagues. However when she started to wander after working hours and did not bother to return home, her participation in the cooperative was jeopardized.

Cecilia used the money she earned in the coop to buy clothes. It became apparent that she did not always know how to deal with money. Once she went to the market in town and she gave all her money away to passers-by. She agreed now with her fellow coop members that they keep her money. In this way she does not have to give her relatives full account of the money she earns and she can spend much of it for her own benefit.

Case 23: Monica Murape: see Chapter 7.

Case 24: Mission Machipisa: see Chapter 8.

Case 25: Apollonia Rusere: see Chapter 6.

Case 26: Violet Mazire: see Chapter 7.

Case 27: Maxwel Mafure: see Chapter 7.

Case 28: Barbara Murwira

Barbara is 30 years old. From birth she has been unable to hear or speak. Her parents visited several traditional healers with her. They cut the muscle under her tongue. The parents believed that this muscle controls the speech and hearing as well. The treatment remained without effect and the parents accepted their daughter's condition as something 'God-given'. Barbara was never examined in a hospital or clinic.

At the age of 22, Barbara married. Her husband was aware of her disability but did not make any objection and a regular amount of *lobola* was paid. However after two years, when it became apparent that Barbara could not conceive,

the husband sued for divorce. Immediately thereafter Barbara was married to someone else, but only as a second wife. This condition was unbearable for her and she returned to her father's house.

Barbara is a very industrious woman. She is involved in various agricultural and craftwork activities from which she earns a reasonable income.

According to informants the condition of Barbara has a cultural cause. Some informants claim it is a *ngozi*, others claim it is a case of *kutanda botso*. The two explanations do not necessarily contradict each other. Informants agree that it is Barbara's mother's family that is behind her disability, and in particular the maternal grandmother. She has been mistreated one way or the other. Some say they do not know how she was mistreated and they say the spirit of the mother has come back as a *ngozi*. Others are more precise. They claim the grandmother is angry because she was not paid the obligatory cow by Barbara's father when he married her mother.

One of Barbara's brothers pointed at marriage problems between his parents. He believed that Barbara's deafness was caused because as a child she was dropped on the floor during a fight of the parents.

Case 29: Marvin Nyakudya

Marvin Nyakudya is 23 years old. He is considered to be mentally retarded and he has not reached a normal length. He is unmarried and he does not have children. He is the oldest son of a family of eight children, four boys and four girls. Their parents died some time ago and now the children fend for themselves. According to one of his younger brothers, Marvin has never been seen by a traditional or scientific healer. Only recently he visited a local clinic, because of in-growing eye lashes.

The brothers and sisters are reluctant to talk about Marvin, they seem to feel ashamed. Marvin himself is not very talkative either. He is not keen to go to a clinic and once he stated that he does not ever want to go to a *nganga*.

Marvin participates also in a cooperative for disabled persons. He enjoys the work and the company. He likes to buy clothes with the money he earns, but it is difficult for him to go to town independently.

Once during a trip to town, Marvin met a girl who also had had growth-problems. Later Marvin indicated to a friend in the coop that he would like to marry the girl. He was 'teased' by his coop members and by other people in the area with his girlfriend in exactly the same way other boys are teased with girlfriends and he enjoyed it.

According to informants in the area Marvin's condition is natural. 'A child like that is a gift from God.'

Case 30: Gwazi Zverumwa

Mr. Zverumwa is about 50. He is married and father of eight children. The case of Mr. Zverumwa was brought to our attention by members of the community. They considered him in need of rehabilitation. During our first visit, Mr. Zverumwa complained about boils and banjons on his feet and we referred him to the clinic. Later it became clear that he had a drinking problem and that he became rather aggressive towards his wife and children when drunk.

Mr. Zverumwa has lost the respect of the community, since he joined Smith's auxiliary forces during the war. At that time it was quite lucrative to join and he earned a good salary. He never had any problems to pay the school fees for his children in those days. Now he has lost the respect of the community.

It is generally believed, by himself, his relatives and the community members that the frequent boils have a cultural cause. Mr. Zverumwa visited a traditional healer, but he does not want to reveal the diagnosis. Neither his wife nor his children were present during the consultation, so they cannot inform us about the diagnosis either. Informants in the community relate the condition to a *ngozi* of a person whom Mr. Zveruma killed during the war.

Mr. Zverumwa is not involved in any farming. He leaves that to his wife and kids. Nor does he earn money in any other way. His older sons work in town and they maintain the family. Because of this situation the father is beginning to lose the respect of his wife and children. Both his wife and his sons insist that Mr. Zverumwa should be serious about treating the cultural cause of his problems (both the boils and the relational problems) and that he should be cooperative in performing the rituals required. The wife threatened that she will divorce him if he does not perform these rituals.

Samenvatting

Ongeveer 10% van de wereldbevolking is op de een of andere manier gehandicapt. In Afrika alleen gaat het daarbij al om 50 miljoen mensen, die grotendeels op het platteland wonen.

Mede binnen het kader van de UN decade van gehandicapten (1983–1992) wordt ook in ontwikkelingsprogramma's tegenwoordig aandacht aan gehandicapte mensen besteed. De onderzoekster is zelf geruime tijd in dit soort projecten werkzaam geweest en het onderzoek vormt daarop in zekere zin een reflectie.

Binnen de zorgverlening aan gehandicapte mensen zijn twee benaderingen in gebruik: institutionele of intramurale revalidatie en *community-based rehabilitation*, een specifieke vorm van ambulante, extramurale zorgverlening. Momenteel wordt op grond van ideologische en, overigens weinig steekhoudende, economische motieven, de extramurale benadering alom gepropageerd. Voor de implementatie van deze benadering is een grondige kennis van de geschiedenis en denkwijze van de samenleving waarin het project plaatsvindt een vereiste. In de praktijk ontbreekt dit inzicht echter vaak en in het onderzoek wordt een poging gedaan de ontbrekende informatie te leveren. Beschreven wordt hoe, met enige voorkennis van de geschiedenis en structuur van de gezondheidszorg in een gebied en met meer inzicht in de manier waarop gehandicapt zijn binnen een samenleving beleefd wordt, de hulpverlening aan gehandicapten op het platteland van Zimbabwe verbeterd zou kunnen worden.

In navolging van Kleinman worden voor deze beschrijving drie invalshoeken gebruikt:

- de invalshoek van de patiënt;
- de invalshoek van de (traditionele) genezer;
- de invalshoek van de traditionele samenleving als geheel.

Op grond van de beschrijving kunnen, globaal gesproken, drie groepen gehandicapte mensen onderscheiden worden, voor wie afzonderlijke zorgopties gelden:

- De geïntegreerden: een groep met een afgesloten ziektegeschiedenis die, ongeacht de aard van hun handicap, een duidelijk erkende plaats en positie in de samenleving innemen. Hulpverleningsprogramma's richten zich vaak

op deze groep omdat hier relatief eenvoudig successen te boeken zijn, maar eigenlijk heeft deze groep nauwelijks hulp nodig; sterker nog, hulpverlening aan deze groep kan stigmatiserend en tegen-productief werken.

- De marginalen: het gaat hier om een groep wier ziektegeschiedenis nog niet is afgesloten, er is in elk geval nog sociale manoeuvreerruimte, zelfs wanneer zuiver medies gesproken de mogelijkheden uitgeput zijn. Deze groep gehandicapten lijkt bij uitstek geschikt voor *community-based rehabilitation*. Zo nodig met behulp van een traditionele genezer, kunnen alle traditionele mogelijkheden benut kunnen worden om een positieverbetering voor hen te bewerkstelligen.
- De devianten: een groep wier ziektegeschiedenis, al dan niet door eigen toedoen, op negatieve wijze werd afgesloten en die uitdrukkelijk buiten de maatschappij is geplaatst en voor wie ook in het hiernamaals geen weg terug meer is. Deze groep gehandicapten behoeft eigenlijk de meeste zorg, maar ze zijn om verschillende redenen moeilijk te benaderen. Zij zijn wellicht het best geholpen met een institutionele benadering.

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In addition to the literature mentioned in this bibliography, use was made of documents and reference material in the National Archives of Zimbabwe and the library of the University of Zimbabwe. The documents and reference material are mentioned at the end of the bibliography. The literature study was carried out at many different libraries in S.E. Africa and the Netherlands. When compiling the bibliography it became clear that often different prints/editions of the same book or article were used. Although I tried to double check all page references of the quotations mentioned in the text, this was not always possible. I apologize for any incorrect references that appear in the text because of this.

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 N 1.1.9., 1897;
 N 3/13;
 NSA 2/1.1.; 2/2/1; 2/3/1; 2/4/1;
 S 138/48, 1923-34; S 246/228, 1937;
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